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ABOUT PSYCHOTHERAPY, INCLUDING CHILD AND ADOLESCENT PSYCHOTHERAPY: QUESTIONS, CHALLENGES, CONTROVERSIES

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family therapy
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Summary

The aim of this article is to present our reflexions on legislative changes in psychotherapy, including child and adolescent psychotherapy, that are currently being introduced in Poland. The authors analyse this process in the context of the crisis in the field of child and adolescent psychiatry and its causes indicated by the initiators of the reform. They put forward the question whether the proposed solutions would contribute to the improvement of the current situation or rather be a source of new problems and tensions including complications in practicing psychotherapy by psychotherapists who have been educated in the previous system, verified by scientific societies. Discussed issues are presented from different perspectives: the perspective of clinical practice with children, adolescents and their families in the public health care system; the perspective of scientific research showing current reflections on issues of defining methods of verifying psychotherapy effectiveness based on literature reviews including up-to-date guidelines to its application in the field of family therapy; and the perspective of the psychotherapy training process, considering possible implications of currently introduced changes in this area. The authors discuss controversial topics in a clarifying and systemized way in order to provoke deeper reflection among psychotherapeutic societies.

Introduction

Recently, within Polish psychotherapeutic circles, there has been an understandable amount of uneasiness and unrest concerning the planned changes of the profession's legal regulations. It is hard not to feel lost when trying to comprehend this quite chaotic process of creation of legislative solutions and endeavouring to form an adequate and sensible response to both the official proposals and backstage ideas. This paper is the effect of our struggles with the constantly changing (often for unknown reasons) outside reality, in which the proposed alterations in the legal context would give a new and unclear shape to the practice of our profession for many years to come.

When searching for the moment of inception of the process of the changes, the culmination of which is rapidly approaching, a systemic mind could go back indefinitely, noticing more and more elements of this puzzle in the previous eras and spheres of reality. Yet the aim of this text is to present

the current crisis and its – perhaps even more critical – solution in a clear and comprehensible manner, as a synthesis of the issues and contexts deemed most crucial by the authors.

In order for the reader to be able to form their own opinion on the current situation, it seems vastly important to begin with a thorough presentation of the position from which it was written. Both authors are employees of the Child and Adolescence Psychiatry Clinic at the Medical College of the Jagiellonian University. Professor Barbara Józefik is a psychotherapist working with families, as well as a psychotherapy supervisor. For many years, she has been treating children and adolescents, while actively popularising psychotherapy and conducting research within the field. She has authored numerous scientific publications. As a founding member and former president of the Scientific Subdivision of Family Therapy of the Polish Psychiatric Association, she participated in the creation of regulations concerning the process of training and certification of competence of individual psychotherapy practice, which is currently functioning within the Polish Psychiatry Association. It is worth noting that since the 1990s, these regulations have been taken into account in the decrees and decisions of the Polish Ministry of Health and Social Services, as well as in the rules and regulations of the National Health Fund.

Feliks Matusiak is a physician specialising in Child and Adolescent Psychiatry. He also holds a master's degree in psychology and has completed the entire course for the psychotherapy certificate. He practices clinical medicine as a physician and works as a psychotherapist with families and individuals. He also conducts research on the process of therapy using quantitative and qualitative methods. Both authors also represent a foundation that organizes and performs accredited general training preparing for the psychotherapy certificate.

We therefore represent the environment of clinical physicians and practicing psychotherapists treating children and adolescents, scientists researching the process of psychotherapy and its effects, as well as the organizers of psychotherapy training. We see those three interwoven areas of expertise as parts forming a crucial context – without understanding which it would have been hard to address the present changes.

Clinical context

The gist of the following paragraph could be summed up as: *crisis in child and adolescent psychiatry*. Even following the media coverage in the recent years in a very cursorily way, there were numerous occasions to stumble upon alarming statements by the National Consultant in the field of child and adolescent psychiatry, professor Barbara Remberk, regional consultants, the Commissioner for Children's Rights Marek Michalak, the Commissioner for Patients' Rights Bartłomiej Chmielowiec, and many other worried representatives of other connected fields and professions. Detailed information on the difficult position of child and adolescent psychiatry in Poland can be also read in the report by Citizens Network Watchdog Poland [1] that can be found on the organization's

website. A sign of paying attention to the gravity of the situation was the founding within the Ministry of Health – on February 20th, 2018 – a team dedicated to solving the issues of mental health of children and adolescents, led by Zbigniew Król, who at the time was an Undersecretary of State in the Ministry of Health. After forming a diagnosis of the problem, the team prepared a solution that would introduce a three-step healthcare model. According to the plan, treating less intense difficulties (i.e. CMDs – common mental disorders) would be the responsibility of local centres for child and adolescent psychology (1st stage referral units) and – in more severe cases – the responsibility of local centres for mental health of children and adolescents (2nd stage referral units). The 3rd stage referral hospitals, or tertiary healthcare providers – specialized, 24/7 psychiatric care centres – would be reserved only for children and youth with severe mental disorders (SMD), which constitute a striking minority among psychiatric patients. A considerable majority of people working within the current system would agree that its great shortcoming is the inadequate distribution of human resources. The work of the handful of child and adolescent psychology specialists (about 400 people in Poland) is mainly focused on solving family conflicts, which – due to impulsive utterances of threats of self-harm or harming others by children or adolescents finally find their way to the Emergency Room. Physicians prescribe medicine for the children, hoping that the family would finally qualify for therapy. It is there that they could finally begin to solve real, crucial issues or find a better way of dealing with currently complex manifestations of normative crises in teenage patients. The physicians are overworked and left without the possibility of fast referral of patients and their families to psychological and psychotherapeutic aid – those are the primary reasons for the overcrowding of the small number of existing stationary child and adolescent psychiatry departments. This, in turn, impedes admitting and treating child patients whose psychopathology is on a larger scale and constitutes a grim danger for their development or even life, but whose expression of their difficulties is not as engaging and visible as a family quarrel on the topic of pedagogical issues. Therefore, the planned new system, in which the help starts from psychotherapeutic care of children and helping families, and a visit to a child psychiatrist constitutes a further part of the intervention algorithm, seemed a sensible solution to the initiators of the reform.

One of the elements of the diagnosis of the difficulties described above and closely connected with the intentions for the changes, was the low accessibility of psychotherapeutic care for children and adolescents. Moreover, the planned transferring of the burden of caring for the so-called "typical" patients onto the groups of child and adolescent psychotherapists entailed – obviously – a requirement for them to be available as per the new system. This seems incontestable. As the remedy for this organizational obstacle, the Ministry of Health-sanctioned team was creating additional conditions and requirements for those who want to study in the field of child and adolescent psychotherapy. This concept was followed by the idea of basically creating a new profession – the profession of a child

and adolescent psychotherapy specialist and the devising of an entire programme of specialist training and requirements for training faculties, where the privileged ones were large public institutions.

It was not that Pandora's box has been opened – the lid has been torn off.

The situation above became the basis for a multi-dimensional, extremely emotional debate on the shape of the introduced changes and their consequences. Although it is impossible to address all the issues, we have decided to pinpoint those that we deem the most crucial, as discussed below.

First and foremost, the planning of the proposed changes – which are of a systemic character – has not been preceded by a discussion that would include representants of specialists representing different backgrounds and raise the topic of the complex factors behind the current decline in the field of child and adolescent psychiatry and a lack of a comprehensive model of organised psychological care and treatment. Secondly, the key issue that caused a lot of unease and anxiety within the community is that of whether the reform allows for a possibility of guaranteeing the same status to certified psychotherapists who already have extensive experience in working with children and young people and those, who are to obtain the specialization in child and adolescent psychotherapy. Within the community of certified psychotherapists, the requirement of having to yet again prove their competence by taking a specialization exam is met with understandable resistance and sense of injustice. This could lead to legal claims in the future, if the newly introduced regulations would prohibit them from practicing child and adolescent psychotherapy or would lead to less favourable employment conditions.

An issue inseparable from the above is that the new proposed form of specialized training in child and adolescent psychiatry is being drawn and organized on the basis of a medical speciality and how it will be applicable to the specific nature of the psychotherapeutic practice. It seems that confining it in the strict timeframe of only four years would be detrimental, as it would not allow for the necessary elasticity – it should take into account the aspect of the psychotherapists' personal growth and gaining abilities in conducting the psychotherapeutic process under the care of their supervisor.

The situation we have outlined above has caused the re-emergence of tensions and arguments between certified societies and representants of other approaches. These disagreements are vital and necessary, as they pertain to what will form and influence the shape of the profession of the child and adolescent psychotherapist for the years to come.

An additional complication comes from the proposal of some of the psychotherapeutic associations that call for including psychotherapeutic interactions within the Integrated Qualifications System (IQS). This is a European system of qualification quality certification, created to facilitate the comparison of competence levels of specialists of a given field from different countries of the European Union. It is not used to regulate the access to a given profession, yet having the IQS certificate could be, for example, a condition of entering a tender or contest (or applying for a job).

The system is adapted to describe qualifications that are not difficult to present procedurally – therefore, there are certain doubts whether it would be sufficient to describe the skills and abilities needed in the profession of a psychotherapist.

The comments above lead us to ask a fundamental question: what kinds of regulations are more beneficial for the field of psychotherapy, namely: what knowledge and skills should a psychotherapist possess in order to successfully treat children and adolescents?

Scientific context

As we have mentioned before, being scientists and researchers is an important element of our identities. In this part of the article, we would like to approach the issue from this perspective. Finding an answer to the question raised at the end of the previous paragraph requires a deeper considering of what is it that makes psychotherapy successful and how to define this success. First, let us ascertain the status of the field of psychotherapy in academic and scientific circles as well as its place in the social system. This is crucial, as often psychotherapy is placed between the humanities and medical science. As a method of treatment, it is connected to the realm of patients, healthcare systems, taxpayers, and insurance companies. As a method of personal growth, it belongs to the clients and the retreat of private offices that avoid the public sector. This text is about the psychotherapy that is inseparable from the whole system of psychiatric help; psychotherapy as a method of treatment that is financed by public funding. Its position in the realm of healthcare providers, healthcare beneficiaries, and the taxpayer entails certain requirements. Like every medical procedure financed via public funding, it should be appropriately effective and affordable at the same time – meaning a satisfactory cost to positive outcome ratio. The role of psychotherapy as part of the domain of medicine requires it to prove its effectiveness and affordability on the rules typical for this discipline. The gold standard of medical procedure assessment used by public institutions (in Poland by *Agencja Oceny Technologii Medycznych i Taryfikacji*, Agency for Health Technology Assessment and Tariff System) is the "proof" of effectiveness in Randomized Controlled Trials (RCT). This research procedure assigns patients randomly to the experimental group or the control group and facilitates a comparison of results of the studied interaction with a large control of outside confounding factors. When the method is used in drug studies, where it is frequent also double-blinded (so that neither the patients nor the researchers know who gets the medicine and who gets the placebo), it has been successful in a relatively reliable assessment of the effectiveness of the drugs. For the research using this method to be possible, there must be a large number of patients in a similar state, who undergo a comparable treatment, preferably unhindered by other forms of interaction. In the field of psychotherapy, this comes down to a large group of patients with the same diagnosis, similar symptoms, without concomitant disorders, who undergo identical therapeutic processes, without additional forms of treatment (like pharmacotherapy) and, additionally, with motivation for treatment.

Here we surely do not need to add that from the beginning, this essentially laboratory paradigm has raised a lot of doubts by many researchers, who noted that it does not reflect the reality of psychotherapy practice.

These dilemmas have resulted in many discussions within the research community that have introduced new approaches and new interpretations in the domain of assessing the effectiveness of psychotherapy. Among these, a significant one is the 1995 publication by E.P. Seligman [2] which differentiates between the various research methods, dividing them into:

- Efficacy studies – conducted in a controlled environment, such as randomized clinical trials, with a control/comparison group;
- Effectiveness studies – studies that reflect the everyday practice in a naturalistic way, with no control groups.

This publication raised the great importance of non-lab-based studies accessing the effects of treating patients with a multitude of problems in conditions that are typical for everyday realities of the work, often dealing with patients with low motivation for treatment. The well-known British scholar, Peter Fonagy had a similar outlook. He postulated for complementing RCT-type research with studies in naturalistic conditions [3]. In the Polish bibliography, a thorough insight into the complex nature of such research in the field of psychotherapy was made by Cezary Żechowski [4], who pointed to certain similarities between the RCT procedures and manualized therapies (such as CBT), thus emphasizing their somewhat privileged position in the struggle to provide a proof of efficacy in less structured therapies, such as psychoanalysis or systemic therapy. In 2011, in Poland a debate on research in psychotherapy took place on the pages of the journal *Roczniki Psychologiczne*, sparked off by the publication of J.M. Rakowska's article *Użyteczność kliniczna interwencji terapeutycznych wspartych empirycznie* ("The clinical utility of empirically-backed therapeutic interventions"). The debate was joined by Aleksandrowicz, Ciepliński, Czabała, Jankowski, Józefik, Paluchowski, and was finally summarized once more by Rakowska [5, 6]. This series of publications thoroughly shows the topic of the current discussion during the time it had been in the making.

The constraints and limitations of RCT-type studies in the field of psychotherapy have been widely commented on in the world literature, which has created a field for new study paradigms to develop – such as practice-based evidence [7], a variant of effectiveness studies which assesses the effects of typical everyday therapeutic practice. Here, generalizations as to the efficacy of interferences in particular groups of patients are made on the basis of research received from many psychotherapy centres. Practice-based evidence is connected with the related term TAU (*Treatment As Usual*) which is used to describe a typical treatment procedure in a given clinical situation. Patients treated "as usual" usually constitute the typical control group in studies on particular interferences.

The remarks above lead us to the term of evidence-based practice (EBP, as an element of EBM, or evidence-based medicine), that is the postulate to use particular therapeutic methods in certain

clinical situations, when there has been scientific evidence of their effectiveness [3, 5, 8]. In the Polish psychotherapeutic literature we have an up-to-date summary of the topic with valuable, critical notes in the journal *Psychotherapia* by Szymon Chrząstowski [9].

Below, we present a short overview of the research showing the efficacy of family therapy in the realm of child and adolescent psychiatry. Both of us work with families, conduct research on the topic of family therapy, and we are both positive that it is very beneficial for patients. Describing all forms of psychotherapeutic interactions evidenced by scientific research far exceeds the aspirations of this text. To those interested in the topic, we recommend the book published in 2015, entitled *What works for whom?: A critical review of treatments for children and adolescents* by Peter Fonagy and associates, which consists of over 600 pages of detailed descriptions of the outcome of various forms of treating children and adolescents in particular clinical situations [8]. Just as interesting and an even more synthetic take on family therapy in the child and adolescent population is proposed by Alan Carr in his systematic overviews [10, 11]. In those concerning family therapy, from the years 2014 and 2016, one can read about the efficacy of [cf. 10, 11]: behavioural programmes in treating sleep disorders in children as well as early childhood eating disorders; many short-term and long-term family interventions in attachment disorders; CBFR (Cognitive-behavioural family therapy); MST (multisystemic therapy); parent-child interaction therapy in treating the aftermath of violence; behavioural training sessions for parents of children with behavioural issues; multimodal programmes for treating ADHD (pharmacotherapy + family therapy or parent training); short-term strategic family therapy, functional therapy, multi-systemic therapy, and MDFT (multi-dimensional family therapy) in treating behavioural disorders and in treating teenage users of psychoactive substances; family-based CBT in panic disorders; attachment-based family therapy (ABFT), child-focused CBT, and interpersonal therapy in depressive disorders; ABFT, MST, and dialectal behaviour therapy (DBT) joined with multi-family therapy when working with teenagers with suicidal risk; an amalgamate of family therapy with individual interventions during grief-counselling; psycho-educational family therapy of patients with CHAD and first episodes of psychosis; family therapy with self-harming teenagers, family therapy with the Maudsley Model in Eating Disorder Treatment; programmes with families with difficulties with uncontrolled diabetes – different, depending on the age of the child.

The views quoted above are more detailed, both when it comes to pointing to particular studies and explaining particular kinds of therapy. We have decided to leave the English names and abbreviations to emphasize the large number of models for the work. The majority of the approaches in the overview are manualized ones that due to being self-descriptive, their name and efficient marketing give the impression of being independent and autonomous schools or even paradigms. An experienced and constantly training family therapist whose professional identity is linked to the systemic school, and who in his practice – depending on the patient's issues, clinical picture, motivation to treatment or family dynamics – uses structural or strategic intervention, narrative work,

family mentalization, elements of psychoeducation or behavioural contracts would struggle to find systemic therapy in this overview, even though it is usually the basic theoretical frame.

While in the domain of research, another noteworthy issue is that of not taking into account the results of qualitative studies. Analysing the overviews of effective therapies and the study reviews that prove them, one could suppose that the right to define what efficacy is and what is effective belongs only to quantitative-based research. But what could be found if we looked outside this methodology? In his article from 2010 [12], Binder presented an inspiring review of research in this topic, supplemented by his own results. He mentioned the review published in 1996 by Connolly and Strupp, in which the authors summarized the available publications on this issue and outlined two main categories of changes/effects of psychotherapeutic processes that are crucial from the patients' point of view: the relief of their symptoms and the change of experiencing themselves. In 2006, Butler and Hill [cf. 12] have shown that instead of mentioning the relief of symptoms, patients more often pointed to more general changes (such as changes in interpersonal relations, a better attitude towards oneself and others) as an effect of therapy that they deemed important. In Binder's own research [12], an analysis of interview transcripts of 10 adult patients who had finished therapy (spanning 1-19 years – 6.3 years in average; finished 2-17 years prior – in average 9.7 years prior) pointed to four crucial areas that defined the "good outcome" of the therapy, namely: (1) establishing new ways of relating to others; (2) less symptomatic distress, or changes in behavioural patterns contributing to suffering; (3) better self-understanding and insight; (4) accepting and valuing oneself [12]. These results clearly show that the criterium of symptomatic improvement measured as the difference between test outcome before and after therapy is one that is quite constrained and does not take into account the longer timeframe in which the "good outcome" of the therapy might come to light gradually – what can sometimes take many years. Another study that points out the constraints of current solutions to the issue of the outcome of psychotherapy has been described in 2012 by Lunn, Poulsen and Daniel – a qualitative study of patients undergoing RCT-type efficacy study in treating bulimia [13]. Five patients undergoing psychoanalytic psychotherapy have been chosen to take part in the qualitative analysis. According to test results, they have been described as: (1) healed; (2) in remission, with improvement of symptoms and attachment patterns; (3) no improvement regarding symptoms, but some regarding attachment patterns; (4) no improvement, but with a positive experience of therapy; and (5) one person who had stopped the therapy with a negative experience of it. The results of this qualitative exploration have shown that the first four patients have largely benefited from the therapeutic process, although in the RCT study the results were only partly visible. The results of the qualitative data from the patient who had stopped their therapy clearly show the incompatibility of this form of intervention with the patient's expectations. To those intrigued we recommend Charlotte Burck's paper [14], which clearly describes the advantages of many qualitative methodologies (such as grounded theory, discourse analysis, and narrative analysis) to analyse the psychotherapeutic

process, the use of which could also facilitate the understanding of the term "good outcome" in psychotherapy.

The above descriptions of the studies pertained to the understanding of what constitutes a good outcome of psychotherapy and how it is currently understood in the world literature. Another element in the evaluation of the effectiveness of psychotherapy, which is practically unnoticed by the RCT methodology, is the issue of the therapist themselves and their features that influence the outcome of psychotherapy, basically regardless of the outlook they represent. In the literature, there is plenty to find on the topic of the effect of the therapist – we recommend the writing of Anderson [15] or Don-Min [16]. In October 2012, a Conference of 3 Sections on the topic of "The person of the therapist. Therapeutic relationship" took place in Kraków, during which a lot of attention was paid to the issue of the influence of the therapist as a person on the psychotherapeutic process.

Context of psychotherapeutic training organization

A superficial analysis of available guidelines pertaining for the preferred forms of psychotherapy in treating children and adolescents would probably point to a necessity of training and educating a large quantity of therapist with narrow specializations, whose therapeutic interventions would amount to a skilful copying of interventions that had a "research-proven efficacy," given appropriate patient selection. This seems to correspond to the vision of psychotherapy limited to technical abilities and of psychotherapists as "psychotherapy technicians."

Yet an extensive analysis of the available research data shows that the tendency of accepting the results of randomized RCT-type research as the only measure of therapy outcome in treating children and adolescents (as it seems to be the case in Poland) is a dangerous tendency indeed. Studies conducted according to this methodology do not reflect the full potential of psychotherapy. It should also be remembered that the current discussion concerns the treatment of children and adolescents, *i.e.* groups that will have the best opportunity to benefit from long-term outcomes of psychotherapy, while those are the ones that often elude the efficacy assessment procedures. The qualitative studies which we have described above show additional benefits, apart from the reduction of symptoms, that psychotherapy can have on the patients' further lives. Better functioning in future relationships, a better vision of self in their adult life – those are vital factors that should be taken into account in the assessment and cost-assessment of those medical procedures. Fonagy [8] notes that almost 50% of chronic mental disorders (with the exception of dementia) start before the age of 14, and 75% before the age of 20. Therefore, it seems that it should be a key issue to allot larger funds in the field of child and adolescent psychiatry, so as to make possible not only a short-term improvement of symptoms, but also an adequate treatment that would pay off in the future. The only question is whether this is the time and the place for a discussion on such a long-term solution, in a system in which there are not enough funds for emergency and life-saving procedures.

However, we claim that this discussion is much needed and crucial, as the outcomes and effects of the proposed solutions will be observed and felt for the years to come. The model of educating in narrow specialties (which is one of the options within the IQS) puts the emphasis on techniques and not on the development of the psychotherapist as an expert (as it has been in the current model). An expert who is able to adjust their work techniques depending on the needs; an expert who understands and is able to critically assess the results of tests and studies; an expert, who constantly improves and deepens self-understanding, thus perfecting their soft, interactive skills that influence the power of the therapeutic outcome. An expert with a wide knowledge of psychology, clinical psychology, psychiatry, neuroscience, social studies, as well as philosophy and culture to which psychotherapy belongs to. An expert who forms their practice in the span of many years and who is accompanied by their supervisor.

Coming back to the issue of training, the question arises: was the diagnosis of an insufficient amount of child and adolescent psychotherapists in the public healthcare system and, what follows, the need for more intensified training, an apt one? The moment the child and adolescent psychotherapy specialty was opened, the Postgraduate Medical Education Centre received motions from over 500 people to recognize their education as equivalent to the specialization, and many more started preparing such motions. This shows that many people have experience in child and adolescent psychotherapy practice. We think that an important source of the current downfall in child and adolescent psychiatry and psychotherapy lies mainly in the many years of insufficient funding allotted to this sphere of treatment, an insufficiently low cost-analysis of healthcare procedures and thus very low salaries for specialists in national institutions. This leads to yet another question: what is it that would convince the newly-educated psychotherapy specialist to remain in public institutions, when their work will still be so meagrely valued and when mental healthcare will remain underfunded? We think that the title of specialized child and adolescent psychotherapist would only make the new therapists more attractive on the free market – far away from the public healthcare system.

Final notes

The changes that are being introduced and planned significantly weaken the solutions and procedures that are currently functioning and that had been developed by the community of psychotherapists in scientific associations. It should not be forgotten that in 1989, the Polish Psychiatric Association introduced, and its Subdivision for Psychotherapy (since 1998 together with the Subdivision for Family Therapy) realized, the procedure for psychotherapist certification. In the following years:

- the general objectives and overall training framework were established (there are various courses preparing for obtaining psychotherapy certification which fulfil certain common criteria which are in accordance with the European Association for Psychotherapy);

- Criteria for the necessary requirements for training institutions were specified;
- The objectives for courses preparing for obtaining supervisor certification were formulated;
- Certification and examining rules (for the psychotherapy certificate and supervisor certificate) and requirements were specified (for example, to guarantee the academic level of education, the members of examining commissions are required to present academic achievements in the field of psychotherapy);

The result of the above is, at present[1]: the functioning of 21 attested training programmes, the accreditation of 29 training centres, over 890 certified psychotherapists, 163 supervisors, and several thousand people who have finished the general training and are currently preparing for their certification.

The described system of training is open for the creation of new programmes, new training and internship institutions; it is flexible, allows for new approaches and new study results. It is diverse, adapted to allow for the pace of learning and the different life conditions of the trainers and trainees. It is worth reminding that the procedures for such certifications are also conducted by other associations, such as the Polish Psychology Association or the Polish Association for Cognitive and Behavioural Therapy.

The upcoming changes lead us to the following questions: how will the new proposition take into account the strengths of the old system? Would it legally sanction the existing certified qualifications? As we have already noted, the current regulations pertaining to child and adolescent psychotherapy do not include the recognition of currently certified qualifications without taking the specialization exam. It is also unclear who would conduct such an exam, as the plans do not include a grandparenting procedure for those who for years have been active in the development of psychotherapy and conducting research within this field.

In the context of the reform of the entire structure of child and adolescent psychiatric care, an absolutely crucial issue is whether it will be properly financed. We think that it is hard to find – in the whole vast field of medicine – a better example of a long-term cost-effective intervention, from the socio-economical point of view, than the psychiatric and psychotherapeutic treatment of children and adolescents. The question remains, whether when pricing the value of the service of psychotherapy, the taxpayer and the system would take into account the benefits of a greater emotional stability and the connected greater ability to build strong and durable relationships, a greater respect for social norms, a greater tolerance of frustration and a stronger endurance in developmental tasks, including education and, what follows, starting work in the future or the better cooperation in the treatment of serious, chronic mental illnesses.

[1] As of November, 2019

Those questions should be adequately answered. As a community, we should be given a guaranteed time for discussing and sensibly verify the long-term consequences of the introduced changes.

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References

1. Maślankiewicz R, Bójko M. Psychiatria dzieci i młodzieży w Polsce – raport. Warszawa: Citizen Network Watchdog Polsnd 2019.
2. Seligman EP. The effectiveness of psychotherapy: The consumer reports study. Am. Psychol. 1995; 50(12): 965–974.
3. Roth A, Fonagy P. What works for whom?: A critical review of psychotherapy research. New York: Guilford Press, 2005.
4. Żechowski C. Próba randomizowana i kontrolowana w psychoterapii psychoanalitycznej – między eksperymentem a kliniką. W: Murawiec S, Żechowski C, ed. Od neurobiologii do psychoterapii. Warszawa: IPIN; 2009, p. 267–281.
5. Rakowska JM. Użyteczność kliniczna interwencji psychoterapeutycznych wspartych empirycznie. Roczniki Psychologiczne 2011; 14(1): 7–22.
6. Rakowska JM. Użyteczność kliniczna interwencji psychoterapeutycznych wspartych empirycznie — podsumowanie dyskusji. Roczniki Psychologiczne 2011; 14(1): 69–89.
7. Margison FR, Barkham M, Evans C, McGrath G, Clark JM, Audin K et al. Measurement and psychotherapy: Evidence-based practice and practice-based evidence. Br. J. Psychiat. 2000; 177(2): 123–130.
8. Fonagy P, Cottrell D, Phillips J, Bevington D, Glaser D. Allison E. What works for whom?: a critical review of treatments for children and adolescents. New York: Guilford Publications; 2015.
9. Chrząstowski S. Praktyka psychoterapeutyczna oparta na danych naukowych — za i przeciw. Psychoter. 2019; 189(2): 45–57.
10. Carr A. The evidence base for family therapy and systemic interventions for child-focused problems. J. Fam. Ther. 2014; 36(2): 107–157.
11. Carr A. Family therapy for adolescents: A Research-informed Perspective. Austr. New Zeal. J. Fam. Ther. 2016; 37(4): 467–479.
12. Binder PE, Holgersen H, *Høstmark Nielsen G*. What is a "good outcome" in psychotherapy? A qualitative exploration of former patients' point of view. Psychother.Res. 2010; 20(3): 285–294.
13. Lunn S, Poulsen S, Daniel SIF. A multiple case study of psychoanalytic therapies for clients with bulimia nervosa. Nord. Psychol. 2012; 64(2): 87–102.
14. Burck C. Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. J. Fam. Ther. 2005; 27(3): 237–262.
15. Anderson T, Ogles BM, Patterson CL, Lambert MJ, Vermeersch DA. Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. J. Clin. Psychol. 2009; 65(7): 755–768.
16. Don-Min K, Wampold BE, Bolt BM. Therapist effects in psychotherapy: A random-effects modeling of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. Psychother. Res. 2006; 16(2): 161–172.

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