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Psychotherapy for **mental illness** in **Europe**

*An exploration on the evidence base
and the status quo*

Eva Woelbert

2015



European Commission

Joint Research Centre
Institute for Health and Consumer Protection (IHCP)

Contact information

Eva Woelbert
Address: Joint Research Centre, IHCP, Public Health Policy Support
Via Enrico Fermi 2749, TP 127, 21027 Ispra (VA), Italy
E-mail: eva.woelbert@ec.europa.eu
Tel.: +39 0332 78 9109
Fax: +39 0332 78 3858

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JRC94870

EUR 27132 EN

ISBN 978-92-79-46165-1 (pdf)

ISSN 1831-9424 (online)

doi:10.2788/25206

Luxembourg: Publications Office of the European Union, 2015

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Summary

- There is strong evidence that, when properly designed and implemented, psychotherapeutic treatments produce robust effects for a range of mental health problems/illnesses. Studies evaluating the outcome of psychotherapeutic treatments adhere to the same rigorous standards applied to the evaluation of medical interventions.
- For depression and anxiety, two common and relapsing disorders, psychotherapeutic treatments produce robust and long-lasting effects.
- New psychological interventions are constantly being developed and tested. There is a strong trend towards integration of previously separate therapy methods, and towards the development of interventions that are tailored for the treatment of a specific illness or dysfunction.
- Cost-benefit analyses suggest that psychotherapeutic treatments yield good value for money.
- In several countries in Europe, psychotherapeutic treatments are not provided as part of the public health system, and where it is provided, effective access can be very limited.
- In several countries in Europe, the activity of providing psychotherapeutic treatment is not regulated by law, leaving scope for unprofessional use and posing serious ethical concerns.
- Countries that have regulated the activity of providing psychotherapy as a profession differ widely in the educational requirements and the associated professional titles, potentially causing problems in professional mobility.
- Not all countries have guidelines in place for the treatment of common disorders such as depression, and the available guidelines differ across countries.
- There may be scope for a systematic comparison of national concepts of psychotherapy across Europe.

1. Introduction

Mental health is increasingly being recognized as fundamental to EU health policy. Several recent policy reports describe the mental health situation and mental health systems across European countries (Samele, Frew and Urquia, 2013; World Health Organization Regional Office for Europe, 2008). These reports focus on mental health promotion and prevention of mental illness, and – where they cover treatment of mental health problems – information on psychotherapeutic treatment for mental illness is quite limited. While psychiatric care, delivered by a medical doctor, is quite tightly regulated in all European countries, this is not the case for psychotherapeutic treatments delivered by health professionals other than medical doctors. Psychotherapy regulation and provision are not comprehensively addressed in any of the current mental health reports. The purpose of this report is therefore to summarize briefly the evidence base supporting psychotherapeutic treatments for mental illness, and to explore their role in the treatment of mental illness in Europe. It is apparent that although robust evidence supports the use of psychotherapy as a treatment of choice for various common mental illnesses, availability is limited and varies greatly across countries. Remarkable heterogeneity exists further with respect to training of professionals and provision of psychotherapy by the public health system. A systematic mapping of psychotherapy professions, effective treatment provision and guidelines across Europe should be considered.

Throughout this report, the term psychotherapy is understood broadly and refers to a non-drug based and non-invasive therapy based mainly on talking.¹ It usually involves an interaction between a client or a group of clients and one or several trained professionals. Historically, psychotherapy as a treatment for mental illness emerged from Sigmund Freud’s work at the beginning of the 20th century, and has developed markedly since then. To give an overview on these developments, this section introduces the three major schools of thought underlying three histori-

1. The meaning and use of this term differs across countries. In some countries, the use of the term psychotherapy implies treatment of a more severe pathology, whereas psychological treatment might refer to routine care.

cally distinct modalities of psychotherapy, and describes current developments in research on new psychological treatments. Importantly, whether or not psychotherapy is an effective treatment for mental illness is no longer an ideological question. In the past centuries, a wealth of outcome evaluation studies have been conducted, which adhere to the same rigorous standards as those applied in evidence based medicine (Barlow, 2004). *Section 2* summarizes the empirical evidence supporting different psychotherapeutic treatments in general, and their specific effectiveness for the most common mental illnesses, namely depression and anxiety disorders. It is possible and warranted to use this evidence in decisions on treatment provision by public health services. *Section 3* describes some examples on the status of psychotherapeutic treatments in different European countries.

Psychodynamic therapies

Psychodynamic therapies form the historical basis of psychotherapy as a treatment for mental illness. With psychoanalysis as a prominent example, psychodynamic therapies are perhaps the best-known of the different therapy modalities. One of the central assumptions of this school is that factors we are not consciously aware of are important drivers for our behaviour. In comparison to therapies developed later, dynamic therapies offer relatively little guidance, and put a strong emphasis on the relationship between the therapist and the patient, and the emerging dynamics. Goals are to increase self-understanding and self-awareness of the patient (Barber, Muran, McCarthy and Keefe, 2013). Historically, it was considered necessary to engage in this process at high intensity (several sessions a week) and for a long time (several years). The associated costs have driven also this school of therapy to develop shorter interventions – with good results. However, long-term, high intensity interventions continue to be delivered to patients, and – in some countries – are reimbursable by public health funds (*e.g.* Germany). Effectiveness studies are not part of the tradition of this school of therapy, and it has long been argued by many practitioners that standard methodology is ill suited to evaluate the processes and the success of dynamic therapies. Nevertheless, in particular the effectiveness of short term psychodynamic therapies for a range of conditions has now been demonstrated in randomized controlled trials. Only a very small number of studies have evaluated the effectiveness of traditional high-intensity long-term treatments in a controlled way, with conflicting results (Barber *et al.*, 2013;

Leichsenring and Rabung, 2011; Smit *et al.*, 2012), suggesting that more evidence on the effectiveness of this type of therapy is needed to justify the provision of these comparatively costly treatments.

Humanistic therapies

Humanistic therapies represent the first significant departure from the psychodynamic tradition. Here, not the therapist but the client is seen as the driver for positive change, which is facilitated by an empathic and respectful therapeutic relationship. The degree to which the therapist directs the process of therapy varies between different versions of humanistic therapy, and may be minimal. Although the founders of humanistic therapy have contributed greatly to making psychotherapy a subject of empirical research, controlled effectiveness studies have played a minor role. Moreover, the appropriateness of applying the concept of evidence-based practice to psychotherapy has been questioned by practitioners. Nevertheless, several randomized controlled trials have now investigated some psychotherapeutic interventions that belong to this school. Overall, the results suggest that these are effective for a range of conditions (Elliott, Greenberg, Watson, Timulak and Freire, 2013). However, humanistic therapies do not play a major role in mainstream psychotherapy training, and are not delivered as psychotherapy within the public health system in many countries. A possible explanation for this is that they are not as historically established as the psychoanalytic therapies are, and also not as well backed up by empirical evidence as the cognitive and behavioural therapies.

Cognitive and behavioural therapies

Cognitive-behavioural interventions are based on the insight that much of behaviour is the result of learning processes (the behaviour component). A lot of attention is further paid to wrong and/or unhelpful beliefs and automatic thought patterns (the cognitive component). The therapist seeks to adjust inaccurate thoughts by encouraging patients to evaluate the evidence supporting these cognitions. Learned reactions may be corrected by new learning. For example, controlled exposure to a fear-inducing environment may allow the patient to experience that the feared outcome does not actually occur, thus overcoming the fear itself.

Cognitive behavioural interventions are widely practised. In contrast to psychodynamic and humanistic therapies, this school has a long tradition of empirical evaluation, and these therapies are therefore among the interventions best supported by evidence from randomized controlled trials. Cognitive behavioural therapy has been found to be effective against several disorders, and potentially superior to other techniques in the treatment of anxiety-related disorders and eating disorders. Moreover, studies including long follow-up periods have demonstrated its long-lasting effects (Butler, Chapman, Forman and Beck, 2006; Hollon and Beck, 2013).

New developments

New forms of psychological treatments are constantly being developed, and also the evidence base supporting different interventions is constantly increasing. This is acknowledged in the recommendations on treatments issued by the American Psychological Association. After publishing a report with a list of empirically supported therapies in 1995, and several updates of this report, a website was created that allows for more frequent updates (APA Presidential Task Force on Evidence-Based Practice, 2006). Two trends are particularly noteworthy:

Firstly, interventions delivered by psychologists and psychotherapists in practice rarely adhere strictly to one of the above described schools. Many practitioners draw techniques from several traditional schools of therapies (Lambert, 2013a). This calls into question the historically strict divide between the schools, which is also reflected in training programs and existing regulations (*e.g.* Germany), and also calls for an evaluation of these eclectic approaches.

Secondly, newly developed interventions tend to be tailored very specifically to a particular pathological condition. Thus, rather than the ‘catch-all’-approach of the early school-based psychotherapies, there is now a development towards more disorder- and process-specific interventions (Barlow, 2004; Emmelkamp *et al.*, 2014). These developments might make adjustments to training and licensing procedures and regulations necessary.

2 . Psychotherapy outcome studies

This section gives a brief summary of the available evidence on the outcomes achieved with psychotherapy. In the following it is useful to distinguish two terms relating to the benefits that can be achieved with an intervention, although it should be noted that these are really endpoints of a continuum rather than two distinct categories. Studies emphasizing the term ‘efficacy’ test an intervention under ideal circumstances, whereas a focus on ‘effectiveness’ implies that a study attempts to quantify the benefits achieved with the intervention in the standard clinical practice (Singal, Higgins and Waljee, 2014).

Efficacy studies

Efficacy studies are conducted to evaluate whether an intervention has the desired effect under highly controlled conditions. In psychotherapy research this means that it is carefully controlled that patients entering the study fulfil specific diagnostic criteria for a well-described disorder. The treatment that is delivered is highly standardized by use of treatment manuals which describe the precise steps to be taken, and the correct implementation is ensured by therapist training and monitoring. In addition, patients are randomly allocated to the treatment group, or the control group. To avoid bias in the evaluation, personnel who assess the outcome of the therapy is blind about this allocation, and the study takes place at several sites (multicentre study).

While in pharmacological outcome studies the comparison of an active component with a placebo control is standard and straightforward, what would constitute a placebo treatment for a psychological therapy is less obvious. Therefore, many psychotherapy outcome studies use a group of people that are placed on a waiting list as a control group. Studies of this type mainly answer the question whether psychotherapy effects are superior to what is attributable to spontaneous improvement. More close control conditions, where also the control groups receive some form of psychosocial intervention, are discussed below, when results on the relative effectiveness of different therapy methods are presented.

The efficacy of psychotherapy interventions has been evaluated in a vast number of studies comparing treated groups with control groups receiving no treatment (Barlow, 2004; Grawe, Donati and Bernauer, 1994; Lambert, 2013*a*). Meta analytic studies are particularly important in this case because they synthesize the results of a set of individual studies in a quantitative way, and allow for a clear picture to emerge. The pervasive theme derived from hundreds of these meta-analytic studies is that psychotherapy has proven to be very beneficial for a wide range of disorders, among which depression and anxiety disorders (Grawe *et al.*, 1994; Lambert, 2013*b*). From these many studies, the size of the treatment effect that can be expected from psychotherapy is estimated as follows: On average 65% of treated persons will have a positive outcome, compared to 35% of the non-treated control group. This compares favourably to the magnitude of the effects achieved with common medical interventions. Data provided by the University of Toronto's Center for Evidence Based Medicine suggests that psychotherapy effects are larger than those achieved with a wide range of standard medical interventions, including those of almost all interventions in cardiology (*e.g.* beta-blockers, and angioplasty) and geriatric medicine (*e.g.* osteoporosis treatment, see also Wampold, 2007).

Treatment of depression and anxiety disorders

Depression and anxiety-related disorders are the most common mental illnesses. Overall, an estimated 14% of the adult population in Europe are suffering from anxiety disorders, and 6.9% from depression (or have suffered from depression within the 12-month interval before the assessment, a common metric referred to as 12-month prevalence; Gustavsson *et al.*, 2011; Wittchen *et al.*, 2011). These two groups of mental illnesses alone cause an estimated EUR 178.8 billion of costs in Europe.² Importantly, more than 50% of these costs, EUR 100 billion, are indirect costs, not attributable to health care expenses, but to factors such as loss in productivity and early retirement (Gustavsson *et al.*, 2011; Smith, 2011). Since these disorders are so common, the following paragraph briefly summarizes the available evidence on effectiveness of psychotherapy for these specific disorders, in particular also in the comparison to pharmacological treatment.

2. Both prevalence- and cost-estimates refer to the year 2010. Prevalence-estimates are extracted from previous epidemiological publications and existing epidemiological databases, with the support of national experts. Cost-estimates are based

More than 40 meta-analytic studies in the past three decades have investigated the effectiveness of psychotherapeutic treatment for depression. Most studied treatments have been found to reduce symptoms substantially and to increase well-being. Depending on the severity of the disorder, between 35% and 70% of patients undergoing psychotherapy for depression experience a complete disappearance of the symptoms (full remission).

Numerous studies have directly compared the effects of psychotherapeutic treatment with those of pharmacological treatment for depression. Overall, at termination of the therapy, these types of treatment produce comparable effects. However, psychotherapy has been found to be more effective than medication in the treatment of mild and moderate cases of depression (Lambert, 2013*b*). In more severe or more chronic cases of depression, and in bipolar mood disorder, the combination of psychotherapy and pharmacotherapy has been found to be more effective than either of these treatments in isolation (Lambert, 2013*b*).

Depression is a disease characterized by a high chance of relapse. Therefore it is important to consider not only the immediate outcomes of the therapy at termination, but also the long-term effects. At follow-up measurements conducted at least one year after termination of the therapy, individuals treated with psychopharmacological treatment were twice as likely to have experienced a relapse as individuals treated with psychotherapeutic treatment (Forand, DeRubeis and Amsterdam, 2013; Lambert, 2013*b*). Thus, while the effects of psychotherapy and pharmacotherapy at therapy termination are largely comparable, psychotherapy is superior at follow-up (Cuijpers *et al.*, 2013).

Psychotherapy has also been found effective as a treatment of a wide range of anxiety-related disorders. In the treatment of panic disorder, success rates are estimated to be between 50% and 70%. Similar to what has been described for depression, psychotherapy treatments seem particularly effective at obtaining long-term effects: relapse rates have been found to be 50% higher for patients that received psychopharmacological treatment in comparison to those who received psycho-

on these 12-month prevalence estimates, as well as existing country- and disorder-specific cost studies. Estimates of older studies were inflation-corrected and foreign currencies were converted to Euro adjusted for differences in purchase power.

therapy. For certain anxiety disorders, several studies found evidence that pharmacological treatment interferes with psychotherapy treatment. When medication was simultaneously administered with psychotherapy, relapse rates were found to be substantially higher than when psychotherapy alone was applied (Forand *et al.*, 2013).

Effectiveness studies

As outlined above, a large number of studies that have been performed under very controlled conditions have demonstrated benefits of psychotherapy. At this point it is important to ask whether these beneficial effects generalize to a routine clinical setting, where several factors may be different: the content and dose of the therapy are less standardized, patients' problems may be less well-described, and the therapists' training may vary. Overall, several studies have confirmed that therapy is also effective in a real-life setting, but more studies of this type are needed (Lambert, 2013*b*).

Negative change

It is important to consider the possibility that patients deteriorate while under therapy, and that psychotherapy may have negative effects. Although difficult to study, the existing evidence on the question suggests that 5%-10% of adults treated in psychotherapy, and 14%-24% of children experience negative change. Although it is not always clear whether this is attributable to the therapy, or constitutes spontaneous negative changes, it highlights an area for improvement and more research (Lambert, 2013*b*). In the absence of regulation of the profession, it is possible that practitioners are insufficiently trained and lack adherence to professional standards, factors which exacerbate negative change in practice (Van Broeck and Lietaer, 2008).

What kind of psychological treatment should be applied?

The results summarized above rely mainly on studies comparing the effects that are obtained by psychotherapy with no-treatment control groups. Given the overall favourable evaluation of psychotherapy in these studies, it becomes clear

that psychotherapy is an effective tool in treating mental illnesses, and the most effective one available in common disorders such as moderate depression and anxiety disorders. However, what is less clear from these types of studies is how psychotherapy should be applied, what are the components responsible for the positive effects, and for how long should patients be treated. While there is broad consensus on the effectiveness of psychotherapy, these latter questions are subject to considerable debate.

A first important question is whether the effects of psychotherapy go beyond fairly general factors such as regular contact, a confidential setting, and expectations of a positive outcome. It should be noted that these are undoubtedly important ingredients of psychotherapy, but they are not specific to a therapeutic approach. In order to justify the provision of a specific form of therapy by highly trained specialists, psychotherapy interventions should prove more effective than some general supportive factors. To address this issue, therapy outcome studies have included active control groups which received an intervention composed of un-specific support, delivered in a comparable number of sessions by trained individuals. This type of control condition is sometimes considered a suitable ‘placebo’ control for psychotherapy research. Overall, results of this research suggest that these general factors play an important role in the effectiveness of psychotherapy: ‘Placebo’ control groups usually improve more than no-treatment control groups. At the same time, psychotherapy is still more effective than these ‘placebo’ treatments (Lambert, 2013*b*).

Secondly, considering the multitude and diversity of psychotherapeutic techniques and the underlying theories, it is important to ask whether there are differences in the effectiveness of these treatments, both generally, and in the treatment of specific disorders. Historically, treatment techniques can be divided into psychodynamic and humanistic therapies on the one hand, which build on the relationship with the therapist and insights gained through the therapy, and cognitive-behavioural therapies on the other hand, which build on action as driver for change. Although some studies have found differences between treatment techniques, the overall picture suggests that short-term psychodynamic and cognitive-behavioural therapies are equally effective (Barber *et al.*, 2013; Cuijpers, van Straten, Andersson and van Oppen, 2008; Lambert, 2013*b*; Wampold, Minami,

Baskin and Callen Tierney, 2002). Research suggests that important active ingredients of psychotherapy are factors which are common to most of the studied techniques.

Differences between psychotherapeutic techniques exist not only in the theory and the content of what is delivered, but also in the length and intensity of the therapy. In order to determine how much therapy is needed to achieve an effect, dose-response relationship studies have been conducted, that have measured progress continuously over the course of the therapy. Based on the available evidence, Lambert (2013a) concludes that for 50% of the patients clinically meaningful changes occur after 13 to 18 sessions of treatment. A further 25%, typically patients with higher initial levels of distress, achieve the same level of change only after 50 sessions (delivered at a frequency of once a week). This suggests that there is large inter-individual variability in the dose-response relationship and that, while about half of the studied patients benefit from relatively short therapies, enforcing rigid limits to the length of therapy may be problematic.

In sum, psychotherapeutic treatments have been found effective for a wide range of mental illnesses. Studies on the treatment of depression and anxiety disorders have demonstrated that the effects of psychotherapeutic treatments are long-lasting. Moreover, recent cost-benefit analyses conclude that the benefits of standard-length psychotherapeutic treatments exceed the costs even in conservative estimations, and that psychotherapeutic treatments are good value for money (Layard, Clark, Knapp and Mayraz, 2007; Wunsch, Kliem, Grocholewski and Kröger, 2013). Although more research on relative cost-effectiveness is needed (Churchill *et al.*, 2001; Doran, 2013), the good long-term effects of psychotherapy suggest that they may be particularly cost-effective in the long run.

3 . Psychotherapy in Europe

The evidence outlined above strongly suggests that psychotherapeutic treatments are valuable, and should be an integral component in the treatment of mental illness. In particular in face of a significant shrinking of available labour force in Europe over the coming years it is not only a moral, but also economic must to ensure good provision of treatment of mental health problems in Europe. With decreasing labour force, the cost of drop outs caused by insufficient treatment of mental health problems will increase.

Surveying the literature on psychotherapy practices in Europe, it becomes apparent that data on provision and regulation of psychotherapy is not readily available. Although several recent reports address the issue of mental health systems in Europe (Huber *et al.*, 2008; Samele *et al.*, 2013; World Health Organization Regional Office for Europe, 2008), they provide only very limited information on psychotherapy. In the following we seek to give a brief overview of the main issues in treatment provision. Overall, it becomes clear that there is large heterogeneity in psychotherapeutic and psychological care across the different European countries.

For the following overview, three main sources of information are considered: a report published in an academic journal in 2008 reviews legal regulations for psychotherapy across 17 different countries (Van Broeck and Lietaer, 2008), making use of available publications and oral communications from professionals in the different countries. An extension and update of this report is expected for 2015 (Van Broeck, personal communication); a report from 2004, commissioned by the Austrian ministry of health, gives an overview on the regulation of psychotherapeutic professions in several European countries (Bednar, Lanske and Schaffenberger, 2004); some limited information is further available from a survey to psychotherapy professionals in a range of European countries published by the German psychotherapist association 'Bundespsychotherapeutenkammer' in 2011. This latter survey interviewed a representative professional in each country in order to gain an overview of national concepts of psychotherapeutic care, with a focus on depression. In the following, some issues raised in the different reports will be elaborated on.

Regulation of the activity of psychotherapy and professional titles

Countries differ in the way the activity of psychotherapy is regulated. Here, it is important to distinguish between the regulation of professional titles that may be carried by individuals with a specific training, and the regulation of the activity of psychotherapy as such.

Regulating the activity of psychotherapy appears particularly important, because in the absence of such regulation, anyone can deliver psychotherapeutic interventions to help-seeking individuals, with or without training and quality control. In this case, the quality of the interventions delivered and the adherence to ethical and professional standards cannot be assured (Van Broeck and Lietaer, 2008). For several European countries³ there appears to be a complete lack of legal regulation of the activity of psychotherapy (Bundespsychotherapeutenkammer, 2011; Van Broeck and Lietaer, 2008).

Considerable heterogeneity exists also in the titles describing the profession of psychotherapy, and the degree to which these titles are protected by law. In several countries, no professional title for psychotherapists is regulated by law, *i.e.* it is not specified by law what requirements have to be met in order to be allowed to carry the title ‘Psychotherapist’ or similar. A lack of legal protection for the title does not necessarily mean that there is no certification and quality control of the profession of psychotherapy, but it is not primarily conducted by the state, but rather by professional associations. This means that several different titles and certifying bodies may exist, which can cause confusion for help-seeking individuals, as well as young or migrating professionals. Moreover, certification may be voluntary and power of enforcement of ethical and professional standards may be limited (Van Broeck and Lietaer, 2008). In the absence of legal protection of titles such as ‘Psychotherapist’, these titles, which are suggestive of professional competences, may still be used by unqualified individuals.

3. Insufficient legal regulation of the activity of psychotherapy is described by professionals for example for Ireland, France, Latvia, Cyprus, Portugal, and Greece.

Among countries that have specified the requirements that have to be met in order to carry a professional title for psychotherapy provision, the definition of the profession and the educational requirements differ substantially (Bednar *et al.*, 2004). Various different titles for professionals delivering psychotherapy exist, such as ‘Psychotherapist’, ‘Clinical Psychologist’ and ‘Health Care Psychologist’. Some countries, such as Austria or The Netherlands have regulated several of these titles, others know only one of these (*e.g.* Germany). The distinctions between the different titles are not always obvious, and definitions differ across different countries (Bednar *et al.*, 2004). While some countries restrict access to psychotherapy training to individuals with Master’s level University Degree in Psychology or Psychiatry, others consider psychotherapy a multiprofessional activity and grant access to a wider range of professionals (Van Broeck and Lietaer, 2008). As a consequence of this heterogeneity, professionals migrating within Europe have described substantial difficulties they encountered in the recognition of their professional qualification (Warnecke, n.d.).

Provision of psychotherapy by the public health system

Although not addressed systematically in the available literature, it is apparent that countries differ widely in the degree to which psychotherapy is provided by the public health system, reimbursed by health insurance, and also in the type and length of treatment delivered. For several countries, it appears that psychotherapy is for the most part not delivered as part of the public health system (Bundespsychotherapeutenkammer, 2011; Huber *et al.*, 2008). For most countries where the public health system does cover psychotherapy costs, professionals describe practical problems that effectively limit the access to (partially) reimbursed psychotherapeutic treatment. For instance in Germany, a survey among a large number of professionals has found that help-seeking individuals face a mean waiting time of 4.6 months to begin a psychotherapy treatment, and that every second request for an intake interview is refused (Schulz, Barghaan, Harfst and Koch, 2008; Zepf, Mengele, and Hartmann, 2003). A 2008 WHO report on ‘Policies and practices for mental health in Europe’ remarks that limitations in funding and availability of psychotherapy ‘are ironic, given the evidence of its cost-effectiveness and lack of side effects’ (World Health Organization Regional Office for Europe, 2008, p. 124).

Countries also differ in the type of psychotherapy that is provided in the public health system. Most countries offer cognitive behavioural and psychodynamic therapies. Some offer humanistic and family therapies as well. A particularly important question with respect to the provision of different therapy techniques in the public health system is how newly developed, evidence-based treatments will enter into routine care in a timely manner. For instance in Germany, a treatment technique is considered for reimbursement in outpatient care only in case of proven effectiveness against several different mental illnesses (Gemeinsamer Bundesausschuss, 2009). Once these criteria are fulfilled, the treatment may be applied to any indication. This regulation is starkly at odds with the current trends in psychotherapy research to develop specific interventions for specific disorders (Barlow, 2004), and may hinder the diffusion of new treatments into clinical practice.

Taking the case of depression as an example, the survey conducted by the German Psychotherapist Association investigated also whether countries have specific concepts for the psychotherapeutic treatment of a specific disorder. Although professionals from some countries referred to existing evidence- and consensus-based treatment guidelines, in many countries no specific regulation seems to be in place for the psychotherapeutic treatment of this common disorder. Professionals from several countries, in particular Portugal, reported that pharmacological treatment for depression was much more widely available than psychological treatment. This is in line with high prescription figures for antidepressant medication (World Health Organization Regional Office for Europe, 2008), but at odds with the proven effectiveness of psychotherapy for depression, in particular mild and moderate cases.

4 . Conclusion

Over the past decades considerable progress has been made in developing effective psychological treatments for mental illnesses. Evaluation studies adhering to the same strict methodological standards applied to pharmacological studies provide ample evidence that psychotherapeutic treatments are effective. Exploring the literature on psychotherapy concepts across Europe, it becomes apparent that there exists heterogeneity in various central aspects on psychotherapy provision: legal protection of the activity of psychotherapy and professional titles differs, and is absent in several European countries. This poses serious questions of quality assurance, but also of professional mobility across Europe. Countries also differ in the degree to which psychological treatments are reimbursable under the public health system, and in the availability of treatment guidelines for common mental illnesses. Overall, data comparing national psychotherapy concepts across Europe is scarce, suggesting that there may be scope for a systematic comparison. Research needs include effectiveness in routine care, negative side effects, as well as relative cost-effectiveness of psychotherapeutic treatments.

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EUR 27132 EN – Joint Research Centre – Institute for Health and Consumer Protection

Title: Psychotherapy for mental illness in Europe. An exploration on the evidence base and the status quo

Author(s): Eva Woelbert

Luxembourg: Publications Office of the European Union

2015 – 26 pp. – 21.0 x 29.7 cm

EUR – Scientific and Technical Research series – ISSN 1831-9424 (online)

ISBN 978-92-79-46165-1 (pdf)

doi:10.2788/25206

Abstract

Mental health is increasingly being recognized as fundamental to EU health policy. The purpose of this report is to briefly summarize the evidence base supporting psychotherapeutic treatments for mental illness, and to explore their role in the treatment of mental illness in Europe. It is apparent that robust evidence supports the use of psychotherapy as a treatment for various common mental disorders. However, availability of psychotherapy is limited and varies greatly across countries. Remarkable heterogeneity exists further with respect to training of professionals and provision of psychotherapy by the public health system. Thus, there may be scope for a systematic comparison of national concepts of psychotherapy across Europe.

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