

# Eastern Europe

Daniel David and Simona Stefan

## Introduction

Clinical psychology, defined as the field in psychology “integrating science, theory and practice to understand, predict, and alleviate maladjustment, disability, and discomfort, as well as to promote human adaptation, adjustment, and personal development” (Division of Clinical Psychology, [Division 12] of the American Association of Psychologists [APA], 2010) has been an important preoccupation for psychologists in Eastern Europe but the profession of clinical psychologist is a relatively new endeavor. What clinical psychologists do, how they are trained, how the profession is formally licensed, what people think of it, and how it came to develop to the point it is today varies among Eastern European countries, and it is beyond the scope of this chapter to describe each case in detail. Still, despite these differences, the image of clinical psychology appears in many ways different from the western world. Inspired in the beginning both by the Pavlovian experimental tradition in the USSR and by the German experimental work starting from Wilhelm Wundt, Eastern European psychology (as all mental health professions) was eventually largely influenced by communist ideology, and now faces somewhat similar challenges related to unclear profession boundaries and licensing standards, operating in societies with generally fewer resources (i.e., as compared to Western Europe and the United States), where people and the medical system still associate mental health mostly with psychiatry. Therefore, in this chapter, we will try to outline (1) a brief history on clinical psychology in Eastern Europe, (2) work settings in clinical psychology, and (3) the current training system and licensing.

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D. David • S. Stefan (✉)

Department of Clinical Psychology and Psychotherapy/International Institute for the Advanced Study of Psychotherapy and Applied Mental Health, Babeş-Bolyai University, No 37 Republicii Street, 400015 Cluj-Napoca, Romania  
e-mail: [daniel.david@ubbcluj.ro](mailto:daniel.david@ubbcluj.ro); [simonastefan@psychology.ro](mailto:simonastefan@psychology.ro)

## A Short History

The beginnings of scientific psychology in Eastern Europe can be traced back to the end of the nineteenth century—beginning of the twentieth century, when former disciples and collaborators of Wilhelm Wundt introduced experimental psychology and founded the first laboratories, like in Romania (David, Moore, & Domuta, 2002; Iliescu, Ispas, & Ilie, 2007), Hungary (Laszlo & Pleh, 1992), or Bulgaria. Poland also began the study of psychology in an experimental tradition, with the first laboratory of experimental psychology founded by Władysław Heinrich in 1903, with two more laboratories following shortly (in 1907 and 1915) (Brzezinski & Strelau, 2005). Therefore, in many Eastern European countries, psychology started in a scientific, experimental background, psychologists here contributing to the international literature and maintaining close ties to the West. In the clinical field (although clinical psychology was not established as a field at international level either), some countries in Eastern Europe began a strong psychoanalytic tradition (including imperial Russia), in some cases continuing to this day (e.g., Hungary; Laszlo & Pleh, 1992).

In Russia, before the communist revolution, inspired by the works of the famous physiologists Sechenov and Pavlov and by the experimental tradition already starting in the West, Russian psychologists (e.g., Bekhterev) initiated laboratories and research institutes rivaling those in western countries, in terms of available technology and knowledge (Grigorenko, Ruzgis, & Sternberg, 1997). However, after the communist revolution, Russian psychology followed a different path. Starting the 1920s, soviet psychologists (Vygotsky, Luria and Leont'ev being the most prominent scholars) enthusiastically outlined new research directions, inspired by the soviet philosophy of creating “the new man”; adopting some ideas from western psychologists, they also criticized their approach and envisioned a new psychology, both materialistic (experimental) and complex, considering cultural variations to a wider extent compared to western psychology (Hyman, 2012). In a seminal book, called *the Historical Meaning of the Crisis in Psychology* (1927; Janoušek & Sirotkina, 2003), the famous psychologist Lev Vygostky criticized the fragmentation in the field and the lack of communication between the different schools of thought (i.e., psychoanalysis, reflexology and behaviorism, Gestalt, personalism), stating that psychology gets further and further away from a unifying perspective, thus struggling with an important crisis. In his view, the Soviet psychology school (i.e., cultural-historical psychology) would be a viable alternative by offering a general, unifying perspective on mental life, guided by the principles of Marxist philosophy.

Prominent soviet psychologists, like Vygostky and Luria were erudite in their knowledge of psychological literature (including western literature), they were in contact with western researchers, and they left valuable works, known today in western psychology as well (e.g., Vygostky's concept of proximal development zone). Unfortunately, cultural-historical psychology did not succeed in becoming the unifying force it had been envisioned, for various reasons.

For instance, although Vygostky stated that this new psychology should be developed in deep connection with practice, this did not happen, as theory and practice grew further apart starting the 1930s, when political control became much more repressive in the USSR. Also, Soviet psychology did not consistently try to synthesize/unify previous psychological knowledge from the other schools, but formulated its own principles and remained relatively isolated from western psychology (Mironenko, 2013). In this sense, Vygostky himself had been accused of “bourgeois leanings” for citing western authors (Grigorenko et al., 1997), which would surely discourage scientific interest in western works, and later, in the 1950s, Pavlov’s approach was officially proclaimed as the only scientific approach in psychology (Avtonomova, 1996). After the 1950s, however, psychologists previously accused of sympathizing with the West were rehabilitated and the political control over psychological science diminished.

Traditionally, since the 1930s, the Russian school followed a theory-driven style of work, proposing elaborate concepts and classifications, and relying much less on experimental work. However, this may also be a reasonable consequence of the consistent lack of funding for psychological research (Ritsher, 1997). Following the years after the Second World War, the Russian school of thought in psychology was gradually largely enforced (and embraced) in the other east-bloc countries as well. One notable exception seems to be Poland, where, following a rather short period of repression in the 1950s, psychology developed relatively free from communist ideology, remained an established profession, and, in the field of psychotherapy, more treatment modalities were embraced (Aleksandrowicz, 2009).

During the communist period (Second World War—1989/1990), in Eastern Europe, many ideas of western psychology were discredited since focusing on the individual’s mental processes and not concentrating on social forces was considered dangerous in societies formed on new collectivist principles (Winstead, 1984). Psychologists in the east started following the Russian model, in terms of philosophical roots and research topics and practice. Therefore, psychology was mostly theory-driven, and experimental endeavors focused mostly on work psychology and educational psychology (e.g., dealing with children with cognitive or sensory disabilities). Clinical psychology and psychotherapy were clearly underrepresented since there were virtually no teaching and licensing programs, communist societies considering they were not needed, as psychiatrists were the only ones dealing with mental health issues. For instance, the soviets claimed that common mental health problems (e.g., depression, anxiety) had been caused by social inequities, and that, once these were eliminated by an equalitarian and prosperous society (like the USSR supposedly was), such mental health issues should no longer occur. Other psychiatric disorders, more severe ones, like schizophrenia, were believed to have biological causes, and were therefore treated by psychiatrists according to a biomedical model (Yakushko, 2005). In this context, psychologists working in mental health settings usually acted as psychiatric assistants, doing mostly testing. Also, this broader vision, that severe psychiatric disorders need medical psychiatric treatment while “neurotic disorders” need only guidance and council (i.e., delivered for instance, by family doctors, in primary care) is still largely spread in Eastern Europe

(Milosz, Winstead, 1984), contributing to the stigma associated with seeking psychiatric/psychological help.

With reference to mental health systems, it is worth mentioning that in the USSR, and not so much in other communist countries, until the 1980s, psychiatric diagnoses and treatment methods were often used to deal with political dissidents. In this sense, president Khrushchev explicitly stated in a speech in 1959 that anticommunist dissidence was inherently a product of mental illness (Tomov, van Voren, Keukens, & Puras, 2007). In those days, such individuals could have been easily diagnosed with what was called “sluggish schizophrenia”, a diagnosis category introduced by Professor Snezhnevsky, the Director of Psychiatry at the Soviet Academy of Medical Sciences (Targum, Chaban, & Mykhnyak, 2013). In his view, this category was characterized by a “negative axis”, including conflict with authorities, poor social adaptation, and pessimism, with no compulsory presentation of psychotic features (Targum et al., 2013). Thus, it can be easily seen how political dissidents could easily fit this diagnosis pattern. Following this diagnosis, suspected political dissidents were sent to special hospitals (maximum security forensic hospitals) and/or regular psychiatric hospitals, and were often subjected to physical, pharmacological, and psychological abuse before being released back into society (Ougrin, Gluzman, & Dratcu, 2006; Petrea & Haggenburg, 2014). Even after being discharged, former patients (either mentally ill or hospitalized on political grounds) could not pursue a normal life since a diagnosis of schizophrenia excluded them from almost all skilled and professional work (Petrea & Haggenburg, 2014). In this sense, it is estimated that about a third of political prisoners in the USSR were institutionalized in psychiatric hospitals (van Voren, 2010). Unfortunately, except the works written by soviet psychiatrists, the sources of information were very limited, and eastern psychiatrists had a rather thin knowledge of western progresses (Targum et al., 2013). Even so, it is not that this policy of treating political dissidents as mentally ill has remained unchallenged, since few, if any Russian psychiatrists actually believed this was the case. The reason why this approach became established lies with the fact that psychiatrists who opposed it frequently lost their jobs and some were even deported to Siberia (Tomov et al., 2007). Surely, this approach to mental health has changed rapidly after the change in the political regime.

Typical for Eastern European countries is the approach of mental health problems almost exclusively in secondary care (i.e., not in primary care, and not in community centers), most countries now in a long process of transition towards a primary and community-based care model (e.g., Bosnia and Herzegovina; Sinanovic et al., 2009; the Republic of Moldova; Zinkler, Boderscova, & Chihai, 2009). Partly, this seems to be a consequence of the long-term stigmatization of mental illness by politics, the media, and even by mental health professionals and the general public. Stigma associated with mental illness is a problem everywhere; however, in former communist countries even more so, since the main purpose of healthcare for disabled individuals (both mentally and physically) was for a long time the protection of “regular” individuals. Therefore, care was not so much focused on integrating suffering individuals in society, but they were rather institutionalized and isolated from the rest (Tomov et al., 2007). This approach was rather common in the eastern

bloc, and its legacy remains to this day. Even now, among the countries of the European Union, former communist countries (especially Romania and Bulgaria) have lower indexes of social integration for people with serious mental illness. However, interestingly, the index is low also in countries which were not part of the communist bloc (Greece, Portugal) (Mental Health and Integration; A report from the Economist Intelligence Unit, 2014).

Concerning costs, mental health care has been and still is free for most people, based on national insurance systems, whereas clinical psychology and psychotherapy services are usually not covered, because, typically, they are not considered part of the medical field. This comes as a consequence of the fact that the health field has been considered to be almost exclusively related to medicine (thus *healthcare* and *medical care* are synonymous in Eastern Europe), and very little to psychology. However, in this respect, eastern European countries are highly heterogeneous, depending on their own scientific tradition, and also on their diverse economic and political situations.

In some instances, apart from being rephrased in terms of ideological purposes, psychology was even forbidden from being studied in universities, although this was not the case in most communist countries. For example, in Romania, psychology as an independent scientific academic discipline was forbidden starting 1977 since the communists considered it was their task (and competence) to help form “the new man”, thus leaving no “role” for psychologists. Later, in 1982, a group of psychologists and physicians invited western colleagues to organize training programs on transcendental meditation, a practice considered subversive by the communist regime (David et al., 2002). Then, by an order of the communist president Ceausescu, psychology was also forbidden as a scientific field. As an aftermath, some of the psychologists involved in this movement were imprisoned or forced to work in factories, while those who were not part of it were transferred to other departments, like Educational Sciences and Philosophy (David et al., 2002). Another example is Poland, where the psychology profession was eliminated and psychological testing forbidden between 1950 and 1956, in practice psychologists performing the attribution of psychiatric assistants, something similar to a lab technician or social worker (Cierpialkowska & Sęk, 2016). After these years of crisis (politically, corresponding to the affirmation of Polish independence in reference to the USSR), however, psychology in Poland reasserted itself as a scientific discipline and valuable practice that was applied to the clinical field as well. Clinical psychology conferences were organized starting the 1950s, and, after the 1960s, departments and units of clinical psychology were organized in universities (see Cierpialkowska & Sęk, 2016).

## Work Settings in Clinical Psychology

After the fall of the Iron Curtain in 1989/1990, a challenging time of transition towards democratic values began for the former communist countries in Eastern Europe, and to some extent continuing to this day, with large differences among

countries. This transition has been particularly difficult because the acute societal needs for modernization met with increasing economic difficulties in most sectors, health, and particularly mental health, included.

As previously mentioned, during communist times, mental health care was addressed almost exclusively in secondary, specialized care, either in hospitals or ambulatory units (policlinics, dispensaries), while neurodevelopmental issues (e.g., mental disability) were also addressed in special education institutions. The stigma associated with mental illness was high, as communist societies emphasized, albeit with some differences between countries, that individuals not well adapted in society due to disability were neither needed nor wanted. Milder emotional problems, like depression and anxiety, were not usually reported to mental health care professionals, and were considered part of normal suffering in life, which, in many Eastern cultures, needs to be kept private (Winstead, 1984). This view persists to this day in Eastern Europe, although things have started to change for a while, especially in urbanized, more economically-developed regions. Interestingly, the stigma remains high even among those who do seek psychological help. For instance, it is not uncommon for people to anxiously ask their psychologist whether they are “truly” mentally ill, considering that psychiatric conditions are inherently a form of madness, associated with continuous decay and a complete loss of control.

With reference to the accessibility of treatment for mental health issues, the situation in Eastern Europe is worse than in the west, most patients in need not receiving adequate treatments. For example, prevalence of depression and suicide rates have increased dramatically in the 1990s and alcohol related diseases are more prevalent than in the West (e.g., Russia, Ukraine, Romania, etc., Jenkins et al., 2015; Petrea, 2012). For instance, in Russia, as a consequence of instability and the high rates of alcohol dependency, suicide rates have increased, along with the number of socially disadvantaged families and social orphans (Kholmogorova, Garanian, & Krasnov, 2013). Currently, many countries in Eastern Europe are implementing reforms in the mental health-care system, with a focus on establishing primary-care services to take over “milder” psychological disorders, so far addressed in the overcrowded secondary care system (e.g., the Russian Federation, former Yugoslavian countries, the Republic of Moldova, the Ukraine, etc.). As this appears as a more constant direction followed through consistent health policy reforms, the inclusion of clinical psychology services in the field of mental health varies widely from one country to another, remaining, to our knowledge, somewhat ambiguous in most cases.

Most clinical psychologists in Eastern European countries work in hospitals, counselling patients with somatic medical conditions, psychiatric hospitals, assisting psychiatrists in diagnosis and treatment management (e.g., psychological testing), child protection services (e.g., assessment and intervention with abused children, assessment of parents and foster parents) or forensic settings (e.g., assessment and intervention with incarcerated individuals, psychological assessments required by court). Clinical psychologists are also expected to conduct compulsory psychological evaluations required for certain professions (e.g., military, teachers, policemen) or when psychological evaluation are needed for reaching administra-

tive decisions (e.g., early retirement). At this point, it is worth mentioning that, after 1989/1990, psychology became a much more popular career choice for youngsters, and many universities started psychology programs. For example, in Russia, in 1984 there were only three universities training very few psychologists, whereas in 2013 more than 300 institutions graduate more than 5000 psychologists (Mironenko, 2013). This increased interest is a good sign, but, unfortunately, the labor market has not adapted fast enough to provide enough jobs, thus pursuing a career in psychology turns out to be a risky choice.

Many clinical psychologists have started working in private practice as well, some also practicing psychotherapy, in various approaches (e.g., cognitive-behavioral therapy, psychoanalysis, humanistic-experiential approaches, etc.). The accessibility of their services to the general population remains relatively low due to high costs (combined with lower incomes compared to western societies) and to the fact that in many cases, psychological services (including psychotherapy) in private practice are not covered by the national insurance policies. However, this situation has started to change to some degree. For example, starting 2014, in Romania, clinical assessment and counseling (and psychotherapy for autistic children) are now covered by the national insurance system for children and adults with various psychiatric and somatic disorders ([www.copsi.ro](http://www.copsi.ro)), although the administrative procedures are still unclear to most practitioners and insurance covers only a very small number of sessions. Also, in Romania, psychotherapy costs are not paid by the insurance system directly to psychologists/psychotherapists, but can only be delivered through the medical system (i.e., therefore, psychotherapy can be covered when delivered by a psychiatrist or by a psychotherapist, when he/she is the employee of a psychiatrist in private practice or works in the medical system).

Even more restrictively, in Russia, clinical psychologists are only allowed to practice psychotherapy when cooperating with medical doctors, and only psychiatrists can obtain an official license to practice psychotherapy. In practice though, many psychologists do provide psychotherapy, often under the label “psychological counselling”, which is not liable to licensing, although it is established as a training program. Therapeutic modalities which have been increasingly popular in later years are psychoanalysis, existential and humanistic psychotherapy, and cognitive-behavioral therapy. Psychotherapy remains yet inaccessible to most people, since costs are not covered by the health insurance system, and mental disorders are usually treated with medication alone (Kholmogorova et al., 2013). Also, apart from the insufficient financing, there seems to be a shortage of well-trained specialists, and a lack of coherence in the system of training, supervision, licensing, and certification. Last but not least, the general population, but also healthcare policy makers are not well informed about the usefulness of psychological work, as mental health problems have belonged almost exclusively to the field of psychiatry. However, some positive changes have occurred as Russian scientists have started to collaborate with Western colleagues to a larger extent. For example, the Moscow Research Institute of Psychiatry has recently collaborated with the US Institute of Mental Health in introducing a program for the detection and treatment of depression in primary care which has increased the use and visibility of psychotherapy in the field of mental health (Kholmogorova et al., 2013).

Overall, the accessibility of psychological services varies between Eastern European countries, as their economic situation is also discrepant (i.e., some countries have been a part of the European Union for a while and have better economies than others), and varies within countries as well, being more accessible to the newly rich and forming middle class in urban areas (Ritsher, 1997).

For a more comprehensive picture, we will briefly describe psychotherapy services available for the population in several central and eastern European countries, as described by the Network for Psychotherapeutic Care in Europe (<http://www.npce.eu/>), a joint effort of mental health care representatives from different European countries interested in improving the practice and accessibility of psychotherapy at an international level.

## Czech Republic

In the Czech Republic, psychotherapy services are financed via multiple insurance systems, either in hospitals, day clinics, or outpatient care. Patients who don't have an insurance can access psychotherapy services in private practice, and this option is also available for insured patients who wish more personalized services (e.g., therapy provided by a particular professional). The most widespread treatment modalities are cognitive-behavior therapy, eclectic, integrative, psychodynamic, gestalt, and family therapy (Vybíral, 2011). Insurance systems cover treatment modalities indiscriminately, depending only on the contracts they sign with different professionals. Patients can be recommended to follow psychotherapy when diagnosed with psychiatric disorders, but also somatic disorders where psychological factors are involved, and also when dealing with stressful life events. Additionally, patients can choose their therapist from a list of licensed professionals, but there is some limitation by the session quotas covered by insurance companies. The insurance companies also differ with respect to how much they cover, and there are also differences in practice between different regions in the country and between large cities and rural areas.

## Hungary

In Hungary, psychotherapy services are available for the population in hospitals, day-treatment and outpatient facilities. Sessions are covered by the national health insurance system, and there are 16 psychotherapeutic methods accredited and supported with no restriction. Most common methods are cognitive-behavioral therapy, dynamic therapy, family therapy, psychodrama and other humanistic approaches, and there are no constraints on using particular methods for particular disorders. Patients in out-patient care can choose sessions and methods freely as long as they

have an indication for psychotherapy (i.e., for affective disorders, anxiety disorders, eating, somatization, sleep disorders, personality disorders, etc.). In most cases, inpatient psychotherapy sessions are delivered in a group format, but the opportunity for individual psychotherapy also exists. However, private practice services are not included, which limits the available services for patients, and there are large differences between cities and the countryside, since psychotherapists prefer working in urban areas, thus increasing the accessibility problem (Harmatta, 2011).

## **Latvia**

In the case of Latvia, psychotherapy in public health care is mostly restricted to medical professionals, who practice mainly psychodynamic approaches, following a specialization in psychotherapy. Requirements and guidelines are regulated by the Latvian Ministry of Welfare, but there are no such regulations for private practice. Patients can access psychotherapy services for various conditions, but the accessibility remains, overall, limited (Lucava, 2011).

## **Poland**

In Poland, psychotherapy services are covered by the national health insurance system and by private insurance companies as well, and are offered in hospitals, day center units, and outpatient care. Psychotherapy is recommended for various conditions, like affective and anxiety disorders, eating, sexual, personality, sleep, psychotic and somatic disorders, and for emotional and behavioral disorders in children and adolescents. Treatment modalities supported by the national health fund are cognitive-behavior therapy, integrative psychotherapy (e.g., person-centered, psychodynamic therapy, gestalt), and family therapy. However, in order to choose a particular therapist and benefit from an unlimited number of sessions, one has to turn to private practice services (Jaraczewska, 2011).

## **The Current Training System and Licensing**

Psychology has become a popular field of study for many young people in Eastern Europe, especially after the fall of the Iron Curtain. There are now many psychology programs training students from bachelor level to doctoral and post-doctoral level, in different areas (e.g., clinical psychology, work and organizational psychology, educational psychology). The duration of these programs varies, as some countries, part of the EU, have adopted the Bologna training system (involving a 3 years

program for bachelor's degree, 2 for master's degree, and 3 for Ph.D.), while others have not. Also, psychologists in the EU states and nine other European countries have the possibility of applying for a EuroPsy (<http://www.europsy-efpa.eu>), a European Certificate in Psychology allowing work mobility of psychologists within the EU. The EuroPsy is a system including education, training and ethical standards which have to be met by psychologists in order to apply (i.e., a 5-year or more academic education in psychology, 1 year of supervised practice, provide evidence of current professional competence, subscribe to a statement of ethical conduct, engage in continuous professional education). It does not offer licenses (since these are nationally established), but a certificate attesting professional competencies of psychologists. Not all countries in Europe have implemented the system, but many, including some from the former Eastern Bloc (e.g., Czech Republic, Hungary, Russia, Slovenia).

In many cases, the formal requirements with respect to education for becoming a clinical psychologist are not yet clearly established and/or enforced, since the work market has not yet been consistently correlated with the higher education system. For instance, in many fields, not only in psychology, one enters the profession (e.g., becomes psychologist) once she completes a bachelor's degree, and master or doctoral studies are not compulsory. For some professional qualifications, master's degrees are compulsory, while doctoral studies are still pursued mostly by those who want to continue a career in research or academia. So, how does one become a clinical psychologist in Eastern Europe?

Since it is difficult to offer updated information on all countries in the former Eastern Bloc, we will exemplify with the situation in Romania (for more details, see David, 2006/2012), briefly describing some of the systems in other countries as well. As previously mentioned, in Romania, psychology as an academic field was prohibited starting the 1970s, and was reestablished only in 1990, so many educational and professional standards, as well as legal frameworks had to be designed from scratch. The law regarding the status of the profession of psychologist passed in 2004 (Law no. 213/2004); the law outlines the attributions and obligations of psychologists regardless of specialty, so, technically, clinical psychology, educational, organizational psychology are not different professions, but different specializations within the field of psychology. Also, one becomes a psychologist after completing a bachelor's degree (undergraduate level). Education can continue to master's degree and doctoral degree, but the formal qualifications are still general (i.e., one gets a doctoral degree in psychology, not clinical psychology). In order to practice as clinical psychologists, psychotherapists, educational psychologists and so on, psychologists have to register with the Romanian Board of Psychologists, established and recognized by law in 2004, an organism responsible for establishing and enforcing professional and deontological standards. Registration with the Board is not compulsory by law in order to practice psychology, but nowadays employers prefer registered psychologists, especially public institutions, and most practicing psychologists are registered with the Board (the Board includes about 30,000 Romanian psychologists, for a population of about 20 million).

At first, one can become a clinical psychologist (i.e., registered with the Board of Psychologists) once he/she completes the bachelor's degree, entering the field *in supervision*. Once supervision is completed, they can become *autonomous* clinical psychologists, afterwards (after 5 years of practice at least), they can become *specialist* clinical psychologists, and, later, after 10 years of practice, *principal* clinical psychologists. Although one can become a registered psychologist after obtaining a bachelor's degree, in order to advance (i.e., become *autonomous* and further), additional academic and practical training is needed, in the form of a master's degree or an equivalent program.

Once a clinical psychologist, attributions refer to psychological testing and assessment, as well as psychological intervention, but for instance, psychologists are not entitled to perform an ICD or DSM based diagnosis with legal implications, without the countersignature of a psychiatrist. At this point, it is worth mentioning that clinical psychology is distinct from psychotherapy in Romania. In order to become a psychotherapist (registered with the Board of Psychologists), one has to complete a training program, lasting for at least 2 years, offered by an accredited (i.e., by the Board) professional association. These associations represent and teach within different theoretical paradigms (e.g., cognitive-behavioral, psychoanalysis, experiential) and are private (usually NGO's) enterprises, not state-level (a situation similar to other countries, like Bulgaria). To conclude, there is a legal framework and a licensing system for clinical psychologists in Romania and most practicing psychologists adhere to it, but psychologists can (and some still do) practice the attributions of a clinical psychologist or psychotherapist without being registered to the Romanian Board of Psychologists. If not licensed by the Board, how can these psychologists be held accountable? For once, they are accountable by law (which refers to psychologists in general, not only to those registered with the Board), and by the ethical codes of the institutions they work in. In practice, this lack of unity in professional standards still creates confusion although things seem to be moving in the right direction.

The situation seems somewhat less clear in Serbia, with graduates receiving the same title, at all levels, regardless of the specialty they study, and the profession of clinical psychology existing in practice, but not being legally recognized. Unlike Romania, in Serbia, psychologists working in health care institutions hold the title of "health associate" at first, and then have the opportunity of enrolling in a specialization of Medical Psychology (which is a postgraduate course at the Medical School). There is no institution similar to the Board of Psychologists (which has professional authority in some matters, as recognized by law), but Serbian psychologists can register at the Association of Psychologists of Serbia, which is a voluntary, professional, and scientific organization, assembling about 20% of psychology graduates.

In Poland, although psychology as a scientific and practical field has a long (and almost uninterrupted history), the profession was formally recognized by the government in 2001. Interestingly, the code of ethics for the profession has been established prior to the legislation, in 1988, and updated in 1991. Currently, standards for

the profession are outlined by two professional organizations. The Polish Psychological Association sets professional standards and enforces the code of ethics, and the Committee of the Psychological Sciences of the Polish Academy of Sciences sets standards for the education and training of psychologists, publishes a scientific journal and organizes scientific conferences. When graduating training in professional psychology in Poland, psychologists can obtain two titles: psychotherapist and clinical psychologist, the latter working mostly in hospitals (Welfel & Khamush, 2012).

In the Czech Republic (unlike Romania and Serbia), *psychologist* is legally recognized as a profession in four different fields, including health sector—“registered clinical psychologist”, and private practice—diagnosis and counseling in psychology. There is a license needed to enter these fields and, in clinical psychology only, a revalidation of the license to practice is needed after 10 years (National Awarding Committee (NAC) for EuroPsy in Czech Republic: Overview, 2013).

## Summary

To our knowledge, there are many professional associations for clinical psychologists and psychotherapists throughout Eastern Europe, but their credential systems are not always correlated with state legislation, and government based professional standards are still not clear enough. Professional boundaries are still being formally defined, and, in the public eye, the situation appears even more confusing; probably also due to a lack of mental health culture, people are not sure when to see a psychologist (not to mention what kind of psychologist), how they differ from psychiatrists, and what kind of services they offer. However, the situation differs widely among countries, as some have better resources than others, and as some countries managed to continue their scientific tradition during the communist regime (e.g., Poland), while others had to develop the field of psychology almost from scratch (e.g., Romania). Also, there are wide discrepancies within countries as well, with people from richer, urban areas accessing psychological services much more often than people in rural areas. Therefore, the gap between and within Eastern European countries is rather wide, with psychological services becoming increasingly more popular and familiar to the public in some regions than in others.

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