Psicoterapeuta: Uma profissao
Psychotherapy as a profession

Horst Kächele

Lecture at Fundacao Instituto Mario Martins - Instituto Goethe,
Porto Alegre / Brazil 16.09.1994

The hundred years of the American Psychological Association´s existence are also celebrated by the publication of a Festschrift: "History of Psychotherapy - A Century of Change" (Freedheim 1992).
In the same year the German Medical Chamber at the annual full assembly decide on the introduction of a new specialty called "Psychotherapeutic Medicine" (Wirsching 1992). When Robert Holt in 1971 asked for a "New Horizon for Psychotherapy" claiming "Autonomy as a Profession" he then only could hope that this development would have made such progress.
With refering to these two events I would like to point to a tension within the field that may direct our discussion.
In Germany psychotherapy has been and still in the majority is a medical field - beginning with Breuer and Freud´s work in the nineties of the last century - even when Prof. Bumke a leading psychiatrist in the thirties called psychoanalysis a matter for the police and even when German psychiatry until today has a somewhat reluctant attitude toward this very special form of theory and practice. However psychiatry is not the only medical field in which issues of psychotherapy are unavodidable; in German medical academia the impact of internal mediciene and neurology has contributed largely to shaping that particular field within medicine which led to a very particular instituional history. When in 1952 Alexander Mitscherlich with the support of the Rockefeller Foundation was able to open the first university clinica for psychotherapy he had to call clinic for psychosomatic medicine as Karl Jaspers the mighty chair for psychiatry objected the use of the term psychotherapy as a specialty name. In other countries especially in the USA professional psychotherapy developed largely out of clinical psychology programs (Shakow & Rapaport 1964; Shakow 1969) and has been the offspring of academic psychology branching off from the dominance of psychiatry in the early fifties. This has been quite poignantly described by Rollo May:

"We few psychologists were continually under the threat of being declared outlaws in our conflict with the narrow wing of the American Medical association" (May 1992, xxiii). The danger practicing psychotherapy by psychologists for them was to be arrested for practicing medicine.
Rogers (1951) was one of the first to point out that quality of training would become a major problem with regard to the fact that more than one third of all psychologists shoewed a special interest in doing psychotherapy.

Today worldwide psychotherapy has become a profession somewhere within medicine, not only as part of psychiatry, but as field of psychosomatic medicine appied to a large variety to patients that are non-psychiatric patients and practied in amny counseling institutions where only the name is different but the psychotherapies remains the same. To illustrate the extension of the field i shall give you some figures:

Germany 1990 (insurance licensed)

3 8 9 5 medical psychotherapists & psychoanalysts
1 2 3 7 psychological psychoanalysts
7 4 0 analytical child-therapists
1015 candidates adult & child analysis
498 medical behavior therapists
1 3 6 0 psychological behavior therapists

These therapists serve a population of about sixty million. I am quite certain that the state of California has less than sixty million inhabitants, but the numbers of psychotherapeutically active people is shocking:

California / USA 1990

10 000 psychologists
6 500 psychiatrists

11 000 clinical social workers
19 000 marriage, family and child therapists

The two figures are not directly comparable as other instutional are involved. What it makes clear that the practioners of psychotherapy are a wide variety of people with diffferent training and academic backgrounds as the Collaborative Research Network (CRN) of the Society for Psychotherapy Research empircially has already amply made clear[1]

What makes a special activity within medicine and within psychology to fuse and become a profession ?
In my opinion we have to look at a diversity of factors that have a different impact in different countries due to the different weight attributed to psychological phenomena in different cultures.
To be honest psychotherapy is not a young profession as it has existed under different names for thousands of years. All societies we know of have devised psychological interventions to handle states of minds that clearly were not amenable to somatic interventions - these have been lumped togeher as various forms of schamanism as Jerome Frank in his still classic monograph on persuasion and healing has pointed out. Lady Macbeth in her psychotic sleepwalking trying to rub off the imagined blod of her hands was in need of a psychotherapist, but there was none; the psychotherapeutic means availalable at her times did not work for that kind of obsessional symptom formation due to string guilt feelings.
However with the natural science revolution of medicine towards the end of the last century which most successfully has replaced romantic medicine the field of psychological interventions as well became more delineated. For Europeans therefore Freud´s discoveries still mark the beginning of a scientific development of psychotherapy because the same spirit that moved somatic medicine was operating in Breuer and Freud´s mind when they together wrote the "Studies on Hysteria" in 1895. However historians of psychotherapy have pointed out that the basic orientation that mind heals the body has been prevailing notion in America´s nineteenth century. "Mesmerism also, and especially its heirs, also foreshadowed many 20th century forms of psychotherapy and its contemporary restrictive groups such as religious cults, mass marathon trainings, and New Age experiential programs" (

[1]The international CRN-study group has been initiated by Prof. Orlinsky from the University of Chicago to study the developments of psychotherapists (Orlinsky et al. 1991).

Cushmann 1992, p.31). The German development with its strands from psychoanalysis and anthropological medicine has been called a counter-reformatist movement (Meyer 1990) trying to overcome the reductionist natural science stance in medicine by re-introducing the subject into medicine (von Uexküll & Wesiack 1988).

Today psychotherapy has developed a core identity where certain requirements are made on the claim to recognize an intervention professional psychotherapy. If we take a definition of psychotherapy wide enough to encompass the many different forms of psychotherapy this definition may run as follows:
Psychotherapy is a deliberate and planned interactional process to influence behavioral disturbances and states of suffering, that in agreement among patient, therapist and society are looked at as in need for treatment with psychological means mostly verbal, also non-verbal, in direction of a defined, shared goal (like symptom reduction or personality change) for which teachable techniques are available based on a theory of normal and pathological behavior (Strotzka 1975,p.4).
I would add that the theory should encompass if possible the epidemiology, etiology, the mechanisms of symptom formation and the mechanisms of cure. A sciencific corpus of psychotherapy is not enough to make this a profession as knowledge about diseases does not per se contribute to its application. We also have to cover the institutional aspects of how a society handle this knowledge by implementing a psychotherapeutic care system.

The epidemiology of those disorders that usually are treated by psychotherapists is an underdeveloped field. Most studies have been performed within the psychiatric context (Häfner & Veiel 1986). Luckily in Germany we have one of the few large scale epidemiological projects that tell us something about the prevalence of those disturbances that are amenable to psychotherapy.
I´ll give you some of the findings from two excellent German epidemiological surveys conducted by Dilling et al. (1984) and Schepank (1987).

Prevalence of psychosomatic-psychoneurotic disturbances in Germany - West

	big town	small town
psychosom. neurosis	11.60	
personality disorders	7.16	
	7.16	
sum	25.9	11.3

Dilling 1984 (small town: n = 1.536)
Schepank 1987 (big town: n = 600)

Schepank´s study randomly selected sample of 600 of individuals from a larger German city (Mannheim). A the team of trained psychotherapists identified 25.9 % as suffering from a neurotic, psychosomatic or personality disorder. The estimation of the research team was that only 11% would be willing to undergo psychotherapeutic treatment (Franz et al. 1990). Factually only one tenth of the identified cases ever enters treatment under our present system of health insurance supported psychotherapy in a city where outpatient and inpatient psychotherapy are readily available.

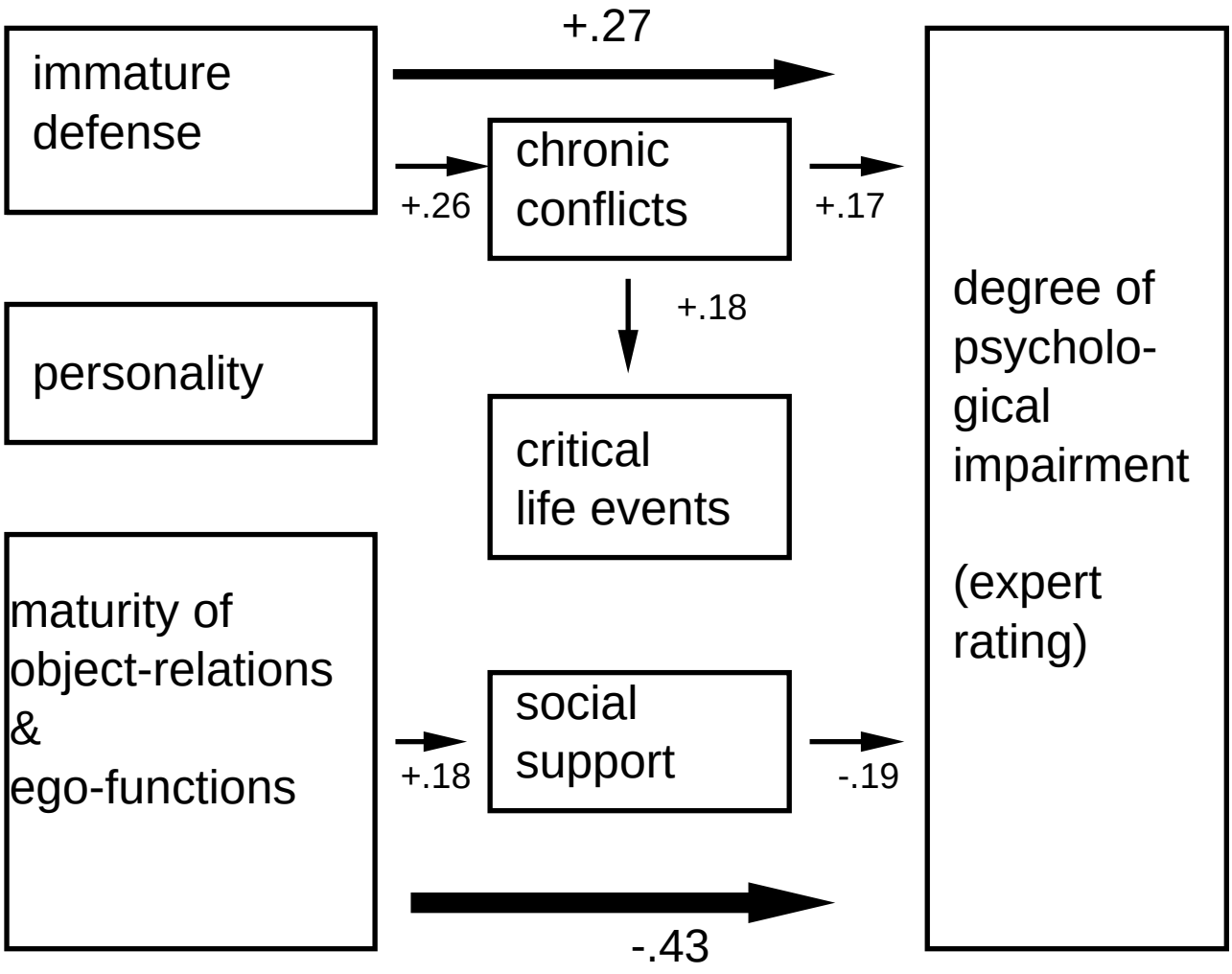
How far are we with our understanding of etiology of psychogenic disorders. The Freudian model of a complementary series of nature and nuture too often in clinical practice has been simplified to only using developmental factors in our ad hoc explanatory models that have most often been based on very small samples if not on just one case. So there are very few studies that suffice the rigorous demands of providing fact based etiological models of explanation.

For example hereditary factors are quite seldom seriously mentioned in our clincial discussions though there is quite substantial evidence that for depressive, obsessional, schizoid types of neurotic disorders these factors have a certain role (Muhs & Schepank 1991). Also for anorexia nervosa - the paradigmatic disturbances of our times in terms of amount of research carried out and in terms of epidemic increase

of eating disorders in general - substantial herditary factors have been identified (Schepank 1992). Very likely we as clinicians are not interested in these factors as they do not tell us how much options for change there is. Another important aspectsof psychotherapy resides in the basic conviction that the development of personality, especially in its dynamic understanding contributes to later psychogenic impairments.

To illustrate the kind of data that we should have at hands for that kind of questions - to make a modest demand to begin with, as prospective studies in this field are as rare as the white elephants - I report the path-analysis from the Mannheim cohort project (Franz.

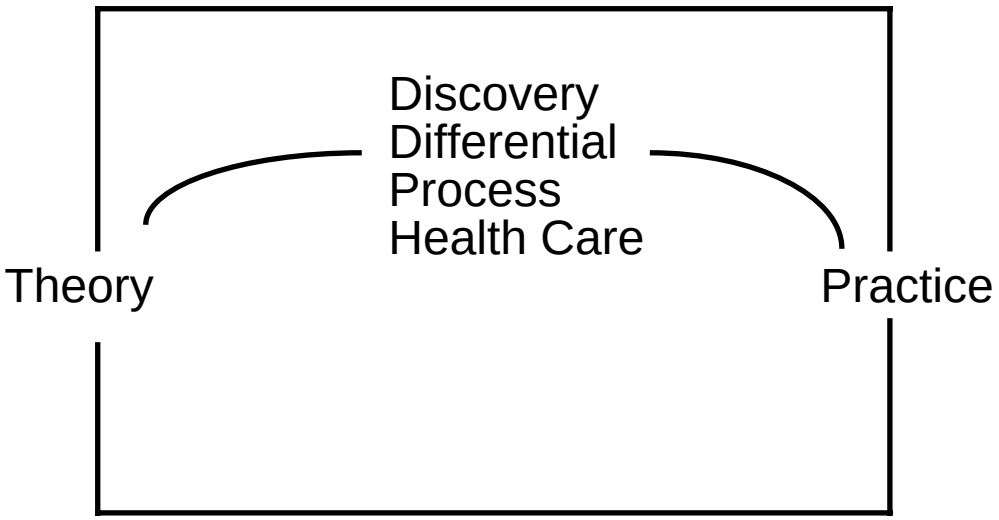
It demonstrates nicely that psychodynamic variables of personality organization - immature defense in the sense of Vaillant (1986) and the maturity of object-relations and ego-functions (Bellak et al. 1973) exert the major influence on the amount of psychological impairment in patients with psychogenic disturbances.



Path-analysis of psychological impairment based on 240 subjects from the Mannheim cohort (Franz, Schellberg, Schepank, 1993)

I shall not discuss our present state of knowledge of symptom-formation (Luborsky 1970) and move on to our knowledge of if and how does psychotherapy help. This brings us to the field of psychotherapy research.

Psychotherapy research at any given time has multiple functions and tasks to perform; it aims at the scientific evaluation of existing practice and at the discovery of new fields of application



The early phases of psychotherapy research in the fifties and sixties were marked by scientific justification and societal legitimation. These questions changed with extension of possible indications, with growing differentiation of treatment procedures and with the progressive implementation of psychotherapy within the health system. The early approach "does psychotherapy work at all" has been replaced by the questions "to whom is what kind of psychotherapy helpful" and "how does what kind of psychotherapy work". To summarize this very important development for the professionalism of psychotherapy I shall quote David Orlinsky´s most recent, concise representation of this development presented to the International Congress of Psychotherapy in Seoul/Korea august 1994 :

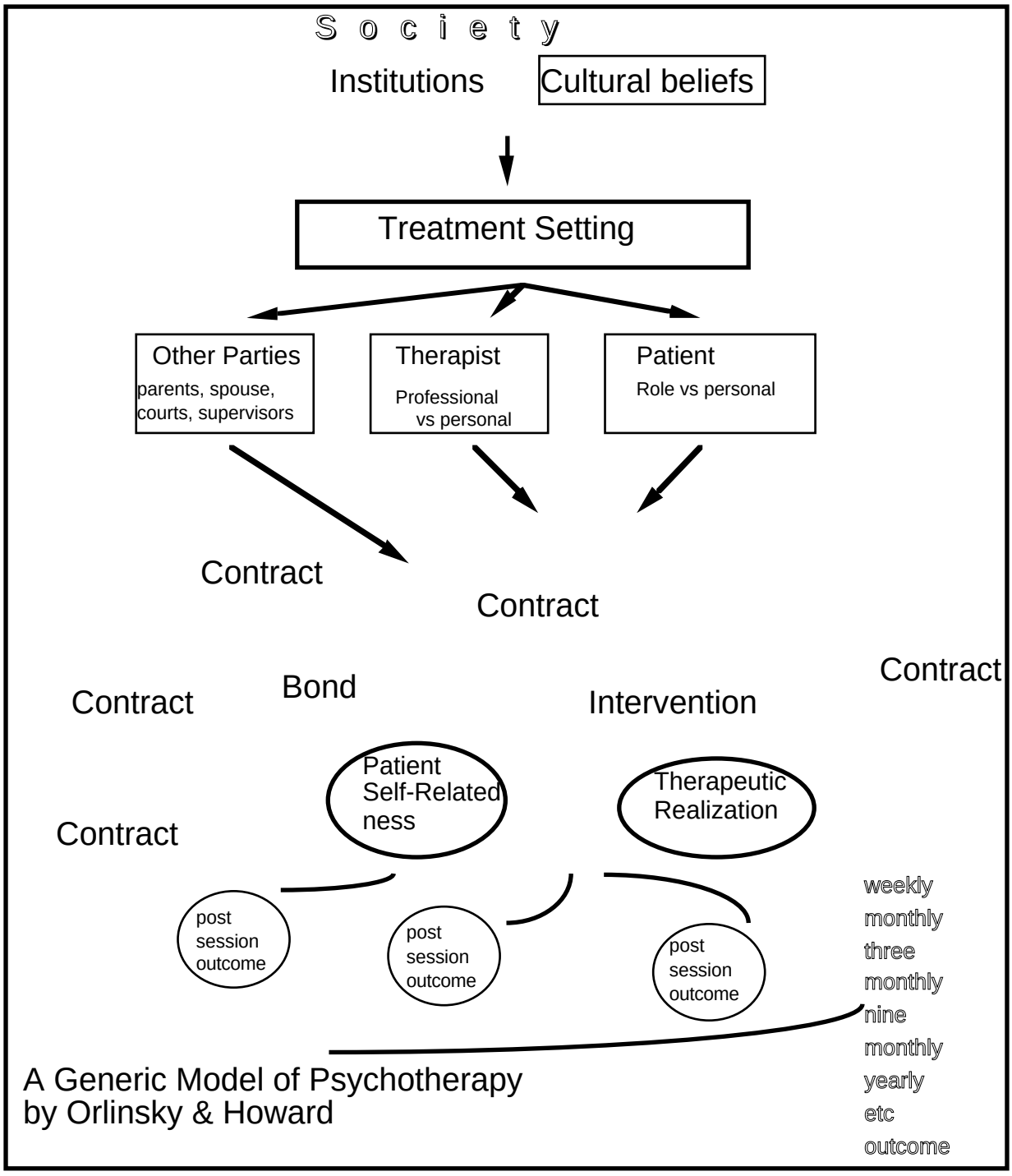
Four periods in the Development of Psychotherapy Research	
Phase I (c. 1927 - 1954)	Establishing a Role for Scientific Research
Phase II (c. 1955 - 1969)	Searching for Scientific Rigor
Phase III (c. 1970 - 1983)	Expansion, Differentiation, and Organization
Phase IV (c.1984 - present)	Consolidation, Dissatisfaction, & Reformulation

Established Facts of Psychotherapy Research to date

1. Outcome Research:
Controlled studies demonstrate the effectiveness of psychotherapeutic treatments.
2. Comparative Outcome Research:
Different treatment methods produce broadly comparable effects.
3. Process- Outcome Research:
Patients´manner of behavior in sessions (e.g. active engagement, nondefensiveness) strongly influences outcome
4. Process-Outcome Research:
Quality of therapeutic relationship experienced by patients (e.g. mutual understanding, respect, liking) strongly influences outcome.

The main argument from research findings for our actual discussion why psychotherapy should be a profession by its own comes from the research supported development of a generic model of psychotherapy (Orlinsky & Howard 1986).

figure: . generic model


Society
Institutions
Cultural beliefs
Treatment Setting
Other Parties
parents, spouse, courts, supervisors
Therapist
Professional vs personal
Patient
Role vs personal
Contract
Contract
Contract
Bond
Intervention
Contract
Contract
Patient Self-Related ness
Therapeutic Realization
post session outcome
post session outcome
post session outcome
weekly
monthly
three monthly
nine monthly
yearly
etc
outcome
A Generic Model of Psychotherapy
by Orlinsky & Howard

This model is not an eclectic model, but it summarizes the ingredients of effective psychotherapy that are part and parcel of any form of psychotherapy that has been scientifically scrutinized. In its details with its own conceptual language it remains truely general and atheoretical. So the basic term of bond is open for theoretical embedding like a psychoanalyst´s perspective of calling this mild positive transference. While it may be true that this model does not yet contain all relevant elements, it does contains those that have been demonstrated repeatedly by empirical studies.

For the psychotherapeutic profession it has become apparent that these operational model can be realized from different vantage points. Systematic outcome research has not yet demonstrated superiority of one or the other treatment approach; however we have learned that outcome results are directed at different audiences - e.g. at psychotherapists who conduct the treatment in question as well as to health professionals from related, often competitive disciplines. Research findings are addressed at those who benefit directly (e.g. patients or their relatives) as well as at those who fund the costs (e.g. insurance companies) or are responsible for adequate health policies (e.g. politicians, unions). The diverse groups may have totally different expectations (Strupp & Hadley 1977). Therefore outcome research has to provide a variety of information to satisfy the needs of the different interest groups.

This perspective leads me to the next step in this argument. Psychotherapy has become a profession because out from clinical field experience and now heavily supported by the findings of research there is no rationale to tie psychotherapeutic activity to a medical pre-qualification, or to a psychological pre-qualification or to a social case worker. This is a puzzling findings, but in my opinion it is the true reason - already embedded in Freud´s discussion of the "Question of lay-analysis" (1926). Psychotherapy as educational procedure remains a value bound, culture dependent intervention so that we are in a position to identify the goals inherent in each of the hundreds forms of psychotherapy. What we will find that there are only a few major goals: emotional insight into the reasons and motives into the dynamics of conflict, change of maladaptive behavior and dysfunctional thought patterns. So all the diversity will melt away to unveil just three basic dimensions of psychotherapeutic activity. These three basic dimensions lead in practice to an

enhancement of eclecticism as pointed out by Bergin & Garfield in the summarizing chapter of the 4th edition of the Handbook of Psychotherapy and Behavior Change (1994, p.821). A professional psychotherapist is not so much an adherent of a school - be it psychoanalytic, or behavior therapy - but a professional problem solver. His main professional attitude has to be directed by flexibility to find out what kind of intervention may be most productive for a patient at any moment. Surveys suggest that some form of eclecticismis preferred by most professionals in North America (Jensen et al. 1990) and in Germany as well as shown by a recent survey (Buchheim et al. 1992).
This will have an impact on training: "In the field of psychotherapy, the effective application of existing knowledge is impaired by exceptionally complex professional problems. On the other hand, the psychological profession is unique in having, among the ranks of occupational, organisational and social psychologists, the necessary expertise for tackling the professional problems by a disinterested research approach“ (Benjamin 1983, p.282).

For psychoanalytic oriented therapists these findings underscore the need to also develop a capacity for flexible application of the psychoanalytic treatment principles (Thomä & Kächele 1991). Surprising enough these are not at variance with the most succinct statement I could find about how psychotherapy works:
"All therapies engage in cognitive reconstruction in the context of core relationships. This is what happens in the therapeutic relationship and in generalizations from therapy to the rest of life, and therapies vary somewhat in how efficiently they effect this process" (Bergin & Garfield, 1994, p.823)

Bibliography

Bellak L, Hurvich M, Gediman H (1973). Ego Functions in Schizophrenics, Neurotics, and Normals. Wiley. New York

Benjamin R (1983) Professional problems of psychotherapy: a survey of problems areas and requirements of a disinterested research approach. In: Minsel W, Herff W (Eds) Methodology in Psychotherapy Research. (vol 1) Peter Lang, Frankfurt a.M., S 273-285

Bergin AE, Garfield SL (1994). Handbook of Psychotherapy and Behavior Change. Wiley. New York, 4th ed.

Bergin A, Garfield S (1994) Overview, trends, and future issues. In: Bergin A, Garfield S (Eds) Handbook of Psychotherapy and Behavior Change, 4th ed. Wiley, New York, p. 821-830

Buchheim P, Cierpka M, Gitzinger I, Kächele H, Orlinsky D (1992) Entwicklung, Weiterbildung und praktische Tätigkeit von Psychotherapeuten. In: Buchheim P, Cierpka M, Seifert Th (Hrsg) Lindauer Texte. Teil 3: Weiterbildungsforschung. Texte zur psychotherapeutischen Fort- und Weiterbildung - . Springer, Berlin Heidelberg New York, S 251-286

Cushmann P (1992) Psychotherapy to 1992: A historically situated interpretation. In: Freedheim DK (Hrsg) History of Psychotherapy - A Century of Change. American Psychological Association, Washington, DC, p. 21-64

Dilling.H, Weyerer S, Enders I (1984).Psychische Erkrankungen in der Bevölkerung. Stuttgart, Enke

Franz M, Schellberg D, Schepank H. (1993). Epidemiologische Befunde zur Ätiologie psychogener Erkrankungen. Zsch psychosom Med. 39:375-386

Franz M, Schiessl N, Manz R, Fellhauer R, Schepank H, Tress W. (1990). Zur Problematik der Psychotherapiemotivation und der Psychotherapieakzeptanz. PPmP Psychother Med Psychol. 40:369-374

Freedheim D (Hrsg) (1992) History of Psychotherapy - A Century of Change. American Psychological Association, Washington, D.C.

Freud S (1926e) Die Frage der Laienanalyse. GW Bd 14 S 207-296

Häfner H, Veiel H (1986) Epidemiologische Untersuchungen zu Angst und Depression. In: Helmchen H, Linden M (Hrsg) Die Differenzierung von Angst und Depression. Springer, Berlin Heidelberg New York, S 65-74

Holt R (1971). New Horizon for Psychotherapy: Autonomy as a Profession. Int Univ Press. New York

Holt R, Luborsky L (1958a) Personality Patterns of Psychiatrists: A Study in Selection Technique. Basic Books, New York

Holt R, Luborsky L (1958b) Personality Patterns of Psychiatrists: A Study in Selection Techniques. (2, Bd 2) Menninger Foundation, Topeka

Jensen J, Bergin A, Greaves D. (1990). The meaning of eclecticism: New survey and analysis of components. Professional Psychology: Research and Practice. 21:124-130

Lewin BD & Ross H (1960) Psychoanalytic Education in the United States. Norton, New York
Luborsky L. (1970). New directions in research on neurotic and psychosomatic symptoms. American Scientist. 58:661-668
Meyer A (1990) Die psychosomatische Gegenreformation: Sind die Hoffnungen erfüllt? In: Ahrens S (Hrsg) Entwicklung und Perspektiven der Psychosomatik. Springer, Berlin, S 7-18
Muhs A, Schepank H. (1991). Aspekte des Verlaufs und der geschlechtsspezifischen Prävalenz psychogener Erkrankungen bei Kindern und Erwachsenen unter dem Einfluss von Erb- und Umweltfaktoren. Zsch psychosom. Med. 37:194-206
Orlinsky D (1994) History of Psychotherapy/Counseling Research in North America. presented to the "Preconference on Psychotherapy Research to the International Conference on Psychotherapy", Seoul / Korea,
Orlinsky D, Gerin P, Davis J, Ambühl H, Dazord A, Davis M, Willutzki U, Davidson Ch, Aapre N, Backx W, Botermans J-F, Jahns, J-F (1991) SPR Collaborative Research Network „International Study on the Development of Psychotherapists" Background and Research Plan. Paper presented at the 22nd annual conference of the Society for Psychotherapy Research, Lyon, France,
Orlinsky D, Howard KI (1986) Process and outcome in psychotherapy. In: Garfield S, Bergin AE (eds) Handbook of Psychotherapy and Behavior Change, 3rd edn. Wiley, New York, S 311-381
Orlinsky DE, Grawe K, Parks R (1994) Process and outcome in psychotherapy - Noch einmal. In: Bergin AE, Garfield SL (eds) Handbook of Psychotherapy and Behavior Change. Wiley, New York, S
Rogers CR (1951) Client-centered therapy. Houghten Mifflin, Boston
Schepank H (1987). Psychogene Erkrankungen der Stadtbevölkerung. Eine epidemiologisch-tiefenpsychologische Feldstudie in Mannheim. Springer. Berlin Heidelberg New York
Schepank H (1992) Genetic Determinants in Anorexia Nervosa: Results of Studies in Twins. In: Herzog W, Deter HC, Vandereycken W (Hrsg) The Course of Eating Disorders. Springer, Berlin, Heidelberg, New York, S 241-56
Shakow D (1969) Clinical Psychology as Science and Profession: A Forty Year Odyssey. Aldine, Chicago
Shakow D, Rapaport D (1964) The influence of Freud on American psychology. (Psychological issues, Bd 4) Int Univ Press, New York
Strotzka H (Hrsg) (1975) Psychotherapie. Grundlagen, Verfahren, Indikationen. Urban & Schwarzenberg, München
Uexküll T, Wesiack W (1988). Theorie der Humanmedizin. Grundlagen ärztlichen Denkens und Handelns. Urban & Schwarzenberg. München-Wien-Baltimore
Thomä H, Kächele H (1991) Psychoanalytic Practice. Vol 2: Clinical Studies. Springer, Berlin, Heidelberg, New York, Paris, London, Tokyo
Vaillant G, Bond M, Vaillant C. (1986). An empirically validated hierarchy of defense mechanisms. Arch Gen Psychiat. 43:786-794

Wirsching M (1992) Konzept zur Einführung einer neuen Ge-bietsbezeichnung für Psychosomatische Medizin und Psychothe-rapie. Prax Psychother Psychosom 37: