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European Psychotherapy Research in the Nineties*

Presidential Address to the 54th European Meeting of the Societ for Psychotherapy Research (SPR)

It is a great pleasure and an honour to open the fourth European conference on psychotherapy research within the organizational frame of the Society for Psychotherapy Research with some thoughts about the past, present and near future of European psychotherapy research. We are meeting in times that are truely exciting and disturbing at the same time as the token of unexpected freedom that was with us shortly after the last European meeting in Berne has been sided by unexpected national, racial and religious upheavals we all thought had passed for ever. Therefore the widening Europe will bring many new challenges for both sides - for Eastern and for Western collegues - and therefore choosing Budapest as our meeting place has deep significance for us all.

It is with great pleasure that I can welcome the new president of the international SPR, David Shapiro, from a European country to be with us and ponder on his favourite issues in European psychotherapy research in the nineties. This circumstance of his being with us is especially important as the British collegues had an important bridging function for the implementation of psychotherapy research from the North-America´s to Europe. Not many of you will know that the first transatlantic SPR conference started as late as 1975 in Boston and then moved on to London - a fact I myself learned only recently by reading up a lecture given by David Orlinsky at the 10th annual conference of the UK chapter in march 1993. It is

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therefore more than apt to welcome David Orlinsky as an American in love with Europe, - and I am sure he knwos all about Europe´s beauty when she was taken away by Zeus from her homeland - as the ambassador of the international SPR among us. From this lecture - which hopefully soon will be available in full length in our journal - I completed my personal knowledge about the history of organized psychotherapy research which to a great part has become identical with the history of this society.

Though the dating of the beginning of systematic psychotherapy research may depend on ones metascientific outlooks on what constitutes research - were Freud & Breuer already psychotherapy researchers when they published the case studies on hysteria in 1895 or did Freud become aware of the necessity of formal data collection when he in the twenties asked his disciple to collect many and deeply analyzed cases to prove the point he attacked Jung on (Freud 1918)?

Especially in its early years the demonstration of successfully treated single cases serves the purpose to convince the public. One of the most venerable examples is the report by the Viennese physician J. Breuer on his famous patient: "Anna O. came with hydrophobia, speech disorders, pareses, etc.; she was treated and the symptoms vanished." For the initial phase of the new method, this procedure was well suited. Collecting single cases, and their intensive clinical discussion, are a natural and useful basis for the implementation and differentiation of a new procedure. A vital method of treatment will continue to value this case approach in order to continue the process of development based on clinical discoveries (Kächele 1981). In general, the strategy of single case oriented research methodology remains of great importance for all types of interventions (Kordy & Normann 1992; Leuzinger-Bohleber & Kächele 1988).

But let us be honest and not deceive ourselves; the field of psychotherapy research has not crowned Freud, or Jung, or one of the many clinician theorists of

the early years, but prefers to point to the year 1930 when the psychoanalyst Fenichel produced a ten year outcome statistics on more than 700 patients being treated at the Berlin Psychoanalytic Institute based on therapists evaluations; with the leading British medical journal Lancet discussing psychotherapy outcome as early as 1935 reporting on 500 cases we may anticipate the beginning of a formal science.

However before the field really started to blossom the shadows and nightmares of the Hitler Regime all over Europe - except Britain - wiped out the early tentative steps, made qualified academics from psychiatry and psychology leave the burned ground and in large numbers settle in North America.

In post war continental Europe psychotherapy and psychosomatics have been very much involved in fighting the sequelae of the war, of the concentration camps, of the separation of children from their parents. Many countries developed a rich clinical culture setting priorities that would not forster the development of formal research. So it may not be by chance that the year 1952 not only saw Eysenck´s powerful attack but also listened to softer voices from the British psychoanalyst Edward Glover (1952) pleading for formal research in psychoanalysis and the north american psychiatrist and psychoanalyst Lawrence Kubie (1952) discussing problems and techniques of psychoanalytic validation. In the same year - as I have learned from David Shapiro´s Ravenscar lecture the first book-length anthology of papers appeared, edited by Wolff and Precker under the title "Success in Psychotherapy".

Even in post war Germany where the generation that still had been trained during the Third Reich had to re-establish psychotherapy as field the early fifties marked the move toward systematic mainly naturalistic research. One of the very first German studies was published by Annemarie Dührssen in 1953 reporting on outcome based on ratings of therapists of a fairly large sample of patients treated at the Berlin Institute of Psychogenic Disorders. Building up a similar institution at

the Munich University Cremerius (1962) reported on over 600 cases that had been followed up for many years[1]. It is in this vein that we can also appreciate the self critical outcome study of the Norvegian psychoanalyst Harald Schjeldrup H. (1955) on lasting effects of the psychoanalytic treatments he provided to his 28 patients before the German invasion had set an end to his clincial practice. He had been professor and director at the institute of psychology since 1922. I would like to better understand why this well knwon and highly respected man - only after the war realized that - not unlike Eysenck - "a number of statistics on the results of psychoanalytic treatments have been published. But the figures do not provide an adaequate basis for an assessment of the effectiveness of analytic therapy, either absolutely or in comparison with other forms of psychotherapy" (p.109). Though we can trace a few happy awakeings of psychotherapy research after the war in Europe as well, the appearance of the first edition of the "Handbook of Psychotherapy and Behavior Change" by AE Bergin & SL Garfield in 1971 confronted the European academic psychotherapy community with the striking fact that a field had developed with only one European representative as author of one of the chapters of the Handbook: HJ Eysenck. Trying to figure the European share in the new field I went through the outcome chapter by Bergin (1971). The result of this search was a meager one: out of about 180 references some fifteen derive from European stock - britisch and continental:

Fenichel was refered to, the aforementioned Lancet discussion from 1935 reporting on 500 cases ; the various contributions by Eysenck especially his negative but very seminal paper on "The Effects of Psychotherapy" (1952), some behaviour therapists like Gelder and Marks from the Maudsley Hospital on desensitization, a Belgian collegue with the name Jonckheere from 1965 reporting on 72 neurotic eclectically treated, the Norvegian psychology professor Harald Schjelde-

[1]This study is even highly praised by Eysenck & Beech (1971) for the relentless pursue of long term follow up

rup I have mentioned before, another Scandinavian named Kringlen (1965) on long term prognosis of obsessions famous and just a little bit of David Malan, an unpublished manuscript from the year 1967. He did not cite the flagship, Malan´s (1963) study of brief psychotherapy.

The question what had happened has intrigued me for quite awhile; this intriguing feeling increased when I read the draft of the „History of Psychotherapy Research“ that had been designed by good friends, Hans Strupp and Ken Howard, where it all began with Freud and then it exiled to the United States.

Although I do not doubt the representativeness of Bergin´s overview though one always finds a few apt references Bergin had missed (slide 2: Bergin´s orphans).

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Some other factors may come to our rumbling minds. I myself had been very proud to write a theoretical dissertation and many of my collegues still today are proud of their armchair theorizing and pseudo-empirical explanatory power.

When after many battles the university in Vienna opened the Institute für Depth-Psychology and Psychotherapy in 1972 Hans Strotzka as newly elected chair in his introductory lecture pointed out that "in contrast to all other comparable countries Austria is lacking nearly completely any effort to objectify the indications for psychotherapeutic treatments and the selection of adaequate treatment methods, it lacks any effort to objectify the course of treatment and its outcome (p.209). Strotzka makes the comparison to the medical practioner who solely based on his own experience would select the appropriate antibiotics for his patients. He leabves no dount that this situation would not be tolewrated in somatic medicine and thus claims that the field of psychotherapy could not continue to support

the highly individualistic notions prevailing in Austrian psychotherapists´minds. He strongly invoked the social responsability to engage in empirical research (Strotzka 1973b). In the same year at a meeting of the middle European psychoanalysts´ associations he addressed the problem that the kind of patients treated in psychoanalysis cannot be referred to by reading the - I quote him - "excellent Handbook , especially the chapters by Garfield and by Luborsky. As cultural aspects are of high relevance the validity of the american results has to be considered very restricted for central European populations (Strotzka 1973a, p.181).

The point I would like to throw into the discussion by quoting one of the highly respected seniors from the field of continental European psychotherapy worlds in the beginnings of the seventies resides in the peculiar mixed feelings these statements leave with us. Twenty years later we are not in a position to claim great progress. It would not be difficult for me to identify honourable collegues from German academica, professors of psychotherapy who would endorse just this individualistic position as the only tenable one to perform psychotherapy. One reason I would like to bring to your attention may lie in the extraordinary success psychotherapy has had in the European countries, especially in German speaking countries Austria, Switzerland and East and West-Germany now unified but also in the northern Scandinavian countries and if not in France though in Paris and Roma. When psychoanalysis was transferred to the Americas it became a medicalized profession. In Budapest where psychoanalysis had a early fruitful start, like in all major European cities after world war one psychoanalysis contributed to create a climate that was supportive of the notion of "treatment as education". „Bildung“ - a word that encompasses education, culture and breeding - threw a magic spell on clever minds which have been justified by an endless debate on the proper epistemology (Thomä & Kächele 1975). Hermeneutics as a European trademark derived from the famous distinction by Dilthey (1894) between "Geisteswissenschaften" (humanities) and "Naturwissenschaften" (natural sciences) helped to

place the daily work of psychotherapy - which is understanding patients´ needs and wishes - outside of the demands of natural science.

Though this line of arguing might equally well apply to North America - the cradle of formal psychotherapy resarch - I tend to believe that it had and still has a stronger foothold in the European mind. To give an example pertinent to this. The leading German psychoanalytic journal *Psyche* has a monthly distribution of seven thousand copies, yet there are no more than two thousand practising psychoanalysts and not all of them are eager reader of that journal. So who consumes the outpouring of psychoanalytic ideas on all topics mankind is dealing with. In contrast to the deep involvement of the psychoanalytic movement - and within this argument this encompases the softer, psychodynamic approaches - with all affairs of society, behaviour therapy rarely has aspired to become overarching, all explaining. Rooted in academic, experimental psychology - at least within its university based fields of practice and theorizing, behavioural approaches tend to remain within the problem solving, goal directed activities too often without the reflective stance of why a symptom has achieved society´s baptism here and now.

Another salient feature of European psychotherapy research being a late comer is intricately tied up with the vast cultural impact of language. This talk by itself demonstrates to me that I remain far off from what I would like to say. The necessity of communicating in a foreign language imposed a special burden which easily could be identified by tracing the independence of research activities in different European countries. Language as cultural tool is not in everyman or every woman´s hand. For many years I had a dim notion about important work of the Argentine psychoanalyst David Liebermann (1970) about semiotics and the role of language in the psychoanalytic process; in the meantime I even own the two spanish written volumes but still have not studied it carefully as no english translation is yet available. How much pertinent work is not known among us within the multilanguage European community I do not even dare to guess. And how many colle-

gues are reluctant to come to our meetings because they are not self-assured enough to pave their way into this group by using the pidgin version of Shakespeares language. Furthermore we all tend to underrate the conceptual influence of language on our communicative efforts. The psychoanalytic community has become painfully aware that Strachey´s translation of Freud´s work changed substantially some of the key concepts; so we should address this issue in greater detail. In one respect the Society for Psychotherapy Research when founding the Journal has made an inroad into the problem of publication by allowing now submission of papers in at least two additional European languages. It would be a productive line - after complaining too much - if the European psychotherapy research community could capitalize on the cultural and linguistic diversity by joining on cross-cultural studies as some of us have already begun.

As this talk is not supposed just to look back in anger but to project unto future developments that may be around I shall now turn to some present and forthcoming strategies where I feel we seem to head for. Talking about we - I refer to my collegues from the Center for Psychotherapy Research in Stuttgart that share with me their ideas and incentives.

As psychotherapy research at any given time has multiple functions and tasks to perform it aims at the scientific evaluation of existing practice and at the discovery of new fields of application. These questions changed with extension of possible indications, with growing differentiation of treatment procedures and with the progressive implementation of psychotherapy within the health system. The early approach "does psychotherapy work at all" has been replaced by the questions "to whom is what kind of psychotherapy helpful" and "how does what kind of psychotherapy work".

Futhermore it has become obvious that the findings from systematic research are directed at different audiences - e.g. at psychotherapists who conduct the

treatment in question as well as to health professionals from related, often competitive disciplines. Research findings are addressed at those who benefit directly (e.g. patients or their relatives) as well as at those who fund the costs (e.g. insurance companies) or are responsible for adequate health policies (e.g. politicians, unions). The diverse groups may have totally different expectations (Strupp & Hadley 1977). Therefore research has to provide a variety of information to satisfy the needs of the different interest groups.

The development of psychotherapy research in the nineties are characterized by a growing diversification of research approaches. Process-outcome research, large scale multi-site studies on the treatment of specific diseases, and health care system research are in our opinion the leading paradigms of the decade.

a. Process research

We are now faced with the seeming paradox that, in spite of the overwhelming and certainly impressive evidence for the most frequently practiced forms of therapy, we are faced with many critical voices complaining that the many outcome studies have not contributed to a better understanding of therapeutic mechanisms. For example, Klaus Grawe, the author of an hotly debated review article (1992) wrote in 1988: "Only those who ignore the results of psychotherapy research can maintain with a certain subjective surety that they already know what is right for their patients." It is within this context that the very material of the therapeutic process is rediscovered and the detailed analysis of single cases once more achieves a prominent status (Dahl et al. 1988; Greenberg 1991; Greenberg & Pinsof 1986). This move entails increasingly focusing on details of the treatment process itself. This attention to specific details of treatment will require new assessment procedures and a better articulation of moment to moment events that significantly influence treatment outcome.

b. Multi-center studies

Detailed process research on multiple cases combined with sophisticated outcome measurement supports finding specific treatments for individual patients with particular disorders which is known as the question of differential indication. For many years substantial research on specific groups of patients remained rare as most servive oriented institutions had to take care of a broad spectrum of patients, which only sometimes allowed for the formation of groups homogeneous with respect to one disease. It took some time to realize that this situation was not principally different from somatic medicine, where the development of multi-center studies led to progress because the desired homogeneity allowed better conclusions.

The multi-center study on the psychodynamic treatment of eating disorders that has been initiated by the Center for Psychotherapy Research in Stuttgart includes a wide range of inpatient and outpatient modalities all over Germany; it also works on the logistics of implementing the study in other European countries. As this multi-center study is heavily involving non-university institutions and offers also clinical exchange programs we feel that this type of research commitment may well turn out to be a prototype for a new look in psychotherapy research (Kächele et al. 1992).

Criterion-oriented research not only constitutes a problem for outcome research with psychosomatic disorders; there it becomes quite visible and leads to additional theoretical questions. In general, the discussion of criteria of outcome has been much neglected in outcome research. There are no standard criteria for the assessment of treatment success at all. Up to now individual research groups have been free to select their own criteria and to operationalize the measurement procedures. This is astonishing since the problems of standardization are well known.

Maybe it is not even desirable to find superficial compromises that are satisfying to no one. It could turn out to be more productive for the further development

of psychosomatic medicine and psychotherapy if we continue to have an open discussion on goals, on criteria of success, and on the chances of reaching these.

c. Evaluation of economic aspects

The investigation of the relation between established therapeutic methods and outcomes is a highly current topic in many western health care systems. How much of which kind of therapy is adequate to guarantee a fair chance to the patient to reach the desired goals? Up to now we have no well established answers to this kind of question. Research on these topics is developing into two directions: (I) cost-benefit and cost-effectiveness analysis (CBA/CEA), and (II) dose-effect models.

I. Cost-benefit and cost-effectiveness analysis

Precipitously rising costs of medical activities led to the call for data providing a rational basis to build a health service system that guarantees affordable high quality treatment.

Cost-benefit and cost-effectiveness analysis (CBA/CEA) are rare and usually receive attention merely from the angle of health policy. Therapists perceive all these approaches as a substantial threat to their freedom to practice therapy as they see fit 'to do the best possible for their patients'--and probably they are right from a micro-perspective focusing on individual patients. However, from the macro-perspective of the clinical institution or the health care system as a whole, their practice might well be sub-optimal.

There is no doubt that all people involved wish maximally efficient psychotherapy, but clinicians as well as researchers hesitate to put this into monetary terms. This is not necessary at all: the point of interest in CBA/CEA is not just decreasing costs, but discovering how to employ scarce therapeutic resources to achieve a maximum of returns. An example of the latter would be a study designed

to investigate how best to distribute sessions over treatments in order to support the processes of psychic development. In this respect CBA/CEA offers an opportunity for the application and validation of theories of psychotherapy, and is complementary to the more familiar areas of psychotherapy research.

Thus in CBA/CEA different interests of different groups are to be distinguished; they do not have to be reconciled: patients and their relatives, insurance companies, employers. In spite of the enormous importance only few investigations are at hand (see (Newman & Howard 1986; Schlesinger et al. 1980; Yates & Newman 1980b)

Dose-effect models

I already referred to the possible linkage of micro-outcomes to macro-outcomes. To test this idea one has to investigate the relationship between the investment of therapeutic means and the outcome of therapy. There are qualitative and quantitative aspects to what constitutes 'therapeutic means'. Up to now only the quantitative aspects have been addressed explicitly (Howard et al. 1986)

Even if such investigations of the economic aspects of psychotherapeutic care have no direct impact on the individual therapist's strategy to care for his patients, they are necessary to optimize patient care from the point of view of a macro-perspective on the health care system.

Investigations of these phenomena have far-reaching clinical implications because they correct the clinician's illusion (Vessey et al 1993) that he or she is treating an representative sample of patients. Epidemiological studies of the incidence and prevalence of psychosomatic or neurotic illnesses, of bodily dysfunctions or emotional disturbances, give an estimate of the need for services; the investigation of therapeutic practices yields an estimate of available resources to meet those needs; and, studies of the patterns of service utilization identify the constituencies served by the delivery system (Howard et al.1992).

Inpatient psychotherapy:

A specialty in some European countries, espeically in Germany East and West is "in-patient psychotherapy". Inpatient psychotherapy is more than just psychotherapy in a hospital. Its general goals are based on the assumption that a convenient composition of a variety of therapeutic factors in a suitable structured institutional setting will allow the treatment of those patients who when treated in an outpatient setting are said to have little chances of success. Dependent on therapists´courage. clinical experience and creativity, and given environmental conditions, new treatments programs are developed for 'difficult' patients. This promotes local solutions and prevents standardization. The sheer amount and diversity of psychotherapeutic and psychosomatic hospitals to be found all over Germany as a well established part of the 'psycho' health care system may come as a surprise to the foreigner; however it is an established fact that in Germany nearby 40 % of all patients receive their psychotherapy as time-limited inpatient psychotherapy (Meyer et al 1991). Inpatient psychotherapy may be characterized as "psychotherapy round the clock in the form of various well organized, coordinated and respectively theoretically justifiable indicated and individually dosed (verbal and non-verbal) intervention techniques" (Schepank & Tress 1988).

This inherent complexity of inpatient psychotherapy challenges conventional empirical research. Inpatient psychotherapy still awaits an empirically based clinical theory which will allow justifiable decisions on the indication (admission to which kind of treatment) and on the spending of diverse therapeutic resources. These demands are not met yet by available empirical research.

Therefore, inpatient psychotherapy will be the coming target of more systematized research because it may turn out that we may learn new things about micro-socio-cultural embedding of diseases - their interactional staging - by studying those aspects of therapeutic communication that misleadingly are called non-

verbal. As all disease processes are anchored in basic biological processes we have to recognize that we do not know much about the elementary signal exchange and the impact of artificially manipulated environments on the course of diseases. We have no adequate conceptions at hand for those processes of semiotization of symptoms that finally lead to full symbolization; the empirical studies on the role of diverse semiotic layerings shaping the psychotherapeutic discourse on the medical ward round point to the usefulness of complex linguistic and semiotic investigations (Bliesener & Köhle 1986).

Inpatient psychotherapy treatment settings also provide options for new concepts, new methods and findings. The so-called adjunct methods that are despised by the established schools may have touched truths that have escaped systematic research up to now. Taking into consideration that in the very most cases psychotherapy (i.e. individual or group psychotherapy) covers only a small portion of the probably active ingredients of an inpatient treatment program the relevance of such a systematic research gap for inpatient psychotherapy becomes obvious.

Besides discovering inpatient psychotherapy as a research option we may expand the notion of inpatient psychotherapy to the world of the hospital where all patients are inpatients in more or too often in less favorable supportive psychological surroundings. If we think of patients in a situation of a bone-marrow transplantation we might like to know more about the defenses and coping resources to better help them to adjust to the life threatening treatment method (Arnold et al.1992); thus we also have to ask what role do certain factors which are acknowledged as relevant in empirical research on in- and out-patient psychotherapy do play in the context of clinical medicine?

We strongly feel that psychotherapy process and outcome research should expand its field of aspiration; it should support the "widening scope of psychologi-

cal medicine" to provide empirical support for the relevance of motives and thoughts in all human disease.

Psychotherapy research as described here should thus link up with liaison and consultation work. One cannot but emphasize the substantial lack of evaluative research in that area of possible psychological impact on medicine though a beginning has been made. It is time to prepare this field for serious and adequately conceptualized research (i.e. to formulate a research program, to develop classification systems, to create specific instruments etc) and to achieve consensus among the scientific community that these fields are worth the personal efforts needed.

These demands create new questions which enlarge the approaches of traditional psychotherapy research; new structural and logistic methodologies are asked for. The efforts to launch studies in these extraneous, off-limit fields of somatic medicine are not small, the awards waiting for the psychotherapy researchers yet might be much greater than we all anticipate today.

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