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Future perspectives in psychotherapy

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Abstract To date, the effectiveness of psychotherapy for the treatment of most mental disorders is empirically well documented. From an "evidence-based medicine" viewpoint, psychotherapy, as compared to other treatments in medicine, can be regarded as one of the most effective therapeutic approaches. The superiority of psychotherapy over pharmacotherapy is particularly pronounced in long-term treatment outcome studies. It is especially cognitive behavioral approaches, such as exposure response management and cognitive restructuring that have shown strong evidence of their efficacy and effectiveness in various populations and settings. However, evidence-based medicine is by definition oriented toward the past, as it only informs us about the well-established, empirically supported treatments. If we rely only on the currently available scientific evidence, new developments will be blocked. Since, for instance, many patients decline treatment, or do not seek professional help at all, there is a need for improvements regarding acceptance of established therapies. In addition, there ought to be scope for new, creative approaches, for which scientific evidence is not yet available. Promising developments include the mindfulness-based therapies, well-being therapy, the use of cognitive enhancers such as D-cycloserine, and Web-based therapies. There is also a trend in psychotherapy training toward teaching specific, disorder-oriented protocols or modules rather than universally applicable therapies. Finally, given the globalization of our societies, culture-sensitive psychotherapists should try to understand the cultural components of a patient's illness and help-seeking behaviors, as well as their expectations with regard to treatment.

Keywords Psychotherapy · Evidence-based medicine · Mindfulness · Web-based therapies · Culture-sensitive psychotherapy

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Psychotherapy: status quo

What is psychotherapy?

According to Senf and Broda's textbook [30], psychotherapy is a scientifically based form of professional action within the framework of the public health-care system and in accordance with its rules. Psychotherapy positioned in this way is based on scientifically comprehensible and empirically supported theories of illness, healing and treatment. Moreover, psychotherapy uses theoretically derived and empirically supported procedures, methods and settings to bring about a targeted change in experience and behavior to treat or prevent illnesses, disorders or complaints, whose causes are wholly or partly psychological. Such a procedure presupposes a thorough diagnosis and a differential diagnosis as well as a qualified differential indication. Moreover, psychotherapy is practised with treatment targets formulated beforehand and evaluated afterwards. At the end of their definition, Senf and Broda stress that psychotherapy is conducted by professional psychotherapists, whose professional qualification has been demonstrated through examination, maintains ethical principles and standards and, finally, satisfies measures of quality assurance and adheres to the economic imperative [30].

In short, a scientifically based psychotherapy is rooted in empirically supported theories of illness, healing and

treatment. It applies theoretically derived and evidence-based procedures to try and bring about a deliberate change in the experience and behavior of patients and, in so doing, treats or prevents mental illnesses.

Does it work?

Psychotherapy can be considered as one of medicine's most effective therapeutic approaches. By no means does psychotherapy need to hide away, for instance, from the comparison with drug treatment or surgery. Take, for example, the prescribing of acetylsalicylic acid to prevent myocardial infarction, which has an effect size (treated versus untreated) of 0.07. Medication for rheumatoid arthritis scores 0.61, which is already in the mid-range of effect sizes, whereas aorto-coronary bypass surgery has a comparatively high effect size of 0.80. The effect size of psychotherapy is 0.88, which is within the same order of magnitude, and that is taking all psychotherapeutic approaches together. If the cognitive behavioral therapies are considered separately, their effect size is as high as 1.21 [8, 10, 16, 17].

Across the majority of mental disorders, most of the therapeutic effect of psychotherapy is achieved within the first 10–20 sessions. This concerns not only the reduction in symptoms, but also the improvement in the patients' subjective feeling of wellbeing and their psycho-social functional level [16, 18]. On the other hand, there are of course patients with chronic mental disorders, such as severe personality disorders, who do need long-term psychotherapy, sometimes over many years [15]. There is also good evidence for the long-term stability of the results once the psychotherapy has been completed. However, this applies, in particular, for cognitive behavioral therapy, but much less so for psychodynamic treatments and relaxation techniques [20].

Use of effective treatments in clinical practice

Despite all these positive reports on the effectiveness of psychotherapy, one big problem still persists: those therapeutic approaches whose effectiveness has been scientifically proven are still used much too little in everyday clinical psychotherapeutic practice. This was demonstrated, for example, in a large representative study carried out in Switzerland into the treatment of anxiety and depression to establish which therapeutic approaches were actually used in real routine practice. Patients with anxiety and depressive disorders were only relatively rarely given treatments whose efficacy was well documented (cognitive therapy and behavioral therapy: 12%, hypnosis and relaxation techniques: 39% of all cases), whereas supportive counseling and pharmacotherapy, which have been demonstrated to promise less lasting success, were used in 70-90% of cases (Margraf, in preparation). It has been known for a long time that only a small percentage of patients suffering from anxiety or depressive disorders are treated by adequately trained specialists. The study just mentioned shows, moreover, that, of these few patients who have access to professional treatment, only a small proportion, in turn, benefit from evidence-based therapies.

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

Evidence-based psychotherapy

Chambless and Hollon [2] postulate that the following criteria would have to be met for a therapeutic approach to be "evidence-based" and/or "empirically supported": the efficacy of the approach must have been demonstrated by a series of randomized controlled trials (RCTs), using appropriate samples and control groups; the samples must have been adequately described; valid and reliable outcome assessments must have been used; and, finally, the results must have been replicated by at least one independent group of researchers. Foa and colleagues make the point that the use of more rigorous scientifc methods in psychotherapy outcome research has increased dramatically in the course of the past 25 years. As a representative example, they describe for the field of traumatic stress research the following features which a well-controlled trial should have [6]:

- Clearly defined target symptoms.
- Reliable and valid measures that allow to establish reliably both symptom severity as well as diagnostic status.
- Use of blinded evaluators.
- Assessor training to ensure inter-rater reliability and to prevent evaluator drift.
- Manualized, replicable, specific treatment protocols.
- Equipoise with regard to treatment conditions.
- Unbiased assignment to treatment.
- Treatment adherence ratings.
- Data analysis conducted according to accepted procedures.

Efficacy versus effectiveness

The purpose of efficacy studies is to examine whether or not an intervention has an effect in ideal conditions in which all the influences can be measured and monitored with precision. It may happen in such trials that the patients are not representative of the everyday clinical situation or only partially so. The research design for efficacy studies stresses internal validity, and for this purpose it is common to perform completers analyses. If such a trial is carried out in properly controlled conditions it may, however, supply valuable information as regards the specificity of the intervention.

Effectiveness studies are different in that they ask the question as to whether or not a particular intervention produces an effect in real clinical conditions. It thus follows that the patients selected for the trial should be more representative of the everyday clinical population. This sort of study design stresses external validity. It is typical for effectiveness studies to perform intent-to-treat analyses. Such trials, however, provide only limited information on the specificity of an intervention.

Thus both efficacy and effectiveness studies have their specific advantages and disadvantages. It would therefore be wrong to want to play them off against one another. On the contrary, it is possible for them to complement one another in a meaningful way, quite apart from the fact that case studies, naturalistic studies, process research and other approaches can provide important additional information to the overall judgment of a therapeutic approach. In subsequent stages of research, attempts are made to understand the mechanism of action more precisely by performing dismantling or component control studies.

Dissemination of evidence-based therapies

Why is it that, although effective psychotherapeutic interventions are available today for the commonest mental disorders, the majority of patients either receive no professional treatment at all or, if they do make their way into professional hands, the therapy that is provided will often not be one for which there is sufficient empirical support?

One reason is that today most psychotherapists are still not adequately trained in empirically supported treatments. Secondly, many psychotherapists do not like working with treatment manuals; in most cases, they have had no experience with using treatment manuals and are afraid that following treatment steps laid down in a manual will constrain them from giving free reign to their creativity. The other side to this is that both patients and health insurance companies are increasingly demanding the use of evidence-based procedures. Therefore, evidence-based medicine is going to shape our everyday lives as therapists. However, having said that, it should also be kept in mind that evidence-based medicine is, by its very definition, based on, and oriented toward, the past; it informs us of the results that have been produced by research up until the present day. If a new intervention has not been empirically studied, it does not mean that it is not effective—it merely indicates that, for the time being, there is still no scientific evidence of its effectiveness.

A greater dissemination of evidence-based therapies in clinical practice is absolutely indispensable. However, if we simply rely on the principles of evidence-based medicine and leave it at that, things will come to a standstill and creative further developments and new developments will be rendered impossible. Genuine scientific progress is only possible if there are creative therapists and researchers who are repeatedly willing to risk trying out new ideas. However, these innovations must, in their turn, face up to critical scientific scrutiny. If sober examination proves that they are ineffective, we must abandon them again, no matter how attractive and promising they might appear to be. If they are effective, these new developments will sooner or later make their way onto the palette of treatments from which the therapist can choose – perhaps as a totally new approach in their own right, perhaps as a new technique, or perhaps as a complement to existing interventions.

Roth and Fonagy, too, place innovative practice at the beginning of a feedback loop—actually one with several sub-loops, within which the field of psychotherapy develops further, finally resulting in improved psycho-social care [25]. They see innovative practice as stimulating the evaluation of case series. New concepts emerging from this are taken up by psychotherapy research and are investigated in randomized controlled trials. The results of this research are fed into professional consensus conferences and have their impact on the development of guidelines. When the latter are, in turn, put into effect, they change clinical practice and lead to an improvement in clinical care through quality-control measures. In addition to this, they also bring about adaptations in training at all levels (initial, advanced and continuous). The experience from clinical practice combined with data from quality management might then provide the occasion for a new round of innovative adaptations in the way patients are dealt with clinically, and, in that way, the creative circle will have completed its 360° turn. Additionally, the process is also sustained and driven forward by external stimuli and inputs, originating, for instance, in basic neurobiological research or innovations in psychopathology.

Promising developments in psychotherapy

If existing psychotherapies are as effective and successful as stated above, why should there be any need at all for

further progress? Is it not possible to consider psychotherapy as a form of treatment that has reached maturity? Would it thus not be our priority to make sure that the effective interventions were disseminated as widely as feasible, so that as many patients as possible would be able to benefit from them? Yes, but there are still several good reasons [28] militating in favor of further enhancements in the spectrum of psychotherapeutic interventions as well as advancing the further continuation of developments, additions and extensions to this spectrum. Here are some of those reasons:

- Not all patients are willing to subject themselves to an empirically supported therapy. Exposure, for example, is considered today to be the treatment of choice for most anxiety disorders, including obsessive compulsive disorders. There are, however, patients who, for comprehensible reasons, cannot agree, at least at a given point in time, to undergo confrontation therapy of this nature.
- The overall dropout rates for empirically supported therapies are approximately 20% [1].
- Around 50% of the patients who complete an evidence-based treatment schedule with success and with a clinically relevant symptom reduction, will still satisfy the diagnostic criteria for the disorder that took them into the treatment to begin with [23, 31].
- Around 50% of patients do not attain a satisfactory psycho-social functional level, even if their symptoms have decreased significantly [21, 23]. At the end of treatment, many patients are still impaired as regards their ability to perform employed work, the quality of their relationships, and their general satisfaction with life.
- One final point is that there is still too little on offer today for patients who do not find their way into psychotherapy, for reasons such as not finding a therapist speaking their language, not being able to attend a psychotherapeutic practice on account of a physical disability, or fearing stigmatization on account of their exposed position within society.

Against the background of all the reasons just outlined, the following sections go on to present a number of examples of creative further developments or new developments. These are worthy of discussion, since they have the potential of contributing to more finely tuned differentiation amongst the possible psychotherapeutic interventions currently available.

Mindfulness and acceptance

The "mindfulness-based therapies" are certainly to be counted amongst the most important further developments and additions to cognitive behavioral therapies in recent years [9]. Kabat-Zinn [11] detached mindfulness from its original Buddhist context and developed a form of training in mindfulness meditation as a complement for treatment of chronic pain, known as "mindfulness-based stress reduction". It was about 10 years ago that cognitive-behavioral therapy took up the notion of mindfulness and integrated it as an addition in its therapeutic concepts, which up until then had been comprised almost exclusively of strategies focused on bringing about changes. After the "cognitive shift" of the 1980s and the "emotional shift" of the 1990s, the integration of elements based on mindfulness in the first decade of the 21st century is referred to as the "third wave" (or "shift") in cognitive-behavioral therapy. In the meantime, mindfulness-based cognitive therapy (MBCT) has yielded good evidence of its effectiveness for major depression, treatment-resistant depression and residual depressive symptoms [19, 32]. Other mental disorders are currently undergoing evaluation.

Well-being therapy

On the basis of Ryff's multidimensional cognitive model of psychological wellbeing [26, 27], Fava developed a short, manual-based psychotherapy. Conceptually, this differs enormously from traditional psychotherapeutic approaches. In a course of eight clearly structured psycho-educative, directive therapy sessions focused on solutions, the therapist does not talk to the patient about problems or symptoms. On the contrary, the focus is solely on enhancing the patient's sense of wellbeing [3]. The aim of the treatment is to achieve an improvement in the following six dimensions: environmental mastery, personal growth, purpose in life, autonomy, self-acceptance, and positive relations with others. The techniques used are self-observation, keeping a structured diary, cognitive restructuring, problem-solving strategies, self-assertiveness training, planned activities for mastering daily life, leisure and homework. Well-being therapy has been used successfully for preventing relapse in recurrent depression [4, 5]. However, it also appears to perform well for treatment-resistant depressions and anxiety disorders as well as for psycho-somatic disorders and post-traumatic stress disorders.

Cognitive enhancers

D-cycloserine was developed in the 1950s for the treatment of tuberculosis. It was only recently discovered that the compound can also influence learning behavior. It was demonstrated that the administration of 50 mg of D-cycloserine immediately prior to each session improved the effect of exposure therapy for fear of heights [24]. This effect appears to be related to the substance properties as a

partial glutamate receptor agonist. It has also been administered successfully to augment CBT interventions for other anxiety disorders and a series of other mental disorders, including depression, eating disorders, substance dependence, and schizophrenia [22].

The experience with D-cycloserine shows that there are no longer any valid grounds for maintaining the earlier distinction and clear demarcation between "psychological" and "pharmacological" approaches to therapy. These two principles of action have now been thoroughly intermixed and act as valuable complements for one another. There can be no doubt that this development is going to go further. There are, for instance, already examples of hormones, such as cortisol or oxytocin, being used in combination with psychotherapy.

Web-based therapies

Starting around the mid 1990s, internet-based treatment protocols have been developed in which patients and therapists never come face-to-face. Many internet-based self-help offers are available today, and there are also psychotherapies in the strict sense of the term. They seem to function well for various types of mental disorders, and are intensively used, although it appears that, for the time being, their users are primarily younger patients. As an example, "Interapy" is a fully web-based writing therapy for post-traumatic stress disorder [14]. The treatment is comprised of ten writing sessions, divided into three phases: self-confrontation, cognitive restructuring and social sharing. Initial investigations into Interapy show substantial and sustained symptom reduction over a follow-up period of 18 months. The vast majority of the patients treated indicated that they had experienced the internet contact with their therapists as "personal", that they had found the internet to be an agreeable medium of communication and, interestingly, that it had not been a problem for them never to have come face-to-face with their therapists [13, 34].

Integrated training in evidence-based, disorder-specific therapies

There has been a recent trend to move more and more away from universally applicable therapies toward the development of disorder-specific protocols or therapeutic modules for specific problems such as emotion regulation, which can occur in conjunction with a whole range of disorders. Accordingly, in the field of advanced and continuous training, there is an ever-increasing number of programs on offer aiming to impart therapeutic knowledge and skills concerning empirically supported therapeutic approaches within a defined diagnostic spectrum. For instance, psychotherapists with clinical experience, who would like to intensify their knowledge and skills in the area of psychotraumatology, can now enroll in a master's course in psychotraumatology at Zurich University (http://www.mas-psychotraumatology.uzh.ch). Its main emphasis is on mediating evidence-based treatments for post-traumatic stress disorder. The course is built on "blended learning", which means that traditional learning methods (lectures, problem-oriented learning in small groups and group supervision) are combined with e-learning (online learning resources, web forum, podcasts and so on). This is a setup that facilitates asynchronous learning, so that it is possible for students from the whole German-speaking world to enroll [29].

Culture-sensitive psychotherapy

Tseng defines culture as a dynamic concept referring to a set of beliefs, attitudes, and value systems that derive from early stages of life through enculturation, and become an internal mode of regulating behavior, action, and emotion [33]. Thus, culture is not static, but changing continuously across generations, responding to ever-changing environmental demands. Furthermore, culture in this 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 psychopathology, to the stage of therapy, and so on. Treatment could be a lot more effective, however, when the cultural dimension is factored in. The resulting culturally relevant, culture-sensitive, or culture-competent 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.

The profile of future psychotherapists

More than a decade ago, Nobel prize winner Eric Kandel wrote that "Insofar as psychotherapy or counseling is effective and produces long-term changes in behavior, it presumably does so through learning, by producing changes in gene expression that alter the strength of synaptic connections and structural changes that alter the anatomical pattern of interconnections between nerve cells of the brain. As the resolution of brain imaging increases, it should eventually permit quantitative evaluation of the outcome of psychotherapy [12]. Today, "neuropsychotherapy" [cf. Ref. [7] and the contribution by Walter and Berger in this issue] has become a reality. Therefore, modern psychotherapists are required to integrate profound

knowledge and advanced skills not only in developmental psychology, psychological theories, psychopathology, and intervention techniques, but in neurosciences and anthropology as well. We need to encourage translational research that transfers advances in basic science to clinical applications, foster the clinician-researcher dialogue, and promote more interdisciplinary collaborative learning.

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References

1. Ballenger JC, Davidson JR, Lecrubier Y, Nutt DJ, Foa EB, Kessler RC, McFarlane AC, Shalev AY (2000) Consensus statement on posttraumatic stress disorder from the International Consensus Group on Depression and Anxiety. J Clin Psychiatry 5:60–66
2. Chambless DL, Hollon SD (1998) Defining empirically supported therapies. J Consult Clin Psychol 66:7–18
3. Fava GA, Rafanelli C, Cazzaro M, Conti S, Grandi S (1998) Well-being therapy. A novel psychotherapeutic approach for residual symptoms of affective disorders. Psychol Med 28:475–480
4. Fava GA, Rafanelli C, Finos L, Conti S, Grandi S (2004) Six-year outcome of cognitive behavior therapy for prevention of recurrent depression. Am J Psychiatry 161:1872–1876
5. Fava GA, Rafanelli C, Grandi S, Conti S, Belluardo P (1998) Prevention of recurrent depression with cognitive behavioral therapy—preliminary findings. Arch Gen Psychiatry 55:816–820
6. Foa EB, Keane TM, Friedman MJ, Cohen JA (2009) Effective treatments for PTSD. Practice guidelines from the International Society for Traumatic Stress Studies, Guilford
7. Grawe K (2004) Neuropsychotherapie. Hogrefe, Göttingen
8. Grawe K, Donati R, Bernauer F (1994) Psychotherapie im Wandel. Hogrefe, Göttingen
9. Hayes SC, Follette VM, Linehan MM (2004) Mindfulness and acceptance—expanding the cognitive-behavioral tradition. Guilford, New York
10. Howard KI, Orlinsky DE, Lueger RJ (1994) Clinically relevant outcome research in individual psychotherapy. New models guide the researcher and clinician. Br J Psychiatry 165:4–8
11. Kabat-Zinn J (1990) Full catastrophe living: using the wisdom of your body and mind to face stress, Pain, and illness. Dell, New York
12. Kandel ER (1998) A new intellectual framework for psychiatry. Am J Psychiatry 155:457–469
13. Knaevelsrud C, Maercker A (2007) Internet-based treatment for PTSD reduces distress and facilitates the development of a strong therapeutic alliance: a randomized controlled clinical trial. BMC Psychiatry 7:13
14. Lange A, Rietdijk D, Hudcovicova M, van de Ven JP, Schrieken B, Emmelkamp PMG (2003) Interapy: a controlled randomized trial of the standardized treatment of posttraumatic stress through the internet. J Consult Clin Psychol 71:901–909
15. Leichsenring F, Rabung S (2008) Effectiveness of long-term psychodynamic psychotherapy. A meta-analysis. J Am Med Assoc 300:1551–1565
16. Lutz W (2003) Die Wiederentdeckung des Individuums in der Psychotherapieforschung. Ein Beitrag zur patientenorientierten Psychotherapieforschung und Qualitätssicherung. dgvt-Verlag, Tübingen
17. Lutz W (2003) Efficacy, effectiveness, and expected treatment response in psychotherapy. J Clin Psychol 59:745–750
18. Lutz W, Lowry J, Kopta SM, Einstein DA, Howard KI (2001) Prediction of dose–response relations based on patient characteristics. J Clin Psychol 57:889–900
19. Ma SH, Teasdale JD (2004) Mindfulness-based cognitive therapy for depression: replication and exploration of differential relapse prevention effects. J Consult Clin Psychol 72:31–40
20. Margraf J (2009) Kosten und Nutzen der Psychotherapie. Eine kritische Literaturauswertung. Springer, Heidelberg
21. Marks I, Lovell K, Noshirvani H, Livanou M, Thrasher S (1998) Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring: a controlled study. Arch Gen Psychiatry 55:317–325
22. Norberg MM, Krystal JH, Tolin DF (2008) A meta-analysis of D-cycloserine and the facilitation of fear extinction and exposure therapy. Biol Psychiatry 63:1118–1126
23. Resick PA, Nishith P, Weaver TL, Astin MC, Feuer CA (2002) A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. J Consult Clin Psychol 70:867–879
24. Ressler KJ, Rothbaum BO, Tannenbaum L, Anderson P, Graap K, Zimand E, Hodges L, Davis M (2004) Cognitive enhancers as adjuncts to psychotherapy: use of D-cycloserine in phobic individuals to facilitate extinction of fear. Arch Gen Psychiatry 61:1136–1144
25. Roth A, Fonagy P (2004) What works for whom? A critical review of psychotherapy research. Guilford, New York
26. Ryff CD (1989) Happiness is everything, or is it? Explorations on the meaning of psychological well-being. J Pers Soc Psychol 57:1069–1081
27. Ryff CD, Singer B (1996) Psychological well-being: meaning, measurement, and implications for psychotherapy research. Psychother Psychosom 65:14–23
28. Schnyder U (2005) Why new psychotherapies for posttraumatic stress disorder? Editorial. Psychother Psychosom 74:199–201
29. Schnyder U, McShine RM (2007) MAS in Psychotraumatology: ein innovativer Studiengang an der Universität Zürich. Schweizerische Ärztezeitung 88:890–892
30. Senf W, Broda M (eds) (2005) Praxis der Psychotherapie—ein integratives Lehrbuch. Georg Thieme, Stuttgart
31. Tarrier N, Pilgrim H, Sommerfield C, Faragher B, Reynolds M, Graham E, Barrowclough C (1999) A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. J Consult Clin Psychol 67:13–18
32. Teasdale JD, Segal ZV, Williams JMG, Ridgeway V, Soulsby J, Lau M (2000) Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. J Consult Clin Psychol 68:615–623
33. Tseng WS, Streltzer J (eds) (2001) Culture and psychotherapy. A guide to clinical practice. American Psychiatric Press, Washington, DC
34. Wagner B, Maercker A (2007) A 1.5-year follow-up of an internet-based intervention for complicated grief. J Trauma Stress 20:625–629