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EDITORIAL

Dear colleagues,

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

In the present issue we are pleased to propose a selection of the key lectures which were presented during the conference organized by the International Federation for Psychotherapy in Marrakech, Morocco, from the 20th to the 22nd of April 2017. The theme was 'The Universal and the Cultural in Psychotherapy'. The site was the Faculty of Medicine and the scientific program was made of 9 plenary lectures, 4 symposia, and 3 workshops. Driss Moussaoui, Casablanca, was the local organizer of the conference and offered a great occasion to build a bridge between Western and non-Western culture in psychotherapy. We warmly thank him for his job.

Paul M.G.Emmelkamp, University of Amsterdam, presented a plenary lecture on “How Evidence-Based are Evidence-Based Psychotherapies in non-Western Countries” highlighting the need to develop psychotherapy research in non-Western countries since still the large majority of the studies on this topic are conducted in the US. Publications from countries with a non-Western background (e.g., Asia, Africa, Latin America) are largely exceptional cases. Further, many Western countries have ethnic minorities, but relatively few studies have addressed the effectiveness of psychotherapy with ethnic minorities within Western cultures.

Franz Caspar, University of Bern, presented a plenary lecture on “Therapy Relationship: Why is it relevant and are there any recipes?” stressing the important role of relational factors in psychotherapy and their influence on outcome. He also made suggestions and proposed elements on how to bring about an appropriate relationship.

Ulrich Schnyder, Zurich, presented a plenary lecture entitled “Trauma is a global issue”. Traumatic events are common in the daily lives of people all over the world and the great majority of the global burden of disease arising from mental health conditions occurs in low and middle income countries, among populations in transition and those struck by forced migration. These mental health problems frequently arise as a result of traumatic events, including war, mass violence, natural disasters, and accidents. By contrast, only a minority of studies in the field of traumatic stress research are performed in low- and middle-income countries.

We are pleased to announce the coming IFP WORLD CONGRESS on “PSYCHOTHERAPY, STRONGER THROUGH DIVERSITY” held from the 7th of June to the 9th of June in Amsterdam, The Netherlands. You can find more details in the webpage www.ifp2018.com.

The IFP board wishes all of you a pleasant reading and Merry Christmas,

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REPORT ON IFP CONFERENCE IN MARRAKECH 20-22 APRIL 2017

Driss Moussaoui
Casablanca, Morocco

The International Federation for Psychotherapy organized a conference in Marrakech, Morocco, from 20 to 22 April 2017. The theme was 'The Universal and the Cultural in Psychotherapy'. The site was the Faculty of Medicine and the scientific program was made of 9 plenary lectures, 4 symposia, and 3 workshops.

The Moroccan Association of Psychoanalysis and the Moroccan Association of CBT were represented by their Presidents. Ten different countries were represented, mostly from Europe.

The positive aspects of this conference were the high quality of presentations and the vivid discussions that took place in the nice environment of the Marrakech Faculty of Medicine. It was clearly shown that the field of Psychotherapy is progressing, including in psychosis. One of the main recommendations of the conference was to find out ways to teach simple psychotherapies to primary health workers, and even to lay people in remote areas, in conditions such as post-natal depression.

The main problems encountered in organizing this conference was the difficulty to mobilize enough attendance for such interesting scientific program, and the difficulty to enroll other countries of the region (apart from Lebanon) in this project. IFP will however continue to organize such scientific events in other parts of low and middle-income countries, because the demand is huge and the availabilities for psychotherapy in low and middle-income countries very scarce.

Driss Moussaoui, MD, was the founder and chairman of the Ibn Rushd University Psychiatric Centre in Casablanca from 1979 to 2013. He was also director of the Casablanca WHO Collaborating Centre in Mental Health from 1992 to 2013. He is a founding member and past president of the Moroccan Society of Psychiatry, as well as past president of the Arab Federation of Psychiatrists. He edited or co-edited 11 books and more than 150 papers in international journals.

He founded with the WPA Executive Committee the Jean Delay Prize (1999) and is the scientific director of the series "International Anthologies of Classic Psychiatric Texts" (World Psychiatric Association).

He is past-president of the World Association of Social Psychiatry (WASP, 2010-2013) and is currently Vice-President of the International Federation for Psychotherapy and member of the French Academy of Medicine. He is also World Psychiatric Association and WASP Honorary Fellow

HOW EVIDENCE-BASED ARE EVIDENCE-BASED PSYCHOTHERAPIES IN NON-WESTERN COUNTRIES

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Most psychotherapy research is conducted in Western countries (i.e., US, Canada, UK, and a few other Western European Countries). For example, in a review of the journal Psychotherapy Research of papers published in the last 25 years, still the large majority of the studies were conducted in the US (Strauss et al., 2015). Publications from countries with a non--Western background (e.g,. from Asia, Africa and Latin America) are still largely exceptional cases. Psychotherapy research in Portugal, Spain, and Latin American countries has evolved significantly. That is apparently less the case in Africa and Asia. Further, many Western countries have many ethnic minorities, but relatively few studies have addressed the effectiveness of psychotherapy with ethnic minorities within Western cultures.

Is psychotherapy evidence based for ethnic minorities in Western countries?

There is little empirical evidence that evidence--based psychotherapies are effective with minority populations. Usually, results are not analysed separately for ethnic minorities within a study. There are few efficacy studies to guide treatment and research with ethnic minorities. Studies on service utilization, attrition, treatment preference, and health beliefs suggest that ethnic minorities may respond differently to psychotherapy both in the US and in Western Europe (Neftci & Barnow, 2016). This may be related to culture-bound values of psychotherapy. Western psychotherapy promotes individualism, autonomy, and achievement, but in many cultures people operate in a more collectivistic fashion. Further, cultures differ with respect to verbal, emotional and behavioral expressiveness which affects the way psychotherapy is experienced in other cultures.

Western psychotherapy tends to value one's ability to self-disclosure and to talk about the most intimate aspects of one's life, but other cultures may not value self--disclosure for fear it brings shame to the family or due to mistrust.

Cultural adaptation: How to evaluate cultural sensitivity of psychotherapy?

Taken together, there is a clear need of cultural adaptations of psychotherapy. It is important that the treatment goals are consonant with cultural expectations of therapy and that the patient agrees with the definition of the problem and the specific treatment. A good candidate for a culturally neutral psychotherapy for depression is behavioural activation (Mir et al., 2015). A recent meta-analysis involving 26 randomized controlled trials (RCTs) into the effects of behavioural activation (Ekers et al., 2014) found behavioural activation superior to controls and medication, but only one RCT involved non--Western population (Iran, Moradveisi et al., 2013). Other studies found behavioural activation as effective as cognitive behaviour therapy (CBT) (Dimidjian et al., 2006; Richards et al., 2016). Thus, behavioural activations may be a promise for developmental countries.

CBT is a Western evidence--based treatment for a variety of disorders and most efforts have been invested in culturally adapting CBT protocols. CBT provides a conceptual framework that uses reasoning approaches (e.g., Beck and Ellis) but this is inconsistent with Eastern and other philosophies. Thus, cultural adaptations have to be made, which implies more emphasis on behavioural than cognitive techniques, less emphasis on the concept of 'self' in favour of the concept of 'the collective' of some cultural groups. In addition, involvement of the family should be considered (e.g., Arab). Further, dependent patterns of behaviour should not be considered as pathological but as normal in some cultures (e.g. Chinese).

The role of the therapist may also have to be modified. In contrast to most Western cultures, in some cultures, therapists are seen as authority figure, which implies that therapist should adapt their role in other cultures.

In the following paragraphs research will be discussed into the effects of culturally adapted psychotherapy. First studies will be reviewed involving ethnic minority groups in Western countries followed by a discussion of the effects of culturally adapted psychotherapy in developmental countries.

Cultural adaptation for ethnic minority groups in Western countries

A number of studies evaluated culturally adapted psychotherapy for minorities in Western countries. Most of these studies were conducted in the US. In 2006 Griner and Smith published a meta-analytic review of culturally adapted

mental health interventions This meta--analysis involved 76 studies with over 25.000 patients. In most of the therapies studies (84%) cultural values and concepts were integrated into the intervention. In addition, 61% of the studies employed ethnic matching between patient and therapist, 74% employed language matching and 17% provided cultural sensitivity training for professional staff. They found a moderately strong benefit of culturally adapted interventions with an average random effect size of .45. Further, interventions targeted to a specific cultural group were more effective than interventions for groups consisting of a variety of cultural backgrounds. Finally, interventions conducted in the patient's native language were twice as effective.

More recent meta-analytic reviews of culturally adapted mental health interventions (Benish et al., 211; Smith et al., 2011; Hall et al., 2016) confirmed the findings of Griner & Smith (2006). The most effective treatments featured the greatest number of cultural adaptations. Not surprisingly, older patients (first-generation) were more responsive to culturally adapted treatment. Asian Americans were more responsive to culturally adapted treatment than patients with another ethnic background.

Another meta-analysis studied the impact of racial/ethnic matching of patient and therapist (Cabral & Smith, 2011). Also here, nearly all studies were conducted in the US. Results reveal that patients see therapist of own race/ethnicity as more positively than other therapist, but here is almost no benefit to treatment outcome from racial/ethnic matching of patient and therapist. This may be due to differential attrition. Presumably, dissimilar patient-therapist dyads are more susceptible to premature termination, but this has to be investigated.

Effects of Western psychotherapy in developmental countries

Post-traumatic stress

Very few studies have been published based on research into the effectiveness of psychotherapy in Africa, Arabic and Asian countries. Recent meta--analyses reviewing RCTs for anxiety disorders and depression did hardly include RCTs from developing countries. Further, Clinical Guidelines are based on research from US and Western Europe. However, we cannot simply generalize the results of studies conducted in Western countries to other parts of the world. Thus, there is a clear need for investigating the effectiveness of culturally adapted psychotherapy in these countries.

Recently, a few RCTs on psychotherapy for post-traumatic stress in non-Western countries have been published. Bryant et al. (2011) investigated CBT for PTSD in terrorist-affected people in Thailand. Twenty-eight patients with PTSD who had been directly exposed to a terrorist attack were randomly assigned to CBT or Treatment as Usual (TAU). CBT was culturally adapted and consisted of: education about trauma reaction, Thai meditation, prolonged imaginal exposure to traumatic memories, in vivo exposure, adaptation of cognitive restructuring in which Buddhist techniques of distancing oneself from one's thoughts were integrated. Therapist had no previous experience with CBT and received a 2-day workshop. Results revealed that the culturally adapted CBT was more effective than TAU in PTSD as rated by the PTSD Symptom Scale--Interview (PSS-I), depression (Beck Depression Inventory, BDI-II) and complicated grief (Inventory of Complicated Grief, ICG). Thus, although eliciting distress in others and although expressing distress is not encouraged in Thai culture, Thai therapists accepted exposure therapy and culturally adapted CBT resulted in reduction of PTSD and depression and reduced persistent grief.

In another study (Weiss et al., 2015) the effect of cognitive processing therapy (CPT) investigated in survivors of torture and militant attacks in Iraq. In a RCT CPT was compared with a culturally adapted transdiagnostic intervention (Common Elements Treatment Approach, CETA) and a Waiting-List Control (WLC) group. CETA was more effective (large effect sizes)than CPT and WLC not only on trauma symptomatology but also on anxiety and depression.

Depression

Naeem and colleagues (2015) developed a culturally adapted version of CBT for depression for patients in Pakistan. This treatment is much briefer (6 sessions) than standard CBT (16 – 20 sessions) and involves psycho--education, symptom management, changing negative thinking, behavioural activation, problem solving, and improving relationship skills/communication. Cultural adaptations involved:

- Involvement family member in therapy sessions and homework.
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- One additional session for the whole family at the start of therapy.
- Therapist initially focusses on somatic symptoms
- Urdu equivalents of CBT jargon.
- Culturally appropriate homework assignments.
- Folk stories and examples relevant to the religious beliefs of the local population were used to clarify issues.

All patients fulfilled criteria for depression (ICD--10) and were randomly assigned to the Culturally adapted CBT or Care as usual. The therapy was conducted by psychology graduates. Culturally adapted CBT proved to be more effective than care as usual on: depression (HADS), anxiety (HADS), and somatic symptoms assessed by the Bradford Somatic Inventory (BSI).

In another study CBT was investigated for perinatal depression in Pakistan (Rahman et al., 2008). In Pakistan 25% of rural pregnant females are depressed (Rahman et al., 2003). This adapted CBT program was developed for ordinary village based primary health workers. This Thinking Healthy Programme consisted of techniques of active listening, collaboration with the family, guided discovery (gently probe for family's health beliefs), stimulation of alternative beliefs and culturally appropriate homework.

CBT started with 7 weekly sessions (4 in the last month of pregnancy, 3 in the first post--natal month) followed by 9 monthly sessions thereafter. In an extraordinary large RCT, CBT delivered by trained primary health workers (N = 463) was compared with the effects of an equal number of visits by untrained health workers (N = 440). Importantly, also the assessment instruments were culturally adapted. CBT proved to be more effective at 6 months and 12 months than the control condition. Depression in CBT group more than halved the rate of depression in the control group. Other positive results were that In the CBT condition infants had less episodes of diarrhoea and were more likely to be immunised whereas mothers were more likely to use contraception and had a better overall and social functioning compared to the control group.

Another interesting development is Self-help CBT programs for depression in developmental countries since such programs have been found to be effective in Europe and US. Naeem et al. (2014) investigated a culturally adapted variant in Pakistan consisting of the following elements:

- Involvement of family members to supervise and support patients (weekly phone calls).
- Self-help book (in Urdu) with examples from local folklore and Islamic religion.
- Psycho-education.
- Symptom management.
- Changing negative thinking.
- Behavioural activation.
- Problem solving.

An RCT was conducted in which two treatments were compared in patients who fulfilled the criteria for depression on the Hospital Anxiety and Depression Scale (HADS): Culturally adapted self-help (N = 96) and Care as usual (N = 96). The drop--outs rates were surprisingly low (2% in self-help condition. Self-help was more effective than care as usual on depression (HADS), anxiety (HADS)and somatic symptoms assessed by the Bradford Somatic Inventory (BSI) and by the Brief Disability Questionnaire (BDQ).

Culturally adapted CBT for psychosis

According to the NICE guidelines CBT is an evidence--based adjunct to medication in schizophrenia, but whether this also applies to patients in developmental countries has hardly been investigated. As discussed above, CBT is underpinned by Western cultural values. Naeem and colleagues have investigated a culturally adapted variant of CBT in psychotic patients in Pakistan. People in Pakistan may attribute spiritual causes to psychotic symptoms and may seek help from faith healers (Furnham at al.,2008; Zafar et al., 2008. Naeem et al. (2015) randomly assigned psychotic patients to culturally adapted CBT of 6 sessions plus 1 family session (N = 59) or routine clinical care (N = 57). A spiritual dimension was included in formulation and treatment pan in CBT. Participants in the CBT condition showed greater improvement than controls in positive symptoms, negative symptoms and general as assessed with the PANNS and on delusions and hallucinations assessed with Psychotic Symptom Rating Scale (PSYRATS). Results are very promising but needs to be replicated in other cultures as well.

Psychotherapy for chronic pain

Psychotherapy methods are widely used in Iran but results of studies are most often published in local media. In the past decade Iranian publications in international journals have dramatically increased. Recently, a review of RCTs into domestic trials of psychological treatment of chronic

pain has been published (Faizi et al 2014). This review is based on the results of 17 RCTs, usually of low methodological quality. In 11 out of 17 RCTs CBT for chronic pain was investigated. CBT was more effective than other psychotherapy approaches.

Transdiagnostic psychological intervention for common mental health problems

The WHO has begun to develop low-intensity psychological interventions for people with common mental health problems (e.g., anxiety, stress, depression, grief). Problem Management Plus (PM+; Dawson et al., 2015) has been developed for people with common mental health problems and/or self-identified practical problems (e.g. interpersonal conflict, unemployment). This intervention is particularly useful for patients with co--morbidity and has a strong emphasis on behavioural rather than cognitive techniques. Problem management is used rather than problem solving to highlight that many practical problems encountered by people living in adversity may not necessarily be solvable (Dawson et al., 2015).

The effects of Problem Management Plus were investigated in a RCT in Pakistan (Rahman et al., 2016). Patients in an area with ongoing conflict were randomized to Problem Management Plus (N = 172) or Enhanced usual care (N = 174). Lay health workers administered 5 weekly sessions of 90 minutes each. At 3 months follow-up Problem Management Plus was more effective in anxiety and depression (both rated with the HADS), post-traumatic stress (PCL-5), and functional impairment (WHODAS 2.0).

Discussion

Sofar, most studies into the effects of culturally adapted psychotherapy have been conducted in Arabic countries. The recent RCTs in Arabic countries have primarily focussed on (culturally adapted) CBT. There have been conducted many more RCTs in other countries as well, but many RCTs are not published in international journals. For example, a recent review of studies conducted in local journals in China reported on the results of 235 RCTs between 1997 and 2014. Three categories were distinguished: Cognitive-psychoeducational therapy, Humanistic--experiential therapy, and Indigenious therapy (e.g., Naikan therapy, sandplay and Morita therapy). Indigenious therapy and humanistic--experiential therapy were more effective than cognitive-psychoeducational therapy. Humanistic--experiential therapy was more effective than cognitive-psychoeducational therapy (Hedges' g = 0.35. Indigenious therapy was more effective than cognitive-psychoeducational therapy (Hedges' g = 0.34). Interestingly, the culturally more congruent therapies (i.e., indigenious therapy and humanistic-experiential therapy) were found to have a larger absolute efficacy (Hedges' g = 1.18) than did the benchmarks in Western Europe and the US.

In sum, the main conclusion of this review is that one size does not fit all. Cultural adaptations that are manualized and tested can advance research, inform practice and be implemented around the world. Research with ethnic minorities has shown that there are definite differences in responses to therapy, as well as in drop-out. Unfortunately, there is still a lack of research into the effectiveness of culturally adapted psychotherapy in most developmental countries. Through cultural adaptations it may be possible to go beyond the one-size-fits-all approach and investigate the effectiveness of psychotherapy that is contextualized in terms of cultural values.

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Paul Emmelkamp has contributed to a number of areas in clinical psychology, psychopathology and psychiatry. He has written and co-edited many books on research into a variety of clinical subjects. Further, he has written over 500 publications in peer reviewed journals or books. He is Editor in Chief of Clinical Psychology & Psychotherapy. He has received a number of honours and awards, including membership of the Royal Netherlands Academy of Arts and Sciences, an honorary membership of the Dutch Association of Behaviour and Cognitive Therapy, and the Senior Heijmans award for his lifetime achievements from the Dutch Institute of Psychologists. In 2006 he was awarded a distinguished professorship ('Academy Professor') by the Royal Netherlands Academy of Arts and Sciences. In 2014 he was elected as the President of the International Federation for Psychotherapy (IFP)

THERAPY RELATIONSHIP: WHY IS IT RELEVANT AND ARE THERE ANY RECIPES?

Franz Caspar, University of Bern, Switzerland

Introduction

"By the mid-1990s, the persistent demonstration that relational factors were significantly associated with outcome prompted Marvin Goldfried, a past president of the Society for Psychotherapy Research (SPR), to half-jokingly suggest the creation of an official SPR bumper sticker "It's the relationship, stupid" (Farber & Lane, 2001, p. 175). Similar quotes concerning the therapeutic relationship can be found throughout the literature.

When I was a young student in Hamburg (Germany), I learned in the department guided by Reinhard Tausch, a pioneer in bringing Client Centered Therapy to Europe and advancing rigorous CCT research, that there is significant quality of relationship - outcome correlation. This meant to us that essentially the relationship was all that mattered. At the same time, we ridiculed what we called "little plants ideology", that is the idea that just like little plants do not need anything else than water and sun to grow, people do not need anything else than unconditional regard and the warmth of the therapeutic relationship to grow and get rid of their mental problems. You may recognize Roger's idea that a good relationship is not only a necessary but also a sufficient condition for good psychotherapy outcome.

Norcross and Lambert (2011) summarized the findings of the American Psychological Association's (APA) Division of Psychotherapy and Division of Clinical Psychology and identified what works in the therapy relationship as follows:

- The therapy relationship makes substantial and consistent contributions to patient success in all types of psychotherapy studied (e.g., psychodynamic, humanistic, cognitive, behavioral, systemic).
- The therapy relationship accounts for why clients improve (or fail to improve) as much as the particular treatment method.
- Practice and treatment guidelines should address therapist qualities and behaviors that promote the therapy relationship.
- Practitioners should routinely monitor patients' responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to repair alliance ruptures, improve the relationship, modify technical strategies, and avoid premature termination (Lambert, 2010).
- Efforts to promulgate best practices or evidence-based practices (EBPs) without including the relationship are incomplete and potentially misleading.
- The relationship acts in concert with treatment methods, patient characteristics, and practitioner qualities in determining effectiveness. A comprehensive understanding of effective (and ineffective) psychotherapy will consider all these determinants and their optimal combinations.
- Adapting or tailoring the relationship to several patient characteristics (in addition to diagnosis) enhances effectiveness (p. 1-2).

It is obvious that the therapeutic relationship matters, but there are more specific questions to be asked:

- *to what extent* is it related to outcome?
- *how* is it related to outcome, and
- *how* can a good relationship be brought about?

In this short paper no attempt is made to replace or report much more comprehensive contributions such as Norcross' book "Psychotherapy Relationships That Work" (2011), or reviews and meta-analyses such as Martin, Garske, & Davis (2000), Norcross & Wampold (2011) or Flückiger, Del Re & Horvath (2017: in press) and Flückiger, Del Re, Wampold, Symonds, & Horvath (2013) I will rather focus on a few central questions which are not so easy to answer, or the answer to which is at least not common knowledge.

In terms of terminology, two concepts have had lasting influence: Greenson (1967) distinguished between the "working alliance" the extent to which a patient is able to cooperate, and the "therapeutic alliance," the capacity of therapist and client to form a personal bond. The other influential distinction comes from Bordin (1979) in distinguishing between tasks, goals, and bond. Tasks is what has to be done to reach the client's goals. Goals are what the client hopes to gain from therapy. The bond forms from trust and confidence that the tasks will bring the client closer to his or her goals. Horvath, Del Re, Flückiger & Symonds (2011) state that "The alliance has been defined in a number of different ways, but the core consensus among these definitions is that the alliance is an emergent quality of partnership and mutual collaboration between therapist and client." (p.5). In the probably most important book on the therapeutic relationship at this time by Norcross and Lambert (2011) while they refer to "numerous elements" of it being defined in the individual chapters, they also use the general definition of the therapeutic relationship

proposed by Gelso and Carter (1985): The relationship is the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed. The term therapeutic relationship as it is used here is in line with this broad definition and not limited to aspects of collaboration, which are usually meant when the term alliance is used.

To what extent is a good relationship related to outcome?

The times when it was possible to naively assume that a therapeutic relationship is a sufficient condition for good outcome are long gone, and not even the assumption that it is a necessary condition holds. It has become common to not being impressed by significant correlations unless they go along with substantial effect sizes - which the studies related to CCT mentioned above did not provide. Flückiger et al. (in press) emphasize the impact of the therapist upon outcome and indicate a correlation between therapist alliance score and outcome of .33. They also refer to a study by Heinonen et al. (2014) examining the relation of self-reported therapist characteristics and outcome, in which self-reported professional characteristics (i.e. experiences as currently skilful and efficacious, less frequent experiences of anxiety, boredom and current difficulties) as well as personal characteristics (i.e. task-oriented and private) were predictive of the formation of better therapist-rated alliances in both short-term and long-term therapies in the therapist perception, while, these characteristics were not predictive of the patients' views.

Correlations (readers unfamiliar with the meaning of the size of correlation coefficients, effect sizes, etc., we refer to a handy introduction by Norcross & Lambert 2011) reported for alliance in meta analyses are generally slightly below r = 0.30, with considerable variation between the original studies (Flückiger et al. in press). Even the highest rea-ched relation to outcome would therefore not justify to say, it's all relationship. It is essential though to see that these values are averages. There is variation in the relationship quality between therapists as well as within one therapist: Some are able to establish a good relationship with almost all of their patients while with others there is more variation from patient to patient. There are also therapies with a constant quality within the course of the therapy while with others there is a clear trend of improvement or deterioration of the relationship, or a repeated up and down.

For some patients, even little details in a relationship are absolutely crucial for staying in therapy vs. dropping out, while others are less sensitive, ready to work productively even in a less than ideal relationship, or even investing actively into getting a derailed relationship back on track. Patients are, after all, not passive objects on which therapist interventions impact, but active participants (Bohart & Wade, 2013).

Several patient characteristics are obviously related to the therapeutic relationship and via the relationship also to outcome. There are two ways to take this into account. In the ATI (Aptitude-Treatment-Interaction Approach; see Clarkin & Levy, 2003), it is emphasized that there is no treatment that is optimal for every patient but treatment needs to be differentially selected. This differential treatment selection is typically done on the level of variables, for example, the patient's reactance level (Beutler, Harwood, Michelson, Song & Holman, 2011). While it makes complete sense to everybody (I assume) that "different folks need different strokes", as Norcross expresses it, differential treatment selection has overall yielded limited effects when used as a prescriptive approach (Watzke et al., 2010) although it seems that considerable effects can be found when the approach is used as basis of supervision (Beutler, Someah, Kimpara & Miller, 2016)

The second approach is more individualized, emphasizing the adaptation to the individual patient beyond the level of variables: Therapist responsiveness (Kramer & Stiles, 2015; Caspar & Grosse Holtforth, 2009). It has been shown that this is an essential approach in the endeavour of optimizing therapy. It is what experienced, good therapists strive for achieving. Another way to describe this approach is contextual, which has been found with experienced master performers in all kinds of domains (Dreyfus & Dreyfus, 2005; Caspar, 2017). Contextual means that therapists are not using crude rules or don't stick to detailed manuals. They much rather construct a procedure in the very moment, based on a good understanding of the patient (case formulation) in which only parts are planned. In this construct many details of the patient and the therapeutic situations are taken into account (Caspar, 2007): No simple rules, but rather an "it depends ..." attitude, ideally going along with a high mental presence of the therapist in the moment (Geller, 2013).

How is it related to outcome?

There are several models of how the therapeutic relationship is related to outcome. Some are related to schools of therapy, some are more independent concepts. For example, in traditional behavior therapy, the therapist can be seen as reinforcing desirable and extinguishing or even punishing less desirable patient behaviors. In addition, once a good relationship is established, the therapist has more credibility and power in encouraging the patient to undertake the steps considered necessary for progress in therapy. In CCT, in a good relationship, a patient is encouraged by the therapist's unconditional acceptance to no longer hide sides of him or her that s/he used to experience as unacceptable. This happens within and outside therapy and leads to corrective experiences. In psychodynamic approaches the relationship is a stage that allows transferences to occur. They can be used for interpretations serving the production of insights, which are then the basis for changes in experience and behavior. This psychodynamic stance is also essential for concepts prescribing how to bring about a good relationship, such as the Alliance Rupture concept (see below). There is a particular psychodynamic approach, which goes beyond using the relationship for transference interpretations, the Control Mastery approach. In this approach and its test concept (Silberschatz, 1986) it is assumed that patients unconsciously create test situations for therapists with the purpose of disconfirming pathogenic beliefs. For example, a patient with the pathogenic belief of not being loveable may behave in a particularly nasty way towards the therapist. If the therapist resists the spontaneous reaction of rejecting the patient and rather stays friendly and available, the patient will be open to therapeutic work and the belief of not being loveable is weakened.

Corrective experiences in the therapeutic relationship or outside, encouraged by the safe relational basis with the therapist, is a general concept working across schools of therapy (Castonguay and Hill, 2012). While corrective experiences can be seen as a common factor, the way in which they are facilitated, their very content and nature, and the way they are discussed and used in therapy vary considerably between different therapeutic approaches.

Another type of interventions that may occur in any kind of therapy (possibly with the exception of traditional psychoanalysis) are therapist self-disclosures, i.e. anything a therapist expresses about himself, may it be details from his/her personal life and experiences or reactions upon this concrete patient (Hill, Spiegel, Hoffmann, Kivlighan & Gelso, 2017). For the effects of self-disclosure it is extremely important that it is driven by the interests of the patient rather than the therapist. A therapist should neither waste therapy time by telling things from private lives (or own achievements ...) nor confront the patient in a less than well deliberated way with emotional reactions upon the patient. This is why McCullough (2006) designates such interventions disciplined personal involvements. Self-disclosure may, depending on the content, work in different ways: Normalizing, giving feedback, showing the therapist's engagement and readiness to reveal personal things, increasing the credibility of what is conveyed to the patient, etc.

For the concept of Motive Oriented Therapeutic Relationship (Caspar, 2007) it is assumed that while also providing corrective experiences, it mainly works by satisfying acceptable motives seen as guiding problematic patient behavior in the relationship: When a motive is satisfied independent of problematic means, the use of the latter becomes unnecessary (see below). The expected effect is that the problematic behavior in the relationship, which often lies in the way of cooperating in therapy becomes less frequent and intense, or disappears completely. The patient's attentional resources are no longer absorbed by dealing with the relationship but by dealing with what is officially the content of therapy and change.

How can a good relationship be brought about?

In the last two sections there were already some hints as to how to bring about a good therapeutic relationship. Asking this question also means to become aware that all the knowledge about the impact of a good relationship upon outcome has limited use for a therapist. Castonguay (2000) has asked "How helpful would it be if a supervisor says “now go and have a good relationship with your patient!”. A good relationship is already a micro-outcome, a product of whatever the therapist and the patient do right. But the practitioner needs to know the *ingredients*. Experienced practitioners have their own recipes, and, of course, everyone has to work with what they are. Although: If you realize that some patients need you to be more flexible in one or another direction than you habitually are, would you not consider trying to develop that flexibility?

In any case, beginners in general, and sometimes even experienced therapists for particularly difficult cases need explicit prescriptive models for what they can do to establish a good therapeutic relationship. Three models have already been mentioned: The test concept, the alliance rupture concept, and the concept of Motive Oriented Therapeutic Relationship.

The first two I will describe only very briefly, the last, as it is our own concept, with some more detail.

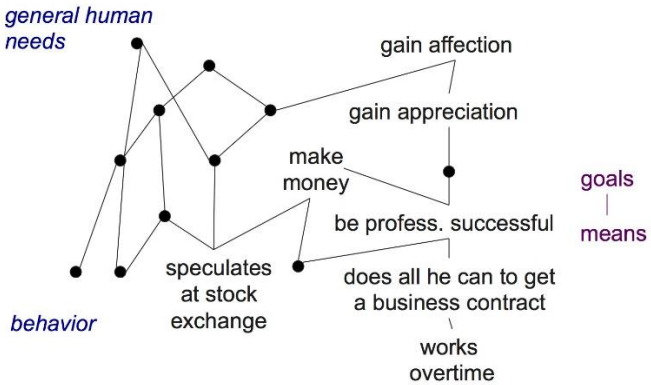
The test concept (Silberschatz, 1986) has a psychodynamic background and as such assumes that important factors in human functioning are unconscious. Nevertheless, referring to pathogenic believes, it can also be seen as a relatively cognitive approach. As already mentioned patients test therapists in order to disconfirm pathogenic beliefs. For an example see above. The therapist's task is to recognize the patient's plan (Curtis & Silberschatz, 2007). In the control mastery approach (different from the Plan Analysis approach, see below), a patient is seen as having one plan, the plan to get rid of pathogenic beliefs and become psychologically healthier. Patient tests are then seen as instrumental for this Plan. Based on the case formulation the therapist needs to resist the temptation of behaving in a way that would confirm the patient's pathogenic belief, but rather behave in what is called a plan-compatible way. It has been shown that this leads to openness to transference interpretations in the process and progress in therapy. Other uses of the relationship by the patient, who is seen as a very active part in the therapy process, is described in Silberschatz (2010).

The Alliance Rupture concept has been formulated and studied by Safran and Muran and others (Safran, Muran & Eubanks-Carter, 2011). It is assumed that ruptures in the therapeutic alliance are unavoidable, they can be used as material, and they need to be mastered for a therapy to continue in a fruitful way. Ruptures are defined as episodes of tension or breakdown in the collaborative relationship between patient and therapist. First of all, the therapist needs to recognize the rupture. He or she is then recommended to meta-communicate about it. This - important! - needs to be done in a *non-defensive way*. By talking about how the rupture came about and what it means to the patient, a resolution can be found, which is related to progress in therapy.

The concept of Motive Oriented Therapeutic Relationship (Grawe, 1992; Caspar 1989, 2007) is based on the Plan Analysis approach. While the same term, plan, is used as in the control mastery approaches' plan diagnosis approach (Silberschatz, 2010), the meaning of Plan is different. Plan is written in the upper case following Miller, Galanter and Pribram's (1960) attempt to distinguish their use of Plan from every day language meaning: they assume that many if not most Plans are not conscious and that non-conscious processing is absolutely needed: Conscious processing requires so many information processing resources and is so slow that nobody could reasonably survive a day on conscious, deliberate processing alone. In the Plan Analysis concept, patients do not only have one plan, striving for change. Rather, their whole interpersonal and intrapsychic functioning is analysed in terms of conscious and non-conscious, adaptive and maladaptive, approach and avoidance Plans.

Clinical Plan Analysis is a comprehensive method striving for explanations for the patient's behavior and experiencing related to the therapeutic relationship and to the patient's problems. A product of Plan Analysis is a two-dimensional Plan structure depicting the patient's most important Plans in an instrumental-hierarchical order. On top are a person's needs, on the lowest level are concrete instrumental behaviors, which mediated by the whole of instrumental strategies, ultimately serve the needs. Figure 1 illustrates such a Plan structure with a non-clinical example.

Fig.1: Schematic example of a Plan structure.



It takes a few days of instruction and practicing to learn the procedure of Plan Analysis case conceptualization; the information given here can only convey an idea of the concept.

Now back to the relationship. Two principles are relevant. The first is that ultimately even the most problematic patient behavior in the relationship serves acceptable motives. Acceptable meaning that even though the *behavior* may be

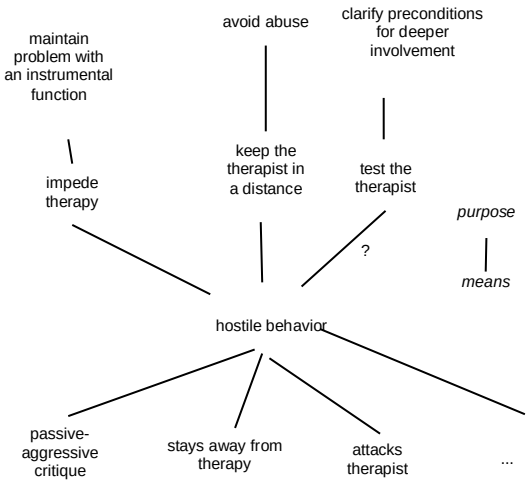
very problematic for the therapeutic procedure, the *motive* itself does not substantially restrict the therapist's possibilities nor threaten his/her professional limits. The rule is thus to go up in the hierarchy of Plans until one arrives at a level, where the motive guiding the behavior becomes acceptable in this sense. One should not go higher than necessary, because approaching the top level in the Plan hierarchy (general human needs) would also mean to lose specificity. Plan Analysis is the basis for making such considerations for the individual patient. As the highest motives are general human needs, which can by definition not be problematic, there is a guarantee that ultimately one will find acceptable motives.

The second principle is to satisfy or even over-satisfy these motives once determined. The purpose is to strip the problematic behavior of its purpose: When a patient gets what he/she is consciously or unconsciously striving for without using the problematic means, it becomes superfluous. Sometimes it is dramatic how immediately a patient can stop using his/her problematic means, sometimes only the frequency and intensity are reduced while the behavior is continued to some extent by habit. It is important that once the patient's functioning is understood, the complementary therapist behavior is proactive, using all possibilities to satisfy the hypothetical patient motive in a way that is non-contingent to the problematic behavior. If this is achieved, concerns that problematic patent behavior will be reinforced, are not justified.

Motive Oriented therapist behavior sometimes means that its sole or primary purpose is in the relationship. It is equally important to conduct interventions targeting the patient's problems in a way that is compatible with the principle of Motive Oriented Therapeutic Relationship. Often *what* is done is determined by the problem-solving goals of an intervention while the *how* and *when* is determined by consideration related to the therapeutic relationship. While the full potential of the concept is shown with problematic patient behavior, adaptive, unproblematic patient Plans can be supported on all levels, from behavior up to the highest motives.

The following example of hostile patient behavior illustrates further that the question of how to deal with difficult patients can't be answered by simple general tricks but that a sound relational strategy requires good understanding of the patient's instrumental functioning: Depending on the motive, the appropriate therapist reaction in the sense of Motive Oriented Relationship would look quite different.

Fig. 2: Hostile patient behavior and possible motives guiding it



It has been shown that the complementarity of therapist behavior in this sense is related to outcome (Caspar et al., 2005), and one of the still very rare experimental studies on the therapeutic relationship shows several positive consequences of a Motive Oriented add on to a psychodynamic treatment approach for patients with a borderline personality disorder (Kramer et al., 2014).

Finally: Even if the Motive Oriented Therapeutic Relationship were of no use for the patient, it is good for the therapist's mental health: When thinking of a patient, for example on a Sunday hike, it is much healthier to focus rather on his or her acceptable motives than on nasty, hostile, boring, or whatever problematic behavior.

Conclusion

The therapeutic relationship is crucially related to a good outcome. While in terms of % of variance, the contribution of relationship is limited, this applies also to the contribution of techniques and other factors. It would not be justified to state that psychotherapy is all therapeutic relationship, but as all major factors have limited impact on the outcome, we need to use all factors we can work with, including the relationship. In addition, and again: the moderate relation between quality of relationship and outcome represents an average: For some patients, staying in a therapy and

working towards a good outcome depends extremely on the relationship.

There are various models for how a relationship contributes to outcome. It is plausible that the impact is composed of several mechanisms, which work with varying profiles in different therapies.

As a good relationship is rather an intermediate outcome of therapy than an ingredient, prescriptive models for how to bring about a good relationship are needed. Three of the not so numerous general concepts have been introduced here.

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Trauma is a global issue

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Trauma is a global issue (Schnyder, 2013). To give just one example, terrorism is a phenomenon that can only be understood and dealt with constructively by adopting a cross-national, cross-cultural perspective. Also, traumatic events are common in the daily lives of people all over the world. When we treat traumatized patients in our own countries, we cannot take for granted that they all speak our language or share our cultural values. Moreover, the great majority of the global burden of disease arising from mental health conditions occurs in low and middle income countries (LMICs) (Ferrari et al., 2013; Magruder, Kassam-Adams, Thoresen, & Olff, 2016; Purgato & Olff, 2015), among populations in transition (Hall & Olff, 2016) and those struck by forced migration. These mental health problems frequently arise as a result of traumatic events, including war, mass violence, natural disasters, and accidents. By contrast, only a minority of studies in the field of traumatic stress research are performed in LMICs (Fodor et al., 2014; Schnyder et al., 2016), also reflected in the low number of publications with LMIC authors (Olff & Vermetten, 2013).

The ISTSS Global Collaboration

In 2010, the International Society for Traumatic Stress Studies ISTSS launched the Global Collaboration to have a stronger global impact on trauma related issues: ISTSS stimulated a process in which eight societies in the field of traumatic stress, agreed to work alongside each other on an equal basis, to identify objectives, facilitate development, and coordinate activities of global importance. The group agreed to focus on one global issue to start, namely childhood abuse and neglect. Clearly, child abuse and neglect is a global public health problem that requires a global solution. As this collaboration's first outcome, Internet information on Childhood Abuse and Neglect (iCAN) was created as an e-pamphlet by members of the global collaboration, located on the homepage of the ISTSS. iCAN provides a comprehensive, scientifically grounded information for adults with a history of childhood abuse and neglect. Currently, iCAN is provided in English, Dutch, German, Croatian, Norwegian, Spanish, Japanese, and Chinese. The information is made available for free at the homepage of ISTSS (http://www.istss.org/public-resources/public-education-pamphlets/ican.aspx), and a number of other websites. For instance, a Chinese version can be found at the AsianSTSS homepage (http://www.asianstss.org). Furthermore, plans for a an application of iCAN for mobile electronic devices are under way.

Another outcome of this initiative is the "globalization" of the Computerized Childhood Attachment and Relational Trauma Screen (CARTS) (Frewen, Brown, De Pierro, D'Andrea, & Schore, 2015; Frewen et al., 2013), a self-report measure designed to measure occurrences of childhood maltreatment (i.e., physical and emotional abuse of self or other family members, sexual abuse towards the respondent, and "bad things" possibly occurring), in addition to the warmth, security, and supportiveness of the respondents' family, peers, and other caregivers. Administration of the CARTS is fully automated by internet website. The Global Collaboration translated and validated the CARTS into multiple languages, including to date: Croatian, Dutch, French, Georgian, German, Italian, Japanese, Norwegian, Russian, and Spanish. A study is currently planned to collect normative responses to the questionnaire, and to obtain responses from clinic-referred participants, in order to further document the prevalence and impact of childhood trauma internationally, as well as to conduct cross cultural comparisons.

A future topic for the Global Collaboration may be refugee mental health. Like child abuse and neglect, forced migration is a global problem, with an ever increasing number of people moving across international borders (over 22.5 million in 2016 (UNHCR, 2017)). A coordinated response, provided by the Global Collaboration, could facilitate continuity of mental health and psychosocial care across borders, including identification of individuals with mental health issues and facilitating their access to evidence based treatments as needed, enhancing their capacity to productively integrate into the host societies with less tensions.

Culture-sensitive psychotraumatology

While there is some evidence of the posttraumatic stress disorder (PTSD) construct's cross-cultural validity, trauma-related disorders may vary across cultures, and the same may be true for treatments that address such conditions. There is also increasing evidence of cultural differences influencing not only psychological mechanisms but trauma-related neural processes and substrates as well (Liddell &

Jobson, 2016). Experienced therapists tailor psychotherapy to each patient's particular situation, to the nature of their psychopathology, to the stage of therapy, and so on. In addition, culture-sensitive psychotherapists try to understand how culture enhances the meaning of their patient's life history, the cultural components of their illness and help-seeking behaviors, as well as their expectations with regard to treatment. We cannot take for granted that all treatment-seeking trauma survivors speak our language or share our cultural values. Therefore, we need to increase our cultural competencies.

Patients who are reluctant to talk about their traumatic experiences, or even engage in trauma-focused exposure therapy, may instead be willing to write or use other ways of accessing the painful memories such as drawing, painting, dancing, singing, or playing an instrument. Also, individual and collective meanings linked to trauma and trauma-related disorders vary across cultures. Thus, survivors may for instance be exposed to stigma and self-stigma in the aftermath of trauma. In other cultures, community and family cohesion are crucial elements of recovery. However, we also need to beware of premature cultural stereotyping. When disseminating empirically supported psychotherapies for PTSD across cultures, a number of additional challenges need to be taken into account: many low and middle income countries have very limited resources available overall and, more specifically, they suffer from a poor health infrastructure. In summary, culture-sensitive psychotraumatology means assuming an empathic and non-judgmental attitude, trying to understand each individual's cultural background.

Wen-Shing Tseng, the founding president of the World Association of Cultural Psychiatry, defined culture as a dynamic concept referring to a set of beliefs, attitudes, and value systems, which derive from early stages of life through enculturation, and become an internal mode of regulating behavior, action, and emotion (Tseng & Streltzer, 2001). Thus, culture is not static, but changing continuously across generations, responding to ever-changing environmental demands. Furthermore, culture in Tseng's sense is specific for each individual and therefore much more important than ethnicity or race. Experienced therapists usually tailor psychotherapy to each patient's particular situation, to the nature of their psychopathology, to the stage of progress in the course of therapy, as well as to a range of other factors. Treatment could be even more effective, however, if the cultural dimension were to be incorporated. Culture-sensitive psychotherapy involves trying to understand how culture enhances the meaning of the patient's life history, the cultural components of a patient's illness and help-seeking behaviors, as well as the patient's expectations with regard to treatment.

Being sensitive to cultural issues has become a sine qua non for being a good psychotherapist. On the one hand, taking into account the cultural dimension adds yet one more challenge to our already demanding profession. On the other hand, it also enriches our work, providing us with opportunities to learn how diverse human beings are and how different a phenomenon such as a flashback or a certain aspect of a traumatic experience can be understood and interpreted depending on the patient's and their therapist's cultural backgrounds.

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Ulrich Schnyder, MD, psychiatrist and licensed psychotherapist. Professor of psychiatry and psychotherapy. Head a.i., Department of Psychiatry and Psychotherapy, University Hospital Zurich, Switzerland. Research activities are currently focused on various aspects of traumatic stress research, including epidemiology, neurobiology, psychotherapy and pharmacotherapy for PTSD, resilience to stress, and, more recently, 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)

JUNE 7-9 2018, AMSTERDAM

WORLD CONGRESS OF PSYCHOTHERAPY 2018

PSYCHOTHERAPY, STRONGER THROUGH DIVERSITY

WWW.IFP2018.COM

The International Federation for Psychotherapy (IFP) has invited the Dutch Psychotherapy Association (NVP) to organize the 22nd World Congress of Psychotherapy on 7-9 June 2018 in Amsterdam, the Netherlands.
In a rather divided world - reflected in competing theoretical perspectives in psychotherapy - we would like to stress the urge for integration and tolerance. Therefore, we chose the theme:

PSYCHOTHERAPY, STRONGER THROUGH DIVERSITY

The NVP is very proud to welcome psychotherapists from all over the world to our country. The NVP has invited scholars and experts from a variety of theoretical perspectives to cooperate in the
Scientific Committee to develop a program that will be both scientifically and clinically interesting, sharing their perspectives on theory, development and research on psychotherapy.

Venue: the 'Beurs van Berlage'

The congress will be held in the Beurs van Berlage, right in the heart of Amsterdam. This landmark red brick building was once commodity and stock exchange, but now serves as a popular conference venue, located in the middle of the city and close to the Central Station.
We very much are looking forward to welcome
you in Amsterdam, on 7-9 June 2018!

nvp nederlandse vereniging voor psychotherapie

IFP international federation for psychotherapy

Nel Draijer, chair NVP

Paul Emmelkamp, president IFP

Please send announcements of your congresses!

The 48th International Meeting of the Society for Psychotherapy Research (SPR)
June 21 – June 24, 2017
Venue: Toronto, Canada
www.sprconference.com

IFP World Congress of Psychotherapy (IFP)
June 7- June 9, 2018
Venue: Amsterdam, the Netherlands
www.ifp2018.com

2nd Workgroup on Psyhcosomatic research and Practice (WPRP)
September 20- September 21, 2018
Venue: Paris, France
http://www.icpmonline.org/world-congresses-workgroups/coming-congresses-workgroups

The 25th World Congress on Psychosomatic Medicine (ICPM)
September 11 – September 13, 2019
Venue: Florence, Italy
www.icpmonline.org/25th-world-congress-florence-2019

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