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Psychotherapy regulation and mental health care in Scandinavia: The contribution of psychotherapy as an autonomous profession and scientific discipline to the shift from a biomedical to a biopsychosocial approach

Regulacija psihoterapije in skrb za duševno zdravje v skandinavskih državah: Prispevek psihoterapije kot samostojnega poklica in znanstvene discipline k prehodu od biomedicinskega k biopsihosocialnemu pristopu

Abstract

This article is based on a qualitative study examining the development of psychotherapy regulation and mental health care in European countries. It focuses on the Scandinavian countries because they are considered to be highly developed welfare states with a long tradition of egalitarian health and welfare policies. Over recent decades, these countries have prioritised improvements in mental health and services, including psychotherapy regulation. The focus has shifted from psychiatric institutional care to outpatient, community-based care and social participation.

Sweden was the first European country to pass a psychotherapy law, in 1985, and Finland followed in 1994. This has contributed significantly that these two countries are more developed in terms of psychotherapy than Denmark, Iceland and Norway, where it is considered a multiprofessional activity. The legalisation of psychotherapy as an independent profession, and the academisation of psychotherapy as an autonomous scientific discipline are two interlinked, mutually reinforcing processes that are crucial for the development of psychotherapy.

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Strategies for developing mental healthcare in Scandinavia indicate a shift from a biomedical/disease-based approach to a biopsychosocial one. However, despite the implementation of many effective strategies and practices to reduce medicalisation and coercive psychiatric measures, data on psychopharmaceutical consumption, overdiagnosis and resistance to medication-free treatment, suggest that the biomedical model still dominates also in Scandinavian countries.

Psychotherapy has the potential not only to soften the biomedical approach, but also to contribute significantly to a fundamental shift in paradigm towards a biopsychosocial approach. Efforts by psychotherapists in Scandinavia and many other European countries to establish psychotherapy as an independent profession and scientific discipline are crucial to its future development. Without professional and academic autonomy, psychotherapists will continue to be marginalised, rather than participate on equal footing with other mental health professionals in developing a biopsychosocial approach.

Key words: psychotherapy regulation, academisation, psychiatry, psychology, mental health, Scandinavia, biomedical approach, biopsychosocial approach

Povzetek

Članek temelji na kvalitativni študiji, ki preučuje razvoj regulacije psihoterapije in skrbi za duševno zdravje v evropskih državah. Osredotoča se na skandinavske države, saj veljajo za visoko razvite države blaginje z dolgo tradicijo egalitarne zdravstvene in socialne politike. V zadnjih desetletjih so te države dale prednost izboljšavam na področju duševnega zdravja in storitev, vključno z regulacijo psihoterapije. Poudarek se je preusmeril od psihiatrične institucionalne oskrbe k ambulantni oskrbi, ki temelji na skupnosti, in družbeni udeležbi.

Švedska je bila prva evropska država, ki je leta 1985 sprejela zakon o psihoterapiji, leta 1994 pa ji je sledila Finska. To je pomembno prispevalo k temu, da sta ti dve državi v primerjavi z Dansko, Islandijo in Norveško, kjer psihoterapija velja za multiprofesionalno dejavnost, na področju psihoterapije bolj razviti. Legalizacija psihoterapije kot samostojnega poklica in akademizacija psihoterapije kot avtonomne znanstvene discipline sta dva medsebojno povezana in vzajemno dopolnjujoča se procesa, ki sta za razvoj psihoterapije ključna.

Strategije za razvoj duševnega zdravja v Skandinaviji kažejo na premik od biomedicinskega/bolezenskega pristopa k biopsihosocialnemu. Vendar kljub izvajanju številnih učinkovitih strategij in praks za zmanjšanje medikalizacije in prisilnih psihiatričnih ukrepov, podatki o porabi psihofarmakov, pretirani diagnostiki in nasprotovanju zdravljenju brez zdravil kažejo, da tudi v skandinavskih državah še vedno prevladuje biomedicinski model.

Psihoterapija lahko pomembno prispeva k razvoju biopsihosocialnega pristopa. Prizadevanja psihoterapevtov v Skandinaviji in številnih drugih evropskih državah za uveljavitev psihoterapije kot samostojnega poklica in znanstvene discipline so ključna za njen prihodnji razvoj. Brez poklicne avtonomije bodo psihoterapevti še naprej marginalizirani, namesto da bi lahko sodelovali z drugimi strokovnjaki s področja duševnega zdravja pri razvoju biopsihosocialnega pristopa.

Ključne besede: regulacija psihoterapije, akademizacija, psihiatrija, psihologija, duševno zdravje, Skandinavija, biomedicinski pristop, biopsihosocialni pristop

1.

Introduction

Since 2006, I have participated in various working groups on the regulation of psychotherapy as an independent profession and autonomous scientific discipline in Slovenia. To perform our role to the best of our ability, we have continuously monitored and studied the development of psychotherapeutic regulation in European countries, learning from their successes and failures (Možina, 2010, 2020, 2022, 2023ab, 2024ab; Možina & Bohak, 2008; Možina & Hus, 2015; Možina & Kranjc, 2019; Možina & Okorn, 2022; Možina et al., 2018, 2020).

This article is based on a Slovenian qualitative study examining the development of psychotherapy regulation and mental health care in European countries (Možina, 2024a). The research design which was applied in the period from 2006 to 2024 was based on archival research and analysis to ensure qualitative descriptive information and understanding of different perspectives. Drawing on Lichtman's (2009) categorisation of qualitative research methods, the study incorporated elements of the biographical method, constructivism, narratology, and participatory inquiry. A comparison of legislative efforts in 30 European countries was conducted and the trajectory of significant events was outlined, including the individual actors, organisations, key moments, and contextual aspects involved.

The following research questions were defined, among others:

- What issues and problems marked the development of psychotherapy regulation in Europe and Slovenia?
- Who were the key figures involved in shaping the development and current state of psychotherapy regulation in Europe and Slovenia?
- Which institutions and associations have played a crucial role (e.g. state institutions and the establishment and development of associations), and what are their relations?

- What professional standards have had a significant impact on the regulation of psychotherapy in Europe and Slovenia in the past and present? How were these standards defined, and by whom?

This article focuses on the Scandinavian countries because they are considered highly developed welfare states with a long tradition of egalitarian health and welfare policies. Improvements in mental health and mental health services have been on the agenda in these countries during recent decades, including improvements in psychotherapy regulation. In light of the many negative effects of the biomedical approach that dominates mental healthcare in Europe, Slovenia and other European countries may find it particularly interesting to be informed how Scandinavian countries are addressing this issue and how the regulation of psychotherapy as an independent profession and academic discipline can facilitate a transition from a biomedical to a biopsychosocial approach, offering numerous benefits.

2. **In what ways can the regulation of psychotherapy in Scandinavian countries inform the regulation of psychotherapy in Slovenia and other European countries?**

In the current debates on the psychotherapy law in Slovenia, opponents of psychotherapy as an independent profession argue that it is a *method* reserved for professionals with a medical background, such as doctors, psychiatrists and clinical psychologists. They argue that only these professionals are capable of diagnosing mental disorders and treating them appropriately. They deny professional psychotherapists, who are not doctors or psychologists by training and whose primary profession is psychotherapy, the competence to diagnose and treat mental disorders. They cite various cases of non-medical psychotherapists overlooking physical pathologies influencing mental symptomatology and the damage caused thereby. Some orthodox Slovenian psychiatrists and clinical psychologists are even pushing for the title 'psychotherapist' to be reserved only for themselves, recommending that professional psychotherapists not employed in the health sector be called 'psychosocial counsellors' (e.g. Jelen Sobočan, 2023; Dobnik Čoderl & Škodlar, 2023). This confrontation was already clearly expressed in the Working Group for the Psychotherapy Act of the Slovenian Ministry of Health in 2018, and is again manifested in the current public debates (Možina, 2024f; Živković & Levstik, 2024).

The confrontation between orthodox psychiatrists and clinical psychologists and psychotherapists, who are committed to the autonomy of their profession,

is not only occurring in Slovenia, but also in many other countries (Enache-Toinoiu, 2013). The necessity of medical knowledge, especially in psychiatric diagnostics and psychopharmacotherapy, for the practice of psychotherapy has been a recurrent topic of debate in public and professional circles in these countries.

The orthodox group in Slovenia supports their view by referencing, *inter alia*, Scandinavian countries and pointing out that:

- "in Finland, psychotherapy is a special profession, but only psychologists, doctors, nurses and social workers can practice it after additional training;
- in Norway, the profession of psychotherapist does not exist, and practitioners of psychotherapy outside the health sector are subject to the provisions of the Alternative Therapies Act;
- Sweden has a law on psychotherapy, which states that only doctors, psychologists, nurses, priests and social workers can practice psychotherapy." (Chamber of Clinical Psychologists, 2024)

As this reference is superficial and distinctly one-sided, with the clear political intent of consolidating a monopoly on psychotherapy, this article aims to provide a more thorough picture of the psychotherapy regulation and mental health care in Scandinavian countries. Narrow comparisons of the state of psychotherapy between countries without understanding the broader context of mental health care are problematic.

3.

An overview of the legal regulation of psychotherapy in Scandinavia

Table 1 summarises the key features of the legal regulation of psychotherapy in the Scandinavian countries, and the text that follows provides a more detailed overview of these countries, listed in alphabetical order: Denmark, Finland, Iceland, Norway, and Sweden.

Table 1

Legal regulation of psychotherapy in the Scandinavian countries.

	DENMARK	FINLAND	ICELAND	NORWAY	SWEDEN
Regulation of psychotherapy	only regulation for psychologists and psychiatrists; The Psychologist Act (Law 1534, 2021)	Act on Health Care Professionals No. 559/94, 1994; Decree on Health Care Professionals No. 564/94, 1994, updated 2011;	only regulation for health professionals; Regulation No. 1130/2012 for psychologists	Health Professional Act and the Patients' Rights Act; Act on Alternative Treatment	Health and Medical Services Act 1982/2017
Psychotherapy as an independent profession	no; pst is multi-professional activity;	yes; independent health care profession	no; pst is multi-professional activity	no; pst is multi-professional activity	yes
Minimum academic requirements for entry to psychotherapy training	master	master	master in psychology	master (medicine, psychology, nursing, social work etc.)	secondary school for entry to the 3-year basic programme: university/ master degree in (dental) medicine or psychology, but also master of social work, nursing or theology after basic programme for entry to the special pst training
Obligatory academic training in psychotherapy	no	yes; only programmes arranged by or together with the universities and psychological or psychiatric institutions	no; academic training in pst is possible but not compulsory	no	no; academic training in pst is possible but not compulsory
Years of training	3 years of post-master's level specialization in pst for psychologists	3-4 years	2-3 years	4 years	3 years basic programme and 3 years specialized pst training

	DENMARK	FINLAND	ICELAND	NORWAY	SWEDEN
Hours of training	min 600 for psychologists; min 180 basic training and 280 specialization in pst for psychiatrists	specific training programmes at least 60 to 80 ECTS (900-1800 hours)	not specified	1,400 hours for alternative psychotherapists	min 2,000 hours
Content of training specified	only for psychologists and psychiatrists	broadly	broadly	broadly	broadly
Recognised approaches	psychoanalytic, psychodynamic, humanistic, systemic, CBT etc.	cognitive, CBT, family and couple, integrative, psychodynamic, solution-focused, Gestalt, etc.	CBT, psychodynamic, gestalt, humanistic, family therapy, existential etc.	CBT, psychodynamic, gestalt, psychodrama, Jungian, integrative, group therapy etc.	CBT, psychodynamic, group, art, child and youth, cognitive, family, interpersonal, hypnotherapy etc.
Minimum age	no	no	no	no	no
Mandatory register and number of pstherapists compared to number of inhabitants	no; 5000 therapists/6 million inhabitants; 0,8 therapist/1000 inhabitants	yes; 8600 therapists/5,6 million inhabitants; 1,5 therapist/1000 inhabitants	yes, for specialists in psychology who are pstherapists; 150 therapists/400,000 inhabitants; 0,4 therapist/1000 inhabitants	no; only voluntary register of alternative therapy providers; no reliable number available	yes; 7700 therapists/10,6 million inhabitants; 0,7 therapist/1000 inhabitants
Legally protected title of psychotherapist	no	yes	yes; title reserved for licenced specialists in psychology	no	yes
Regulating organisations	Danish Association for Psychologists; Danish Psychiatric Society	Ministry of Health and VALVIRA	Directorate of Health; Ministry of Welfare	Ministry of Health and Welfare; Ministry of Labour and Social Inclusion	National Board of Health and Welfare; National Agency for Higher Education
Privileges of psychologists and psychiatrists	yes	no	yes	yes	no
Financing of psychotherapy services	not paid by public health insurance, paid only if provided by an authorized health care expert or partly for psychologists in private practice	free pst services through HUS and KELY system	since 2020 covered by public health insurance	usually not covered but there are exceptions, e.g. partial reimbursement for psychiatrists and licensed psychologists	often reimbursed by public insurance, sometimes with private insurance supplementation

Sweden was the first in Europe to pass the law on psychotherapy in 1985 and Finland followed in 1994 with a law that protects the title psychotherapist and regulates psychotherapy as an independent profession. In Denmark, Iceland and Norway psychotherapy is considered multiprofessional activity, involving professionals from various backgrounds.

3.1. **Denmark: The primacy of psychologists in the field of psychotherapy in a country without a psychotherapy law**

Psychotherapy is not regulated as an independent profession and psychotherapist is not a protected title, and thus anyone can call himself a psychotherapist and even practice psychotherapy without proper training. Due to the lack of regulation, the total number of psychotherapists is unknown. Psychotherapy is not a part of the Danish public health care system. There are no legal regulations or registration specifically concerning psychotherapy or psychotherapists except for the regulations concerning health care personal and psychologists set by the Danish Ministry of Health (EAP, Denmark, 2016).

People struggling with mental health issues typically consult a psychologist. If they visit a GP first, the GP will refer them to one. To specialize in talk therapy, psychologists must complete a Master's degree in clinical psychology. Once the thesis has been completed, they can begin treating people. After two years of full-time work and 160 hours of supervision, they can obtain a licence to work with health insurance. Psychologists are therefore primarily responsible for providing therapy (Konnerup Schwensen, 2019).

3.1.1. **The Association of Danish Psychotherapists**

The Association of Danish Psychotherapists (Dans Psykoterapeutforening) (hereinafter the Association), which was founded in 1993 and by 2016 had around 1,600 members, represents psychotherapists in Denmark. Members of the Association must use the title 'psychotherapist MPF', which stands for Member of Danish Psychotherapists Association. The title is a guarantee for therapist's appropriate educational background and experience. A MPF psychotherapist is a bi-professional that has:

- a bachelor's or master's degree followed by at least 3 years' work experience in the humanities, pedagogy or social and health care fields, e.g. educator, teacher, social worker, nurse, doctor, psychologist or physiotherapist – or equivalent and
- a 4-year psychotherapist training in a psychotherapeutic center that is approved and evaluated by the Association. Part of this training is obligatory self-therapy, which is not part of the regular education for psychiatrists and psychologists. But if psychologist furthers his education as a specialist in psychotherapy, there is a requirement for 80 hours of self-therapy.

A survey (van Deurs, 2003 in Jacobsen, 2009) found the educational background of 29% was social work, while 22% had some other academic background (of those 7% were either psychologists or physicians), and 14% were pedagogues. Other members had backgrounds as nurses, teachers, educational therapists, etc.

The Association defines psychotherapy as "a collective term for various clinical treatment methods that aim to help people deal with psychological and personal problems. The methods derive from established psychological principles, professional expertise and research. Psychotherapy often takes place individually, but is also practiced in groups and with couples and families." (<https://psykoterapeutforeningen.dk/psykoterapi/terapiretning>)

A MPF psychotherapist is ethically obliged to stay professionally up-to-date, to receive regular supervision and to comply with the Association's ethical rules. The ethical rules help to ensure that the psychotherapy takes place in a qualified and professional manner. If a member does not comply with the rules, the client has the option of submitting a complaint, which is dealt with by association's ethics committee. The Association approves many psychotherapy modalities and methods, for example analytic/psychodynamic, existential, systemic, narrative, integrative, Jungian, experience-oriented, neuroaffective, metacognitive, CBT, NLP, family, couple therapy (ibid.).

MPF psychotherapists have usually different theoretical orientations than psychologists and psychiatrists. In 2009, about 25% did body work/therapy (e.g. biodynamics), another 23% Gestalt therapy, 11% psychodynamic therapy, and even less CBT. Half of the Association's members (49%) worked in an independent, private psychotherapy practice. As the training of psychotherapists other than psychologists and psychiatrists is very varied, and some of their theoretical orientations are rather dubious, so also is their image in the eyes of the public (Jacobsen, 2009).

With psychotherapy as a treatment method, MPF psychotherapists work to (ibid.):

- prevent and treat psychosocial and/or psychosomatic disorders;
- help people to change inappropriate thought and behavior patterns in the direction of increased quality of life and personal maturation and integrity;
- help people make healthy life choices;
- support people in crises and difficult life situations.

A MPF psychotherapist is trained to prevent and treat problems such as: anxiety, stress, discontent of children and young people, depression, family problems, divorce and relationship problems, assault, violence, placements of children and young people outside the home, abuse, grief and crisis, trauma, eating disorders, keeping young people in education etc.

Psychotherapists are not trained to deal with severe mental disorders (e.g. schizophrenia, psychoses, personality disorders) or make clinical diagnoses. Therefore, many psychotherapists also collaborate with both psychiatrists and psychologists. Only psychiatrists can prescribe medication and decide about diagnoses. Some psychiatrists also use psychotherapeutic methods in their conversation with patients and can take further training in psychotherapy (ibid.).

MPF psychotherapists are often employed in the social and health sector: in the municipalities, in psychiatry as a link between regions and municipalities, in the job centres, in private companies and institutions and in organisations that work with vulnerable population. Many MPF psychotherapists are also private practitioners with their own clinic, where they specialize in one or more areas of treatment. It can be, for example, couple, family or child therapy. Four out of ten members of the Association work as independent psychotherapists full time and have their own clinic or practice. The other members are either full-time employees in the public sector at, for example, schools, hospitals and in job centres or in private companies and organisations. Others supplement the job as a psychotherapist with another job (ibid.).

The Association also approves educational institutions. By 2016, 35 institutes were registered as the members of the Association. All institutes are evaluated by an independent consultancy company on the basis of extensive quality criteria. The list of evaluated educational institutes can be found on the organisations website (ibid.). Psychotherapy training does not take place within the public system, but there are several private providers. As a result, there are differences in the content, scope, duration and prices of the different training courses. As an example, it is stated that the usual duration of training in psychotherapy is 4 years. However, admission is conditional on the completion of an appropriate length of higher education (5 years) or a medium length (3 years) in the psychological, educational or health professions (e.g. psychologists, doctors, teachers, nurses, social workers, occupational therapists, etc.) (ibid.).

3.1.2. The primacy of psychologists in the psychotherapy field

The title 'psychologist' has been protected since 1994 and psychological activity is regulated by Law 1534 of 2021 (The Psychologists Act). Authorisation is not mandatory for the practice of psychology, but it is requested within certain areas of work, for example for psychological testing of children, for psychotherapy, etc. Authorisation can be granted to any person, who has: 1) graduated from a Danish university with a degree in psychology and 2) who has thereafter completed a supplementary, practical education of two years according to the regulations set down by the Supervisory Board (Psykolognævnet, 2022). After 'authorization' psychologists can specialize in more than 10 different fields, also in psychotherapy.

Psychologists are by far the largest group of professional psychotherapists in Denmark and are considered a social profession; however, authorised psychologists often work in the health care sector. The Danish Psychological Association (Dansk Psykolog Forening) has over 12,000 members (Danish Psychological Association, 2025). In 2009, it was estimated that approximately 3,000–3,500 psychologists practised psychotherapy full-time or part-time, and this number has grown since then. By comparison, the number of Danish psychiatrists practising psychotherapy could be counted in the hundreds. The majority of the 720 psychologists employed in various psychiatric settings have practised psychotherapy. They are the most important profession in these settings. Treatment mostly takes the form of outpatient psychotherapy, but inpatient psychotherapy is also offered to a limited extent. Of the 2,115 psychologists working as private practitioners, most practise psychotherapy, counselling, and psychotherapy-oriented guidance (Jacobsen, 2009).

Of the 1,584 psychologists with a specialisation, 799 have specialized in psychotherapy with adults, which takes at least three years of postgraduate training (360 hours of theory courses, 160 hours of clinical supervision, and 80 hours or more of personal therapy). With an additional two years of training (30 hours theory on supervision, and 40 hours of supervision on their own supervisory work), psychologists can qualify as supervisors on the specialist level. The government endorses neither the specialisation nor the supervisor certificate of approval. It is only a certification given by the Danish Association for Psychologists (DPF). The DPF and the Danish Psychiatric Society mutually recognise each other's specialists in psychotherapy, meaning that psychologists can be teachers or supervisors for psychiatrists in their psychotherapy training and vice versa. Psychologists have a very positive image among the general population and their professional skills are both respected and frequently requested. In psychiatric settings, many patients request session with a psychologist (ibid.).

In the 1990s, among psychologists the analytic/psychodynamic orientation was most prevalent (80%), followed in relative salience by humanistic (32%) and systemic (19%) orientations, whereas cognitive (9%) and behavioral (3%) orientations were barely represented. Meanwhile, in 2010 the analytic/psychodynamic orientations were salient for just over half (54%) and shared first place with cognitive orientations (54%). The behavioral orientation was four times more prevalent (12% as compared to 3% in 1995), and the prevalence of humanistic orientations was much lower (12% as compared to 32% in 1995) (Jacobsen et al., 2012).

3.1.3. Psychiatrists also have privileges in the field of psychotherapy but mostly do not practice it

Among the physicians, psychotherapy is most frequently offered by psychiatrists. Some general practitioners also offer psychotherapeutically oriented consultations as one of their many free services. Only a few have a proper psychotherapy training, while the majority have only very limited or no training (Jacobsen, 2009). Some basic training is included in the specialisation of psychiatry. This includes 10 hours of theory on general psychotherapy (research, ethics, assessment, etc.), 25 hours of psychoanalytically-oriented theory, and 25 hours of theory on CBT. Furthermore, one must practice psychotherapy for at least 60 hours and receive the same amount of supervision.

After the basic training and two years of clinical work in psychiatric settings, the psychiatrist can specialize in psychotherapy. This includes 80 hours of psychotherapy practice, 80 hours of supervision, and 60 hours of theory. If the theoretical orientation is psychodynamic, it also takes 60 hours of personal therapy (100 hours in group). If CBT is the theoretical orientation, one must instead receive 20 sessions of feedback on personal style.

Finally, one can undergo supervision training (40 hours of theory and 40 hours of supervision of one's own supervisory work). This qualifies for a teacher function in the specialization in psychotherapy (ibid.).

Unfortunately, mostly psychiatrists do not practice psychotherapy. There are many reasons for this (ibid.):

- the shortage of psychiatrists leads to huge caseloads and does not leave much time for psychotherapy;
- most of psychiatrists focus more in psychopharmacotherapy;
- the psychiatric categorial diagnostic system fosters an orientation towards description of symptoms and not towards deeper understanding of the patient;
- many educational courses, but not the psychotherapeutic ones, are sponsored by pharmaceutical firms.

Thus, for psychiatrists proper psychotherapeutic training can only be achieved with great personal costs. Furthermore, in times of predominance of biological psychiatry, there is less and less interest in psychotherapy training among psychiatrists, so that a more psychotherapeutic orientation is seen among the older psychiatrists. From the point of view of psychologists and other psychotherapists working in psychiatric settings, this situation is problematic. While the psychiatrists are in charge of treatment and refer to psychotherapy, the new generations are less capable of making proper psychotherapeutic assessment and of understanding of what a successful treatment takes in terms of setting frame, and treatment process (ibid.).

In May 2025, the Danish parliament, the Folketinget, has supported a major reform to stop the underfinancing of the country's psychiatric care. They called it a historic day, saying that new state funding would provide the sector with much-needed hospital beds and health care workers in the future. The overarching goals are to treat patients earlier and closer to home, to improve the quality of psychiatric treatment, to reduce waiting times, to create coherent support pathways and to ensure that psychiatry care will be a safe and attractive workplace for health care workers. At the same time, the agreement opens for more forms of coercion in Danish psychiatric care. It states that the most intrusive forms, such as belting, will be reduced and that this will be done by introducing new options for coercion that are less intrusive. The sector will now receive an additional €354 million in state contributions in 2030 (compared to 2019), marking a 35% increase. This means that the funding will increase successively from €27 million for 2025 to €200 million annually by 2030 (Kleja, 2025).

The parties have also agreed on a new right for children and young people, for which waiting times in psychiatric care are currently considered much too long. This will be determined by law and means that children and young people could have assessment and treatment combined so that they receive faster and better help. The first assessment process must begin within 30 days of referral, and the child or young person must start treatment within 60 days of referral (ibid.).

3.1.4. Financing of psychotherapy services

A major issue is the access to public funding. Psychotherapy is not paid by public health insurance apart from the psychotherapy that is provided by an authorized health care expert. General practitioners are paid by the National Health Service for brief psychotherapy treatments, even without having any formal training in psychotherapy. Psychiatrists in private practice are likewise paid by the regions for even prolonged psychotherapy treatments (Jacobsen, 2009). Psychologists' services in health care settings are part of the Psychiatric Health Care System and are part of the publicly funded health care system. While patients can consult physicians free of charge, they have to pay when consulting a psychologist or a psychotherapist in private practice. On average, an hour of psychotherapy with a member of the Association of Danish Psychotherapists cost €100 in 2016 (EAP, Denmark, 2016).

In some cases, the services of psychologists in private practice are partly covered by public health insurance. In this case, the person is referred by a general practitioner and specific criteria have to be met (EAP, Denmark, 2016). List of criteria when deciding on a referral to a psychologist/psychotherapist are:

- victim of robbery, violence and rape;
- victim of road traffic accidents and other accidents;

- relatives of a seriously mentally ill person;
- persons suffering from a seriously debilitating illness;
- relatives of persons suffering from a seriously debilitating illness;
- relatives of the recently deceased;
- persons who have attempted suicide;
- women who have had an unwanted abortion after the 12th week of pregnancy;
- persons who have been victims of sexual abuse before the age of 18;
- persons over 18 years of age with mild to moderate depression;
- persons aged 18 to 38 with mild to moderate anxiety disorders, including obsessive-compulsive disorder;
- persons aged 18 to 38 with mild to moderate anxiety disorders, including obsessive-compulsive disorder;
- compulsive disorder (OCD).

There is a quota for each of these 11 items/criteria, e.g. the quota for depression and anxiety often fills up quickly, resulting in even longer waiting lists. The number of psychologists eligible for this public funding (through referral) is limited by public funding contract. In addition, there is an annual limit on the number of referrals through the public funding system (The Danish Health Care System - Regarding Psychotherapy).

Thus, many psychological services are also financed by direct payments from clients/patients or their private health insurance. Psychotherapists' services are paid directly by clients/patients, usually through private health insurance and, as mentioned, are not part of the public health care system (EAP, Denmark, 2016). The activities of psychologists and psychotherapists employed in other state-run institutions are funded from other public sources. In private institutions, they are mainly funded by direct payments from clients.

3.2. **Finland: The legal regulation of psychotherapy as an independent profession and the academisation have given a strong impetus to its development**

3.2.1. **A brief history of the development of the psychotherapy regulation**

The development of national guidelines for psychotherapy and psychotherapist training in Finland began in 1979 with the establishment of a national expert group. This group was tasked with defining psychotherapy in the context of mental health care, assessing the demand for psychotherapy services and establishing official training criteria for psychotherapists. The group included representatives of relevant stakeholders from the public health care system, mental health organisations and authorities, the Social Insurance Institution of Finland (SII), and major psychotherapy training organisations. Training

criteria for psychotherapists were drawn up for both the special and advanced special (trainer) levels. Initially, the special level training was intended for individuals working in public health care. These criteria were subsequently largely used as the basis for present-day, university-based psychotherapy training (Lindfors, 2024).

In contrast to the traditional description of psychotherapy as “an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behavior which have caused a person to seek treatment” (Strupp, 1978), the above working group proposed a more structured concept: “Psychotherapy is targeted to persons with psychiatric disorder, those who have problems in their psychological development or psychological problems in their interpersonal relationships, all of which can be manifested psychologically, socially or somatically. The aim of treatment is the reduction or removal of problems caused by the disorder and enhancement of psychological development and functioning. The methods need to be based on theories with adequate research evidence. Provision of psychotherapy requires professional competence based on training, and needs to be carried out in cooperation with the client(s) and a professional(s), in a confidential therapeutic relationship” (Lindfors, 2024, p. 18). To this day, it remains a generic description of psychotherapy (and of other psychosocial interventions), allowing variability in how knowledge- and skills-based competence in the specific therapeutic orientation and its methods is secured through training and in practice across different schools of psychotherapy.

Since 1994, there has been legislation protecting the title of ‘psychotherapist’ and regulating the profession as an independent one (see Act on Health Care Professionals No. 559/94 and Decree on Health Care Professionals No. 564/94) (Finlex, 2018, 2024). This legislation has improved client safety by ensuring that those responsible for treatment are adequately trained. It has also clarified the status of psychotherapists as health care professionals, along with the associated responsibilities and regulations. Psychotherapy has been defined as a goal-directed professional activity in the health care sector, which aims to improve patients' psychological health and functional capacity. Psychotherapy aims to eliminate or alleviate mental illnesses and emotional pain, increase the quality of life, support an individual's psychological development and provide tools for tackling mental disorders.

However, psychotherapy training remained somewhat fragmented, being carried out by a variety of private institutions and organisations with differing quality standards and concepts of professionalism. Some university departments also provided psychotherapy training for psychiatrists or psychologists specialising in psychotherapy. The training at Jyväskylä University paved the way for

integrative psychotherapy. Although the authorising national agency outlined the criteria for acceptable training programmes, assisted by expert groups, the fact that the professional title of psychotherapist could only be granted upon completion of the training caused continuous insecurity for the organisers and participants of psychotherapy training, especially in cases of new programmes and approaches to therapy (Lindfors, 2024).

The 2011 update to the decree concerning health care professionals – preceded by years of preparatory work in numerous committees and expert groups – introduced new requirements for obtaining the protected occupational title of psychotherapist. This is an independent health care profession, and the update authorised the provision of psychotherapist training exclusively to universities offering psychology or medicine courses. The aims were to unify and improve quality criteria for psychotherapy training, implement training within the public university education system, and enhance research possibilities on psychotherapy (*ibid.*).

Psychotherapist training programmes are professional continuing education comparable to the continuing education of health care professionals. It is only available to candidates who have already completed (Seikkula, 2011):

1. an applicable master's-level degree at a university, or an applicable qualification in health and social services at a university of applied sciences; the degree must include, or the candidate must have otherwise completed, 30 credits of studies in psychology or psychiatry;
2. a post-secondary nursing qualification plus a specialisation in psychiatry if the qualification did not include studies in psychiatry.

Applicants to the programmes are required to have experience in working with clients in the mental health sector or corresponding experience (two or more years), as well as applicable prior education in the health care or social care sector. This means that psychotherapy training tends to be multiprofessional, so that it can involve nurses, social workers, theologians, special educators or teachers, in addition to doctors and psychologists. Educational opportunities are spread evenly throughout the country (*ibid.*).

From the beginning of the year 2012 only psychotherapy training programmes arranged by or together with the universities and psychological or psychiatric institutions are accepted. The scope of training must be at least 60 to 80 credits, divided between theoretical studies, supervised clinical psychotherapy with clients, personal psychotherapy and final written project work. The competence is proved by a proficiency test (Lindfors, 2024).

Thus far, university-based psychotherapy programmes have mostly been carried out in cooperation with external training institutes or other organisations

with expertise in the specific psychotherapeutic and pedagogic orientation. The fact that universities are not obliged to provide psychotherapy training and do not receive financial support from the state budget has limited possibilities for research and training development. Psychotherapy training is costly for students, which creates an inequality issue as only those who can afford to cover all costs themselves can participate in the training, unlike those specialising in the medical profession, for whom state-subsidised, university-based training is available. Currently, the government's mental health policy aims to introduce a two-level psychotherapy training plan, with the lower-level training being free for trainees (*ibid.*).

Around 1,300 therapists were trained in the first 10 years of university-based psychotherapy training, which is slightly fewer than during the period when private institutes were responsible for training. The largest proportion of the new therapists, by therapy orientation, have been cognitive or cognitive behavioral therapists, together representing around 40% of all new psychotherapists. This is followed by family and couple therapists (16%), integrative therapists (13%), psychodynamic therapists (12%), solution-focused therapists (8%), and a few other minor programmes. There has been an increasing trend towards higher percentages of cognitive and cognitive behavioral therapists, as well as integrative therapists, in recent years. There is significant variation in the training programmes provided by different universities. The number of programmes for training child psychotherapists has been particularly low (*ibid.*).

There are tensions between psychotherapeutic schools and approaches that focus more on relationship issues versus those that promote specific techniques and treatment packages based on manuals. Treatment effectiveness could be advanced by thoughtfully stratifying and integrating the use of low-intensity therapies, evidence-based therapeutic techniques, and new technologies alongside traditional specialist-level psychotherapies (*ibid.*).

Overall, there has been a relatively wide range of programmes for different psychotherapeutic modalities, but there has been a lack of coordination and consensus regarding how psychotherapist training should be guided and developed in line with population needs for different levels of social and health care. This should acknowledge the wide range of mental disorders, different age groups and therapy orientations. Quality control of psychotherapist training is much better monitored nowadays than before, and there are more opportunities for students with different psychotherapeutic orientations to interact (*ibid.*).

After successfully completing a programme, students are granted the right to use the protected occupational title of psychotherapist by the National Supervisory Authority for Welfare and Health (Valvira) (<http://www.valvira.fi/web/en/>

healthcare), which also takes care of the verification of psychotherapy practitioners and new psychotherapeutic modalities and methods. Legal regulation does not determine the content of education and modalities that are acknowledged. The law authorises the Ministry of Health to run the register of psychotherapists and sets certain conditions for performing psychotherapy (*ibid.*).

However, there is a need for more psychotherapists. In 2008, there were 4,500 psychotherapists on the official register (Finland has a population of 5.5 million), although there were even more because not all those who are qualified have the title of psychotherapist (Seikkula, 2011). By the end of 2023, there were 8,608 registered psychotherapists, almost 40% of whom were approaching retirement age or had already retired (Lindfors, 2024).

A national survey of approximately 5,000 registered psychotherapists and their practices in 2009 provided valuable insights into the services offered and the profession (Valkonen et al., 2011, in Lindfors, 2024). Of those providing individual psychotherapy, around half (55%) had undergone training at a psychodynamic or analytic institute. The proportions of therapists trained in cognitive therapy, CBT, trauma therapy, solution-focused therapy and cognitive analytic therapy were 15%, 9%, 7% and 4% respectively. Overall, 36% of therapists had received family therapy training, and 6% had received group psychotherapy training. The proportion of psychoanalytic psychotherapists (68%) and cognitive behavioral therapists (25%) providing SII rehabilitative psychotherapy was higher than the proportion among all registered psychotherapists. One in five psychotherapists had received training in psychotherapy targeted at children or adolescents. Approximately two-thirds of patients had been referred to psychotherapy by the public sector. However, only one in three therapists considered that their patients had received sufficient guidance in seeking psychotherapy. Many psychotherapists highlighted the need for better preparation and evaluation of suitability when referring patients to psychotherapy. Long-term psychotherapy (lasting more than one year) appeared to be the predominant form, with as many as three-quarters of therapists reporting it as the most typical length of treatment they provided. Information was also gathered on the workload of psychotherapists' practices: the majority practiced part-time alongside other professional responsibilities, either in the private or public health care sector. Around a third of them had a full-time private practice (Lindfors, 2024).

Since then, there has been a remarkable change in the range and diversity of psychotherapies provided by trained psychotherapists. A recent study (Selinheimo et al., 2024, in Lindfors, 2024) included 15,208 patients who received 'rehabilitative psychotherapy' between 2014 and 2021. The three most

prevalent therapy orientations were solution-focused (23%), cognitive (24%) and psychodynamic/analytic (27%), followed by cognitive analytic (5%), family therapy (5%), trauma (5%) and integrative (7%) psychotherapy. While these figures are derived from rehabilitative psychotherapies provided to patients rather than by the professionals delivering the treatments, they demonstrate the field's rapid evolution. The proportion of psychodynamic/analytic therapies has decreased significantly, while solution-focused therapy has increased in prevalence by the greatest amount. Unexpectedly, solution-focused therapy appears to be the leading type of long-term rehabilitative psychotherapy, despite the mean duration of all the different types of rehabilitative therapies being more than two years (*ibid.*).

It is not known how many social and health care professionals in the public sector are registered psychotherapists and how the training status in different therapeutic orientations is distributed in different parts of the country. In the Helsinki and Uusimaa hospital district area (HUS) recent data were received (Suoma, 2024, in Lindfors, 2024) on psychotherapy services purchased from external, private sources. They show similar changes as described above. During 2022-23, the three most prevalent psychotherapy orientations among the 3,834 patients who were provided a generic voucher for short- or long-term psychotherapy from HUS psychiatry were solution-focused therapy (29%), followed by cognitive (23%) and psychodynamic psychotherapy (17%), followed by cognitive behavior (11%), cognitive analytic, integrative and other modalities (<10%). However, if the specific therapy interventions provided by the HUS psychiatry voucher were also included, such as exposure therapy or therapy for bipolar disorder, the prevalence of the cognitive behavior therapies would be much higher. Likewise, if the focus would be on therapies provided within the HUS psychiatry as its own service, cognitive behavioral therapies emerge as dominant, and the proportion of some treatment orientations, like psychodynamic and solution-focused, probably much lower. In comparison to the late 1980's a major change has occurred: at that time 90% of therapies organized by HUS psychiatric clinic as externally provided services were psychodynamic/analytic, with only a small proportion being individual cognitive therapies and family therapies (*ibid.*).

In the Finnish practice guidelines for mental disorders, cognitive behavioral treatments dominate among the treatments with A-level evidence, as there are more RCTs available for these treatments. However, there are a number of other evidence-based approaches with equally strong evidence, as well as others with B-, C-level evidence, which can be considered as options on the basis of clinical judgement and patient preference. However, the general finding of

minor or no clinically significant differences in the efficacy of different types of evidence-based treatment for patients with depressive disorders, personality disorders, and other mental health conditions tends to be overlooked in the service system (*ibid.*).

3.2.2. Financing of psychotherapy services

There are two ways to access free psychotherapy services. The first is through the public system of psychiatric hospitals and clinics (HUS = Helsinki-Uusimaa hospital/health system). The whole country is divided into 22 health care districts. The second is through health insurance (KELA-subsidised therapy), which since January 2011 has given every citizen the right to psychotherapy if prescribed and referred by a psychiatrist. This option was set up to support private psychotherapy practice for children, adolescents and adults. In this case psychotherapy is one form of rehabilitation provided by The Social Insurance Institution of Finland (SII) (Korkeila, 2009).

Licensed psychotherapists are eligible to provide KELA and HUS free psychotherapy services. This means that a person can obtain 20 sessions for free from HUS for psychotherapy, or up to 80 sessions per year (up to 3 years) for KELA therapy. Obtaining KELA-supported therapy requires a so-called 'B-lausunto' document from a psychiatrist, with a waiting time of 3 months before therapy is granted and a minimum of 2 visits with the psychiatrist. Psychotherapists are licensed by VALVIRA in Finland, and unfortunately VALVIRA very rarely grants licences to foreign educated psychotherapists. This means that most foreign-educated psychotherapists cannot offer subsidised psychotherapy sessions and cannot use the title psychotherapist (*ibid.*). KELA both funds rehabilitation services and provides income security (Rehabilitation Allowance) during participation in rehabilitation. In 2017, the total number of beneficiaries was 120,165 and the overall costs were €453 million. Recipients of psychotherapy services were the single largest group of patients and their number has markedly increased during the 2000s (Keskimäki et al., 2019).

The most common modalities in subsidised 'rehabilitative psychotherapy' include psychodynamic, cognitive, cognitive-behavioral and cognitive analytic, solution-focused and integrative psychotherapy in individual, group, couple and family settings (Kausto et al., 2022). Initially, only long-term psychotherapy was funded, but since 2007, short-term psychotherapy has also been funded (Seikkula, 2011). In the period from 1994 to 2002, the insurance paid for 53,800 treatments, of which about 60% were cases of depression (*ibid.*).

Rehabilitative psychotherapy aims to support an individual's employment, staying at work and return to work, but it is not linked to occupational health services (OHS) or other employer measures aiming to maintain employees'

work ability. The SII can compensate rehabilitative psychotherapy for 1 to 3 years with a maximum of 80 sessions per year and 200 sessions in 3 years. The applicant must be aged 16–67 and have a diagnosed mental health problem that threatens work ability (or ability to study). This excludes patients whose likelihood to return to working life is low, as well as retired and adolescents. The need for and suitability of the individual for psychotherapy is evaluated by a psychiatrist. To get into this rehabilitative psychotherapy, a psychiatrist statement and a minimum of three months treatment without sufficient response are needed. This creates a structural delay and a practical bottleneck due to the shortage of psychiatrists. The SII uses over 100 million euros annually to fund psychotherapy for over 60,000 persons (Saarni et al., 2023).

To supplement SII-funded psychotherapy also hospital districts and municipalities offer psychotherapies, often outsourced to private practitioners. Helsinki and Uusimaa hospital district (HUS, the largest in Finland) uses vouchers to provide outsourced psychotherapies free of cost for the patient. Therapists are accepted to the system according to certain criteria. Different vouchers are given to different patient groups according to evidence-based guidelines. For example, patients with bipolar or psychotic disorder can be treated only by a clinically experienced psychotherapist trained in cognitive or integrative frameworks, whereas a patient with uncomplicated unipolar depression can select a psychotherapist of any evidence-based framework. The supply of short, structured psychosocial treatments targeted to mild to moderate symptom levels has been very limited, with only internet-delivered CBT being available nationwide. A national First-line Therapies initiative is trying to remedy this by introducing a selection of evidence-based psychosocial interventions into primary care (Saarni et al., 2022).

In the public sector, each county has to be certified by an insurance company to meet the so-called Treatment Excellence Guidelines for psychotherapeutic treatment of schizophrenia, personality disorders and alcoholism. Psychotherapists must be registered with a national public insurer in addition to being licensed as a psychotherapist. In the public sector, psychotherapy is also provided by a number of other professionals and students under the supervision of qualified psychotherapists (Seikkula, 2011). Since 2016, a quality control system called the Finnish Psychotherapy Quality Register (FPQR), a comprehensive database on availability, quality, and outcomes of psychotherapies, has been introduced to monitor the course of treatment from session to session (Saarni et al., 2022, 2023).

3.2.3. The organisational challenges of the psychotherapy service system

The growth in demand for rehabilitative psychotherapy is probably due to more favourable attitudes towards psychotherapy in general, greater recognition of mental health conditions, and a lack of alternative ways to access psychotherapy. The majority of patients have a depressive or anxiety disorder as their main diagnosis, with recurrent major depressive disorder being the most common. Around three-quarters of patients are women. There are issues with it being unevenly available geographically and socioeconomically (Lindfors, 2024).

Due to the growing demand for psychotherapy, health care resources must be allocated more efficiently according to patients' needs. In order to reduce inadequate responses to treatment and unnecessary costs, research-based information is required on the selection criteria that are potentially relevant for treatment choice, as well as on the effectiveness of different treatments and the stability of improvements, including sustained remission and the absence of the need for additional treatments (*ibid.*).

Important questions regarding the regulation of psychotherapy include when it is appropriate to implement it alongside medication, when it should be used alone, and when short- or long-term treatment is appropriate. Short-term therapies have generally been found to be as effective as psychiatric medication, and more effective than being on a waiting list. This proves that improvements in treatment are not just due to the placebo effect or regression to the mean (Churchill et al., 2001; Cuijpers et al., 2008; de Maat et al., 2006). Although long-term therapies, mostly psychodynamic, are widely used in clinical practice, they have been studied to a lesser extent. In particular, comparative research on the effectiveness of long-term and short-term therapies is scarce (Knekt et al., 2008a, b; Lindfors & Keinänen, 2020). Furthermore, few studies have examined the effectiveness or cost-effectiveness of therapies over the long term or in relation to outcomes other than symptoms, such as work ability or social functioning.

This was the reason for launching the renowned Helsinki Longitudinal Study, which has been running since 1995. This comprehensive investigation explores the effectiveness, sufficiency and suitability of various psychotherapeutic approaches, providing valuable insights into the treatment of mood and anxiety disorders. Exploring factors related to the suitability of different therapies for individual patients, the study includes a five-year follow-up period to track the long-term effects of the different therapies. Key findings to date are summarised below (Heinonen et al., 2017; Knekt et al., 2008a, b, 2011, 2012, 2015, 2016; Maljanen et al., 2012):

- Both short- and long-term psychotherapies have been shown to be effective for the treatment of patients suffering from mood or anxiety disorders.
- Therapies of the same length have, on average, been found to be equally effective.
- Short-term therapies often show quicker improvements in the initial stages of treatment, particularly in psychosocial functioning and work ability.
- Long-term therapies may be more effective in the long run, especially for reducing symptoms and improving work ability and recovery for those with depressive disorders.
- Part of the patients benefited sufficiently from shorter therapies, but many needed additional psychiatric treatment.
- Factors affecting sufficiency of and suitability for treatments of different length can be identified and used for allocating resources with greater precision to meet the needs and characteristics of individual patients.
- Patients with better pre-treatment psychological dispositions benefited in general from short-term therapy sufficiently, whereas patients with worse predispositions, such as poor psychological suitability or self-concept and those with childhood adversity, more often needed long-term therapy to recover. These and other recent findings on the predictors and moderators of psychotherapy effectiveness have highlighted the value of thorough pretreatment assessment.

In contrast to the demand for and provision of rehabilitation services, there has been a severe lack of psychosocial and therapeutic services in primary health care. However, in 2018, the Finnish Council for Choice in Healthcare recommended psychotherapeutic and psychosocial services, stating that: "Empirically-supported psychotherapies and psychosocial treatment and rehabilitation methods need to be included as service choices belonging to goal-directed treatment and rehabilitation at all phases".

Currently, a stepped care model based largely on the British NHS Talking Therapies (formerly Improving Access to Psychological Therapies (IAPT)) is being developed, primarily within HUS Psychiatry and in collaboration with the Wellbeing Counties. The programme prioritises short-term CBT interventions for common mental health issues such as depression and anxiety, and has introduced a selection of other evidence-based psychosocial interventions into primary care. It also aims to organise structured training for the implementation of these interventions nationwide through the Firstline Therapies Initiative. The programme has been divided into several projects and is currently being implemented and evaluated by its developers. A thorough evaluation of the project and its implications is needed to highlight its benefits, limitations, and potential pitfalls.

Similarly, further research focusing on the entire psychotherapy system is required to reveal potential discrepancies between treatment guidelines and clinical practice at all levels of social and health care (ibid.).

In 2023 it has been estimated that approximately 120,000-140,000 people in Finland require some form of psychotherapeutic intervention. Since January 2023, the 22 wellbeing service regions have been responsible for arranging psychosocial and psychotherapeutic treatment or rehabilitation for their citizens. So far, little information is available on how the different areas are planning to provide these services. Guidelines have been proposed for developing a research-informed quality assurance system. A 2021 survey of psychotherapy services arranged by previous health care districts indicated that their output was significantly lower than that of SII-funded rehabilitative psychotherapy. There has been an increasing trend in providing psychosocial interventions and self-help programmes via the internet: more than 14,000 people have participated in remote, internet-based cognitive therapy. Significant investment has focused mainly on developing short-term manualised cognitive behavioral programmes, but has also covered interpersonal therapy (IPT) and counselling (IPC). However, no investment has been directed towards implementing evidence-based guided or online psychodynamic treatment formats (ibid.).

Government policy aims to increase private psychotherapy rather than expand psychotherapy services within the public sector. This trend is increasing due to the growing bureaucratic burden and staff burnout in public institutions, while private practitioners report greater job satisfaction (Korkeila, 2009). This reduces the availability of adequate treatment for people from lower social strata, since clients in private practices must cover some of the costs themselves. Furthermore, more private practitioners work in urban areas than in rural areas, creating an imbalance in the provision of high-quality psychotherapy services (Seikkula, 2011). The Finnish example therefore illustrates the difficulty of regulating psychotherapy services in a way that allows equitable access to quality services for all segments of the population.

In March 2025, developments occurred in two key areas related to psychotherapy. The first was the potential ban on conversion therapy, which refers to pseudoscientific practices aimed at changing a person's sexual orientation or gender identity. The second was the ongoing reform of the Act on Social and Health Care Professionals. Specifically, Parliament backed a citizens' initiative to ban conversion therapy, but the government is reportedly stalling on enacting the law. Additionally, the comprehensive reform of the Act on Social and Health Care Professionals is ongoing and includes changes to the occupational therapy profession that could affect how psychotherapists are classified and recognised as experts. A key aspect

of the reform is a review of the requirements for using the title 'psychotherapist'. The reform is expected to be completed by 2027 (Helsinki Times, 2025).

In summary, although the psychotherapy profession in Finland has grown stronger over the last 45 years, with more versatile therapy models and approaches emerging, these are not being distributed or used optimally. Many people are not referred for psychotherapy based on their needs and preferences. Inequality issues regarding the availability of psychotherapy must be addressed (Lindfors, 2024).

3.3. **Iceland: A new bill to cover psychotherapy under public health insurance**

Psychotherapy is regulated within the broader framework of health care professions, rather than having a separate, specific law for psychotherapy. Psychiatrists are authorised to practise psychotherapy as part of their medical specialty, and psychologists can practise psychotherapy after completing specialist training and obtaining a licence. Psychotherapists are included in the register of health care professionals. The Directorate of Health grants licences to practise as a licensed health care professional, including specialists in psychology and psychotherapy. The State Diagnostic and Counselling Centre maintains the register (Directorate of Health of Iceland, 2025).

3.3.1. **The mental health situation in Iceland**

Epidemiological data on mental health in Iceland at the end of the 20th century revealed a rise in alcoholism. Mental disorders affected around 20% of people aged 5–60, but this figure increased after the age of 70 due to organic mental disorders. The incidence of first consultations with psychiatrists was less than one per cent per year. Demand for services far exceeded availability. It was estimated that between 40,000 and 50,000 Icelanders suffer from a mental disorder at any given time. However, psychiatrists only treated around eight thousand patients each year. Around 7,000 patients received prescriptions for psychotropic medications other than hypnotics each month. Most of these medications were prescribed by general practitioners as the main treatment for mental health conditions. Around 1,600 people were admitted as inpatients each year for alcoholism and other drug abuse (Helgason, 1994).

An epidemiological study in 2017 showed that the youngest participants (aged 18 to 20) had the highest prevalence of depression, anxiety and stress. The decline in the mental health of young people is alarming, as is the fact that those already taking psychiatric medication for various mental health disorders reported low mental health. Currently, medical treatment and cognitive behavioural therapy (CBT) for depression

are the only forms of treatment partially subsidised by the government. The COVID-19 pandemic has exacerbated psychological distress in the general population, intensifying symptoms of depression, anxiety and stress (Sigurðardóttir et al., 2023).

According to OECD data, Iceland continues to have one of the highest levels of antidepressant use in the world. Average consumption reached 157 daily doses per 1,000 inhabitants in 2022 (Statista, 2022). Although psychotherapy is recognised as a crucial component of comprehensive mental health care, especially for treating conditions such as depression and anxiety, psychiatrists in Iceland, unlike in other Nordic countries, often prescribe antidepressants to patients with milder forms of depression or anxiety disorders rather than just severe cases.

As of 2021, Iceland was allocating almost 12% of its health care budget to mental health services. This is approximately 2% higher than the global average for mental health spending (Maassen, 2022).

3.3.2. Psychotherapy training

Psychotherapy training usually involves a multi-year programme combining academic study and supervised clinical practice. A master's degree in psychology is a prerequisite, followed by specialised training of two to three years in a particular psychotherapy approach (e.g. CBT, psychodynamic, humanistic). While some other health care professionals, like doctors or social workers, may work with psychotherapeutic approaches, the title 'psychotherapist' is reserved for those with a recognized psychology qualification and a specialist license.

Psychotherapy training is primarily offered through university programs and specialized courses. The University of Iceland and the Reykjavik University offer master's degrees in clinical psychology and applied psychology, with specializations in clinical, quantitative, or social psychology. Additionally, specialized training in areas like CBT, Nordic psychedelic training, and positive psychology is available through various institutions and courses (e.g. TRE trauma release, clinical hypnotherapy, somatic trauma therapy). Universities collaborate with institutions such as Landspítali University Hospital and health care centers to provide students with internship and field study opportunities.

The training of psychiatrists varies considerably, and there are not enough of them (Ledbetter, 2022). Some receive their training in Iceland, while the majority train abroad in countries such as those in Northern Europe or the USA. The requirements for practising psychiatry in Iceland are set out in government regulations proposed by the Faculty of Medicine at the University of Iceland. Accordingly, psychotherapy training is not a mandatory part of the curriculum. Consequently, the integration of psychotherapy theory and practice into Icelandic psychiatry depends largely on the interests and initiatives of

individual psychiatrists. Psychotherapy training for psychiatrists typically includes generic skills (such as establishing a therapeutic alliance), basic practitioner skills (supervised practice in one modality) and advanced training for those interested in specialising. Psychologists and social workers who have received psychotherapy training play a role in educating psychiatrists, but this is not a formal part of the curriculum (Sigfusson, 1995).

3.3.3. Important psychotherapy associations

Icelandic Association of Psychotherapists (SALM - Félag sálmeðferðarfræðinga) was founded on 24 October 2019. Membership is open to individuals who have completed an accredited psychotherapy course. SALM provides the public with information about practising psychotherapists' services and treatment approaches. In accordance with the policy of the European Association for Psychotherapy (EAP) SALM works to develop, support and maintain the quality of the independent psychotherapy profession. It has around 50 members (Icelandic Association of Psychotherapists, 2025).

The Icelandic Association for Cognitive and Behavioural Therapies (IACBT; Félag um hugræna atferlismeðferð) is also a relevant psychotherapy organization (IACBT, 2025). It was founded in 1986 and in its early years was firmly rooted in the behavioral tradition and its mission was to advance the study and application of behavioral therapies. Over the past 20 years the association has grown with over 100 members, mostly psychologists, and its emphasis has changed as well. Today, the association consists of professionals who are interested in promoting and advancing the cognitive and behavioral therapies in practice and in theory. The association offers special training for professionals in the methods of CBT in association with the Oxford Cognitive Therapy Center (OCTC). The association is a member of the European Association for the Cognitive and Behavioral Therapies and hosted the 41st Annual Congress of EABCT in Reykjavík, Iceland in September 2011.

3.3.4. Psychology is a well-regulated field

The main credit for psychology being a well-regulated field in Iceland goes to the Icelandic Psychological Society (Sálfræðingafélag Íslands = SAL). The Psychological Association of Iceland was founded in 1954. The Psychologists Act was enacted in 1976. The Regulation on the Professional Licensing of Psychologists was issued in 1990. The Association of Psychologists in Iceland was established in 1993. Psychology became a recognised health care profession in 1996. In 2005, both associations united under the name Icelandic Psychological Society (SAL). In 2012, the Ministry of Welfare updated the regulations on the education, rights and obligations of psychologists, as well as the criteria for granting licences and specialist licences, with Regulation No. 1130/2012 (Government of Iceland, 2012).

The number of SAL members has steadily increased. In October 2018, there were 656 members, mostly women. Of these, 426 had full membership, 88 had professional membership, 119 had additional membership, and 23 were honorary or pension members. Women make up the vast majority at 491, while men make up the minority at 165 (Icelandic Psychological Society, 2025).

Similarly to Finland and Sweden, Iceland regulates the profession of 'psychologist' under the Health Professionals Act and considers them to be health care professionals. In 2013, Iceland reformed its legislative framework applicable to health professionals. The aim of this reform was to consolidate all regulated health professions under one act and to simplify and harmonise the requirements. Licences are granted for all recognised clinical specialist fields of psychology involving direct interaction with patients/clients, as well as diagnosis and treatment. This results in higher qualification requirements, including specialist postgraduate studies totalling 60 ECTS credits, as well as three years of mandatory professional practice, resulting in an overall training period of around eight to nine years. However, the law does not describe the fields in detail (European Commission, 2016).

In addition to psychotherapists and psychologists, coaches are also active. Interestingly, a study comparing coaching and psychotherapy in Iceland (involving 37 certified coaches and 92 psychotherapists) has shown that goal setting may be as relevant to therapy as to coaching. It also suggests that therapists may not focus on the past as much as previously believed and that coaching may involve more than simply helping clients to set goals and achieve success (Stefánsdóttir, 2020).

3.3.5. Psychotherapy services

Psychotherapy services are mostly provided by psychologists and psychotherapists. Psychologists often work in health care settings such as hospitals and clinics, whereas psychotherapists may work in private practice or other settings. E.g. Health Centers of the Healthcare Institution of West Iceland (HVE) (2025) offer assessment of mental health problems and psychotherapy (mostly CBT) for children and adults, both individual and group therapy. Psychologists' services cover all municipalities in the West or HVE's area of operation. A referral is required from a doctor in HVE's psychological services. The focus is on the treatment of mild to moderate anxiety, depression and PTSD. Treatment is based on a limited number of sessions according to the clinical judgment of psychologists. Serious mental problems are referred to appropriate treatment options outside health care or to the HVE Mental Health Team. Psychologists at HVE work as part of multidisciplinary teams, working in collaboration with other professions of the institution as well as other institutions such as social

and school services, the Children's and Adolescent Psychiatry Department of Landspítala, the State Diagnostic and Counseling Center and the Children's Mental Health Center and Child Protection.

3.3.6. Financing of psychotherapy

In June 2020, Iceland's parliament passed a bill ensuring that psychotherapy would be covered by public health insurance on the same basis as other health services (Ćirić, 2020). The bill was implemented in 2021. The Icelandic Psychological Association (IPA) welcomed the bill, having fought for improved access to psychotherapy for decades. In Iceland, a single psychotherapy session can cost around ISK 17,500 (USD 126/EUR 113). According to Statistics Iceland, around one third of the country's residents say they cannot afford mental health services. Health clinics report that around 30% of the population visits them. The bill stated that including these services within the public health insurance system would eliminate 'unnecessary suffering' while also providing long-term savings for the country (ibid.).

Before the 2020 bill was passed, the prerequisite for partial reimbursement by the Iceland Health Fund for psychology/psychotherapy services was a referral from a health care expert. For children with serious mental health, behavioural, or developmental disorders, referrals had to come from a multidisciplinary diagnostic team or a child psychiatrist. The referral was valid for six months from the start of treatment. If a referral had not been issued or was more than six months old, the Iceland Health Fund did not contribute to the cost of the service. The maximum number of available referral treatments was 10 hours for children and 12 hours for individuals aged 18 and over.

Additionally, NGOs enable Icelanders to receive therapy-focused mental health treatment at no personal cost. Iceland has a long-standing tradition of self-help groups, including Alcoholics Anonymous (AA) and other 12-step groups. The first AA groups emerged in Reykjavik in 1954 and in Akureyri in 1973. Since then, 12-step programmes have expanded hugely. Currently, there are around 228 AA meetings held each week in Iceland. There are also self-help groups for survivors of sexual abuse, cancer and bereavement (Ívarsson, 2015).

It is worth noting that Iceland's population of around 320,000 tends to have closer contact with their extended family than is typical in larger societies. This creates a network of familial support in times of need. In the event of a minor crisis, people expect to talk to a family member (Herman, 2004). This has an impact on professional helpers, who find it difficult to specialise. Typically, psychiatrists treat a variety of patients, make diagnoses, and prescribe medication and other forms of treatment. In their daily work, they often fulfil many roles that extend beyond their immediate professional sphere (Ívarsson, 2015).

In 2003, volunteers who have experienced mental health struggles themselves and have vast experience in the mental health care system founded Hugarafll (2025). Together the volunteers work toward the common goal to improve the Icelandic mental health care system while dissolving prejudices surrounding mental health challenges and protecting the rights of those suffering. The organization has managed to provide several services, ranging from basic counseling to trauma rehabilitation, for anyone older than the age of 18 without the need for residency, insurance or financial cost (Maassen, 2022).

3.4. **Norway: Many professionals are practicing psychotherapy but no psychotherapy profession**

Psychotherapy is not an independent profession and is not regulated by a specific law but under the Health Personnel Act. Psychologists and psychiatrists are authorized health care professionals, while psychotherapists may also practice after specialized training. Psychotherapy is provided in public and private settings (Rønnestad, 2006).

Public insurance often covers psychotherapy, sometimes with private supplementation. The majority of mental health services, including psychotherapy and counselling, are provided in various forms of outpatient clinics. To a limited extent, psychotherapy is also provided in inpatient settings. Teams in mental health facilities consist of psychiatrists, psychologists, social workers, psychiatric nurses, who may provide psychotherapeutic services, and sometimes physiotherapists, occupational therapists and educators. Psychiatric nurses and social workers conduct psychotherapy and counselling, particularly within mental health and social service institutions for children, adolescents, and families (ibid.).

The majority of psychotherapists are members of their 'national' professional association (e.g. Norwegian Psychological Association, Norwegian Medical Association, Norwegian Nursing Association, The Norwegian Association of Family Therapy - NFFT). The NFFT is an association of psychotherapists specialising in family therapy, with around 1,000 members working in various contexts, including child and adolescent psychiatry, family counselling offices, child protection services, work facilitation agencies (NAV), adult psychiatry and schools. The NFFT is currently working on establishing its own certification for certain groups of members, with the aim of influencing the Health Directorate towards accreditation (ibid.).

Practitioners of medicine, psychology and nursing must have a licence to practice. Although the status of these professions is relatively high in the eyes of the public, the need for treatment is far greater than what can be met by

professionally trained practitioners. The market for alternative and non-traditional treatments is growing (ibid.).

3.4.1. **Norwegian mental health care system**

Mental health care in municipalities is provided by general practitioners, psychologists, psychiatric nurses and social workers. Many municipalities have multidisciplinary mental health outreach teams (Sperre Saunes, 2020).

Mental health care for children under 18 is fully covered. Preventive mental health services for children and adolescents are provided through the school system (ibid.). The Family Counselling Offices in all regions and counties in Norway offer services free of charge, primarily for couples and individuals with children under 18. Professionals are psychologists, psychiatrists, social workers, child protection workers, special pedagogists and educators - all with further education in Family Therapy or a Master degree in Family Therapy. These Family Counselling Offices are organised by The Norwegian Directorate for Children, Youth and Family Affairs, and they are rather unique in Europe, and a very important part of systemic psychotherapy in Norway.

For specialised care, general practitioners can refer patients either to private psychologists and psychiatrists or to community mental health centres, which provide acute care (inpatient, outpatient and day care) and rehabilitation services and also monitor and support primary care. These centres are spread throughout the country and often include psychiatric outreach teams (ibid.).

More advanced specialised services are provided in in-patient psychiatric wards in general hospitals or in psychiatric hospitals. Inpatient treatment is free of charge and outpatient services are subject to the same cost-sharing as other outpatient visits. Psychiatric services in hospitals and community mental health centres are fully (100%) funded by block grants from the Regional Health Authorities (RHAs). Private psychiatric hospitals account for about 12% of mental health care, including services for eating disorders, nursing home care for elderly psychiatric patients and some outpatient practices of psychiatrists and psychologists, most of which are contracted by the RHAs (ibid.).

The role of private addiction treatment centres (mainly for drugs and alcohol) is significant and mostly funded through contracts with the RHAs. In general, treatment for drug dependence is provided by specialised treatment units, while general practitioners are involved in opioid substitution treatment (ibid.).

Norway also follows international trends in using multifamily groups to treat schizophrenia, eating disorders and addiction; psychoeducational groups to treat bipolar disorder and personality disorders; dialectical behavior therapy to treat self-harm and borderline personality disorder; and 12-step groups to treat addiction in the Alcoholics Anonymous tradition.

3.4.2. Community-based mental health care

Community-based mental health care in Norway consists of local Community Mental Health Centres (CMHCs), which cooperate with general practitioners and primary mental health care in the municipalities, as well as with psychiatrists and psychologists in private practice. CMHCs have been developed since the 1980s to provide a wide range of comprehensive mental health services in local catchment areas. CMHCs have outpatient clinics, mobile teams and inpatient units. They serve the larger population of patients requiring specialised mental health care and also work with hospital-based mental health services. Both CMHCs and hospitals are run by 19 publicly funded health trusts (Ruud & Friis, 2021).

Increasing resources for community-based mental health care was a key objective of a national mental health plan between 1999 and 2008. In parallel with the development of community-based mental health care, the use of specialised inpatient mental health services per 100,000 adult inhabitants aged 18 and over has gradually decreased by 53%, from 176 beds in 1998 to 86 in 2017. Of these, the number of hospital beds per 100,000 adult population was 91 in 1998 and 46 in 2017, while the number of CMHC beds was 81 in 1998 (including 41 psychiatric nursing home beds) and 36 in 2017 (when there were no remaining psychiatric nursing homes). Over the past decade, 40% of inpatient beds providing adult mental health services were in CMHCs. The number of beds in CMHCs has decreased over the past decade, while there has been an increase in mobile teams, including crisis resolution teams (CRTs), early psychosis intervention teams, and assertive community treatment teams (ACT teams). Team-based care for mental health problems is also part of primary care, including care for patients with severe mental illness. Involuntary admissions are mainly to hospitals, but CMHCs can continue such admissions and issue community treatment orders for involuntary treatment in the community (ibid).

Although community mental health care serves a large group of people with mental disorders, most resources are still spent on inpatient services. The overall assessment is that increasing specialisation has improved services. However, it may also have resulted in more fragmented services and less continuity of care from providers that patients know and trust. This can be a particular problem for patients with severe mental disorders. As the outcomes of routine mental health services are not usually measured, the impact of community mental health care on patients and their families is largely unknown (ibid).

3.4.3. Psychotherapy as a part of the psychiatric and psychological services

Psychologists and psychiatrists are the professional groups that provide an important part of psychotherapeutic services, alongside psychiatric nurses

and social workers who also provide psychotherapy and counselling within the mental health and social care system. According to the World Health Organisation (WHO), there are more psychiatrists working in public health services per head of population than in any other country (approximately 30 psychiatrists per 100,000 people) (McCarthy, 2016). The proportion of psychologists and other mental health professionals is also among the highest in the world (approximately 48 per 100,000 people) (Eurostat, 2017). There are no statistics on the number of psychotherapists among them.

3.4.4. Psychiatry and psychotherapy

Unlike American psychiatry, Norwegian psychiatry is less focused on categorical diagnosis and the medicalisation of mental health. It is more psychosocial, so that the harmful effects of the reductionist medical model are less pronounced. An important strategy for improving access to mental health services has been the development of community mental health centres, which have primary responsibility for outpatient services, outreach teams, day care services and almost half of inpatient psychiatric services (Pedersen, 2005). There are national guidelines for the treatment of specific diagnoses, but practice-based evidence, patient preferences and attention to cultural issues seem to be becoming increasingly important.

This is reflected, for example, in the development of group psychotherapy (Lorentzen et al., 2015). Most group therapists are nurses, of whom only 50% have formal training, so there is a need for more group therapists with formal training. Psychodynamic groups were the most common, followed by cognitive behavioral, psychoeducational, social skills/coping and artistic/expressive groups. Norway also follows international trends in the use of multifamily groups for the treatment of schizophrenia, psychoeducational groups for patients with bipolar disorder and personality disorders, dialectical behavior therapy for self-harm and borderline personality disorder and 12-step groups for the treatment of addictions in the AA tradition.

A recent survey (Lorentzen & Ruud, 2014) of representative public mental health services showed a range of different groups: psychodynamic groups were most common, followed by CBT, psychoeducational, social skills/coping, and art/expressive groups. The most common diagnoses of patients ($n = 2,500$) were mood disorders (21%), personality disorders (16%), schizophrenia/psychosis (13%) or social phobia (10%). Patients with depression or personality disorders mainly attended psychodynamic groups; those with psychosis/bipolar disorder attended psychoeducational groups, while CBT groups were used across several diagnoses. As a result of the development of decentralised, community-based psychiatry and the systematic training of group therapists, access to and quality

of group therapy has improved. Some clinical group research is taking place, both within and outside institutions.

In 1970, Norway became the first Scandinavian country to require psychiatrists to undergo psychotherapy training (Seeman & Lauren, 1984). These days, it takes a resident five years to become a specialist in adult psychiatry. This period includes clinical training in most areas (acute, long-term/rehabilitation, outpatient, etc.) and educational (theoretical) programmes covering areas such as psychotherapy, service models, the patient-therapist relationship, leadership and legislation. One year of residency may be in another relevant medical specialty. Psychotherapy training (practice and supervision) requires a minimum of 3 years of residency: 2 years of psychodynamic training, focusing mainly on the role of the therapist and the patient-therapist relationship, and a further year focusing on the treatment of patients with either psychodynamic, cognitive or group analytic therapy. This requires at least 110 hours of supervision in addition to theory and patient therapy. Many psychiatrists undertake further training in one or more forms of psychotherapy (Reitan & Lien, 2023).

The general arrangements for postgraduate specialist training are organised by the national health authorities, but regional health trusts are responsible for the detailed content, including administration, management and research. Regional and local health trusts, rather than universities, are responsible for postgraduate training. The Norwegian Psychiatric Association (NPA) is responsible for quality control in psychiatric training. Most psychiatrists and assistant doctors are members of the NPA, which is part of the Norwegian Medical Association (NMA). The NMA is responsible for almost 100% of all doctors, both as a professional organisation and as a trade union. The NPA is concerned with professional conditions and professional development, as well as the general conditions and structure of mental health services. It has specialised sections on preventive psychiatry, biological psychiatry, psychotherapy, forensic psychiatry, consultation-liaison psychiatry, gerontopsychiatry, emergency psychiatry, quality issues, fundamental problems in science and psychiatry, residency training, etc. The association and its sections work in close cooperation with the NMA, local health authorities and other professional organisations (including the Norwegian Association of Psychologists), as well as several user organisations (*ibid.*).

3.4.5. Psychology and psychotherapy

The law regulates the acquisition of the title of psychologist and the licensing of psychologists to work within the health care system: after six years of study, including one year of supervised practice. The holder of a bachelor's degree in psychology can acquire the title of psychologist and apply to the Norwegian National Board of Health for a licence to practice (van Baalen, 2002).

Psychologists can obtain specialist status, which grants a licence as a specialist in psychology (with subspecialties), after completing various theoretical, practical and supervisory requirements for a minimum of five years. To become a specialist in clinical psychology or psychiatry, three years of clinical supervision are required. The clinical subspecialties within psychology include training in psychotherapy. With the exception of one specialisation within the Norwegian Psychological Association (clinical psychology with psychotherapy), neither the specialisations within the Norwegian Medical Association nor the Norwegian Psychological Association require individual therapy. However, the vast majority of Norwegian psychotherapists in various professions have had at least one course in individual therapy during their career (Rønnestad, 2006).

Several universities (e.g. Oslo, Bergen, Trondheim and Tromsø) offer professional training in psychology leading to a licence. Although there are some common elements in the programmes, there are also some different emphases in the different locations. 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 continues but is complemented by a cognitive/systemic/family orientation (*ibid.*).

Licensed psychologists with specialist status provide psychotherapy in private practice within a state-regulated system with partial reimbursement by the state. Licensed psychologists without specialist status and therapists trained in private training institutions (e.g. Gestalt therapy, psychodrama) also provide some psychotherapy, but outside the reimbursement system (*ibid.*).

Although within the public health system the medical profession has traditionally been at the top of a power hierarchy, this is gradually changing as members of other professions have taken over administrative leadership of medical institutions, and as psychologists can be professional leaders of child and adolescent mental health institutions. In terms of social recognition, the psychology profession has for decades had a strong position within individual psychotherapy. It is quite common for psychologists to supervise members of other professions in their individual psychotherapy practice. Other forms of psychotherapy, such as group psychotherapy, family therapy and couples therapy, are carried out by members of different professions. The Institute for Group Analysis has contributed significantly to the training of group psychotherapists for more than 20 years (*ibid.*).

In principle, there is no difference between the professions 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 its members and the state. The overall picture is that there is more cooperation than conflict between the professions (ibid).

3.4.6. Self-regulation of psychotherapy

Although there is no legally regulated independent profession of psychotherapist, the Norwegian Association for Psychotherapy (Norsk forbund for Psykoterapi - NFP) (NFP, 2024a) was founded in 1998. It is a voluntary umbrella organisation of Norwegian psychotherapy associations and institutes that meet the EAP quality requirements. NFP therefore has no direct individual members, but only institutions or organisations through which it brings together more than 500 psychotherapists.

To be accepted into an NFP-recognised programme, an educational institution must meet the minimum standards of the NFP or EAP. These standards also apply to members of psychotherapeutic associations. There are currently three educational institutions and six provider organisations operating under the NFP umbrella, covering the following psychotherapeutic modalities Gestalt Therapy, Art and Expressive Therapy, Psychodrama, Psychosynthesis, Analytical (Jungian) Therapy, Integrative Therapy.

Most training in psychotherapy is provided by private training institutions, some of which are partly publicly funded and require participants to have completed basic training in medicine, psychology, nursing or social work. The main training institutions are Institutt for psykoterapi, Psykoanalytisk institutt, Institutt for Aktiv Psykoterapi, Institutt for Gruppeanalyse, Norsk Karakteranalytisk Institutt. Some public mental health institutions offer 3-year scholarships for postgraduate training to the above-mentioned candidates. For children and adolescents, the regional mental health centres provide both psychotherapy services and psychotherapy training. Training is usually open to licensed mental health professionals and social workers. In addition, there are some private training institutions that do not require prior professional training. These institutions do not receive public funding (Rønnestad, 2006).

The profession of psychotherapist is not one of the health professions covered by the special Health Professions Act (Lov om helsepersonell) (Lovdata, 2023), which lays down requirements for the practice of health professions, including duties of confidentiality, reporting and documentation, and the provision of immediate assistance. The Act also covers the conditions for obtaining a licence or specialisation, the obligations involved and the grounds for withdrawal.

All persons holding a permit or licence under the Health Personnel Act are entered in the register of health professionals at the National Board of

Health (Helsedirektoratet), a specialised administrative body under the Ministry of Health and Welfare and the Ministry of Labour and Social Inclusion. The professions listed in the register include the profession of psychologist (psycologist), but not the profession of psychotherapist. Those who have been trained in other EU/EEA countries or outside the EU/EEA can also be registered (Helsedirektoratet, 2024).

Most psychotherapy services are provided outside the health care system. Psychotherapists are subject to the provisions of the Act on Alternative Treatment (Lov om alternativ behandling av sykdom mv), which contains rules on alternative treatment of illnesses and aims to ensure the safety of patients seeking or receiving alternative treatment (Lovdata, 2003). The Act also contains rules on confidentiality, the use of titles in alternative treatment and marketing, etc. Intentional or grossly negligent violation of the Act is punishable by a fine or imprisonment for up to three months. In particularly aggravating circumstances, the penalty may be increased to imprisonment for up to two years.

There is no national register of psychotherapists, but there is a voluntary register of alternative therapy providers, the Register for Utilization of Alternative Therapies (Register for utøvere av alternativ behandling) (NAFKAM, 2024), which includes alternative therapists who meet certain professional criteria, e.g. training standards and exclusion criteria, ethical guidelines, formal systems for handling client complaints, membership of recognised professional organisations, insurance, etc., thus ensuring minimum quality standards. Many therapists of different psychotherapeutic modalities from NFP member organisations are also included in this register. In order to be registered, an individual must apply through his or her own organisation, which must guarantee his or her registration; in addition, the individual must be insured for his or her activity and meet other requirements, e.g. be insured and meet the conditions of the required qualification (NFP, 2024b). Professionals registered in the alternative register are entitled to use (e.g. for the presentation and advertising of their activities) the designation 'registered' in connection with their title of therapist (i.e. with a title according to the psychotherapeutic modality they practice). For example, it is possible to find a Jungian therapist (Jungiansk terapeut MNFAP), a Gestalt therapist (Gestaltterapeut MFGT, Gestaltterapeut MNGF), a psychodrama therapist (Psykodramaterapeut MNFPSG), a psychosynthesis therapist (Psykosyntheseterapeut), etc. However, a practitioner defined only as a psykoterapist is not even offered as a possible category in the search engine.

So-called alternative practices are also increasingly being integrated into public health care, but they are carried out by health professionals in legally recognised health professions. Therefore, several parts of the legislation

regulating licensed health professionals (psychologists, doctors, psychiatrists, nurses, etc.) can also be applied in this context to psychotherapists or personnel providing psychotherapy (EAP, Norway, 2021). In the case of health care personnel providing psychotherapy outside the health care system or using methods not recognised by the health care system, they are covered by the Act on Alternative Therapies (in addition, of course, non-health care personnel are also covered by the Act on Alternative Therapies).

The cost of one hour of psychotherapeutic treatment ranges from EUR 60 to EUR 130. Services provided by members of NFP member organisations are self-pay and are generally not covered by health insurance, but there are certain exceptions (EAP Norway, 2021). It is worth noting that in the past, therapy providers included in the Register of Alternative Therapy Providers were exempt from VAT on services, which was later abolished. The NFP website states that they are still working to reinstate this possibility (NFP, 2024b).

3.5. Sweden: The first in Europe to pass the psychotherapy law in 1985

3.5.1. A brief history of the development of the psychotherapy regulation

In 1978, under the initiative of the Association for Social and Mental Health, an organisation of patients and their close relatives, psychotherapy was introduced in psychiatric treatment as an alternative to treatment with medication. At the same time, public pressure created by the association prompted the government to establish the first public education programme in individual psychodynamic psychotherapy at the Umea University and Stockholm University the following year. The programmes had two stages which lasted for 4-5 years as a part-time study (49 and 90 credit points respectively). Today, psychotherapy is a multiprofessional activity, which means that education and training in psychotherapy is available to professionals in other fields as well, such as social workers, theologians, physiotherapists and nurses. (Grebo & Elmquist, 2002; Häggström, 2010).

Before 1978, psychotherapy was primarily practised by physicians and clinical psychologists. Since the inception of psychoanalytic training in the 1930s, Swedish psychoanalytic organisations have had set procedures for granting the title of psychoanalyst to psychiatrists and clinical psychologists. Norway has typically been the most progressive country in establishing psychoanalytic and other psychodynamic movements in Scandinavia, with Sweden following and Denmark often lagging behind. Sweden remained more conservative for years, adhering to the organic model at one extreme and supporting one of the world's most orthodox psychoanalytic movements (Seeman & Lauren, 1984).

The psychodynamic approach developed significantly in the 1970s, resulting in a redefinition and paradigmatic shift in Swedish psychology, as well as

a substantial quantitative advance. In 1978, psychologists were granted state licences. The right to diagnose patients led to much negotiation and dispute between psychiatrists and psychologists. Psychiatrists were ambivalent about psychotherapy and divided on the issue, partly leaving this area to psychologists. In particular during the 1980s, psychologists attempted to establish a monopoly on psychotherapy, but were unsuccessful (Johnsson & Svensson, 2013).

The procedure of issuing licences for all psychotherapeutic modalities was granted by the government in 1985 after the decision of the Parliament that psychotherapy was an independent profession. Between 1985 and 1999 only the National Board of Health and Welfare regulated the granting of licences to perform psychotherapeutic activity in public health. Later, the Swedish National Agency for Higher Education joined in the supervision. The National Board only tests the final qualification of the candidates, while the National Agency introduced a much stricter supervision over specific stages of education and training (Grebo & Elmquist, 2002).

There are many recognised modalities, e.g. psychodynamic psychotherapy, CBT, cognitive therapy, interpersonal therapy, art therapy, group therapy, child & youth psychotherapy, family psychotherapy, and psychotherapy with hypnosis. The availability of specific modality can vary depending on the region and the level of care (primary or specialized). For example, while CBT is widely available, access to other therapies may be more limited and dependent on specific clinics or regions (Svensson, 2025).

3.5.2. Psychotherapy training

Psychotherapeutic training consists of three steps (Grebo & Elmquist, 2002; Svensson, 2025):

- Stage one is the *basic three-year programme*, which is available to candidates who finished secondary school and it ends with the Bachelor's degree (first level diploma of the Bologna system). Beside theory and personal experience a candidate on this stage can perform psychotherapy under supervision. Most of them work in hospitals or institutes for patients with special needs. This level is included in the training programme for becoming a psychologist, but also other occupations such as physicians, behavioral scientists, nurses, clergy and social workers, can apply for doing this training either at a university or in private institution. It is common for courses to focus on a specific discipline within psychotherapy, such as CBT or psychodynamic therapy.
- Based on the regulations of the Swedish National Board of Health and Welfare (Socialstyrelsen, 2015) on specialist training for physicians, an education plan for basic psychotherapy training for psychiatrists has been established. Consequently, a basic psychotherapy course, accessible only to physicians,

has been offered annually since 2013. The programme's main objective is to prepare physicians for the situations they will encounter in their future clinical practice. This programme primarily focuses on communicating scientific theoretical knowledge and understanding of psychotherapeutic disciplines, such as cognitive behavioural therapy (CBT), cognitive therapy, psychodynamic therapy and family therapy. The programme also covers psychotherapeutic methods for treating psychological distress. This broad education provides physicians with the opportunity to reflect on various types of psychotherapy. It also enables them to improve their skills and learn to discern which therapy is appropriate for each patient, in relation to pharmaceutical or other treatment methods (Johansson & Fahlke, 2019).

- Stage two is a *specialized training* in psychotherapy. Psychiatrists and psychologists can directly enter this stage. Specialists of other professions e.g. social workers, dental practitioners, general physicians, nurses, theologians etc, are required to complete stage one beforehand. There is no minimum entry age specified. Specialized education lasts for at least three years with at least 2,000 hours, but most of the candidates complete it in five years and it consists of theory, supervised psychotherapeutic practice and personal experience. It ends with a diploma that enables the candidates to apply for a licence. Only few private institutes got the accreditation to perform the second stage since it requires scholarly teachers. It is therefore difficult to get a place to study on the second stage and most of the candidates are overqualified in clinical experience, supervision and personal experience as well.
- Stage three enables psychotherapists to be granted the title of *supervisor*. The psychotherapy supervision training is usually one and a half year, half-time studies, and consists of a combination of theoretical studies and supervised supervision.

In order to practice as a clinical psychologist in Sweden, students must complete five years of master's-level university studies in the national Psychology Programme (Master of Science in Psychology, 300 European Credit Transfer and Accumulation System [ECTS]) and then undertake one year of practical training under continuous supervision (Swedish: Praktisk Tjänstgöring för Psykologer [PTP]). Following successful completion of the PTP programme, the student is granted a licence to practise as a clinical psychologist by the Swedish National Board of Health and Welfare (<https://www.government.se/government-agencies/national-board-of-health-and-welfare--socialstyrelsen/>). They can then provide clinical psychological treatment without supervision in private settings or within the Swedish public health care system. During the five-year psychology programme, clinical psychotherapy courses are often taught in

the latter part of the programme. These courses may be taught separately or integrated into other psychology programme courses. During these courses, psychology students are taught theoretical psychotherapeutic knowledge and are permitted to apply it during supervised psychotherapeutic treatment with patients presenting milder psychological problems. As mentioned above, in order to become a licensed psychotherapist rather than a licensed clinical psychologist in Sweden, students who have completed the clinical psychology programme must undertake an additional three-year psychotherapy diploma course (Lindqvist Bagge et al., 2024).

An individual who wishes to use the title psychotherapist must obtain a licence issued by the National Board of Health and Welfare. The Board register and keep a register of all health and care professionals (HOSP). Supervision of the work of all health and care workers is carried out by The Swedish Inspectorate for Health and Social Care (IVO). The register is open to persons who have trained as a psychotherapist in Sweden or who are qualified to practice as a psychotherapist in one of the other EU Member States.

The number of psychotherapists has been growing slightly each year. In 2002, there were approximately 4,000 certified psychotherapists, compared to 7,666 in 2020 (Statista, 2023). In 2002, their first professions were distributed as follows: 60% were psychologists, 20% were social workers, 10% were physicians, and 10% were theologians, nurses, and physiotherapists.

Between 1996 and 2011, only 12% of licensed psychotherapists were also qualified as physicians. At the same time, around 5–10% of the population required psychiatric treatment, but only 3–4% sought psychiatric care. Of those who received psychiatric care, around 47% were treated with psychopharmacology, 13% with psychotherapy, and 40% received both (Hadlaczky et al., 2012). As in the rest of Europe, relatively few doctors or psychiatrists in Sweden undergo psychotherapy training to the standard required for independent practice, despite their privileged position in relation to other professions in terms of both education and psychotherapy practice. This is despite the fact that the Swedish Psychiatric Association (2024) suggests it is a major disadvantage, as patients benefit greatly from having a psychiatrist trained in psychotherapy. Such a psychiatrist can take responsibility for all aspects of treatment, including investigations, diagnoses, drug prescriptions and consultations on various psychological treatment options.

As mentioned above, a basic psychotherapy course has been included in the psychiatric specialisation programme since 2013. An evaluation of the programme (Johansson & Fahlke, 2019) showed that, although the physicians were satisfied with the programme, few of them intended to undertake further

training to become licensed psychotherapists. Several physicians mentioned structural and organisational obstacles in the health care system as a reason for this. For example, they said that psychiatric leaders often view psychotherapy as time-consuming and outside the remit of primary psychiatry. At the same time, there is a severe shortage of psychiatrists, and departments cannot afford to allow physicians to educate themselves to become licensed psychotherapists.

The Swedish National Board of Health and Welfare does not keep a record on the modalities of licenced psychotherapists, but most of them (nearly 80%) are psychodynamic with the share of CBT therapists increasing (Grebo & Elmquist, 2002). The Board also accredits training institutions which offer specialized training in psychotherapy and establishments for practice (including public health institutions, clinics and private practices) where trainees perform psychotherapy under supervision. Professional ethics is regulated by the Medical Responsibility Board (HSAN) for all health professions. The Board is a governmental authority that consists of eight members – representatives of health professions, the parliament and professional unions (Van Broeck & Lietaer, 2008).

There are 22 regulated health care professions in Sweden, which require a licence from the National Board of Health and Social Welfare (Socialstyrelsen), a Swedish government agency. Among the regulated professions are the professions of psychologist (psykolog) and psychotherapist (psykoterapeut) (Socialstyrelsen, 2020). In the European Commission's database on regulated professions in each country Member States, Sweden is listed as the legal basis for the regulation of the profession of psychotherapist Articles 1 and 5 of Chapter 4 of the Patient Safety Act 2010 (Patientsäkerhetslag) (European Commission, 2023a).

3.5.3. The Swedish mental health system

The opening paragraph of the Swedish Health Care Act, 1982, states that the community should provide high quality, mental health care, on par with primary care and in cooperation with the patients and their families. The goal of the Swedish mental health system, therefore, is to meet the needs of the mentally ill in community settings, where they can be integrated into the community and attain a higher degree of autonomy and a good quality of life (Silfverhielm & Kamis-Gould, 2000).

Services for people with mental health issues have been governed by the Social Services Act (1980), which regulates municipal social services, and the Health Care Act (1982), which regulates all health care, regardless of who provides it. The Involuntary Psychiatric Care Act and the Forensic Psychiatric Care Act (both 1991) was introduced to regulate involuntary care and treatment. The Law on Support and Services to the Disabled (1994) specifies the rights of people with

chronic or persistent disabilities, including those with severe and persistent mental illness (*ibid.*). The Municipal Financial Responsibility Act (1990 and 1995) stipulates that municipalities must pay county councils for the care of patients who remain in inpatient facilities due to a lack of adequate municipal services (*ibid.*).

Together, these laws aim to increase social investment in the lives of people using mental health services by ensuring access to quality housing, daily activities, work, recreation, rehabilitation and social relationships. These statutes assign roles and responsibilities for social welfare and primary health care for people with mental health conditions to social services and medical care organisations, respectively. The legislation also obliges municipal social services to engage with disabled people and collaborate with the county council and other social organisations to plan assistance programmes. Specific services that disabled people can receive are listed, including counselling and support, personal assistance, housing with special services, contact persons, and companions (*ibid.*).

Sweden is divided into six health care regions, each of which has a university hospital. Each county council has at least one hospital with the capacity to provide inpatient care. 'Catchment areas', the structural units for financing, staffing and providing all mental health services in geographically defined areas of between 30,000 and 120,000 residents, were introduced in order to improve the availability and accessibility of services for patients in need (Hansson et al., 1995). However, the catchment area structure is now being disregarded to some extent, as several areas have joined together to provide some specialised services, such as treatment for eating disorders and forensic services.

Most stand-alone mental hospitals in Sweden have closed and been replaced by inpatient care in general hospital psychiatric clinics, supplemented by small nursing homes and halfway houses (Goldie & Fredén, 1991). The amount of inpatient care has decreased significantly. While there were 4.6 psychiatric beds for every 1,000 residents in 1962, this figure had fallen to just 0.75 by 1997. This was partly achieved by transferring dementia patients to geriatric wards, but mostly through a drastic decrease in the hospitalisation of patients with schizophrenia (Silfverhielm & Kamis-Gould, 2000).

The number of inpatients per 100,000 people has fallen from 92 in 1994 to 64 in 1997 — a reduction of around 30% in three years. Consequently, the remaining beds have been used for patients with more severe impairments. At the same time, responsibility for caring for patients who do not require hospitalisation was transferred to local communities. Ambulatory and outpatient services are located in ordinary housing areas or alongside health centres. A couple of

million visits are made to such services every year. This has been made possible through teamwork involving all inpatient personnel (*ibid.*).

Advocacy associations, such as client and family associations, receive financial support from the state and occupy a strong and vital position in Sweden. The most notable of these are the Swedish Consumers' Association (RSMH), founded in 1992, which has 21 member organisations (Sveriges Konsumenter, 2025), and the National Collaboration for Mental Health (NSPH, Nationell Samverkan för Psykisk Hälsa) (NSPH, 2025). The NSPH is a network that brings together various patient, user and family organisations within the field of psychiatry. The NSPH works to develop and improve psychiatric care and support for those affected by mental illness, including their families. The Swedish Church and other religious and charitable organisations play a lesser role.

In 2016, the Swedish government introduced and implemented a mental health strategy focusing on "prevention and awareness, accessibility to care and greater emphasis on vulnerable groups" (DeLuca, 2023). This includes introducing methods to prevent severe conditions and increasing access to mental health treatments, e.g.:

- numerous crisis hotlines staffed by volunteers are readily available, e.g. SPES, available to those grieving the loss of a loved one to suicide, The Rainbow Line, available to LGBTQ+ individuals, Kvinnofridslinjen, available to women facing violence or threats of violence, and BRIS, available to anyone who needs support.
- the Young Health Programme (YHP), founded and operated by AstraZeneca. YHP is a global disease prevention program with a unique focus on mental health awareness for those aged 10 to 24. Researchers collected findings by surveying 1,350 discussions with the BRIS (Children's Rights in Society) child helpline. They published the results so mental health professionals could access those findings. Patients, their families and health care professionals utilized five short films based on the team's findings as part of their treatment process. To date, more than 29,000 children have used these methods to receive support for their respective conditions.

Public services are widely distributed across Sweden with a rapid turnover of patients in inpatient care, and an increase in outpatient consultations in recent years. In 2018, 410,000 patients received inpatient and/or outpatient psychiatric care, which is a 43% increase since 2008 when accounting for population growth. The largest increase was seen in the 10–14 and 15–19 age groups, primarily due to hyperactivity disorders (F90). Among girls diagnosed with hyperactivity disorder between the ages of 15 and 19, the increase was almost sevenfold (660%). Overall, diagnosed conditions in the 15–19 age group increased by 157% over

this 10-year period. Concurrently, there has been an increase in self-reported psychosomatic and depressive symptoms among teenagers, particularly 15-year-old girls. 57% of these girls reported symptoms such as headaches, irritability, dysphoria, stomach aches and sleep disturbances (Allgulander, 2020).

These high rates are puzzling experts in a society with generous social benefits for child and adolescent care and the new phenomenon of helicopter parenting. They argue that these increased rates of self-perceived and diagnosed psychiatric disorders in teenagers may be due to adverse screen time, problematic social media use, cyberbullying, pressure to conform, and even boredom. However, others attribute these increases to greater detection, broader diagnostic criteria, overdiagnosis, and the fact that children with a psychiatric diagnosis are entitled to additional support at school. Overall, the growing burden on psychiatric services for young people is a topic of much debate (*ibid.*).

In light of the numerous challenges currently facing the Swedish mental healthcare system, the issue of increasing bureaucratisation is becoming increasingly pressing. Many clinicians are concerned that so much tax money is being spent on administration. Introduced in the 1980s, the concept of New Public Management became a basis for healthcare services by 1995, making them accountable and measurable. As a result, physicians began spending a disproportionate amount of time entering data into electronic health records. They were instructed to work according to algorithms created by administrators with no field experience or medical training. This was referred to as the 'kidnapping' of work time and content - time that should have been spent on patients, who had become 'customers'. While Sweden has 35,000 physicians, it also has 44,000 administrators. The number of physicians increased by 16% between 2010 and 2017, while the number of administrators increased by 36% (*ibid.*).

In summary, the Swedish mental health system is characterised by its proactive approach, which emphasises prevention, accessibility and the integration of new technologies. It is organised into a decentralised structure, with county councils responsible for treatment and forensic services, and municipalities responsible for general social services. The system has undergone significant deinstitutionalisation, shifting focus from large mental hospitals to community-based care. Municipalities provide care for individuals with mental health conditions, including school-aged children and patients who have recently been discharged from a medical facility. This division of roles and responsibilities creates a strong need for collaboration and coordination of activities on behalf of service users (*ibid.*).

3.5.4. Psychotherapy in the health system

Psychotherapy is an integral part of the health care system, generally practised at all levels, from primary to specialised care. The availability and scope of psychotherapeutic treatment can vary depending on location within the country. A range of different psychotherapy approaches are available, including psychodynamic therapy, CBT, EMDR and family therapy. CBT is the most common.

In a naturalistic study (Werbart et al., 2013), the outcomes of three types of therapy practiced in public psychiatric health care were presented. Data were collected over a three-year period from 13 outpatient psychiatric care services that participated in the online Quality Assurance of Psychotherapy in Sweden (QAPS) system. Of the 1,498 registered patients, 14% never commenced psychotherapy, 17% discontinued treatment and 36% withdrew from the study. Outcome measures included symptom severity, quality of life, and self-rated health. The outcomes of 180 patients who received CBT, psychodynamic therapy, or integrative/eclectic therapy were studied after dropout representativity was controlled for. Patients showed significant improvements, and all therapy types generally produced good outcomes in terms of symptom reduction and clinical recovery.

Within a country, there are different systemic solutions to the extent to which psychotherapy provided by psychotherapists in private practice is financed by the Health Care System or by different forms of health insurance (SPR - Sweden). Psychotherapy services are often reimbursed by public insurance, sometimes with private insurance supplementation, further supporting its integration into the health care system.

A notable example of how psychotherapy is organised is the system used in southern Sweden. There, the health care system offers psychotherapists in private practice, including CBT and psychodynamic practitioners, the opportunity to register with the regional primary health care system. Individual health care units can then refer patients to these psychotherapists for treatment, with the cost covered by the primary health care system. In other areas of Sweden, however, it can be very difficult for patients to obtain publicly funded psychotherapy (Svensson, 2025).

Although mild and moderate disorders constitute the greatest number of cases and have been on the rise over the past several decades (OECD, 2013, 2019, 2023; Platana, 2015), OECD reports stated that they were not a priority area in Sweden's mental health strategy. One exception was the Rehabilitation Guarantee initiative. Since 2008, the Swedish government has invested 1.75 billion Swedish kronor in this evidence-based programme, which aims to prevent absenteeism and facilitate a return to work. It includes CBT for depression

and anxiety. Although Sweden has been committed to increasing the delivery of psychological therapies, particularly CBT, concerns have been raised about their accessibility in primary care. Only 15% of patients with moderate mental health issues received specialist treatment. This is also connected to financial barriers, as although psychological therapies and CBT are available in primary care, they are not always fully reimbursed. Nevertheless, in 2011, 24% of Swedes consulting a health care provider for a mental health issue reported seeking help from a psychologist, compared to an OECD average of 14%. While this suggests that psychologists may be more accessible in Sweden than in other OECD countries, it is difficult to assess without considering the overall need for treatment and the rate of help-seeking behaviour.

3.5.5. Academization of psychotherapy in Sweden

In January 1972, a two-year, full-time programme in psychotherapy and community mental health training was initiated at the Psychology Department of Gothenburg University. This represented the first such training within a university setting in Sweden and, for the first time, provided extensive university-sponsored mental health services (Tuckman, 1975). Since then, the integration of psychotherapy training into university curricula has been successful. Several universities now offer psychotherapy training, including in Stockholm, Lund, Karlstad, Gothenburg, Uppsala, Östersund and Umeå and Luleå, with many incorporating practical elements. Karolinska Institutet's Centre for Psychotherapy Education & Research is a leading provider, offering traditional courses as well as programmes commissioned by Stockholm County Council. The Centre integrates practical experience by placing students in health centres and psychiatric clinics.

Universities are finding it difficult to secure funding for psychotherapy research, primarily because it falls between the remit of the various research councils and their sub-units. For researchers working within the health care system, regional research centres provide an alternative source of funding. In addition to state-sponsored research, there are private foundations that accept applications for psychotherapy research. While these private funding opportunities are welcome, they lack the financial resources to fund major projects (Svensson, 2025).

Collaborating on research projects between universities and the health care system can be challenging for the participating organisations. Typically, psychotherapy treatments conducted as part of research projects are carried out by therapists working in the health care system in their respective workplaces. The health care system does not explicitly aim to participate in research. However, this overarching aim may conflict with more pressing tasks at the

specific treatment centre, where the benefits of participating in research may be less apparent (ibid.).

Research councils offer starting grants aimed at researchers at the beginning of their careers to promote independence and establish their research. However, these grants are likely to present some of the same difficulties described above. A more accessible option is likely to be the postdoctoral positions offered by psychology departments at universities (ibid.).

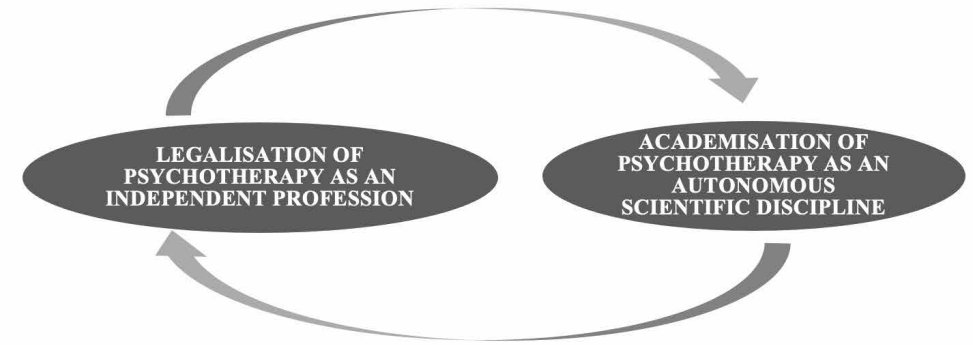
4. **Comments on the regulation of psychotherapy in Scandinavian countries**

4.1. **For psychotherapy to develop, it is crucial that it is regulated as an independent profession and autonomous scientific discipline**

Of the Scandinavian countries, Sweden and Finland are the most psychotherapeutically advanced. This is largely due to their successful regulation of psychotherapy as both a profession and a scientific discipline. The development of psychotherapy in both countries over the last 40 years demonstrates that two interlinked, mutually reinforcing processes are key: efforts to legalise psychotherapy as an independent profession stem from the profession itself, while efforts to establish psychotherapy as an autonomous scientific discipline stem from the field of psychotherapy science (Figure 1). Professional development is primarily associated with clinical practice, while scientific development is primarily associated with research. Legalisation is linked to the profession and requires specific legislation, whereas academic education is linked to higher education legislation. This is why, in both countries the transition of psychotherapy training into universities has been successful.

Figure 1

Efforts to legalise psychotherapy as an independent profession are linked to and reinforce each other in a circular way with efforts to academise psychotherapy as an autonomous scientific discipline.



4.2. **If psychotherapy is not regulated as an independent profession, this hinders its development**

The situation in Denmark shares many similarities to the situation in Slovenia: no psychotherapy law, no protection of the title psychotherapist, so that anyone can call himself a psychotherapist, no central register, psychotherapy training partly regulated by state for psychiatrists and psychologists, umbrella association of psychotherapists is taking care of professional self-regulation, general practitioners, psychiatrists and psychologists, who practice psychotherapy in the public health care system do not have enough training in psychotherapy, etc. As in Denmark, the main issue is the access to public funding of psychotherapy services. Clinical psychologist and psychiatrists have a privileged position and refuse to allow psychotherapists to be included in the public health system.

In terms of similarity, Jacobsen's description of the relations among professionals who practice psychotherapy is particularly interesting:

"... there is a hierarchy between physicians and other professions due to the fact that psychiatrists are in charge where they are employed as management persons in psychiatric settings. Thus they have the right to make decisions about the treatment (referral, type of treatment, termination, medication, etc.). Another contributing factor is their better access to public funding ... The relationship between psychiatrists and psychologists is characterized both by mutual respect, recognition and collaboration and by competition, some frustration or occasionally even envy and discredit. Psychologists working in psychiatric settings would often like to have more authority ...

The huge caseloads of psychiatrists do not leave as much time for them to concentrate on the psychotherapeutic treatment as they might like. Psychologists can be annoyed that they often have the experience and expertise but not the authority, while psychiatrists may long for the ability to concentrate on fewer patients over time ... While the physicians seem to have a higher social status, the psychologists are generally being recognised as having the best psychotherapeutic training and skills. In general, however, the relationship between the two professions is quite good, as reflected in the fact that their ... professional associations arrange many common courses, accept each other as teachers and supervisors, and are trying to harmonize their specialist training programmes.” (Jacobsen, 2009, pp. 8-9)

In Slovenia there is also a dual relationship between psychiatrists and psychologists, as described by Jacobsen (Možina, 2024f). As Slovenian clinical psychologists are on average better trained in psychotherapy than psychiatrists (who, like in Denmark, do not have time to practice psychotherapy and new generations of psychiatrists have less and less interest in psychotherapy), this expertise helps them to strengthen their status in relation to psychiatrists, as they are a hierarchical step below them. However, in relation to psychotherapists outside health care, whom both psychiatrists and clinical psychologists see as adversaries and unwanted competitors, they speak with one voice together against psychotherapists, as if the complex dual relationship of cooperation and competence (as well as frustration, envy and discredit, as described by Jacobsen) does not exist between them. For clinical psychologists in particular, the efforts of psychotherapists to be integrated into the public health system are also a serious threat, as they fear that they will lose the primacy over the provision of psychotherapeutic services in the public health system, and thus the field in which they outperform psychiatrists and confirm their status and reputation.

In Norway, psychotherapists are also at a disadvantage compared to psychiatrists and clinical psychologists, due to the dual regulation that treats health professionals and alternative therapies separately. This is why Slovenian psychiatrists and clinical psychologists like to refer to Norway when they try to prevent psychotherapists from entering the healthcare system and relegate them to the status of ‘alternatives’.

4.3. **The definitions of psychotherapy in Scandinavian countries don’t restrict the practice to doctors and psychologists**

Despite various descriptions and definitions of psychotherapy provided by researchers and professional associations around the world, there is no consensus on its definition (Plantade-Gipch et al., 2020). Some organisations’ definitions

are based primarily on its placement in the health system or in the activities of a particular professional group (e.g. psychiatrists, (clinical) psychologists), while others define it more broadly and even emphasize that the predominant field of psychotherapeutic practice is outside the health system (Young, 2011). Also, the gap between psychotherapy research and practice hinders achieving one complete and comprehensive definition of psychotherapy (Goldfried et al., 2014). Therefore, the choice of definition depends largely on the stage of psychotherapy development in each country, as well as the political and economic interests of the relevant stakeholders.

If we look at the definitions of psychotherapy in Scandinavian countries, neither of them restricts the practice of psychotherapy to doctors and psychologists (Table 1), what is being tried in Slovenia. They are following the scientific approach which includes the importance of deriving interventions on evidence-based practice and practice-based evidence (Holmqvist et al., 2014, 2015; Høstmælingen, 2025; Ogden et al., 2018; Saarni et al., 2022, 2023; Santesson, 2025; Werbart et al., 2013), as well as adjusting the treatment to the particular situation of the patient, taking into account life contexts, personal characteristics, culture, preferences and values (Duncan et al., 2010; Axelsson et al., 2023).

Table 1
Definitions of psychotherapy in Scandinavian countries.

The Psychological Association of Denmark (Danske Psykolog Forening) https://www.dp.dk/om-dp/english/	Psychotherapy is targeted to persons with psychiatric disorder, those who have problems in their psychological development or psychological problems in their interpersonal relationships, all of which can be manifested psychologically, socially or somatically. The aim of treatment is the reduction or removal of problems caused by the disorder and enhancement of psychological development and functioning. The methods need to be based on theories with adequate research evidence. Provision of psychotherapy requires professional competence based on training, and needs to be carried out in cooperation with the client(s) and a professional(s), in a confidential therapeutic relationship. There are different schools of psychotherapy, such as psychodynamic, cognitive-behavioral, and humanistic, and therapists often integrate elements from different approaches.
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MIELI Mental Health Finland https://mieli.fi/en/mental-ill-health/how-to-seek-help/psychotherapy/ The Finnish Psychological Association https://www.psyli.fi/en/front-page/ Psychological Practitioners Finland https://ppf.nettisivut.fi/	Psychotherapy is a form of mental health treatment involving interpersonal interaction where a therapist helps a patient address issues like depression, anxiety, and stress through talking and listening, rather than medication. It aims to bring about changes in feelings, thoughts, behaviors, and attitudes that led the individual to seek treatment. Psychotherapy is a form of treatment based on the interaction of two or more people. In psychotherapy, a person talks with a psychotherapist or in a therapy group, for example, about the things they need help processing. It is targeted towards individuals with psychiatric disorders, developmental problems, or relationship issues that manifest psychologically, socially, or somatically. The aim is to reduce or eliminate the problems caused by these issues and enhance psychological development and overall functioning. It's a collaborative effort between the therapist, client, and potentially other professionals, conducted within a confidential therapeutic setting.
Icelandic Association of Psychotherapists (SALM - Félag sálmeðferðarfræðinga) https://salm.is/	Psychotherapy is a comprehensive, conscious and structured treatment of psychosocial, psychophysical, emotional, communication and/or behavioral problems, using scientific psychological methods. Psychotherapy is a humanistic approach that views the individual as a whole and emphasizes concepts such as free will, belief in one's own abilities and self-actualization. It seeks to help people use their abilities and achieve their best well-being. Through interaction between one or more individuals and one or more psychotherapists, work is done to help the individual achieve personal goals. Psychotherapy requires both general and specialized education/training and uses methods that are based on evidence-based theoretical foundations and confirmed clinical experience. A psychotherapist is a mental health professional trained to treat individuals with psychological, emotional, and psychosocial problems. Depending on their specialization, they may work with individuals, couples, groups, or families.
Norwegian Association for Psychotherapy https://nfpsykoterapi.no/loven-og-rettigheter/	Psychotherapy is a psychological science linked to the social sciences. It is only in psychiatry (hospitals, outpatient clinics, day centres, etc.) and biological psychiatry that psychotherapy is placed under medical science.
Swedish Psychological Association (Sveriges Psykologförbund) https://www.saco.se/en/worklife/our-unions/swedish-psychological-association/	Psychotherapy is a professional, planned, and scientifically-based method of treating psychosocial, psychosomatic, and behavioral disturbances or suffering through interaction between a therapist and one or more individuals, aiming for change and personal growth. It's considered a comprehensive form of treatment for mental health issues, involving talking with a qualified professional to address emotional, behavioral, and mental health concerns. The core of psychotherapy is the therapeutic relationship between the therapist and the individual(s) seeking help. This interaction is a planned and conscious process. The primary goal is to alleviate suffering, promote personal growth, and facilitate positive changes in attitudes and behaviors. While medication may be a part of treatment for some, psychotherapy emphasizes talking through issues and exploring underlying causes, rather than solely relying on medication.

4.4. **Privileges of psychiatrists and (clinical) psychologists in the field of psychotherapy**

In our study (Možina, 2024a), the following countries were included in the general overview in alphabetical order (Table 2): Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Luxembourg, Malta, the Netherlands, Norway, Poland, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, and United Kingdom. In 1985, Sweden accepted the first legal regulation of psychotherapy with the introduction of the licence distribution system for different psychotherapy modalities. Legal regulation gradually followed in Austria, Finland, Germany, Italy, the Netherlands, Switzerland (consisting of cantons' regulation), France, Malta, Luxembourg etc.

Psychiatrists and clinical psychologists have privileges in the field of psychotherapy in all countries except those where psychotherapy is regulated as an independent profession and autonomous academic discipline (Austria, Finland, Malta, Germany, Sweden), with the exceptions of Croatia and Luxembourg.

Although Norway does not have a law on psychotherapy and psychotherapists are not regulated as a separate profession, it has a very well-developed mental health care system in which psychotherapy plays an important role. The relationship between the three disciplines - psychiatry, psychology and psychotherapy - and the professionals in these disciplines is more collaborative than in many other European countries. In a large study of sources of influence on the professional development of psychologists and psychiatrists in Norway, it was shown that the profession appears to have little influence on perceived development as a psychotherapist, and that other therapist qualities, often personal qualities, are more important for therapeutic processes and outcomes (Lorentzen et al., 2011). The results of this study are not only important for understanding the situation in Norway, but may also be instructive for other European countries, especially those where there are strong polarisations about which pre-professions are more suitable or better as a basis for psychotherapeutic activity.

4.5. **The dominance and harm caused by the biomedical/disease approach to mental health can be reduced by adopting a biopsychosocial/community-based approach**

Exploring the broader context of the mental health care development, it is evident that, in recent decades, the biomedical/disease approach has become increasingly prevalent in Europe than the biopsychosocial approach, despite its harmful consequences such as overdiagnosis and the medicalisation of mental

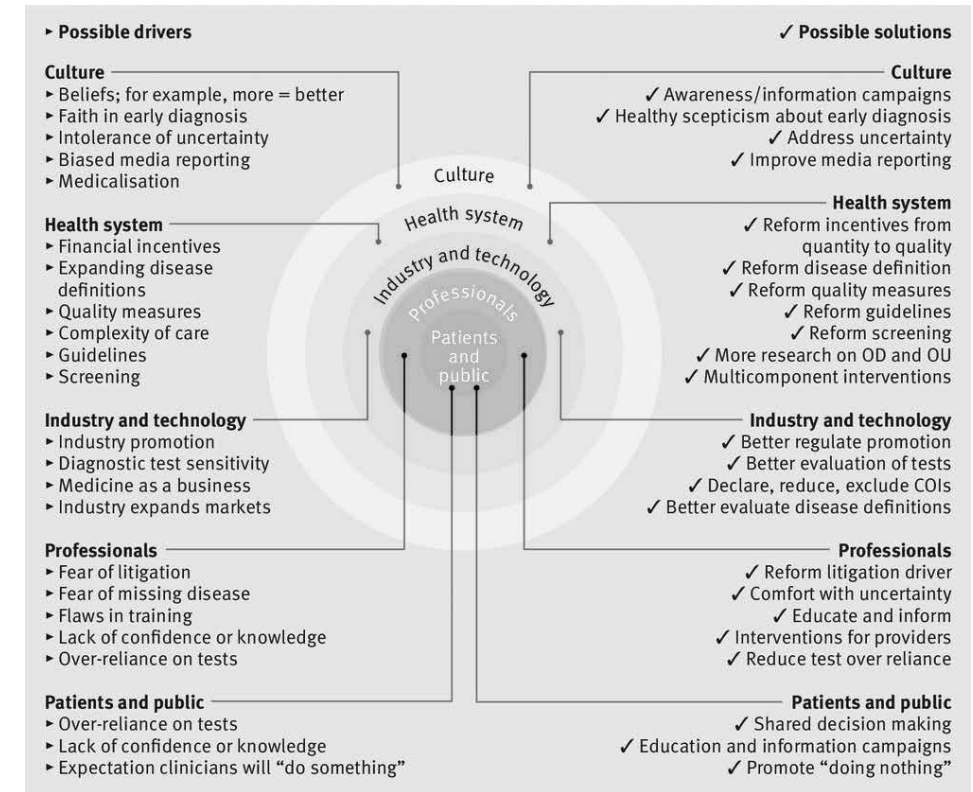
health (Davies, 2013; Možina, 2021a, 2024abcde; Pathirana et al., 2017; Sadler, 2016; Timimi, 2025). These anomalies are largely the result of lobbying by the pharmaceutical industry in favour of drug treatment and by health insurance companies in favour of the shortest and most cost-effective treatment, regardless of whether or not someone has a psychiatric diagnosis (Gøtzsche, 2015; Oravec, 2015; Timimi, 2013, 2014). The biomedical/disease approach makes prescribing medication very easy — all you need is a diagnosis and the associated symptoms. Although all European countries face problems stemming from the predominance of a biomedical/biological approach to mental health, there are important differences between Slovenia and the Scandinavian countries, as the latter are more developed.

4.5.1. The problem of overdiagnosis

Overdiagnosis is a challenge to the sustainability of human health and health systems. Its causes, despite undoubtedly good intentions in diagnosing, are as complex and multifaceted as the potential solutions. In the Figure 2 it is shown how possible drivers and solutions of overdiagnosis span in five domains: culture, the health system, industry, professionals, and patients and the public.

Figure 2

Overdiagnosis and related overuse. Mapping possible drivers to potential solutions. COI=conflict of interest; OD=overdiagnosis; OU=overuse (Pathirana et al., 2017, p. 9).



Awareness of this problem is higher in Scandinavian countries than in Slovenia. In 2018, two conferences on overdiagnosis were held: 'Too Much Medicine' in Helsinki and the sixth annual Preventing Overdiagnosis conference in Copenhagen. Over 600 of the world's leading researchers and thinkers in the field of preventing overdiagnosis came together to highlight the problems caused by medical excess, and to identify evidence-based practices for mitigating the harms of excessive medical intervention.

In the debate among experts and in the public what are the causes of the dramatic increase in the number of girls between the ages of 15 and 19, diagnosed with hyperactivity disorder, overdiagnosis is also mentioned (Allgulander, 2020). In the editorial to May 2025 issue of *Acta Paediatrica* Ingemar Engström, an affiliated professor of child and adolescent psychiatry at the School of Medical Sciences at Örebro University, pointed out that in Sweden the fundamental factor for the increase in diagnosis and treatment not only of ADHD in adolescents,

but also other psychiatric diagnoses, particularly depression and anxiety is medicalization:

“Medicalization includes a psychological contagion effect, upheld particularly by social media. This discourse fosters an individualised and individualising culture with a focus on the self and personal well-being, where ordinary life challenges are given a medical label. We live in a world where the boundary between health and illness has shifted in problematic ways. As soon as a person exhibits symptoms that are perceived as deviant or problematic, a medical diagnosis is readily available as an explanatory framework. However, the risk is that too many problems are immediately described and understood as medical conditions, with prescription of drugs being the primary solution” (Engström, 2025, p. 2).

The anomalies of the biomedical approach to mental health are not only the result of its epistemological narrowness (Šugman Bohinc & Miškulin, 2024), but also of the ‘cancerous growths’ in the health care system, as Verhaeghe (2014, p. 140-145) described them. They result from the neoliberal trend, which is turning health care into a profitable business. Continuous structural ‘improvements’ leads to increasing control over employees and everything is sacrificed at the altar of measurability. There is less and less time to deal with patients, and less focus on the work itself and more on administration, management and control, as also pointed out by the Swedish psychiatrist Allgulander (2020). With constant pressure to cut costs, ever-increasing sums of money are being spent on things that serve no purpose related to care. The explosion of rules and regulations creates an increasingly opaque system of control, and the growing administrative burden stifles creativity and lowers productivity. As the rules are increasingly being determined by health insurance companies and the management of institutions, clinical and academic independence is also increasingly being lost.

4.5.2. Slovenia is more rigid in its implementation of the biomedical/disease approach than the Scandinavian countries

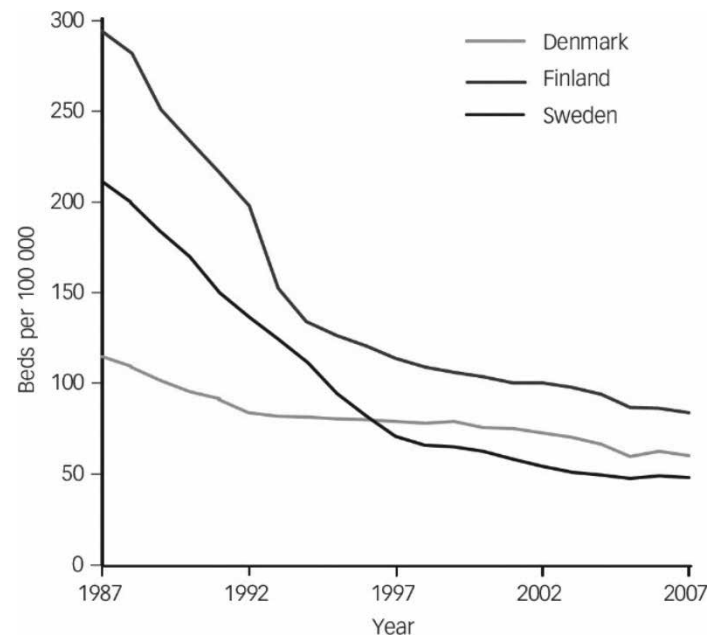
Despite these global trends being even more prevalent and harmful in developed countries, Slovenia fares worse than Scandinavian countries because Slovenian doctors, psychiatrists, clinical psychologists and other medical professionals are more rigid and orthodox in their implementation of the biomedical/disease approach (Možina, 2024cd). This is evident from the assessments of the state of mental health, which were carried out by independent international organisations, such as the Council of Europe and the World Health Organization (WHO). Experts from the WHO have concluded that Slovenia is lagging behind many other European countries in shifting the focus of mental health care

from a biomedical to a biopsychosocial approach (WHO, 2020). At the same time, efforts to develop community-based forms of psychosocial support (e.g. Flaker, 2012, 2023; Možina, 2002; Švab & Švab, 2013; Švab et al., 2023) and to integrate psychotherapy into the mental health care system (e.g. Možina, 2021a; Barat, 2023; Oravec, 2023; Kamenarič, 2024; Levstik, 2024), have been positively evaluated.

For example, the treatment of psychotic patients is mainly based on antipsychotic drugs, while psychosocial rehabilitation is insufficient. The regime includes formal occupational therapy, therapeutic communities and group therapy. In reality, psychiatric hospitals represent a very medicalised environment with many negative effects of institutionalisation. Despite the fact that “many psychiatrists and psychologists are well educated, not only in their own field but also in areas such as philosophy (many of them are distinguished authors), and although in the last 15 to 20 years many health professionals have received training in various forms of psychotherapy, relatively little effect is seen in the day-to-day running of psychiatric services” (Zaviršek & Flaker, 1995, p. 33). Psychotherapy has not brought any significant changes to the dominant biomedical model in psychiatric hospitals, although there are some psychotherapy units.

By contrast, mental health services in Scandinavian countries have undergone thorough reform, shifting the focus from psychiatric institutional care to outpatient, community-based care and social participation. Community mental health services were implemented gradually from the mid-1980s and were fully implemented at the end of the 1990s. The reduction in the number of hospital beds for psychiatric patients (Figure 3) has been met with an increase in psychiatric treatment in primary care and growth in housing institutions provided by social care (Wahlbeck et al., 2011). Overall, the reform of mental health care has profoundly changed the living conditions of people with mental health conditions.

Figure 3
Psychiatric hospital beds per 100,000 inhabitants in Denmark (bottom line), Finland (upper line) and Sweden (middle line) 1987-2007 (Wahlbeck et al., 2011, p. 2).



The strategies for developing mental health care in Scandinavia also point towards a shift from a biomedical/disease to a biopsychosocial approach. E.g. the Finnish mental health strategy for the period 2020-2030, shifts the focus from prevention (which they see as presupposing pathology) to salutogenesis, which in practice means health promotion. This is a further step away from the biomedical model. In this way, they look at the whole mental health spectrum and the focus is not on the diagnosis or mental disorder, but on how well a person is living, integrated into the environment, etc., even if he or she has symptoms of a particular mental disorder. They look at the whole mental health context, including whether people have access to cultural events, the library, the community and individual support (Finnish Institute for Health and Welfare, 2025).

A report commissioned by the Council of Europe's Committee on Bioethics (DH-BIO) (WHO, 2021) also describes many effective practices in Scandinavian countries that reduce the use of medicalization and coercive measures:

- Denmark: the Soteria Model Denmark (Whitaker, 2021).
- Finland: Open Dialogues Model (Možina, 2024e);
- Iceland: the Hugarafll organization (Hugarafll, 2025);
- Norway: the Family Group Conferencing (Havnen & Christiansen, 2014),

Medication free treatment (Whitaker, 2017, 2024), the Basal Exposure Therapy combined with Complementary External Control (Whitaker, 2024);

- Sweden: the Personal Ombudsman System (WHO, 2021), the Project for improved cooperation between psychiatry and home care, and the Soteria House (Council of Europe, 2021).

However, despite the relatively successful development of good practices to promote a biopsychosocial approach to mental health care in Scandinavian countries, the biomedical approach still dominates (Margrete Flåm, 2021). For example, there is a documented trend of increased psychotropic drug use, particularly among children and adolescents, with variations across different countries. While antidepressant and anxiolytic use is prevalent, studies also show a rise in the use of psychostimulants and antipsychotics. Sweden, for instance, shows a higher prevalence of antidepressant use compared to Norway and Denmark (Bojanić, 2024; Gómez-Lumbreras et al., 2021; Ollerup et al., 2024; Rasmussen et al., 2025).

There is also a noticeable trend of increased diagnoses for certain mental disorders, particularly in children and adolescents, with ADHD and autism being prominent examples (Allgulander, 2020; Forslund et al., 2020; Gyllenberg et al., 2023; Merten et al., 2017). While this could indicate a genuine rise in these conditions, it also raises concerns about overdiagnosis, or the potential for misdiagnosis and over-treatment. The increase isn't limited to ADHD and autism, with other neuropsychiatric diagnoses also showing similar patterns (Piiksi Dahli et al., 2020; Roksund et al., 2016; Engström, 2025).

Seppänen and Eronen (2012) reported that the rate of involuntary hospitalisation (including the use of involuntary medication) in Finland was high compared to other European countries, but began to fall gradually during the first decade of the 21st century. Finnish legislation and psychiatric units therefore continue to prioritise the need for treatment over personal autonomy, particularly in cases where there is a risk of self-harm. Similarly, the legislation emphasises the responsibility of the medical profession to ultimately decide on treatment, albeit within clearly defined legal constraints, a stance that may be perceived as paternalistic. Although Finland is a liberal democracy, its population is culturally homogeneous and places great value on expert opinion. This somewhat counteracts pressures towards less medical discretion and stronger legal regulation of psychiatric treatment, as has been adopted elsewhere in the EU. Nevertheless, while Finnish mental health law is generally considered effective in practice, the treatment of psychiatric disorders, which do not tend to adhere to rigid legal concepts, continues to be debated, if not considered controversial, among various interest groups and professions within the psychiatric community.

An illustrative example showing the difficulties of shifting the focus from

biomedical to biopsychosocial/human rights approach is the Medication Free Treatment Project at the Åsgård psychiatric hospital in Tromsø, Norway (Oravec, 2017; Whitaker, 2017, 2024). The Ministry of Health's mandate for medication-free treatment was the result of years of lobbying by five user organisations that came together in 2011 to form Fellesaksjonen for Medisinfrie Behandlingsforløp (Joint Action for Drug-Free Treatment in Psychiatry). Remarkably, this mandate required the health ministry to override the objections of the medical profession and listen to a group of people who usually have little political standing in society. In 2015, Norway's Minister of Health, Bent Høie, ordered the country's four health districts to set aside beds for medication-free treatment. It meant that psychiatric patients could choose to be treated without psychiatric medication in a hospital setting and, if they were already taking such medication, receive inpatient support to taper off it (Reitan et al., 2024; Standal et al., 2021, 2024). The six-bed medication-free ward in Tromsø was the first in Norway to open in response to Høie's directive.

Other medication-free treatment possibilities were introduced in Norway over the next couple of years, for example the Hurdalsjøen Recovery Centre, a private hospital that opened outside Oslo in 2015, and basal exposure therapy (BET), which is offered as an inpatient service at Blakstad Psychiatric Hospital and designed to help chronic patients taper off their medication.

These initiatives attracted the attention of the World Health Organization (WHO) and Dainius Pūras, the United Nations Special Rapporteur for Health at the time. Both the WHO, under the leadership of Michelle Funk, and Pūras called for a radical paradigm shift in mental health care (WHO, 2021). This shift was away from the biological model and towards a human rights model that honoured the right of psychiatric patients to make choices about the care they wanted to receive. The medication-free efforts in Norway were seen as pioneering such treatment.

Although all four health districts in Norway complied with the Health Minister's directive to some degree by setting aside at least a few beds for medication-free treatment, these beds were mostly reserved for patients without a psychotic diagnosis, and the opposition of institutions and experts advocating the biomedical approach has never stopped (Oedegaard et al., 2022; Yeisen et al., 2019). Although evaluation studies have demonstrated the effectiveness of medication-free treatment as a viable alternative for people uncomfortable with the current medication focus of mental health care (e.g. Beyene et al., 2023; Nytingnes & Rugkåsa, 2021; Reitan et al., 2024; Standal et al., 2021, 2024), the biomedical establishment struck back (Whitaker, 2024):

- In June 2023, the Hurdalsjøen Recovery Center closed after a new government

decreed that public funds would no longer be used to pay for patients to receive care at a private hospital.

- In October 2023, the University of North Norway Hospital, which runs Åsgård Hospital, announced plans to close the six-bed 'medication-free' ward and instead rely on 'consultants' to support drug-free treatment services at outpatient clinics throughout the region.
- In June 2024, the Vestre Viken Hospital Trust, which operates Blakstad Psychiatric Hospital, announced plans to close the inpatient BET service.

In summary, the examples of psychopharmaceutical consumption, coercive psychiatric measures and reluctance to allow the option of medication-free treatment show that, despite positive shifts away from the biomedical model, it still prevails in the Scandinavian countries.

And what is the role of psychotherapists? The contribution of psychotherapists to the shift from a biomedical to a biopsychosocial approach is ambiguous. On the one hand, they have had a constructive influence, as evidenced e.g. by their involvement in development of the Finnish Open Dialogue, an exemplary biopsychosocial approach. However, many professionals who practice psychotherapy around the world, not just in Scandinavia, advocate a disease-oriented approach and use of a specific approach/method for a particular form of mental disorder according to the current DSM or ICD psychiatric categorisation. This is particularly evident in CBT, which is almost exclusively practised by medical or psychological professionals (e.g. David et al., 2018; Hofmann et al., 2012; Marcus et al., 2014; Mayo-Wilson et al., 2014; Tolin, 2014, 2015). Although CBT has contributed to the establishment of psychotherapy as an effective substitute or complement to psychopharmacotherapy, it has not problematised the biomedical/disease model. It has also tried to assert its primacy over other psychotherapeutic approaches by emphasising its specific action and neglecting contextual factors. In countries where the overall context of mental health care is rigidly biomedical, doctors and clinical psychologists who practise CBT tend to be ardent advocates of a disease-oriented approach. This is the case in Slovenia. In Sweden, however, although CBT therapists form the largest group among all psychotherapeutic modalities, they are part of a mental health system that is more open to biopsychosocial approach and is therefore considered to be 'softer' from a biomedical perspective. So it is possible to conclude that the extent to which CBT therapists are biased towards the biomedical model depends on the broader context.

Conclusion

Efforts to regulate psychotherapy are embedded in the broader context of mental health care. In all European countries, including Scandinavia, the field of mental health care is confronted with the problems and harms caused by the prevailing biomedical/disease approach. As the development of modern psychotherapy since Mesmer has only partly taken place in the context of medicine and health care, and has been largely informed by a broader humanistic background and by clinical practice in other sectors of society, e.g. social care and education, psychotherapy cannot be crammed into the Procrustean bed of the biomedical/disease approach. The Scandinavian countries are a good example in this respect. Compared to Slovenia and many other European countries, their mental health care systems are relatively advanced. This means that the biomedical approach is 'softer' and psychotherapy can develop more freely, even though it is not regulated as an independent profession.

However, psychotherapy has the potential not only to soften the biomedical approach, but also to contribute significantly to a fundamental shift in paradigm towards a biopsychosocial approach. Bruce Wampold amply demonstrated this potential in his books and articles about the 'great psychotherapeutic debate' (Wampold, 2001; Wampold & Imel, 2015; Možina, 2020b, 2021ab). Based on extensive research into common factors, Wampold developed the 'contextual model', which is transdiagnostic, transtheoretical, and transcultural (Wampold & Imel, 2015; Flückiger et al., 2024). This model plays an important role in the effort to provide a scientific basis for the biopsychosocial approach. It is only within this approach, and with the corresponding organisation of the mental healthcare system, that psychotherapy will be able to maintain its essence and contribute to the development of a new unifying paradigm for the entire field of mental healthcare (Anchin, 2008, 2012; Anchin et al., 2024; Duncan et al., 2010; Magnavita & Anchin, 2014; Melchert, 2011, 2013, 2015, 2016, 2020; Miller et al., 1997).

International comparisons of legal regulations show that psychotherapy will survive, but not flourish, if it remains solely in the hands of doctors and psychologists as a method or area of specialisation (Možina, 2010, 2022, 2023b, 2024ab; Možina & Kranjc, 2019). This is clearly illustrated by the Scandinavian countries. Sweden and Finland, which have regulated psychotherapy as an independent profession, are particularly good examples of this. Therefore, the efforts of psychotherapists in many European countries to regulate psychotherapy as an autonomous profession and scientific discipline are crucial for its further development. Without professional and academic autonomy, psychotherapists

will continue to be marginalised, rather than participate on equal footing with other mental health professionals in developing a biopsychosocial approach.

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