Central Europe

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Introduction

It does not seem to be an arbitrary choice to revert to a Viennese scholar when trying to grasp the history and status quo of Clinical Psychology in Central Europe. Most people intuitively associate Sigmund Freud with Vienna, and thus, innately denominate one of the most influential founders of modern Psychology, who would not only be of great significance to Psychology and Psychotherapy in Central Europe but to Psychology and Psychotherapy all over the world. Also, the first author of this chapter held the first chair for Clinical Psychology in Vienna from 1998 to 2013 and thus, may be regarded a contributor to the establishment of academic Clinical Psychology in Austria and especially in Vienna. The two co-authors are, in turn, very familiar with the current educational system in Austria for Clinical Psychologists as they have, themselves, recently completed this training. The expertise from these two different positions hence, contributes to the holistic view approached in this chapter. In the following, these historical and recent developments shall be discussed in more detail and depth.

At first however, a chapter dealing with the status of Clinical Psychology in Central Europe is challenged to narrow down the term 'Central Europe'. The conception of Central Europe as a region is influenced by historical, political as well as economical notions and thus, may considerably vary regarding its demarcations: for

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instance, one may argue that Central Europe may not only include Austria, Germany, Switzerland, but also Poland, Hungary, Slovenia, the Czech Republic, Slovakia and even the Baltic States as well as parts of Romania and Ukraine given that they all share some cultural and historical roots (c.f. Magocsi, 2002). However, as the current academic and legal status of Clinical Psychology differs significantly across the above mentioned countries, a chapter trying to equally account for all of these historically grown differences would quickly go beyond its scope. Hence, the present chapter will predominantly focus on the so called DACH-countries, Germany (D), Austria (A) and Switzerland (CH) where German is the first language for the majority of the population (c.f. Ammon, 2015). The advantages of such an approach are more in-depth insights into the particular developments and historical preconditions that led to what is now known as Clinical Psychology in large parts of Central Europe. Furthermore, it allows for a more differentiated analysis of current circumstances regarding Clinical Psychology's legal status, academic developments and practice. At present, these three seemingly close countries differ significantly with regards to their legal conception of Clinical Psychology and Psychotherapy. In Austria, for instance, the professions of Clinical Psychologists and Psychotherapists are regulated separately and thus, entail two entirely different, legally distinct professional guilds. In Germany and Switzerland, in turn, such overly strict dichotomy does not exist.

This being said, this chapter will briefly outline the history of Clinical Psychology, before moving on to a description of the status quo in Germany, Austria and Switzerland. The latter will not only include current views of Clinical Psychology in each of these three countries but will also consider differences in legal conceptions, education and training as well as research and practice. Above all, the contradictory legal and academic conceptions of Clinical Psychology and Psychotherapy (and, inevitably connected to this, the differing understanding of treatment vs. therapy or different interventions in general) will be discussed in detail for each country as they hold the key for many misunderstandings and—amongst others—vocational disparities between these countries (leading to, for instance, reduced mobility of professionals). Finally, possible changes of current practices shall be outlined and an outlook onto future developments of Central European Clinical Psychology in the twenty-first century shall be provided.

Historical Roots

To appreciate Clinical Psychology in its current form and to furthermore understand why its implementations and legal underpinnings differ in such an extent between the three neighboring countries Austria, Germany and Switzerland, one must revert to a brief analysis of its history. However, as is often the case with the portrayal of historical developments, an overview over the history of Clinical Psychology is subject to interpretation and judgement, and thus, shall never make the claim to be

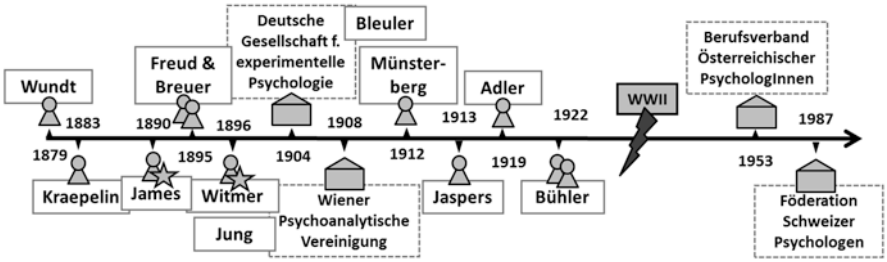

Fig. 1 Milestones of (Clinical) Psychology in Germany, Austria and Switzerland. Note: The *stars* in this figure designate the birth of Clinical Psychology as a discipline (marked by both the publication of James' *Principles of Psychology* and Witmer's establishment of the first psychological clinic). The two figures next to Bühler each indicate an important historical character (Karl and Charlotte Bühler). WWII: World War II (1939–1945). The institution's names are given in German, below they are spelled out in English as well

exhaustive and objective. It may be argued that the roots of today's Clinical Psychology reach as far back as to Roman and Greek philosophers and medics such as Hippocrates (460–370 BC) and may be traced throughout the Middle Ages and the Renaissance up until its—more or less—definitive emergence at the end of the nineteenth century (c.f. Petermann & Reinecker, 2005). However, for the purpose of this chapter, the authors will make an effort to concentrate mainly on the developments that took place in the three countries of interest. Figure 1 roughly depicts the historical milestones of Clinical Psychology in Germany, Austria and Switzerland. Apart from the most significant events, these countries' prominent historical figures are displayed and shall be discussed in more detail in the following.

In general, it is believed that Clinical Psychology as a sub-discipline of Psychology has a relatively short history, with an estimated beginning between the end of the nineteenth century and the beginning of the twentieth century (Petermann & Reinecker, 2005). Many view the year 1896 as the formal beginning of Clinical Psychology; it was around this time that American psychologist Lightner Witmer (1867–1956), a former student of Wilhelm Wundt, established the world's first psychological clinic at the University of Pennsylvania in Philadelphia and started to offer courses in clinical psychological methods (Reisman, 1991). Another trainee of Wundt, American psychologist and philosopher William James (1842–1910) may furthermore be regarded a key figure in the formation of Psychology as a scientific discipline: With his monumental book *Principles of Psychology* he laid the cornerstone for a natural scientific approach to Psychology.

The fact that the formation of Clinical Psychology as a discipline may be considered to first have taken place in the U.S. and not in a European country such as Germany or Austria necessitates a closer look at the parallel developments in Central Europe.

Developments in Germany

European Psychology, at this time, was closely related—if not at times identical—to medical concepts and in particular to Psychiatry and Neurology; most of its representatives originated from the medical sciences, and it was not until the German physician Wilhelm Wundt (1832–1920) called himself a psychologist that this designation started to be more frequently used among scholars. Wilhelm Wundt is commonly considered to be the father of modern scientific Psychology as he was the first to open a psychological laboratory at the University of Leipzig in Germany between 1875 and 1879. Also, Wundt introduced the idea of empirical verification of psychological theories and concepts and thus, laid a significant cornerstone for the birth of experimental Psychology (Reisman, 1991). Following this key event, various advances took place which little by little—and at times simultaneously—finally contributed to what we today consider to be the discipline of Clinical Psychology.

Around 1896, at approximately the same time as Witmer established the first psychological clinic in Philadelphia, another of Wundt's students, German psychiatrist Emil Kraepelin (1856–1926), published his notorious script *The Psychological Experiment in Psychiatry* ("Der psychologische Versuch in der Psychiatrie"), which would later constitute the foundation of modern classification systems. One of his most significant contributions was the illustration of how psychological methods such as the psychological experiment could be valuable tools for psychiatry (Kryspin-Exner, 2004b; Petermann & Reinecker, 2005). Soon after, in the spring of 1904, the *German Society for Experimental Psychology* ("Deutsche Gesellschaft für Experimentelle Psychologie") was founded in the context of the first congress for Experimental Psychology in Gießen, Germany, an event which additionally strengthened the position of Psychology in academia (Traxel, 1985). The society started with 85 members and would soon rise to approximately 200. However, in 1929 during the Viennese congress ("Wiener Kongress") it was rearranged and extended to include not only experimental Psychology but Psychology in general, and today it is well known as the *German Psychological Society* (Deutsche Gesellschaft für Psychologie, 2015).

Another student of Wundt and a rigorous advocate of Applied Psychology, the German psychologist Hugo Münsterberg (1863–1916) is also thought to have significantly contributed to the development of Clinical Psychology as a scientific discipline (Hergenhahn & Henley, 2013). Together with his colleague Wilhelm Specht he coined the term "Pathopsychologie" and edited the corresponding scientific journal "Zeitschrift für Pathopsychologie" (1912–1919) in which he defined mental illness as a deviation from normal mental processes; accordingly, psychological disorders, in his belief, could be explained with theoretical models of Psychology and treated with common psychological methods (Wirtz & Strohmer, 2013; see also Bastine, 1992). A position contrary to Münsterberg was taken by another German intellectual, the psychiatrist and existentialist philosopher Karl Jaspers (1883–1969), who in his book *General Psychopathology* ("Allgemeine Psychopathologie", Jaspers, 1965, 1973) perpetuated

the idea of symptoms as the smallest entities of a mental illness (Wirtz & Strohmer, 2013). Like his Swiss colleague Eugen Bleuler (see section "Developments in Switzerland"), Jaspers held a strong psychiatric position and may today be regarded as one of the pioneers of common classification systems for mental disorders (Kryspin-Exner, 2004b).

All of these examples illustrate how, around the turn of the century, first advances of German psychologists and psychiatrist to establish Clinical Psychology as an independent field of research and practice bore fruit. However, these developments may not be viewed as separated from progress in the realm of Psychotherapy but rather as concurrent and even reciprocal developments. Analogous to Austria, where Sigmund Freud with his method of psychoanalysis (for more details see section "Developments in Austria") lay the cornerstone for modern Psychotherapy, in Germany, too, a strong tradition of psychotherapeutic methods formed, some of its prominent figures being Ernst Kretschmer (1888–1964), Arthur Kronfeld (1886–1941) and Georg Groddeck (1866–1934), to name a few (c.f. Pritz, 2002). In other words, understanding the emergence of Clinical Psychology would be virtually impossible without, at the same time, considering the development of psychotherapeutic methods.

As flourishing as the advances in both Clinical Psychology and Psychotherapy were at the beginning of the twentieth century, World War I and II (WWI and II) abruptly interrupted these progresses. Academic advances in Psychology during WWII ceased almost completely in large parts of Europe as most scholars were of Jewish origin and were forced to emigrate during Nazi reign. In the U.S., however, Psychology was booming due to the need to develop assessments for military purposes and to treat veterans (c.f. Petermann & Reinecker, 2005; Pritz, 2002). After WWII, psychologists in Germany resumed their efforts and began to increasingly expand their expertise in psychological assessment, treatment and counseling. Again, this was—almost inseparably—related to and strongly influenced by developments in Psychotherapy, such as the formation of Client-Centered Therapy by American psychologist Carl Rogers (1902–1987) or the emergence of Behavioral Therapy in the 1940ies and 1950ies. Similarly, the work of German psychologist Hans Jürgen Eysenck (1916–1997) who was born in Berlin and later emigrated to London where he developed his well-recognized theories of intelligence and personality, had a great impact on Clinical Psychology in Europe.

In sum, the demand expressed by Emil Kraepelin (see above) to use psychological methods and theories to explain and treat mental disorders was finally met (Petermann & Reinecker, 2005). Furthermore, therapy methods such as Psychoanalytic Therapy (from 1967) and Behavioral Therapy (from 1980) could be officially applied by psychologists in Germany and were reimbursed by statutory health insurance as long as a medical doctor assumed responsibility (Petermann & Reinecker, 2005). However, the passing of a law regulating the self-employed practice of psychologists, who had an according postgraduate training took until 1998. It was by this time, that many professorships no longer bore Clinical Psychology in their title but also "Psychotherapy", a change that is still in effect today (see section "Status Quo of Clinical Psychology").

Developments in Austria

Austrian history regarding the development of Psychology and, in particular, of Clinical Psychology is evidently tied to the foundation of the initially called 'talking cure' and later termed Psychoanalysis by Sigmund Freud. To understand how this achievement could take place, one has to revert to the spirit in a late nineteenth century *fin-de-siècle* Vienna. It was during a time of social and political crisis and impending societal disintegration that the Viennese intelligentsia found fertile grounds for the development of their ideas (Schorske, 2012).

Among the leading pioneers of this era, if not the most important pioneer, was Sigmund Freud (1856–1939) who received his medical degree at the University of Vienna in 1881 and subsequently became more interested in Psychology than in neurology. He visited Jean-Martin Charcot (1825–1893) at the *Hôpital de la Salpêtrière* in Paris, France to learn how to apply hypnosis to patients with hysteria, and he kept in close contact with his colleague and father figure, neurologist Josef Breuer (1841–1925) (Reisman, 1991). In the early 1880ies Breuer treated a young woman suffering from hysteria who later became to be known as the infamous *Anna O.* By inducing catharsis, Breuer used a rather unconventional method at that time; Breuer discussed *Anna O.* with Freud multiple times and this would finally culminate in a mutual publication, *Studies in Hysteria* ("Studien über Hysterie") in 1895 (Reisman, 1991). Following this, however, the relationship cooled and Freud proceeded developing what would soon be known widely as Psychoanalysis. Many intellectuals followed him, one of the most prominent examples being Austrian medical doctor Alfred Adler (1870–1937) who would later break with classical psychoanalysis and form his own school of Psychotherapy, *Individual Psychology* ("Individualpsychologie"). Around 1908 the *Vienna Psychoanalytical Society* ("Wiener Psychoanalytische Vereinigung") an advancement of the *Wednesday Psychological Society* ("Psychologische Mittwoch-Gesellschaft") which assembled on Wednesdays in Freud's apartment was established. It included many prominent members such as—among others—Adler, Otto Rank (1884–1939) and Swiss psychiatrist and psychotherapist Carl Gustav Jung (1875–1961, for details see section "Developments in Switzerland"). This society was the first of its kind, but would soon be followed by many others all over the world; not to forget the significant influence of successors Anna Freud (1895–1982), Melanie Klein (1882–1960), Heinz Kohut (1913–1981) and Otto Kernberg (1928), who became famous for their work on personality disorders; for a review see "Austria: Home of the World's Psychotherapy" (Sulz & Hagspiel, 2015).

Other important figures which each significantly contributed to Viennese Psychology at the beginning of the twentieth century are German psychologist Karl Bühler (1879–1963) and his wife Charlotte Bühler (1893–1974). In 1922 Karl Bühler founded the first Department of Psychology at the University of Vienna, where he served as a professor of Psychology and Philosophy between 1922 and 1938 (c.f. Galliker, Klein, & Rykart, 2007). His wife, Charlotte, also became a professor in 1929 and vigorously supported the newly established Viennese Department

of Psychology. She dedicated her research to Developmental Psychology and to the study of systematic observation of behavior and the behavior of children in everyday situations, and in the 1920ies she opened the city's first *Child Adoption Center* ("Städtische Kinderübernahmestelle") (c.f. Bühring, 2007).

Another development taking place in Vienna in the 1920ies through to the 1930ies is worth noting at this point as it also bore far-reaching consequences for scientific Psychology: The so called "Wiener Kreis" (*Vienna Circle*). This circle included a group of scholars such as founder Moritz Schlick (1882–1936) and—at the periphery—Viennese philosophers Karl Popper (1902–1994) and Ludwig Wittgenstein (1889–1951) (c.f. Stadler, 2015). The Vienna Circle followed the self-proclaimed aim of promoting the philosophical position of Empirical Positivism which would become a central approach to contemporary statistical methods in modern Psychology.

Similar to Germany, in Austria WWII also inflicted a comparable halt of research and practice. Apart from the above mentioned, many other prominent psychologist and psychoanalyst such as Austrian neurologist and psychiatrist Viktor Frankl (1905–1997) who with his *Logotherapy* ("Logotherapie") may be regarded as the father of the "third Viennese school of Psychotherapy" emigrated. Frankl would later return to Vienna, after having taught at diverse U.S. universities, and would ultimately become known for his culture specific approach to Psychotherapy as well as for his notorious statement: "Jede Zeit hat ihre Neurose—und jede Zeit braucht ihre Psychotherapie" (Frankl, 2015 [1977])—*Every age has its own neurosis, and every age needs its own Psychotherapy.* Another Austrian psychologist who emigrated and followed his career in the U.S. was Frederick Kanfer (1925–2002). He made a quite significant contribution to today's cognitive behavioral therapy with the development of the self-management-therapy and with the so called SORC-model (a model of operant conditioning) (c.f. Sulz & Hagspiel, 2015).

Only few psychologists and psychotherapists remained in Austria to perpetuate Freud's heritage after the end of WWII (c.f. Pritz, 2002). In contrast to Germany, however, in post-war Austria, the development of Psychology and Psychotherapy did not go hand in hand and did not result in conjoint professorships and occupational profiles. By 1953 the first *Austrian Psychological Association* ("Berufsverband Österreichischer Psychologen") was brought into being as a reaction to the need of psychologists with an academic background to publicly distance themselves from other occupational groups that such as palm readers and fortune tellers (Berufsverband Österreichischer PsychologInnen, 2015a, 2015b). A corresponding psychotherapeutic association, the first *Austrian Psychotherapeutic Association* was not founded until 1981. At that time only medical doctors were officially allowed to apply Psychotherapy, however, most of those who actually practiced Psychotherapy did not originate from a medical background (Lenz, Rabenstein, & Görgen, 2011). The purpose, thus, of the association was to promote Psychotherapy and to legally strengthen this occupational group. It was, however, not until 1990 that an according law passed; this law regulated the occupational profile of psychologists and clinical psychologists on the one hand, and psychotherapists on the other and, hence, sealed their fate as two separate professional guilds. The consequences of

this historical division shall be discussed in more detail in the next section, when the status quo of Clinical Psychology in Austria is examined.

Developments in Switzerland

Psychology and Psychotherapy in Switzerland undoubtedly had their roots in psychoanalysis. One of Switzerland's most prominent figures in the history of Psychology and Psychotherapy, Swiss psychiatrist Eugen Bleuler (1857–1939) was closely linked to Freud's psychoanalysis, posing as one of the members of Freud's *Vienna Psychoanalytical Society* until he resigned in 1911. He was highly interested in the method of hypnosis, visiting himself—like Freud—Charcot in Paris and eventually became the director of the Burghölzli, the psychiatric hospital of the University of Zürich. Bleuler is most commonly known for his contribution to the conceptualization of schizophrenia which replaced the concept of dementia praecox, coined earlier by Kraepelin (Berrios, 2011). Also, he paved the way for the founding of the *Swiss Psychoanalytical Society* in 1919.

A student and assistant of Bleuler, Swiss psychiatrist Carl Gustav Jung (1875–1961) represents another important figure in the history of Swiss Psychology and Psychotherapy. He, too, was a follower of Freud's psychoanalytical theories and served as the president of the *International Psychoanalyst Association* between 1910 and 1914. However, the publication of *Psychology of the Unconscious* in 1912 ("Wandlungen und Symbole der Libido") led to a definitive divergence between Freud and Jung (c.f. Reisman, 1991). From this point on, Jung further developed his psychological concepts of the collective unconscious and archetype, leading to a separate branch of psychoanalytical methods which constitutes the main approach in Switzerland after classic Psychoanalysis (c.f. Pritz, 2002).

The overall development of Psychology and Psychotherapy in Switzerland was rather slow, generally lagging behind developments in other parts of the world (Pritz, 2002). After WWII, Swiss Psychotherapy was characterized by a pluralism of methods and approaches which all led to canton specific schools and associations, with the *Swiss Association of Psychotherapists* (established in 1979) being its largest representative. At the same time, Clinical Psychology professorships led to an arrival and thus, greater influence of behavioral therapeutic methods, and in the 1980ies the *Federation of Swiss Psychologists* ("Föderation Schweizer Psychologen"), the now largest association of psychologists in Switzerland, was founded (FSP 2015a, 2015b). Until recently, this association has promoted the right of psychologist to be the only other occupational group besides medical doctors to practice therapy in Switzerland and has managed to pass a law in 2013 that regulates the profession of psychologists and psychotherapists. Thus, similar to Germany and in stark contrast to Austria, Clinical Psychology in Switzerland may be viewed as closely linked to Psychotherapy. The current status of Swiss Clinical Psychology and its consequences for cross country mobility shall be discussed in more detail in the next section.

Status quo of Clinical Psychology

To define the status quo of Clinical Psychology, one has to first ask: What is Clinical Psychology? Concept such as counselling, Health Psychology, assessment and classification as well as prevention, treatment and rehabilitation of mental disorders seem to be at the core of Clinical Psychology. Following this notion, Clinical Psychology and Psychotherapy clearly cannot be regarded the same discipline or approach. According to Strotzka's (1969) definition, for instance, Psychotherapy may be seen as an essential part or subdomain of Clinical Psychology. Hence, in the following, their relationship shall be considered under this premise. Still, current statutory rules and educational programs only partly account for this definition. Especially in Austria there is a strict division between Clinical Psychology, Health Psychology and Psychotherapy. Furthermore, counselling and treatment are often used interchangeably in clinical psychological contexts and it is not considered that the objectives of counselling and treatment are inherently different (c.f. Kryspin-Exner, 2004a). Instead, the integrative, multimethodological and mostly evidence-based treatment approach of clinical psychological services would rather fit into existing therapeutic goals defining today's psychotherapeutic work than into counselling. This is, however, a notion that has yet to be realized in Austria. In contrast to Austria, German and Swiss regulations have already accommodated Strotzka's conceptualization of Psychotherapy: In both countries, predominantly medical doctors, psychologists and pedagogues who have successfully completed their—often quite time consuming—training may offer psychotherapeutic services to patients.

Germany

Education and Training. In Germany, two laws exist which allow admission to Psychotherapy: (1) the Psychotherapy law ("Psychotherapeutengesetz") and (2) the Healing Practitioner law ("Heilpraktikergesetz").

On the one hand, in Germany there is a profession called *Medical Psychotherapist* ("Ärztlicher Psychotherapeut"); generally, medical doctors (with an additional qualification in psychosomatic medicine, psychiatry and Psychotherapy or in child and adolescent psychiatry and Psychotherapy) who complete a 5-year training are admitted to this profession. However, they must have a proper additional qualification in Psychotherapy or Psychoanalysis or complete a corresponding psychotherapeutic training. In contrast to these medical psychotherapists, the so called *Psychological Psychotherapists* ("Psychologische Psychotherapeuten") need to graduate from 5-year academic studies in Psychology and are required to have an additional academic qualification in Clinical Psychology. *Child and Adolescent Psychotherapists* ("Kinder- und Jugendpsychotherapeuten"), in turn, may originate from the disciplines of medicine, Psychology and pedagogics alike. All of these three training options (medical psychotherapist, psychological psychotherapist and child and ado-

lescent psychotherapist) require the completion of academic studies and a state approved license. The according training incorporates not only theoretical studies but also a practical training (600 h) and 1800 h of hands-on training or work experience. In Germany, a psychological psychotherapist may specialize in psychoanalysis, depth Psychology, behavioral therapy, person-centered Psychotherapy (or talk-Psychotherapy) and systemic Psychotherapy, however reimbursements for patients are only given for a selection of specific therapeutic schools (see below).

On the other hand, psychotherapeutic interventions may be offered to patients in the realms of the *Healing Practitioner Law* ("Heilpraktikergesetz"). This occupational group, however, is not allowed to use the occupational title "Psychotherapist". Instead, this group is not bound by any specific treatment method and may acquire the title of an accredited Healing Practitioner by passing the Healing Practitioner exam. In Germany, these exams may be taken in private associations.

Today, there is a lively debate in Germany about providing an academic Psychotherapy graduation instead a post-graduate training for people who completed an academic education in medicine, Psychology or pedagogics ("Direktausbildung"). A number of corresponding models and conceptualizations for the realization of this endeavor have already been published and are being discussed quite lively at this point (e.g. Fydrich et al. 2013; Rief, Fydrich, Magraf, & Schulte, 2012).

Practice. In Germany, with a population of around 81 million, there are around 13,400 Psychological Psychotherapists, 3,100 Child and Adolescent Psychotherapists and 5,300 Medical Psychotherapists who are mostly employed in outpatient settings or private practices. Additionally, there are Psychiatrists and Pediatricians in private practice as well as around 7,000 Psychotherapists in inpatient clinics (Bundespsychotherapeutenkammer, 2015). However, a reimbursement for patients via statutory primary health care is only possible for the group of psychotherapists who are specialized in one of three accredited psychotherapeutic schools: depth Psychology, psychoanalysis or behavioral therapy (according to the so called guideline policy, "Richtlinienverfahren") (Gemeinsamer Bundesausschuss, 2014).

Austria

Education and Training. In Austria, clinical psychologists are subject to two federal laws: (1) the so called *Law for Clinical Psychologists and Health Psychologists* ("Psychologengesetz für Klinische Psychologen und Gesundheitspsychologen") and the (2) *Psychotherapy Law* ("Psychotherapiegesetz"). On July 1st 2014, a new law for clinical psychologists and health psychologists was passed. The amendment to the Psychotherapy law is still pending, but is expected for the next couple of years. The current Austrian law strictly separates the postgraduate training for clinical psychologists from the one for psychotherapists.

Clinical psychologists are required to graduate from a 5-year academic training in Psychology (without the additional requirement of specializing in Clinical Psychology, as it is in effect in Germany). Additionally, they have to successfully

complete a 2 year post graduate training, comprising both a theoretical education and (in most cases financially not well compensated) hands-on practice. Altogether, 2,188 h of practice have to be completed in a health care institution (e.g. an inpatient clinic). In addition to the title of a clinical psychologist, there is a parallel training for health psychologists which may be completed together with the training for clinical psychologists as it has comparable requirements. In Austria, health psychologists are allowed to provide services within the realms of prevention, health promotion and rehabilitation. In contrast, clinical psychologists are also allowed to diagnose patients according to ICD guidelines. Both trainings may be completed via a number of specialized non-governmental education facilities.

Psychotherapists, in turn, may originate from diverse occupational backgrounds, usually referred to as "Quellenberufe" (so called source professions). This category subsumes medical and social professions such as medical doctors, psychologists, pedagogues but also social workers, teachers, nurses etc. However, persons not belonging to this class of "Quellenberufe" may also acquire the permission to initiate Psychotherapy training and consequently, practice Psychotherapy. For this, they have to file a petition to the *Austrian Federal Ministry of Health* ("Bundesministerium für Gesundheit"). In general, psychotherapists are not required to complete academic studies, yet the number of Applied Universities and post-graduate Centers which offer courses within the scope of psychotherapeutic sciences is on the rise in Austria and thus, a trend towards providing a forthright education like in Germany may be observed ("Direktausbildung").

Today, most federally accredited educational institutions providing curricula for psychotherapists remain in the hands of private associations. To achieve the title of a psychotherapist, the trainees—after having completed a basic training ("Propädeutikum")—have to choose one of the 23 currently licensed psychotherapeutic disciplines or schools of thought (see Table 1).

The training comprises (extra-occupational) theoretical courses as well as hands-on experience which, much like in the case of clinical psychologists, is only poorly compensated. The overall time for training is around 6–8 years, however, psychotherapists are allowed to practice from quite an early stage on, provided that they are closely supervised. Upon completion of the training, both clinical and health psychologists as well as psychotherapists are registered at the *Austrian Federal Ministry of Health* ("Bundesministerium für Gesundheit"; the according list may be accessed online: http://klinischepsychologie.ehealth.gv.at/). Furthermore, additional qualifications such as the licensed industrial psychologist ("Arbeits- und Organisationspsychologe") or the licensed child and adolescence psychologist may be acquired via diverse professional institutions.

Practice. In Austria, with a population of approximately 8 million, 7,871 psychotherapists and 8,692 clinical psychologists were registered in 2014. Around 98% of clinical psychologists held the additional title of a health psychologist. Also, double qualifications in Clinical Psychology and Psychotherapy make up around 25% of all practitioners. The majority of psychotherapists are female, and around 61% work in private practices. In Austria, there is a shortage of psychologists and psychotherapists in rural areas, most psychologists have settled in cities; in fact, the majority of clinical psychologists work either in Vienna or Salzburg (GÖG/ÖBIG, 2014).

Table 1 23 Psychotherapy disciplines/schools of thought in Austria (BMG, 2015)

Cluster I: Depth Psychology and Psychoanalysis	
Psychoanalytical methods	*Depth Psychology*
Analytical Psychology	Autogenic Psychotherapy
Group analytic Psychotherapy	Daseinsanalysis
Individual Psychology	Dynamic group therapy
Psychoanalysis	Hypnotherapy
Psychoanalysis-oriented Psychotherapy	Guided affective imagery
	Concentrative movement therapy
	Transactional-analytic Psychotherapy
Cluster II: Humanistic orientation	*Cluster III: Systemic orientation*
Existence analysis	Systemic family Psychotherapy
Existence analysis and logotherapy	Neurolinguistic programming
Gestalt theoretical Psychotherapy	
Integrative gestalt Psychotherapy	*Cluster IV: Behavioral therapy*
Integrative therapy	Behavioral therapy
Psychodrama	
Person-centered Psychotherapy	
Person-centered approach Psychotherapy	

The main task of clinical psychologists in the Austrian health care system is conducting psychological assessment which is fully reimbursed via the statutory primary health care. Usually, a referral from a medical doctor is required in order to be eligible for reimbursement. However, short-term and long-term clinical psychological treatment—which, in contrast to Psychotherapy, may be understood as a multimethodological approach based on theories and models of Psychology and evidence-based methods focusing in the first line on maladaptive psychological functions of biopsychological and neuropsychological processes (cognition, emotion, learning processes and experience)—is not reimbursed via statutory primary health care at this point in time. Yet, in the context of their intervention (be it counselling or treatment) clinical and health psychologists may autonomously apply therapeutic interventions which need to be financed privately by the patient or, alternatively, via complementary insurance (Berufsverband Österreichischer PsychologInnen 2015a, 2015b).

For psychotherapists the situation is slightly different: Here, too, a referral from a medical doctor is required. However, part of the psychotherapeutic treatment—and in some cases the whole treatment—is reimbursed by statutory primary health care. In contrast to clinical psychologists, psychotherapists are bound to their school of thought and have to clearly designate their additional qualification (e.g. Person-centered Psychotherapy or Behavioral Therapy etc., see above).

Switzerland

Education and Training. On April 1st 2015 the *Federal Law about the Psychological Profession* ("Bundesgesetz über die Psychologieberufe, PsyG"; for the legislative text—in German—see Bundesversammlung der Schweizerischen Eidgenossenschaft, 2013) not only officially established proprietary titles for psychologists but also regulated education, training and occupation of psychotherapists in Switzerland (Law News, 2013). Previously, practicing Psychotherapy and Psychology had been a matter of each Swiss canton and thus, often resulted in quite differing approaches (c.f. Pritz, 2002). The new law now accomplished a country wide harmonization and synchronization of criteria for education, training and practice (FSP, 2013a). Hence, only those who have a master degree (or a comparable degree) in Psychology may bear the title of a psychologist. To offer psychotherapeutic services, one has to additionally complete an according postgraduate training in Psychotherapy (Law News, 2013).

In general, a distinction is made between two professional groups, psychologists and psychotherapists, which each have different training backgrounds and areas of practice (FSP, 2013a):

1. *Psychologists*: have a master degree or diploma in Psychology and are allowed to conduct counseling but not Psychotherapy.
2. *Psychotherapists*: a distinction is made between psychologists who receive additional training in Psychotherapy who are then allowed to call themselves *Specialist Psychologist for Psychotherapy FSP* ("FachpsychologIn für Psychotherapie FSP") or *Psychological Psychotherapists* ("Psychologische Psychotherapeuten") and medical doctors with a degree in psychiatry who go through the according psychotherapeutic training (*Medical Psychotherapists*, "Medizinische Psychotherapeuten").

Additionally, the *Federation of Swiss Psychologists* ("Föderation der Schweizer Psychologinnen und Psychologen, FSP") has introduced so called specialist titles which are designated with the ending FSP, one of which is the title *Specialist Psychologist for Clinical Psychology FSP* ("Fachpsychologe/Fachpsychologin für Klinische Psychologie FSP") (FSP 2015a, 2015b). It requires an additional postgraduate training for psychologists which may be completed via the *Swiss Association of Clinical Psychologists* (der Schweizerischen Vereinigung Klinischer Psychologinnen und Psychologen SVKP) and which incorporates further training in Psychotherapy (SVKP, 2015). However, the accreditation is still pending (c.f. FSP 2015a, 2015b).

Practice. According to recent data (FSP, 2013b), 5,700 Psychological Psychotherapists currently work in Switzerland (with a population comparable to Austria of approximately 8 million), most of them part-time. Most prominent are four areas of occupation: (1) self-employed in a psychotherapeutic practice, (2) delegated in a psychotherapeutic practice, (3) in an outpatient clinic and (4) an inpatient clinic (FSP, 2013a). For the first occupational group, a reimbursement via

statutory primary health care is not possible at this time, patients have to pay for this kind of Psychotherapy privately or they are reimbursed via complementary insurance. So called delegated psychological psychotherapists are employed at a medical practice; their services are supervised by a medical doctor and may be reimbursed via the statutory health care system. The psychological psychotherapists wage is subject to negotiations with the employing medical doctor. There has been extensive debate and attempts to change this situation which initially posed as an interim solution until the occupation of psychotherapists would be regulated by law (FSP, 2013a). Even though the corresponding law has passed, a tangible model for implementation is still to be drawn.

General Considerations and Outlook

Today, the continuous and rapid growth in the number of mental disorders in Europe undoubtedly poses one of the greatest challenges for the health care system. One year prevalences between the years 2005 and 2010 demonstrate large increases in overall psychological disorders from 27 to 38% (Wittchen et al., 2011).

Towards a Clinical Psychology in the Digital age

In light of the mostly poor provision of clinical psychological or psychotherapeutic services in rural areas (in all three countries of interest) new approaches to treatment and intervention need to be considered. Here, especially eMental Health Programs (c.f. Rochlen, Zack, & Speyer, 2004) as well as online therapy and training come into play (Lehenbauer, Kothgassner, Kryspin-Exner, & Stetina, 2013). They may be used to reach out to people who live in an area with a low density of supply of psychotherapists or clinical psychologists or persons who are immobile or bed-ridden. However, the peculiarity of technological applications such as the Internet is that on the one hand new problems may surface and that on the other hand known mental disorders may take on a new shape (c.f. Kryspin-Exner, Felnhofer, & Kothgassner, 2011). For instance, behavior based addictions in combination with the use of the Internet have been on the rise and have been reported to be highly comorbid with other psychological disorders (Kuss, Griffiths, & Binder, 2013). Similarly, bullying and ostracizing others via digital media is a considerably novel phenomenon (Petermann & von Marées, 2015). The fairly open culture and seemingly borderless reach of virtual space renders many persons, especially children and adolescents, quite vulnerable, especially considering that the emotional reaction to cyberbullying or virtual exclusion is comparable to face-to-face bullying and social exclusion (Kothgassner et al., 2014).

Clinical Psychology and the Challenge of Demographic Change

Furthermore, the current and predicted demographic change poses a great challenge for Europe not only with regards to the increase in numbers of socially isolated and depressed persons but also with respect to the rise in chronic and degenerative diseases such as Alzheimer's disease (Weyerer & Schäufele, 2004). Diverse EU programs and national funds try to live up to these developments. For instance, technology aided interventions and surroundings (i.e. Smart Homes) shall help the elderly participate in society (e-inclusion) as well as be more active via social networks in order to prevent isolation and depression (Active Ageing, c.f. Felnhofer et al., 2014). Similarly, fall detection and fall prevention systems, nursing robots as well as the use of automatic aids or even the application of deep brain stimulation in the case of Parkinson patients is promoted to help facilitate coping with every-day life (Hartanto et al., 2015; Kaiser, Oppenauer-Meerskraut, Kryspin-Exner, Czech, & Alesch, 2010; Planinc & Kampel, 2013; Suryadevara & Mukhopadhyay, 2014).

Pathways from Clinical Psychology to Clinical Neuroscience

Apart from developments in technology-based treatment, many research groups in Central Europe focus on a neuroscience approach including mainly structural and functional brain imaging methods. The main objectives of this approach are, on the one hand, to understand mental processes and their biological associations and, on the other hand, to use these methods for the assessment of mental diseases. At this time, however, this approach does not seem to significantly enhance diagnostic reliability, let alone, to be used as a stand-alone assessment of psychological disorders. Neuroimaging and electrophysiological methods may provide diagnostic markers associated with mental disorders, but lack the sensitivity and specificity to be qualified as a useful tool to predict criteria for psychiatric disorders or to help distinguish specific mental disorders from other diseases (ADHD-200 Consortium, 2012; Linden, 2012). Concerning the substantial costs as well as the problems of usability with a wide range of psychiatric patients (e.g. problems with head motion), neuroscience methods are in critical need for both significant improvement and more research (van Dijk, Sabuncu, & Buckner, 2012).

Another point of entry for neuroscience into Clinical Psychology is the gradually increasing use of neurofeedback, i.e. for the treatment of ADHD or antisocial personality disorder (Arns, Heinrich, & Strehl, 2014; Konicar et al., 2015). In light of these biological trends in Clinical Psychology, it is important to remember the social context and developmental aspects rather than focusing only on not yet empirically proved neurobiological procedures. They are a scientific challenge but should be better integrated into existing health care settings as they are less cost intensive and thus, may be regarded as low-threshold (c.f. Pickersgill, 2011).

Issues of Clinical Psychology in Society and Practice

Studies suggest that only 10% of those in need of clinical psychological or psychotherapeutic services actually receive treatment (Wittchen & Jacobi, 2001). On the one hand, this puts more emphasis on the role of Psychology as a profession (i.e. by actively involving Central European psychologists in the development of criteria for a rather medically oriented ICD-11); on the other hand, however, there are still considerable societal resentments towards individuals with mental disorders, although more than a third of the population suffers from a psychological disorder during the course of their lives. This attitude feeds social stigma which in turn both hinders the timely call for help in those concerned and may promote a chronification of mental disorders. The absence of low-threshold services especially in rural areas (as well as affordable interventions) may be in part responsible for those low rates of treated patients in Central Europe.

Hence, the efficient application of technology based approaches as well as further development of psychological and psychotherapeutic services should be pursued with more rigor. Especially regarding the transition from adolescence to adulthood or from an in-patient clinic to out-patient treatment, substantial gaps in coverage are observed, mostly due to regional differences in health-care services provision. Improving these transitions is considered to be one of the greatest goals for the near future. However, there are many barriers to transition such as a lack of insight into mental health problems or the social stigma associated with mental health problems for young people. Empirically-based studies, especially RCT (randomized control trials) studies are needed to improve standardized and accurate services for young adults (Paul, Street, Wheeler, & Singh, 2015; Paul et al., 2013).

Today, Clinical Psychology in Central Europe is—not least because of the current increase in refugees seeking shelter in Europe—in dire need of including transcultural approaches. Culture sensitive psychological treatment and assessment constitute essential means in order to avoid misdiagnosis which may not only prolong treatment but also critically decrease acceptance of psychotherapeutic and clinical psychological interventions (Lago, 2011).

Another issue is the challenge regarding the development of Clinical Psychology and Psychotherapy education in future. The differing educational standards and diverse occupational titles for similar or even the same services undoubtedly pose as the greatest stumbling blocks for pragmatic low-threshold solutions. Fundamental restructuring may be regarded a chance for improved patient-centered provision of psychological and psychotherapeutic services (in Germany, for instance, it is common for a university to house patient clinics for research and teaching purposes).

Summary

From a historical perspective, the developments of Clinical Psychology in Central Europe paint a heterogeneous picture. Apart from the establishment of an empirical Psychology via Wundt and his successors, a strong tradition of Psychoanalysis and

In Depth-Psychology schools took hold of the three DACH-countries. The large variety of Psychotherapy schools has not only critically influenced the formation of Clinical Psychology but has also contributed to the now quite multifaceted and conflict prone landscape of Clinical Psychology in Central Europe: Austria, Germany and Switzerland—three countries sharing common cultural roots—are characterized by differing (at times contradictory) legal situations regarding the education, training and vocational standards for Clinical Psychologist. This leads to both a reduced cross-country mobility of professionals and difficulties in mutual exchange on all levels.

Today, Clinical Psychology in Central Europe also faces another challenge which may be critical for its future place in health care: Technological developments provide Psychologists with a wide range of possibilities for application in both assessment and treatment situations. However, the potential of many technologies is still not being used or is being used inconsiderately. Another challenge consists of providing psychological or psychotherapeutic services to all of those in need: For instance, institutional structures are needed for minors with mental disorders who are in the process of transitioning from adolescence to adulthood. Similarly, there is an increasing necessity to attend to traumatized refugees with different cultural backgrounds. This highlights the importance of culture sensitive Psychotherapy and Clinical Psychology.

In sum, there is a need to fundamentally restructure patient-centered provision of psychological and psychotherapeutic services in Central Europe. But whether the so called *Bologna Process* (an agreement to ensure comparability in academic education across European countries) and the subsequently initiated direct education of psychotherapists in Germany and also possibly in Austria will fit the requirements for change remains to be seen. The difficulty of harmonizing these structures even in countries of similar cultural and language background (i.e. the DACH-countries), reflects the upcoming challenges for the European Union and the European health care system.

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