Person-Centered & Experiential Psychotherapies
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rpcp20

The New Integral Multidisciplinary Guidelines in the Netherlands: The perspective of person-centered psychotherapy / Die neuen integralen multidisziplinären Richtlinien in den Niederlanden: Die Perspektive der Personzentrierten Psychotherapie / Las Nuevas Guías Multidisciplinarias Integrales en los Paises Bajos. La Perspectiva de la Psicoterapia Centrada en la Persona / De nieuwe Nederlandse integrale multidisciplinaire richtlijnen in de ggz. Het perspectief van de cliëntgerichte psychotherapie

Giel J. M. Hutschemaekers [a] & Martin van Kalmthout [b]
[a] Arnhem and Radboud Universiteit Nijmegen, the Netherlands
[b] Mook, the Netherlands

Available online: 11 Aug 2011

The New Integral Multidisciplinary Guidelines in the Netherlands: The perspective of person-centered psychotherapy

Die neuen integralen multidisziplinären Richtlinien in den Niederlanden: Die Perspektive der Personzentrierten Psychotherapie

Las Nuevas Guías Multidisciplinarias Integrales en los Paises Bajos. La Perspectiva de la Psicoterapia Centrada en la Persona

De nieuwe Nederlandse integrale multidisciplinaire richtlijnen in de ggz. Het perspectief van de cliëntgerichte psychotherapie.

Giel J. M. Hutschemaekers[1] and Martin van Kalmthout[2]

[1] Arnhem and Radboud Universiteit Nijmegen, the Netherlands

[2] Mook, the Netherlands

Abstract. In the new Dutch multidisciplinary guidelines for mental-health care, person-centered psychotherapy has been omitted. The consequences of this verdict may result in the Person-Centered Approach being excluded from regular treatment. This omission is based on the view that intervention should be evidence-based. This evidence-based emphasis has resulted in guidelines that restrict good treatment to interventions focused on complaint reduction. Other treatment goals are excluded because they lack enough evidence. Person-centered psychotherapists are in an excellent position to open this discussion.

Zusammenfassung. In den neuen holländischen multidisziplinären Richtlinien für die psychische Gesundheitsversorgung wurde die Personzentrierte Psychotherapie ausgelassen. Die Konsequenz dieses Verdikts kann dazu führen, dass der Personzentrierte Ansatz aus der regulären Behandlung ausgeschlossen wird. Das Fehlen des Personzentrierten Ansatzes basiert auf der Sichtweise, dass eine Intervention evidenzbasiert sein sollte. Diese Betonung auf Evidenzbasierung resultiert in Richtlinien, die gute Behandlung auf Interventionen beschränkt, welche auf die Reduktion von Beschwerden fokussiert sind. Andere Behandlungsziele sind ausgeschlossen, weil sie genügend Evidenz vermissen lassen. Personzentrierte Psychotherapeuten sind in einer ausgezeichneten Position, diese Diskussion zu eröffnen.

Author note. Contact addresses: Prof. Dr Giel J. M. Hutschemaekers, Clinical Psychology and Academic Centre Social Sciences, Radboud Universiteit Nijmegen, the Netherlands, e-mail: <g.hutschemaekers@acsw.ru.nl>. Dr Martin van Kalmthout, Bracamonteweg 2, 6585 KP Mook, the Netherlands, e-mail: <M.vankalmthout@planet.nl>.

Resumen. En las nuevas guías holandesas para el cuidado de la salud mental, la psicoterapia centrada en la persona ha sido omitida. Las consecuencias de este veredicto tal vez resulten en que se excluya al enfoque centrado en la persona del tratamiento regular. Esta omisión está basada en la opinión de que la intervención debería estar fundamentada en evidencia. Este énfasis en fundamentación en evidencia se ha manifestado en guías que restringen al buen tratamiento a intervenciones enfocadas en la reducción del malestar. Otros objetivos de tratamiento son excluidos porque no tienen suficiente evidencia. Los psicoterapeutas centrados en la persona están en una excelente posición para abrir esta discusión.

Samenvatting. In de nieuwe Nederlandse multidisciplinaire GGZ-richtlijnen, ontbreekt cliëntgerichte psychotherapie als aanbevolen therapievorm. Op termijn kan dit er toe leiden dat cliëntgerichte psychotherapie niet langer erkend wordt als reguliere behandelvorm. Oorzaak hiervan is de keuze om de richtlijn te beperkten tot evidence-based interventies. Daardoor wordt behandeling beperkt tot klachtenreductie. Andere behandeldoelen, waarover minder evidentie is, blijven buiten beschouwing. Cliënt gerichte psychotherapeuten bevinden zich in een uitstekende positie om hierover de discussie te starten.

Key Words: client-/person-centered therapy, multidisciplinary guidelines, levels of evidence, treatment goals

The current generation of guidelines for appropriate psychotherapeutic care has basically wreaked havoc in the sector. In many countries, but in particular the USA, UK, Australia, Germany, and the Netherlands, heated discussions on the suitability of person-centered psychotherapy for the treatment of psychological disorders have been taking place. The result has not always been positive and has led, in some countries, to the omission of person-centered forms of psychotherapy from the guidelines altogether (Bohart, O'Hara, & Leitner, 1998). It has been suggested that this is largely a consequence of the medical–psychiatric character of the guidelines themselves, which weigh interventions only in terms of their capacity for complaint reduction (Hutschemaekers, 2003).

A few years ago, professionals working in the main areas of Dutch mental-health care decided to adopt a new, integral, multidisciplinary approach. In this new approach all of the important professionals (general practitioners, psychiatrists, psychotherapists, psychologists, psychiatric nurses, social workers and therapists using non-verbal methods) had to consult and collaborate with each other. This article will give a brief description of this Dutch project in order to clarify the position of person-centered psychotherapies in five new Dutch integral multidisciplinary guidelines. We will show that the adoption of such an integral and multidisciplinary perspective has not led to more favorable recommendations with respect to the inclusion of person-centered psychotherapy. For this reason, we will raise the question of just how the current situation should be understood. Finally, we will focus on the arguments that could affect the consequences of this development for person-centered psychotherapy.

THE NEW INTEGRAL MULTIDISCIPLINARY GUIDELINES IN THE NETHERLANDS

The first mental-health care guidelines were mainly produced by medical societies, such as the American Psychiatric Association in the United States and the Royal British College of Psychiatrists in England. These guidelines consisted of 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances' (Eddy, 1990). In the Netherlands, the first initiatives for mental-health care guidelines were undertaken by general practitioners and psychiatrists (Hutschemaekers, 2003). Although these guidelines were formulated by specialists coming from different disciplines, they were essentially monodisciplinary because they were accepted and approved only by professionals belonging to the discipline that was responsible for these guidelines. The initial guidelines were very heterogeneous: they followed different formats, used different diagnostic criteria, and presented very different treatment options. They also disagreed regarding the essential patient characteristics that were necessary in order to assess appropriate treatment. At the same time, the guidelines were predominantly medical, with medical and pharmacological treatment clearly favored (Tiemeier et al., 2002). None of these guidelines left room for person-centered psychotherapy, no matter in what form or variant.

In 1998, widespread critique of the first generation of guidelines led to the establishment of a National Steering Committee of the five most important professional societies within the field of mental health, namely: the professional societies for general practitioners, psychiatrists, nurses, psychotherapists, and psychologists. In 2000 the Steering Committee presented its vision on the development of new, integral, multidisciplinary guidelines. The new guidelines had to be evidence-based — that is, grounded on the best available knowledge — with five levels of possible evidence distinguished, in keeping with the principles of evidence-based medicine (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2000). The choice of an intervention had to be undertaken on the basis of best evidence and a preference given to those interventions with the greatest probability of success. Subsequently, the Steering Committee suggested that the development of these integral guidelines should be pursued along the lines of three main dimensions (Cohen-Kettenis, Dekker, Groot, Raben, & Trijsburg, 2000). The first dimension concerned the phases and the tasks of the care process itself and could range from a single treatment phase to all possible phases of treatment. Integral guidelines should focus not only on one task, but on all the different tasks involved in the following phases: diagnosis, biological interventions, psychological interventions, non-verbal interventions, practical interventions, social interventions, nursing interventions, daily care interventions, protective interventions, and, finally, the coordination of these activities and the tailoring of them to meet the individual needs and desires of the patient. The second dimension had to address the number of disciplines that would be involved in the care process, from just one to all those relevant. The third dimension concerned the formulations of the guidelines themselves and ranged from a document containing all available evidence to a document in which this evidence is translated into general guidelines for clinical practice. Finally, these guidelines had to be transformed into individualized systems of disease management.

Five guidelines

In early 2000, the first working groups for the formulation of the second generation of guidelines were set up. They focused on diagnostics and the treatment of anxiety and mood disorders. Later on, working groups followed for schizophrenia, attention-deficit hyperactivity disorder (ADHD), eating disorders, personality disorders, trauma treatment, substance abuse, and lastly a guideline for hard-drug addiction. Experts from all of the relevant professional societies participated in the working groups, which consisted of general practitioners, psychiatrists, psychotherapists, psychologists, nurses, social workers, creative therapists, and psychomotor therapists. Together, with some patients, they formulated an agenda for the various study aspects such as the care phases, the types of intervention, and so forth. Subsequently they searched and studied the relevant literature and supplemented this information with the 'collective sense of the professions'. These efforts led, in December 2003, to the first multidisciplinary guideline for anxiety disorders (LSR, 2003). The guidelines for mood disorders, schizophrenia, ADHD, and eating disorders followed in 2004 and 2005. The expectations for the new guidelines were high as they were intended to provide a valuable alternative to the previous guidelines.

The following conclusions on person-centered psychotherapy were included in the new guidelines.

Depressive disorders

In the guideline for the treatment of depression, person-centered psychotherapies are simply not included in the treatment recommendations. 'The effectiveness of these interventions has not yet been systematically studied to a sufficient extent to justify conclusions with regard to the efficacy of such and the durability of the effects' (LSR, 2005c, pp. 83–4).

Anxiety disorders

There is no general consensus for the whole category, although conclusions on separate anxiety disorders have been made. With regard to person-centered psychotherapy, the conclusions are almost exactly the same. In the case of Generalized Anxiety Disorder, the working party concludes that 'Although a short-lasting psychoanalytical as well as a short-lasting non-directive intervention appear to have some effect, the effects of cognitive behavioral therapeutic interventions were considerably larger' (LSR, 2003, p. 142). For other disorders, for example, obsessive-compulsive disorder, the following is stated: 'There are no randomized controlled trials in which the effectiveness of this therapeutic method has been evaluated' (p. 112). The conclusion was that there is no indication for person-centered psychotherapy for the psychological treatment of anxiety disorders.

Schizophrenia

Psychotherapeutic interventions for schizophrenia appear to be effective. This is certainly the case for cognitive behavioral therapy. As far as counseling is concerned, the conclusion is as follows: 'When compared with standard forms of care and other treatments, counseling does

not produce a convincing positive result on psychiatric symptoms. In addition, the effects of the treatment are not consistent and counseling is therefore not recommended' (LSR, 2005c, p. 97). The same holds true for person-centered therapy: it is lacking evidence.

ADHD

There is no specific information concerning person-centered psychotherapy for this disorder. However, behavioral therapy does appear to be effective when offered to parents and teaching staff of sufferers (LSR, 2005a).

Eating disorders

Ambulatory psychotherapy is recommended for this disorder (LSR, 2005d). There is no prioritization of specific forms of this kind of treatment. However, treatment must be directed at weight recovery, abstinence from binge eating and purging behavior, recovery of the body image, and dysfunctional cognition (p. 127). In addition, ambulatory psychotherapy is recommended for adult patients following weight recovery in a clinical setting. This could be, for example, cognitive behavioral therapy.

For bulimia, the conclusion is that forms of psychotherapy other than cognitive behavioral therapy have hardly been researched at all (p. 134). Because cognitive behavioral therapy is so effective, this is the treatment that is recommended.

The results are meagre. Only for the treatment of anorexia nervosa has a door been left open for person-centered psychotherapy. For all other cases, person-centered psychotherapy is not considered as an appropriate treatment.

POSSIBLE CONSEQUENCES

Many psychotherapists have reacted with necessary skepticism to the new guidelines. Although the Dutch Association for Psychotherapy (which represents all of the specialized psychotherapy societies) has accredited the guidelines, rumor has it that daily practice will hardly be affected by them. After all, they are 'only' guidelines, and on the first page is the statement that these guidelines may be deviated from if good reasons are given for doing so. The question to ask at this point then is whether this attitude of rejection is sensible.

Taking this stance could mean that the Person-Centered Approach is placed outside the guidelines, where it will lose its credibility and legitimacy (Lietaer, 2003; Takens, 2004). If we do nothing about this situation, person-centered psychotherapy will disappear in the Netherlands as a fitting intervention for the treatment of, for example, depressive disorders, bulimia, and anxiety disorders. A few years ago, the Professor of Guideline Development at the University of Amsterdam, J. Swinkels, argued along the lines that the application of interventions that do not have the designation 'fitting' should be prohibited or, in any case, remain outside the realm of financing by health insurers (Swinkels, 2003).

The potential threat that ensues from the new guidelines, moreover, increases the deadlock in which person-centered psychotherapy has arrived (van Kalmthout, 2002). For example,

within the training for psychology, less and less attention is being paid to the Person-Centered Approach. The highly questionable point here is the extent to which the Person-Centered Approach can maintain its place within the current training and education for psychotherapy. We are therefore forced to ask ourselves whether person-centered psychotherapy is appropriate in this day and age (Hutschemaekers & Oosterhuis, 2004).

As well as these possible long-term consequences, the threats for the short term are even more terse. Within the large mental-health care institutions in the Netherlands, the guidelines are being translated into standard care programmes, with the result that person-centered psychotherapy is being pushed more and more into a defensive position. Moreover, sometimes interventions are offered to patients simply because they are included in the guidelines. In addition, we have to acknowledge the fact that the Minister of Health, Welfare and Sport Affairs has now determined that he will make the guidelines the point of departure for the new financing system for health care in the Netherlands that will be based on the so-called DTC, or diagnosis and treatment combinations. A DTC works on the grounds of care providers receiving a standard amount of payment for interventions that have been included in a particular DTC. The full implication of this process will be known only in a few years' time. However, even now we can see that person-centered interventions will eventually no longer be financed by government and that this in turn will be extended to the health-care insurer. This point demonstrates that there are reasons enough not to just accept the situation as it is and ignore the new multidisciplinary guidelines.

Above all, there is an intrinsic argument that psychotherapists working with person-centered treatments should be interested in the outcome of the guidelines. How can it be the case that their interventions fall outside the guidelines? Why have all the separate guideline committees reached this conclusion? Does person-centered psychotherapy indeed not come up to scratch with the demands of this day and age, and are other therapies ultimately more effective? If the answer to this question is 'yes', then we have to ask ourselves whether the situation in the Netherlands is a portent for what to expect for person-centered psychotherapy in other countries. In short, there is every reason to delve deeper into the material and question the reason why person-centered psychotherapy has seemingly been kept out of the new multidisciplinary guidelines.

THE EVIDENCE FOR THE PERSON-CENTERED APPROACH

How have we reached this situation outlined above? Takens (2003) finds it incomprehensible that person-centered psychotherapy is being set aside as an insufficiently researched treatment modality. He seems to be supported in his arguments by the literature, which states that empirical support for person-centered psychotherapy clearly exists. In fact, effectiveness studies show person-centered psychotherapy to be very promising (Cain & Seeman, 2002; Elliott, Greenberg, & Lietaer, 2004). Lietaer summarizes the evidence as follows: 'Our therapeutic approach is effective and specific for depression, trauma, and abuse, and for relationship problems; it is also possibly effective for anxiety disorders … In addition, many research results show client-centered

experiential psychotherapy to be promising for the treatment of problems of aggression, borderline and other personality disorders, psychosomatics, eating disorders, schizophrenia, and quality of life in connection with somatic illness' (Lietaer, 2003, p. 9).

Takens postulates that the drafters of the new guidelines have not taken into account enough knowledge from the perspective of person-centered therapy. This is a serious accusation to make, especially in view of the fact that a number of the drafters were put forward by the Dutch Association for Psychotherapy itself. In order to establish the extent of the truth held in this argument we questioned the representative of the Dutch Association for Psychotherapy, F. Albersnagel, for the working group focusing on depressive disorders, on the grounds of which research and criteria they used to arrive at their conclusion not to include person-centered psychotherapy in the guidelines.

Did the drafters of the guideline for depression take all of the available evidence concerning the effectiveness of person-centered psychotherapy into account? 'Very much so,' answered Albersnagel (Albersnagel, 2004). A summary of his statement now follows: 'In addition to information from primary sources, we favored the client-centered approach by using the chapter by Elliott and colleagues, for retrieving evidence.' This chapter (Elliott, Greenberg, & Lietaer, 2004) refers to a total of 11 studies with (amongst others) a study group of subjects with depression. 'From this total, nine of the 11 studies were rejected, owing to either the number of patients per group being too few, or a research design that was not controlled. This is in accordance with what the authors Elliott et al. themselves determined, with 25 as the minimum number of patients and all research conditions controlled. Therefore, only two empirical studies exist that comply with the strict requirements that the drafters of the guideline adhered to. One of the two studies was conducted in the specific context of primary care (King et al., 2000); the second used a study group that was recruited by a non-standard method (Watson et al., 2005). Recruitments made through the use of the media, in general, led to strongly motivated clients with fewer symptoms than the average clients from the mental-health care sector. Neither study has been set aside, but when compared with the many efficacy studies on cognitive behavioral therapy, it seems that the evidence in favor of the client-centered approach is extremely limited. In addition, we made use of the evaluation of experiential psychotherapies made by Chambless and Hollon (1998) and the York I and York II studies described there. The last study concerns an unpublished manuscript. This also contained insufficient evidence for Elliott et al.'s conclusion that process-directive experiential therapies are specific and efficacious. This is the reason for the conclusion that: "the effectiveness of experiential and humanistic psychotherapies has not yet been sufficiently proven" (LSR, 2005b).'

Takens' argument that the drafters of the new guidelines have not taken into account the available knowledge from the perspective of person-centered therapy is contradicted by Albersnagel. According to him, the drafters of the guidelines have used the available literature concerning the efficacy and effectiveness of client-centered psychotherapy. It is not ignorance of the client-centered literature that explains its absence in the guidelines. According to Albersnagel, it is the 'quality of the research' and the reported level of evidence that explains its absence.

EXPLICIT AND IMPLICIT GUIDELINE RULES

The formal argument regarding the disappearance of person-centered interventions from the list of appropriate interventions in the guidelines is related to the explicit rules used in their construction. The new, integral, multidisciplinary guidelines need to be evidence-based: guidelines should be based on results forthcoming from scientific research. If there is a choice between alternative treatments, then the intervention that has been shown to be effective should be preferred (Sackett et al., 2000). In the 1980s the Cochrane Association constructed criteria for establishing the rigor of scientific evidence; these are the so-called levels of evidence. Simply stated, these levels indicate the extent to which the effectiveness of an intervention is empirically grounded.

At the top of the hierarchical list of scientific knowledge (step 1) are the outcomes from research according to the method of randomized controlled trials (RCTs). Characteristic of the RCT is its controlled and experimental nature. The effectiveness of a new intervention (experimental condition) is determined by comparison with an existing intervention or a placebo (control condition). Strict methodological rules are put into place regarding blindness for the treatment condition, the inclusion of patients, the application of interventions, and the effect measurements that are adhered to (mostly the degree of symptom reduction). One rung down the hierarchical ladder (step 2) is that of the controlled but not randomized study. Here, as well, the seemingly experimental character is foremost: unequivocal and defined determining variables, exclusion of any disturbing factors, and clear description of the target group and dependent variable. Another rung (step 3) down the hierarchical ladder is that of the controlled cohort and case control studies. These studies determine the effects of an intervention by comparing them with a control group. Step 4 concerns the results gained from pre and post measurements. At the bottom of the ladder is that expertise belonging to the individual professional or the opinion of an expert.

In sum, the stricter the design and the smaller the chance of disturbing factors, the harder the evidence and the higher the place on the hierarchical ladder. Reliability and replication are more important, according to this hierarchy, than the validity and the representativeness of the research results. In the mental-health guidelines, person-centered psychotherapy has come off worst with respect to very specific behavior therapeutic techniques, cognitive-behavior therapy, interpersonal therapy, and medication.

Much discussion is possible on the evidence-based points of departure (Hutschemaekers, 2003; Hutschemaekers & Tiemens, forthcoming). Since the start of the 'Empirically Supported Treatment' (EST) project (Elliott, 1998) fierce debates have been taking place on the advantages and disadvantages of this approach (Rowland & Goss, 2000). The point of view that raises the randomized controlled trial (RCT) to be the golden standard of scientific research has been an especial cause of much controversy (Bohart et al., 1998). Without repeating the arguments here (see Chambless & Ollendick, 2001), it is clear that the choice for the evidence-based criterion is not in favor of the Person-Centered Approach. Takens even proposes that the one-sided attention paid to evidence derived from the RCT is one of the most important arguments explaining the omission of person-centered psychotherapy in the guidelines (Takens, 2003).

We think that Takens is right when he says that the drafters of the new multidisciplinary guidelines have not been critical enough when weighing up the evidence. They have also not looked sufficiently into the disadvantages of the exclusive primacy of the RCT. This particular favoring of the RCT means that the Person-Centered Approach is indeed put at a disadvantage (Bohart et al., 1998); other research methods would possibly offer better perspectives (Elliott, 1998; Lietaer, 2003). We are less sure, however, of the strategic value of these arguments. The developers of the guidelines could actually agree with Takens' arguments by recognizing that no criterion whatsoever is completely neutral in nature. Subsequently, they could argue that there are none or hardly any alternatives available for weighing up research outcomes. Moreover, their argument could state that their choice for the levels of evidence does at least receive international support and is being applied in many areas of general health care (AGREE, 2003). We are worried that the discussion on the value of the levels of evidence, and the alleged objectivity of RCT research, will set off a rearguard reaction. Furthermore, this defensive battle could mean that attention is drawn away from a much more important argument, which will be presented below, in favor of the Person-Centered Approach.

The choice to weigh up interventions according to their level of evidence is defensible. So too is the guideline that where there are competing interventions, the one with the highest level of evidence should be favored. Nevertheless, it is highly debatable whether or not the formulators of the guidelines have fully taken this rule into account. We suspect that only those interventions that have evidence at level 1 have been recommended in the new guidelines. Interventions with a lower level of evidence are never seen as fitting, even if the level of evidence of the alternative interventions is even lower. The way this rule is applied is not explained anywhere in the guidelines. Therefore, we call this the *implicit* guideline rule. The criticism should focus on this implicit rule because its effects could be very dramatic. To illustrate this point: take a seriously depressed patient, where a decision must be taken on whether or not to hospitalize the patient in order to reduce or avoid the risk of suicide. Would this intervention be fitting here? This intervention does not have level 1 evidence and could probably never receive it, owing to the serious ethical problems that it would constitute in an RCT. According to the system of the new guidelines, where only level 1 evidence appears to be considered, this intervention would never be able to be recommended.

The consequences of this implicit guideline rule strike at the heart of the original design of integral, multidisciplinary guidelines mentioned at the start of this paper. We can tightly bundle these consequences together with the slogan that, as a result of the implicit guideline rule, the Dutch integral multidisciplinary guidelines are not integral, not multidisciplinary, and cannot even be referred to as guidelines. We will now look briefly at these three statements.

Firstly, the integral nature of the guidelines is affected as a result of the implicit guideline rule. The fact of the matter is that the implicit guideline rule means that the care described in the guidelines is reduced to that of proven effective interventions. The great majority of these are those interventions aimed at a reduction in the number or severity of complaints. Those interventions aimed at other aspects of the care are much less suitable subjects for an RCT. Therefore, sometimes therapeutic goals that are considered extremely necessary treatment measures belonging to an integral approach just disappear from the picture altogether. Some

examples of this are: reducing demoralization, organizing support, empowerment, learning to live with the limitations of life, existential depth, self-actualization.

Secondly, the guidelines have lost their multidisciplinary character. According to the original objectives, the new guidelines should provide an answer to the question of which type of intervention is appropriate at what point in time of the care process. The implicit guideline rule means that, in fact, only those interventions with level 1 evidence have been considered. These interventions are those aimed at reducing complaints. Usually, these interventions are those carried out by psychiatrists, clinical psychologists, and psychotherapists. Interventions carried out by other professionals therefore disappear from the picture.

Thirdly, the implicit guideline rule leads to the point where we can no longer refer to the new guidelines as such. According to the accepted definition (also adhered to by the formulators of the guidelines) a guideline recommends appropriate care for each phase of the care process. This means that phases are named for which objectives are formulated and subsequently interventions are described and weighed. As well as a thorough analysis of the literature, this process also requires sufficient clinical expertise. In other words, drawing up guidelines means making a connection between the experience of experts (the collective sense of the profession) and existing scientific evidence. The new guidelines go nowhere near reaching this definition; in fact they are merely a summary of interventions that have been proved to be effective.

SOME CONCLUSIONS

In spite of the promising points of departure of the new Dutch integral multidisciplinary guidelines, person-centered psychotherapy is absent. Takens (2004) has suggested that this absence is mainly due to a lack of knowledge of empirical outcome studies within the person-centered tradition. In this article we have argued that we are not so sure that this is really the case. Although it is true that the Person-Centered Approach boasts a long tradition of empirical research, it lacks knowledge at level 1 on the evidence-based standard as indicated by the new guidelines.

What then could turn the tide for the Person-Centered Approach? First of all, RCT research could be intensified in order to gain more empirical, level 1 evidence. Both more as well as more significant results are necessary: all the more so because evidence at level 1 on the Person-Centered Approach in reducing complaints is still lacking. At the same time, our advice is that we should not expect everything to come from the RCT. We suspect that Lietaer and Takens are right when they suggest that the RCT approach does not fit in very well with person-centered psychotherapy (Lietaer, 2003; Takens, 2003). A second approach consists of going into battle with the application of these too one-sided evidence-based standards of scientific knowledge. In fact, there are numerous good arguments that could be made against the evidence-based standard (Chambless & Ollendick, 2001; Elliott, Greenberg, & Lietaer, 2004; Takens, 2003). However, our viewpoint is not to go into too much detailed discussion on this standard. This would not only lead to the fighting of a losing battle, but also distract us from where the real problem lies.

Our most important criticism towards the developers of the guidelines is not that they are too orthodox, but that they are not orthodox enough. Instead of consistently applying the evidence-based standard and repeatedly making choices between interventions on the basis of their level of evidence, an implicit choice has been made not to make choices. This means that only interventions with level 1 evidence have been included in the guidelines. This is in spite of the fact that guidelines are supposed to recommend the most fitting kind of care for a specific situation, taking into account the problems of the patient and the objectives to be achieved. To this end, the integral, multidisciplinary guidelines are not integral, not multidisciplinary, and really not even guidelines. The biggest problem concerning this approach is that mental-health care will be reduced to mainly dealing with complaint reduction.

Our suggestion would be to turn the discussion around: do not claim that the new guidelines go too far, but on the contrary declare that they do not go far enough. Guidelines should include recommendations on matters for which no level 1 evidence exists. This would create room for target areas in mental-health care other than just the reduction of complaints alone. In turn, this might necessarily leave room for other sources of scientific knowledge, including that based on other levels of evidence and even the 'collective sense of the profession.'

One significant advantage of this strategy is that other disciplines will become partners. These other professionals could be psychotherapists coming from different frames of reference or from other professional groups, including nurses and social workers. The expertise of these professionals should also be brought into the discussion, despite the fact that their contribution to mental-health care has been studied to a far lesser extent, and not at all according to the RCT method. Furthermore, this strategy also offers possibilities for including representatives from patient organizations in the discussion. The clients themselves know only too well that psychotherapy is hardly ever solely fixed on the reduction of complaints. A broader description of objectives and the accompanying interventions is therefore in their best interests.

We call for representatives of the person-centered tradition to enter the discussion on new guidelines by inviting the drafters of guidelines to reflect on those matters that are serious and that have not been dealt with in the present guidelines. These serious matters should be chosen with some caution: their relation to mental-health care should be unambiguous; they have to deal with actual problems and they should be about issues where level 1 evidence is not strong. Naturally, these serious matters should contain the core elements of the person-centered range of thought. Elsewhere we have given the initial impetus for working out three relevant issues. These are: the development of the therapeutic relationship, empowerment, and the existential dimension of mental-health care (Hutschemaekers & van Kalmthout, 2004; van Kalmthout, 2004). These are issues for which the expertise of the person-centered psychotherapist is either unique or complementary to the expertise of others within inter/multidisciplinary teams. This brings us to our firm opinion that within the individual professional groups, attention will increasingly be focused on matters that concern the core of the person-centered range of thought, and that are of considerable value for the mental health-care sector.

REFERENCES

AGREE (2003). Development and validation of an international appraisal instrument for assessing the quality of clinical practice guidelines: The AGREE project. *Quality and Safety in Health Care 2003, 12*, 18–23.

Albersnagel, F. (2004). *De tijd zal het leren: Een reactie op Takens' bespreking van de CBO conceptrichtlijn Depressie*. Groningen, Netherlands.

Bohart, A. C., O'Hara, M., & Leitner, L. M. (1998). Empirically violated treatment: Disenfranchisement of humanistic and other psychotherapies. *Psychotherapy Research, 8*, 141–157.

Cain, D. J., & Seeman, J. (2002). *Humanistic psychotherapies: Handbook of research and practice*. Washington, DC: American Psychological Association.

Chambless, D. L., & Ollendick, T. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52,* 685–716.

Cohen-Kettenis, P. T., Dekker, J. H., Groot, P. A. d., Raben, C. J. T., & Trijsburg, R. W. (2000). Naar geïntegreerde richtlijnen in de GGZ: De visie van de Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de Geestelijke Gezondheidszorg. *Maandblad Geestelijke Gezondheidszorg, 55*, 782–789.

Eddy, D. M. (1990). Clinical decision making: From theory to practice. Designing a practice policy: Standards, guidelines and options. *Journal of the American Medical Association, 22*, 3077–3081, 3084.

Elliott, R. (1998). Editor's introduction: a guide to the empirically supported treatments controversy. *Psychotherapy Research, 8*, 115–125.

Elliott, R., Greenberg, L. S., & Lietaer, G. (2004). Research on experiential psychotherapies. In M. Lambert (Ed.), *Bergin & Garfield's handbook of psychotherapy and behavior change* (5th edn.) (pp. 493–539). New York: Wiley.

Hutschemaekers, G. (2003). Multidisciplinary guidelines in Dutch mental health care. Plans, bottlenecks and possible solutions. *International Journal of Integrated Care, 3,* ISSN 1568-4156 <www.ijic.org>.

Hutschemaekers, G., & Kalmthout, M. van (2004). De evidentie van het cliëntgerichte gedachtegoed. *Tijdschrift Cliëntgerichte Psychotherapie, 42*, 5–17.

Hutschemaekers, G., & Oosterhuis, H. (2004). Psychotherapy in the Netherlands after the Second World War. *Medical history, 48*, 429–448.

Hutschemaekers, G., & Tiemens, B. (forthcoming). Threat or challenge? Professionals and the new evidence-based policy. In J. W. Duyvendak, T. Knijn, & M. Kremer (Eds.), *Professionals between people and policy: Transformations in care and welfare in Europe*. Cheltenham, UK: Edward Elgar.

Kalmthout, M. van (2002). The future of person-centered therapy: Crisis and possibility. *Person-Centered and Experiential Psychotherapies, 1&2,* 132–143.

Kalmthout, M. van (2004). Person-centered psychotherapy as a modern system of meaning. *Person-Centered and Experiential Psychotherapies, 3,* 192–206.

King, S., Sibbald, B., Ward, E., Brower, P., Lloyd, M., Gabbay, M., & Byford, S. (2000). Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care. [Monograph]. *Health Technology Assessment, 4*(19), 1–84.

Lietaer, G. (2003). De empirische ondersteuning van experiëntieel-humanistische psychotherapieën: Stand van zaken en taken voor de toekomst. *Tijdschrift voor Cliëntgerichte Psychotherapie*, *41*, 5–24.

LSR (2003). *Richtlijn voor de diagnostiek en behandeling van angststoornissen*. Utrecht: Landelijke Stuurgroep Multidisciplinaire Richtlijnen in de GGZ.

LSR (2005a). *Richtlijn voor de diagnostiek en behandeling van ADHD*. Utrecht: Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de GGZ.

LSR (2005b). *Richtlijn voor de diagnostiek en behandeling van depressieve stoornissen*. Utrecht: Landelijke Stuurgroep Multidisciplinaire Richtlijnen in de GGZ.

LSR (2005c). *Richtlijn voor de diagnostiek en behandeling van Schizofrenie*. Utrecht: Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de GGZ.

LSR (2005d). *Richtlijn voor de diagnostiek en de behandeling van eetstoornissen*. Utrecht: Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de GGZ.

Rowland, N., & Goss, S. (Eds.). (2000). *Evidence-based counselling and psychological therapies: Research and applications*. London: Routledge.

Sackett, D. L., Strauss, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence-based medicine. How to practice and teach EBM*. New York: Churchill Livingstone.

Swinkels, J. (2003). *Richtlijnontwikkeling in de geestelijke gezondheidszorg*. Amsterdam: Vossiuspers UvA.

Takens, R.J. (2003). Hoe evident kunnen cliëntgerichte psychotherapieën zijn? *Tijdschrift voor Cliëntgerichte Psychotherapie, 41*, 25–40.

Takens, R. J. (2004). Richtlijnen en denkwijzen. Een reactie op de conceptrichtlijnen depressie en angststoornissen. *Tijdschrift voor Psychotherapie, 30*, 39–51.

Tiemeier, H., Vries, W. J. d., Loo, M. v.h., Kahan, J. P., Klazinga, N., Grol, R., & Rigter, H. (2002). Guideline adherence rates and interprofessional variation in a vignette study of depression. *Quality and Safety in Health Care, 11*, 214–218.

Watson, J.C., Gordon, L.B., Stermac, L., Kalogerakos, F., & Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting and Clinical Psychology, 71*, 773–781.