Discussion of the therapeutic care of the psychogenically ill is fraught with difficulties. The danger of a tendentious interpretation of the epidemiological data analyzed by us, which is in any case considerable, would be greater still were it not we ourselves who risked putting forward interpretations and drawing conclusions. There is also no doubt that all estimates of need and proposals pertaining to care lack a proper foundation in the absence of basic epidemiological data on true prevalence rates.

Epidemiological knowledge on the true rates of prevalence among the psychogenically ill cannot be directly converted into a specification of the necessary number of therapeutic places (out- and/or inpatient) (Cooper and Bickel 1984). The conceivable measures and recommendations range from self-help, spiritual guidance, and neighborhood care, through a plethora of medicaments, somatic treatments, and out-/inpatient psychotherapy of widely varying intensity and orientation, to rehabilitation, retirement, recurrent imprisonment (e.g., for exhibitionism), social assistance (e.g., in cases of chronic alcoholism), or silent suffering and endurance; alternatively society might simply register with regret another suicide. Key influences on treatment uptake are the patient’s attribution of his symptoms, the diagnostic skill of the specialist consulted, the network of care, and last but not least, financial considerations and public opinion.

It is certain only that even in the Federal Republic, where a very generous system exists for the financing of psychotherapy (see Excurses in Chap. 9, p. 114ff.), considerably fewer patients have in the past received specialist psychotherapy than in fact required it.

On the basis of the true rates of prevalence of psychogenic disorders ascertained by us, we estimate that the treatment needs of the current West German urban population in the 25- to 45-year-old age group are approximately as depicted in Fig. 9. This estimate does not distinguish between individual psychotherapeutic procedures.

1. The lower half of the pie chart that has not been drawn contains those essentially in stable good health, to whom no consideration need be given in planning care.
2. The pie chart shows the ca. 50% of the population who, in terms of point prevalence, display clear psychogenic symptoms of such an intensity that were they to present to a specialist institution as patients seeking help, a clinician would assign to them an ICD diagnosis from the range 300-306. The left half of the chart (=25% of the population) represents those persons with an ICD diagnosis who are only slightly disturbed and would not exceed the cut-off point using our case definition. Even so, half of them (i.e., ca. 12% of the population) demand special attention because they constitute the population at risk. In the past they mostly will have received drug treatment, but they require an offer of advice or care, e.g., from a general practitioner competent to deal with psychological questions. Some of these persons will also doubtless already be among the current patients of psychoanalysts and behavioral therapists (justifiably, in view of their quite favorable prognosis).

3. In the ca. 25% who would be diagnosed as cases (right half of the pie chart), we estimate the need and capacity for treatment thus:
   - Approximately half of this group (=ca. 12.5% of the total population) require outpatient psychotherapy (from autogenic training through dynamic brief therapy and crisis intervention to intensive long-term individual or group therapy).
   - Ca. one-sixth (=ca. 4% of the population) require inpatient specialist psychotherapy or inpatient rehabilitative measures.