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EDITORIAL

Dear Colleagues,

The IFP board is glad to send you this latest Newsletter.

The present issue first presents an editorial from President Driss Moussaoui which addresses the current COVID-19 pandemic in the framework of the most important crisis that human beings have had in the present century. He highlighted the relevant role that health workers have and have had in these days and as well as the relevant role of mental health workers are having and will have in the coming days.

After this, Martina Belz, Research Associate, psychologists and psychotherapist, illustrates how she was forced to change her face to face therapy to her patients into online therapies and encourages us to use the specific condition of the COVID-19 pandemic to be creative, open for new and surprising effects, ready for more metacommunication and adjustments and interruptions during therapy, since they can be manageable and even very powerful.

Tom K J Craig, Emeritus Professor of Social Psychiatry, already gives a nice example of how clinicians can be creative to help their patients. He describes a sophisticated model of AVATAR therapy for voices which might represent a great innovation in the treatment of hallucinations. A multi-centric controlled trial jointly intending to strengthen the evidence of efficacy and safety to the point where the therapy can move out of research into service delivery in the NHS and be disseminated to interested parties internationally will come as soon as the COVID-19 pandemic will be over.

Then, Franz Caspar, Emeritus Professor for Clinical Psychology and Psychotherapy, illustrates current trends in psychotherapy research and suggests that more recent research has led to a revival of the old notion that the therapist matters.

In the end, Ulrich Schnyder, Emeritus Professor of Psychiatry and Psychotherapy, nicely summed up the history of the International Federation for Psychotherapy, highlighting that, today, mutual learning between clinicians and researchers, and a culture-sensitive approach to psychotherapy are the basic principles of the IFP's mission statement.

The IFP Board wishes all of you a pleasant reading.

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EDITORIAL FROM THE PRESIDENT

Psychotherapy in times of the corona virus

Driss Moussaoui, M.D.
President, International Federation for Psychotherapy

"I could be bounded in a nutshell, and count myself a king of infinite space"

William Shakespeare, Hamlet

Since the start of the twenty-first century, humankind has been struck by three notable crises: the 11 September 2001 terrorist attack on the World Trade Centre, the 2008 worldwide financial crisis, and the 2019 Coronavirus disease (Covid-19) pandemic. The first crisis immediately killed thousands and eventually led to war in many countries, spreading a sense of collective fear and sometimes paranoia. The second crisis put many countries in a dire economic and social state, leading to much social and psychological pain and suffering that has lasted for years. However, whilst the two first crises were man-made, the third appears to have originated from a natural cause, albeit triggered by the trade of wild animals in the city of Wuhan, China. The Covid-19 pandemic serves as a reminder that for thousands of years, mankind was plagued with epidemics killing hundreds of millions of people around the world. The last epidemic, the HIV/AIDS virus and illness started in the 1980's and has resulted in the death of more than 30 million people, or half of those infected.

Many people today tend to think that epidemics are either a thing of the past, to be found only in history books, or an issue for the poorest of African countries. Further, few people are aware that in fact, every one of us is made up of more bacteria and viruses than cells (about a 9:1 ratio) and that most of these microbes live in symbiosis in our bodies, until for whatever reason, the immune system's equilibrium is disrupted, and illness develops. Viewed through this lens, Covid-19 is only one in a long chain of occurrences that has happened and will continue to happen in the future every ten to twenty years. This is why the present psychosocial atmosphere that may feel so surreal to some, may become familiar in the future with the return of one or more corona viruses or other epidemics. It is worth examining the present situation more closely to see what can be learned from the experience.

The Covid-19 quickly spread throughout the world, hence becoming a global pandemic. It is more contagious and more lethal than the seasonal flu. The reaction of the authorities was immediate in some countries and somewhat delayed in others. Approximately, half of the population of the world is or has been locked down and fear of a huge sanitary disaster has consistently dominated the headlines, with the media and social media constantly citing the data for the new cases, number of people tested, number of those who recovered, and the deaths. This led to widespread fear of illness of unprecedented magnitude. As with any headline news nowadays, the information has of course been mixed with all kinds of fake news, thus increasing confusion and anxiety. This also resulted in a fear of using the health services, in turn leading to an increase in deaths from cardiovascular and metabolic diseases. Despite the fact that there have been higher death rates in the USA and in Western European countries -especially amongst ethnic minorities- than in other parts of the world, Asian, African and South American countries, fortunately, have not yet experienced the catastrophic death rates that were anticipated.

The results of the pandemic have not all been bleak, for example as demonstrated by the social solidarity among family and community members in many places and instances, and for the first time in decades, an improved image of health workers and their contribution to society. Mental health workers have also demonstrated their solidarity by setting up a number of networks for free consultation and advice for those in need of immediate psychological and psychiatric help, especially through video calls. This happened in many countries, with high, middle or low income.

As to the effect on mental health, the lockdown situation has led to an increase in and exacerbation of anxiety disorders, depression, suicidality, substance abuse, domestic violence, post-traumatic stress disorder, and other psychosocial disturbances, especially in vulnerable people, including homeless, refugees and prisoners. The lockdown may also lead to a sense of feeling trapped, which may become intolerable to some people, especially in restricted living space. Therefore, the help of psychotherapists is needed now more than ever by their previous patients, as well as by those,

new, under stress with the lockdown who perceive a huge threat, including for their families and humankind at large.

Whilst the real dangers posed by Covid-19 should not be underestimated, there is also a problem of perception. We forget that the WHO estimates that 650,000 people die from seasonal flu every year, while the total number of deaths related to Covid-19 on the 2nd of May 2020 stood at 239,622 (a figure that admittedly reflects the lockdown measures adopted in many countries). This is without mentioning the annual number of suicides (more than 800,000 worldwide), traffic accidents, deaths and injuries by firearms, overdoses, deaths due to smoking, etc. One can readily imagine the huge psychological burden it would represent if twice a day the headlines were splattered with the figures of death of any of these categories. The socio-political as well as the financial and economic aspects will not be addressed here, despite their importance.

Aside from the essential daily work of psychotherapists, It is the duty of mental health workers at large, and psychotherapists in particular, to build a basic understanding of the disease and stay abreast of key medical development, in order to help clarify technical questions where needed, and reassure the patient. This is particularly important in the face of spread of misinformation. Further, mental health workers can help promote the regular use of preventive measures (use of masks and antiseptic liquids, physical distancing). The family dynamic may be an important resource both for the psychotherapist and the patient to use in order to ease the load of anxiety and stress from each member of the family, as social bonds can be a strong positive leverage for mental health. It is an art that can be learned to make collective moments useful and enjoyable. Mental health workers may also wish to consider promoting psychological help with relaxation as well as meditation techniques and mindfulness, along with the mainstream types of psychotherapy. The internet provides various reputable resources which may be recommended. Physical exercise, reading, watching movies or documentaries can all be moments of enlarging one's internal horizon, despite the lockdown.

Another very important task for all mental health workers is to help health workers who are in the front line fighting the illness, especially in emergency rooms and intensive care units. This needs of course an institutional organization, being in the private or in the public sectors.

Covid-19 pandemic will ultimately be controlled if not overcome with preventive measures, vaccination (if possible; we still don't have a vaccine for HIV/AIDS) and pharmacological treatment. However, it may become a seasonal infection, just like the seasonal flu. For years to come, we will have to absorb the psychological (how many claustrophobic/agoraphobic syndromes and post-traumatic stress disorders will emerge?) and socio-economic shocks produced by this pandemic and the physical health consequences of this event. But we, psychotherapists, will hopefully be better equipped to deal with global catastrophes such as this one.

Founder and chairman of the Ibn Rushd University Psychiatric Centre in Casablanca from 1979 to 2013, director of the Casablanca WHO Collaborating Centre in Mental Health from 1992 to 2013. Founding member and past president of the Moroccan Society of Psychiatry and of the Arab Federation of Psychiatrists. He is past-president of the World Association of Social Psychiatry (2010-2013) and is currently Member of the French Academy of Medicine; World Psychiatric Association and World Association of Social Psychiatry Honorary Fellow

Psychotherapy from a distance

Martina Belz, Zurich, Switzerland

Maria, a woman of 28 years, suffering from depression with intense feelings of loneliness comes in for a first session in early March right before the shut down in Switzerland because of the COVID-19 pandemic. Maria is a smart and good-looking young woman, who has just finished law school and started to work in a well-known law firm. While her career is going well, she feels that her emotional and social life is a big chaos. First thing she tells me is that finally she has a "fantastic boyfriend" but is terribly afraid of losing him and be lonely again, an old familiar feeling which has accompanied her as long as she can remember, independent of whether she was in a relationship or not. This time she really wants to try everything to make the relationship work. She tells me that she does everything to please her boyfriend but is afraid that this is not enough. Two prior relationships had started out very promising but even though she tried so hard, the men left her after a while for another woman. By the time the shutdown has been declared by the Swiss government I have seen Maria twice. By then I have a first picture of her biography and what she had taken from her experiences for future relationships. Would the therapeutic alliance be stable enough to switch to online therapy[1] at that point? What could I possibly know from a roughly sketched out case conceptualization that could help me to transfer therapy into a virtual world?

Maria grew up with a father with traits of a narcissistic personality disorder. Her mother provided the admiration her father constantly required and took his emotional abuse. While her father was often away, her mother developed a severe alcohol problem and was hospitalized several times because of depression. Consequently, Maria had early in her life to take care not only of her little brother but also of her mother who was often drunk when she got home from school while her father was not at home. As long as she was in school, she felt safe in a world of numbers and letters. But she also remembered having great times with her father when he was in a good mood doing "crazy" things with her and being "super nice", charming and entertaining. So, Maria grew up very watchful, ready to attend to her parents at any moment but not to expect much from her father, self-absorbed and lacking in empathy, and her depressed mother. Instead she had to attend to their parents and their needs at any moment. This way she never really learned how to take care of herself emotionally. Instead. she decided that it was better not to expect and need too much from a close relationship. School and a cognitive world became her haven. Knowing all this about Maria, it was obvious to me how important a reliable and predictable therapeutic relationship would be for a good working alliance including a corrective emotional experience.

After Maria had been referred to me by a colleague who had recommended her to go for Emotion Focused Therapy (EFT), she expected that we would primarily work with her emotions and learn to deal with her emotional chaos. She had already heard that this would involve chair work and was ready for it. In case she would agree to meet online: would it be possible at all to work with EFT including the use of one of the pillars of EFT, chair work[2]? Would I be able to be empathic and see and hear and attend to her feelings despite the electronic distance?

Even though I had some experience with *extra* online sessions via Skype once in a while in an already well-established therapy, I was rather insecure and hesitant to *start a completely new* therapy (after limited initial contact) with a patient for whom the therapeutic relationship seemed so crucial. Should I be completely transparent by talking about my insecurity? This might prompt her, following her old patterns, to protect me instead of taking care for herself. Should I therefore just go ahead, offering and recommending online therapy despite my insecurity if this would work? After all, it is a powerful therapeutic factor to evoke positive expectations with patients.

Thus, there were two areas of **questions** to clarify:

1. What are the prerequisites for doing online therapy *in general*, legally, ethically, technically and concerning data security? Are there special regulations by law or by the relevant professional associations? Which are the chances, risks and limits, indications and contraindications for online- therapy? How to do diagnostics? How to deal with suicidality? What is the state of evidence related to online-treatments, what

1 Here, the term on-line therapy is used for therapy with communication between patient and therapist in real time, with sound and video through electronic means without physical presence of the therapist, not self-help via internet with asynchronous therapist assistance.

2 EFT chair work: A technique in which the patient moves between two chairs, acting as a different part of the self or a significant other on the one chair and the experiencing self on the other, so as to evoke unresolved emotions, generate new, more resilient emotional responses and develop a new self-organization

are evidence-based online-treatments (see references), advantages and disadvantages?

2. Which are the consequences doing online therapy with this *individual* patient drawn from the individual case conceptualization?

Some answers: ("what do you have to consider?")

1. In many countries the COVID-19 pandemic has enhanced new regulations for doing online therapy with patients. The differences between countries are huge and have to be clarified before starting (e.g., is online therapy legal, who is allowed to do it, does the insurance cover online therapy, if so: how many sessions, can you do therapy from home-office or only from your regular practice rooms, are there regulations concerning certified video-talk-programs, and many more).

2. The basis for online therapy, just like for face-to-face (f2f) therapies, is an individual case conceptualization. This helps to develop a strategy for the therapeutic relationship as well as for the technical possibilities and limitations. The expected consequences for the therapeutic relationship can be deducted from the case conceptualization just analogous to expectations regarding effects and side effects of any intervention in f2f therapy. But keep in mind that possible limitations might have to be made more explicit right from the beginning and metacommunication may be necessary as it can be more difficult to decipher the nonverbal behavior of the client (usually you do not see the whole person, the facial expression is often less clear etc.). Several kinds of technical interventions are only partly or not at all possible.

For Maria it was important to keep in mind which interpersonal patterns with relevance for the therapeutic relationship would have to be expected based on her history with significant others. Together we found that she might have a hard time to tell me what she really needs from therapy and that she might have a tendency to try to please me and take care of me and eventually withdraw inwardly and keep the relationship on a more superficial level avoiding the hot spots. We agreed that this could be a trap for both of us and that both of us would watch out and bring it up if we see it happening. So when the shutdown was announced I immediately got in contact with her telling that for the next weeks or maybe months I could offer her only online-therapy but if she decided that she wanted f2f therapy we could postpone the therapy altogether until a termination of the lockdown, or I could try to find a therapist who is still offering f2f therapy during the lockdown. Maria clearly decided to do online-therapy on a weekly basis with me. We also agreed that we would check after each session whether this procedure worked for her.

As we did not have any forerun in doing chair work in f2f therapy, both of us did not know if and how this would work in online therapy. Thus, I wrote an email to Maria before our first online session and asked her to prepare her room in the following way: I asked her to set up two chairs in front of her computer and a box of paper tissues. The latter turned out to be very important because in an online setting it can get just as emotional as in regular f2f therapy. Next I explained that she would need one chair that she normally sits on and another one for whatever part of herself we might want to give a voice (e.g., the critical voice, the voice of significant others). In order not to take up too much space I asked her to set up the chairs just side by side without much distance in between them. When we met online for the first time everything was well prepared by Maria. This was important because first thing Maria reported was that her boyfriend broke up with her and that she felt that it was all her fault. She should have done more for him, be more loving, give him more attention, accept and balance out his tantrums. This seemed to be a clear marker to do chair work with her critical voice. When she agreed to do chair work, I asked her to turn to the other chair so that she could directly face the other chair and I could see her in both positions from the side. This position is just the same as in the therapy room, which made it possible that Maria was fully engaged in the first chair work. She could open and experience her loneliness and her anxiety to lose the other unless she does all she can to meet their needs. For me as a therapist some technical problems came up because I could not see and hear her as clearly as I am used to. I had to ask her repeatedly to say things again, I had to speak louder, and to do it in a way which did not interrupt the process too much but kept me attuned at the same time. The more emotionally involved she was the harder it was to really understand everything and really see her facial expression or her bodily posture. During the chair work I had in mind how important it is for Maria to become more aware of her needs and eventually express them. I prioritized to support her process and put my needs to understand and see her at last. She came to a resolution with an

"I do count". Getting back together after the chair work, trying to make sense of what she just experienced, I told her that I could see how engaged she was in the process but because of the technical limitations I could not see and understand everything completely but did not want to interrupt her frequently. I said that I was not sure if I should have interrupted more often and would like to know what it was like for her and what would be the best for her. So besides clarifying technical aspects with her, this was also a possibility to show her that I take her needs seriously. In the meantime, we do online therapy on a weekly basis and have done more chair work including unfinished business with her parents. She is still in home-office and she experiences our "weekly date" not only as therapeutically helpful but also as an orientation point which helps her deal with uncertainty and isolation during the pandemic. She is writing a therapy diary which seems to be an additional way of working through her emotional world.

What I learned from and with Maria helped me to work online with other patients as well and to see how important it is to tailor the online treatment to the individual patient.

Here are some aspects that turned out to be important with other patients:

- For Carl, a 26 year-old medical student, living in a shared apartment, it was a big step forward in standing up for himself and his needs when he asked his five other flat mates to consider that he needs a quiet space while we are doing online therapy. By the time we switched to online therapy, Carl and I had already met for 16 f2f therapy sessions, so by the time we had to cancel the sessions in my private practice we could build on a solid therapeutic alliance. However, up until then Carl did not want to let his flat mates know that he is in psychotherapy. One of the central issues were his difficulties to take up more space and stand up for his needs. So, this new setting pushed Carl to show a behavior he had tried to avoid for so long.
- Nadia is a 45-year-old highly traumatized refugee. Last time I had seen her was two years ago at the end of a long-term, quite successful trauma therapy. When she contacted me this time she told me that one of the reasons she did not want to continue psychotherapy was that even though she profited a lot from the therapy she could never leave behind the idea that maybe some secret service persons from her country were still trying to find her and get a hold of her. Now the COVID-19 pandemic reactivated feelings of uncertainty, worry and isolation. Therefore, she contacted me again at the beginning of the lock down by email. She told me that she had a hard time dealing with loneliness, powerlessness, shame, fear and anxiety, which reminded her of the time when she had to live in a camp before she could come to Europe. And as urgently as she needed support and a trustful relationship to avoid retraumatisation, her history of prosecution and wiretapping made it difficult to trust in any kind of online therapy. Knowing her background, it was clear to me that a secure, stable and reliable therapeutic relationship was the most important part of our work. We decided to meet online on a weekly basis provided that she would have complete control which topics to bring up and how much deepening she would allow. She also insisted not to mention time, people and places and avoid everything which could be traced back to concrete events of her former life. This was in line with her pronounced need for control, she concentrated on the few things she could control like washing hands, staying at home, and controlling the time and content of our meetings. Here the setting of online therapy was even advantageous as it helped her to have a good reason to keep the necessary distance to stay in control and balance herself. This should not be seen as avoidance, as we have discussed whether and when she may ultimately be ready to address these fears, and that this was not the case at this point.

These is just a selection of patients that I continue to see during the lockdown. What I have learned in this unusual time is the following:

- there is an urgency in helping people change their maladaptive emotional responses to uncertainty, worry, isolation, loneliness and loss of control;
- sometimes we are (almost) the only contact our patients have during the lock down and therefore we represent a very important structure-giving resource for making it through this crisis;
- we have a special responsibility during the lock down to be available for online sessions which puts an extra burden on us as therapists and take special care of ourselves;
- this is an extraordinary possibility to help patients to have corrective experiences (e.g., Maria said that the most important and surprising effect of our online sessions was not that she made progress concerning her initial therapy goals but that she learned to deal with the isolation and that she does not need a constant stream of activities to regulate

her emotions);
- not all patients want online therapy on a regular basis, so this incision caused by lock down could also be a chance to find out what it would be like be without therapy if only for a while;
- online therapy is not an all or nothing way; for some patients keeping in touch via email or a phone call once in a while can be a good solution and enough to get through this period and come back when life is more back to normal and f2f therapy is available again;
- most important: online therapy can work very well; it can be just as helpful and powerful as f2f therapy;
- techniques which are very experiential (i.e., evoking emotions and working with them) can very well be set up in online therapy; even if it seems awkward at the beginning, therapists and patients get more skillful and flexible over time;
- an individual case conceptualization is a prerequisite for online therapy, as the digital variable can introduce additional demands and issues that you and your patient are not familiar with and not prepared for. A case conceptualization can help not to be caught flat-footed, to develop ideas how to deal with them, and to anticipate potential side effects;
- for patients who are distracted from the work on their problems by allocating too much attention to the therapist's relation to them, or who prefer anyway to have a more distant relationship with the therapist, the physical distance between them and the therapist may enable them to engage more in the therapeutic process.

Be creative, open for new and surprising effects, ready for more metacommunication and adjustments and interruptions during therapy. This is manageable and can be very powerful. This is an extraordinary time that may help us to try out new ways of working with our patients that did not seem attractive or even possible before the crisis.

I would like to invite you to a trip into the future. Just image that you are one year from now. It is May 2021 and you sit in your office, patients come to f2f therapy and you do business as usual. Are patients coming with the same problems and topics as they did before the crisis? Is everything the way it was before? Or even better? Looking back will we wonder at something? We might be surprised that we found out that video conferences and online therapy that we had refused to work with turned out to be quite practical and productive. And at the same time, we find ourselves appreciating rather traditional ways of f2f therapy again and combining it in a much more natural and skillful way than we could imagine. We will be astonished how we managed to continue working with our clients and experience them as well as us in new ways, and that it is more important to stay open and connected than doing the perfect evidence-based intervention.

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Martina Belz, studied Psychology, Cultural Anthropology and Classical Archeology at the Universities in Tübingen and Freiburg, Germany. She finished her master-level training in Psychology in 1977 and received a Ph.D. in Psychology 1994 from the University of Freiburg (D) for a thesis about lay theories of health. Between 1977 and 1990 she worked in clinical-psychological institutions. From 1990 to 2006 she held several positions at the Institute for Psychology at the University of Freiburg (D) as research associate, clinical faculty and head of different research projects and Director of the Postgraduate Psychotherapy Training Institute. From 2007-2019 Research Associate, Department of Clinical Psychology and Psychotherapy, University of Bern and psychotherapist in private practice in Bern, Switzerland. Engaged in manifold activities in psychotherapy training as lecturer and supervisor at several institutions in Germany and Switzerland with a focus on the topics of Case Conceptualization, Therapeutic Relationship, Emotion, Chronic Depression, Exceptional Experiences and Gender with congress papers and publications in textbooks and journals. Since 2019 she is retired and works in a private practice in Zurich, Switzerland.

AVATAR therapy: a promising new psychotherapy for auditory hallucinations

Tom K J Craig, London, UK

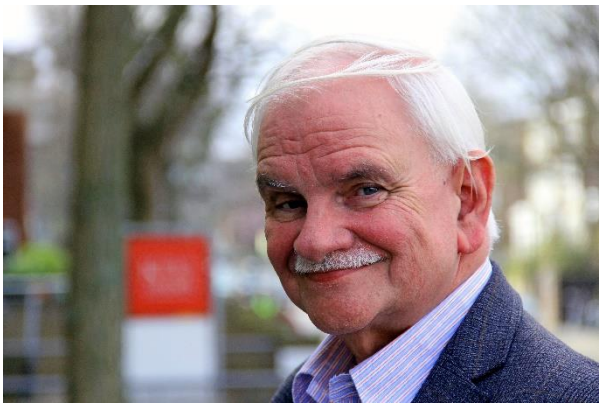
AVATAR therapy, invented by Professor Julian Leff[1], is a novel approach for the treatment of auditory hallucinations in people suffering from psychotic disorders including schizophrenia. The treatment is based on a therapist-assisted dialogue between the patient and their hallucinated voice. Computer software is used to create an 'avatar' that is a close match to the appearance and acoustic characteristics of a chosen voice. Where more than one voice is heard (as is common in schizophrenia) the patient selects one to work with – usually the most dominant or fearful. The patient and therapist then sit in separate rooms in front of computers on which the avatar appears and is controlled by the therapist who can speak either has him/herself or in the voice of the avatar. The heart of the system is the transformation of the therapist's speech to closely match the acoustic qualities of the chosen voice using software developed by Professor Mark Huckvale at University College London. The intention is to help the patient gain a sense of power and control over the avatar by progressively changing it in response to the unfolding dialogue, from persecutory towards being more friendly and supportive. The first pilot study reported striking improvements with 3 of 16 patients reporting a complete cessation of their voices[1]. Another pilot study using the same research design but delivered in immersive virtual reality and with different voice transformation technology reported similar results[2]. This early work was subsequently replicated in our single-blind randomized controlled study which established superior efficacy over an active comparator treatment[3].

The person's relationship with their voice is central to the therapy. Before starting, a detailed account of the voice, its relationship to the patient's current and past personal relationships, links to previous trauma and any specific cultural influences are assessed. This is used to generate a formulation of the origin and purpose of the voice in the person's life and to identify the characteristics of the voice that the therapist will act. The therapy itself comprises one session weekly over about 7 weeks including the creation of the avatar. The avatar is both a validation of the patient's experience (many said to us that we were the first therapists to really understand what hearing voices was like) and a way of letting the person visualize and access what is usually an unseen experience. In the short initial sessions, the avatar speaks verbatim the threating content of the patient's voices while the therapist advises the patient on 'turning to face' the avatar and manage anxiety (including relinquishing safety behaviors). In response the avatar acknowledges the change and encourages further dialogue e.g. '*You are pretending to be tough today…'* to which the patient might be encouraged by the therapist to respond along the lines of '*I am not pretending, you are not going to get me upset anymore'.* As the therapy progress, the sessions lengthen (to around 15-20 mins) and evolve into a far more dialogic exchange between the avatar and patient. The themes of this dialogue reflect the initial formulation but also unfold in the light of new information as it emerges. The therapist, speaking as the avatar, might draw parallels between current and past experiences or position the avatar as an aspect of the individual ('*you know I only say the things you think about yourself…')* or as a remnant of some earlier traumatic experience from which the person had now escaped ('*I can see you are no longer the little girl I was taking you for… you really are in charge now'*). These later sessions often involve some specific work on self-esteem, such as asking the patient to read a testimonial from friends or family attesting to their positive qualities, the avatar acknowledging truth in these statements. In most cases the movement of the dialogue is toward the point where the avatar speaking as the voice agrees to leave the individual.

Why is this therapy so effective? Most patients are terrified of the voices and the presumed entities behind them. Not only do voices seem to know everything about the sufferer, they are intrusive, hostile, and threatening. Some are blaming, demeaning, and punishing. The response to this is a mixture of anxious avoidance and helplessness and the first, arguably most potent intervention, is one of managing anxiety and promoting assertiveness. This includes an element of exposure, but also expectancy violation, challenging the omnipotence and power of the voice. For example, deliberately going against commands from the avatar by using small behavioral experiments to tackle issues such as fearful avoidance of specific situations. In addition to reducing anxiety and bolstering self-confidence, later sessions are more attuned to understanding the meaning of the voice in the person's life as explored in the assessment formulation and modified as the dialogue unfolds. The avatar makes interpretative statements including suggestions that voices are a part of the self or an echo of earlier abusive and

humiliating experiences.

These thoughts about mechanism are speculative but form the basis of a new study. This multi-center, controlled trial jointly led with my colleague Professor Phlippa Garety at KCL, is intended to strengthen the evidence of efficacy and safety to the point where the therapy can move out of research into service delivery in the NHS and be disseminated to interested parties internationally. It is also an opportunity to disentangle the therapeutic ingredients by comparing two models of AVATAR therapy, one focused on the anxiety management / assertiveness component and the other including the more interpretative element, comparing both approaches to a treatment as usual control condition. This study should have started but has become caught up in the Covid-19 pandemic so will now be delayed until much later in the year with results not available before 2024/5.



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Tom qualified in medicine at the University of the West Indies and trained in psychiatry in Nottingham UK. He was appointed to Kings College London as Professor of Community Psychiatry in 1990 with his clinical base in the South London and Maudsley NHS Trust. His clinical research focuses on developing and evaluating community-based psychiatric services and the promotion of these solutions at a National and International level. These programmes have included residential alternatives to the hospital asylum, specialized services for homeless mentally ill people, supported employment programmes, services for first episode psychosis and studies of the computer-based AVATAR programme for the treatment of auditory hallucinations

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Current trends in psychotherapy research

Franz Caspar, Bern, Switzerland

As I'm writing this text, the number of Corona infections is still on the rise in most countries. It is difficult in this situation to write about current trends in psychotherapy research without at least briefly referring to the pandemic. When you read this, the worst may be over in many countries, but the pandemic will have left lasting effects in our life including psychotherapy and psychotherapy research. The range of effects will be broad. A rise in the interest in topics such as loneliness, the consequences of being jobless, domestic violence, among others, can be expected. Above all, many forms of psychotherapy without physical coming together of patient and therapist will have become more popular. We have known for a while that effect sizes of internet therapy can be as high as those of face to face therapy, and that the therapeutic relationship plays an important role, although in a partly different way (Berger, 2017). It has nevertheless been wise not to recommend online therapy too much ahead of solid empirical findings. At least temporarily, the situation has changed: without claiming that what they can offer is perfect, therapist and mental health service providers have been forced into either end or pause therapy, or to provide some form of therapy on distance. My wife has tried to continue EFT chair work with patients who had been introduced to this kind of interventions face to face before the epidemic. Single case observation shows that it has worked well. She would never have tried without having been forced to find a solution. Other therapists have certainly tried other kinds of intervention. While past research on internet therapy in situations in which face to face therapy has been impossible, for example in war zones (e.g., Knavelsrud et al., 2015) may already inform us about the use of internet in extreme situations. As the extreme has become common, we will quickly accumulate anecdotal experience, and hopefully researchers will hopefully catch the chance of collecting more data systematically.

In a 2015, editorial of an IFP newsletter I addressed the question whether there is any use of psychotherapy research for practitioners– with a generally positive answer, an "it depends" included. This editorial gives an overview of current trends in psychotherapy research, which, I must commit, is biased: I give particular attention to developments which I see as useful for practitioners and not primarily for the career of psychotherapy researchers nor suitable for publication in what we call "one-word journals" such as Science, Nature, or Lancet, which have encountered more criticism recently. I hope and assume that this is in the interest of a majority of IFP newsletter readers.

Four trends I find most relevant for practitioners:

- Decreased interest in some trends that have been dominating for decades.
- Increased attention to what matters for practitioners.
- Paying attention to responsiveness, that is, adapting to the individual patient beyond diagnosis.
- Paying attention to the therapist.

With regard to two trends which *have been dominating* for a while, some *disillusionment* has taken place (although not with everybody). There has been a focus on *approaches* of *intervention*, randomized controlled trials (RCTS) serving the proof of effectiveness, and manualization of interventions and homogenization of patients serving the (alleged) requirements of RCTs. But the limits of such a focus have become increasingly evident. There has been extensive discussion between proponents and skeptics of the approach, and there is no way that this could be reflected in this brief paper. Most readers are expected to be familiar with at least part of this discussion anyway. So I want just to mention the lack of external validity of many if not most studies and the failure to find clear evidence for the superiority of any bona fide approach for example for the treatment of depression, which is the primary or comorbid diagnosis of a big part of our caseload. This has led the maybe most prominent meta-analytic researcher in this field, Pim Cuijpers, to a rather pessimistic view of methodological problems and the use of further studies (Cuijpers et al 2018).

RCTs are still the via regia for causal proofs but they come along with some adherent issues, they are very costly in terms of research money and researcher time, and it is thus an illusion that the world of psychotherapy could be conquered this way. In addition, counter to the development in engineering and much of the natural sciences, which is ever accelerating, not only developments in psychopharmacology have slowed down: it has also become increasingly difficult to develop better approaches of psychotherapy.

For another disillusionment, related to the use of neurobiological research for mental problems, let's read one who has favored this approach for a long time: "I spent 13 years at NIMH really pushing on the neuroscience and genetics of

mental disorders, and when I look back on that I realize that while I think I succeeded at getting lots of really cool papers published by cool scientists at fairly large costs - I think $ 20 billion - I don't think we moved the needle in reducing suicide, reducing hospitalizations, improving recovery for the tens of millions of people who have mental illness," says former NIMH director Thomas Insel, and, unlike many others in charge: "I hold myself accountable for that."[3]

The *increased attention to what matters for practitioners* I have addressed a while ago (Caspar, 2015a) and would like to refer readers to this text, accessible on the IFP homepage, and keep it short here. To show that the relation between research and practice is not a one-way road is an ongoing motto of this newsletter.

Paying *attention to responsiveness*, that is, adapting to the individual patient beyond diagnosis is a trend overarching several more detailed approaches, from emphasizing and further elaborating case formulation methods to stressing intercultural awareness and sensitivity. The notion that many patient properties beyond diagnosis are relevant is quite old. William Osler, one of the four founding professors of Johns Hopkins Hospital and sometimes referred to as the father of modern medicine, stated that it is more important which patient has a diagnosis than which diagnosis a patient has. It has been stated already that the chances of developing an approach, which is superior in general, are low. The key to improving the effect of psychotherapy for our individual cases is the custom-tailoring with regard of many properties of the patients beyond diagnosis.

Differential treatment selection is a keyword: the difficulty of demonstrating the general superiority of one approach over the other may partly be a consequence of the fact that not the whole range of patients profits equally from each feature of an approach.

This is captured by the notion of aptitude-treatment interaction (ATI). For example, an autonomy vs. structure giving approach is not working better or worse in general. Whether one or the other is more advantageous depends on the patient's reactance level, which is the general tendency of reacting negatively to perceived threats to autonomy (Beutler & Harwood, 2000). While corresponding to experience in practice ("different folks need different strokes"), there are few experimental proofs that therapies following the principles of differential treatment selection are clearly more effective. How can this be explained? One plausible explanation is that an individualization on the level of variables such as reactance, internal vs. external coping, or severity, are much more coarse-grained compared to the refined individualizing considering very detailed particularities of the case by proficient practitioners. We would need more refined research methods (best first qualitative assessment, which is then quantified; Caspar, 2005) to trace this kind of individualization.

An interesting approach is the personalized advantage index (DeRubeis et al, 2014). It is assumed that not all patients with a disorder profit equally well of all treatments. If, for example, we think of interpersonal patient difficulty (whatever the precise definition is), it is plausible that for easy patients, a therapist does not need to be particularly skillful for a good outcome. For extremely difficult patients, a therapist needs to be extremely skillful to have a chance at all, but nevertheless, successes are so rare that they do not become statistically significant. For the group with elevated but not yet extreme difficulty the success depends most on the variable "therapist interpersonal skillfulness". If all patients are lumped together, there is no very high correlation between skillfulness and outcome, while there is a substantial correlation for the group between the extremes. DeRubeis and colleagues were able to calculate according to which variables it would make a difference, by which approaches patients with depression had been treated, and how much better the results could have been with every patient in the individually more advantageous treatment.

Such considerations may lead to a different view of general effect sizes reported for one or another treatment and could contribute to more differentiated treatment selection. A parallel differentiation would be a more deliberate definition of what precisely is the goal of an attempt at improving an already good therapeutic approach. Do we want to raise the mean outcome, which would be difficult due to ceiling effects for the patients doing well already? Do we want to raise the improvement rate specifically for the patients who are not doing so well with the old treatment? It might then be wise to target the difficulties that can possibly be influenced by an

[3] www.wired.co m12017 I 05/star-neuroscientist-tom-inselleaves-google-spawned-verily-startup/; for those who would prefer to have it somewhat more elaborated: Caspar 2015b

improved treatment, and not mix them with treatment independent difficulties in an un-reflected way. Do we want to raise the rate of patients who enter the recommended form of therapy and stay in therapy long enough to give it a chance to work? This kind of questions rather than just arguing with average effects have a better chance of bringing about useful research and of leading us to existing research holding answers to such questions.

Research related to *therapists* has attracted more interest in the past few years (for an overview: Castonguay & Hill 2017). An obstacle to such an interest has been the search for the best treatment approaches for mental disorders in competition with psychopharmacological treatment. Would you buy an antidepressant, if it comes with the information that its effects depend on the physician prescribing it, or on the interpersonal competence of the pharmacists providing it for you? And if you have the choice between an antidepressant without factors possibly limiting its effects, and psychotherapy coming with a lot of "it depends …" would you not as a patient as well as an insurance prefer the medication? Under such conditions it has been attractive to advertise psychotherapeutic methods without too much attention to the therapist. Therapists would make things complicated and contribute error variance.

More recent research has, however, lead to a revival of the old notion that the therapist matters. The therapist contributes approximately 7% to the outcome variance (Barkham et al., 2017). This may seem little, but as the most positive estimations of the contribution of the right method are around 10%, 7% are much too much to be neglected. Research has also shown that the most effective therapists show superior outcomes consistently in their caseload, whereas there are also some therapist producing negative effect sizes, that is, harming their patients consistently. There is some but still relatively little research on master therapists. It suggests that they are typically "voracious learners", with a solid personal self-esteem, yet always questioning whether what they do with their patients could be improved. They practice more analysis, reading and inter-/supervision.

This is in line with research in professional expertise *in general*, which may provide valuable information while research in *psychotherapeutic* expertise is still scarce (Caspar, 2017). Research on expertise shows, among others, that experts invest more into in-depth analysis, they consider much more context (that is, more aspects relevant for their action, which leads back to the topic of "responsiveness", above). Most professionals improve their performance with an increase of experience, but only to a certain level, which one may designate "good enough". To continue the curve of improvement, additional effort is required. An already pretty old model (Ericsson, 1993) which has recently become very popular in psychotherapy training and continued education, is the "deliberate practice" approach. It is defined by a number of elements, which make advanced learning particularly effective. Learners have to be motivated to develop efforts to improve their performance, the learning goal is clearly defined and a correct understanding of goal and task after brief instruction is possible, the design of the task takes into account the existing knowledge of the learners, immediate, informative feedback for learners is provided, the same or similar tasks can be repeated and errors can be corrected. To what extent and by how many programs and persons all these conditions can be met remains to be seen. At this point it is important to see that therapist related research is in motion.

Overall, my impression is, that in spite of severe limitations in the funding of psychotherapy research, the field is developing further in a promising direction to provide insights which are actually important for practitioners.

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The origins and history of the IFP

Ulrich Schnyder, Zurich, Switzerland

At the beginning of the 20th century, the German speaking countries played an important role in the development of psychotherapy as a recognized therapeutic approach to address the suffering of people with mental disorders. In 1926 and 1927, the first international conferences on psychotherapy were held in Baden-Baden and Bad Nauheim, Germany (Heim, 2010). Probably in 1928, during the third international congress, Ernst Kretschmer from Tübingen founded the "Allgemeine Ärztliche Gesellschaft für Psychotherapie", AÄGP, serving as its president until 1934. This was one of the first membership organizations for the emerging profession of psychotherapists. The AÄGP soon developed into a society with members from various countries. It was therefore temporarily named "Überstaatliche AÄGP" (supranational AÄGP), then "Internationale AÄGP", until on the occasion of the seventh international psychotherapy congress, again in Bad Nauheim, the "International General Medical Society for Psychotherapy" IGMSP was inaugurated. Carl Gustav Jung from Zurich, Switzerland, was elected to serve as the first President of the IGMSP.

World War II brought the activities of the IGMSP to a halt. After the war, the organization of world congresses resumed as early as 1948 in London, UK. Interestingly, the theme of the London conference was "The problem of guilt in psychotherapy"! However, it was only in 1958 at the world congress in Barcelona, Spain, when the "International Federation for Medical Psychotherapy" IFMP was formally established as the successor organization of the "Internationale AÄGP". Medard Boss, Switzerland, had been holding the somewhat loose threads together since 1954 already. He became the first president of the IFMP, serving in that role until 1967. Subsequently, Boss was succeeded by Pierre-Bernard Schneider, Switzerland, (1967-1979), Finn Magnussen, Norway, (1979-1988), and Edgar Heim, Switzerland, (1988-1998).

During Edgar Heim's presidency, the IFMP lost its "M": Given the increasing number of clinical psychologists training and working as psychotherapists, and, even more so, engaging in psychotherapy research, the Board of Directors then decided to open up the Federation and invite psychological associations to join as equal partners the group of professional membership organizations that had until then been medical associations exclusively. Thus, in 1991, the Federation dropped "Medical" and was renamed into "International Federation for Psychotherapy" (IFP).

In 2003, IFP Past President and Honorary Member Edgar Heim had officially been mandated by the IFP Board to write up the history of the IFP. He collected minutes of Board meetings, correspondence between members, congress proceedings, and other historical documents related to the IFP. Edgar Heim ended up producing a compelling account of the development of psychotherapy, with a special emphasis on organizational aspects of that development during the 20th century. This highly informative document was published both in German, as a book, and in English, as a Supplement to the IFP's official journal, Psychotherapy and Psychosomatics (Heim, 2009; 2010).

The German speaking countries continued to be well represented among the IFP's membership societies as well as on its Board of Directors: Wolfgang Senf, Essen, Germany, served as president 1998-2002, followed by Ulrich Schnyder, Zurich, Switzerland (2002-2010), then Franz Caspar, Bern, Switzerland (2010-2014), notably IFP's first president with a background as psychologist. In addition, Alfried Längle, Vienna, Austria, and Michael Rufer, Zurich, Switzerland, served as Board members. With over 1'400 participants, the 20th IFP World Congress in Lucerne, Switzerland, reached an all-time high in attendance. It was during this period that regional IFP conferences and workshops were introduced and held in various countries (Singapore 2003, Amsterdam 2004, Taipei 2005, Hangzhou 2006, Venice 2006, Zurich 2006, Shanghai 2007, Hannover 2008, Jakarta 2008, Vienna 2008, Zurich 2009, Jakarta 2010, Zurich 2010, Cebu 2011, Rome 2011). Also, a Research Committee was established and the IFP started granting an "IFP Award" on a regular basis. Of note, for the first time in 20 years, the 21st IFP World Congress was once again held in an Asian country: Shanghai, China, hosted a very successful congress in 2014.

Paul Emmelkamp's presidential term lasted from 2014-2018, with the 22nd IFP World Congress being organized in his home town, Amsterdam, The Netherlands, in 2018. During this congress, the IFP Council elected their first non-European IFP president, Driss Moussaoui from Casablanca, Morocco. The current Board of Directors is formed by Franz Caspar (Zurich, Switzerland), François Ferrero (Geneva, Switzerland), and Fiammetta Cosci (Florence, Italy), and

supported by two presidential advisors, Norman Sartorius (Geneva, Switzerland) and Ulrich Schnyder (Zurich, Switzerland).

The 20th and beginning 21st century have seen an unprecedented rise of psychotherapy as an effective treatment for a majority of mental disorders. Over the decades, what was previously regarded as far off current scientific standards has developed into a discipline based on sound scientific principles. Today, psychotherapy can be seen as one of the most powerful therapeutic approaches in medicine. The IFP has always seen psychotherapy as a culturally sensitive and scientifically based discipline (which must not necessarily preclude us from seeing psychotherapy as an art as well), meaning that advancement of psychotherapeutic practice should go hand in hand with innovations in psychotherapy research. Clinicians should learn from researchers about the efficacy and effectiveness (or lack thereof) as well as about adverse side effects of specific psychotherapeutic approaches or techniques. Conversely, researchers should listen to clinicians in order to generate clinically relevant and meaningful research questions and hypotheses (cited from Schnyder, 2010). Today, mutual learning between clinicians and researchers, and a culture-sensitive approach to psychotherapy are the basic principles of the IFP's mission statement.

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Ulrich Schnyder, MD, psychiatrist and licensed psychotherapist. Professor Emeritus of Psychiatry and Psychotherapy. He was Head a.i., Department of Psychiatry and Psychotherapy, University Hospital Zurich, Switzerland. Research activities have been focused on various aspects of traumatic stress research, including epidemiology, neurobiology, psychotherapy and pharmacotherapy for PTSD, resilience to stress, and, refugee mental health. Past President, European Society for Traumatic Stress Studies (ESTSS). Past President, International Federation for Psychotherapy (IFP). Past President, International Society for Traumatic Stress Studies (ISTSS). Recipient of the 2013 Wolter de Loos Award for Distinguished Contribution to Psychotraumatology in Europe (ESTSS), and the 2016 Lifetime Achievement Award (ISTSS)

Summary of the IFP news in press in Psychotherapy and Psychosomatics

Christoph Flückiger, Zurich, Switzerland

Deciding on the number of psychotherapy sessions to satisfactorily treat a patient is a vital clinical as well as economic issue in most mental health systems worldwide. Flückiger, Wampold, Delgadillo, Rubel, Visla and Lutz present a systematic review that investigates on this issue by examining the mean number of sessions of 20 naturalistic samples across 8 countries published between 2015 and 2019. In individual therapy (k=17), the number of sessions was not fixed, whereas 3 samples of manualized group or family therapy referred to a fixed number of sessions. In all samples, the mean number of sessions were lower than 50 sessions with a range from 2.86 to 45.1 sessions. The authors conclude that there is little convergence across countries (and their policies) regarding how treatment duration should be decided. The authors underscore the relevance of cross-cultural scientific societies such as the International Federation for Psychotherapy (IFP) to consolidate evidence-based psychotherapy knowledge across particular countries and psychotherapy orientations.

CONGRESS CALENDAR

Unfortunately, due to the COVID-19 pandemic, several congress in 2020 were canceled or postponed.

Notwithstanding this, please send announcements of your congresses!

20th WPA World Congress of Psychiatry
October 14 – October 17, 2020
Venue: Bangkok, Thailand
https://wcp-congress.com/

The 26th World Congress on Psychosomatic Medicine (ICPM)
September 1 – September 3, 2021
Venue: Rochester, US
http://www.icpmonline.org/26th-world-congress-rochester-2021

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