PSYCHOTERAPIA 3 (186) 2018
pages: 39-53

Lech Kalita[1], Magdalena Chrzan-Dętkoś[2]

# INTERNSHIP PROGRAM AS AN EFFECTIVE AND ECONOMICAL APPROACH TO INCREASING THE AVAILABILITY OF PSYCHOTHERAPY

[1] private practice

[2] Institute of Psychology, University of Gdańsk

**psychotherapy effectiveness**
**internship**
**psychotherapy availability**

**Summary**

The prevalence of mental disturbances combined with the limited access to psychotherapeutic services points to a need of developing a web of psychological support. This article is an attempt to find a solution to this problem, which has not only social but also economic aspects: it describes the outline of a model of an internship program for psychotherapy trainees and provides an example of implementation of this model in public institutions. The project included 19 subjects (patients) who underwent 1 year of psychotherapy led by trainees (n=5) under weekly group supervision. The outcomes of psychotherapy were evaluated by questionnaires of mental health, measured 3 times during the course of treatment. Outcomes: 1 year of psychotherapy led to a significant improvement in mental well-being by 51%, lessening the risk of developing mental disorders. Conclusions: Trainees in evidence-based psychotherapies are able to provide effective psychotherapy, especially under supervision focused on common factors in psychotherapy, regardless of the modality. The provided example of the implementation of an internship model is a cost-effective, simple and effective variant of increasing access to psychotherapy.

## Prevalence of mental disturbances

Mental disturbances are one of the main civilizational health hazards in the modern world. According to WHO, one in four people will experience at least one form of mental disturbance throughout their life [1]. This diagnosis of public health is confirmed by a recent research conducted in six big European countries. *European Study of the Epidemiology of Mental Disorders,* which included Belgian, French, German, Dutch and Spanish populations (over 20,000 respondents) proved that 21.2% of subjects experience a mental illness, affective disorder, anxiety disorder or substance addictions at some point in their lives [2]. Mental disturbance is a problem of similar scale also in Poland. The epidemiological study of mental disturbance (EZOP), based on CIDI scores of over 10000 subjects proved that at least one mental disturbance defined in ICD-10 and DSM-IV will occur in 23.4% of the general population [3]. One in four subjects in this group will experience more than one disturbance, and one in twenty-five – three and more disturbances.

**The demand and access to psychotherapeutic services**

Psychological therapies are proven to be among effective methods of treating mental disorder. The general review of literature unanimously points that psychotherapy – both in isolated form and combined with pharmacological help – is more effective than placebo; psychotherapy is at least as effective as pharmacotherapy; and psychotherapy can increase health benefits from pharmacological therapies [4–7]. One of the crucial problems in both global and local perspective is the limited access to mental health services, including psychotherapy. According to WHO, 76 to 85% of the population in low and medium income countries and 35-50% of the population in high-income countries have no access to such services [1]. There is no systematic national research data on the availability of psychotherapeutic services in Poland, but in general conclusion from the above-mentioned EZOP study, the authors conclude: "In recent years, about 1.5 million patients have accessed mental health institutions. If this figure is compared to the predicted number of potential patients (6-7.5 million), we can observe a definite disproportion, that can be understood as a suggestion (…) that "the demand is largely not met" [3, p. 273]. Data gathered in EZOP suggest that health policy provides help for about 25% of potential patients, while Straathdee and Thornicroft [8] stress that help should reach about 80% patients suffering from serious mental illness and about 33-50% of patients suffering from depressive disorders, anxiety or addictions.

Increasing the access to psychotherapy is one of the main concerns both on a global scale and in Poland. WHO identifies "providing consistent, integrated and accessible mental health services in local communities" as one of the four basic aims in the mental health action plan for 2013-2020 [1]. The authors of the EZOP study also recommend: "Effective and cost-effective treatment requires a profound reorientation of the mental health care system. We must move decisively towards community services, which would provide not only highly specialized services but also services accessible via basic mental health institutions, social services, and non-governmental organizations; these would combine into a support network, promoting health and shielding patients from the destructive interaction of mental disturbance and its perception. Our research shows that such a model is better accepted by the public opinion than the 'hospital-centered' model, focused on large psychiatric hospitals" [3, p. 277]. The Polish Ombudsman's Report on Mental health protection in Poland gives similar recommendations: "The second aim, which is even more important, is to build a support network, which would include every possible public and private institution and local communities in a common action for mental health protection. If this element is neglected, the financial effort put into the high development of the specialized mental health care system will not be reflected in sufficient results. This means that we need to organize an interdisciplinary system of mental health care, spanning beyond the medical framework" [9, p. 15].

## Cost-effectiveness of psychotherapeutic services accessibility

Numerous research outcomes suggest that psychotherapy is a cost-effective method of treating mental disturbances [10–14]. Lazar [15] in her review article claims that psychotherapy is not only an effective but also a cost-effective service (though it is not "cheap"), as it leads to savings stemming from lowering additional medical services and social costs of mental disturbance. Such an indirect definition of low costs of psychotherapy, as formulated by Lazar, might be one of the reasons for the limited access to psychotherapeutic services and for difficulties in their popularization. Psychotherapy is a proven method of treating mental disorders but its cost is high in definite numbers, which means that increasing access to psychotherapy – more so in the social web paradigm, advocated by WHO, EZOP and the Polish Ombudsman – calls for the creation of new models which would be directly cost-effective.

## Effectiveness of therapies conducted by psychotherapists in training

Lazar [15] and Castelnouvo [14] stress the need to provide services of sufficiently high quality, based on methods with empirically proven effectiveness. Although there is a lack of universal, consistent global, European or even national regulations in the psychotherapy training [16], numerous countries have applied similar general rules of training [17]. According to guidelines of the European Federation of Psychologists' Associations [18], the training should span over at least 3 years, include theoretical lectures, clinical supervision and personal experience (personal therapy). Large national professional organizations (Polish Psychiatric Association, Polish Psychological Association) apply training requirements consistent with those guidelines. Thus, it can be suggested that trainees in psychotherapy in basic evidence-based approaches undergo training organized according to similar formal parameters.

There has been a limited number of research focused on the effectiveness of psychotherapies led by trainees. Atkins and Christensen [19] show in their review that trainees can lead effective psychotherapy, though qualified professionals achieve higher effectiveness in specific areas – their clients are less prone to drop-outs and enjoy higher well-being due to the therapy. Strosahl et al. [20] emphasize that trainees can achieve as good results as qualified professionals, though they need more sessions to do so.

Solem et al. [21] studied the effectiveness of therapies led by 10 trainees. The therapists have led an average of 17 hours of cognitive-behavioral therapy with two hours of group supervision and one hour of individual supervision each week. There were medium to large effect sizes regarding the reduction of depressive symptoms (BDI [*Beck's Depression Inventory*] = 0.76; ADIS-IV [*Anxiety*

*Disorder Interview Schedule*] = 2.90). In 62% of patients, there was a significant reduction of obsessive-compulsive symptomatology (OCI-R) [22].

Dennhag and Armelius [23] have conducted a research on 187 patients and 187 psychotherapy trainees. The therapists have led a single patient through 50 hours (two terms) or two patients through 25 hours each (one term). Therapies were led in psychodynamic (PT) and cognitive-behavioral (CBT) paradigms. Effectiveness was measured by SASB: AFF (Structural Analysis of Social Behaviour) and SCL-90 (mental health symptomatic questionnaire) and proved to show medium and large effect sizes. Clinically significant improvement of mental health in patients treated through one term occurred in 20-23% patients in CBT and 27-43% patients in PT, while in patients treated through two terms – in 49-54% patients in CBT and 35-41% patients in PT. Multidimensional variance analysis showed that therapeutic modality is not responsible for effectiveness, while 2% of effectiveness is related to the length of therapy (longer therapies were slightly more effective). Trainees met in weekly groups of 3 or 4 persons where they discussed their clinical work for an hour.

These results illustrate that trainees can provide effective psychotherapeutic services if they apply empirically approved therapeutic methods and benefit from regular supervision.

## Supervision of psychotherapy trainees

The issue of supervision in psychotherapy spans beyond the scope of this article and has been widely discussed [24–26]. Weck, Kaufmann and Witthoft [27] present a brief commentary on the practical picture of supervision in psychotherapy training. Their paper is focused on defining topics and processes in the supervision of 791 trainees in cognitive-behavioral and psychodynamic psychotherapy. Most commonly discussed topics were the therapists' interventions; therapeutic alliance; preventing drop-outs; and therapeutic aims. The most commonly applied method was case discussion. The authors point out that there were no significant differences in the process of clinical supervision between the modalities (CBT and PT).

This picture of supervisory practice seems consistent with the idea of common factors in psychotherapy, elaborated by Wampold [28]. According to Laska, Gurman and Wampold [29], the three main factors with effect sizes (*d*) of 0.5 and higher regarding the effectiveness of psychotherapy, are: agreement on therapy goals (11.5% variance); empathy (9%); and therapeutic alliance (7.5%).

## Internship model

In the light of the presented recommendations, research data and available clinical experiences, an internship model was created as a response to the demand of increasing the accessibility to psychotherapeutic services in local communities, based on the existing infrastructure and minimal financial and organizational input, while retaining high quality of service.

This internship model is based on the work of trainees leading once-weekly therapies for one year. Therapies are led in the modality in which the given trainee is gaining competence. Psychotherapy is a cost-free service for clients of public institutions which employ its existing infrastructure to recruit patients and provide consulting rooms and an hour of group supervision for trainees each week. The model is illustrated by an exemplary implementation in Specialized Institutions in Gdynia.

## An exemplary implementation of the internship model

The internship was conducted in Specialized Institutions from October 2016 to September 2017. Five trainees led 19 individual psychotherapeutic treatments. In total, the interns led 950 hours of psychotherapy and benefited from 45 hours of group supervision.

The internship program for training psychotherapists was constructed to achieve two goals in parallel: provide cost-free psychotherapeutic services for clients in the local community, and allow trainees to gain practical experience under the guidance of a supervisor. The clients of the Specialized Institutions often suffered from social and economic difficulties that rendered private psychotherapeutic services virtually impossible. The implementation of the internship program was a method of increasing the access to therapeutic services for clients of the Institutions, creating such a possibility for 20 people (one patient dropped out from therapy).

Interns were recruited from candidates who met specific requirements. The internship was offered to trainees of psychotherapeutic programs consistent with the Act of the Minister of Health (Act on mental services, 6.Nov.2013). Candidates needed to have completed at least 2 years of psychotherapeutic training. The internship agreement was signed for one year and obliged the interns to provide 4 hours of therapy weekly and to participate in 1 hour group supervision weekly.

The group of interns consisted of 5 women: S1, a therapist who had already completed training in psychoanalytic psychotherapy; S2, a therapist in training in Gestalt psychotherapy; S3, a therapist in training in psychodynamic psychotherapy; S4, a therapist in training in systemic psychotherapy; and S5, a therapist who had completed training in integrative psychotherapy.

The interns led psychotherapies with clients of the Specialized Institutions who required psychotherapeutic help but were not able to receive such services due to long waiting lists in public health care clinics. Referrals were made by consultants of the Specialized Institutions during their usual professional duties (e.g. psychologists in the crisis intervention center, psychologists in day-care institutions). Among the patients referred to the Specialized Institutions, most were admitted in the crisis intervention center and their psychological problems, in the opinion of consultants working with them, required longer and deeper work than a time-limited intervention. The patients of the

interns were mainly diagnosed with depressive disorders, the causes of which went beyond the current crisis.

The interns were responsible for the individual development of their professional workshop, which was part of their psychotherapeutic training. The internship program provided a several-hours inside training regarding institutional procedures and consistency of the therapy setting. A crucial feature of the internship program was the participation in regular supervisions, understood as a basic tool for developing practical psychotherapeutic competences. An on-going supervision was also helpful in monitoring the adherence to professional standards and ethics of the interns.

In the supervisor's work with the group of interns, four distinct phases of work could be clearly distinguished. Each phase was characterized by specific relational phenomena and pragmatic supervisory needs of the interns. The phases clearly corresponded to the general phases of the development of the group process, which develops according to the pattern: orientation → conflict → cooperation and cohesion → specific and constructive activity (see e.g. [30]).

During the first phase of supervisory work, the group was dominated by relational phenomena typical for newly formed groups: the participants co-created an atmosphere of suspicion and persecution. The first phase of the group's work was focused on the formulation, with the patient, a clear goal of the annual psychotherapy. We also focused on the technique of work – the interns asked about various specific arrangements related to the material conditions of the therapy and conducting initial consultations.

In the second phase of the supervisory group's work, relations based on suspicion and distrust were transformed into rival relations. In this phase of the work, the participants' competitive approach to each other meant that attempts to formulate hypotheses about the psychological functioning of patients required a parallel translation of these hypotheses into "several languages" of different theoretical background and then expressing them with one simple concept common to all participants. The supervisor supported the group in building a context to understand the problems of their patients and to develop more effective interventions corresponding to achieve the goals outlined in the first phase.

The third phase began around the middle of the internship. Thanks to the earlier mitigation of relational patterns of suspicion and distrust in the supervisory process, and then hostile rivalry, the group entered into a phase of cooperation, mutual appreciation of different proposals, technical and theoretical pluralism and a deep commitment to working for the benefit of patients. The supervisor focused on issues related to the therapeutic alliance and developing ways to use empathic understanding for addressing the basic problems of the patient (i.e. the goals of therapy). Most of the therapeutic processes conducted by interns developed positively, but the interns had a tendency to develop new issues in the work with their patients. They needed some support in the consistent,

systematic limitation of the scope of their annual work to the therapeutic goals negotiated at the beginning of their work.

In the last, fourth phase of the supervising group's work, experiences of gratitude and satisfaction prevailed, interspersed with sadness associated with the end of the cooperation and the failure to complete all possible therapeutic goals. The trainees undertook separative relational topics in their work with their patients and indicated that they were very much helped by the possibility of discussing their own separation issues during the supervision.

The interns worked with their patients in psychotherapy independently. Each intern engaged in the psychotherapeutic process with the knowledge and methods gained in their basic psychotherapy training and adhered to standards of therapy setting presented during the internal training. Each client could complete a time-limited, one-year psychotherapy with one session per week. The institution provided a consulting room for the interns and their patients. Each intern was particularly responsible for: conducting psychotherapy in a professional and ethical manner; adequately organizing their schedule (negotiating time of sessions with clients; resolving organizational problems); documenting the general process of therapy in form required by institution; detailed documenting of the therapy sessions, in a form required by the supervisor; regular supervision of their work with clients; evaluating the progress of their work with the provided tools.

The coordinator of the internship program was responsible for recruiting interns; preparing and conducting internal training regarding standards of work; client recruitment and referrals; providing contact with the supervisor; evaluating the internship program.

The supervisor was responsible for developing practical psychotherapeutic abilities of the interns and for ethical and professional standards of their services. Supervisory work was focused on common factors in psychotherapy, non-specific for any theoretical modality, i.e. on the consistency of the patient's and the therapist's goals; supporting empathy in the therapeutic relationship; and strengthening therapeutic alliance.

The psychotherapeutic processes led by interns were evaluated by questionnaires. Measurements were made at the beginning of therapy, in the middle phase and at the end of the annual work. The internship program was also evaluated regarding its efficiency in developing the interns' abilities: the trainees assessed how their regular work under supervision had helped them in raising their professional competences. At the end of the internship, the trainees had an opportunity to discuss their experience with the supervisor and to gain feedback on their psychotherapeutic work.

## Evaluation of the effectiveness of the internship program

The effectiveness of psychotherapies led by trainees was measured by the General Health Questionnaire GHQ-12, designed to measure the mental health of adults [30]. This questionnaire is

helpful in differentiating people, whose psychic well-being has undergone temporary or chronic breakdown due to emotional difficulties, problems, or psychic illness and in determining the risk of developing mental disorders. The GHQ-12 global measurement scale spans from 0 to 36 points.

The study was conducted on a group of 19 people (n = 19) benefiting from psychotherapy in the internship program. The group included 12 women and 7 men. Among the reported problems, chronic mood disorders prevailed, although it should be noted that psychiatric diagnoses were missing in the study population. Consultants directing to therapy as exclusion criteria accepted temporary crises on the one hand (here, crisis intervention was offered instead of psychotherapy), and on the other hand – psychiatric diseases (the treatment of which was considered to exceed the competence of trainees).

Clients treated by trainees were asked to answer to GHQ-12 three times: at the beginning of therapy, in its middle phase (i.e. after 6 months of treatment) and at the end of the psychotherapeutic process (i.e. after 12 months of treatment). Each intern conducted psychotherapy based on techniques assimilated in the course of their psychotherapeutic training (i.e. psychoanalytical, psychodynamic, systemic, integrative and Gestalt techniques.) A common element in the working technique were the supervisor's guidelines on concentration on therapeutic alliance and developing ways of using empathic understanding for addressing the basic problems of the patients.

Average scores in the first measurement were 20.2 points, in the second measurement – 14.6, and in the third measurement – 10.4 points.

According to Polish population norms, 20.2 points is a high score (9$^{th}$ sten); 14.6 is also a high score, though it is significantly lower (7$^{th}$ sten), while 10.4 is a medium score (6$^{th}$ sten).

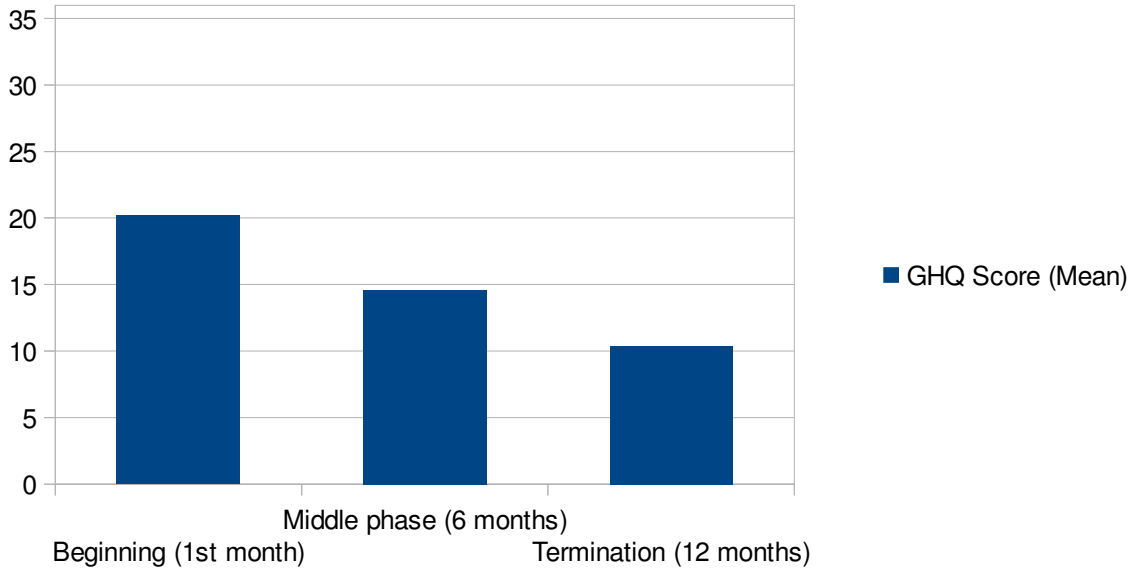


Figure 1: **Average GHQ-12 results. Comparison at the beginning, in the middle, and at the end of therapy.**

## Statistical analysis

The number of subjects (n=19) allowed to obtain statistical significance of the change in psychic well-being by Student's t-test for dependent samples. Comparison was made between mean GHQ scores form the 1st and 3rd measurement (at the beginning and at termination of psychotherapy), between the 1st and 2nd measurement (at the beginning and in the middle phase, after 6 months), and between the 2nd and 3rd measurement (in the middle phase and at termination, after 12 months).

Table 1. **Results of paired samples t-test of 1st measurement vs 3rd measurement:**

| Group | N | Mean | CI 95% | Standard deviation | Min | Max |
|---|---|---|---|---|---|---|
| 1st measurement | 19 | 20.158 | 16.163–24.152 | 8.884 | 4.0 | 36.0 |
| 2nd measurement | 19 | 10.421 | 7.894–12.948 | 5.621 | 1.0 | 22.0 |

p-value: <0.001 (2.493e-4);

t statistic: 4.548;

Degrees of freedom (df): 18

The analysis proved that mean scores differ significantly between the 1st and 3rd measurement (at the beginning vs at termination of treatment) with a confidence level higher than 99% ($p<0.001$).

Table 2. **Results of paired samples t-test of 1st measurement vs 2nd measurement:**

| Group | N | Mean | CI 95% | Standard deviation | Min | Max |
|---|---|---|---|---|---|---|
| 1st measurement | 19 | 20.158 | 16.163–24.152 | 8.884 | 4.0 | 36.0 |
| 2nd measurement | 19 | 14.579 | 11.488–17.670 | 6.874 | 5.0 | 26.0 |

p-value: 0.009757;

t statistic: 2.89;

Degrees of freedom (df): 18

Table 3. **Results of paired samples t-test of 2nd measurement vs 3rd measurement:**

| Group | N | Mean | CI 95% | Standard deviation | Min | Max |
|---|---|---|---|---|---|---|
| 2nd measurement | 19 | 14.579 | 11.488–17.670 | 6.874 | 5.0 | 26.0 |
| 3rd measurement | 19 | 10.421 | 7.894–12.948 | 5.621 | 1.0 | 22.0 |

p-value: 0.002852;

t statistic: 3.451;

Degrees of freedom (df): 18

The analysis proved that the means between the 1st and 2nd measurement (beginning vs middle phase; p=0.009) and between the 2nd and 3rd measurement (middle phase vs termination; p=0.003) are significantly different with a confidence level higher than 99%.

The conducted statistical analyses have shown that:

1) In the course of the conducted psychotherapy, the mental state of clients improved by an average of 51% (9.8 points).
2) Effects are statistically significant with confidence level over 99%.
3) This improvement has led to lessening the risk of mental disturbance from high to medium according to population norms.

We would like to stress that due to the number of participants and the use of one short questionnaire, the study is of a pilot nature and requires repetition in subsequent editions of the internship and extension of the palette of psychometric methods used.

**Effectiveness regarding professional development of interns**

The very small group of interns (n=5) allows only for descriptive statistics regarding the effectiveness of professional development.

In response to the question: *In what degree did the internship fulfill your expectations?,* the interns on average scored 6.8, where 1=did not fulfill expectations at all; 7=totally fulfilled all expectations.

In response to the question: *Did the experience and knowledge gained in the internship increase your professional competence and ability?,* the interns on average scored 7, where 1=did not increase competence and ability at all; 7=highly increased competence and ability.

In response to the question: *Did the internship increase your theoretical knowledge about psychotherapy?, the* interns on average scored 5.8, where 1=did not increase theoretical knowledge at all; 7=highly increased theoretical knowledge.

In response to the question: *Did the internship increase your practical experience in conducting psychotherapy?,* the interns on average scored 7, where 1=did not increase practical experience at all; 7=highly increased practical experience.

In response to *Please rate the organizational aspect of the internship,* the interns on average scored 6, where 1=very bad; 7=very good.

In response to *Please rate communication skills of the supervisor,* the interns on average scored 7, where 1=not communicative at all; 7=very communicative.

In response to the question: *Would you recommend this internship to other psychotherapy trainees?,* the interns on average scored 7, where 1=definitely no; 7=definitely yes.

In response to the question: *What was your most important experience in the internship – please choose 2 most important aspects,* item "regular supervision" was chosen 4 times, item "being the part of a group and cooperating with other interns" was chosen 4 times, and items "being able to conduct psychotherapy in a public institution" and "being able to observe how others conduct psychotherapy" were chosen once.

In response to the open-ended question: *What changes would you include in next editions of this kind of internship programs?,* one answer concerned less demanding hours of group supervision (it was offered at early morning) and one answer concerned the need to address theoretical issues by supervisor more often.

The final supervisory session and the discussion concerning the summary of the internship allowed to gather qualitative data concerning experiences from the annual cooperation. In the discussion about the most important changes in clinical work, as a result of the annual supervisory work, S1 noted that she had begun to use theory in a less intellectual way and that she had simplified the language she used with her patients; S2 stated that she had begun to pay more attention to giving her patients responsibility for their own treatment; S3 emphasized that she had learned to work in a more systematic way and with greater restraint in using her emotions in therapeutic work; S4 indicated that she had improved her skills in finding a balance between providing support and work for insight; and S5 recognized that she had become more proficient in determining the appropriate distance in working with patients, allowing her to be close to their experiences while keeping the professional distance.

## Cost-effectiveness of the internship program

ZPS is an institution implementing its activities mainly from municipal funds. Psychotherapy for members of the local community is a free service, not related to health insurance. Every person in need of help, including uninsured persons, can report to the Crisis Intervention Center, a bustling part of the ZPS. Until the internship program was launched, ZPS offered its clients therapeutic services only as part of a limited pool of therapy places in external offices: thanks to the public funds obtained, the ZPS signed contracts with private psychotherapists providing psychotherapy in the form of a single session per week. For the client, this help was also free of charge but the institution paid psychotherapists working in private practices a standard market rate per hour for their work with the clients.

The internship program was conducted on the basis of an existing institutional infrastructure. The institution provided a consulting room for the interns (the trainees shared a single room – each intern worked on a different weekday) and organizational back-office regarding patients recruitment and everyday administration chores. The only cost of the internship program was the supervisor's fee.

On the basis of common free-market fees, it may be assumed that if the cost of one hour psychotherapy is Y, the cost of one hour of supervision is 1.1 Y. Thus, the following formula might be used to calculate the cost-effectiveness of the internship program:

Hours of psychotherapy led by the interns = 950.

Hours of paid supervision for interns = 45.

Cost of supervision for interns = 49.5 Y (45 x 1.1 Y).

Cost of enabling a client's access to 1 hour of psychotherapy = 0.05 Y (49.5 Y / 950).

The above simple formula proves that the internship allowed the institution to offer effective psychotherapeutic services for its clients for only 5% of standard fees of qualified psychotherapists.

## Discussion concerning cost-free psychotherapy

One of the most controversial elements of the internship program is the idea of the voluntary work of the psychotherapists. It is obvious that financial compensation is the basic gain for the performed work. In a work requiring not only a temporary commitment and intellectual effort but also intensive emotional involvement, the issue of remuneration is obvious. What is more, remuneration for psychotherapeutic work is one of the basic barriers protecting from potential abuse: situations in which the therapist could expect non-financial gratuities from the patient, compensating for the unequal participation in the relationship (e.g. praise, expressing appreciation, submission to the therapist's comments, building private relationships and so on). For these reasons, financial remuneration can be treated not only as a basic benefit included in the employment relationship, but it is also one of the foundations of an ethical and safe therapeutic relationship.

However, the labor market in many industries uses the phenomenon of free work in exchange for non-financial gratuities, mainly related to the acquisition of experience, building contacts or the possibility of gaining access to a specific professional environment. From a formal point of view, the described program was a form of volunteer work. The interns were contracted for voluntary work. The name "internship" was introduced for two reasons: first, the authors of the program wanted to emphasize the periodic time – a limited formula of cooperation, covering only one year, without the possibility of extension. Secondly, naming the cooperation an internship is a response to the requirement of the majority of psychotherapy schools, demanding a "clinical internship", what in practice means the requirement of direct, independent psychotherapeutic work with patients.

The financial issues were discussed with the interns at the recruitment stage. People who applied for internships were aware from the very beginning that they would not be paid for their work. Among the motivations reported by all candidates was a strong motivation to gain clinical experience – which all the potential interns recognized as a value compensating their effort. From the perspective of the creators of the program, the attitude of interns who wanted to gain and increase their practical

competences in the institutional work under supervision before entering the labor market independently (i.e. opening private offices) seems responsible and ethical.

Summarizing the program, the interns were satisfied with the effort undertaken, they pointed to the benefits from the internship program (cited above). They also reported readiness to work independently with patients, obtaining standard remuneration for their work.

The above-mentioned experiences seem to suggest the possibility that non-financial cooperation that can be satisfactory for both the institution and the training therapists. We believe that in the described model, the factors that protect the interests of therapists can be easily pointed out:1) time-limited internship, securing the interns from becoming entangled into longer work without remuneration; 2) taking into account the motivation of interns already during the recruitment process; 3) the idea of volunteer work described as "internship" what means a transitional stage in a professional life leading a therapist to independent work.

We warn against the creation of institutional solutions based on a longer or undefined time of cooperation based on the voluntary work of psychotherapists. We believe that voluntary work in the emotionally demanding profession of psychotherapy makes sense only as a short episode in the way to independent work under financially satisfactory conditions.

## Recapitulation

This article illustrates an exemplary implementation of the internship program for psychotherapy trainees. The suggested model might be one of the solutions to global and local recommendations regarding broadening access to mental health services. This proposition was formulated on the foundation of empirical data from research on psychotherapy effectiveness. The cited studies have shown that trainees of evidence-based psychotherapies working under supervision are able to provide effective psychotherapies. The evidence for common factors in psychotherapy allows for offering internship programs which are not grounded in particular therapeutic modalities and to utilize work of trainees from differing therapeutic modalities in a single internship program. This exemplary implementation proved to be effective regarding the therapeutic effect (a significant change was achieved regarding psychic health and risk of developing mental disorders), professional development of interns (though the small number of interns and the lack of standardized measurement method makes these results only provisional), and cost-effectiveness (the internship program allowed for 95% savings in comparison with standard fees of qualified psychotherapists). The small number of both interns and subjects makes these results preliminary, thus the research is being continued – the internship program has been launched for next editions.

**References**

1. World Health Organization. World Health Report 2001. Mental Health: New Understanding, New Hope; 2001.
2. Alonso J, Angermeyer MC, Bernert S, Bruffaerts R, Brugha TS, Bryson H, et al. Prevalence of mental disorders in Europe: Results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. Acta Psychiatrica Scandinavica, 2004. Supplementum 109(420):21-27.
3. Moskalewicz J, Kiejna A, Wojtyniak B. red. Epidemiologia zaburzeń psychiatrycznych i dostęp do psychiatrycznej opieki zdrowotnej – EZOP Polska. Warszawa: Instytut Psychiatrii i Neurologii; 2012
4. Smith M, Glass G, Miller, T. The benefits of psychotherapy. Baltimore: John Hopkins University Press; 1980.
5. Lipsey M, Wilson D. The efficacy of psychological, educational, and behavioral treatment. Confirmation from meta-analysis. Am. Psychol. 1993; 48(12): 1181–1209.
6. Norcross J, Wampold, B. Evidence-based therapy relationships: research conclusions and clinical practices. Psychother. (Chic). 2011; 48(1): 98–102.
7. Huhn M, Tardy M, Spineli L, Kissling W, Forstl, H, Pitschel-Walz, G et al. Efficacy of pharmacotherapy and psychotherapy for adult psychiatric disorders: a systematic overview of meta-analyses. JAMA Psychiatry, 2014; 71 (6): 706–715.
8. Strathdee G, Thornicroft G. Community psychiatry and service evaluation. In: Murray R, Hill P, McGuffin P, ed. The Essentials of Postgraduate Psychiatry, 3rd Edition. Cambridge: Cambridge University Press; 1997.
9. Szafrański T. Ochrona zdrowia psychicznego we współczesnym świecie. In: Wciórka J. ed. Ochrona zdrowia psychicznego w Polsce: wyzwania, plany, bariery, dobre praktyki. Rzecznik Praw Obywatelskich, Warszawa; 2014.
10. Emmelkamp PM, David D, Beckers T, Muris P, Cuijpers P, Lutz W. et al. Advancing psychotherapy and evidence-based psychological interventions. Int. J. Methods Psychiatr. Res. 2014; 23(Suppl. 1):58–91.
11. Clark D, Layard R. Why more psychological therapy would cost nothing. Front. Psychol. 2015; 6:1713.
12. Hunsley J. The Cost-Effectiveness of Psychological Interventions. Ottawa, ON: Canadian Psychological Association; 2002.
13. Mukuria C, Brazier J, Barkham M, Connell J, Hardy G, Hutten R et al. Cost-effectiveness of an improving access to psychological therapies service. Br. J. Psychiatry, 2013; 202, 220–227.
14. Castelnuovo G. Not Only Clinical Efficacy in Psychological Treatments: Clinical Psychology Must Promote Cost-Benefit, Cost-Effectiveness, and Cost-Utility Analysis. Front Psychol. 2016; 7: 563.
15. Lazar SG. The cost-effectiveness of psychotherapy for the major psychiatric diagnoses. Psychodyn. Psychiatry 2014; 42, 423–457.
16. Fiorillo A. Training and practice of psychotherapy in Europe: results of a survey. World Psychiatry, 2011; 10(3): 238.

17. van Deurzen E. Psychotherapy training in Europe: similarities and differences. Europ. J. Psychother Couns 2001; 4 (3): 357-371.
18. EFPA. Training Standards for Psychologists specializing in Psychotherapy; Brussels, ed. EFPA 2017.
19. Atkins DC, Christensen A. Is professional training worth the bother? A review of the impact of psychotherapy training on client outcome. Austral. Psychol., 2001; 36, 122-130.
20. Strosahl KD, Hayes SC, Bergan J, Romano P. Assessing the field effectiveness of acceptance and commitment therapy: An example of the manipulated training research method. Beh. Ther. 1998; 29:35-
21. Sholem S, Hansen B, Vogel PA, Kennair LEO. The efficacy of teaching psychology students exposure and response prevention for obsessive-compulsive disorder. Scand. J. Psychol. 2009; 50, 245–250.
22. Foa EB, Huppert JD, Leiberg S, Langner R, Kichic R, Hajcak G et al. The Obsessive-Compulsive Inventory: Development and validation of a short version diagnostic tool for screening patients with OCD, utilizing empirically derived cutscores. Psychol. Assess. 2002; 14, 485–496.
23. Dennhag I, Armelius BÅ. Baseline Training in Cognitive and Psychodynamic Psychotherapy during a Psychologist Training Program. Exploring Client Outcomes in Therapies of One or Two Semesters. Psychother. Res. 2012; 22:515-526.
24. Kilminster S, Jolly B. Effective supervision in clinical practice settings: a literature review. Med. Educ. 2000; 34(10):781–881.
25. Schlessinger N. Supervision of Psychotherapy. A Critical Review of the Literature, Arch Gen Psychiatry, 1966;15(2):129-134.
26. Milne D. How Does Clinical Supervision Work? Using a "Best Evidence Synthesis" Approach to Construct a Basic Model of Supervision. Clin. Supervisor, 2008; 27:2.
27. Weck F. Topics and techniques in clinical supervision in psychotherapy training. Cogn. Beh. Therapist, 2017, 10, e3.
28. Wampold B. How important are the common factors in psychotherapy? An update. World Psychiatry, 2015; 14(3): 270–277.
29. Laska KM, Gurman AS, Wampold BE. Expanding the lens of evidence-based practice in psychotherapy: a common factors perspective. Psychother. 2014;51:467–81.
30. Jedliński K. Trening interpersonalny. Warszawa: Wydawnictwo W.A.B., 2008.
31. Goldberg D, Williams P, Makowska Z, Merecz D. Ocena zdrowia psychicznego na podstawie badań kwestionariuszami Davida Goldberga. Podręcznik dla użytkowników kwestionariuszy GHQ-12 i GHQ-28. Łódź: Oficyna wydawnicza instytutu medycyny pracy; 2001.

E-mail address: l.kalita@psyche.med.pl