

Günther Krampen, Professor in the Department of Psychology at the University of Trier, Germany, has had a keen interest in Autogenic Training for many years. As Autogenic Training originated in Germany, Krampen is well placed to set AT in its historical and clinical context.

I. Preamble

Since the early 1960s, in the western world, clinical depression has often been treated with anti-depressant medications. These medications subsequently became the benchmark by which to measure the efficacy of other treatments for depression. During the last few decades, in addition, depression has also often been treated in North America and the UK with Cognitive Behaviour Therapy (CBT).

Treatments for clinical depression often seem to follow fashions. The introduction of anti-depressant medications during the late 1950s and early 1960s became, as mentioned above, the benchmark in term of efficacy for comparing other forms of treatment for depression. During the last few decades, particularly in North America and the UK, Cognitive Behaviour Therapy (CBT) gained credibility as a valid approach for treating depression.

There are many different forms of depression, and no one approach works in all cases of depression. Depression can be precipitated by stressors in our lives: for example, bereavement and other forms of significant loss – such as ill health. Decades ago it was common to view mental illness or mental distress as being the result of the individual not having enough gumption: and so there was a feeling that all that was required was for the sufferer to “pull themselves together”.

We now know this is not the case. While our mental attitude to whatever befalls us is of great importance for our long term well being, it is important to appreciate that distressing mental states are bodily states as well. Elissa Epel has put it this way:

Psychological stress is a physiological whole body state.

Elissa Epel¹

Anxiety and Depression can be regarded as forms of psychological stress, and so should also be thought of in terms of “physiological whole body states”. Autogenic Training is a discipline that can be regarded as bringing about positive and appropriate changes in our “physiological whole body state”². The research that we are going to review in this article indicates that Autogenic Training can bring about long term benefits in terms of reducing the relapse rate in patients suffering from depression who have received psychotherapy / CBT and AT as a combined therapy, compared with those who have received psychotherapy / CBT alone.

Background comments on the origins of Autogenic Training

Autogenic Training was developed in Berlin by Johannes Schultz in the 1920s. Schultz, a psychiatrist and psychoanalyst, had already been studying the therapeutic effects of hypnosis for a decade or so. Krampen comments on three important factors to consider regarding the origins of AT.

1. Schultz, as a result of this extensive research, decided upon the AT approach in preference to the then common hetero-suggestive treatments (i.e. traditional hypnosis). The AT approach can be regarded as an “historically early self-control and self-management method.” (Krampen 1999 p 12)

¹ BBC Radio 4: Wednesday, 6th July 2011 (Frontiers); see also: Epel 2009

² In this sense it is a non-specific type treatment (i.e. for specific disorders); partly because of this, it can bring about a wide range of non-specific benefits – such as an increased feeling of Well-Being.

2. Schultz analysed his AT work with patients methodically. He often taught AT to individuals, but also introduced the teaching of AT in groups; in addition, he was interested in introducing AT for healthy individuals.

From the beginning Schultz was engaged in empirical studieswhich not only analysed the applicability and the effects of autogenic training in clinical samples, but also in healthy persons too – together with preventative treatment indications.

Krampen 1999 p 12

3. As indicated above, Schultz introduced the practice of teaching AT in groups. He was thus one of the first (if not the first) to adopt group treatment – with the potential benefits that this can bring with group members learning from each other (and of course being a form of Social Support).

Background to Krampen Study

Günther Krampen, Professor in the Department of Psychology at the University of Trier, Germany, followed up the patients in his study for three years. The patients were initially divided into three groups, as shown in Figure 1.

Group	Duration (total 20 weeks)	
	10 weeks	10 weeks
A	40 Psychotherapy sessions	
B	AT alone (10 sessions)	20 Psychotherapy + continuing AT practice
C	Control	20 Psychotherapy + AT (10 sessions)

Figure 1
Basic Layout of Research
(Krampen 1999)

Comments re Figure 1

- Psychotherapy embraced CBT approaches
- AT: Autogenic Training

Group A: 40 psychotherapy sessions over 20 weeks.

Group B: 10 AT sessions during first 10 weeks; then for second 10 weeks 20 psychotherapy sessions plus on-going AT.

Group C: Control group for first 10 weeks; then for second 10 weeks 20 psychotherapy sessions plus 10 AT sessions.

All subjects were suffering from depression [ICD-10: “depressive episode”; “long term depressive reaction”; and recurrent depression” – see Krampen 1999 p 13 for further details]. The CBT and AT sessions were given by six experienced psychotherapists.

One of the main outcome measures was the BDI depression score (Beck Depression Inventory). In addition, we will look at the “Symptom Check List for Autogenic Training”, specifically developed in Germany for patients being treated with Autogenic Training (AT-SYM – Krampen 1991).

Results i: Some general comments

Measurements were made at various stages, as outlined in Figure 2:

Pre-test	
Post-test 1	10 weeks
Post-test 2	20 weeks
Follow up 1	8 months
Follow up 2	3 years

Figure 2
Pre-test, Post-test, and follow up schedule

The sample size was relatively small, and it should be noted that for the three year follow up involved 48 patients.

Results ii: Relating to BDI scores

We will first look specifically at the results of the interventions on the Depression Scores of the participants in the study. These are summarised in Figure 3.

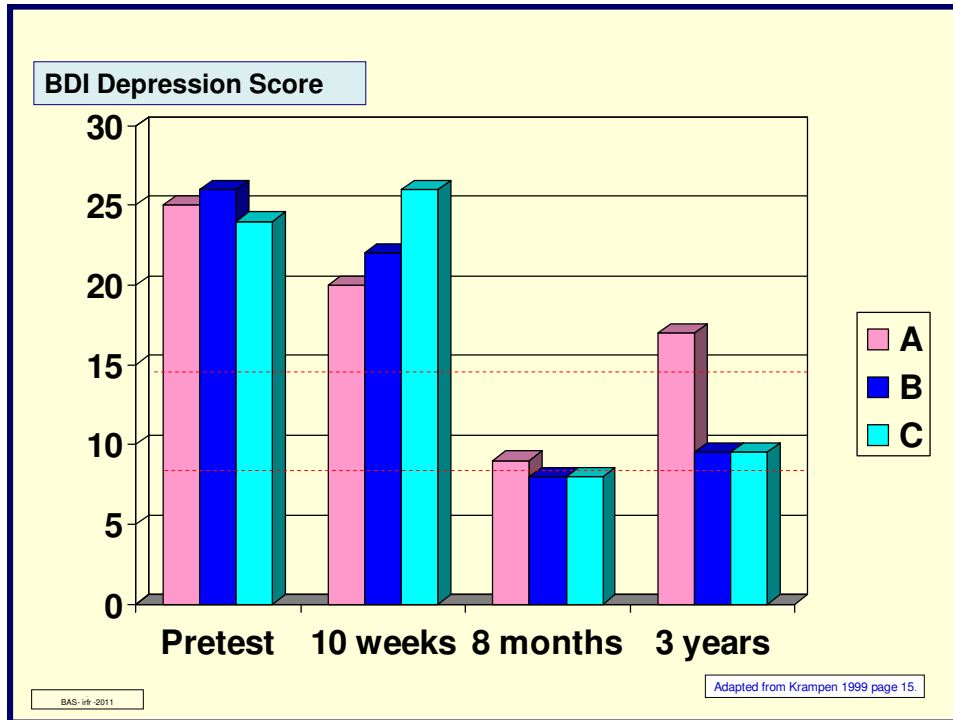


Figure 3
Summary of Depression outcomes
Adapted from Krampen 1999 p 15
Reconfigured in colour

Legend:

- Group A: Psychotherapy alone
- Group B: Psychotherapy after first 10 weeks of AT
- Group C: Control for 10 weeks: then Psychotherapy & AT

Comments on Figure 3.

- The two dashed red lines relate to the degree of depression. Below the lower line, no depression. Above the higher line, clinical depression; between the two lines, mild depression.
- Note that at the ten week test, CBT shows the best response.
- All three groups are more or less equal by 8 months.
- At three years, Groups B & C (AT combined with CBT) are both doing significantly better than the CBT alone group.

Note: The twenty week follow up has been omitted. (The scores for groups A, B, and C were here: 10.5; 8; and 16.5 respectively).

So what is going on here? Depression is not simply a mental state: it is also a whole body state. Autogenic Training is a non-specific treatment³. The psycho-physiological shift that Schultz described

³ Except perhaps for Insomnia and Raynaud's disease (Grawe et al 1994; Krampen 1998; Linden 1994; 1990; and Bowden et al 2011)

(Schultz 1932; Schultz & Luthe 1969) is a generalised psycho-physiological shift that can affect many mental and bodily domains⁴. In order to produce such effects, we have to have patience and keep at our AT practice (see e.g. D1). This seems to be one of the implications of Krampen's study.

Autogenic Therapy combined with psychotherapy seems to have a protective effect on recurrent depression at three year follow up. In fact, Krampen states that psychotherapy alone (at three years) was four times more likely to have failed compared with combined Psychotherapy and AT (Krampen 1999 p 16). He goes on to state:

Thus long term (i.e. 3 years plus – IR) lasting reduction of depressive symptoms is significantly better for patients under psychotherapy with autogenic training than for those under psychotherapy without autogenic training.

Krampen 1999 p 17

Results iii: Relating to Psychosomatic scores

In the early 1990s, Krampen developed a checklist relating to psycho-somatic type complaints.

The "Symptom Checklist for Autogenic Training" (AT-SYM; Krampen 1991), a German symptom checklist including four-point rating scales of 48 mainly psychosomatic complaints with indicative relevance to autogenic training (internal consistency $r_{tt} > .89$).

Krampen 1999 p 13

With this background, we will now look at the psychosomatic scores in this study, which are summarised in Figure 4.

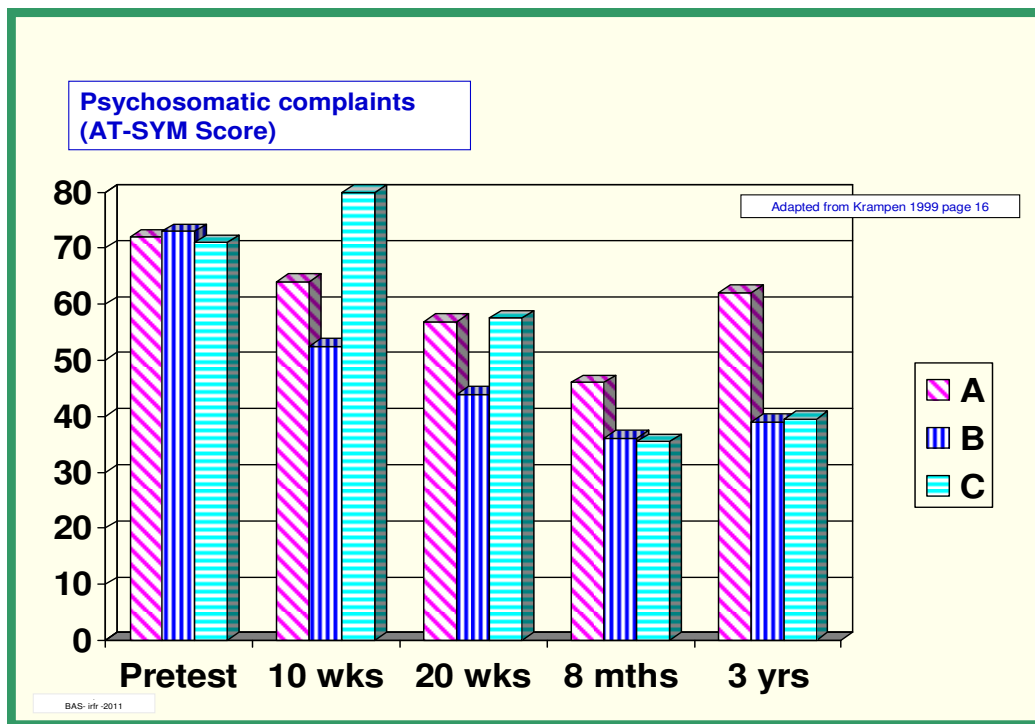


Figure 4
Summary of psycho-somatic scores from pre-test to follow up
(Based on Figure 3 of Krampen 1999 p 16; reconfigured in colour)

Legend:

Group A: Psychotherapy alone

Group B: Psychotherapy after 10 weeks of AT

Group C: Control for 10 weeks: then psychotherapy & AT

⁴ "mental and bodily domains" may imply the Cartesian Dualism; so perhaps we should, correctly speaking, say the "mental-body domain".

Comments on Figure 4 /

Comments on Figure 4

- The psychosomatic scores (AT-SYM) are shown at: pre-test; post tests (10 weeks and 20 weeks); and follow ups (8 months and 3 years).
- At 10 weeks, Group C, the control, showed a slight increase in psychosomatic symptoms. This may have related to the mental distress of being in a control group⁵ while others are having positive interventions.
- At 8 months, Group A (psychotherapy alone) are already showing increased symptoms compared to Groups B & C.
- This difference becomes even more pronounced at 3 years, with Group A scoring around 60, while the psychotherapy plus AT groups (B & C) are continuing to show relatively low levels (around 40) of the AT-SYM scores.

This is further evidence that on-gong practice of Autogenic Training can have significant benefits, reducing somato-psychic symptoms, and increase well-being.

Some caveats and conclusions

This research project on the effects of psychotherapy with or without Autogenic Training was sophisticated in terms of the psychotherapeutic and Autogenic approach. It is important to note that:

- The 6 psychotherapists each had at least eight years psychotherapeutic practice (three females and three males).
- Each has “special psychotherapy training” plus professional CBT training; plus at least one other psychotherapeutic approach (such as Gestalt, family therapy, client focused therapy).
- All treatments were carried out under “double professional supervisions”: that is, both clinical supervision and research supervision.
- In addition: “According to adaptive indication strategies, the focus of (integrative) psychotherapy was changed rationally from behaviour-oriented and problem-centred treatment to supportive treatment and to psycho-dynamic treatment and *vice versa*” (Krampen 1999 p 18).
- Furthermore, despite the group setting for the Autogenic Training component, there was specific tailoring of the AT to the individual’s needs (Krampen 1999 p 18 again).

I mention this because it is sometimes not appreciated that the results from research trials often reflect on the particular set up, organisation, and internal working dynamics of the therapists; and the modus operandi that has been created by the prime movers of the clinical project. This means that such original research cannot always be duplicated in a different setting, with different assumptions, and with a different work ethic.

Notwithstanding the above caveats, this is an important study by Krampen. His conclusions include:

- Thus, long term reduction of depressive symptoms is significantly better for patients under psychotherapy-with-autogenic-training than in those under psychotherapy without autogenic training.

Krampen 1999 p 17

- Thus, there is significantly greater long-term, lasting reduction on psychosomatic symptoms in depressive outpatients under psychotherapy-with-autogenic-training than with those under psychotherapy without autogenic training.

Krampen 1999 p 17

The efficacy of Autogenic Training is directly related to the psycho-physiological shift that Schultz highlighted, and this can bring about a whole body state change. Amongst other things, this will result in a reduction in SNS induced afferent inputs to the brain that can be the cause of internal distress and not feeling right in ourselves. Axiomatic with a reduction of these “negative” afferent inputs will be positive afferent inputs that will result in us having positive “background feelings” (Damasio 1999, pp 286-287): this then moves us towards the sphere of inner harmony and general well-being (A3).

⁵ My understanding of this research is that the control group had to be a control group with no treatment. You cannot give placebo CBT or placebo AT.

Post script

Anti-depressant medications, CBT, and Mindfulness Based Cognitive Therapy for depression

Anti-depressant medications

During the last couple of decades or so, the yardstick for measuring the efficacy of treatments for depression has been anti-depressant medications – in the form of the tri-cyclic anti-depressants or the Selective Serotonin Reuptake Inhibitors (SSRI)⁶. This was called into question by a Cochrane review in 2003 (Moncrief 2003). The background to this, and the essence of Moncrief's review, are summarised below.

There is some doubt as to the true efficacy of anti-depressant medications such as the SSRIs.

- Historically, double blind placebo controlled trials have tended to match the active drug, here the anti-depressant, with an inactive placebo. In such trials, the anti-depressant was clearly shown to be effective compared to the placebo.
- However, when the inactive placebo was replaced with a placebo that matched the side effects of the anti-depressant, it was found that the anti-depressant really only had a marginal effect.
- This would suggest that patients in double blind trials can have a very good idea that they are on the real medication [because of the side effects] and it is at least partially this belief that they are on something that will make them better that makes them better; and not the medication itself. (Moncrief et al; Cochrane Review: 2003.)

CBT

In an extensive review of the literature, reported in the SIGN guidelines (2010), psychological therapies such as CBT and Interpersonal Therapy were found to be an effective treatment for depression. There are aspects of Autogenic Training that overlap with some aspects of CBT.

Mindfulness Based Cognitive Therapy (MBCT) for depression.

During the last decade or so, significant research has shown that MBCT is an effective approach to those suffering from recurrent depression (Segal 2002; Williams 2007; SIGN 2010). One of the features of such depression is negative ruminations, including negative judgements about ourselves. The MBCT approach specifically addresses these issues. Some Autogenic Therapists now embrace aspects of Mindfulness (and CBT) in their approach to AT.

References and sources /

⁶ And some authorities have suggested that all research into the efficacy of treatments for depression should include an anti-depressant medication for comparison with the treatment being evaluated.

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[Linked themes in this Autogenic Dynamics section](#)

A2	Autogenic Training Meta-analysis (Stetter and Kupper 2002)
A3	Towards a concept of happiness and well-being
B6	Perceptions, flowers, and reality
C2	Mindsight – our seventh sense and associated pre-frontal cortex functions
D1	Reflections on foundations for mindful living (after Kabat-Zinn)