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IFP
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newsletter

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EDITORIAL

Dear colleagues,

The IFP board is glad to send you our latest Newsletter. The next page, of course, is devoted to the current 2014 IFP congress in Shanghai. We are glad that the Asian Pacific Association for Psychotherapy (APAP), a member of IFP, co-organized the conference. It is an extraordinary event and more than 80 symposia and workshops have been carefully prepared to exchange ideas, share developments, promote global health and enhance our friendship. We wish all the IFP congress participants a really pleasant time at the conference!

The main topic of the present issue is the psychotherapeutic profession(s) as well as education and training in psychotherapy. Psychotherapies have evolved as sub-disciplines within the professions of medicine (particularly psychiatry), psychology (particularly clinical psychology) and, in certain countries, within the profession of social work (e.g., US) or counselling (e.g., UK). With so many professionals who practice psychotherapy and with so many differences among countries, it seems interesting to know more about education and training in psychotherapy in different areas.

We here present an overview on unity and diversity among the psychotherapeutic professions by Prof. David Orlinsky, University of Chicago, as well as the reports on the state of the art of education and training in psychotherapy in Chile, China, Denmark, and Switzerland. I really thank the authors of these reports (Prof. Verónica Bagladi from Chile, Prof. Zhao Xudong and Dr. Qian Jie Tongji from China, Dr. Claus Haugaard Jacobsen from Denmark, Prof. Ulrich Schnyder and Peter Schulthess from Switzerland) who did a terrific job! These are either drawn from, or modeled

on, a collection of reports on psychotherapy professions in many countries (initiated by Prof. David Orlinsky) that may be found on the Society for Psychotherapy website (http://www.psychotherapyresearch.org/?page=89) This is not a comprehensive treatment of the issue but a solicitation to maintain attention on this hot topic due to the disparities among different areas and professions. I briefly refer to the state of the art of education and training in psychotherapy in Italy, the country where I live and work, as an example of disparity among professionals. In Italy, physicians and psychologists can have the title of psychotherapists. Among physicians, psychiatrists receive such a title when they complete their residency program in "psychiatry and psycho-therapy" and ask to be registered in the official list of psychotherapists of their region. Thus, they are trained at the University while receiving a salary as residents. On the other hand, other physicians and psychologists are trained in psychotherapy in private schools. Thus, they have to pay a fee, often higherthan their yearly salary, and the training programs are officially recognized by the Ministry of Education but not implemented by the public educational authorities. Italy has been historically considered the land of contradictions, so hopefully the disparities I highlighted are an exception worldwide among the countries and represent the counterpart of a variety of backgrounds and training paths that reflect Italy's cultural richness. However, the state of the art described in other countries (for details please see below) is sometimes not so far from our land of contradictions!
We then report a brief overview of the five randomized-controlled multi-center psychotherapy studies that were conducted within the German Eating Disorder Diagnostic and Treatment Network (EDNET) as an example of psy-chotherapy application in clinical and research activities. Prof. Stephan Zipfel and Prof. Martina de Zwaan, through their EDNET consortium, demonstrated that randomized controlled multi-center psychotherapeutic trials in eating disorder patients can be successfully conducted with respect to strict methodological standards.

For the next Newsletter we can, among other things, announce a discussion related to an international col-laborative longitudinal study of development in psychotherapist trainees being planned within the Society for Psychotherapy Research, and also distance education which is rapidly gaining importance. As a globally oriented Federation, the IFP wants to focus on this field which, given the rapid developments of technology, will certainly become increasingly appealing for all sorts of educational activities such as webinars, curricular trainings, and supervision.

The IFP board wishes all of you a pleasant reading and a pleasant staying in Shanghai,

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Shanghai Congress News

Franz Caspar, Ph.D. and Xudong Zhao, M.D.

Dear IFP members

As organizers of the congress which will begin in just a few days, we pass on the latest news.

Till the weekend of April 26/27th, 1103 participants from 29 countries had already registered through the website, 981 of them domestic, and 122 from other countries. This is a great attendance! Above all the domestic committee with all its helpers deserves a great applause!

The program includes 3 keynote presentations and 11 plenary papers, 9 special fora, 53 symposia, 28 workshops, and 27 posters. There will evidently not only be a very good attendance but, even more important, also a rich program. Many papers will be translated or at least the slides will be projected in parallel in English and Chinese. Important persons from politics and the health system are regular participants or have announced their visit. So there is good reason to hope that the congress will also have a positive impact not only on the knowledge and networking of the participants but also on the health system as far as the understanding of psychotherapy is concerned. This is important for a country with its first Mental Health Law, which is still in the process of building up services.

Shanghai is a great city, with a rich history still visible in some of the older buildings and areas, but growing at a breathtaking pace. At this time of the year, the air pollution situation is not too bad, therefore "breathtaking" has not to be taken literally. Participants who can afford to spend extra days or even weeks in Shanghai and China will have or had the problem of choosing between many attractive possibilities.

The conference site has proven its qualities already at a conference of the German-Chinese Academy for Psychotherapy (an IFP member) some years ago, and many other conferences, so we can expect a well organized conference also with respect to the conference site.

The newly formed IFP research committee has worked efficiently: For the first time in the life of IFP, a research award will be given at the end of the conference as a sign that, although not a researchers' association, IFT stands for a strong belief that research is needed for progress in the practice of psychotherapy.

Decisions whether you want/can participate at the conference have most probably been made months ago, so we can not assume that many who had not planned to come anyway will change their mind based on the above good news. But we hope that those who will come see their decision strengthened and confirmed, and a little bit we hope that the others will regret that the can't come.

Best,

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Unity and diversity among the psychotherapeutic professions: a challenge to professional education

David Orlinsky

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It is a commonplace to note that while there are many professional psychotherapists, there is no profession of psychotherapy; that is, no profession in which all psychotherapists are trained, to which all belong, and for which all are accountable. There are, instead, several different professions, each one having some members within it who practice psychotherapy and some who do not. Most prominent among the secular professions in which psychotherapy is practiced are medicine and psychology, joined by other professions differing according to country (e.g., social work in the USA, counselling in the UK). Psychotherapy is thus a subspecialty practice within several different professions.

Recognizing the broad commonalities shared therapists having different professional backgrounds, Henry et al. (1971) in a classic study of psychiatrists, psychoanalysts, psychologists, and social workers, concluded that psychotherapy is essentially a distinct profession, which they referred to as *The Fifth Profession* (Henry et al. 1971). The same de facto commonality among psycho-therapeutic professions was also heralded in *New Horizon for Psychotherapy: Autonomy as a Profession* edited by Robert Holt (1971), in which the authors of varied chapters clearly thought that an ideal training for therapeutic practitioners would include some aspects of the curricula offered in medical schools, graduate clinical psychology departments, social work education, psychoanalytic institutes.

What does more recent research show about therapeutic professions? Strangely, research reviews in the authoritative *Handbook of Psychotherapy and Behavior Change* did not include the word 'profession' in the index until the fourth edition (Beutler et al. 1994) – despite the fact that psychotherapists' professions have been listed in sample descriptions of almost all published psychotherapy studies. In their review of therapist characteristics, Beutler and his colleagues noted that in most studies professional discipline and 'the type and amount of training are confounded' (p. 234). If at all significant statistically, differences between pro-fessions appeared to be slight, sometimes favoring one and sometimes another – but, without controlling the effects of other confounded variables (like gender, theoretical orientation, and work setting) even the differences that were found are difficult to interpret.

In an effort to correct this problem, Lorentzen, Rønnestad and Orlinsky (2008) examined the impact of professional discipline by comparing four groups of psychiatrists and psychologists from Norway and Germany on various aspects of therapeutic experience while controlling for theoretical orientation, career level, gender, and nationality. Examining more than 2,500 cases, only a few aspects of therapeutic experience were found where professional discipline made a statistically impact as a main effect,

and then always accounting for less than 1% of the variance. If these results are confirmed in future studies, it will be reasonable to conclude that other therapist characteristics than the therapist's profession – often personal qualities – have far more effect on therapeutic processes and outcomes. Evidently it makes relatively little difference, when interacting with patients in the therapy office, which type of academic degree the therapist has earned in the process of becoming qualified to practice.

A commonsense conclusion would be that each discipline in which psychotherapists have traditionally been trained likely contributes something important to the therapist's ability to function. However, professional training in these fields might also impair the psychotherapist's ability to function in certain typical ways. For example, medical training often is biologically reductionistic; social work training often may underemphasize intrapsychic aspects of the patient's subjectivity; doctoral training in psychology may often over-emphasize the cognitive or intellective aspects of the psyche and view individuals abstractly without taking account of their social and cultural context.

Paradoxically, while research seems to show that the therapist's professional discipline makes little difference in the actual practice of psychotherapy, the professional disciplines collectively control access to psychotherapeutic work for those with the talent and inclination to do it. Given current economic and institutional patterns, these professions also directly or indirectly control access to therapeutic aid for persons who need and can benefit from it. Hopefully, further research about psychotherapists (e.g., Orlinsky & Rønnestad, 2005) will increase scientific attention and suggest possible solutions to this problem of professions and professional education in psychotherapy.

Note

This article was excerpted from Orlinsky DE (2009). Research on psychotherapy and the psychotherapeutic profession(s): A brief Introduction. *European Journal of Psychotherapy and Counselling, 11*(2):183–190. More information about the therapeutic professions in different countries can be found online at http://www.psychotherapyresearch.org/?page=89

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The psychotherapeutic profession in Chile

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Context

In the Latin American reality we find that, according to the World Health Organization (WHO) and the World Federation of Mental Health (WHO 2004a; 2004b), around 150 million people have mental or neurological disorders, or psychosocial problems. Following the more developed countries, where 15.6% of the burden of disease is attributable to alcohol, Latin America is in second place, with a load of 14.7%. Between 15% and 23% of children and adolescents suffer from mental health problems; somewhere around 17 million young people from Latin America and the Caribbean - aged between 5 and 17 years old - have mental disorders sufficiently severe to require treatment (Bagladi, 2009).

The Chilean Study of Prevalence of Psychiatric Pathology (Vincent et al., 2002; 2010; 2012), showed that 36% of the population over 15 years had a psychiatric disorder at some point in their lives, while a 22.6% had had a disorder in the last 6 months. The found prevalence rates are generalizable to the universe of people older than 15 years living in a home. Minorities living on the street or in institutions (e.g., hospitals, prisons) were excluded. Thus, it is possible to assume that the actual prevalence rates are higher since these minorities have a higher incidence of mental illnesses. According to gender analyses, emotional and anxious disorders are significantly more frequent in women than in men (ratio 2:1 and 2.7:1, respectively), while substance abuse is most prevalent in men than in women (ratio 2.4:1).

The National Committee for Drugs Control in Chile (CONACE) recently ran a survey study in different universities and observed that 17% of the students have alcohol dependency, 16.2% consume marijuana, 4.1% use antidepressants (without any prescription), and 3.55% cocaine (Chadwick, 2003). Since the rates increase every year, the future looks rather dark. Linked to the consumption of alcohol, research conducted by CONACE allowed it to trace a trend in the general population between 12 and 64 years. A series of studies in schoolchildren have highlighted a decreasing age of the first use, a rise in the consumption of alcohol in women, and an increasing tendency to poly-drug use. On the other hand, studies run in the general population, show that 3.7% would like to receive help for alcohol consumption, 2.8% for drugs consumption, and 1.7% for both (CONACE, 1998; 2000; 2002; 2004; 2006; 2008; 2010).

Regarding depression, our studies did show, in our capital city (Santiago), a prevalence of 5.35% for a "depressive episode" in the last week (2.7% for men and 8.0% for women, respectively) and a prevalence of depressive disorders of 14.7% in men and 30.3% in women who consulted in the General Polyclinic. In studies with adolescents, it was found that symptoms of depression were present in 13.9% of males and in 16.9% of females. Studies on anxious or depressive symptoms in women during pregnancy, reveal a prevalence between 16.7% and 35.2% (Jadresic and Araya, 1995; De la Barra et al., 2004; Minoletti and López, 1999, 2000; Vicente et al., 2010).

Concerning the child and adolescent population, the absence of epidemiological data is a common factor all over the world and especially in developing countries. In Chile, studies in specific populations provide data to assert a 24% prevalence of psychiatric disorders, being the most prevalent disorders regarding activity and attention (6.2%). Anxious disorders constitute the most frequent diagnosed group with a 18.9% prevalence, while the analysis of specific pathologies showed higher prevalence rates of separation anxiety disorders (9.5%) and generalized anxiety disorder (9.2%) (Araya et al., 2001; De la Barra et al., 2004; Vicente et al., 2010).

According to the national survey of disability, at least 1 in 4 families have at least one member affected by a mental behavioral disorder resulting in family dysfunction, decreased quality of life, social discrimination; or the loss of economic or social support networks. According to studies conducted by the Ministry of Health of Chile this data is also associated with the burden of disease and the risk attributable to mental disorders. The Ministry made in 2000 the National Plan for Mental Health and Psychiatry, given the need to implement a model of outpatient care, as a way to achieve greater equity and effectiveness. Its focus has been the access to primary, secondary, and tertiary-preventive interventions, aimed at early detection, early diagnosis, early treatment, rehabilitation, and social integration of people with mental illness in order to achieve a greater success rate. The main axis included within the “Plan” was the incorporation of attention problems and mental health disorders in primary care and the increase in the problem-solving capacity, as well as the diversification of the supply services (MINSAL, 2000a; 2000b; 2001; 2007; DIPRES, 2009; FONASA, 2009a; 2009b).

Clinical Psychology and Psychotherapy

As it is well known, Clinical Psychology is the branch of Psychology devoted to the generation and application of psychological knowledge and understanding, to the improvement of physical and mental well-being (APA, 2000). This emphasizes the application of existing scientific knowledge and the generation of new information, which will help expand the field of psychology to serve the needs of the people. Thereby, through the generation and application of psychological science, clinical psychologists seek to improve mental functioning and well-being of individuals (Bagladi, 2009).

The most associated activity with clinical psychology, is Psychotherapy. Fernández-Álvarez and Opazo (2004) pointed out that psychotherapy is one of the most emblematic cultural products of our time. They explained that this is showed both through the amount of applications it has reached across the world and through the profound effects it can have in society. For the authors, psychotherapy has become consolidated as a vast range of procedures, which are administered with very heterogeneous formats and modalities, in almost every corner of the earth.

Psychotherapy in Chile

Opazo and Bagladi (2008), referring to the situation of psychotherapy in Chile, wrote: "*From an overview, psychotherapy in Chile looks healthy. Many therapists in action, many patients coming to therapy, a lot of people speaking freely about their therapies, etc. Even men are coming to therapy almost as much as women, what in the past was quite different"* (p.128). But the challenges to psychotherapy in our country are important. Private consultation is expensive and insurance companies do not help too much in these issues. Even so, private practice is widespread, and many psychiatrists and psychologists are involved fulltime in their private practice. Since private consultation is expensive, many come to public hospitals where they can find inexpensive, brief therapy and "brief sessions". Anyhow, the government and the municipalities are increasingly aware of social pathology; therefore, they invest more money contracting fulltime psychologists and developing social programs against alcoholism, substance abuse, etc.

In Chile, clinical psychologists have been forced to develop intervention strategies consistent with the contingent needs of the population. For instance, some abandoned individual therapy and carry out community interventions instead, in which the emphasis has been social pathology. Programs organized along these lines by various public and private entities have proved very interesting. An example of such programs is the Assistance Program for Abused Women and Children, carried out by the Outpatient Clinic of the School of Psychology at Catholic University, using international funding. This program did not only involve the provision of services to individuals, but also to different sectors of the community (e.g., hospitals, schools, neighborhood centers, and judicial and police sectors), illustrating how clinical psychology can and must coordinate its actions with different sectors of the population (Opazo and Bagladi, 2008).

Another example is provided by the Primary Care Program for Women Depression, implemented by the Ministry of Health (MINSAL) in 2001. *"By means of interdisciplinary work, this program seeks to generate in women requesting counseling, the activation of their personal resources as well as those of the community, so that they can overcome depression and prevent relapses"* (Bagladi, 2002, p. 428).

According to our Constitution, in Chile, psychotherapy must be undertaken by psychologists and psychiatrists. Psychotherapists have played an important role in government posts and the population has increasingly demanded their services. An important aspect of the history of clinical psychology in Chile has been the search for meeting points between psychologists and psychiatrists. Although this has not been one task free of obstacles to overcome, in our country we can find more frequently good examples of interdisciplinary work, at different levels of the work of professionals in the field of health.

For the present report I will only refer to psychologists that are psychotherapists because these professionals have broadly characterized the field of psychotherapy in Chile. Additionally, psychologists have developed psychotherapy training, group associations and professional certification, shared and socially validated.

A study carried in 2010, with 1,798 psychologists (15% of the total population) (26.4% men, 73.6% women, average age of 35 years, 98.4% graduates and 22.8% with graduate studies master/PhD), shows that the main area of expertise is clinical psychology (40.7%); followed by organizational psychology (19%), and educational psychology (10.2%). In terms of incomes, the study indicates that the field of research is the highest-paid, but only 1.5% of psychologists is dedicated to this activity (CONAP, 2013).

Through the last decades, there has been a wide proliferation of Universities offering the career of Psychology. According to the data provided by the Chilean Association of Psychologists, our country currently has more than 50 Schools of Psychology and there are 7,600 psychologists in Chile, approximately one psychologist per 2,200 inhabitants (Opazo and Bagladi, 2008).

Traditionally, psychologists graduated from the Psychology Department at the University of Chile, or the School of Psychology at Catholic University. During the 80s, many new Schools of Psychology appeared, some better than others.

Being aware of this situation – in terms of society and psychology as a profession - the Chilean Psychologists' Association and the Society for Clinical Psychology decided that something should be done to protect patients and society from therapists coming from the “wrong places”. Therefore, they decided to create a supra-ordinate organization: the National Accreditation Committee for Clinical Psychologists (1993). The Committee decided that Accreditation would be a “must”, let us say an obligation for every psychologist working in psychotherapy. This involves an extra effort of 2 years after regular education as a psychologist.

This forced psychologists to come back to study, with many hours of clinical practice, under supervision, at accredited Universities or Institutes. Some of these institutions are eclectic, some others are psychodynamic, humanistic, cognitive, systemic, integrative, etc. (Bagladi, 2002). To January 2014, the Committee has accredited approximately 1,918 psychotherapists coming from very different persuasions.

It is difficult to say how many psychologists follow each approach. Today, eclecticism, psychodynamic, cognitive-behavioral, systemic, and integrative should be the main approaches in Chile.

Eclecticism looks like a good option to many psychologists who want to feel free to seek for the best solutions, where no specific approach shows better than the others; therapists that work with addictions are often an example of this case. Cognitive Behavioral Therapy has become very popular within

government institutions dealing with mental disorders, especially with depression. Many hospital services have adapted different modalities of psychodynamic brief therapy and psychodynamic group therapy to deal with depression, personality disorders, etc. Systemic family therapy is often applied to childrens' disorders and/or at low income levels; of course many "high class" families come to systemic therapy too. Finally, in recent years we have an important development of the integrative approach in the field of theory and practice in psychotherapy (Bagladi, 2002; Opazo and Bagladi, 2008).
In Chile over the years, psychologists have created different organizations. Within these, the Chilean Society for Clinical Psychology is one of the most important. To date, it has about 1,450 members, coming from many different theoretical branches, spread across the country. This Society organizes conferences, seminars, lectures, and professional meetings, periodically. It has an ISI publication in matters concerning psychotherapy, and it actively works in conjunction with the College of Psychologists of Chile advising in matters related to the clinical practice. Another sign of an open-minded attitude is found through the different Universities that train in many different psychotherapeutic approaches.

Psychotherapist's training

Professionals engaged with psychotherapy should be part of a professional and scientific work
that requires specialized training. In the light of the results of research and clinical practice, and theoretical development, it can be considered that an adequate formation involves (Bagladi, 1997, 2002, 2003):

1. proper, solid and comprehensive theoretical training. Referred to both normal and abnormal psychological functioning; and conceptual training on one or more approaches in clinical psychology and epistemology.
2. Training in subjects concerning research to be able to assess scientific studies; and, most importantly, to be able to transfer research data to clinical practice.
3. Training clinical skills. This training correlates significantly with the decrease of drop outs in therapy and with the results of the therapy (only when the studies are highly controlled and of a greater methodological rigor).
4. Relational skills training. It has been argued that training programs should provide the opportunity to develop effective interpersonal skills. Personal skills are necessary to develop and maintain a therapeutic relationship that facilitates change.
5. Training in specific intervention skills. Training of psychotherapists should include both technical and interpersonal skills.
6. Supervision is a consistently indicated factor as a central variable training programs; it is a central link between the formal teaching, learning, and practice. It is assumed that supervision provides important experiential-professional growth and a potential source for increasing psychotherapy skills.
7. Importance of the self-knowledge and personal therapist's work. There is agreement on the need to promote the development and personal growth of the therapist, both through the achievement of specific skills and the development of insight. This training includes personal development, improvement of professional practice and the recognition of limitations and resources. Another point of consensus is the importance and significance of life experiences of the therapist, beyond psychotherapy.

Finally, psychotherapists training is a permanent process. As in any profession, to be a good professional implies an ongoing process; but here is a main issue. Exercising requires empirical/ theoretical update, frequent clinical practice, teamwork and/or supervision.

Being a psychotherapist demands a high amount of energy, both physical and emotional. Many years of research have emphasized the contributions of clinical practice and how it affects both personal and professional life of the psychotherapist (Guy, 1995). Many years ago, a research conducted by Mahoney (1997), which involved 325 mental health professionals, brought the following results: 43% suffered from irritability or felt emotionally exhausted, 44% suffered from non-restorative sleep, 42% doubted their effectiveness as therapists, 38% had to deal with problems in their intimate relationships, and 35% had suffered episodes of anxiety or depression. A similar study conducted in Chile with psychologists and psychiatrists attending a Congress of psychotherapy found that a 96% of psychotherapists estimated a high energy cost for being a psychotherapists (less than 4% of the respondents estimated a low cost). In addition, the same therapists reported negative consequences of the practicing psychotherapy: therapists with less than 5 years of experience reported frequent anxiety problems, perfectionism, psychosomatic disorders, and loneliness. Psychotherapists with over 5 years of experience reported anxiety, fatigue and perfectionism (Bagladi, 1997).
Working as a clinicians involves treating different problems and the most recurrent cases demand a high emotional connection with the patient. This entails that the therapist has to deal with emotional stress and different emotional challenges. So, an important tool the therapist must develop involves protecting towards different emotional damages (Diaz and Hevia, 2009; Aron and Llanos, 2004).

A study that included Chilean psychotherapists of different ages, different theoretical approaches, different years of experience, and different types of practice (private and public), provides us with interesting results about the consequences of psychotherapeutic practice (Menares, 2004). Chilean psychotherapists pointed out among the negative consequences those of affective nature ("*paralyzation of personal life, sentiment of confusion and anguish, emotional 'drain', contamination with negative emotions and alienation; boredom and lethargy; decrease in job satisfaction; feelings of vulnerability*"); of physical nature ("*exhaustion, somatic disorders*"); of

interpersonal nature ("*decrease in the ability of listening and containing, tendency to isolation, transferring psychotherapeutic judgments to the relationships with colleagues, idealization or depreciation of clinical work, 'psychologization' of relations and tendency to over-theorize, conflicts with other colleagues, strong requirements from significant others"*).

Psychotherapists also noted the following positive consequences of psychotherapy practice: "*vicarious learning of human experience, being responsible about life, self-self-consciousness, personal and spiritual growth, increased internal coherence, intellectual enjoyment, openness to learning, increased tolerance to pain, therapeutic skills development, and optimization of interpersonal relationships".*

An interesting contribution of the previous study is that psychotherapists identified a number of protective and risk factors for the negative consequences of the exercise of their profession. Within the risk elements regarding the therapists: "*deficiencies in training, insufficient life experience, some personality traits (hypersensitivity, narcissism, etc.), low awareness of personal boundaries and inadequate integration of the professional role. Additionally, ascribing to a pathology-centered approach increases narcissistic traits and poorness in the comprehensive work".*

In parallel, therapists identified risk factors associated to the therapeutic work: "*listening to complex content, receive intense emotions of human suffering, solitude, physical and psychological isolation and the risk of omnipotence"*.

They also noted appropriated as extra therapeutic risk factors: "*costs of training, economic pressures and overwork, the presence of vital crisis, and cumulative effect by long practice".*

On the other hand, some of the noted protective factors in psychotherapeutic practice were: "*high motivation towards the professional role, love for the profession, a healthy personality structure, history of stable life, clinical experience and maturity, having a supportive family, having a group of peers and friends, trust in psychotherapy, awareness of the necessity of training".*

As professional protective factors identified: "*personal psychotherapy, supervision, exchanging with colleagues, therapeutic skills, continuous improvement (e.g., courses, workshops, reading), proper training and belonging to a group of peers (professional institutions)"*.

And finally, satisfaction factors: "*seeing positive results, overcoming obstacles, along with getting recognition for their own work".*

Psychotherapist´s certification

As has been shown, the role of entities that meet and regulate the actions of psychotherapists is very relevant. For example, Zurita (2010) observed that psychotherapy involves an isolated practice, a private practice within a private office. Hence, many hours without any relationships away from the patients. Thereafter, it is very important that psychotherapists interact with other psychotherapists, sharing knowledge and experiences, discussing cases, etc.

The above relates to the role of professional associations. They have the mission to facilitate a contact of their members many. They recommend that accredited psychotherapists conduct psychotherapy to psychologist in training. They suggest the proper supervisors, organize, and promote accredited training courses, facilitate publications and research projects, organize or participate in congresses, seminars, conferences, symposia, and above all, contribute regulating our profession. These associations are also responsible for ethical and deontological standards, and they are linked other national and international organizations.

To become a psychotherapist, no school is able to meet all of these requirements. They provide only the basic training of an undergraduate. The graduate accreditation brings the specific requirements a psychotherapist needs; besides, there is a social recognition of these supplementary efforts.

Today, the existing high levels of competition, along with the globalization of the economy, requires highly effective professionals, able to focus on achieving results and not only on good intentions. The main thing, therefore, is to focus the attention on the central issues which will result in effectiveness and efficiency, i.e., identifying which variables really determine the necessary skills (Baeza, 2010).

To cope with the previous challenges, Chile has created the National Committee of Accreditation for Clinical Psychologists (CONAPC); an institution that has a pioneer role within Latin America. The first task of CONAPC was the accreditation of psychotherapy specialists. The need to create this Committee was arisen in 1993 taking into account four fundamental elements: 1. the advance and development of psychology; 2. the existence of specialties and subspecialties, including clinical psychology; 3.the diversity of theoretical approaches and technical procedures; 4. the growth of social demands for quality and effectiveness in psychological care. CONAPC was officially founded in June 22, 1994 sponsored by the Chilean Society for Clinical Psychology and the College of Psychologists of Chile (Bagladi, 1997; CPCH, Ag, 2000; CONAPC, 2001).

Professional accreditation seeks to improve the quality of human resources in different regions taking into account the idiosyncrasies. The system of professional accreditation will have several advantages for our population at the level of the impact on the vocational and labor market. It will encourage continuous learning, personal and professional progress; it will have policies and functional and expeditious channels for interdisciplinary work in health; it will promote regional recognition and maintain permanent and expeditious communications between national and international bodies.

The minimum training stipulated by this Commission to be an accredited psychotherapist, implies: undergraduate and graduate training (theoretical and practical), work with patients, monitoring psychotherapy, self-knowledge, and a final work susceptible of being published. Each requirement can be fulfilled in a minimum of hours. Thus, this Commission accredits and recognizes psychotherapy specialists, supervisors, training programs (institutional and tutorials), training courses. It also processes the renewal or withdrawal of accreditation. To date, CONAPC has certified about 2,000 psychotherapists and 350 supervisors, as well as it has recognized various programs and training courses.

Even though it was recognition among peers, the creation of this Committee allowed the incorporation of clinical psychologists within the National List of benefits coming from the National

Health Fund for Chile. This is a great achievement for the psychotherapist profession in our country.
Currently, this Committee is seeking to extend the benefits that clinical psychologists and psychotherapists can have, considering that we must respond to the current needs and requirements the national context requests; considering the work done in MECESUP and EUROPSY. Also, continuous training as a requirement is being implemented. Since 2013, lifetime accreditation was no longer accepted.
After 5 years, all accredited therapists must submit their background for the new certification. All of these also fit well with other international requirement, such as APA and EUROPSY.

International´s links

Since Latin America shows a high prevalence of mental health disorders in conjunction with psychosocial problems, there is a common need for improving psychotherapists training. This is why Chilean institutions have begun to work in conjunction with FLAPSI (Latin American Federation for Psychotherapy). Taking into account all these needs, the Chilean institution is opening to work together with psychologists and psychiatrists. This means that therapy will reach wider groups within society. The Latin American Federation for psychotherapy includes: Argentina, Bolivia, Brazil, Chile, Ecuador, Mexico, Panama, Peru, Uruguay, Venezuela, and Colombia.

While it is clearly needed, the implementation of an adequate qualification and accreditation system is an arduous and extremely complex task. Facing this challenge requires a properly qualified human capital for the development of these functions, responsible and seriously devoted and committed to this goal of excellence and professional ethics (Bagladi, 2011).

Discussion

At the end of this brief report of the profession of psychotherapist in Chile, I consider that the work of my colleagues over the years has been serious, challenging and hard. It has been thus for the characteristics of our country and our Latin American reality. But at present we can convincingly point out that Chilean psychotherapists have helped the quality of life of our people, are validated and respected socially, have improved their training and possess a profound ethical awareness of the importance and power of their professional work. Chilean psychotherapists have been able to generate a serious and effective system to certify and endorse its professional quality; and they are actively participating to achieve these same standards and professional exchange with Latin American psychotherapists roads to ensure a psychotherapeutic practice that continue to take pride for his contribution and quality.

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The psychotherapeutic profession in China

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As a country with one billion and 34 million population and under dramatic social change, China has been experiencing vast mental illness problems for decades. Currently, there is 16 million population diagnosed with severe mental illnesses, over 26 million population diagnosed with depression, 67 million troubled by symptoms of anxiety and depression, and 173 million population under psychologically unhealthy condition. WHO's recent statistics shows that neuron-psychiatric disorders counts for the top disease burden in China, exceeding cardiovascular disease, respiratory system diseases, and cancers.

The most recent publicized data from Peking Psychological Crisis Study and Intervention Center also indicates that there has been increasing occurrences of suicide and severe physical attacking crime due to psychological symptom. One-hundred eighty thousands population involving mental illnesses commit suicide every year and 2 million populations execute suicidal attempt. Many public statistics also confirmed the great needs for mental health service and the insufficiency of psychotherapeutic professions in current China.

China's psychotherapeutic professions emerged 20 years ago. The ideal Chinese therapeutic profession team should include psychiatrist, psychotherapist, psychological counselor, social worker, and nurse. Substantial progress as the practitioners have made, the specific profession are still under developing. Till now, the main characteristics of this team are: *insufficient total population*, *imperfect governance of the profession, lacking of recognized standard in managing the psychotherapeutic professions, and absence of professional association with authority.*

Insufficient professional psychiatrists

Currently, there are only 20 thousand of psychiatrists in China, a number that can hardly satisfy the social needs for therapeutic services. Experiences from developed countries suggest one clinical psychologist or psychotherapist for every 1000-1500 population; per this guideline, China will in need of 100 thousand new psychotherapists in the coming future.

The fact of the deficient psychotherapy training for psychiatrists can make the case even worse. According to the statistics, there are about 3000 people obtaining qualification of psychotherapist in the medical institutes across the whole country. Besides some psychiatrists, most of them are physicians of other subjects and nurses, only few are psychologists. Most of them have never received formal psychotherapy training and are incompetent to practice psychotherapy. Furthermore, many psychiatrists are preoccupied with patients, considering the unbalanced relationship between costs and investment in psychotherapy treatment; therefore, they are lacking of motivation to provide psychotherapy, which requires tremendous training, besides drug therapy.

As a result, the psychotherapy service is a scarce resource in Chinese medical institutes, and the mental health service in China remains maid of the dominating biological medicine model.

Imperfect governance of the profession

First, it is unclear of the professional status and position of psychotherapist. According to the regulation of the present Law of Mental Health, there are only psychiatrists and psychotherapists who are legally permitted to practice psychotherapy in the medical institutes. However, the Examination of Psychotherapist, which was originally set up by the National Bureau of Health since the year of 2002, does not clearly grant the permission to the exam-takers with psychological education background from non-medical schools. Many provinces only permit the ones who work in the hospital with medical education background to take the exam.

Second, the career path for psychotherapist is narrow, with no clear defined career ladder to reach senior professional level. This leads to the result that the professional with psychological education background could not work cooperatively with psychiatrist in the hospital or in the community medical institutes. Even if they work in such medical institutes, they may easily quit due to the lack of promotion.

Furthermore, the boundary between psychotherapy and psychological counseling service is vague. According to current Law, the psychotherapists are only allowed to practice within medical institutes. The dictating of medical institute and non-medical institute diverged psychological counseling from psychotherapy. As a result, though capable to provide psychotherapy service, many therapeutic professionals in China, such as counselors in university counseling centers, are not legitimate to do so.

Lacking of recognized standard in managing the psychotherapeutic professions

Current Law encourages the practice of psychotherapy service and considers it the important way to increase the mental health of the whole society. However, the standards vary across provinces. Multiple state departments issue similar professional certification with different standards and examinations. Some of them are obviously too loose. The Human Resource and Social Welfare Department has initiated the certified psychological counselor examination since 2003, which is the most influential state examination. Till now, there have been accumulated over 400 thousand certificates since 2003. However, comparing with their cohort abroad who are required to own master's level

degree and two or three years of professional training before taking the exam, the prerequisite for Chinese certified psychological counselor examination is overly low, which only requires associate degree of college with no limitation on major, and with no requirements on neither standardized internship nor practice process.

Absence of professional association with authority

The administration of the professional regulations of psychological services such as individual or organization registration and management requires the formal professional association. Presently, the Law has initial regulation on the qualification of the psychotherapists and the work place of practice in medical institute but no regulation or requirement for the registration of psychological counselors and organizations. There are various academic societies related to psychological counseling and psychotherapy playing important roles in mental health education and improvement for many years. The distinguished ones include: 1. China Association For Mental Health. It includes over ten committees such as Committee of Psychotherapy and Counseling, Committee of Psychoanalysis, Committee of Group Psychotherapy and Guidance, Committee of Mental Health of College Student, etc. . 2. Chinese Psychological Society. It includes the Committee of Clinical Psychology and Counseling and Registration System of Clinical Psychologist and Institution. The later one was set up in 2007 and has founded the strictest and most scientific registration standards and ethics regulation in China. The most qualified psychotherapists and good-quality counselors have gathered together in this society.

These two national-level academic associations, however, have not been entitled by the authorities to effect as organs for profession administration, and they have not worked coordinately and cooperatively. Besides, The Chinese Society of Medicine and the Association of Physicians of China have similar committees, but no effects on non-medical population. Thus, a united and efficient professional association with authority to guide, manage and coordinate the whole sector with diverse professions is still absent.

Outlook of the psychotherapeutic professions in China

The Law of Mental Health of People's Republic of China was firstly passed in October 2012 and began to be in effect since May 1st, 2013. Passing of the law has been widely considered a watershed moment in the history of mental health and psychotherapeutic professions. It clearly and specifically makes rules and regulation on the treatment and right protection of the patients of mental disorders. Though still imperfect, the law defines psychotherapy as a medical treatment and shows new trends in developing the psychotherapeutic professions in China, which including addressing the importance of mental health from a state strategy level, hiring more psychological education back-group professionals in medical institutes, investing in building up practitioners' capability as well degree education of clinical psychology and counseling, encouraging private psychological institution and partnership, and regulating the profession through cultivating professional associations outside government.

Those preferable changes have encouraged Chinese psychotherapeutic professionals to strive to bring this profession in line with the international standard of practice. The 21st IFP World Congress of Psychotherapy held in Shanghai China on May 9 -11, 2014 would become a historical event that marks the international debut of Chinese psychotherapeutic professions as well as the worldwide new attitude and dynamics the psychotherapeutic community can achieve through the international exchange and cooperation.

The psychotherapeutic profession in Denmark

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In recent years psychotherapeutic services has gained ground in the general population in Denmark (5.6 mill inhabitants) mainly because of expanded public subvention of psychologists. A variety of brief treatments are growing and the number of Cognitive Behavioural Therapy (CBT) therapist is increasing.
The title "psychotherapist" is still not protected nor is the profession of psychotherapy the subject of any official legislation.
Because the training, the therapeutic approach, and the economic terms vary with each profession I will describe the psychotherapist and the psychotherapies in Denmark by looking at each of the three largest professions practicing psychotherapy. These are 1) the psychologist, 2) the psychiatrist and, 3) member of the Association for Psychotherapists. I will primarily deal with adult psychotherapy. Unfortunately, for more than a decade, there has been a disastrous lack of supply of proper child psychotherapy and a lack of well-trained child therapists too.

The psychologists
During the last fifteen years there has been a considerable growth in the numbers of Danish psychologists (with an increment on 59 % only the latest 6 years). This development mirrors the increasing popularity of psychologists, who have a very positive image among the general population and whose professional skills are both respected and frequently requested. Currently, there are 9,751 active members of the Danish Psychological Association (DP). Psychologists are by far the greatest professional body practicing psychotherapy. A rough estimate would be that around 3,500 to 4,000 psychologists practice psychotherapy as a major work activity. In 2008, 799 were specialized in psychotherapy with adults – today the number may somewhere around 900 – and 1,688 is a member of The Danish Psychotherapeutic Society for Psychologists.
Their training: It takes a five-year university degree (3 years bachelor degree and 2 years master degree, both in psychology) to become a psychologist. The title is protected. The universities offer primarily academic training. The Danish doctoral study (PhD) focuses only on training in research methodology and other academic skills. No clinical training is included. After graduation a general 'authorization' as psychologist is attained after at least *two* years of postgraduate clinical work and 160 hours of clinical supervision. After 'authorization', the psychologist can specialize within eleven different fields – one of them is psychotherapy. Specialization takes at least *three* extra years of postgraduate training (360 hours of theory courses, 160 hours of clinical supervision, and 80 hours of personal therapy). With an additional *two* years of training (30 hours theory on supervision, and 40 hours of supervision on their own supervisory work), psychologists can qualify as supervisors on the specialist level.
Psychotherapeutic approaches: The psychodynamic/psychoanalytic[1] orientation is still the significant most influential approach amongst Danish psychologists practicing psychotherapy, while CBT is the second most influential therapeutic approach (Jacobsen et al., 2013). However, if one only looks at the newcomers to the psychotherapeutic professions for the last 30 years a historic shift has taken place; from a total dominance of the psychodynamic approach the CBT has gained ground and in 2010 there were a few more novice therapist having a CBT approach compared to novice psychodynamic therapists. Thus, in the future we may see a dominance of CBT amongst psychologist practicing psychotherapy (Jacobsen et al., 2012). The humanistic/existential and the systemic approaches are also represented, although they are significant less important. Many psychologists are trained in both psychodynamic therapy and CBT.
Work settings, treatment length, and economic conditions: Psychologists provide psychotherapeutic services in a many different public and private settings. These public services are sponsored either by the state, the regions, or the municipalities. In public services psychotherapy is especially being practiced by the around 1,100 psychologists working in mental health institutions and outpatients psychiatric clinics. During the last 10-15 years there has been a major increase of psychologist working in such psychiatric settings, where they provide most of the psychotherapy being provided. They have gained respect and greater influence. Recently, the treatment (including psychotherapy) provided to psychiatric patients is given as fixed "packages" based on ICD-10 diagnosis. That is, patients are given a certain assessment procedure, followed by a fixed number of psychotherapy sessions (typically 20-30 session and preferably the "best treatment" for a given diagnosis). Many see this as a major setback, as patients are seen as having uniform personalities with a certain set of symptoms to be addressed, and not as human being with an idiosyncratic background and present situation in need of a customised treatment.

A vast majority of the 1,762 psychologists plus some employees in full-time private practice provide psychotherapy, counselling, and psychotherapeutic oriented guidance. A major explanation to the late growth in psychotherapeutic treatment in Denmark is due to expanded public support and health insurances enabling clients with varied socioeconomic background to seek brief

[1] While psychoanalytically-oriented psychotherapy plays a major role, there are only 31 active psychoanalysts.

psychotherapeutic help for a broad range of problems. These subventions are primarily given to psychologists having an agreement with the responsible public authorities, insurance companies or the like. While many psychologists in private practice are still fully paid by their clients/patients, an increasing number (currently 815) now have a contract with the National Health Service which pays for 60% of the treatment to a maximum of 12 sessions[2]. Only a limited numbers of those contracts exist.
When regional subvention in 2008 were given to clients at the age 18-37 diagnosed a mild or moderate depression, many sought psychotherapeutic treatment for their suffering. A further increment came in 2012 when all citizens having a mild or moderate depression were given public support for their treatment disregard their age and treatment for anxiety disorder for the age of 18 to 38 years were added to the list of causes for the subvention. However, in order to reduce costs the Regions have set a maximum for these expenses resulting in waiting time for treatment. Furthermore, some are not able to pay the 40% co-payment, so we still have a social bias in the access to psychotherapy.

The psychiatrists

Among the physicians, psychiatrists most frequently offer psychotherapy. In contents, these services are comparable with the ones given by psychologists in psychiatric settings.
The psychiatrists are organized in The Danish Psychiatric Society (DPS). DPS has currently 1,140 members (including those who are undergoing training to specialize as a psychiatrist). However, only 200 psychiatrists are recognized as specialized in psychotherapy.
Psychotherapeutic approaches: 71.5% of the psychiatrists specialized in psychotherapy have a psychodynamic approach, while 30% are specialized in CBT and finally 1.5% in systemic therapy (nine members are specialized in two different approaches). However, during the latest six years the increase of specialist in psychodynamic therapy amongst psychiatrist has only been 14%, while the increase for specialist in CBT has been 216%. Thus, just as for the psychologists the future may bring a dominance of psychiatrists practicing CBT.
Work settings, treatment length, and economic conditions: Due to a shortage of psychiatrists in mental institutions and in outpatient psychiatric units, psychiatrists quite often have a huge caseload. For this and many other reasons psychiatrists quite often do not have proper time or conditions for practicing psychotherapy. While some psychiatrists working in private practice have a biological approach, others are skilful psychotherapists. Their treatment is fully public founded. Thus, due to the time limits for psychotherapeutic treatment in psychiatric settings and for clients referred to psychologists in private practice with public subventions, patients in need of long-term psychotherapy free of charge should consider consulting a psychiatrist in private practice. The only alternative is to pay for long-term treatment, which is unaffordable for many patients.

[2] This partly public payment requires that the clients are (1) referred by their general practitioner, (2) the reason of referral has to be one of the following: (a) exposed to robbery, violence or rape; (b) traffic accident or other accidents; (c) being a close relative to a person with severe psychological/psychiatric disorder/disease; (d) having a disabling disease or (e) being a close relative to one; (f) being a close relative to a deceased; (g) having tried to commit suicide; (h) women having an abortion after the twelfth week of pregnancy; (i) having been exposed to incest or other sexual abuse before 18 years of age (j) having a mild or moderate depression or (k) age 18-38 suffering of anxiety disorders. With the exceptions of (i), (j) and (k), referral must take place within six months of the incident that qualified for referral. Still the maximum amount of 12 sessions remains. Client referred with depression or anxiety disorder can have another 12 sessions adding up to a maximum of 24.

Their training: Students of medicine receive no instruction in psychotherapy, but some basic training in psychotherapy is included in the physicians' specialization in psychiatry. This includes 10 hours of theory on general psychotherapy (research, ethics, assessment, etc.), 25 hours of psycho-analytically-oriented theory, and 25 hours of theory on CBT. Furthermore, one must practice psychotherapy for at least 60 hours and receive the same amount of supervision. It is a new initiative that the training includes an equal extent of training in both psychodynamic therapy and CBT.
After the basic psychotherapeutic training and two years of clinical work in psychiatric settings, the psychiatrist can specialize in psychotherapy. This includes 80 hours of psychotherapeutic practice, 80 hours of supervision, and 60 hours of theory. If the theoretical orientation is psychody-namic, it also takes 60 hours of personal therapy (100 hours in group). If CBT is the theoretical orientation, one must instead receive 20 sessions of feedback on personal style. Finally, one can undergo supervision training (40 hours of theory courses and 40 hours of supervision of one own supervisory work). This qualifies for a teacher function in the specialization in psychotherapy.

Other psychotherapists

In this section, I will deal with those psychotherapists with other educational backgrounds than as a psychologist or physician by focusing on the Association for Psychotherapists (Psykoterapeutforeningen - PF), which imposes some reasonable demands for membership and organizes many members. Founded in 1993, the latest years have shown a huge growth in the total numbers from 279 members in 2003 to the current 1,536 members in 2014.
Their training: To attain membership, one must have (a) a relevant prior professional training (at least *three* years) with a psychological, pedagogical, social, or health orientation, plus (b) 250 hours of personal therapy, (c) 150 hours of supervision, and (d) 300 hours psychotherapy theory. The duration of psychotherapeutic training must be at least four years. Alternatively, one must have undertaken a psychotherapeutic training program certified by the Association for Psychotherapists.
A former survey (van Deurs, 2003) found the educational background of 29% was social work, while 22% had some other academic background, and 14% were pedagogues. Other members had backgrounds as nurses, teachers, educational therapists, etc. In 2014, only 2.5% are psychologists (personal communication with Erik Wasli, chairman of PF).
Psychotherapeutic approaches: Usually, the members have different theoretical orientations than psychologists and psychiatrists: a recent survey shows that 18.4% identify themselves as having gestalt approach, while 17.8% have a psychodynamic approach, 11.5% have an existential and humanistic approach, 10.8% have a family and couples approach while 10.8% do body work. Only 1.3% identifies themselves as CBT therapists (ibid.).

Work settings, treatment length, and economic conditions: About 40% of the Associations' members work in an independent, private psychotherapeutic practice, while 33% are part-time employees in public services and part-time working in private practice, and 19% are employees (ibid.).

Both the Danish Psychological Association and the Association for Psychotherapists are working on attaining a Government endorsement of psychotherapists – but these endeavours do not necessarily include each other, and this seems to be an unpronounced but potential issue of conflict. The fact that only 2.5% of the Association for Psychotherapists' members are psychologist, may signal such profession conflict.

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The psychotherapeutic profession in Switzerland

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Current situation of psychotherapeutic professions

1. Identity of the psychotherapeutic professions

In Switzerland, psychotherapy was legally recognized as a profession of its own until 2013, although there was no legislation on the federal level regulating psychotherapy as an independent profession. Most of the cantons had legislations for non-medical psychotherapists, albeit with much variation across cantons. In 2013, a new national law was put into effect, regulating non-medical psychotherapy as a psychological profession. There are now two different groups of psychotherapists: Psychiatrists specialized in "psychiatry and psychotherapy" and psychologist specialized as "psychotherapists".

Psychiatrists: According to a long tradition of over 50 years, Swiss specialists in psychiatry are 'psychiatrists and psychotherapists' by definition. The profession is legally regulated in a federal law for the medical professions. After six years of medical school, doctors go through another six years of specialty training as residents, including two years of inpatient psychiatry, two years of outpatient psychiatry, and one year in any clinical field of medicine other than psychiatry (e.g. neurology, internal medicine, surgery). During their residency years, future psychiatrists undergo formal psychotherapy training with a minimal duration of three years. They have to make a choice between the psychodynamic, cognitive-behavioral, or systemic approaches. All numeric requirements requested for certification as a 'psychiatrist and psychotherapist' are to be fulfilled within one of the three approaches mentioned above, which makes cross-fertilization difficult. Nevertheless, many psychiatrists, once licensed, seek and receive training in other psychotherapeutic approaches in addition to the approach they were originally trained in. Thus, a majority of specialists in 'psychiatry and psychotherapy' would declare their therapeutic approach as eclectic. About half of psychiatrists work in institutions (psychiatric hospitals, outpatient clinics) and half in private practice. Psychiatrists in private practice typically see themselves as psychotherapists primarily, although of course they are allowed to prescribe medication, and to refer patients to a psychiatric hospital on a compulsory basis. As compared to other medical specialists, psychiatrists are at the lower end of the income spectrum; however, they do earn more than non-medical psychotherapists. Most psychiatrists are members of the Swiss Association of Psychiatrists and Psychotherapists. In addition, there is also a Swiss Medical Association for Psychotherapy.

Psychological psychotherapists: According to the new law of psychological professions, psychotherapists need to have a master's degree in psychology including clinical psychology and psychopathology. After finishing their university degree they have to undergo formal postgraduate psychotherapy training of at least three years, including personal therapy, theory, and supervision. In addition, they are required to do clinical work in an institutional setting for one year, e.g., in a psychiatric hospital or a psychiatric outpatient clinic. Due to earlier regulations there are many experienced non-medical psychotherapists who are not clinical psychologists, but have a degree in other social sciences. They have gone through an intensive postgraduate training in psychotherapy of usually five years including clinical practice. The new law for psychological professions also sets minimal standards for psychotherapy training. Training programs need to be accredited by the federal department of health. On an interim basis, more than 60 programs are temporarily accredited. They will all undergo a final accreditation within five years.

Psychological psychotherapists in private practice are until now only partly reimbursed by the public health care system. Some work as employees under the supervision of psychiatrists which allows them to perform "delegated" psychotherapy with easy access to reimbursement by the public health insurance but at the cost of being dependent on a psychiatrist, while others prefer to stay independent and to charge their patients, some of whom have private insurance and can thus benefit from partial reimbursement. The question of including psychological psychotherapy in the public health insurance is (since the new law is in effect) in political discussion again. Non-medical and psychological psychotherapists are typically members of the Swiss Association of Psychotherapists (Assoziation Schweizer Psychotherapeutinnen und Psychotherapeuten ASP) or of the Federation of Swiss Psychologists (Föderation der Schweizer Psychologinnen und Psychologen FSP).

The image in the Swiss general public of psychotherapy in general, and psychotherapists in particular, is probably still quite ambivalent in spite of recent changes towards a better recognition. There is a trend to favoring psychologists over psychiatrists, mainly because psychiatrists are allowed to prescribe medication and to make involuntary referrals, and are therefore seen by some as the "bad guys." On the other

hand, it is increasingly recognized publicly that psychiatrists are generally clinically more experienced, particularly when it comes to severe mental illness. And, last but not least, 90% of the costs of psychotherapy performed by psychiatrists is reimbursed by the public health insurance, while non-medical psychotherapists are only partly reimbursed.

2. Relations among the psychotherapeutic professions

There are in fact tensions between psychiatrists and psychological psychotherapists in Switzerland. Psychiatrists, by virtue of their medical training, have the greater social status and income. They are exclusively allowed to prescribe drugs and to compulsorily hospitalize a patient. Mental health inpatient and outpatient facilities are headed by medical directors, meaning by psychiatrists, not psychologists. In other words: psychiatrists have more power. On the other hand, psychologists are usually more competent regarding research methodology, which provides them with some power as well, particularly in academic institutions. Also, since their fees are smaller, insurance companies increasingly tend to favor non-medical psychotherapists over psychiatrists, arguing that non-medical psychotherapists can provide the same service for less money. Despite this, there usually is good interdisciplinary cooperation between the two groups of psychotherapists. The cooperation is given by law, when a patient of a non-medical psychotherapists also needs pharmacotherapy.

3. Relation of the professions to the health care and/or social service systems

Switzerland has a health care system with mandatory basic insurance for everybody. This is provided by competing private insurance companies who have to accept everybody without reservation. Public health insurance covers 100% of inpatient health care and 90% of outpatient health care (10% cost sharing by the patient). On top of this, people can have private insurance which basically provides more convenience during hospital stay (e.g., access to single rooms) but makes no difference in medical treatment. Private insurance has no impact on outpatient service provision.

There is no clear distinction between medical and mental health benefits; however, more recently, we have seen a tendency among politicians to restrict mental health benefits, particularly psychotherapy. Patients are charged by their therapists, and are expected to pay their bills personally; they then submit the bill to their insurance company who will reimburse 90% of the total sum.

II. Future prospects of the psychotherapeutic professions

4. Factors instigating change in the psychotherapeutic professions

As mentioned above, non-medical psychotherapists currently have no direct access to reimbursement by public health insurance. However, understandably, they are fighting strongly, and with good arguments, for being granted such access. On the other hand, authorities are reluctant because they are afraid of an increase in health costs. Although, according to Swiss legislation, any medical treatment including psychotherapy must demonstrate its efficacy, usefulness, and cost effectiveness in order to be reimbursed, no clear-cut scientific criteria are currently applied across-the-board; neither are there any best practice evidence-based treatment guidelines that psychotherapists would have to adhere to.

There is a gap between the researchers trying to disseminate empirically supported therapies, on the one hand, and the clinicians in private practice and in clinical institutions trying to preserve their individual freedom, on the other hand. Researchers are frequently seen by clinicians as sitting in their ivory tower, far away from the clinical reality of a psychotherapist's practice, while clinicians are often seen by researchers as being hostile towards research and resistant to empirical research findings. Nonetheless, dissemination of novel, empirically supported treatment approaches does take place increasingly; but clinicians, although well trained, are generally very reluctant to actually conduct manualized treatments in purely clinical (meaning non-research) settings. It can be expected that faced with increasing restrictions regarding the reimbursement of long-term psychotherapies, clinicians will be more willing in the future to adopt and apply evidence-based, time-limited, manualized treatments. In order to make a constructive contribution and generate data that can inform the authorities on the realities of psychotherapists in private practice, the Swiss Charter for Psychotherapy has initiated a psychotherapy process and outcome study, using a naturalistic research design, in collaboration with psychotherapists in private practice, universities and colleges of higher education.
(see: www.psychotherapieforschung.ch).

5. Basic skills to be required for training and practice in the psychotherapeutic professions

Switzerland is far from requiring certain basic "skill-sets" of professionals who provide psychotherapy. Not unlike in other countries, there is still quite some rivalry going on among representatives of different "schools." Unfortunately, the rich diversity of treatment approaches allowed by our system is currently not sufficiently utilized for the development of a set of basic essentials. In most places, with only a few exceptions, psychotherapy training is offered by private institutions that are strictly bound to their respective therapeutic orientation: psychoanalytic, cognitive-behavioral, systemic, humanistic, etc. This is in line with current legal regulations for non-medical psychotherapists and for the specialty title in 'psychiatry and psychotherapy' which force residents to choose between the psychodynamic, cognitive-behavioral, or systemic approaches.

Some experts think that this situation can only be overcome if psychotherapy training is taken over by independent agencies, such as universities, who have an interest in disseminating evidence-based treatments rather than defending the status of any given approach. They state that we could start discussing about a certain minimal set of skills that each and every psychotherapist should be familiar with, e.g., principles of transference and counter-transference, exposure treatment in anxiety disorders, cognitive techniques, working with couples and families, etc. Other important players in the field, however, do not share this view, pointing to the danger of psychotherapy training becoming too much dependent on a few professors who

would pursue their personal preferences, rather than strengthen the scientific foundations of psychotherapy; they state that such a step would ultimately result in a constriction of the diversity we are currently enjoying, and which appears to be appropriate for an ever more diversified society.

6. Relation of psychotherapy research to the psychotherapeutic professions

If we understand psychotherapy as a culturally sensitive and scientifically based discipline (which must not necessarily preclude us from seeing psychotherapy as an art as well), advancement of psychotherapeutic practice should go hand in hand with innovations in psychotherapy research. Clinicians should learn from researchers about the efficacy and effectiveness (or lack thereof) as well as about adverse side effects of specific psychotherapeutic approaches or techniques. Conversely, researchers should listen to clinicians in order to generate clinically relevant and meaningful research questions and hypotheses. Evidence-based medicine (or psychotherapy) is by definition oriented towards the past, in that the currently available evidence only informs us about what has already been achieved and established. To avoid suffocation, evidence-based psychotherapy must be complemented by innovation which usually emerges from creative practitioners' ideas rather than from theorists.

Unfortunately, not much of a creative researcher-clinician dialogue is taking place in Switzerland. Mutual learning seems to be a difficult thing to do. Clearly, more research will have to be done, both on therapy and on therapists. Maybe even more importantly, more emphasis has to be placed on helping researchers and clinicians to listen to one another, to foster a dialogue which, in our opinion, carries tremendous potential for guiding the psychotherapeutic professions in constructive directions. Each step we take in bridging the gaps between schools, cultures, professional identities, and particularly in bridging the gaps between researchers and clinicians, will be a step towards the establishment of psychotherapy as an advanced, scientifically well-grounded and culturally sensitive treatment approach.

An encouraging step in that direction is the naturalistic study the Swiss Charter for Psychotherapy has initiated in collaboration with psychotherapists in private practice, universities, and colleges of higher education: the research group in charge made an effort in going through a laborious process of mutual exchange and a multitude of feedback loops, and thus succeeded in bridging gaps and surmounting barriers that traditionally exist between researchers and clinicians. This goes in line with new regulations that commit membership institutions of the Swiss Charter for Psychotherapy to incorporate teaching the principles of psychotherapy research in their psychotherapy training curricula.

An example of psychotherapy application in research and clinical activities. The EDNET – Eating Disorder Diagnostic and Treatment Network

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We want to give a brief overview of the 5 randomized-controlled multi-center psychotherapy studies that were conducted within the German Eating Disorder Diagnostic and Treatment Network (EDNET). These multi-center trials include: 1) an outpatient treatment trial for Anorexia Nervosa (AN) (ANTOP study) comparing two new forms of treatment (focal psychodynamic psychotherapy – FPT and enhanced cognitive-behavioral therapy - CBT-E) with an optimized treatment as usual (including outpatient psychotherapy); 2) a trial comparing a day-patient treatment after short inpatient care versus continued inpatient treatment in adolescents with anorexia nervosa (ANDI study); two internet-based relapse prevention trials for patients with 3) AN (VIA study) and with 4) Bulimia Nervosa (BN) (IN@ study) after discharge from inpatient treatment; and 5) a Randomized Clinical Trial (RCT) comparing internet-based guided self-help for overweight and obese patients with full or subsyndromal binge eating disorder in comparison to a face-to face CBT intervention (INTERBED study, de Zwaan et al., 2012). Some basic study characteristics are summarized in the Table 1. For those studies which have already published their main results, we will briefly summarize the results and give some additional information. Associated studies are grouped around these core proposals covering aspects of neuropsychology, structural as well as functional neuroimaging, genetics, endocrinology, and moderators and mediators of treatment outcome.

Although lifetime prevalence for anorexia nervosa is only between 0,6%-1% (Hudson et al., 2007) and thus represents the eating disorder with the lowest rate, due to the severe course and bad outcome (Zipfel et al., 2000), international experts in this field like Prof. Bulik (2014) state in her commentary to our ANTOP study for the Lancet under the title "*The challenges of treating anorexia nervosa*", that *"despite the positive aspects gleaned from the ANTOP study (Zipfel et al., 2014), we still need to serve patients with anorexia nervosa and their families better. We need to discover how to provide better, faster, and lasting results in the management of this disorder. Psychotherapeutic interventions are only partly effective"*. Ten years after an expert panel at the National Institute of Health (Agras et al., 2004) proclaiming that research and treatment of AN should be prioritized, there is still a long way to go. And the same conclusion comes from a Cochrane Review by Hay et al. (2003), who strongly advise to take an effort in well planned and designed psychotherapeutic studies for the treatment of AN. In total, five multi-center psychotherapeutic RCTs have been conducted within the EDNET consortium (see Table 1). In the following chapter a summary is given of the major outcomes of the three RCTs that have already been completed and published.

Table 1: Details of randomized controlled psychotherapy studies in EDNET consortium

Study	Principal Investigator, Co-PI	Setting, Duration of Therapy	Follow-up	Diagnosis	Randomized Patients	Primary Outcome	Participating Centers	Treatment Centers
1. ANTOP	Zipfel, Herzog	outpatient (40 sessions, 10 months)	3 and 12 months, 5 years.	AN > 18 years	242	weight gain (BMI)	10	10
2. ANDI	Herpertz-Dahlmann	inpatient vs. inpatient/daypatient treatment (1 year)	18 months	AN 11-18 years	172	weight gain (BMI)	6	6
3. VIA	Fichter	relapse prevention www-based (9 months)	9 months	AN > 16 years	258	relapse (BMI)	10	1
4. IN@	Jacobi	relapse prevention www-based (9 months)	9 months	BN > 18 years	258	number of symptom-free patients	12	1
5. NTERBED	de Zwaan, Hilbert	outpatient, 4 months internet based guided self-help vs CBT (face-to-face)	6 and 18 months	BED and subsyndromal BED >18 years	178	reduction in number of binge episodes	7	7

1. Focal psychodynamic therapy, cognitive behavior therapy, and optimized treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomized controlled trial.
(PI: Prof. Stephan Zipfel, University of Tuebingen, Co-PI: Prof. Wolfgang Herzog, University of Heidelberg).
Background: Psychotherapy is the treatment of choice for patients with anorexia nervosa, although evidence of efficacy is weak. The Anorexia Nervosa Treatment of OutPatients (ANTOP) study aimed to assess the efficacy and safety of two manual-based outpatient treatments for anorexia nervosa—focal psychodynamic therapy and enhanced cognitive behavior therapy versus optimized treatment as usual.
Methods: The ANTOP study is a multicentre, randomized controlled efficacy trial in adults with anorexia nervosa. We recruited patients from ten university hospitals in Germany. Participants were randomly allocated to 10 months of treatment with either focal psychodynamic therapy, enhanced cognitive behavior therapy, or optimized treatment as usual (including outpatient psychotherapy and structured care from a family doctor). The primary outcome was weight gain, measured as increased body-mass index (BMI) at the end of treatment. A key secondary outcome was rate of recovery (based on a combination of weight gain and eating disorder-specific psychopathology). Analysis was by intention to treat.
Findings: Of 727 adults screened for inclusion, 242 underwent randomization. At the end of treatment, 54 patients (22%) were lost to follow-up, and at 12-month follow-up a total of 73 (30%) had dropped out. At the end of treatment, BMI had increased in all study groups (FPT 0·73 kg/m², CBT-E 0·93 kg/m², TAU-O 0·69 kg/m²); no differences were noted between groups at 12-month follow-up, the mean gain in BMI had risen further (1.64 kg/m², 1.30 kg/m², and 1.22 kg/m², respectively), but again no differences between groups were recorded.
Interpretation: Optimized treatment as usual, combining psychotherapy and structured care from a family doctor, should be regarded as solid baseline treatment for adult outpatients with anorexia nervosa. Focal psychodynamic therapy proved advantageous in terms of recovery at 12-month follow-up, and enhanced cognitive behavior therapy was more effective with respect to speed of weight gain and improvements in eating disorder psychopathology. Long-term outcome data will be helpful to further adapt and improve these novel manual-based treatment approaches

2. Day-patient treatment after short inpatient care versus continued inpatient treatment in adolescents with anorexia nervosa (ANDI): a multicentre, randomised, open-label, non-inferiority trial (Herpertz-Dahlmann et al. 2014)
(PI: Prof. Beate Herpertz-Dahlmann, University Aachen)
Background: In-patient treatment (IP) is the treatment setting of choice for moderately-to-severely ill adolescents with anorexia nervosa, but it is costly, and the risks of relapse and readmissions are high. Day patient Treatment (DP) is less expensive and might avoid problems of relapse and readmission by easing the transition from hospital to home. We investigated the safety and efficacy of DP after short inpatient care compared with continued IP.
Methods: For this multicentre, randomized, open-label, non-inferiority trial, we enrolled female patients (aged 11–18 years) with anorexia nervosa from six centers in Germany. Patients were eligible if they had a body-mass index (BMI) below the tenth percentile and it was their first admission to hospital for anorexia nervosa. Patients were assigned to continued IP or DP after 3 weeks of inpatient care. The treatment program and treatment intensity in both study groups were identical. The primary outcome was the increase in BMI between the time of admission and a 12-month follow-up adjusted for age and duration of illness. Analysis was done by modified intention to treat.
Findings: Between Feb 2, 2007, to April 27, 2010, we screened 660 patients for eligibility, 172 of whom we randomly allocated to treatment. DP was non-inferior to IP with respect to the primary outcome, BMI at the 12-month follow-up.
Interpretation: DP after short inpatient care in adolescent patients with non-chronic anorexia nervosa seems no less effective than IP for weight restoration and maintenance during the first year after admission. Thus, DP might be a safe and less costly alternative to IP. Our results justify the broad implementation of this approach.

Relapse after inpatient therapy is a common finding in 30-50% of patients. Based on this unsatisfactory finding, two relapse prevention studies applying web-based solutions were conducted to investigate the efficacy of this new approach. The one study including patients with anorexia nervosa has already been published.

3. Does internet-based prevention reduce the risk of relapse for anorexia nervosa? („VIA"; Fichter et al. 2012) (PI: Prof. Manfred Fichter, Prien/Chiemsee, München)
Background: Technological advancements allow new approaches to psychotherapy via electronic media. The eating disorder literature currently contains no studies on internet intervention in anorexia nervosa.
Methods: This study presents a RCT on an internet-based relapse prevention program (RP) over nine months after inpatient treatment for AN. The sample comprised 258 women, randomized to the RP or treatment as usual (TAU). Expert- and self-ratings were evaluated by intent-to-treat analyses. Concerning age, age at onset, and comorbidity, both groups were comparable at randomization.
Findings: During the RP, the intervention group gained weight while the TAU group had minimal weight loss. RP completers gained significantly more body weight than patients in the TAU condition.
Interpretation: Important factors for successful relapse prevention were adherence to the intervention protocol and increased spontaneity. Considering the unfavorable course and chronicity of anorexia nervosa (AN) internet-based relapse prevention in AN following inpatient treatment appears a promising approach. Future internet-based programs may be further improved and enhanced.

Conclusion

The EDNET consortium has demonstrated that randomized controlled multi-center psychotherapeutic trials in eating disorder patients can be successfully conducted with respect to strict (GCP-conform) methodological standards. Although the German Ministry of Research significantly supported the EDNET consortium in the past, there are alarming signs, that despite the clear success of this funding scheme, there will not be a substantial funding for psychotherapy research in the near future.

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