

# **The Psychotherapeutic Professions in Norway**

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## **I: Current Situation of Psychotherapeutic Professions**

### ***1. Identity of the psychotherapeutic professions.***

In Norway, the professions of psychology and medicine (psychiatry) have a strong standing as providers of mental health services including psychotherapy. As will be described below these professions are awarded different forms of privileges and responsibilities by the state. Members of the professions of psychiatric nursing and social work also conduct psychotherapy and counseling within the mental health and social service system. This is particularly so in institutions for children, adolescents and the family.

Psychotherapy is provided in different settings, both public and private, financed by the state and also privately. The bulk of mental health services, including psychotherapy and counseling, is provided by different forms of out-patient clinics. Psychotherapy is also provided in in-patient settings, but to a limited degree. These public mental health institutions are staffed by teams consisting of psychiatrists, psychologists, social workers, psychiatric nurses, which may provide psychotherapeutic services, and sometimes by physical therapists, occupations therapists and pedagogically trained professionals.

Licensed psychologists with a specialist status and psychiatrists are also providing psychotherapy in private practice within a state regulated system with partial reimbursement from the state. Licensed psychologists without a specialist status, and therapists trained by

private training institutions (e.g. Gestalt therapy, Psychodrama) are also providing some psychotherapy, but outside of the reimbursement system.

The basic training programs in the health or social service field such as medicine, nursing and social workers provide no training in psychotherapy. Psychology does, but to a limited degree. Professional studies of psychology and medicine is now a six year program, where students can enter professional school immediately following high school. However, as requirements are quite high, most students have additional academic or practice background before entering professional school.

Most training in psychotherapy is provided by private training institutions, some of which are partly publicly financed and which require participants to have completed basic training in medicine, psychology, nursing or social work. The major training institutions are: Institutt for psykoterapi, Psykoanalytisk institutt, Institutt for Aktiv Psykoterapi, Institutt for Gruppeanalyse, Norsk Karakteranalytisk Institutt. Some public mental health institutions provide 3-year educational stipends to post-graduate training for members of the professions mentioned above. For children and adolescents, regional mental health centers provide both psychotherapeutic services and psychotherapy training. As a rule, the trainings options are open to licensed mental health professionals and to social workers.

The professions of psychology and medicine also offer a specialist status which give licensure as specialists in psychology (with subspecialties) and psychiatry after completion of various practice requirements, course requirements, and supervision requirements with a duration of minimal five years. To become specialist in clinical psychology or psychiatry in Norway, there is a requirement of three years of clinical supervision. For psychiatry, at least two years of psychodynamically oriented supervision provide by an approved supervisor is mandatory. For

the third year, supervision is not restricted to any particular theoretical orientation. In the clinical subspecialties within psychology, psychotherapy training is included. Except for one specialty within the Norwegian Psychological Association (Clinical psychology with psychotherapy) neither the specialities within the Norwegian Medical Association nor the Norwegian Psychological Association have personal therapy as a requirement. But as is the case in most Western countries, a substantial majority of Norwegian psychotherapists of various professions have at least one course of personal therapy in their career (Orlinsky, Norcross, Rønnestad & Wiseman, 2005 check reference).

In addition to the training programs described above, there are some private training institutions which require no prior professional training. These institutions receive no public funding.

A substantial majority of all professionals practicing psychotherapy, belong to their 'national' professional association (Norwegian Psychological Association, Norwegian Medical Association, Norwegian Nursing Association. Practitioners of medicine, psychology and nursing need to be licensed to practice. Even though the status of the above professions are reasonably high in the eyes of the public, treatment needs go way beyond what the professionally trained practitioners can meet. The market for alternative and non-traditional treatment forms is increasing.

## ***2. Relations among the psychotherapeutic professions.***

The practice of psychotherapy within the public health system, is embedded within a social structure in which the profession of medicine traditionally has been on the top of a power hierarchy. This is gradually changing as members of others professions have taken over the administrative leadership of medical institutions, and as psychologists can now be professional

leaders of child-and adolescent mental health institutions. When it comes to social recognition, the psychology profession has for decades had a strong position within individual psychotherapy. It is quite common that psychologists supervise members of other professions in their individual psychotherapy practice. Psychotherapies in other treatment formats, such as group psychotherapy, family therapy and couples therapy are carried out by members of various professions. The Institute of Group Analysis has for more than 20 years contributed substantially to the training of group psychotherapists.

As will be described below, there is in principle no difference between the profession of psychology and medicine when it comes to reimbursement privileges for psychotherapy. However, as the Norwegian Medical Association is stronger than the Norwegian Psychological Association, the former has negotiated better economic contracts between their members and the state. The larger picture is that there is more collaboration than conflicts between the professions. Typically, post-graduate training institutions are open to members of different professions.

### ***3. Relation of the professions to the health care and/or social service systems.***

A substantial proportion of professionally trained practitioners within the medical, psychological, nursing and social work professions are employed within the public health or social service system, either directly by employment or indirectly by way of reimbursement. There are no official statistics on the proportion of clients being aided by non-traditional or alternative treatments. But it seems that the proportion is increasing. Psychologists and psychiatrist are the professional groups that provide most of the psychotherapeutic services. There are approximately 1100 psychiatrists and 4.500 psychologists in Norway (verify this). There are no statistics on the number of psychotherapists among them, due in part to lacking definitions of psychotherapy.

The service pressure within the out-patient adult clinics is considerable, allowing mostly for short term consultations. However, some would qualify for the term psychotherapy from the perspective of the practitioners themselves. Within the field of child and adolescent mental health, there has been a movement away from a focus on long term counseling and psychotherapeutic work towards increasingly doing diagnostic work and assessments and shorter forms of psychotherapy and counseling.

Most of the psychologists and psychiatrists in private practice who have specialist status, have contracts (for part time or full time practice) with the county. These contracts ensure that diagnostic, consultation and psychotherapeutic services are provided and ensure economic compensation for the work done. Only a medical doctor can prescribe medication and admit patients to a hospital against their will. Both medical doctors and psychologists with certification as a specialist in clinical psychology can authorize sick-leaves.

A minority of psychologists and psychiatrists practice psychotherapy outside of the public health system. Patients pay for these services in full.

## ***Part II. Future Prospects of the Therapeutic Professions***

### ***4. Factors instigating change in the psychotherapeutic professions.***

For the professions of psychology, medicine and nursing, graduation from the authorized Norwegian professional schools, including practice periods and internship, qualifies for licensure. Professionals educated in other countries are individually assessed for licensure by licensing authorities. It is still uncertain what impact the Bologna declaration of 1999 will have on higher education in Norway. Work is under way for a EuroPsy with standard requirements for professional training in psychology. The Norwegian Ministry of Education and Research is the

responsible national authority in this process. A recent university reform in Norway, adapting the degree system to the Anglo-American degree system (Bachelor, Masters and Ph.D.) resulted in a one-year reduction (from 7 to 6 years) in duration of professional psychology training. No change in the duration of medical and nursing practice; x and y years respectively.

Recently, national health authorities are providing practice guidelines for the treatment of patients with various psychiatric diagnosis. There is a debate within the professions of the usefulness of these guidelines. The critique are at different levels of conceptions: Epistemological, methodological, theoretical and empirical. Briefly stated, the debate is most heated on the issue of the status of RCT-designs.

In 2004, the Norwegian Knowledge Center for the Health Service was established. The Center, which is scientifically and professionally independent, is organized under the Directorate for Health and Social Affairs. The Center is summarizing and dispersing scientific knowledge relevant for prevention and treatment of various physical and mental conditions. The Center, which collaborates with the Cochrane Collaboration, is also the Nordic countries' host for the Campbell Collaboration. The Center has no authority to develop or implement health policies. Some of the recommendations have stirred considerable controversy. The same types of critique as was articulated against the practice guidelines formulated by the national health authorities is being voiced against the Center.

The major step taken in response to the influences above, is stimulating discussions on the issues within the professions. Formats for these discussions are conferences, work-shops, public (press) debates, articles and chapters in journals and professional books. The Norwegian Psychological Association has recently adopted as their official policy the definition of evidence based practice as defined by the American Psychological Association (Levant, 2005). The

Norwegian Psychological Association took another step to counter the biologically oriented practice guidelines for affective disorders issued by the Norwegian health authorities (ref. here) by publishing an alternative treatment guideline (ref.)

#### ***5. Basic skills to be required for training and practice in the psychotherapeutic professions.***

The type of skills required, depends on the educational philosophy of the training institution. The term 'skills' and 'training' may also be objected to and by some replaced by 'attitude', education, 'dannelse' (Norwegian), or 'Bildung' (German). With the influence of the European psychoanalytic tradition and also the strong influence from the Anglo-American approaches to training (with the large variations therein), there are vast differences in ideal 'skill-sets'. In spite of this there are some common elements. Training and practice need to be scientifically based, although there are considerable variations in the epistemological foundation for training and practice, ranging from the natural science conception of medically oriented approaches to the hermeneutic and cultural approaches of more interpersonally oriented psychologies. Four of the universities in Norway (Oslo, Bergen, Trondheim and Tromsø) provide professional training in psychology leading to licensure. Although there are some common elements across programs, there are also some distinct emphases at different sites. Tromsø and Trondheim have a stronger emphasis on cognitive and behavioral approaches while Bergen and Oslo are known for a greater variation in theoretical orientation. Oslo, the first Norwegian university with a psychology department, has traditionally, been a strong site for psychodynamic training, which is continuing but supplemented with a cognitive/systemic/family orientation. So, what skills are required vary by training site.

#### ***6. Relation of psychotherapy research to the psychotherapeutic professions.***

During the last ten to fifteen years, there has been an increasing interest within the professions of clinical psychology and psychiatry in treatment research. Expressions of this is the funding of several psychotherapy research projects, international publications by Norwegian authors on the topic and practice workshops focusing psychotherapy process-outcome research. It seems that the pressure from the outside (i.e. official health authorities etc.), greater awareness of the international debate on the issues, and the general zeitgeist of empirical documentation for treatment effects have fuelled an interest among practitioners on the question of “what works” and how best study the processes and outcomes of psychotherapy. It is essential that this trend continues. More time should be devoted to the teaching of psychotherapy research within basic professional training in the universities. Also, research findings generated from psychotherapy research should be mandatory in specialist training arranged by the professional associations and in the educational programs of psychotherapy training institutions.

As indicated in sections above, there is debate, both within the professional associations and in the public on the knowledge base for professional practice, and on the status of evidence based practice, and how best to conceptualize it. Generally speaking the medical profession will favor the definition of evidence based practice as defined for example by the Institute of Medicine (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000), giving priority to RCT designs. However, this is not reflected in the specialist training of Norwegian psychiatrists, where, as mentioned above, two of the three years of supervision need to be psychodynamically oriented.

There is a strong tendency within Norwegian health and social services authorities to aspire to base medical and social services on research knowledge generated under controlled conditions and summarized preferably by meta-analyses. However, there are strong voices

against this aspiration. As mentioned, the Norwegian Psychological Association has adopted the American Psychological Association's statement on evidence based practice in psychology (Levant, 2005) as their policy. The statement, with the three foundations to be integrated, i.e. the best research evidence, clinical expertise in the context of patient characteristics, culture and preferences (ibid.) can also be a blueprint for basic and post-graduate training (Rønnestad, 2008). Process-outcome research (e.g. Orlinsky, Rønnestad & Orlinsky, 2005) and research on psychotherapy integration (Goldfried, 2005; Grawe, 2004) have already shown promise to improve psychotherapy training (Rønnestad & Ladany, 2006). There are two recent examples of this. One is the work done at the University of Bern (Caspar, 2005; Flückinger, 2005; Grawe, 2005), where outcome effect sizes of student therapies were enhanced after basing psychotherapy training on empirically demonstrated principles of change. The other is the work by Crits-Christoph et al., (2006) which demonstrated in a pilot study that working alliances were enhanced after specifically training students according to the interpersonal aspect of the Generic Model of Psychotherapy (Orlinsky & Howard, 1987).<sup>1</sup> This approach may be seen as a renaissance of the research on empathy training, which has a long tradition since Roger's landmark contributions more than 50 years ago. There is abundant documentation that therapist empathy can be at least moderately enhanced by specific empathy training. This is not only so in the United States, where most research on therapist empathy have been conducted, but also for the training of therapists in Norway (Nerdrum, 1997; Nerdrum & Rønnestad, 2002). It is likely that psychotherapy training can be enhanced if training programs draw explicitly from the available and abundant process-outcome research and to a larger degree base training on empirically validated treatment dynamics.

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<sup>1</sup> See the special section on psychotherapy training in *Psychotherapy Research*, 2006, volume 16 for a more detailed presentation of these perspectives.

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