VGCt Vereniging voor Gedrags- en Cognitieve therapieën

REPORT ON WCBCT 2019

By Mieke Ketelaars and Saskia Mulder

VGCt Vereniging voor Gedragstherapie en Cognitieve Therapie

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Preface

In July 2019 the scientific team of the Dutch Association for Behavioural and Cognitive Therapy (VGCt) attended the WCBCT conference. Which new developments can be expected? And what to do with them? This booklet consists of two parts. Part I consists of several interviews with experts. Part II consists of a summary of several symposia and a reaction of Dutch experts in the field.

About the authors

Mieke Ketelaars has been working as a scientific journalist at the VGCt since 2019. Her activities include the development of knowledge products such as factsheets, news items and podcasts. After studying Child and Adolescent psychology at Leiden University in The Netherlands, Mieke obtained her PhD at Radboud University Nijmegen, studying the classification of pragmatic language impairment. During that time she also worked as a psychologist at various clinical centers. After several years as assistant professor and program manager, Mieke became increasingly involved in translating scientific knowledge to a wider audience. As such, she is editor-in-chief for the Dutch Journal of Orthopedagogics (Tijdschrift voor Orthopedagogiek) and writes monthly columns for several magazines.

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Saskia Mulder works as the team leader of the scientific and educational team at the VGCt. After studying Clinical Psychology at Utrecht University in The Netherlands, she obtained her PhD in Developmental Psychology, also in Utrecht. Her PhD project was focused on the effectiveness of cognitive behavioral social skills training program for children. In addition to her PhD training program she was also trained in CBT. After obtaining her PhD, she worked as a lecturer and researcher at Utrecht University, where she was focused on the implementation of the intervention she studied in her PhD project. She was also involved in investigating the effectiveness of Dutch anti-bullying programs and developed the Master Course Cognitive Behavioral Therapy for children and adolescents. After ten years of working at the University, she started working at the VGCt, where she hopes to bring scientific knowledge closer to practice and to raise the level of training for cognitive behavioral therapists and cognitive behavioral therapists.

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Part I – Interviews with experts

1.Professor Paula Schnurr

Paula Schnurr is a psychologist and the Executive Director of the National Center for PTSD in the Department of Veterans Affairs. She also is a Professor of Psychiatry at the Geisel School of Medicine and a Fellow of the American Psychological Association and the Association for Psychological Science. Her research focuses on the long-term effects of traumatic exposure, particularly on physical health and quality of life, and on the treatment of PTSD.

In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?
Knowledge about CBT is not executed optimally, in terms of both the use of effective CBT as well as the fidelity with which it is used. CBT may not be a silver bullet, but as an approach to treatment, it is the most effective we have. Yet it is underused, and when used, is not used with enough to fidelity to optimize outcomes.

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In the next ten years, what will be the most promising development in CBT?
How to enhance the effectiveness to promote greater treatment response for more people.

What should research focus on next regarding CBT?
Strategies to promote greater treatment response for more people, including the optimization of treatment selection.

What is the best idea you got as a result of the conference?
There was no single best idea. I especially enjoyed the case discussion about the treatment of complex PTSD regarding the need to used phased treatment.

2.Professor Judith Beck

Judith Beck is President of Beck Institute for Cognitive Behavior Therapy, a non-profit organization in Philadelphia, USA. The Beck Institute offers national and international training in CBT, certification of clinicians and accreditation of organizations. Dr. Beck is also clinical professor of psychology at the University of Pennsylvania.

In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?

We have seen that there is often a large practice gap between what research has demonstrated to be effective and what many practitioners actually do. There's been an explosion of CBT research on so many fronts in the past 10 years, but it seems to take a great deal of time for it to filter down to clinicians. I always tell trainees that I'm a much better CBT therapist now than I was five years ago and I hope to be much better 5 years from now. To improve my skills, I attend quite a few conferences each year, discuss research with colleagues, and keep up with the literature.

In the next ten years, what will be the most promising development in CBT?

I think there will be many, but I'll just mention one. In the U.S., (and elsewhere), there is an increasing focus on recovery. The goals are to promote mental health and wellness, recovery, resilience, and empowerment. We are developing a center for recovery-oriented cognitive therapy at the Beck Institute. Rather than focusing on individuals' symptoms, a major emphasis is on identifying their strengths, values, resources, and positive qualities and inspiring them to work toward their aspirations—what they really want their lives to be like. Rather than being primarily problem-focused in session, we orient treatment toward taking steps to fulfill the individual's goals and predicting (and managing) obstacles that could get in the way: unhelpful cognitions, skills deficits, and practical problems.

What should research focus on next regarding CBT?

Research should continue focusing on what kind of treatment works for whom, how to use technology and paraprofessionals to help millions more people, investigating important psychological processes in therapy; using cognitive science to inform treatment, integrating CBT into primary care (and other medical specialties); opioid addiction (a very big problem in the US), and CBT for serious mental illness. There should also be more research on the best ways to teach, supervise, evaluate, and disseminate CBT (which we're working on at the Beck Institute).

What is the best idea you got as a result of the conference?

My personal reflections were on how skilled and dedicated the clinicians I talked to were. I was impressed!

3.Professor Richard Hastings

Richard Hastings is Professor of Psychology and Education and the Cerebra Chair of Family Research at the University of Warwick. The majority of his research focuses on the psychological needs of children and adults with intellectual disabilities and/or autism and their family members (including parents and siblings). Richard is a Fellow of the Academy of Social Sciences, the British Psychological Society, and the International Association for the Scientific Study of Intellectual and Developmental Disabilities.

In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?

Children and adults with intellectual disabilities are up to five times more likely to experience mental health problems, yet they are often excluded from treatment developments in cognitive and behavioural therapies; compounding mental health inequities.

What should research focus on next regarding CBT?

The major challenge for practice and research in cognitive and behavioural therapies in general in the next 10 years, and the main gap between current scientific evidence and practice, is access to psychological therapies for the wider population. In particular, the international cognitive and behavioural therapies community needs to prioritise adaptation of, and access to, therapies for marginalised groups especially individuals with intellectual disabilities. At present, children and adults with intellectual disabilities face a triple inequity: higher levels of mental health problems, exclusion from services, and exclusion from the evidence base for psychological therapies.

4.Professor Robert deRubeis

Rob DeRubeis has been a member of the Psychology faculty at the University of Pennsylvania since he received his PhD in Clinical Psychology from the University of Minnesota in 1983. During his time at Penn he has served as Associate Dean, Department Chair, and Director of Penn's Doctoral Training Program Clinical Psychology. Along with his students, he has developed assessment tools, including measures of therapist adherence and patient's absorption of cognitive therapy skills, and he has introduced to the field a variety of clinical research methods, including mega-analysis and investigations of sudden gains.

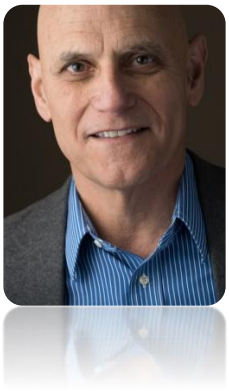
In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?
In the most typical clinical trials of CBT for depression, it begins with twice-weekly sessions and there is a time or session limit. Both of these features appear to be important in bringing about change and in focusing both the client's and therapist's efforts.

In the next ten years, what will be the most promising development in CBT?
We will see more and more adaption CBT to the features of the client, based on precision medicine research in this area. This will include a refined understanding of when and for whom digital interventions will be a good or even the best option.

What should research focus on next regarding CBT?
Research should focus on the optimal matching of intermediate goals (ability to distance, enhancement of positive experiences and affect, ability to recognize and address thoughts that underlie emotional and behavior disruptions) to clients. It should also focus on effects of therapy that go beyond short-term symptom reduction, such as social and occupational functioning and the enduring positive benefits of therapy.

What is the best idea you got as a result of the conference?
Research is showing that it is typical for patients to endorse a lower level of agreement on the tasks and goals of therapy just prior to a given session than they did at the end of the previous session. This pattern is more pronounced at the beginning of therapy. This would seem to account, at least in part, for the fact that concentrating the sessions early in therapy results in lower dropout and better outcome, relative to spacing the same number of sessions out once-weekly from the beginning. Data in support of these two phenomena were presented in two different panels, but they complement one another beautifully.

5.Professor Steven Hayes



Steven C. Hayes is Nevada Foundation Professor in the Behavior Analysis program at the Department of Psychology at the University of Nevada. His career has focused on an analysis of the nature of human language and cognition and the application of this to the understanding and alleviation of human suffering. He is the developer of Relational Frame Theory, an empirical behavioral account of human higher cognition, and has guided its extension to Acceptance and Commitment Therapy (ACT). In concert with Stefan Hofmann and other colleagues he has more recently been attempting to help transition evidence-based intervention from a "protocols for syndromes" to a process-based approach.

In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?

A lot of the scientific knowledge on CBT is done in the context of randomized controlled trials (RCTs) with specific protocols and very few people execute CBT that way. Systems of care have restrictions for example in terms of number of sessions, the conditions under which patients come in. So I'm not sure we've done as good a job as we should as scientists in giving practitioners in what they need. I believe they need knowledge that can be applied to specific individuals and the context of their strengths and weaknesses. In other words, we need a new way of functional analyses. That requires some changes in how we do our scientific research. I think we also need to support clinicians in being able to deploy some of these methods. For example, research recently showed that many clinicians feel discomfort with exposure. Their own emotional reactions towards it predict whether or not they are willing to use the procedure. That is really an unfortunate place to be where we have scientific knowledge that may not be deployed because of psychological processes of the provider, without really considering the tools they need. It's only half done, and waving fingers to people and telling them they should be science based is not really a dissemination, it's naming and blaming. If you really want to take dissemination seriously, you need to think of the providers as part of the system and of psychological knowledge you need.

In the next ten years, what will be the most promising development in CBT?

It is hard not to be influenced by the things I am currently working on. But I do believe that with the stumbling of the DSM and ICD it opens us op to things that are more in our roots, of focusing more on individuals, focusing more on processes of change and focusing more on the deployment of treatment methods in the form of evidence based kernels that link to these evidence based change processes. So I think you are going to see more efforts like IAPS trying to alleviate the burden of mental health problems by increasing the number of evidence based providers. But I think the knowledge base we are applying is a changing picture and that we are going to see protocols broken up into kernels and clients looked at ideographically and in terms of specific processes that predict either prosperity or struggles.

What should research focus on next regarding CBT?

I think the most important thing is to focus on processes of change. If you do that I think you have to be Catholic with a small c. CBT has to break down the walls, open the windows, whatever physical metaphor you wish to use to process evidence based knowledge from all approaches. That does not mean a cacophony, but I think that means we really need to involve the practice

community and looking at the complex network of change that develop over time. We need to be less comfortable with the idea that group designs actually apply to variation within the individual over time. That is an old message that behavioural analysts emphasized in the early days of CBT, but it is getting new form because of a greater understanding of the statistical violations that we make regularly in our research and because of the advancements in statistical analytical tools.

What is the best idea you got as a result of the conference?
I would really say it was an idea that I got, because it is one that I had, but it is one that was underlined the most and maybe I was most pleased to see. It started of in the opening talks, emphasizing the larger cultural and historical context in which CBT looks at itself. There is no one who turns on the television as a serious person, who does not understand the world is facing huge social and environmental, physical en behavioural challenges. My first book was on behavioural principles to alter behavior, to alter environmental problems such as energy use. This was forty years ago. The research I have to say, did not really do that much. We are back at it now. We better really focus on how to deal with immigration and climate change, and more. If we can not do that, I think our future is filled with bleak politicians with bleak visions, feeding of the fear of people. One of the things was a comment as to what the German people might have thought was going on before the rise of the Third Reich. Are we the people who are now feeling that same set of discomfort, of anemia. It altered how I gave my invited address. I talked more about what was going on in the developing world as a result of ACT and how we are trying to deploy it in Africa and solve problems in ways that do not actually exacerbate mental health problems in indigenous societies. I had not seen that kind of sensitivity that frequently at CBT conferences before. So the best idea I come away with is that maybe we are ready to move away from simply protocols for syndromal pathologies to move back to our original vision of trying to understand the psychological processes that change the trajectories of human lives. And if you do that, maybe we can apply that same knowledge not just to depression or anxiety and such but also to behavioural health issues of diet, exercise, disease and so on, but also to stigma and prejudice and compassion and things that seem to be so needed in the modern world. I hope that is true. I would give greater meaning to the great effort that the founders of our tradition put into developing a robust evidence based approach to psychological intervention.

6.Professor Kate Harkness

Kate Harkness is Professor of Psychology and Psychiatry, and Director of the Mood Research Laboratory and the Mood and Anxiety Assessment Service at Queen's University in Kingston, Canada. She received her Ph.D. from the University of Oregon and completed her residency and post-doctoral fellowship at Western Psychiatric Institute and Clinic in Pittsburgh, Pennsylvania. Her research focuses on how stress and trauma in childhood lead to critical changes in biological and psychological processes that heighten vulnerability to depression. She is also working with the Canadian Biomarker Integration Network in Depression (CAN-BIND) to develop profiles of markers that predict response to cognitive-behavioural and somatic treatments

In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?

I am going to focus specifically on depression in answering these questions as that is my area of competence. One difference is that in clinical practice therapists who specialize in CBT generally apply the same CBT approaches to all clients referred to them for treatment. However, the scientific evidence suggests that not all individuals with depression are likely to benefit from CBT. For example, evidence shows that clients with high levels of anhedonia, or with comorbid personality pathology do not respond well to CBT and would benefit more from other treatment approaches such as behavioral activation (in the former case) or anti-depressant medication (in the latter case).

In the next ten years, what will be the most promising development in CBT?

My hope is that in the next ten years, through gaining a deep understanding of the mechanism of action of CBT (at cognitive, affective, and neurological levels of analysis), we will be able to realize a truly personalized approach to treatment and will be able to (a) target our administration of CBT to those who are most likely to benefit from it, and (b) refine our CBT approaches to more effectively target pathological mechanisms.

What should research focus on next regarding CBT?

There definitely needs to be more research examining which types of clients are most likely to benefit from CBT (i.e., baseline psychological, environmental, and neural predictors or response) and what are the cognitive-affective, therapeutic process, and neural mechanisms of action of CBT.

What is the best idea you got as a result of the conference?

The most useful thing I learned was something I can use in my own therapeutic work and in my CBT teaching and supervision. Christine Padesky made a distinction between the "neutral therapeutic face" and the "therapist smile." She talked about when it is most appropriate to use a therapist smile to calm client anxiety and increase alliance. Most intriguingly she cited evidence that the therapist smile may help to decrease amygdala activation associated with anxiety, thereby helping the client to better and more effectively engage in the session.

7.Professor Omer van den Bergh

Omer Van den Bergh is supervisor of the Flemish Association for Behavior Therapy. Since 1988, he teaches health psychology at the University of Leuven to students of psychology, medicine and physical education. He is founder and was director of the Research Group on Health Psychology at the University of Leuven from 1998 till 2015, and co-founder of a spinoff company of the University of Leuven providing services to prevent stress and improve well-being in organizations. Since 2016, he is ombudsperson of the KU Leuven, and emeritus professor since October 2018. Omer Van den Bergh is expert in the broad area of the relationship between health and behaviour. Specific key words in his work are subjective health and respiratory psychophysiology in response to stress and aversive somatic experiences. He is especially inspired by learning psychology and symptom perception theory to investigate the links among these issues.

In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?
Scientific knowledge reveals rather abstract principles and mechanisms; clinical practice requires huge creativity in translating and implementing these principles and mechanisms into a real-life relationship with a specific patient (having an illness theory, specific beliefs and wishes, etc.). Even for treatment effect studies and RCT's describing a standardized protocol, implementing it in a real-life relationship with a patient still requires this creativity.

In the next ten years, what will be the most promising development in CBT?
Blended treatments in which specific pharmacological agents are used to enhance behavioral treatments, because we will better understand the neurobiological mechanisms underlying the effects of behavioral treatment.

What should research focus on next regarding CBT?
Implementation science (and action): progress for mental health of the general population everywhere in the world will much more benefit from developing societal and political structures that facilitate a better implementation of existing knowledge than from any new finding revealed by scientific research.

What is the best idea you got as a result of the conference?
The issues described above under point 2 and 3.

8.Professor Thomas Ehring

Thomas Ehring has been Chair of Clinical Psychology and Psychotherapy at the LMU Münche since 2015. His research interests include the aetiology and treatment of PTSD, the role of early traumatization as a risk factor for psychopathology as well as transdiagnostic problems such as repetitive negative thinking (pondering, worrying) and problematic emotion regulation.

In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?
My main focus are trauma-related disorders. In this area, we know that trauma-focused treatment (i.e., processing the trauma memory and changing trauma-related appraisals/schemas) is most effective to treat PTSD. However, this is still under-used in clinical practice.

In the next ten years, what will be the most promising development in CBT?
It is exciting to see that a lot of researchers are currently looking at how to provide evidence-based tools to personalize treatment, e.g., by moving from disorder-focused to transdiagnostic approaches, using network modeling to identify promising treatment targets, or using dynamic data on treatment processes to predict symptom change. In my opinion, this is a very promising development that has a high potential of improving our clinical practice.

What should research focus on next regarding CBT?
Although CBT is highly successful in many areas, a substantial proportion of patients does not respond, dropout of treatment, or relapse even after successful treatment. We need to better understand these failures and develop specific treatment approaches for these groups.

What is the best idea you got as a result of the conference?
Starting to use process data collected during treatment (e.g., via smartphone-based assessments) in a more systematic way in my own clinical work: plotting it in a way that it is easily accessible to the patient and using it as a data base for the collaborative work.

9.Professor Stefan Hofmann

Stefan G. Hofmann, is professor for Pyschology at the Boston University. His research is focused on CBT, anxiety disorders, depression, translational clinical research, neuroscience and emotion.

In your opinion, what is the main difference between scientific knowledge on CBT and how it is executed in clinical practice?

CBT is rooted in cognitive science and functional analysis of the behavioral tradition. Over the years, CBT has turned into a very pragmatic treatment approach that gave rise to a very large number of treatment protocols for specific DSM syndrome. Although this approach has become popular within the medical model of psychiatry, it has to some extend inhibited scientific progress. CBT has become restricted to techniques to target DSM symptoms rather than understanding, testing, and expanding the theoretical assumptions of the CBT model. Not surprisingly, treatment efficacy has leveled off and it has become clear that the simplistic latent disease model of contemporary psychiatry has outlived its utility. A more process-focused approach will help today's students, scholars, and clinicians push out the boundaries of tomorrow's consensus. The goal is progress. People are in need and are seeking answers from our field. It is up to us to provide for them. The era of protocols for syndromes is over, and the collapse of that former vision gives CBT and evidence-based therapy more generally a chance to reconsider its future from the ground up. The agenda suggested by PBT is positive, possible, and progressive.

In the next ten years, what will be the most promising development in CBT? What should research focus on next regarding CBT?

I will answer both questions together. My friend and colleague Steve Hayes and I believe that the most promising development in CBT is the move away from the protocol-for-syndrome-approach and toward a process-based therapy (PBT) approach. We believe that this has many and far-reaching implications, including the following:

The Decline of Named Therapies. We believe that named therapies that are defined by sets of techniques will become much less dominant as packages and protocols are broken down into procedures linked to processes. Indeed, the term "cognitive behavioral therapy" is already becoming too narrow because the therapeutic change that occurs is by no means restricted to cognitive and behavioral processes. Other processes that have become prominent include social, motivational, emotional, epigenetic, neurobiological, and evolutionary factors. In a process-based era, there is just no need to name every technological combination and sequence, any more than there is a need to name every architectural design or layout of city roads. Named technological protocols will continue to have a role for some time, but as procedures and processes take center stage, most of them will begin to move to the sidelines.

Greater Scalability. The contemporary approach of treatment development and implementation has resulted in a mindboggling list of highly specialized treatment protocols for an ever-expanding number of DSM-defined disorders. This has impaired scalability and accessibility to adequate care, as is evident in recent efforts to improve dissemination and implementation by the National Institutes of Mental Health. PBT can facilitate training and dissemination of evidence-based mental health care by training clinicians in strategies that target a set of core therapeutic processes.

The Decline of General Schools and the Rise of Testable Models. We predict that amorphous systems, schools of thought, and vague theoretical claims will either fold into more specific and testable models and theories or be recognized as broad philosophical approaches.

The Rise of Mediation and Moderation Studies. Even now, agencies and associations that certify evidence-based intervention methods have failed to require evidence of processes of change linked to the underlying theoretical model and procedures deployed. That cannot continue in a process-based era. Theoretical models that underlie intervention need to specify the processes of change linked to that intervention for a particular problem, person, and context. Even if the intervention works well. The most important point is that an intervention should be thought of as evidence-based only when science supports the usefulness of that intervention and its component procedures, and the functional linkage to its underlying model.

New Forms of Diagnosis and Functional Analysis. As PBT approaches evolve, core processes that are used in new forms of functional analysis, and person-based applications, will become more central. The rise of statistical models that can delve into individual growth curves and personal cognitive and behavioral networks holds out the hope for a reemergence of the individual in evidence-based approaches.

From Nomothetic to Idiographic Approaches. Contemporary psychiatric nosology, which views psychiatric problems as expressions of latent disease entities, forces a nomothetic system onto human suffering. Consistent with this approach, in the protocol for syndrome-era CBT, protocol X was developed to treat psychiatric disease X, whereas CBT protocol Y was developed to treat disease Y, while all but ignoring any differences between individuals. However, in order to answer PBT's new foundational question a purely top-down, nomothetic approach will never be enough. This question requires a bottom-up idiographic approach in order to understand why in a particular case a psychological problem is maintained and how the change process can be initiated.

Processes Need to Specify Modifiable Elements. The practical needs of practitioners present the field with a natural analytic agenda. This is one reason that different philosophies of science can more readily coexist within CBT than in many other areas of science: contextualists may view pragmatic outcomes as truth criteria in and of themselves, whereas elemental realists may view them as the natural outgrowth of ontological knowledge, but both can agree on the practical importance of outcomes for intervention work. One implication is that processes that are clearly modifiable, and theories and models that specify contextual elements that can be used to modify processes of change, are inherently advantaged in a PBT approach to empirical therapy. Cognitions, emotions, and behavior are all the dependent variables of intervention science. Awareness of that simple fact adds the next key feature.

The Importance of Context. If a dependent variable is going to change in psychology, ultimately it needs to be done by changing history or situational circumstance. Said in another way, context needs to change. That is exactly what a therapeutic technique does. Intervention scientists are far better at measuring the emotional, cognitive, or behavioral responses of people than they are at measuring the historical, social, and situational context. Although understandable, the latter needs continued attention in a process-based approach. This truism about measurement suggests that theories and models that specify the relationship of processes of change to methods of manipulating these processes should be advantaged over theories and models that omit this key step. Identifying this relationship is a demanding criterion that few current models and theories meet. It is easier to develop models of change that are not specifically

tied to intervention components, but the treatment utility of our models requires this important step.

Component Analyses and the Reemergence of Laboratory-Based Studies. The considerations we have touched upon partly explain why carefully crafted component studies have reemerged in CBT. It is possible to drill down in a very fine-grained way to specific process-based questions with clinical populations in the laboratory, but it is much harder to do in randomized controlled trials of packages and protocols. It is unwise to allow packages to exist for many years before they are dismantled, but in a more process-based era, treatment developers can build information about component processes from the bottom up, allowing even a meta-analysis of scores of component studies to inform clinical work.

New Approaches to Training. A PBT approach requires that practitioners need to be able to detect changes in key processes, to direct intervention toward them, and to continually adjust to person specific indications of progress. This will require more flexible forms of clinical training that are less focused on linear sequences of technology, and more focused on reading and responding to empirically proven indications of progress in establishing healthy processes of change.
Integration of Behavioral and Psychological Science with the Other Life Sciences. Behavioral and psychological science does not and cannot live in a world unto itself: behavior is part of the life sciences more generally. The enormous increase in attention to the neurosciences in modern intervention science reflects this more holistic and biologically friendly zeitgeist – in the modern era we want to know how psychological events change us as organisms and vice versa. There are other shoes still to fall, however, that are part of this same zeitgeist.

New Forms of Delivery of Care. As the changing role of practice shows, the world of apps, websites, telemedicine, and phone-based intervention is upon us. For decades psychotherapy trainers have worried that there will never be enough psychotherapists to go around given the enormous human need for psychological care. That sense of overwhelming need only increases when we think of global mental health needs, or when we realize that therapy methods are relevant to social problems (e.g., prejudice) or to human prosperity (e.g., positive psychology and quality of life). Fortunately, there is no reason to think of psychotherapy as being limited to a fifty-minute, one-on-one, face-to-face intervention. Human beings can change because they read a book, use an app on their smartphone, or receive a brief follow-up call from a nurse. A process-based approach is able to encompass these methods because of the relatively controlled research strategies that can document process changes as these methods are used, and because of the branching, interactive, and dynamic possibilities that many forms of technological intervention permit.

A Science of the Therapeutic Relationship. The therapeutic relationship and other common core processes themselves require an analysis. It is not enough to know that general therapy features predict outcome; common core processes need to be manipulated and shown to matter experimentally. Evidence-based intervention methods are having an impact on our understanding of the therapeutic relationship itself. For example, it has been shown empirically that psychological flexibility can account for the impact of ACT, but it can also help account for the impact of the therapeutic alliance. Thus, as processes of change enter into PBT from traditions outside of CBT, we can expect a dynamic interaction in the research being done that will lead to new knowledge.

The Role of Culture. Only a few countries on the planet can afford the kind of grant infrastructure that funds large, well-controlled outcome studies. All are in the West, and all are dominantly white. Yet at the same time, the world is awakening to enormous global health needs,

which include mental and behavioral health needs across the globe. It is important to examine whether processes of change in evidence-based therapy are culture bound—in the main, the answer so far appears to be reassuring. PBT holds out hope that it can draw additional information from the world community while it can also better fit itself to such needs. For example, if a process mediates outcome and it's culturally valid, clinical creativity can be put to use figuring out how to best move that process in culturally sound and contextually appropriate procedures that are adjusted to fit specific needs.

What is the best idea you got as a result of the conference?
It was a great conference, but unfortunately, I was extremely busy with my own presentations and workshops and was unable to attend other people's presentations. However, I was really pleased about the resonance and positive response I received. And of course, it is always wonderful to see my old friends. The field is changing! It's an exciting time!

Part II – Summaries of symposia

Not you should, but you should consider: trauma-focused therapy

By Mieke Ketelaars and Agnes van Minnen

If there is anyone who knows about PTSD, it is Paula Schnurr. Her message? Let's focus on optimizing current treatment forms instead of developing new ones. A description of her invited address at the WCBCT with a response from Dutch professor Agnes van Minnen.

Guidelines

There is a plethora of guidelines concerning PTSD. However, instead of regarding these guidelines as a strict description of the standard care that should be provided, Schnurr suggests we use them for informational purposes and to guide our decision-making process. Although the guidelines differ on details, all regard protocol-based trauma-focused psychotherapy as the gold standard, be it through imaginary exposure, Cognitive Processing Therapy (CPT) or EMDR. Of course, specific patient preferences or lack of availability of protocol-based trauma focused psychotherapy may be reason to go a different way. In this case, guidelines suggest alternatives in the form of pharmacotherapy or non-trauma-related psychotherapy.

Effective but not effective enough?

How well do these treatments actually work? Reasonably well according to Schnurr. Although PTSD is known as a difficult-to-treat disorder, both success rates and dropout rates are similar compared to other disorders. Interestingly, there are no clear differences in effectiveness between the different forms of psychotherapy. For example, remission rates after six years are 77.8 percent for CPT and 82.5 percent for prolonged exposure.

Positive results notwithstanding, Schnurr warns against a passive course of action. She argues that improvements in treatment outcomes are both possible and necessary. Although trauma-focused psychotherapy is especially effective in reducing symptoms in the area of avoidance and numbing, the results are less positive for other clusters, especially hyperarousal. Many patients still suffer from symptoms such as sleep difficulties and feelings of anger after treatment. And it is precisely those problems that have major repercussions for the quality of life.

'Trauma treatment is effective, but not for everyone and not for all problems.'

Improving the current arsenal

In summary, trauma treatment is effective, but not for everyone and not for all problems. This is precisely why Schnurr wants to work on improving current treatments, for example through the use of reinforcing elements in treatment. Although we need more research, there are suggestions that additional treatments such as transcranial magnetic stimulation may boost treatment results. The same can be said for personalization of treatment. Using of biomarkers and algorithms, it may be possible to tailor our treatment to individual patients. But we may also benefit from the provision of alternative formats. For example, a great deal of research is currently looking into short, intensive forms of treatment (see, for example, van Woudenberg et al., 2018). Last but not least, we should not forget the potential effect of empowerment. Through shared decision-making, we can turn patients into active partners, thus improving their outcome.

Dutch Professor Agnes van Minnen agrees with Schnurr's recommendations to improve existing forms of treatment, which have already proven to be effective. *'The new inhibition model by Michelle Craske may provide us with a new impulse. Sidestepping a hierarchy in exposure, this model aligns the exposure to the specific negative expectation of the patient. This often means that we move to the most difficult part of the trauma more quickly and see effects occur faster. Implementing an intensive treatment format may have similar results as does varying the context. So instead of staying in one treatment room with one therapist, it may be helpful to change therapists (therapist rotation). There is some evidence that results in a better generalization of what is learned during exposure.'* She is less optimistic about the addition of resources to treatment. *'A recent review shows that many drugs that initially proved promising (such as D-cycloserine and oxyticin) are less effective than we had hoped. Neither do psychological additions such as system therapy and creative therapy. There are exceptions though: adding cortisol or aerobic exercise to exposure therapy does seem promising. Especially the additional effect of exercise is interesting, as psychologists can easily implement it in their treatment regime.'* Having said that, van Minnen warns against using exercise separately. Instead, it should be combined with exposure. *'The underlying assumption is that learning, an important process during exposure, is strengthened because of the physiological effects of exercise.'*

Acknowledgment

The VGCt scientific team thanks Agnes van Minnen very much for her expert reaction to the invited address presented at WCBCT and summarized here.

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No pain, no gain? Negative effects in psychotherapy

By Mieke Ketelaars

Are negative effects an inevitable part of therapy? That was the central question of the symposium 'No pain, no gain'.

According to researcher Philipp Herzog, the answer to this question depends on the definition of negative effects. Does it concern adverse reactions to a correctly performed treatment only? Or can adverse reactions also be considered negative effects if they are the consequence of incorrectly performed treatments? And what about side-effects? These are legitimate questions, but they are rarely asked in research or clinical practice. For instance, only a quarter of the RCTs actually report on the occurrence of negative effects. Even fewer studies focus on the impact of those negative effects on the psychological burden and quality of life.

Instruments

In order to gain more insight into negative effects, Alexander Rozental and colleagues developed and implemented the Negative Effects Questionnaire. The NEQ has a good empirical basis and is also available in Dutch (www.neqscale.com). Their research shows that negative effects often occur in therapy. Most notably, patients report negative effects such as increases in stress or anxiety, unpleasant memories and unpleasant feelings. Of course, one can ask whether these effects are actually part of the treatment. Nevertheless, they are effects that patients judge to be a direct and negative consequence of treatment.

Therapeutic process

A limitation of the NEQ is that it only assesses negative effects retrospectively. This can be an issue, as patients sometimes remember events differently, but also because issues such as dissatisfaction with treatment and a discrepancy between expectations and experiences may influence the answers. To overcome this limitation, Herzog and colleagues developed a process scale: SEPIPS. Comparable to Rozenthal, they found high rates of negative effects: no less than 76.2 percent of outpatients experienced at least one negative side effect in the two preceding weeks. At 92.3 percent, this was even higher for intramural patients. Herzog also noted that both groups differed markedly in the level of perceived stigma and care dependence (the extent to which patients feel dependent on their therapist or treatment). Inpatients in particular reported more negative effects dealing with perceived stigma and care dependence. More positive is their finding that most side effects appear to have little influence on the quality of life.

'Negative effects often occur in therapy.'

Care dependency: desirable or not?

Of all negative effects, care dependence may be the most complex in nature. One could argue that it is a positive and maybe even necessary aspect of therapy, as it fosters an environment in which the active ingredients of therapy can work. At the same time, care dependency has the potential to undermine self-mastery. This dilemma is also known as the Scylia-Charybdis dilemma. The number of patients reporting on care dependency are considerable: 10 to 18 percent of (former) psychiatric patients feel very dependent or even addicted to treatment and no less than 29 percent feel that they are worse off after termination of therapy because of the lack of conversations with the therapist.

But is it even fair to regard care dependency as a negative effect? Or is it a personality trait? In order to assess the nature of care dependency, PhD student Naline Geurtzen and colleagues developed the Care Dependency questionnaire (English: CDQ). This questionnaire measures the degree of dependence on therapy and consists of three parts: submissive attitude, strong need for contact with the therapist and lack of other observed alternatives. Their research into 113 patients with personality disorders shows that the need for contact increased during psychological treatment. However, the score on the "lack of other observed alternatives" scale decreased and the score on the submissive attitude scale remained constant. This fluctuation over time suggest that care dependency can not be regarded as a personality trait. Remarkably, they did not find much evidence for a relationship between care dependency and symptom reduction. Only the scale "lack of observed alternatives" was found to be associated with symptom reduction: a stronger decrease in perceived lack of alternatives resulted in larger symptom reductions.

‘Care dependency has the potential to undermine self-mastery, but also to undermine self-mastery.’

Depending on the type treatment?

But is it fair to combine all treatments when assessing care dependency? One could argue that some forms of therapy depend more on the therapeutic relationship than others and this can have a strong effect on care dependency. To test this hypothesis, Sarah Glanert looked at the effects of CBASP and MCT on care dependency in depressed patients. Because CBASP depends on the therapeutic relationship, she assumed that this treatment would evoke greater care dependency compared to MCT. In contrast, the results showed that both groups of patients felt equally dependent on care. However, in contrast to Naline Geurtzen's research, she saw less fluctuation over time. Moreover, a stronger need for contact turned out to be a negative predictor for the outcome of depressive symptoms. As such, whether care dependency is in fact a personality trait or not remains to be seen.

In conclusion, the theoretical framework and valid and reliable instruments have made it possible to gain more insight into the negative effects for psychotherapy. The next step will be to implement the new instruments in clinical practice. Only then can we inform our patients on a higher level.

The researchers in the symposium:
Philipp Herzog
Alexander Rozental
Naline Geurtzen
Sarah Glanert

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Treatment of psychosis: accepting or rewriting?

By Mieke Ketelaars and Tonnie Staring

The psychosis field psychosis is characterized by a certain degree of restraint in the use of new treatments. To some extent, this can be expected: after all there is a risk that new, intensive forms of treatments may aggravate psychotic symptoms. But two symposia at the WCBCT reveal interesting new developments.

Mindfulness

In recent years, interventions based on mindfulness principles have increasingly been deployed in a range of psychological problems. The underlying principle of these interventions is the focus on observing and accepting sensations and the responses they evoke. Interestingly, this embracing attitude toward mindfulness based programs seems absent in the field of psychosis, with many clinicians being wary of the potential negative effects. University of Bath researcher Pamela Jacobson finds the reluctance unjustified. Although negative effects have been reported in research, most studies were uncontrolled. Moreover, they typically focus on the effect of intensive meditation on psychotic symptoms, not so much on mindfulness-based treatments per se. Jacobsen agrees with the notion that intensive meditation can be accompanied by social isolation, sleep deprivation and limited food intake. And yes, these aspects are indeed related to the risk of psychotic symptoms. But mindfulness-based treatments do not involve intensive meditation, and as such the risks do not apply. Jacobson strengthens her argument with data from her own study, which do not find evidence for an increase in stress due to mindfulness based treatment.

Benefits

Although the focus on negative effects is important to estimate potential treatment risks, it also paints a rather one-sided picture. After all, it is equally important to look at the potential benefits that mindfulness based programs can have. University of Bath professor Paul Chadwick suggests there are in fact a number of reasons that plea for the addition of mindfulness to regular treatment options such as CBT. Perhaps the most important reason is the finding that people with psychosis who deal better with their problems indicate they look at their problems with more acceptance and distance. And it is precisely these skills that are targeted in mindfulness based treatments. In addition, it would be valuable to give patients choice in the matter of treatment. Support for the positive effects comes from pilot research by both Lyn Ellett and Kerem Böge. For instance, Ellet's results show that group treatment is acceptable and feasible and reduces problems. However, as the research design was not intended to attribute treatment effects to the treatment, a larger study is needed. Dutch clinical psychologist and psychosis expert Tonnie Staring suggests there is more evidence available. *'Mindfulness based treatments do not seem to have an effect on psychosis symptoms, but they do reduce stress and have been shown to be effective with recurring depressions. So, enough reasons to implement mindfulness based treatments for at least some of the patients.'*

'Although the focus on negative effects is important to estimate potential treatment risks, it's also paints a rather one-sided picture.'

Imagery rescripting
Another approach described during one of the WCBCT-symposia, is that of Imagery Rescripting (IR). IR is mainly used for patients with psychosis who suffer from traumatic experiences. In fact, some of those traumatic experiences can manifest themselves as psychotic symptoms. IR works on changing the meaning and emotions linked to a memory or intrusion. According to University of Reading researcher Craig Steel, IR offers a number of advantages compared to exposure. For example, patients often experience IR as less emotionally intense. But IR is also easier to generalize to other (traumatic) memories. In addition, IR focuses on changing the personal meaning of a trauma rather than the perceptual experiences of a certain intrusion. Benefits notwithstanding Staring finds the argument that IR would be less stressful than exposure an example of excessive caution. *'That suggests that patients with a vulnerability to psychosis cannot handle regular trauma therapy. But we now know that they can handle it. At least just as well as other patients.'*

The question then is, does IR work in practice? Although a definite yes is still out, there is in fact research supporting its effectiveness. For example, a series of case studies illustrated by Steel suggest that IR-based treatment reduces the frequency and associated stress of auditory hallucinations both after treatment as well as in follow up. As with mindfulness based treatments, more research is needed to confirm Steel's results.

During the symposium on IR, there were also indications that IR can be combined with other approaches. For instance, Chris Taylor presented his findings about iMAgery focused therapy, a combination of IR with more schema therapy principles. iMAgery focused therapy is based on the principle that negative life experiences may result in negative schemas and that negative schemas may subsequently maintain psychotic symptoms. Staring agrees: *'We already have a lot of experience with and knowledge on imagery techniques. The fact that evidence for IR techniques is growing is important within the broader CBT-framework which is the treatment of choice.'*

'We may in fact be preoccupied with the development of new treatments, which may be at the dispence of the evidence-based care we have to our disposal.'

More attention
Is it too early to speak of a real change in the psychosis field? Perhaps, but there does appear to be an increase in small pilot studies. Whether that will lead to a broader arsenal of evidence-based treatments remains to be seen as both treatment types require broader validation in research. In addition, according to the experts in the symposia, we must also be cautious: existing treatment protocols cannot simply be applied to patients with psychosis. Adjustments such as shorter exercises, frequent supervision and explicit attention to psychotic symptoms are necessary. But even more, working with psychotic patients requires thorough clinical training and experience. This prevents unnecessary risks and increases the chances of optimized care.

Staring for one welcomes the increased attention. *'We know a lot about some interventions, but not all interventions are equally researched or employed. Having said that, I see a lot of mindfulness based treatment efforts in the Netherlands. The same can be said for IR. As such, there may be less of a restraint in the Netherlands compared to other countries. In fact, this year a large survey among*

ambulatory psychosis teams in the Netherlands showed that the demand for psychiatric trauma treatment in the field of psychosis is being met. That is an impressive achievement, but also one that requires constant attention.' However, he is also cautious about current developments. *'We should not abandon the current treatment options. The 2019 survey also indicated that CBT - for which we established a great deal of evidence – is often overlooked. Only a quarter of the patients with psychosis receive CBT and half of them receive care by non-trained staff, despite our care standards stating otherwise. We may in fact be preoccupied with the development of new treatments, which may be at the dispense of the evidence-based care we have to our disposal. That is a major concern we cannot overlook.'*

The researchers participating in the symposia:
Paul Chadwick
Lyn Ellett
Pamela Jacobsen
Kerem Böge
Craig Steel
Chris Taylor
Katherine Newman-Taylor

Acknowledgments
The VGCt scientific team thanks Tonnie Staring very much for his expert reaction to the studies presented at WCBCT and summarized here.

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Children with psychological problems. Do you treat the child or the parent?

By Saskia Mulder, Susan Bögels and Lisbeth Utens

There is a multitude of interventions to help children and young people with various types of problems. The Dutch database of effective youth interventions database already contains 230 programs for help in growing up and raising children, and new developments continue to emerge. Two of these new developments were discussed during an open paper session at the WCBCT. They show great opportunities, but also raise many questions. What is actually most effective? Do you treat parents, children? Or both? And in what way?

Treating ADHD in children with MBCT

Worldwide 3.4% of school-age children are diagnosed with ADHD (Polanczyk et al., 2015). Many of these children have problems with executive functions. They have problems with cognitive flexibility, inhibition, working memory, planning, self-control and regulation. As we wrote earlier this year, interventions based on mindfulness have a positive impact on attention, executive functioning and behavioral regulation. Given these effects, mindfulness interventions are expected to be eminently suitable for adolescents with ADHD. However, Tercelli and Ferreira (2019) conclude in there systematic review that there is still insufficient evidence for the effect of mindfulness-based interventions on the core symptoms of ADHD. Although mindfulness-based interventions do help to reduce parental stress and improve family functioning, the studies included in this review were of poor quality, making it difficult to draw conclusions. Evans and colleagues (2018) also concluded earlier that the studies are of such poor quality that making strict conclusions is not possible.

During WCBCT, Huguet and her colleagues presented the preliminary results of their thorough RCT research in which the effects of mindfulness-based cognitive therapy (MBCT) in treating children with ADHD were examined. Their results show that the intervention had a significant beneficial effect on attention problems, symptoms of hyperactivity and impulsivity and total ADHD symptoms and emotion regulation skills according to parents (see also Huguet, Eguren, Miguel-Ruiz, Vallés, & Alda, 2019). Teachers only saw significant greater improvements in hyperactivity and impulsiveness in children in the intervention group compared to children in the control group. There was no significant difference in executive functioning: children in both groups improved.

Conclusion VGCt scientific team and remaining questions

Based on this study, one could expect that MBCT might be a good treatment for children with ADHD at this age, but unfortunately the study is limited to a pre-post design, so we do not know whether there is a lasting effect. Parents were hardly involved, if at all, in this intervention. The question is whether it is sufficient to only offer a child program to (young) children, precisely because parental functioning has a major influence on the functioning of children (Essau & Sasagawa, 2008). Parental stress, for example, has a negative impact on the child's development (Pahl, Barrett, & Gullo, 2012). In fact, when parental stress is less, interventions aimed at reducing children's symptoms are more effective (Bodden et al., 2008).

What would happen to the effects of the intervention if parents also followed an MBCT course? As described earlier, Tercelli and Ferreira (2019) concluded that MBCT reduced parental stress for children. Would adding an MBCT training for parents further reduce parental stress and improve the functioning of parents? If so, it could influence the effectiveness of MBCT for children. We

asked MBCT expert prof. Susan Bögels, to respond to the questions raised by this study. Prof. Bögels is the author of the program 'Mindfull parenting' (Bögels & Restifo, 2013) and a leading expert in MBCT research. Susan Bögels: *'From the very first time I gave mindfulness training to young people with executive function problems, such as ADHD, but also autism, and behavioral disorders (Bögels et al., 2008) we involved the parents in a parallel mindful parenting training. And we still do that, which has a number of reasons. Research shows that parents experience a lot of stress due to the impact of these children 's executive function problems, and therefore they might overreact, which can reinforce the problems. Mindfulness helps them to cope better with their own stress and to respond less impulsively. In addition, parents learn by meditating what mindfulness is and can therefore better guide their children with their mindfulness exercises. Parents can also suffer from similar problems because of genetic affinity for which mindfulness can help them. And finally, children learn attention in relation to an attentive parent. Our research into MY mind, a mindfulness training for children with ADHD, autism and behavioral disorders and their parents, shows that this combined approach not only improves the attention hyperactivity and behavioral problems of the children, but also those of the parents, should they have such problems. Moreover, the stress and overreactivity of the parents is reduced. It is actually an emotion regulation program for the family! So good reasons for the parents to also learn mindfulness and mindful parenting skills!'*

'Parents experience a lot of stress due to the impact of these children 's executive function problems.'

Improving parental functioning in children with internalizing problems

The following research presented at WCBCT dealt with one of the questions raised by the previous presentation. It was investigated whether it would be useful to add parent training to a protocol aimed at reducing internalizing problems and increasing resilience in children aged 5 to 7, the so-called 'FUN FRIENDS'.

'The Strong Not Tough: Adult Resilience Program' (Barrett, 2012a, 2012b) aims, unlike most other parent programs, to improve parenting skills instead of teaching parents how to help their children. Parents received training in mindfulness, emotion recognition skills, relaxation techniques, attention training, cognitive restructuring, problem solving skills, conflict handling and assertiveness training.

In an open trial (which is a study without a control group), Fisak and colleagues (2018) investigated the combination of the two training programs among 178 children aged 5 to 7 years and their parents. Comparison between pre- and post-measurement showed that both the parental functioning and functioning of the child improved, the amount of internalizing problems decreased and became resiliently higher. There was also a positive relation between the reduction of maternal stress and the reduction of anxiety in the child post child intervention.

Conclusion VGCt scientific team and remaining questions

This study suggests that it may be useful to run a parent program in parallel with a child program. However, as in the study examining the effectiveness of MBCT on ADHD symptoms, here too the quality of the research is limited. There is no control group and no long-term measurement.

Based on this study were ask ourselves; How useful is it really to make parents more competent and thereby increase the effectiveness of the child program? This study unfortunately does not answer this question. Follow-up research with multiple randomized groups (1. only a child program 2. a child program with a 'classic' parent program that teaches parents to help their child 3. a child program with skills training for parents) and long-term measurement(s) is needed to answer this question. A related question is: how large is the influence of parental functioning and parental stress on the functioning of the child? And if that influence is large, could it also be sufficient to help a child by only reducing parental stress and improving parental functioning without treating the child him- or herself?

‘Could it be sufficient to help a child by only reducing parental stress and improving parental functioning without treating the child?’

We asked expert prof. Lisbeth Utens for a response to this research and the questions that also do not call for research. Prof. Utens translated the ‘FUN FRIENDS’ into Dutch (‘Fijn: Vrienden!’, Dr. Elisabeth M.W.J. Utens) and is a leading expert on research in this field.Lisbeth Utens: *‘The study by Fisak et al. (2018) included 178 children (5-7 years) who had been referred to an outpatient clinic in Brisbane, Australia, with mainly anxious and depressive symptoms. They were offered FUN FRIENDS and the parents the parent program. However, complete data from pre-measurement to post-measurement were available for only 59 fathers and 96 (?) or 100 mothers (the precise number is not clear; 41 x reporting by mother only, 55 x by both parents, 4 x father only). Significant improvements were reported in both the functioning of the child and of the parents, including a reduction in internalizing problems. But to what extent this is determined by bias (- those who did complete the post measurement may have been more motivated) is unclear. Due to the absence of a control group, we cannot firmly conclude whether this reported progress is greater than if only a child had received treatment. This is unfortunate, because the sample size would probably have been sufficient to include a control group.’*

An earlier open trial to the FUN FRIENDS program (Barrett et al., 2015), among preschool children who were referred for at least one anxiety disorder, showed the same methodological problem. Due to the lack of a control group, the significant improvements are difficult to interpret. Therefore, studies, with larger samples, including control groups and in particular randomized controlled trials (RCT’s), are needed to properly value the effectiveness of both interventions. After all, it is clinically very relevant to be able to offer good help at an early stage.

How big is the influence of parental functioning and parental internalizing problems on the functioning of the child? Regarding the influence of parents on the functioning of their child, the question always arises: what are the contributions in this regard to nature versus nurture influences? For anxiety disorders, numerous studies have shown familial aggregation of anxiety ("anxiety runs in families") (Rapee, 2012), with a 4 to 6 times higher chance of developing anxiety disorder for children of parents with anxiety disorder (Hettema, Neale, & Kendler, 2001). More and more knowledge about genetic influences is becoming available. On the other hand, many studies show the influence of parental characteristics, such as parenting styles (overprotection, rejection, less emotional warmth), modeling, quality of the parental relationship and family functioning (Liber, Van Widenfelt, Goedhart, Utens, van der Leeden, Markus, & Treffers, 2008; Rapee, 2012). In his review, Ron Rapee (2012)

discusses a series of studies that show that various measures of emotional distress (either anxiety and / or depression in father / mother) predict a worse treatment outcome in the child.

Could it also be sufficient to help a child by reducing only parental stress? A study by Scheidler and colleagues (2015) shows that in families with a higher level of parental psychopathology before starting the treatment of the child, there was more improvement in family functioning and the burden on the parents (caregiver strain) after child anxiety treatment, and this predicted a greater decrease in anxiety in the child. The authors concluded that improvement in family functioning and less burden on parents improve treatment outcomes for anxious children, especially in families with parents who are more psychiatric. These results indicate that it helps to reduce parental stress, but, in this study, the child also received treatment at the same time.

The question then arises: To what extent is it useful to involve parents in the treatment of their child's CBT treatment? Science does not provide a clear answer to this. Two meta-analyses (both from 2014) show remarkably little overlap in the included studies. The one meta-analysis (Thulin et al., 2014) shows no difference whether or not parents were involved in the CBT treatment of their child. The other meta-analysis (Manassis et al., 2014) shows that CBT with active parental involvement resulted in better long-term outcomes (up to 1 year of follow-up) than CBT with less or no parental involvement. This was especially true for studies with a focus on contingency management techniques or transfer of control. In 2017, Gibby and colleagues wrote in their review that in the longer term (in studies with a follow-up of at least 2 years) more anxiety reduction occurred after CBT with parental involvement than after CBT only with the child (without parents). It is possible that by involving parents, especially in the long term, the generalized techniques are better generalized and retained in the home situation, so that therapy gain is better preserved. It is also possible that the parents learn from the techniques that a child with anxiety is given during the treatment.

A recent meta-analysis (Kreuzen et al., 2018) investigated whether involving parents in the treatment of the child, would also affect the child in other areas than just on anxiety. This was indeed the case. More involvement of parents in the anxiety treatment of their child/teenagers appeared to have beneficial long-term effects, in particular on overall functioning and comorbid symptoms.

Could it therefore be sufficient to help a child by improving parental functioning without treating the child himself? Improving parental functioning can also be understood as: strengthening therapeutic skills by providing them with treatment information (which often consists of internet CBT or bibliotherapy). This is also referred to as parent-mediated therapy. The above-mentioned meta-analysis (Kreuze et al., 2018) showed moderate effect sizes for parent-mediated therapy for the (pre-post) decrease in anxiety symptoms in children and a small decrease in their depressive symptoms, but no improvement in found their overall functioning. More research needs to be done into parent mediated therapy.

Very little is known about the effectiveness of parent-based therapy. Very recently, the results of a randomized (non-inferiority) trial of the effectiveness of parent-based therapy versus CBT treatment, which was only given to the child, have been published (Lebowitz, Marin, Martino, Shimshoni, & Silverman, 2019). Family accommodation is a phenomenon that often occurs in families with a child with an anxiety disorder. Family accommodation is understood to mean: changes in the behavior of parents and family members that help to alleviate or prevent anxiety in the child (such as getting

involved in avoidance). To reduce this accommodation for parents with a child with an anxiety disorder, Lebowitz and Omer developed the Supportive Parenting for Anxious Childhood Emotions program (SPACE). They found in a study with 124 children with a primary anxiety disorder (7-14 years) that the new, parent-based treatment (parent-based treatment) was just as effective on both the primary and secondary anxiety outcome measures as the CBT treatment offered to the child (child only therpay). These positive results have clinical implications. For example, according to the researchers, SPACE could be used when children are too scared for treatment, or do not want to come to treatment, or when, for example, communication or development problems make individual or cognitive interventions impossible. In view of the positive results and the broad clinical application possibilities, further research should be carried out in addition to this form of therapy. Employees of the academic center for child and adolescent psychiatry de Bascule, Amsterdam, translated the book by Lebowitz and Omer into Dutch and applied the SPACE program to clinical practice. The intention is to start investigating this in the very short term.'

Acknowledgments

The VGCt scientific team thanks Susan Bögels and Lisbeth Utens very much for their expert reaction to the studies presented at WCBCT and summarized here.

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