

HOW DOES PSYCHOANALYSIS AND PSYCHOANALYTIC PSYCHOTHERAPY FARE IN EUROPE TODAY?

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Abstract: There are two fundamentally different models in European countries to provide universal health care. Psychoanalysis and psychodynamic psychotherapy seems to fare better with one system rather than with the other. In countries like the emerging Eastern European democracies and the Balkans, there appears to be very little in terms of public funding for psychological therapies. In these countries, psychoanalysis and psychoanalytic psychotherapy are re-emerging on a small scale in private practice.

The availability of Psychoanalysis and psychoanalytic psychotherapy as a treatment model within the public sector varies significantly amongst European countries.

There are a number of modalities with some variants when it comes to universal health care provisions in Europe and in my view these modalities can ultimately be surmised as two clearly distinct categories through which universal health care across Western Europe is provided or acquired by the population at large.

One of those systems (System A) is financed through general taxation and often controlled by the central government, sometimes like in Sweden in conjunction with local government and often as a combination of the two. It is therefore more susceptible to financial pressure, economic downturns and highly vulnerable to budgetary squeezes of the ever-expanding health care costs.

This leads to determined attempts by some governments to streamline and manage services, impose strict links between diagnosis, treatment method and results and with it the risk that medical care is no longer regarded as " a social good but rather as a commercial commodity. "

In this system psychoanalysis and psychodynamic psychotherapy are increasingly deemed too expensive and consequently marginalized.

The United Kingdom as one example has for a long time enjoyed psychoanalytic psychotherapy in primary and secondary health care provision. This is swiftly disappearing and often practically no longer the case in the public sector.

There remains a strong private sector that is self-regulated and offers psychoanalysis and psychoanalytic psychotherapy as well as training within its institutions as well as clinical services for the public but within private practice. So far these institutions have regulated themselves, however currently the government is intend on regulating the profession.

I would like to quote some of Prof. Glenys Parry's findings. (She is from the University of Sheffield, Center for psychological services research)

The NICE guidelines that appeared about 10 years ago (National institute for Health and clinical excellence) included a review of "psychological treatments in its systematic review of research evidence and clinical guidelines recommendations." This has led to " a realization that cognitive behavior therapy in particular is underprovided."

By 2006 a major new government initiative was launched to provide "improving access to psychological therapies" (IAPT) aimed to "provide appropriate stepped care across primary and secondary services, provided by a new workforce trained in either "low intensity CBT- based guided self-help or high intensity CBT."

While the government claims this initiative and the 171mil. Pound sterling committed to it were not intended to reduce the availability of other treatment modalities there is some evidence there has been disinvestment from NON CBT services. Some people in the UK describe these services as a treatment model of a revolving door. Patients come in for 12 intensive sessions of cognitive behavior

therapy leave through the door and come back in through back door again. Current NHS policy allows psychological therapies to be commissioned from private or not for profit sector, which includes a number of BCP member institutions and this mixed economy is set to potentially grow.

Psychodynamic psychotherapy models, including psychoanalysis, are in these times often viewed with political intentionality as anachronistic treatment methods that are not only too expensive but not very effective and hence increasingly deserve to be marginalized. Necessity, as they say, is the mother of invention, and necessity apparently requires treatment models that can be streamlined and delivered at low cost. In various domains this affects the relationship between doctor and patient and as far as psychoanalysis is concerned, the central focus of its treatment model is the personal relationship with the patient! As a health minister in Sweden said: 'psychoanalysis might be a good treatment method but it's simply too expensive!'

As far as treatment methods are concerned strict links are increasingly being imposed between diagnosis, treatment and predictable outcome. Public agencies and professional organisations demand increasingly evidence based practice, empirically supported techniques and standardized treatment manuals. The problem is that these sort of standardizations create a culture that make it increasingly difficult for psychoanalysis and all it stands for to compete in the public sector.

A number of other countries in Europe . Germany, Austria, the Czech Republic, Switzerland & Hungary however, use an alternative system of universal health care provision (system B) in which there is a much stronger link between individual payment and the consumption of health care. In this system the power to purchase services tilts in various ways in favour of the patients.

One such structure is health insurance as seen in Germany for example, mandated to the individual by the government, and acquired through regulated but self-managed insurance companies. Its operations are often financed by statutory contributions from the insured and contributions from the employers. Other and similar structures combine a number of components including one related to earned income, contributions from employers, local government and state contributions. The amount of GDP spend on health care in systems A and System B of health remains approximately the same. This system of health care provision is not to be mistaken for private health care or what we know in this country as private health insurance. The universality of health care provision for example rests anchored in government regulation to assist low- income groups and protects patients with pre-existing illness.

According to some analysts system B has 3 key benefits:

- 1) No artificial cap on health care spending
- 2) Individuals are motivated to be cost conscious
- 3) Providers are constantly motivated to improve their services for fear of losing custom

I believe this latter system for the provision of health care is more effective in maintaining a more diverse treatment spectrum and is successful when it comes to recognizing psychotherapy as a viable treatment model by leaving the choice of treatment- modality to the public. Furthermore, these two distinct models of financing health care across the European continent are not only intimately linked with the presence or indeed increasingly absence of a psychodynamic and psychoanalytic treatment model of psychotherapy but I believe that they have

much wider implications for our profession as a whole, especially with a view to the future.

With the marginalization of the psychoanalytic treatment method in national health provisions, psychoanalytic thinking gets marginalized in a society as a whole. This has a bearing on the national narrative not only in terms of mental health and mental illness but also on how we perceive ourselves as people with unconscious and conscious minds and what it is that informs us in our on-going experience.

With psychoanalytic thinking marginalized, the interest of potential and suitable new candidates to come forward for training in psychodynamic psychotherapies and psychoanalysis and invest in a future in the profession erodes quickly. With little prospect or guarantee to make a living in the profession many of the most talented candidates stay away or go elsewhere. I understand that for example in Denmark it is very difficult to find candidates for training in psychoanalysis and psychoanalytic psychotherapy, and this is a concern that haunts psychoanalytic societies in a number of European countries including the UK

Some argue that psychoanalysis will have to retreat to the private sector and be better for it because it can regulate itself in line with the required setting, the treatment objectives, confidentiality and so forth. In the long run however, I fear the professional standing eroded in the public sector will erode its standing in the private sector as well.

It is relevant that in countries where health insurance has a stronger 'purchaser' component, Psychotherapy is regulated by statutory law and the various treatment modalities are clearly defined. This allows psychoanalysis as a recognized modality to compete on a level playing field with other treatment methods in the public sector.

A psychoanalytic treatment model as you all know depends on the reality of the unconscious process and the subjective response to this process on the part of the analyst. These aspects are of course non-negotiable, but I think that the importance of professional autonomy is not incompatible with the fact that the profession should and could be regulated by statute if that insures a level playing field for our model of working with patients.

Christer Sjodin, a Swedish psychoanalyst, makes a convincing case in a recent paper (Oct2010 IFP) as to why psychoanalysis is increasingly becoming an 'impossible profession within the public welfare -system' in Sweden. It's health care system mirrors in great parts the one in the UK, and currently experiences the same radical cuts and shake up of the system and it's radical 'ideological' underpinnings in which health care is seen increasingly as a commercial commodity rather than a fundamental social good. Sjodin argues that the demand by public agencies and professional organizations for evidence based practice, empirically supported techniques and standardized treatment manuals, ultimately affects the doctor - patient relationship and infringes on professional autonomy. With the overlapping of health care professionals and management tiers it ultimately affects and erodes confidentiality between doctor and patient.

The problem is not that health care is provided through general taxation free at the point of delivery. The problem is that the integrity, autonomy and independence of the profession is threatened because the government in power decide not only what it can afford, but what the most affordable treatment method for the patient should be and this then becomes the only available

treatment model. I believe there is an element of pragmatism in these policies but politics and ideology are also involved.

The individual patient is left with little choice in the public sector and can potentially make his/her choices in the private sector if she/he has the means to do so or is indeed aware of the existence of alternative treatment models to those offered in the NHS.

The amount of GDP spend for health care across western Europe remains approximately the same, independent of the system of delivery (on a spectrum from approximately 7%-12% in including Southern and Eastern European economies) but there is evidence as suggested by the data in Germany that the system which has a stronger link between the individual stakeholder and health care provision is the system that provides psychoanalytic treatments as a method of choice far more effectively and in the process maintains the profession in robust health.

I have already argued that this clearly has a long-term effect on the capacity of the profession to regenerate itself, to attract candidates for the profession and to remain an attractive treatment method for the population at large.

It comes therefore to my mind as no surprise that in countries where this system prevails namely Germany, Austria, Switzerland and to a certain degree France (here the insurance companies are state controlled and have never gained self-management responsibility) but also in emerging Eastern European countries like Hungary and the Czech republic Psychoanalytic psychotherapy plays a more central part in the public sector.

It might be historically relevant to the development of this particular health care system procurement that central European countries have wrestled with universal health care for far longer than the UK and their system of health care provision has organically grown over time. It might also be relevant that psychoanalysis is deeper entrenched historically in the public conscious and hence in the political process of central European nations.

It is interesting however that Finland and Norway with national- health service provisions of System A offer a range of treatment options including psychoanalysis to the population and they seem to remain committed to a diversity of treatment modalities with the patient choice intact. I am not sure exactly why this. A factor might be that these two countries have small populations and remain relatively affluent but there is also evidence that there research is very rigorous and they apply clinically what works best for the patient in the long term.

The review of the data coming out of Germany makes for interesting reading. It is also an important indicator for the application of psychoanalysis and psychodynamic psychotherapy in the public health sector. To a large extent it is applicable to other countries that subscribe to health system B alas with some variables.

German data

In 2011, 86 health experts for psychodynamic psychotherapy and analytical psychotherapy of the various statutory insurance companies in Germany considered 164.857 reports (requests for this type of therapy). About 4% of those applications were rejected while amendments were requested of about 11,2%. In total 15.2% of applications were not accepted unopposed. Added to this are the treatments paid for by private insurance which amount to approximately 20% of the total amount accepted by statutory insurance companies. Furthermore approximately 10% of treatments are pre-financed by the patient and later reimbursed by the insurance companies. In these cases no report or other quality assessment is applied.

This amounts to about 215.000 treatments not including the 4% of rejected proposals.

By comparison and when it comes to behavior- modification therapy the figures are similar. In 2011 73 assessors compiled 151465 reports. Rejection of applications amounted to 3% and 9,2% of the applications were not accepted without further amendments or corrections. The ratio of the private patients is here lower while the number of later re-imburements is probably higher in CBT. Therefore there are about 400,000 psychotherapeutic treatments per year in Germany alone.

Eastern Europe

The picture looks a bit different when we consider Eastern European and the Balkan countries. They have emerged from more or less totalitarian rule over the past 20 years. But some of these countries are quickly reconnecting with traditional modalities od indeed introducing new ones. The psychoanalytic tradition is gradually re-emerging.

In Poland and Hungary the profession is regulated or about to be regulated by law; in the Czech Republic the profession is not regulated. The Check republic and Hungary subscribes however to an insurance system (system B) which cover about 95% of the population. Psychotherapy is paid for after approval of the insurance company's specialist medical assessment teams. There is a sense that also in these countries exists a level playing field for different treatment modalities which include psychoanalytic psychotherapy.

From what I understand the situation in Slovakia as well as in the countries of former Yugoslavia to be, psychoanalytic psychotherapy is predominantly practiced in small numbers in private practice.

In Slovakia for example, practicing psychoanalytic psychotherapists and psychoanalysts increased over the last four years from 3 to 12.

These small societies in countries of Eastern Europe are often dependent on supervision and financial aid from abroad in order to develop their institutions, training facilities and a presence in the public mind. The European Federation of Psychoanalytic Psychotherapy (EFPP) of which the BPC is a member is helping to revive these institutions in Eastern Europe with clinical and financial help.

It is perhaps worth acknowledging that most countries in Eastern Europe spend about 4%-7% of GDP for national health care hence considerably less then the Western European countries which has an impact on the total expenditure of mental health.

Southern Europe

Countries in Southern Europe have greater difficulties having psychotherapy recognized by the public health system. Greece, Portugal and Cyprus do have very limited specific psychotherapeutic health care provision unless it is inpatient care or treatment prescribed by a psychiatrist, that is to say pharmacotherapy treatment The profession in these countries is neither regulated or recognized nor is the title "psychotherapist" protected. However the title psychologist is protected. Since in these countries psychotherapy does not seem to be high on the list of mental health care provision mostly pharmacotherapy is prescribed by psychiatrists to patients suffering from depression.

It is interesting to observe that Portugal for example scores on a European average in terms of prevalence of depression but it's consumption of anti-depressive medication per capita is highest on the continent. So is the suicide rate in certain parts of the country. Mental healthcare in the 10 year national mental health care plan, supports mainly a medical model and perspective.

What strikes me about the Southern European situation in particular and this is perhaps most evident in Portugal, Greece & Cyprus, is that in the absence of a

psychotherapeutic tradition and more to the point even, in the absence of a core profession or regulated title of "psychotherapist," psychotherapy remains but an addendum to the medical profession rather than a profession in its own right.

Italy in this regard is the exception and the norm. While having a rich tradition in psychoanalysis and dynamic psychotherapy and a profession that is regulated by statutory law psychotherapy remains attached to psychiatry and psychology but is not recognized as a profession in its own right.

Evidence , statistics

The official European average for depression is given at 10-12%. (there might be a much higher unofficial figure) Women suffer from the condition twice as much as men. The mental health provision in Europe specifically for this condition are as follows:

Italy, Ireland, Austria, Portugal & Greece have no specific provision or strategy for the condition

Denmark & UK subscribe to a stepped care in the management of depression; CBT

Switzerland, the Czech Rep, Latvia
Multidisciplinary approach, psychodynamic, group, alliance against depression

Germany, France, the Netherlands, Hungary Poland & Finland subscribe to a mixed psychotherapy/pharmacotherapy approach

PSYCHOTHERAPEUTIC PROFESSION

1) Where the profession is regulated by statutory law

Germany, France, the Netherlands, Finland, Switzerland, Hungary, Austria, Italy; Latvia some countries like France title protected but not profession)

Some of these countries accept only medical doctors or psychologists to practice in the profession

2) No statutory law or law currently in the pipelines

Portugal; no statutory regulation
Ireland; no statutory registration Czech Republic; Poland (law in pipeline)
UK; law in pipeline.
Denmark; title of psychotherapist not protected

Some of these countries train psychotherapist in psychotherapy organizations If they are members of the EFPP they adhere to the minimum training standards of the European federation and adhere to its code of ethics.

Conclusion

Psychoanalysis and psychodynamic psychotherapy is alive in most European countries. In some countries however the discipline still forms very much part of a treatment option available in the public health system. This however is so because analysis remains a treatment of choice on a level playing field, financed by the mandatory insurance policy each citizen is obliged to hold. It can operate

in the private and public consulting room in line with its required setting and confidentiality while remaining in the public domain. It is the insurance company that either pays directly for the treatment or reimburses the patient for treatment received or procured.

In other countries however psychoanalysis is increasingly banished to the private sector and is losing relevance in the public health sector and is in fact in danger of losing relevance in the public domain.

This has potentially repercussions in terms of the attractiveness of the profession for suitable candidates for psychoanalytic institutions and may condemn these organizations potentially to a very marginal existence unless we act.

With this in mind, it remains imperative, to find ways and means to keep the profession as a viable treatment model and a relevant set of ideas alive if not in the public health system so at least in the public domain.