The Psychotherapeutic Professions in Poland

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I. Current Situation of the Psychotherapeutic Professions

1. Identity of the psychotherapeutic professions.

In Poland there are different practices called “psychotherapy” offered to the public. Some of them are addressed to the ill, some to healthy persons (e.g., guidance or coaching for personal development). Psychotherapists – medical doctors (most of them psychiatrists), psychologists, nurses, pedagogues, sociologists, priests, etc., work mainly in private practice, and the number of practitioners is not known. Most of them are trained in different psychotherapeutic orientations (“modalities”) by some institutions or societies (3-4 years of studies), but anyone can call himself “psychotherapist” even without any particular educational background.

To open a private psychotherapeutic practice in Poland one needs only administrative and fiscal registration, which results in the existence of some highly unprofessional services. Generally, people consider psychotherapy as a “soft alternative” of psychiatric consultation. In public institutions – mainly psychiatric ambulatories and wards – training in psychotherapy is a condition of employment. Psychotherapy is obligatory part of specialization in psychiatry. Some societies – e.g. the Polish Psychiatric Association and the Association of Polish Psychologists – offer the Certificate of Psychotherapist to their trainees after 4 years of postgraduate study of minimum 1200h.
The Psychotherapy Section (formed in 1960) and the Family Therapy Section of the Polish Psychiatric Association have now more than 1500 members – mainly psychologists, medical doctors, etc. (every professional engaged in the health service may be a full member of PPA). The PPA is currently responsible for 17 training programs. The Psychotherapy Section of the Association of Polish Psychologists (formed in 1998) is responsible for 6 similar programs. Both associations confirm competencies of trainees after at least 4 years’ postgraduate training program, through a careful procedure of certification (oral exam, including presentation of professional skills, case study and theoretical knowledge). Training programs in those Associations cover theoretical background – different approaches to psychotherapy, psychotherapeutic skills, personal training and supervision. Till 2008 PPA has certified more than 450 psychotherapists, and APP more than another 90 (mainly psychologists). About 100 of the experienced, certified psychotherapists have the status of supervisors (after supplementary training and examining procedures). Both Associations keep registers of psychotherapists and have complaint procedures; the National Insurance Fund recognizes the PPA and APP certificates. Moreover, about 20 other smaller psychotherapeutic societies exist. The field of psychotherapy of addicts is governed by independent rules, with separate programs of training and certificates, also recognized by NIF.

2. Relations among the psychotherapeutic professions.

Some psychologists would like to consider psychotherapy as one of basic forms of professional activity reserved only to their profession. Formally, a medical doctor should refer a patient to psychotherapy, but in fact access to psychotherapist is open. There is no domination of medical doctors; a clinical psychologist who is a psychotherapist can become the head of psychotherapy department. So there are no serious conflicts among medical doctors,
psychologists and other professions, but at the same time a vivid conflict among the societies exists.

In 2004 The Polish Federation of Psychotherapists (PFP) was formed, which competes with the PPA for the position of representative in The European Association for Psychotherapy, (temporarily, both PFP and PPA play the role of NUO/NAO in EAP). Some societies that are not recognized by The National Insurance Fund, but conduct training in psychotherapy and also offer certificates of psychotherapists, criticize the position of PPA and APP as being “monopolistic.” On the other hand, an informal forum was formed called the “Psychotherapy Council,” in which all psychotherapeutic societies are represented, provides a platform for discussion and cooperation.

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

Psychotherapy, despite a specific evidence-based orientation, is accepted in Polish mental health services. In private practice, there are free market regulations. The cost of one session varies from 15 to 80 Euros. The National Insurance Fund covers full expenses for 24 ambulatory individual or group sessions (in 2008 average ca 20E each), and 12 weeks of stay in a ward offering psychotherapy (average ca 30E [!] per day). On particular conditions, treatment may be prolonged or repeated in the same year. In order to get a contract in the Fund, the institution must employ certified psychotherapists and supervisors. Because only PPA and APP certificates are currently recognized by the Fund, psychotherapists who completed some other training programs cannot get money from it. This is the reason for tension and intensive conflicts, particularly because of the danger of uselessness of trainings offered by other societies (training is very
expensive, and is at the student’s own cost). Conflicts concern economic aspects, as well as the sole concept of psychotherapy (“medically oriented” or “wider” helping activity).
II. Future Prospects of the Psychotherapeutic Professions

4. Factors instigating change in the psychotherapeutic professions.
   
   A legal act establishing psychotherapy as a ‘medical’ profession (but one that is open to psychologists and other professionals) is expected this year. Until this act is passed, certified psychotherapists allowed to conduct treatment activity in the health care system (medical doctors as well as psychologists or other professionals) will be obliged to have clinical experience and 4 years of postgraduate study including theoretical knowledge, personal training and supervision. According to current opinion in Poland, cognitive-behavioral as well as psychodynamic, systemic, humanistic and integrative approaches are “evidence-based”. This limits such educational programs to those approaches (even to only one of them).

   When establishing psychotherapy as a ‘medical’ profession, it seems important to distinguish psychotherapy, understood as a treatment of definite disorders and psychosocial help in illness, from coaching and guidance of healthy persons. The expected legal regulation of mental health professional services would probably be a stimulating factor in this process. Consecutively, the regulation of “psychosocial personal helping” (counseling) is needed.

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

   Psychotherapists in mental health network (especially when is the only one facing a patient, in a private practice based on individual therapy) are the only persons who have access to all data concerning patients’ state, and should be responsible for the health of the patient in every aspect. Medical doctors could be involved only when the psychotherapist realize that such intervention is necessary, and sends the patient to the consultation. This shows the necessity of a
wide knowledge of general pathology, evident for medical doctor-psychotherapist, but not for psychologists and other professionals.

Conducting psychotherapy also requires a wide knowledge of psychology and psychopathology; this is a part of education needed mainly by medical doctors who are not psychiatrists. By the way, many “theories of psychotherapy” seem to be more useful in understanding general rules of personal development and of psychopathology than as a basis for psychotherapy theory and practice.

Due to vast differences in individuals’ conditions and reasons of illness, psychotherapy should be steered by the individual’s specific etiopathology, discovered and conceptualized by the psychotherapist (“psychotherapeutic diagnosis”) and not by theoretical concepts and paradigms. Being devoted to some theory is a factor that garbles direct clinical experience, rational observation and correct deduction. Accordingly, a therapist should be acquainted with the wide spectrum of theoretical approaches and existing treatment modalities, not in only one.

The particular skills of a person who provides psychotherapy should be:

a) Openness, not narrowed by theoretical premises, so as to hear and observe what the patient communicates verbally and nonverbally, unwillingly (unconsciously) expressing his or her disturbance in psychic processes;

b) Ability to form temporary, working hypotheses that reasonably explain the essence and causes of the individual’s disorder (“interpretation” of the meaning of symptoms, structure of mechanisms, etc.); and
c) Effective intervention, in a way that provokes corrective changes in disturbed psychic processes – pushing on the process of insight, changing dysfunctional cognitive schemata, creating corrective experiences, etc.

It need not be the same in personal helping services. In counseling, a model of training limited to one particular theory or “modality,” and an ability to respond to the openly expressed needs of a person seeking help, perhaps could be a sufficient basis for acting.

6. Relation of psychotherapy research to the psychotherapeutic professions.

Nowadays, research on psychotherapy is not an important influence on the practice of psychotherapy – except for the formal decision (based mainly on “common opinion”) as to what is “scientifically proven” and what is not. In Poland, a general skepticism dominates among psychotherapists regarding “scientific” data. In the domain of psychotherapy effectiveness, the most accepted concepts are the “Dodo effect” plus particular indications of some approach (modalities) in some disorders. Evidently, those concepts are very convenient and “politically correct.”

Only a very few Polish psychotherapists are engaged in research activity. Our national journal “Psychoterapia” predominantly features theoretical considerations, personal impressions and case studies, rather than reports of scientific research. The lack of interest in research seems to be justified, at least to some extent, by the evident distance of “scientific” conclusions about psychotherapy effects from everyday clinical experience. But on the other hand, the current rules of training create rather irrational “believers” in some approach than people who are open to reality and to science.
Moreover, the results of research based on the concepts of “approaches” and “modalities” cannot be coherent to the clinical reality of psychotherapy process and effectiveness due to improper paradigms. Neither ‘efficacy’ (*vis-a-vis* placebo effect) nor subjective feeling (even if shared by patients and their therapists) is a real criterion of improvement, and the best proof of the scientific character of a given treatment, because (first of all) the group construction according to “approach“ cannot create really homogenous units.

It seems more reasonable to assess psychotherapy effects according to change in the main dimensions of disorder treated. Differences in those dimensions in the case of anxiety disorders, personality disorders, affective disorders (not mentioning the most important differences – in the individual, personal traits of disturbance) are not sufficiently reflected either in assessment tools or in research methodology.

I guess that research aimed at psychotherapy, understood as a method of treatment fitted to the given person’s psychopathology (in its dynamic meaning), would help to define the appropriate set of therapeutic aims, as well as the basic set of therapeutic skills (such as mentioned in the point 5) that ought to be common to practitioners and providers of professional training in psychotherapy. At the moment, research results are not very helpful in obtaining such a goal, nor are efforts aiming to assess common opinion on the value of some treatment factors present in different modalities.

It seems to me that the evidence-based practice of ‘helping’ (widely understood) should be different from the evidence-based practice of ‘treatment’ (specific to disorders). For instance, the rule of following the patient’s overtly expressed (even sometimes negotiated) needs is
adequate in ‘helping’ but not so much in ‘treatment’. This also should be a subject of further studies and research.