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The Challenge of Psychoanalytic Psychotherapy in Japan: Medical Administration, Clinical Practice, Psychoanalytic Training

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Abstract

The health insurance system plays an important role in psychiatric care and affects psychoanalytic psychotherapy, which is performed within psychiatric care. The actual state of psychoanalytic psychotherapy under the health insurance system varies from country to country. However, there are few papers discussing psychoanalytic psychotherapy on the health insurance system in Japan. Recently I have discussed psychoanalytic psychotherapy and health insurance system in Japan in the context of the association with evidence-based practice. In this review, various challenges currently facing psychoanalytic psychotherapy in health insurance system in Japan were discussed from four main perspectives as follows.

a) Practice of psychoanalytic psychotherapy in the health insurance system

b) Training of psychoanalytic practitioners in psychiatric care

c) Evidence-based psychoanalytic psychotherapy

d) Access to psychoanalytic psychotherapy

Keywords: Health insurance system; Medical fee system; Evidence-based practice; Psychoanalytic psychotherapy; Psychoanalytic training

Introduction

Although the principle of psychoanalysis is universal to humanity and spans across borders, the clinical practice of psychoanalysis varies from country to country. The health insurance system, which serves as the basis for protecting people's health, is important to psychiatric care in each country, but the actual practice s of psychoanalytic psychotherapy in the health insurance system vary. For the sake of development in the area of psychoanalytic psychotherapy, it is useful to know the actual state of psychoanalytic psychotherapy with regard to the health insurance system of each country. However, there are few papers discussing psychoanalytic psychotherapy on the health insurance system in Japan [1]. I have discussed in a previous paper psychoanalytic psychotherapy and the Japanese health insurance system with respect to the Evidence-Based Practice (EBP) in recent years [2]. The challenges of psychoanalytic psychotherapy under the health insurance system.

The Challenges of Psychoanalytic Psychotherapy Practice under the Health Insurance System

In general, health insurance systems are classified into three categories: state-run, social, and private. The social health insurance system was introduced in Japan in 1961, and universal public health insurance has been established [3]. Currently, patients between 6 and 70 years of age pay 30% of their medical fees for medical care received at insurance-covered medical institutions while the remaining 70% of their medical fees are paid to each medical institution by the medical fee examination and payment agency. However, medical fees are paid for medical treatment by physicians registered as an insurance doctor, but not for medical act by clinical psychologists alone in insurance-covered medical institutions [4]. 'Clinical Psychologists' are certified by the Foundation of the Japanese Certification Board for Clinical Psychologists, which was established in 1988, and are required to have completed a designated postgraduate course in clinical psychology.

Medical remuneration for medical practices has been stipulated by the government since 1958 and is revised every two years. Psychoanalytic treatment was a mainstream of psychiatric treatment in Japan at that time, and there were three 'talking therapies' among the specialised psychiatric therapies covered by the Ministry of Health and Welfare in 1958: 'Standard-type psychoanalytic therapy', 'brief-type psychoanalytic therapy', and 'psychotherapy'. According to the 1961 national treatment guidelines, 'standard-type psychoanalytic therapy' was deemed appropriate three times weekly for deeper neurosis, and 'brief-type psychoanalytic therapy' was specified as appropriate twice weekly or less for shallower neurosis. These dated concepts of 'standard-type psychoanalytic therapy' and 'brief-type psychoanalytic therapy' from the period appear to be equivalent to the psychoanalysis and psychoanalytic psychotherapy of today, respectively.

'Brief-type psychoanalytic therapy' was abolished in 1976 with 'psychotherapy' divided according to inpatient and outpatient practices in 1988. However, since medical fees for 'standard-type psychoanalytic therapy' and 'psychotherapy' are still recognised even now, the terms 'psychoanalysis' and 'psychotherapy' appear to be well established in the Japanese medical system. However, there are a number of issues in psychoanalytic psychotherapy within the current Japanese health insurance system.

The first is an issue regarding the name of psychoanalytic treatment and the actual state of this treatment. Currently, the medical compensation for 'standard-type psychoanalytic therapy' is limited to six times a month in sessions of 45 minutes or more. This would indicate that 'standard-type psychoanalytic therapy' in the health insurance system is essentially psychoanalytic psychotherapy or dynamic psychotherapy conducted on a weekly basis. This reflects a mismatch between the name and the actual practice of psychoanalytic treatment in the health insurance system. This mismatch might be because the health insurance system in Japan was the product of incremental "muddling-through" rather than an orderly and rational process [5]. This mismatch may also lead to misunderstanding to psychoanalysis by the Japanese people. The challenge is how to resolve mismatches such as these between the name and the actual practice; however, it is not easy for Japan's public medical administration to change the system once it has been established.

The second issue is regarding medical fee remuneration for psychoanalytic treatment. The medical remuneration for 'standard-type psychoanalytic therapy' has not changed since 1996, when it was increased from 3600 yen to 3900 yen. Meanwhile, in 2010, the medical remuneration for 'outpatient psychotherapy' was increased from 3600 yen to 4000 yen for sessions of 30 minutes or more and reduced from 3500 yen to 3300 yen for sessions of 30 minutes or less. As a result of this medical fee remuneration revision, insurance-covered medical institutions are increasingly requesting medical fees for 'outpatient psychotherapy' rather than 'standard-type psychoanalytic therapy' when they perform psychoanalytic psychotherapy. This appears to indicate that the Japanese government is moving toward abolition of medical remuneration for 'standard-type psychoanalytic therapy'. In any case, given that the current price of the McDonald's Big Mac in Japan is 390 yen, these medical fees would be not high.

In order to carry out psychoanalytic psychotherapy at insurance-covered medical institutions, a medical management perspective is required; however, it is currently difficult to continue psychoanalytic psychotherapy with medical insurance alone. In Japan, mixed medical care, which combines insurance and non-insurance treatment for one patient at the same time, has not been approved because of the increased cost burden on some patients, which leads to the collapse of the public health insurance system for all. There are few cases of psychoanalytic psychotherapy being conducted at insurance-covered medical institutions as an out-of-insurance practice, and from a medical management perspective, a compromise method is often employed within the insured treatment in which patients pay a reservation fee of around several thousand yen, which is independently decided by each medical institution. In the future, the challenge will be how to ensure that the Japanese health insurance system reflects the actual state of psychoanalytic psychotherapy and that psychoanalytic psychotherapies are sustainable in terms of medical care management. However, it will not be easy to make psychoanalytic psychotherapy sustainable within the public health insurance system given the current difficulties of Japan's healthcare finance [6].

Challenges in Training Psychoanalytic Practitioners in Psychiatric Care

To provide patients with a certain level of medical practice within the public health insurance system, therapists essentially must acquire evidence-based medical techniques in professional training. The Japanese Society of Psychiatry and Neurology (JSPN), Japan's largest academic psychiatry organisation, was established in 1902. After a long period of discussion, the JSPN decided to introduce a certified psychiatrist system in 2002 and began certifying physicians who met the prescribed requirements as certified psychiatrists in 2006. The medical specialist system is the cornerstone of the specialist of Japan's psychiatric care.

Meanwhile, the largest academic psychoanalytic organisation in Japan, the Japan Psychoanalytical Association (JPA), was established in 1955. The JPA was the same organisation as the Japanese branch of the International Psychoanalytical Association (IPA), the Japan Psychoanalytic Society (JPS), until 1980. Although members of international psychoanalytical organisations such as JPS are allowed to join after the completion of psychoanalytic training, as an academic organisation, this is not a membership requirement of the JPA. Since 2000, the JPA has been certifying psychiatrists and clinical psychologists who have met certain requirements as psychoanalytic psychotherapy practitioners for the therapeutic identity of its members. However, since the JPA, an academic organisation, does not have a training institute like the JPS, JPA training is basically individual and self-regulated, and personal psychotherapy is not included in the certification requirements of psychoanalytic psychotherapists (JPA model) [7]. However, some members of the JPA have trained at international and domestic psychoanalysis institutes, including the JPS [8]. Since the JPA has also contributed to the approval of medical compensation for 'standard-type psychoanalytic therapy' since 1958, it may be expected that the JPA will provide psychoanalytic training program as a subspecialty to certified psychiatrists who completed training program for senior resident [9]. However, there will be several challenges in training psychoanalytic practitioners within Japan's psychiatric care system.

First, there is the issue of psychotherapy training for senior resident psychiatrists aiming to become certified psychiatrists. The item of psychotherapy in the psychiatrist training programme is mainly considered by the JSPN Psychotherapy Committee. In the second edition of the senior residency

training manual of the JSPN, published in 2018, psychiatry certification consisted of practicing supportive psychotherapy, understanding Cognitive Behavioural Therapy (CBT), psychodynamic psychotherapy, either Morita therapy or Naikan therapy, and experiencing one of these therapies under supervision.

The required practical experience of psychodynamic psychotherapy for certified psychiatrists is merely the basic certified psychiatrist training. Certified psychiatrists are not fully trained in psychoanalytic psychotherapy techniques, but the current health insurance system allows them to request a medical fee for 'standard-type psychoanalytic therapy'. There are no departments within the JSPN that carry out psychoanalytic training as a subspecialty, so, for certified psychiatrists to receive more specialised psychoanalytic training, they must undergo further training at the JPA, JPS, and Japan Academic Association of Psycho-analytical Psychiatry (JAAPP) etc. In the future, the challenge will be how to systematise psychoanalytic training as a subspecialty for certified psychiatrists to provide patients with psychoanalytic psychotherapy as a specialised technique in psychiatric treatment within the health insurance system. As such, it may be necessary for the JSPN to work in an organized, coordinated manner with the JPA, JPS and JAAPP etc.

Second, there is the issue of psychoanalytical academic activities and training. Currently, the academic activities undertaken by the JPA are not necessarily backed by psychoanalytic training. A future challenge will be how to ensure that psychoanalytical academic activities have a foundation of psychoanalytic training. To this end, it may be necessary for the JPA to coordinate with psychoanalytic institutes, including the JPS.

The third issue is the number of members and the ratio of doctors to psychologists in psychoanalytic organisations. According to JPA membership statistics in November 2021, JPA membership had a slightly upward trend but has started to decline since 2010, and, in 2021, it dropped to 2557, back to the levels seen in the 2000s. The proportion of psychiatrist JPA members continued a long-term downward trend, falling below 1/4 for the first time to 24.7%. It is expected that JPA member numbers and the percentage of psychiatrists will continue to decrease in the future.

In 2021, the total number of psychoanalytic psychotherapists certified by the JPA was 214 (113 physicians, 101 psychologists), garnering 8.2% of the total membership. Of these, 52.8% were physicians with the number of certified supervisors at 90 (61 doctors and 29 psychologists), accounting for 3.5% of the total with 67.8% being physicians. This would indicate that previous JPA leaders included a large proportion of psychiatrists, and dynamic psychiatrists led JPA. However, the percentage of psychiatrists leading JPA is expected to continue to decrease.

The challenge in the future will be how to sustain psychoanalytic psychotherapy in the health insurance system given the diminishing number of psychiatrists involved in psychoanalytic clinical practice and academic activities in Japan. To this end, it may be necessary to admit non-doctors, such as 'Certified Public Psychologists', as practitioners of psychoanalytic psychotherapy in the health insurance system. 'Certified Public Psychologists' is a national qualification for psychologists and first introduced in Japan in 2017. The Certified Public Psychologist Act stipulates the following as: If the clients who 'Certified Public Psychologists' are involved need to psychiatric care or have already received it, they must accept instructions from their physicians.

Challenges for Evidence-based Psychoanalytic Psychotherapy

In recent years, the public health insurance system has required that medical treatment provided to patients at insurance-covered medical institutions be EBP in order to effectively and efficiently protect people's health. From the EBP perspective, it might be required that clinicians be guided by the best available evidence and it might be thought that science could be separated from pseudoscience on psychotherapy practice [10]. Since the beginning of Japan's public health insurance system, the government has recognised medical remuneration for 'standard-type psychoanalytic therapy'; however, this was basically 'experience-based practice' and not the EBP of today. Japan's Ministry of Health, Labour and Welfare is conservative and will not adopt the results of overseas clinical research directly into Japan as is.

To continue the practice of psychoanalytic psychotherapy within the public health insurance system, clinical research will need to be conducted on the efficacy and cost-effectiveness of psychoanalytic psychotherapy with Japanese participants according to medical condition, the Ministry of Health, Labour and Welfare will need to approve enough medical fee for psychoanalytic psychotherapy, and dynamic psychiatrist will need to carry out evidence-based psychoanalytic psychotherapy. However, there are several challenges in conducting clinical research in psychoanalytic psychotherapy in Japan.

First, there is the issue of clinical research interest among psychoanalytic practitioners. Until now, the academic activities of the JPA have centered on clinical case studies. Case reports, expert opinions and personal observations etc. is classified the lowest level of evidence, level V [11]. Psychoanalytical research with a high level of evidence has rarely been conducted in Japan. Many of the psychoanalytic researchers in Japan seem to be pure clinicians, who tend to prefer non-peer-reviewed, free-form clinical essays published as book by publishers or clinical essays such as those published in the IPA journal. Japanese psychoanalytic psychotherapy practitioners tend to focus on internal and subjective experience-based practice, and they may have a tendency to view empirical case studies as high-value psychoanalytic research. How to increase psychoanalytic practitioners' interest in clinical research beyond empirical case studies is a challenge for the future. As such, various academic activities will need to be carried out within the JPA.

Second, there is the issue of the organisations to which psychoanalytic practitioners belong. Heisaku Kosawa, the founder of the JPA, was a psychiatrist, but many of the early steering committee members and regular JPA members were

professors and psychiatrists at university medical schools. Recently, limited numbers of JPA members work in university medical and psychology departments, and it seems that increasing numbers of members are involved in clinical practice at clinical facilities such as hospitals, clinics, and private consultation rooms [12]. In Japan, it would be difficult to earn research grants unless you belong to a research institute, such as a university. Therefore, it may be difficult for JPA members to conduct high evidence-level clinical research. The question of how JPA members will conduct clinical research on the efficacy and cost-effectiveness of psychoanalytic psychotherapy is a current issue. To this end, the activities of the JPA evidence working group, established in 2015, are highly anticipated.

Challenges in Psychoanalytic Psychotherapy Access

The public health insurance system requires that a certain level of medical practice be provided to patients fairly and smoothly. This also applies to psychotherapy. With its effectiveness in clinical researches in Japan, CBT was first recognised in the public health insurance system in 2010 as a medical remuneration item in 'cognitive therapy and cognitive behavioural therapy' [13,14]. In the medical fee system, a total of 16 claims can be made for 30 minutes or more with a remuneration of 4800 yen when performed by a physician and 3500 yen when performed by doctor and nurse. For CBT, under the current medical fee system, a total of 16 claims can be made for 30 minutes or more with a remuneration of 4800 yen when performed by a physician and 3500 yen when performed by both physician and nurse. Therefore, the one-time medical fee is higher than that of 'standard-type psychoanalytic therapy'. Thereafter, a national Centre was established to carry out CBT training and research, and CBT training is being actively undertaken nationwide. CBT, which is closely linked to national health policies, would now be the mainstream of psychotherapy in Japanese psychiatric care.

In contrast, psychoanalytic psychotherapy has a long history in Japanese psychiatric care, but, as outlined above, there is a possibility that it could effectively disappear from medical fee system. Since the training for psychoanalytic psychotherapy is essentially concentrated in the major cities, JPA-certified psychoanalytic practitioners are unevenly distributed in the metropolitan central business districts, making up less than 1% of the total number of psychiatrists and clinical psychologists in Japan. Having departed from national medical policy, psychoanalytic psychotherapy would now be a non-mainstream offshoot in psychiatric treatment in Japan. Nevertheless, it is likely that there are still patients who truly need psychoanalytic psychotherapy, yet it will not be easy for them to gain access to psychoanalytic practitioners. Therefore, the question of how to ensure access for patients who require psychoanalytic psychotherapy is a current issue.

This will require clinical collaboration with certified psychiatrists who do not have a psychotherapy subspecialty and certified psychiatrists who have a different psychotherapy subspecialty such as CBT. Thus, it is important that all certified psychiatrists have an understanding of psychoanalytic psychotherapy and CBT as psychiatric subspecialities and work together for patient health and well-being rather than competing for patients within the health insurance system.

Conclusions

In this paper, I have discussed some of the challenges of psychoanalytic psychotherapy in Japan. Psychoanalytic practice is closely related to psychiatric care. Publicly available psychoanalytic psychotherapy is necessary to protect the health of the Japanese people effectively and efficiently within the health insurance system, which is the foundation of psychiatric care. Currently, psychoanalytic psychotherapy faces a crisis of survival in Japan's health insurance system. Psychoanalytic treatment may be torn down by the conflict between public psychiatric care and private practice.

On the other hand, there may be an occasional consideration that psychoanalysis is a different dimension of practice from psychiatric care or that psychoanalysis is a practice that exists intermediate space between medical and non-medical practice. In particular, private-practice psychoanalysts and psychotherapists engaged in psychoanalytic practice outside of psychiatric and health insurance systems may not be interested in psychoanalysis within psychiatric care.

Actually, both 'clinical psychologist' and 'certified public psychologist' have certain responsibilities in psychiatric care. In recent years, there have been increasing opportunities for psychological support for patients with a variety of biopsychosocial problems, and it may be difficult to carry out psychoanalytic clinical practice completely independently of psychiatric care. In addition, the complete separation of psychoanalysis and psychiatric treatment can be attributed to a defensive attitude from psychoanalytic practitioners regarding psychiatric treatment. In order for psychoanalytic psychotherapy to be feasible in Japanese psychiatric care, it is important to work together on two paths: those that adapt to psychiatric care and those that function as non-medical practices.

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At the time of writing, I am the chair of a certification system committee in the JPA. I express my sincere gratitude to the people involved in the JPA and the JPS for training me as a psychoanalytic psychotherapist and psychoanalyst in Japan. I sincerely hope that psychoanalysis in Japan will develop further and survive in various critical situation of psychoanalysis.

Conflict of Interest

No potential conflict of interest was reported by the author.

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