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A Long Way to Professionalism: The History of the German Psychotherapy Law

Dirk Vangermain[a] Gernot Brauchle[b]

[a] Private Practice, Potsdam, Germany
[b] Institute of Psychology, UMIT – Health and Life Sciences University, Hall/Tyrol, Austria

Key Words
History of psychotherapy · Psychotherapy rules · Psychotherapy law.

Summary
Some 11 years ago, on January 1st, 1999, the psychotherapy law (German – PsychThG) came into effect. After many years of inter-professional political controversy, non-physician psychotherapy was at last given an adequate legal foundation through the creation of two new academic healthcare professions. Nevertheless, the psychotherapy law was at first a matter of intense controversy. After its 10th anniversary, the attainments of the law are appreciated, on the one hand; but on the other hand there is a new discussion on the possible need of reforming the psychotherapy law, especially in consequence of the research evaluation on psychotherapist training which was published recently. In this article, a differentiated presentation is given of the varied history of the psychotherapy law, from the first health insurance-supported psychotherapies and the non-physician psychoanalysts in the Germany of the early 1920s to the research evaluation just mentioned, which is closely interwoven in the little-researched Germany history of psychotherapy. The history of behavior therapy in Germany is given special recognition in this context.

Schlüsselwörter
Psychotherapiegeschichte · Psychotherapie-Richtlinien · Psychotherapeutengesetz

Zusammenfassung
Vor nunmehr 11 Jahren, am 01.01.1999, trat das Psychotherapeutengesetz (PsychThG) in Kraft. Nach mehreren Jahrzehnten berufspolitischer Kontroversen war es endlich gelungen, die psychologische Psychotherapie durch Schaffung zweier neuer akademischer Heilberufe auf eine adäquate gesetzliche Grundlage zu stellen. Dennoch war das Psychotherapeutengesetz zunächst sehr umstritten. Werden anlässlich seines 10. Geburtstages einerseits die Errungenschaften des Psychotherapeutengesetzes für den Berufsstand der Psychologischen Psychotherapeuten sowie der Kinder- und Jugendlichenpsychotherapeuten gewürdigt, wird andererseits gerade, vor allem infolge der jüngst veröffentlichten Ergebnisse des Forschungsgutachtens zur Psychotherapeutenausbildung, eine Diskussion um die mögliche Reformbedürftigkeit dieses Gesetzes entfacht. Von den ersten Kassenpsychotherapien und den «Laienpsychoanalytikern» ohne ärztlichen Grundberuf in den 1920er Jahren bis zum genannten Forschungsgutachten zur Psychotherapeutenausbildung nach dem PsychThG erfolgt in diesem Beitrag eine differenzierte Darstellung der wechselvollen (Vor-)Geschichte des PsychThG, die eng mit der wenig erforschten deutschen Psychotherapiegeschichte verwoben ist. Die Geschichte der Verhaltenstherapie in Deutschland erfährt in diesem Zusammenhang eine besondere Würdigung.

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Dipl.-Psych. Dirk Vangermain
Rudolf-Breitscheid-Str. 39
14482 Potsdam-Babelsberg
Tel. +49 331 5812740
dirk.vangermain@umit.at

The First Psychotherapies Covered by Health Insurance

Quite early in the 100-year history of psychotherapy in Germany, efforts were made to establish it as a medical science equivalent to somatic medicine, by professionalizing and regulating it, and to obtain at least partial reimbursement of psychotherapeutic services by health insurance. For example, the Berlin Psychoanalytic Institute and its chairman, Karl Abraham, played an outstanding role, setting itself the task of providing poorer strata of the population with free psychotherapeutic treatment. In fact, by 1922, the Institute had already succeeded in obtaining payment from the statutory health insurance funds for some individual cases of psychoanalytic treatment [Heim, 2009]. But the establishment of psychotherapy covered by statutory health insurance as a regular insurance benefit would take many decades [Helle, 1998].

The 'Non-Physician Psychoanalysts'

In the 1920s there were already, especially in Germany's metropolitan centers such as Frankfurt and Berlin, many established psychotherapists, then still predominantly psychoanalytic in orientation. Most of them were doctors, but there were also some among their ranks who had not studied medicine, the so-called 'non-physician analysts.' In contrast to many other countries, they found favorable working conditions in the Weimar Republic, because 'the legally mandated "freedom to cure" (*Kurierfreiheit*) for non-physicians in Germany also allowed non-physician analysts to work in a health profession' [Schmidbauer, 2000, p 322]. This was also explicitly endorsed by Sigmund Freud, who, although himself a doctor, vehemently opposed a physicians' monopoly in psychoanalysis [Schmidbauer, 2000].

Psychotherapy under National Socialism

After the National Socialists seized power, many psychoanalysts who were of Jewish origin or were critical of the regime were persecuted, murdered, or forced to emigrate, mainly to the USA. However, there were definitely also psychotherapists who were close to National Socialism, or at least made their accommodations with those in power and served them, to a greater or lesser degree, such as Matthias Heinrich Göring, Harald Schultz-Hencke and Johannes Heinrich Schultz, the founder of autogenic training. The ambivalent role of Carl Gustav Jung is also mentioned in this context. It is essential to counter the widespread assumption that psychoanalysis and psychotherapy were inherently anti-fascist [Berndt, 2004; Heim, 2009; Schmidbauer, 2000; Stierlin, 2003]!

It is also worth mentioning that the National Socialist government in 1939 passed the Non-Medical Practitioners Law (RGBI, I, p 251), which, with few changes as to detail, remains in effect today, and which rescinded the above-mentioned 'freedom to cure' in Germany. This law required someone who was not a doctor but who wanted to practice medicine, including psychotherapy, to have permission. Half a century later, controversies and litigation still arise over this [Schildt, 2007].

Psychotherapy in the Postwar Years

The exodus of many psychoanalysts and liberal psychiatrists was blamed for the fact that after World War II, the population, which was suffering not only materially but also psychologically from severe war trauma, received poor psychiatric and virtually no psychotherapeutic care [Stierlin, 2003]. The small amount of outpatient psychotherapy that still existed was not usually reimbursed by the health insurance funds, but had to be paid for privately [Berndt, 2004]. Although the social climate of West Germany's postwar and economic miracle years did little for the time being to remedy the situation, that changed in the 1960s.

In 1963, the Clinical Psychology Section was founded within the Association of German Psychologists (Berufsverband Deutscher Psychologen, BDP), which had existed since 1946; it was tasked with ensuring that the clinical-psychotherapeutic profession was staffed by Diplom psychologists* ((bitte folgende Fußnote auf dieser (gesetzten) Seite unten anfügen: *The German Diplom-Psychologe degree is formally equivalent to a master's degree in the US or British system, but provides more scientific content and qualifications in a broader range of working areas. See *www.bdp-verband.org/psychologie/faq_recognition.html#08–translator's note*.)) [Fydrich and Kommer, 2004].

On July 1, 1964, the Federal Social Court (Bundessozialgericht), in its 'Neurosis Ruling,' stated clearly: 'Mental disorders – neurotic inhibitions that the insured person cannot overcome on his own, even with reasonable exertion of will – are a disease' [Sponsel, 2006, p 12]. This much-discussed ruling was not only very important for public awareness of the existence of and need for treatment of mental disorders, but also formed a crucial legal basis for the reimbursement of medical costs by insurance underwriters. In fact, the health insurance funds began at that time, initially on a voluntary basis, to partly cover the costs of psychotherapy. Just as important at the time were the Dührssen studies of 1962 and 1965, which go down in the history of psychology as the first empirical studies of the effectiveness of German psychotherapy. With these two large-scale catamnestic studies of over 1,000 patients, Anne Marie Dührssen and her colleagues demonstrated that the average expected length of hospital stay for psychoanalytically treated patients with neurotic diagnoses, compared to both untreated patients and a random sample, turned out to be significantly lower within the follow-up period of 5 years [Dahm, 2008; Helle, 1998].

The Psychotherapy Guidelines

In addition to the Neuroses Ruling, the results of the Dührssen studies were crucial for achieving the first of the two major milestones in the history of German postwar psychotherapy: the adoption of the first Psychotherapy Guidelines on May 3, 1967, which then went into effect on October 1, 1967. These guidelines for the first time allowed analytical and depth psychotherapy by physicians to legally qualify for standard health insurance benefits [Helle, 1998; Dahm, 2008; Waldherr, 2003]. A special feature was the introduction of 'depth psychotherapy,' which originally, however, was just a kind of short-term psychoanalysis that promised cost savings [Helle, 1998]. The methods of behavioral therapy [Daiminger, 2007] and client-centered psychotherapy [Helle, 1998] that were already well established in the USA, however, found as little acceptance in the psychotherapy guidelines as did the possibility of treatment by psychotherapists who were not doctors [Sponsel, 2006].

As important as the adoption of these guidelines was for the establishment and development of psychotherapy in Germany, and as much as it may also have relieved patients to have their treatment covered by health insurance, there was at first not much change with respect to the dismal supply of care providers. Thus Helle [1998] reports that in 1969 there were all of 190 psychotherapeutic doctors authorized to receive insurance payments for treatment in West Germany!

But the social changes of the late 1960s and 1970s, including the gradual export of the 'psycho-boom' from the USA to West Germany, led to an increasing demand for psychotherapy [Jaeggi, 2004].

Therefore the Clinical Psychology Section of the BDP, back in 1968, sought to include a binding regulation on the provision of health care by Diplom psychologists. Training curricula were developed and negotiations were opened up with health insurance funds, representatives of the physicians' self-administration bodies and politicians concerned with medical issues, which at first seemed very promising [Daiminger, 2007]. We shall explain below why it took 30 years to reach this goal.

Nevertheless, the widening gap between demand for providers and their supply was now increasingly being closed by psychotherapists with non-medical professional training. Furthermore, in the wake of the 'psycho-boom,' new therapeutic methods took off, in addition to psychoanalysis, notably behavioral therapy, talk therapy and Gestalt therapy, but also many other methods of greater or less reliability and effectiveness [Jaeggi, 2004]. The courts increasingly ruled in favor of patients' legal claim to insurance benefits for psychotherapy, based on the 'Neuroses Ruling' and the Psychotherapy Guidelines. The health insurance funds were thus also forced to cover costs for psychotherapy that was not performed by doctors and in was not in any policy directive.

Reimbursement for Psychotherapy and the Process of Delegating Authority

Reimbursing the costs of psychotherapy (according to SGB V § 13) thus spread as a quasi 'shadow economy' alongside the official Psychotherapy Guidelines. Therapy on a cost-reimbursement basis was, throughout its existence, an unsatisfactory emergency solution for all concerned: It offered neither the patients nor the therapists sufficient legal, financial and planning security, and always suffered from image problems due to a lack of quality control, despite efforts to improve the situation. For it was not possible for either the patients or the health insurance personnel or the courts to distinguish which therapists were competent, which therapeutic methods were effective and successful and for which patients psychotherapy was really indicated [Best et al., 2008].

The least enthusiastic about the reimbursement process, as expected, were the functionaries who determine medical policy guidelines. So, under pressure, they decided in 1972 to include in the Psychotherapy Guidelines the delegation of authority for certain medical treatments to non-physicians [Fydrich and Kommer, 2004]. This decision stipulated that psychotherapists without a medical license, specifically psychology graduates, could be added to the list of delegated therapists if they had graduated from an approximately 5-year postgraduate training program at an institution specially licensed for this purpose by a policy guideline (at that time, only for psychoanalysis and depth psychology), which included, among other things, a usually unpaid 1-year internship in a psychiatric clinic. The delegated therapist was thus allowed, on the instruction (delegation) of a psychiatrist or psychotherapeutic doctor, to perform psychotherapeutic treatment for reimbursement by insurance. However, the intention was to abolish the delegation process – i.e., to stop referring to treatments by 'non-doctors,' as soon as enough doctors would advocate such psychotherapeutic care (which, however, never occurred). Whether it was intended to keep the barriers to participation in the delegation process so high that the doctors would have no serious competition, or to enable them to get rid of the competition again quickly if necessary, in any case, the delegation process failed because it was largely ineffective. It succeeded neither in ensuring adequate care for the population, nor, until the Psychotherapists Law took effect, in eliminating the unpopular reimbursement procedures [Schildt, 2007].

The Belated Establishment of Behavioral Therapy by Policy Directive

In 1966, and thus about the same time as the adoption of the first Psychotherapy Guidelines, which were initially reserved exclusively for doctors working in psychoanalysis and depth psychology, the first German Center for Behavioral Therapy

was set up in Munich, at the Max Planck Institute for Psychiatry, under the direction of Johannes Brengelmann [Daiminger, 2007; Margraf, 2000]. Also at this time and in this context, Brengelmann's first co-workers, namely Jarg Bergold and Karl-Herbert Mandel, set up the first behavioral clinic at the University of Munich. That was the beginning of outpatient behavioral therapy in Germany [Margraf, 2000].

Like Hans-Jürgen Eysenck, under whose guidance he had previously worked at Maudsley Hospital in London, Europe's first center for behavioral therapy, Brengelmann was a charismatic and aggressive advocate of this still-young method of therapy. So he and his early colleagues set against the prevailing psychodynamic methods, the 'great propagandistic trinity ...: scientific method, cost effectiveness and efficacy' [quoted by Daiminger, 2007, p 97], which they understood to be still the chief claim of behavioral therapy. This pioneering and 'missionary work' – Jarg Bergold retrospectively describes himself and his colleagues who worked with Johannes Brengelmann as 'preacher troops' [quoted by Daiminger, 2007] – led to the rapid spread and popularity of behavioral therapy in Germany. Soon other centers were set up for research, teaching and use of behavioral therapy, for example at the University of Münster, under the direction of Lilly Kemmler [Margraf, 2000]. In 1968, the Association for the Advancement of Behavioral Therapy (Gesellschaft zur Förderung der Verhaltenstherapie, GVT) was founded, Germany's first specialist association for behavioral therapy. It had about 450 members in 1969 [Margraf, 2000].

At a time of the 'psycho-boom' and the growing gap in supply of psychotherapeutic care, which medical psychoanalysts even then could not come close to filling, as well as at the time of the student movement and social awakening, the rapidly growing popularity of the young and modern methods of behavioral therapy, which promised to be scientific, economical and effective, seemed logical, if not even inevitable [Daiminger, 2007]. Contributing to its generally positive, social and emancipatory image, was the fact that the less well-educated social strata [Jaeggi cited by Daiminger, 2007] and psychiatric patients with chronic disorders, for whom psychoanalytic intervention was considered out of reach, seemed to be treatable with the help of behavioral therapy.

The spread of behavioral therapy was also associated with the expansion of clinical psychology in Germany, which developed along with behavioral therapy as an approach to treatment that counterposed a genuine psychological, empirically scientific and non-dogmatic concept of treatment, to the doctors' monopoly on treatment, as well as what was widely perceived to be the authoritarian and elitist dogmatism and personality cult of the psychodynamic 'schools' [Daiminger, 2007]. The expansion of behavioral therapy therefore benefited from the 'luck of good timing' [Kemmler, cited by Daiminger, 2007, p 214], and offered many Diplom psychologists in clinical practice, in particular, a 'broad identification potential' [Daiminger, 2007, p 222].

As mentioned above, the BDP since 1968 has tried to get professional licensing specifically for clinical psychologists. This, however, required clearly defined job descriptions and training curricula that did not yet exist for behavioral therapy [Daiminger, 2007]. There was no postgraduate training in the modern sense – someone who wanted to learn behavioral therapy had to attend the appropriate university lectures, and preferably the guest lectures and workshops of the protagonists of behavioral therapy from the U.S., England and South Africa, such as Eysenck, Skinner, Wolpe, Lazarus and Kanfer. Moreover, the motto was: 'learning by doing and experiencing' [Hand, 2006, p 5]!

If the first years of behavioral therapy in Germany were a bit adventurous and chaotic, still there was great euphoria, an enthusiastic optimism and a conviction, which may seem arrogant today, that 'anything goes' [Daiminger, 2007, p 43]. With increasing expansion and institutional establishment, however, there came growing conflicts within the behavioral therapy movement in the 1970s.

A potential substantive conflict here was the so-called 'cognitive turn' [Margraf, 2000], whose origins in Germany are mainly traceable to the visiting professorship of Frederik Kanfer at the Psychological Institute of the University of Münster in 1970 [Daiminger, 2007]. In any case, it was not *the* behavioral therapy at that time, but very different concepts and procedures on the part of different schools of thought. In particular, many cognitive concepts, such as those of Beck and Ellis, were still considered to be independent therapeutic methods and not as behavioral therapy at all. Only in the 1990s was there a largely consensual integration of learning theory and cognitive approaches into an integrated concept of behavioral therapy [Margraf, 2000].

Furthermore, during the 1970s there were growing professional-political disputes among behavioral therapists, as well as what seemed at times like the erection of insurmountable barriers between 'camps.' These are to be understood mainly in the context of the Marxist student movement of social criticism, but also of the contemporary external critique and sometimes discriminatory hostility toward behavioral therapy. Prejudices to the effect that behavioral therapy involves primitive psychology or 'rat psychology,' oriented to authoritarian drill [Mitscherlich, cited by Margraf, 2000, p 13] as a power instrument of the ruling elite, were quite common at that time. Sometimes also formulated in a differentiated way, it was especially the critique of positivism – i.e., the critique of the scientific basis of behavioral therapy by the Frankfurt School (which is beyond the scope of this article) – which put the behavioral therapists, with their overwhelmingly emancipatory understanding of the Self, under great pressure to justify their views [Daiminger, 2007].

In addition to the GVT, and originally as a professional complement to it, the German Professional Association of Behavioral Therapists (Deutscher Berufsverband der Verhaltenstherapeuten, DBV) was founded in 1971 [Margraf,

2000], with the goal of promoting a professional and social-welfare-based legal system for behavioral therapy, in which the association would concern itself with protecting the integrity of the title 'behavioral therapist' and setting up training guidelines, and in which `negotiations with legislators, doctors' associations and health insurance funds [should lead] to making it possible for Diplom psychologists to practice therapy on their own responsibility' [Schulte, quoted by Daiminger, 2007, p 190].

Subsequently, however, there was fierce controversy between the two associations and within the GVT. Some of the professional objectives of the DBV were fundamentally called into question and criticized as reactionary [Jaeggi, quoted in Daiminger, 2007]. In particular, many students in the GVT demanded equal participation for student members and wanted 'the training not to go around in elitist circles again and ... for the Diplom to be a professional qualifying instruction program and not an entry-level examination, after which one first receives one's professional training' [Schaldhaußer, quoted in Daiminger, 2007, p 200]. Also what was perceived as Johannes Brengelmann's authoritarian leadership style and more behaviorist approach came under increasing criticism within the GVT. The disputes escalated, and in 1972 Brengelmann was forced to resign and a new board was elected, but this one too had to resign as early as 1973, and was replaced by an interim board under the leadership of August Rüggeberg. Johannes Brengelmann and his supporters resigned from the association and founded the Institute for Therapy Research (Institut für Therapieforschung, IFT) in Munich [Daiminger, 2007].

One of the statutes of the BDP-oriented, certified postgraduate training course to qualify as a 'DBV Behavioral Therapist' was terminated as a result of these conflicts, as was the already advanced stage of the DBV's negotiations with the statutory health insurance funds and the associations of doctors who receive insurance compensation [Daiminger, 2007].

The GVT and DBV in 1976 merged to become the German Society for Behavioral Therapy (Deutsche Gesellschaft für Verhaltenstherapie, DGVT), which in the coming years, with up to 7,500 members, became one of the largest therapy associations in the world [Daiminger, 2007]. Far more contentious, however, was the professional significance of this association. Socially critical, leftist in orientation, and close to the trade unions, the DGVT was, for many of its members, the 'society of reference' and a progressive 'political force,' which represented the 'good conscience' of behavioral therapy [Daiminger, 2007], giving it the authority to refute criticism of this treatment method. Furthermore, with its orientation toward community psychiatry and community psychotherapy, the DGVT undoubtedly was very beneficial in caring for the mentally ill near where they live [Daiminger, 2007; Fliegel, 2005]. However, the DGVT saw municipal, community therapeutic facilities as being more sensible than individual clinics covered by insurance. Alongside its 'critique of the medical model of the field' [Daiminger, 2007, p 255], it radically rejected especially the newly created process of delegation of medical authority. 'Instead of a university examination to receive a diploma,' it called for 'a state examination, which would authorize the holder to practice medicine' [Fydrich and Kommer, 2004, p 37], and rejected, at first, the need for postgraduate therapeutic training. With this attitude, according to a widespread complaint, the DGVT contributed significantly to the delay in establishing directives for behavioral therapy procedures, but also to the delay in achieving the Psychotherapy Law [Daiminger, 2007].

Despite all these disputes, contradictions and problems, behavioral therapy in Germany experienced an enormous expansion during the 1970s. Most psychological institutes, by the end of the decade, had departments of Clinical Psychology, the majority of them oriented toward behavioral therapy [Daiminger, 2007]. The resulting increased research activities, as well as the cognitive turn, resulted in considerable substantive progress. 'By the end of the '70s, the usefulness of behavioral therapy was generally accepted' [Margraf, 2000, p 16].

The above-described stance of the DGVT led in 1980 to the founding of associations and training institutes that were willing to participate in the process of delegating medical authority, including the Association of Clinical Behavioral Therapy (Fachverband für Klinische Verhaltenstherapie, FRP) [Fydrich and Kommer, 2004] and the German Society of Behavioral Medicine and Behavior Modification (Deutsche Gesellschaft für Verhaltensmedizin und Verhaltensmodifikation, DGVM) [Daiminger, 2007]. In 1980, behavioral therapy was included in the delegation process, however initially only for settlement with the substitute insurance funds (*Ersatzkassen*). In 1984, the Association of Psychotherapists Covered by Health Insurance (Vereinigung der Kassenpsychotherapeuten) was founded, to represent the professional interests of behavioral therapists in the delegation process [Fydrich and Kommer, 2004]. On the other hand, 'still in 1985 ... a membership meeting of the DGVT [spoke out] against a definitive establishment of behavioral therapy as a service provided by physicians covered by health insurance' [Daiminger, 2007, p 337]. But at last, in 1987, it was no longer possible to prevent the acceptance of behavioral therapy as part of a fully comprehensive policy directive for all statutory health insurance funds [Dahm, 2008; Daiminger, 2005; Fydrich and Kommer, 2004].

By the end of the 1980s, the DGVT also finally reconsidered the matter. Thus, the previous model of training by a 'Working Group' based on self-study and small groups [Daiminger, 2007] was replaced by a training course in cooperation with the Distance University of Hagen (FernUniversität Hagen), which, with the exception of clinical-psychiatric activities that are still very controversial today [Strauss et al., 2009], was quite comparable to the guidelines for training therapists who participate in the delegation process. Furthermore, the DGVT gradually came to recognize the need for constructive participation, with a willingness to compromise, on a Psychotherapy Law [Daiminger, 2007].

Initial Efforts for a Psychotherapy Law

Both the 1973 preliminary report and the 1,800-page final report of the Psychiatric Commission of Inquiry in 1975 pointed to glaring deficiencies, both in inpatient and outpatient psychiatric and psychotherapeutic care. In addition to equalizing the categories of mental and physical illness, eliminating significant deficiencies in inpatient psychiatry, the Commission demanded a reduction in hospital stays and better outpatient psychotherapeutic care, including by psychotherapists with non-medical training [Dörner, 2000]. The reports of the Commission of Inquiry and the broad public discussion that ensued were the trigger for the later reform of psychiatry.

In 1976, the Psychotherapy Guidelines were revised, such that the chronically mentally ill and mentally disabled were included in outpatient psychotherapeutic care (which, oddly enough, was not previously the case).

The reports of the Commission of Inquiry led, at the same time, to the first discussion of a Psychotherapists Law that would include psychotherapists without a medical license [Helle, 1998]. Then in 1978, the first draft bill was submitted and discussed, for a Psychotherapists Law limited to professional regulations, but it failed quickly due to the disunity of the psychotherapists' associations and the resistance of medical functionaries [Bertram, 2006]. It would take about 10 years before a federal government seriously dealt with this issue again.

After the Federal Social Court in 1982 confirmed the obligation of health insurance funds to reimburse psychotherapy services – although this did not make standard health benefits available under the Psychotherapy Guidelines – there was a further increase in reimbursement for psychotherapy. As a result, some statutory health insurance funds, with the technicians' health insurance fund (the TK model) leading the way, reached an agreement with the psychotherapists' associations, in this case the BDP, to provide pragmatic and non-bureaucratic reimbursement of expenses in return for acceptable qualification standards for psychotherapists [Fydrich and Kommer, 2004; Pota and Lang, 2009; Waldherr, 2003].

As mentioned above, under the Non-Medical Practitioners Law [Heilpraktikergesetz] of 1939, anyone who was practicing medicine without a medical license – thus including psychotherapy–had to have permission according to the terms of this law. A complaint by the BDP, which criticized this as inappropriate for a professionally qualified Diplom psychologist, was rejected by the Federal Administrative Court (Bundesverwaltungsgericht) in 1983. After that, psychotherapists in private practice without a medical license were forced, until the PsychThG went into effect, to obtain a certificate as a complementary health-care practitioner (limited to the practice of psychotherapy), or else face the threat of criminal prosecution [Schildt, 2007]. At the same time, the Federal Administrative Court called for a more appropriate solution, in the form of a Psychotherapists Law [Sponsel, 2006].

In 1989, the BDP, along with the DGPs [Deutsche Gesellschaft fur Psychologie, German Psychologial Society] adopted guidelines for a curriculum for clinical psychologists/psychotherapists, as a counter to the Psychotherapy Guidelines and the delegation process [Fydrich and Kommer, 2004].

Health Minister Ursula Lehr, herself a psychology professor, renewed the effort for a Psychotherapists Law in 1989. She commissioned a research report, conducted under the leadership of A.E. Meyer with the collaboration of Klaus Grawe and Rainer Richter, which appeared in 1991 and confirmed the urgent need for a Psychotherapy Law to improve care, assure quality and provide legal security for all parties. It also included specific proposals for very restrictive provisions on the inclusion of professional psychotherapists in the health system, for which the new health-care profession of 'psychologists specializing in psychotherapy' was to be created. This was clearly oriented to the delegation rules of the Psychotherapy Guidelines, and was integrated to a significant extent into the Psychotherapy Law that was later adopted [Steglich, 1991].

Around the same time, on October 3, 1990, the two German states were unified, which brought with it additional legal regulatory requirements, including in the field of psychotherapy [Pabel, 2009].

The 'Psychologist Specializing in Medicine': Exemplary Legal Regulations in the GDR?

For all the manifest shortcomings of psychiatric and psychotherapeutic care in the territory of the former GDR, there was nevertheless one aspect that put the health-care system of the old Federal Republic to shame, which is that there had long been a pragmatic system in the GDR for equitable inclusion of professional psychotherapists in health care: In 1981, the postgraduate course of study for 'psychologists specializing in medicine' was introduced; it was offered part-time and free of charge, and its graduates were entitled to equal rights in psychotherapeutic work alongside physician specialists in clinical psychotherapeutic practice [Frohburg, 2004; Pabel, 2009]. The psychotherapeutic skills imparted were quite comprehensive with respect to method of treatment: Alongside a focus on talk therapy and behavioral therapy, there were also elements of psychodynamic treatments such as catathymic image perception, as well as suggestive and hypnotherapeutic approaches [Frohburg, 2004].

However, psychotherapists were hardly established in independent practice in the GDR; outpatient psychiatric and psychotherapeutic care occurred predominantly in so-called 'counseling centers for psychologically damaged people and the elderly,' which were affiliated with municipal clinics and in which the doctors and psychologists worked as employees. In addition to advisory and therapeutic advice, however, these counseling centers were responsible for 'monitoring ... and

education of vulnerable citizens, ... [which] implied cooperation with the institutions of "domestic security"' [Heitmann, 1999, p 26]! Without judging the extent to which the staff of the counseling centers performed these 'tasks,' this quotation simply references the fundamental problem. Also for this reason, an important alternative presented in the GDR were the therapeutic facilities and counseling centers run by churches, of which, however, there was a much smaller number [Heitmann, 1999; Pabel, 2009].

Accelerated Steps to Psychotherapists Law

After disputes within the BDP, leading members of the association resigned and in 1992 founded the German Association of Psychotherapists (Deutscher Psychotherapeutenverband, DPTV). At the same time, there was a merger between the associations whose members were predominantly part of the insurance reimbursement process, in the Psychotherapy Working Group (Arbeitsgemeinschaft Psychotherapie, AGPT), and those whose members participated in the delegation process, in the Working Group of Guidelines Associations (Arbeitsgemeinschaft der Richtlinienverbände, AGR), in order to combine their respective interests in achieving a Psychotherapy Law [Fydrich and Kommer, 2004]. Many different models for such a law were then drafted and discussed, with intense controversy [Schildt, 2007].

A reworked draft of the Psychotherapy Law of 1993, taking account of the results of the above-mentioned research report, contained, in addition to professional regulations, social-welfare regulations for accreditation of professional psychotherapists to the statutory health funds. The draft, which was modified significantly by the legislative Health Committee, also included many provisions of the law that was passed 5 years later, such as the requirement, stated in a policy directive, for proof of expertise. On the other hand, it included the requirement of a report by a consulting psychotherapeutic doctor, as well as a 25% patient co-payment. This co-payment provision led to the failure of the bill, first in 1993, then again after a second and third reading, and finally after the futile convening of the legislative Conciliation Committee in 1994, in the Bundesrat, where the Social Democratic Party had a majority [Schildt, 2007].

In 1996, the state social court of North Rhine-Westphalia declared the TK [technicians' insurance fund] provision to be unlawful, along with general agreements between psychotherapists' associations and the statutory health insurance funds for regulated reimbursement [Schildt, 2007]. At that time, however, over half the psychotherapy covered by statutory health insurance was paid for through reimbursement procedures [Waldherr, 2003], upon which most insurance coverage depended, as well as the livelihood of many thousands of psychotherapists. The indignation of most psychotherapists who were not doctors, and their associations, was correspondingly great. And then on May 14, 1997, there was a demonstration in Bonn with over 5,000 participants, organized by the AGPT, against the obliteration of the livelihood of an entire profession, for improvement of psychotherapeutic care and for a Psychotherapists Law. More than 100,000 signatures were also collected for this objective [Bertram, 2006; Sponsel, 2006].

Good Things Are Worth Waiting For: The Adoption of the Psychotherapy Law

Despite this 'pressure from the street' and the persistent advocacy of then-Health Minister Seehofer for a Psychotherapy Law, this was occurring in the wake of fierce disputes between the AGR and the AGPT, mainly about the transitional provisions of the proposed law, and also the resistance of the medical profession, especially to the now-favored 'integration model' of professional psychotherapists in the self-administration of the medical profession. Nevertheless, a new bill again passed the Bundestag on November 27, 1997, along with a co-payment law requiring 25% payment by the patient. Essentially because of this provision, but also because of other hardships, such as the time-slot provision in the transitional arrangements, both laws initially failed in the Bundesrat on December 19, 1997 [Schildt, 2007].

A reworking of the law, as well as the change of the majority in the Bundesrat, finally led to the Bundestag's adoption of the Psychotherapy Law on February 12, 1998, after a second reading [Best et al., 2008]. With the consent of the Bundesrat, the Psychotherapy Law was finally passed on June 16, 1998, and went into effect on January 1, 1999 [Fydrich and Kommer, 2004]. At the last minute before the law went into effect, the new federal government under Gerhard Schröder agreed to strike out the controversial co-payment provision, which was originally contained in the draft law [Schildt, 2007].

'Integration Problems' of a New Profession

However, the implementation of the Psychotherapy Law, in particular because of its transitional provisions, was initially extremely difficult and fraught with conflict [Nilges, 2001]. The integration of professional psychotherapists and child and adolescent psychotherapists into the system of doctors supported by statutory health insurance, which the Psychotherapy Law, as adopted, saw as the 'integration model,' met with fierce opposition and controversy. There was criticism of the underrepresentation of professional psychotherapists compared to doctors' representatives in the decision-making bodies of the insured health-care system, along with a required high minimum rate of accredited physician psychotherapists (at least 40%, according to the planning guidelines), which had, among other things, negative effects on many re-

gions that still faced an inadequate supply of providers. The integration of the many professional psychotherapists into the insured health-care system and the associated expansion of the volume of psychotherapeutic services, while the budget for fees was capped at the same time, initially also led to substantial fee reductions for psychotherapy [Best et al., 2008].

The most important historical milestones on the way to professionalism and establishment of the new profession are the so-called 10-Pfennig judgments of the Federal Social Court of August 25, 1999, on the basis of which there was a gradual improvement in the fee situation [Stellpflug, 2008], and the foundation of the Chamber of Psychotherapists in 2000 and the Federal Chamber of Psychotherapists in 2003 [Fydrich and Kommer]. The importance of the recently published research report on training of psychotherapists [Strauss et al., 2009], whose reform proposals are the subject of controversy, is also not to be underestimated [Rief, 2009]. The Psychotherapy Law is thus continuing its suspenseful history.

Conflicts of Interest

As an established, self-employed professional psychotherapist, I do not feel obligated to anyone in a way that could cause conflicts of interest in relation to this article.

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