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Zurich, June 2009

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EDITORIAL

Dear colleagues,

things develop peacefully and constantly in IFP. We enjoy a cooperative spirit and are preparing the new epoch for IFP. About all the actual ongoing Prof. Schnyder in his function as president will again give you interesting information in detail. The main business now is the preparation of the next years 20th World Congress in Luzern, Switzerland.

Some of the scientific work of our president is devoted to the evaluation of psychotherapy with the aim to ascertain high quality psychotherapy for our patients. Prof. Schnyder had several occasions where he could present his view and discuss it with many other professionals. In the paper which he submitted upon request he put together his ideas about the benefit and limitations of evidence based psychotherapy. The need to continue in developing new approaches in psychotherapy may come into conflict with this policy – you will find good suggestions how to deal with this bias.

Once more I want to express my invitation to feel free to submit papers or any information of interest for our members to this journal. Our next edition is planned for November!

Best wishes and greetings from Vienna and Zurich

Alfried Längle

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President's Message

Dear friends and colleagues

The most important news this time is that the IFP has a new President-elect! **Professor Franz Caspar, PhD**, of Bern, Switzerland, was unanimously elected **President-elect** by the IFP Council in November 2008. Congratulations, Franz, and all my very best wishes for a successful presidential term!

Franz Caspar is currently Professor for Clinical Psychology and Psychotherapy, University of Bern. His previous affilitations include the chair of Clinical Psychology and Psychotherapy, University of Freiburg, Germany (1999-2005), and the chair of Clinical Psychology and Psychotherapy of the adult, University of Geneva (2005-2007). He is a Past President of the Society for Psychotherapy Research (SPR). He is also a member of the Steering Committee, and Chairman of the Research Committee of the Society for the Exploration of Psychotherapy Integration (SEPI). He is an internationally renowned psychotherapy researcher, and very well respected in the scientifc community. As you all will learn soon, he is also a very likeable person. There is no doubt the IFP will have a very strong next President!

Professor Caspar has already assumed office as a member of the IFP Board. At the General Assembly which will be held during the 20th IFP World Congress of Psychotherapy in Lucerne, Switzerland, in June 2010, he will be formally elected. At the end of the Lucerne Congress, Franz Caspar will take over as President of the IFP for the following four years.

The planning of the **20th IFP World Congress of Psychotherapy** in Lucerne, Switzerland, 16.-19.6.2010 is well under way. The majority of plenary speakers are already confirmed. A number of additional, specially featured sessions such as key issues debates and pre-conference workshops, etc. are currently being planned. A professional Conference Organizer („Organizers“: http://www.organizers.ch) has been contracted, and a Congress website is operational as of now, informing you on the progress of our planning: please visit the Congress website at www.ifp-fmpp2010.com! The call for abstracts will be published in August this year.

Our World Congress will be organized by the Foederatio Medicorum Psychiatricorum et Psychotherapeuticorum FMPP (http://www.psychiatrie.ch), which is an umbrella organisation that unites the Swiss Societies for Psychiatry and Psychotherapy, both for Adults as well as for Children and Adolescents. The conference is also co-sponsored by the World Psychiatric Association WPA. The venue will be the „KKL Luzern“, the Culture and Convention Centre Lucerne (http://www.kkl-luzern.ch): This magnificent building was designed by French architect Jean Nouvel. Built between 1995 and 2000, the KKL ranks today as one of the most spectacular modern buildings in Switzerland. The KKL Luzern is centrally located in the town of Lucerne, directly on Lake Lucerne and right next to the railway station. The old town centre is only a few hundred yards from the KKL Luzern, as is Lucerne's distinctive landmark, the Chapel Bridge.

In my capacity as chair of the scientific program committee, however, I would like to convince you that, apart from Lucerne's great touristic appeal, it will be worthwhile from a scientific viewpoint, too, to attend the 20th World Congress of Psychotherapy! The theme will be **"Psychotherapy: Science and Culture"**. Wen-Shing Tseng, President of the World Association of Cultural Psychiatry, and one of the plenary speakers of this conference, defines culture as a dynamic concept referring to a set of beliefs, attitudes, and value systems, that derive from early stages of life through enculturation, and become an internal mode of regulating behavior, action, and emotion. Thus, culture is not static, but changing continuously across generations, responding to ever-changing environmental demands. Culture-sensitive, culture-competent psychotherapy involves trying to understand the cultural components of a patient's illness and help-seeking behaviors, as well as the patient's expectations with regard to treatment.

Psychotherapy, however, is also a scientifically based treatment. It is practised by academically trained professionals who use empirically supported therapies wherever possible in order to improve their patients' health status and well-being. Given the development and maturation of the field, psychological, neurobiological, and other basic scientific knowledge is required to understand and appropriately treat mental disorders. Thus, psychothera-

pists are increasingly confronted with the challenge of developing their skills in interdisciplinary and interprofessional communication and knowledge management. In other words, psychotherapists have to constantly engage in mutual, transcultural and interprofessional learning, for which this conference provides a unique opportunity!

While the conference theme will be used to highlight certain issues we intend to focus on, we don't want to be exclusive. Our general aim will be to better understand what our patients are struggling with, and how to treat them. Furthermore, apart from looking into psychopathology and other forms of psychosocial dysfunction, the conference will also address issues such as salutogenesis, resilience, and post-traumatic growth.

Under the guidance of Dr. Sylvia Detri Elvira, a member of the IFP Council, the Indonesian Psychiatric Association Section on Psychotherapy will hold their **3rd National Conference on Psychotherapy in Indonesia** on May 1-2, 2010. The theme of the conference will be „The healing power of understanding: its strength and its limitation". Please feel free to contact Dr. Sylvia Detri Elvira (sylvia.d.elvira@gmail.com) for more information!

The Asian Pacific Association of Psychotherapists APAP keeps being active as well: The Philippine Psychiatric Association will host the **6th APAP conference in Manila, Philippines**, in January 2011. Dr. Alma Jimenez and Dr. Maria Imelda Batar, President of the Philippine Psychiatric Association, will be jointly instrumental in organizing this conference.

I am very pleased, indeed, to announce that we now have a second Chinese membership society: The application for membership of the **Committee of counseling and psychotherapy, China association for mental health** was approved by the IFP Council in November 2008. A very warm welcome to Professor LÜ Qiuyun, MD, president, and Professor Xudong Zhao, MD, president-elect, and to all members of the Committee of counseling and psychotherapy, China association for mental health! I am looking forward to a long and fruitful collaboration!

The **Secretarial Office in Zurich** is running smoothly under the watchful guidance of Cornelia Erpenbeck. She is responsible for all administrative matters concerning the IFP and may be contacted at her office should there be any queries. To further optimize the visibility of the IFP, I would like to encourage all our members to introduce a link to the IFP website (http://www.ifp.name) on your respective homepages. We would be happy to do so vice-versa: please feel free to approach Cornelia Erpenbeck in case you need a hand!

IFP-sponsored master classes, workshops and seminars: The aim of these events is threefold, namely to help disseminate novel, evidence-based psychotherapeutic approaches, to raise the international profile and recognition of the IFP, and to recruit individual IFP members, thus generating income for the IFP. An extremey successful workshop on Positive Psychotherapy was held with Professor Nossrat Peseschkian (Germany) on Positive Psychotherapy in Zurich, January 16-17, 2009. Also, we organized a seminar on CBT for Eating Disorders with Professor Chris Fairburn (UK) in Zurich March 27-28, 2009. With close to 60 participants, this workshop was a great success as well. More IFP-sponsored master classes, workshops and seminars to follow! For further information, please visit our website at http://www.ifp.name.

Collaboration with other international societies: There is an ongoing collaboration with the European Psychiatric Association EPA: Professor Möller, EPA President, and Professor Sartorius, a member of the IFP Council, invited me to be one of the speakers in the Presidential Symposium on ethical issues in psychiatric treatment organized during the forthcoming European Congress of Psychiatry in Munich, 27 February – 2 March 2010. The Presidential Symposium has now become a tradition, regularly dealing with ethical issues related to the theme of the congress. I will be giving a talk on „Ethical problems related to the use of psychotherapy".

Finally, as always, all our members, meaning individual members of the IFP as well as individual members of associations who have membership status with the IFP, are offered the IFP's official journal, "**Psychotherapy and Psychosomatics**", at a substantially reduced subscription rate. For details, please contact S. Karger directly at:

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Best regards

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Mission Statement

1. The IFP is a worldwide umbrella organisation for psychotherapy. The Federation is open to professional societies, institutions and individual members.
2. The IFP aims to promote, endorse and maintain high professional and ethical standards of psychotherapy in practice, research, and training.
3. The IFP fosters a worldwide intercultural, interdisciplinary dialogue and mutual learning among psychotherapists, psychotherapy researchers, psychotherapeutic orientations, traditions, and related sciences.
4. The IFP provides a platform for the development of theories, methods and treatment approaches, and promotes the integration of psychotherapeutic thinking in clinical and non-clinical fields.

The IFP realizes its aims by means of

- World congresses (every four years)
- Regional congresses
- Supporting and co-chairing the organization of scientific congresses of their members and/or national umbrella organisations (and under certain conditions supporting them also logistically and financially)
- Supporting scientific activities in research, practice, and training, particularly activities of intercultural relevance
- Information transfer by constantly updated homepage and newsletters

Psychotherapy benefits from diversity - evidence versus creativity

Ulrich Schnyder, MD, Zurich, Switzerland

"Take nothing on its looks; take everything on evidence. There's no better rule."
(Charles Dickens, Great Expectations, 1861).

Abstract
To date, the effectiveness of psychotherapy for the treatment of most mental disorders is empirically well documented. From an "evidence-based medicine" viewpoint, psychotherapy, as compared to other treatments in medicine, can be regarded as one of the most effective therapeutic approaches. The superiority of psychotherapy over pharmacotherapy is particularly pronounced in long-term treatment outcome studies. It is especially cognitive behavioral (CBT) approaches, such as exposure response management and cognitive restructuring, that have shown strong evidence of their efficacy and effectiveness in various populations and settings. However, evidence-based medicine is by definition oriented towards the past, as it only informs us about the well-established, empirically supported treatments. If we rely only on the currently available scientific evidence, new developments will be blocked. Since, for instance, many patients decline treatment, or do not seek professional help at all, there is a need for improvements regarding acceptance of established therapies. In addition, in the field of psychotherapy as elsewhere in medicine, there ought to be scope for new, creative approaches, for which scientific evidence is not yet available.

1 Introduction

What has psychotherapy got to do with creativity and evidence? Is there such a thing as psychotherapy without creativity? Is it possible to transpose the demands of "evidence-based medicine" to the field of psychotherapy in the sense of "evidence-based psychotherapy"? Are the two approaches not mutually exclusive – in other words is creativity in psychotherapy not stifled by a unilateral focus on evidence? Or does evidence not get lost if we understand psychotherapy excessively one-sidedly as an "art" alone, whose effectiveness it is not possible to capture and measure with scientific methods? Let me state at the outset that I regard these questions as rhetorical. If psychotherapy is to continue to have a place in our health-care system as a scientifically based therapeutic approach for treating mental disorders, then both of these aspects are going to need to be nurtured in future. We must be willing to face up to the justified questions regarding effectiveness; we must develop suitable methods of investigation adapted to the field; and we have to make sure that effective methods are encouraged and disseminated and that ineffective approaches are abandoned or modified. We must, however, also leave space for creative further developments and new developments, because a unilateral fixation on the principles of evidence-based medicine would spell the end of any form of development.

The first thing I want to do in this paper is to show where we stand today as regards the effectiveness of psychotherapy. I follow that by commenting on evidence-based medicine in general and the concept of evidence in psychotherapy in particular. Finally, my last section presents a number of examples of creative further developments or new developments in the field of psychotherapy, which hold out considerable promise for the future.

2 Psychotherapy: where do we stand today?

2.1 What is psychotherapy?

According to Senf and Broda's textbook on integrative psychotherapy (Senf and Broda 2005), psychotherapy is a scientifically-based form of professional action within the framework of the public health-care system and in accordance with its rules. Psychotherapy positioned in this way is based on scientifically comprehensible and empirically supported theories of illness, healing and treatment. Even during this first part of their definition, it is becoming clear that the authors are formulating an ideal view, which we are still far away from in practice. Moreover, according to Senf and Broda, psychotherapy is characterized by the fact that it uses theoretically derived and empirically supported procedures, methods and settings to bring about a targeted change in experience and behavior to treat or prevent illnesses, disorders or complaints, whose cause is wholly or partly psychological. Such a procedure presupposes a thorough diagnosis and a differential diagnosis as well as a qualified differential indication. Moreover, psychotherapy is practised

with treatment targets formulated beforehand and evaluated afterwards. As things stand today, not all of that has yet become a matter of course, since it happens by no means infrequently in practice that treatments are started without the therapist and the patient spending the initial sessions working together, in a spirit of partnership, to establish a consensus as to “what the problem really is”, what target or targets they are going to set for the treatment and what criteria they are going to apply at the end of it to appraise its success. At the end of their definition, Senf and Broda stress that psychotherapy is conducted by professional psychotherapists, whose professional qualification has been demonstrated through examination, maintains ethical principles and standards and, finally, satisfies measures of quality assurance and adheres to the economic imperative (Senf and Broda 2005). The wording of Swiss legislation is fairly close to the formulations of the two German authors in that it demands, for instance, that psychotherapeutic treatments follow the requirement of effectiveness, suitability and cost-consciousness, if the outlay is to be defrayed by the compulsory health-insurance schemes.

From the above, it follows that a scientifically based psychotherapy is rooted in empirically supported theories of illness, healing and treatment. It applies theoretically derived and evidence-based procedures to try and bring about a deliberate change in the experience and behavior of patients and, in so doing, treats or prevents illnesses, disorders and complaints whose cause is wholly or partly psychological.

2.2 Does psychotherapy work and, if so, how?

If we now move on to compare psychotherapy with other forms of medical treatment, it soon emerges that psychotherapy can be considered as one of medicine’s most effective therapeutic approaches. By no means does psychotherapy need to hide away, for instance, from the comparison with drug-based therapies or surgical treatments. Taking the example of prescribing acetylsalicylic acid to prevent cardiac infarction, that has an effect size (treated versus untreated) of .07. Medication for rheumatoid arthritis scores .61, which is already in the mid-range of effect sizes, whereas aorto-coronary bypass surgery has a high effect size of .80. The effect size of psychotherapy is .88, which is within the same order of magnitude – and that is taking all psychotherapeutic approaches together. If the cognitive behavioral therapies are considered separately, their effect size is as high as 1.21 (Grawe et al. 1994; Howard et al. 1994; Lutz 2003a; b).

So we know today with a good level of precision that psychotherapy is a very effective procedure for treating mental disorders. However, we know more than that. There is good evidence, for example, that most of the therapeutic effect is achieved with the majority of mental disorders within the first ten to twenty therapy sessions. This concerns not only the reduction in symptoms, but also the improvement in the subjective feeling of wellbeing and the psychosocial functional level of the patients treated (Lutz 2003a; Lutz et al. 2001). On the other hand, we also know that there are people with very complicated, chronic mental disorders, such as severe personality disorders, who need long-term psychotherapy, sometimes even therapeutic accompaniment throughout the whole of their lives. In a meta-analysis carried out recently, Leichsenring and Rabung showed that such patients can achieve a measurable therapeutic gain from psychodynamically oriented long-term psychotherapy (Leichsenring and Rabung 2008). There is also good evidence for the long-term stability of the results once the psychotherapy has been completed. However, it ought to be added that this applies, in particular, for cognitive behavioral therapy, but much less so for psychodynamic treatments and relaxation techniques (Margraf 2009). Yet another limitation ought to be added too, namely that, just like any effective method of healing, it is possible for psychotherapy to produce unexpected, adverse side effects. Moreover, it also has to be admitted that we still know too little about gender-specific differences and also about the effect of psychotherapeutic interventions on patients from underprivileged parts of society, such as those with a migration background.

In evidence-based medicine, randomized controlled trials (RCTs) are regarded as the gold standard when it comes to testing the effectiveness of a therapeutic procedure. Many of the findings referred to already, for instance, were established through RCTs. One of the preconditions for performing an RCT is the existence of a treatment manual, in which the therapeutic procedure is described with the greatest possible accuracy (more on that subject in Section 3). However, there are many psychotherapists who reject the use of a treatment manual,

because they believe that it is going too far in standardizing the therapeutic process and might even jeopardize it. Psychotherapy, they say, is an art, a creative process that ought not to be impeded by using "recipes" like out of a cookery book. Such an attitude is comprehensible if considered against the background of the perception of the profession that western psychotherapists have today and the way in which they are socialized within it. Psychotherapists see themselves as free, creative entrepreneurs responsible for their actions. They are thus not really able to identify themselves with the role of the loyal follower of manuals developed by academic researchers. From the scientific perspective, however, there are virtually no valid arguments that can be put forward in favor of such an attitude. Schulte, by way of example, showed that standardized manual-based treatments lead more frequently to extensive or even complete remission of symptoms than do customized, individualized ones (Schulte 1991).

2.3 Inadequate dissemination of effective therapies

Despite all these positive reports on the effectiveness of psychotherapy, one big problem still persists: those therapeutic approaches whose effectiveness has been scientifically proven are still used much too little in everyday clinical psychotherapeutic practice. This was brought out, for example, in a large representative study carried out in Switzerland into the treatment of anxiety and depression to establish which therapeutic approaches were actually used in real routine practice. It emerges from its results that patients with anxiety and depressive disorders were only relatively rarely given treatments whose efficacy was well documented (cognitive therapy and behavioral therapy: 12%, hypnosis and relaxation techniques: 39% of all cases), and that, by way of contrast, counseling and psycho-pharmaceuticals, which have been demonstrated to promise less lasting success, were used to treat these mental disorders very much more frequently, to be precise in 70-90% of all cases (Margraf, in preparation). Anxiety and depressive disorders, two mental disorders with very high lifetime prevalence, can be considered in this context as representative of most mental disorders, for which psychotherapies are available with very good documented evidence of effectiveness, based on a large number of randomized controlled trials. It has been known for a long time that only a small percentage of patients suffering from anxiety or depressive disorders are treated by adequately trained specialists. The study just mentioned shows us, moreover, that, of these few patients who have access to professional treatment, only a small proportion, in turn, benefit from evidence-based therapies.

Those of us living in the so-called "western" world, particularly in Europe, find ourselves faced with a somewhat strange situation. There are many good, fully trained and clinically experienced psychotherapists working in specialized institutions or in private practice. Today, very effective treatment options are available to us for the most frequently occurring mental disorders, and most people have a health insurance which would cover a large part of the treatment costs. Yet most sufferers of mental disorders are either not receiving any professional treatment at all, or the effectiveness of one they are receiving is not scientifically proved.

3 Use of the term "evidence" in psychotherapy

It has become popular to talk about "evidence-based medicine", and there can be no doubt that, in future, in the field of psychotherapy, too, there will be more and more questions asked about the extent to which empirical support exists for the effectiveness of a given therapeutic technique. What, however, do we mean precisely when we use the word "evidence" and what are "empirically supported therapies"? Chambless and Hollon postulate that the following criteria would have to be met for a therapeutic approach to be allowed to call itself genuinely "evidence-based" and/or "empirically supported": the efficacy of the approach must have been demostrated by a series of RCTs; these RCTs must have been performed with appropriate samples and control groups; the samples must have been adequately described; valid and reliable outcome assessments must have been used; and, finally, the results must have been replicated by at least one independent group of researchers (Chambless and Hollon 1998).

3.1 Randomized controlled trials (RCTs)

Foa and colleagues make the point that the use of more rigorous scientifc methods in psychotherapy outcome research has increased dramatically in the course of the past 25 years. As a representative example, they describe for the field of traumatic

stress research the following features a well-controlled trial should have (Foa et al. 2009; Foa and Meadows 1997):

- Clearly defined target symptoms: it is essential to begin by clarifying which psychopathological symptoms or syndromes are to be treated. Based on this, appropriate measures can be selected to assess improvement. Diagnostic status should be ascertained, and a threshold of symtom severity should be specified for inclusion into the study. Moreover, additional inclusion and exclusion criteria must be clearly articulated.
- Reliable and valid measures: Research instruments with good psychometric properties should be employed. For studies targeting a particular diagnosis, instruments should be used that allow to establish reliably both the (dimensional) symptom severity as well as the (categorical) diagnostic status over the course of time.
- Use of blind evaluators: First, the evaluator should not be the same person conducting the treatment. Second, patients should be trained not to reveal their treatment condition during the evaluation, so as not to bias the blind evaluator's ratings.
- Assessor training: The quality, i.e. the reliability and validity of psychometric measurements depends to a large extent on the skills of the investigators. Such quality can only be guaranteed through a thorough training of raters provided by a member of the research team with clinical experience. Interrater reliability (i.e. the comparison between several investigators in the same study) needs to be demonstrated to ensure that the quality of measurements remains constant throughout the study, and repeated calibrating assessment procedures must be applied to prevent "evaluator drift".
- Manualized, replicable, specific treatment programs: the use of a detailed treatment manual is important to ensure consistent treatment delivery across patients and across therapists. Treatment manuals are also indispensable for the replication of a study by independent research groups. Only if these conditions are satisfied it will be admissible to draw conclusions regarding generalizability.
- Equipoise with regard to treatment condicions: If more than one active treatment is involved in the comparison ("active-active control"), study therapists must be equivalent regarding their professional background, clinical experience, allegiance, and training. They must also receive equivalent amounts of supervision in each model throughout the trial.
- Unbiased assignment to treatment: As far as possible there should to be no difference between the comparison groups regarding factors that might influence the course of the therapy. Neither patient nor therapist should be allowed to choose the patient's treatment condition. Instead, a patient should be assigned randomly to a treatment condition, or via a stratified sampling approach. That is the only way to prevent the occurrence of systematic bias in the assignment to groups. In addition, each treatment modality should be delivered by at least two therapists as a means of distinguishing between the effects of the treatment and the effects of the therapist.
- Treatment adherence: The purpose of treatment adherence ratings is to determine whether the treatments are performed as planned, and whether components of one treatment condition drifted into another.
- Data analysis conducted according to accepted procedures: All participants who were randomized and who received treatment should be included in all data analyses. Including only "completers" can potentially bias outcomes. In clinical reality, there will always be some patients who drop out of treatment before its end. Therefore, "intent-to-treat" analyses are the best way to comprehensively understand the effectiveness of a treatment.

3.2 Efficacy versus effectiveness

In assessing the usefulness of a given psychotherapeutic intervention, the scientific literature often distinguishes between efficacy and effectiveness. The purpose of efficacy studies is to examine whether or not an intervention has an effect in ideal conditions – almost laboratory conditions – in which all the influences can be measured and monitored with precision. It is clear that such a research design is bound to have an influence on the selection of study participants; it may happen in such trials that the patients are not representative of the everyday clinical situation or only partially so. The research design for efficacy studies stresses internal validity, and for this purpose it is common to perform only a completers analysis. If such a trial is carried out in properly controlled conditions it may, however, supply valuable information as regards the specificity of the intervention.

Effectiveness studies are different in that they ask the question as to whether or not a particular intervention produces an effect in real clinical conditions. It thus follows that the patients selected for the trial ought to be more representative of the everyday clinical population. This sort of study design stresses external validity. As already mentioned, it is typical for effectiveness studies to perform intent-to-treat analyses. The restriction, however, is that such trials provide only limited information on the specificity of an intervention. So both study designs have their specific advantages and disadvantages. It would thus be wrong to want to play them off against one another when appraising them. On the contrary, it is possible for them to complement one another in a meaningful way, quite apart from the fact that case studies, naturalistic studies, process research and other approaches are capable of adding important additional information to the overall judgment of a therapeutic approach. The situation today, however, remains that randomized controlled trials represent the unchallenged gold standard for the scientific appraisal of the effectiveness of a psychotherapeutic intervention.

The methodology of randomized controlled trials was originally developed for testing the effectiveness of new pharmaceutical drugs. The usual practice in pharmacology is to begin by developing a new molecular entity in the laboratory and then to determine its mode of action. After that, efficacy trials are performed to test whether the new substance works in controlled (laboratory) conditions. Finally, effectiveness trials are carried out to investigate whether or not the compound continues to perform positively in clinical practice. In psychotherapy research, the process is frequently rather different. The first event to occur is often an innovative, attention-grabbing case study, in which a creative mind reports on initial experience with a new therapeutic intervention. Others pick up the idea and investigate it with greater precision in open trials using case series. In this way, the initial effectiveness information is gathered. Now, it is only once it has been shown that the intervention has something positive to offer in clinical practice that the first controlled trials are carried out with randomized research designs. As a general rule, it is only in the subsequent stage of research that attempts are made to understand the mechanism of action more precisely and to "separate the wheat from the chaff" by performing dismantling or component control studies. These may, for instance, serve to identify ineffective treatment components, which can then be discarded when the treatment manual is revised.

3.3 Dissemination of evidence-based therapies

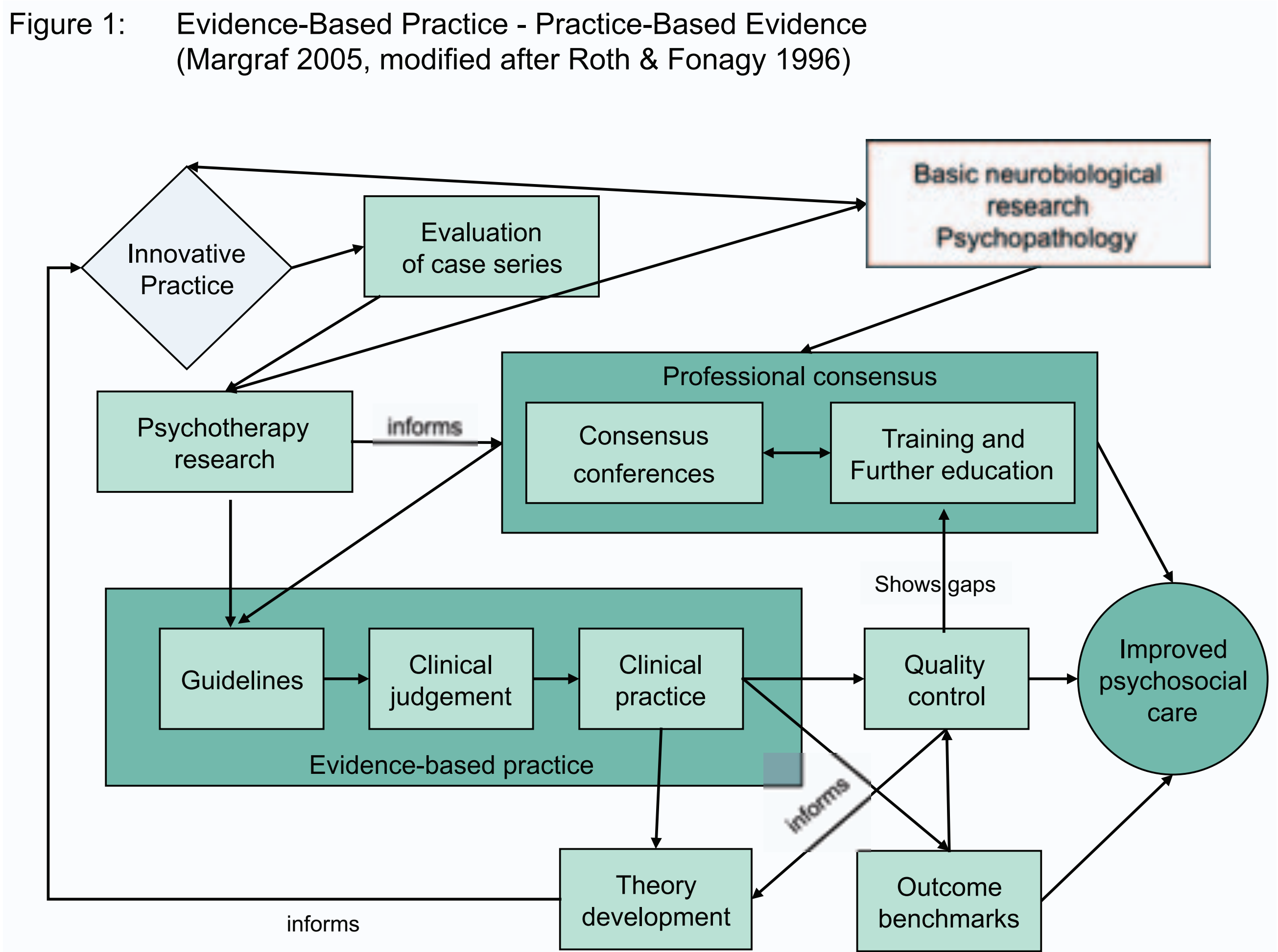
Now is the time to return to the problem already mentioned that, although very effective means of psychotherapeutic treatment are available to us today for the commonest mental disorders, must sufferers of mental disorders either receive no professional treatment at all or, if they do make their way into professional hands, the therapy they are given will often not be one for which there is empirical support. Is there an underlying explanation for this situation?

One reason is that today most psychotherapists are still not adequately trained in empirically supported treatments. A second reason, as has already been mentioned, is that many psychotherapists do not like working with treatment manuals; in most cases, they have had no experience of so doing and are afraid that following treatment steps laid down in a manual will constrain them from giving free rein to their creativity, so that their patients will not be treated as well as they might have been. The other side to this is that both patients and the organizations that fund treatments are more and more demanding the use of evidence-based procedures. The triumphant advance of evidence-based medicine and "informed patients" (who, to be frank, are the ones we prefer to see) leave us with no choice. In future, we are increasingly going to have to face up to the question as to the extent to which the effectiveness of our therapeutic interventions has been borne out by empirical evidence.

So, evidence-based medicine is going to shape our everyday lives as therapists more and more. However, having said that, it would be a massive mistake to forget that evidence-based medicine does no more than state the situation as regards empirically supported therapies. Evidence-based medicine is thus, by its very definition, based on, and oriented towards, the past; it informs us of the results that have been produced by research up until the present day. If a new intervention has not been empirically researched up until the present, it does not mean that it is not effective – merely that, for the time being, there is still no scientific evidence of its effectiveness.

A greater dissemination of evidence-based therapies in clinical practice is absolutely indispensable. However, if we simply rely on the principles of evidence-based medicine and leave it at that, things will come to a standstill and creative further developments and new developments will be rendered impossible. Genuine scientific progress is only possible if there are creative therapists and researchers who are repeatedly willing to risk trying out new ideas. By very definition, new is not something that can yet be empirically supported. All the therapies that are today considered to be scientifically established were new once upon a time, and there was then still no empirical evidence to support them. That is why it must continue to remain possible today for new discoveries to be made. However, these innovations must, in their turn, face up to critical scientific scrutiny. If sober examination proves that they are ineffective, we must abandon them again, no matter how attractive and promising they might appear to be. If they are effective, these new developments will sooner or later make their way onto the palette of treatments from which the therapist can choose – perhaps as a totally new approach in their own right, perhaps as a new technique or perhaps as a complement to existing interventions.

The field of psychotherapy as a scientifically rooted method of healing is only going to develop further if we manage to subject those procedures that are not yet adequately empirically supported to a critical scientific examination, to improve its existing evidence-based methods in stages – but with determination – and to take seriously any new impulses, which usually come into being as the result of creative therapeutic activity. Evidence and creativity must not be allowed to be mutually exclu-



sive! It is only out of a suitable balance between sober empirics, on the one hand, and playful creativity, on the other hand, that genuine scientific progress can emerge!

Roth and Fonagy, too, place their faith in innovative practice at the beginning of a feedback loop – actually one with several sub-loops (Fig. 1), within which the field of psychotherapy develops further in accordance with the motto of "evidence-based practice – practice-based evidence", resulting, in the final analysis, in improved psycho-social care (Roth and Fonagy 2004). They see innovative practice as stimulating the evaluation of case series. New concepts emerging from this are taken up by psychotherapy research and investigated in randomized controlled trials. The results of this research are fed into professional consensus conferences and have their impact on the development of guidelines. When the latter are, in turn, put into effect, they change clinical practice and lead to an improvement in clinical care through quality-control measures. In addition to that, they also bring about adaptations in training at all levels (initial, advanced and continuous). The experience from clinical practice combined with data from quality management might then provide the occasion for a new round of innovative adaptations in the way patients are dealt with clinically, and, in that way, the creative circle will have completed its 360°. Additionally, the process is also sustained and driven forward by external stimuli and inputs, originating, for instance, in basic neurobiological research or psychopathology.

4 Creative developments

Progress and further developments are not of themselves, however, sufficient reasons for psychotherapy to keep moving ahead. If existing psychotherapies are as effective and successful as stated above, why should there be any need at all for progress? Is it not possible to consider psychotherapy as a form of treatment that has reached maturity? Would it thus not be our priority to make sure that the effective interventions were disseminated as widely as feasible, so that as many patients as possible would be able to benefit from them? Yes, but there are still several good reasons (Schnyder 2005) militating in favor of further enhancements in the spectrum of psychotherapeutic interventions as well as continuing with developments, additions and extensions to this spectrum. Apart from that, trying to stand still in this field would mean retrogressing, since alternative approaches, such as pharmacotherapy, are currently developing in a particularly dynamic manner. Here are some of those reasons:

- Not all patients are willing to subject themselves to an empirically supported therapy. Exposure, for example, is considered today to be the treatment of choice for most anxiety disorders and also for obsessive compulsive disorders. There are, however, patients who, for comprehensible reasons, cannot agree, at least at a given point in time, to undergo confrontation therapy of this nature.
- The overall dropout rates for empirically supported therapies are approximately 20% (Ballenger et al. 2000). A patient's dropout may occasionally reflect their severe psychopathology that had been underestimated before commencement of the treatment. Discontinuation of treatment is very often the expression of a failed therapeutic alliance. Then again, it might also point to the therapeutic method being unsuitable for this patient in this situation. In all these circumstances, it is good to have therapeutic alternatives available to offer to patients.
- Around 50% of the patients who complete an evidence-based treatment with success and with a clinically relevant reduction in symptoms, still satisfy the diagnostic criteria for the disorder that took them into the treatment to begin with (Resick et al. 2002; Tarrier et al. 1999).
- Another finding, which is probably even more important, is that around 50% of these patients do not manage to attain a satisfactory psychosocial functional level, even if their symptoms have ebbed perceptibly in the context of their therapy (Marks et al. 1998; Resick et al. 2002). Many of these patients are still impaired as regards their ability to do employed work, the quality of their relationships and their general satisfaction with life.
- One final point is that there is still too little on offer today for patients who do not find their way into psychotherapy, for reasons such as not finding a therapist speaking their language, not being able to attend a psychotherapeutic practice once a week on account of a physical disability, or fearing stigmatization on account of their exposed position within society.

Against the background of all the reasons just outlined, the following sections go on to present a number of examples of creative further developments or new developments. These are worthy of discussion,

since they have the potential of contributing to more finely tuned differentiation amongst the possible psychotherapeutic interventions available to us.

4.1 Mindfulness and acceptance

The “mindfulness-based therapies” are certainly to be counted amongst the most important further developments and additions to cognitive behavioral therapies in recent years (Hayes et al. 2004). The Buddhist idea of “sati” translates as “carefulness” or “mindfulness”, but also as “contemplation”, “recollection” and “memory”. As Buddhists understand it, mindfulness means being fully conscious in the present, without passing any judgment, being just “a witness at one with oneself”. Buddhism distinguishes between four foundations of mindfulness:

- contemplation of body
- contemplation of feelings and emotions
- contemplation of mind, and
- contemplation of mind-objects.

Zen Buddhism came into being sometime around the fifth century A.D., originally as a reform movement, stressing the central significance of meditation. The western world was unaware of the existence of Zen until the nineteenth century, after which it was gradually introduced to it, inter alia, through Schopenhauer’s philosophy and various publications in Germany from 1920 onwards. The first direct contacts between Zen and psychotherapy came about through meetings between Carl Gustav Jung, Erich Fromm, Charlotte Selver and Fritz Perls, on the one hand, and Zen Buddhists, on the other hand, in the USA.

The name of Jon Kabat-Zinn has gone down in history on account of a phenomenon that took place in the western world and which could possibly be called the “secularization” of mindfulness. Kabat-Zinn detached mindfulness from its Buddhist context and developed a form of training in mindfulness meditation as a complement for treatment of chronic pain, known as “mindfulness-based stress reduction” (Kabat-Zinn 1990).

It was about ten years ago that cognitive-behavioral therapy took up the notion of mindfulness and integrated it as an addition in its therapeutic concepts, which up until then had been comprised almost exclusively of strategies focused on bringing about changes. “The good in the bad” was re-discovered as a paradox and acceptance of facts as facts was seen as the real basis for genuine change. After the “cognitive shift” of the 1980s and the “emotional shift” of the 1990s, the integration of elements based on mindfulness in the first decade of the 21st century is referred to as the “third wave” (or “shift”) in cognitive-behavioral therapy. In the meantime, mindfulness-based cognitive therapy (MBCT) has built up good evidence of its effectiveness for major depression, treatment-resistant depressions and residual depressive symptoms (Ma and Teasdale 2004; Teasdale et al. 2000). Other mental disorders are currently undergoing evaluation.

4.2 Well-being therapy

On the basis of Carol Ryff’s multidimensional, cognitive model of “psychological wellbeing” (Ryff 1989; Ryff and Singer 1996), Giovanni Fava developed a short, manual-based psychotherapy, to which he gave the name of “Well-Being Therapy”. Conceptually, this differs enormously from traditional psychotherapeutic approaches. In a course of eight clearly structured psycho-educative, directive therapy sessions focused on solutions, the therapist does not talk to their patient about problems, burdens or psychopathological symptoms. On the contrary, the focus is solely on enhancing the patient’s sense of wellbeing (Fava et al. 1998a). The aim of the treatment is to achieve an improvement in the following six dimensions:

- Environmental mastery
- Personal growth
- Purpose in life
- Autonomy
- Self-acceptance, and
- Positive relations with others.

The techniques used are tried-and-trusted elements from cognitive-behavioral therapy: self-observation, keeping a structured diary, cognitive restructuring, problem-solving strategies, self-assertiveness training, planned activities for mastering daily life, leisure and homework. Well-being therapy has been used successfully for preventing relapse in recurrent depression (Fava et al. 2004; Fava et al. 1998b). However, it also appears to perform very well for treatment-resistant depressions and anxiety disorders as well as for psycho-somatic disorders and post-traumatic stress disorders (Belaise et al. 2005).

4.3 Cognitive enhancers

D-cycloserine is a substance that was developed in the 1950s for the treatment of tuberculosis. It was

only recently discovered that D-cycloserine can also have a positive influence on cognitive capacity and, in particular, learning behavior. It was demonstrated that a single dose of 50 mg of D-cycloserine significantly improves the effect of an exposure session for treating fear of heights (Ressler et al. 2004). This effect appears to come from the substance's properties as a partial glutamate receptor agonist. It has also been administered successfully to augment CBT interventions for other anxiety disorders, post-traumatic stress disorder and a series of other mental disorders, including depression, obsessive-compulsive disorder, eating disorder, substance dependence and schizophrenia (Norberg et al. 2008). Several other substances are currently undergoing trials, and it may prove possible for psychotherapy to use them as cognitive enhancers in a similar way.

A number of points have emerged very clearly from the experience with D-cycloserine, including the following. Today there are no longer any valid grounds for maintaining the earlier distinction and clear demarcation between "psychological" and "pharmacological" approaches to therapy. These two principles of action have now been thoroughly intermixed and each one acts as a valuable complement for the other. There can be no doubt that this development is going to go further. There are, for instance, already examples of hormones, such as cortisol or oxytocin, being used in combination with psychotherapy. It is true that such interventions are still only at an experimental stage, but we can look forward to what might turn out to be a fascinating outcome to this research.

4.4 Internet-based therapies

Starting around the mid 1990s, internet-based treatment protocols have been developed in which patients and therapists never come face-to-face. This is regarded as a provocative state-of-affairs for therapists with a traditional training, who grew up in the days before the internet came along. Can such an arrangement, they ask, still be called psychotherapy? What has happened to the therapeutic alliance, which, after all, is considered the most important factor in obtaining a therapeutic effect? Many internet-based self-help offers are already available today, and there are also some psychotherapies in the strict sense of the term. They seem to function well for various types of mental disorders, and are intensively used, although it appears that, for the time being, their users are primarily younger patients.

At this stage, I should like to introduce just one example: "Interapy". It is a 100% internet-based, cognitive behavioral writing therapy for the treatment of post-traumatic stress disorder. The approach was developed originally by Alfred Lange in Amsterdam and was later adapted by Andreas Maercker and colleagues for the German-speaking world. The treatment is comprised of ten writing sessions, spread over a period of five weeks. The therapist and patient communicate solely in writing via the internet. The therapy is divided into three phases: self-confrontation, cognitive restructuring and social sharing. Moreover, detailed psycho-education is a key element of all three treatment components. In the first four self-confrontation texts, the patients are prompted to describe in detail the traumatic event they had experienced. In order to strengthen self-confrontation, they write in the first person and use the present tense to describe their sensory perceptions in detail, such as the visual and audible impressions they experienced during the traumatic event. In the second phase, that of cognitive restructuring, the primary activity is working out new views of the traumatic event. The participants write a letter of support to a fictitious friend who has been through the same traumatic experience, challenge the grounds for any feelings of guilt and shame the recipient may have and reflect on potentially positive effects that suffering the trauma may have in the sense of post-traumatic growth. The final phase is concerned with social sharing and a farewell ritual. Through the medium of a letter, the patients put the traumatic event behind them. They can choose to write this letter to themselves, to a close friend or to another significant person who was involved in the traumatic event. In the final analysis, the letter does not have to be sent to the addressee.

Initial investigations into Interapy, although still without controls, show a substantial reduction in participants' symptoms and that they manage to sustain this reduction throughout a follow-up period of 18 months. The vast majority of the patients treated indicated that they had experienced the contact with their therapist as "personal", that they had found the internet to be an agreeable medium of communication and, moreover, that it had not been a problem for them never to have come face-to-face with their therapist (Knaevelsrud and Maercker 2006; 2007; Wagner and Maercker 2007). The general rule,

however, is still that the organizations responsible for funding health care will not yet pay for internet-based therapies. Despite that, even today, such therapies already represent a valuable additional option in the range of available treatments, for example for patients living in regions with very sparse medical and therapeutic care (such as development workers), or those who are tied to their homes on account of a physical disability or for some other reason. Such therapies might also represent an alternative for people who are reluctant to engage in a direct contact with a therapist or the risk of stigmatization (such as people working in professions helping others, members of the police force or fire brigade, and so on).

4.5 Integrated training in evidence-based, disorder-specific therapies

It is not only in the further development of psychotherapeutic methods that there has been a recent trend to move more and more away from universally applicable therapies towards protocols for specific disorders or therapeutic modules for highly specific part-problems (such as emotion regulation), which can occur in conjunction with a whole range of disorders. In the field of advanced and continuous training in psychotherapy, there is an ever-increasing number of programs on offer aiming to impart therapeutic knowledge and skills concerning empirically supported therapeutic approaches within a defined diagnostic spectrum. This is at least a partial response to the wish of many therapists to be able to specialize to a certain extent. One example of how they can do this is the master's course in psychotraumatology now available at Zurich University (www.mas-psychotraumatology.uzh.ch):

Zurich was the first university (and still remains the only one in the world) to offer a course, which began in 2007, in parallel with continuing professional practice, for psychotherapists with clinical experience, who would like to intensify their knowledge and skills in the area of psychotraumatology (Schnyder and McShine 2007). Its main emphasis is on mediating evidence-based treatments for post-traumatic disorders, in particular post-traumatic stress disorder (Foa et al. 2009; Friedman et al. 2007). The course lasts four semesters and leads to the academic title of "Master of Advanced Studies in Psychotraumatology". It is aimed at specialists who hold a degree in medicine or clinical psychology and, furthermore, it presupposes at least two years of clinical experience with sufferers of mental disorders as well as an advanced level of training in psychotherapy. The course is built on "blended learning", which means that traditional learning methods (lectures, problem-oriented learning in small groups and group supervision) are combined with e-learning (online learning resources, web forum, podcasts and so on). This is a setup that facilitates asynchronous learning, so that it is possible for students from the whole German-speaking world to enroll.

To sum up, it could be said that psychotherapy has a lot to do with scientific evidence but also a lot to do with creativity. The lifeblood of a scientific discipline is the constructive interaction between these two poles: the sober analysis of what we have attained, which ought today to satisfy the yardstick of empirical support, and the new ideas of creative minds, without which there can be no growth and no further development.

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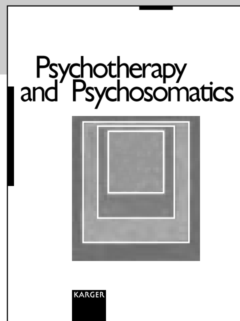

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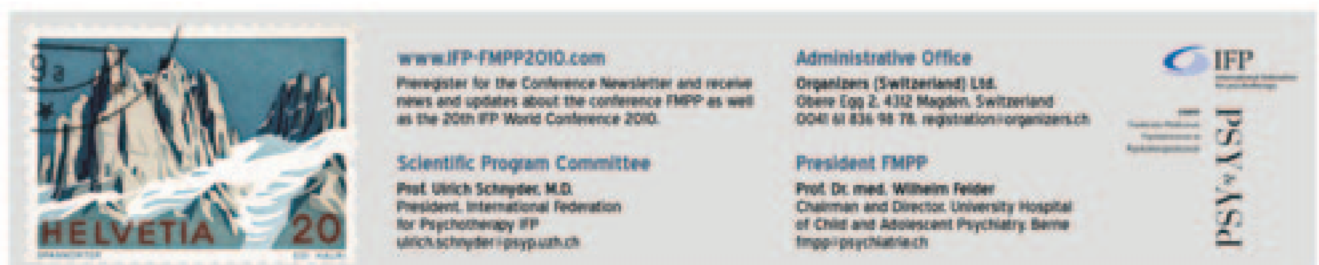

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