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Theorising medical psychotherapy: Therapeutic practice between professionalisation and deprofessionalisation

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Abstract
Psychotherapists in mental health institutions as a professional group are part of the medical system, and from this perspective, as representing an occupation that serves the public health interests, as well as those of the individual seeking help. Despite the different existing therapeutic approaches and diverse forms of therapy deriving from these approaches critical theories, however, consider psychotherapy as a profession with a specific jurisdictional claim and own highly specific interests. In contrast to most of the recent discussion around therapy culture, in this article, I argue that sociology and social theory could benefit from an understanding of psychotherapy as a profession with a separate logic and claim for jurisdiction for mental health. Moreover, I present some general trends showing that, regarding psychotherapy, we face a concurrence of a professionalisation, and simultaneously, an already ongoing deprofessionalisation. To develop my argument, I first discuss the perspectives of sociology of the psychotherapy professions. Second, I present the potential lack of professionalism in four dimensions. Third, I discuss possible tendencies of deprofessionalisation. Finally, I conclude by pointing out the importance of theorising the psychotherapy professions for medical sociology.

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Introduction

Psychotherapists in mental health institutions as a professional group are part of the medical system, and from this perspective, as representing an occupation that serves the public health interests, as well as those of the individual seeking help. Despite the different existing therapeutic approaches and diverse forms of therapy deriving from these approaches, critical theories, however, consider psychotherapy as a profession with a specific jurisdictional claim and own highly specific interests (Abbott, 1988; Foucault, 1965). If one assumes that professions and the process of professionalising play a central role in the modernisation of societies, as well as the cultivation of specific expert knowledge, then psychotherapy and psychotherapeutic knowledge take up a special role (Turner, 1995). Over the last decades, a so-called culture of therapy developed in Western societies that led to a dissemination of the 'psy' discourse in daily life routines and personal relationships (Furedi, 2003; Illouz, 2008). This development has significant consequences for identity and concepts of the self, rationality and emotionality, as well as ideas about normalcy and deviance (Cushman, 1995; Illouz, 2008; Rose, 1990). Nevertheless, therapy culture is also a professional project. It is connected to the emergence and development of corresponding professions and semi-professions, and with this, professionals gain authority over central societal lifestyles through which they can legitimate their professional practice. Medical Psychotherapy as a profession is an occupation that has specific characteristics, such as expert knowledge, a monopolised field of jurisdiction as well as professional organisations. To speak of psychotherapists as one coherent professional group is certainly inadequate. Of course, there have been numerous developments since the first Freudian psychoanalysis session. Different strains of paradigms can be named, notwithstanding the fact that there are more and more integrative parts of these paradigms in the very actual settings of psychotherapeutic treatment and that there are plenty of different therapeutic techniques offered, and not just by psychotherapists. Alongside the classical psychoanalytical therapy, with the idea of sub consciousness, childhood-related inner conflicts and transference/countertransference to be analysed in the session, over the last decades the cognitive behavioural paradigm has challenged the in-depth techniques (Lambert, 2013). Cognitive behavioural therapy is focused on the idea of changeable thoughts and emotions as well as behaviour, especially those considered as 'unhelpful'. Systemic therapy again focuses on the relationships between individuals as part of a systems mostly working with group and family therapy. Trauma-focused therapy again focuses on somatic experiences and aims to help the patient overcome traumatic incidences which may have caused a variety of symptoms. Humanistic approaches such as person-centred or gestalt therapy focus on self-actualisation and do not locate themselves within the medical model since their self-understanding is based on empathy and the idea that patients are clients and should be considered more as equals, despite this also humanistic approaches had had an impact on the medical psychotherapeutic training (Lambert, 2013). Psychotherapy in

institutionalised settings is indicated if the person suffers from a diagnosable mental illness following the standards of the 'International Statistical Classification of Diseases and Related Health Problems' (see WHO 2018) or 'Diagnostic and Statistical Manual of Mental Disorders'. According to the American Psychological Association, psychotherapy works through structured talks in a therapeutic setting that is based on a trustful relationship between the patient and therapist. Psychotherapy aims at alleviating or even healing mental illnesses (Lambert, 2013).

Moreover, psychotherapists cultivate a specific ethos and exercise a comparably strong autonomy. Following Strauss et al. (1964), psychotherapy professions working in clinical institutions share a specific treatment ideology, understood as a set of beliefs and ideas professionals hold about the possible causes and aetiology of their patients' mental illnesses. In addition, this ideology includes the principles behind the role of the patient and psychotherapists, as well as the ideas about the efficacy of the applied intervention and therapeutic treatments (Scheid, 1994).

Although there is a vast body of literature on psychotherapy and its outcomes, little is known about professionals from a sociological point of view. There are studies on the effects of therapists in terms of the outcome and effectiveness of therapeutic treatment in clinical psychology (Heinonen & Orlinsky, 2013; Lambert, 2013; Lilienfeld et al., 2013; Okiishi et al., 2003; Orlinsky, 2008). However, concrete psychotherapeutic practices remain understudied in sociology, even in research that addresses the medicalisation of social problems and the increasing tendency of diagnostic manuals to include emotional states formerly deemed normal (Frances, 2013; Furedi, 2003). Only in the field of psychological and medical anthropology have studies recently been investigating the knowledge systems of behavioural therapy and psychoanalysis (Davies, 2009; Luhrmann, 2001) or cultural differences in psychotherapy and the practice of psychotherapists (Kleinman, 1988).

While there is a long tradition of looking at psychiatry and psychotherapy and the so-called psy disciplines (Rose, 1990) – either from a Foucauldian perspective or with a focus on the role psychotherapy plays in securing the social order by co-constructing norms and deviance (Szasz, 1970) – studies specifically devoted to psychotherapists are missing. According to Foucault, psychotherapy is part of the governmentality subjectivation, and through this, the Protestant culture of confession is replaced by psychoanalysis (Foucault, 1965). This subjectivation creates a self-relation that conforms to normalisation in creating the neoliberal self, and in doing so, establishes a 'responsibilisation' of the self (Rose, 1990). The psyche is the centre of power, and governmentality governs with 'psycho politics' (Sedgwick, 1982). This again relates to a 'psychiatrisation' of daily life, as Castel et al. (1982 call it.

Following the sociology of deviance, it has been argued that psychotherapy and psychiatry are agents of social control and supporters of the status quo. Deviations from social norms are brought into the purview and control of the psychotherapy professions and interpreted as 'illness'. Mental conditions and attitudes that are considered a risk for the social order are being handled by reinterpreting them as pathologies, and in doing so, bringing them into the diagnostic framework (Conrad, 2007). Instead of continuing to understand the psychotherapy professions through a Foucauldian perspective or one of a

sociology of deviance, this article seeks to formulate an immanent critique of the psychotherapy professions from the view of a sociology of professionalism.

Why would social theory and the sociology of health and illness benefit from analysing psychotherapists as a profession? Currently, we face an increase in mental illness: Depression and states of exhaustion have by now assumed almost epidemic proportions (Compton et al., 2006; Ferrari et al., 2013). The World Health Organization (WHO, 2018) predicts that, besides cardiovascular disease, depression will become the leading cause of disease in industrialised countries by 2020. It should be noted, however, that the evidence of this tendency is controversial since the statistical increase could also be an effect of changes in the acceptance of mental illness or a changed willingness of general practitioners to diagnose psychic crises as such (Mulder, 2008). Irrespective of whether the statistical increase in diagnoses truly represents a growing number of individuals suffering from mental illness or indicates changes in the social acceptance of mental illness and the willingness of the medical profession to diagnose it (Horwitz, 2002; Horwitz & Wakefield, 2007), the growing number of diagnoses goes hand in hand with an increase in treatment and a rising demand for psychotherapy (Robert Koch-Institut, 2015; Strauß, 2015b). Thus, for more and more individuals in the industrialised nations of the West, psychotherapy is becoming an important institution, and the number of people who have been treated by psychotherapists has increased over the last years (Olfson et al., 2002). This development puts the spotlight on psychotherapists as agents in the field of mental health and illness. In contrast to most of the recent discussion around the psychotherapy professions and therapy culture, in this article, I argue that the sociology of health and illness could benefit from an understanding of psychotherapy as a profession with an independent logic and claim for jurisdiction for mental health. This benefit lies in the disclosure of new fields of empirical research that help in gaining more insight into processes that have recently been discussed as effects of therapy culture (Furedi, 2003; Illouz, 2008; Rose, 1990). The main argument of all these contributions has to do with the effects of psychotherapy: Therapy privatises feelings and troubles at the expense of politicising them. Therapy increasingly – and conveniently – blames individuals for structural injustices rather than collectively tackling the sources of these injustices (patriarchy, capitalism, racism, war, etc.). In the process, it breeds a culture of narcissistic self-obsession. The authors of the therapy culture have been arguing mainly based on analysing discourses and effects one can find in a new version of subjectivation. However, the aim of this article is to add another dimension to their argument in looking at the therapeutic practise within mental health institutions such as psychiatric and psychosomatic hospitals, and in doing so, focusing on the professionals more than on the therapeutic subject. Moreover, I present some general trends showing that we are facing a concurrence of professionalisation and an already ongoing deprofessionalisation. To develop my argument, I first discuss the perspectives of sociology of the professions on psychotherapy. Second, I present the potential lack of professionalism in four dimensions. Third, I discuss possible tendencies of deprofessionalisation. Finally, I conclude by pointing out the importance of analysing the psychotherapy professions for an understanding of mental health and illness.

Medical psychotherapy in the frame of the sociology of the professions

Based on the perspective of the sociology of the professions, there are two complementary ways of looking at medical psychotherapy: First, psychotherapists have a distinct normative programme, and following Evetts (2013), they are part of an ideological agenda. Second, psychotherapists follow a professional project that seeks to extend their jurisdiction and, in doing so, retain power (De Swaan, 1990). From this angle, one can employ three different approaches to analyse psychotherapy and professionalism, which are as follows: (1) the functional approach, which looks at specific characteristics of occupations; (2) the interactional approach, which considers the inner processes in the professional practice; and (3) the power–knowledge approach that looks at the mentioned questions of professional hegemony, power and jurisdiction. Psychotherapy can be examined following two central questions: What role do psychotherapists play in society and what specific function do they fulfil? How do they follow a normative programme in doing so?

The function of psychotherapy in and for societies

Parsons (1951), as one of the most significant representatives of this approach, analysed the function that professions take up for every society. In his view, the development of professions and professionalism as such can be interpreted as a general expression and answer to the increasing problems of coping with social life. In this sense, professionalism marks a parallel to the rationalisation Weber ([1905] 2006) described. Professions as services with a high expert knowledge have the task of controlling deviant behaviour, and consequently, control norms in society. In this view, psychotherapy is an occupation that treats affective states that are commonly seen as abnormal and, at the same time, converts these affective states into ones that could be considered normal. This follows the logic of normal = healthy, deviant = ill. Psychotherapy does contribute to offering a service to both the individual and society. Following Parsons, psychotherapists act universally, neutrally, with an output-related and patient-oriented approach, and they always focus on the common welfare as opposed to following their interests of power and jurisdiction (Parsons, 1964).

On the level of the general functional logic between specific functional systems, to mark a different approach within this broader field, psychotherapy can first be described as a functional field of psychosocial advice. Their shared logic deals with the action problems of individuals regarding their options to participate in different functional fields. This aims at treating action-related problems with the goal that individuals can behave self-reflexively towards themselves and their problems (Schützeichel, 2010, p. 129).

The codes healthy/sick (or just/unjust; normal/deviant) should be changed in a positive direction (Kurtz, 2000). Psychotherapists have a specific role in the psychosocial field since their self-understanding as a profession is not only a *counselling* one but also a profession that can *heal*. Again, this brings the problem that, other than in the medical field, there is no such thing as a clear definition of health and illness. Depending on

which therapeutic paradigm one follows, this definition can vary – there are categorisations of conscious/subconscious, functional/dysfunctional and so on, but there is no universal idea of mental health. From the systems theory point of view, it is also important to stress that concrete occupational practice, such as that of psychotherapists working in mental health institutions, can be affected by deficiencies. The basic conditions include increasing time pressure and enforced pressure to make decisions. Given this issue, it becomes clear that professional practice can also be characterised by failure. Hence, it seems to be noteworthy that there is rarely a discussion of failure or malpractice or even side effects in psychotherapy (Berk & Parker, 2009; Leitner, 2012). I return to this point below.

Other than in the medical treatment of organic affliction, there is only diffuse knowledge about the various factors that are effective in psychotherapy. Professional organisations uphold the interpersonal relations of the patient and therapist as one of the main factors in effective treatment. As a result, psychotherapy is no longer only a treatment but becomes a mindset. Part of every profession is the development of a specific ethos. Ethical and moral principles lead action (Rosenbaum, 1982). Therapists should protect their patients from impairment and injustice and only treat in the patient's best interest. They should maintain professional confidentiality, and especially, they must not misuse the patient for their own – especially sexual – purposes. For this reason, it is a central part of a professional attitude to avoid building a personal relationship with a patient and refrain from treating relatives or other acquaintances. This ethos differs from physicians, who can do the latter.

With some exceptions, as mentioned above, psychotherapists' self-understanding is analogous to that of physicians. Ideas of help, support and company are among them. Above this, it is important that everything that is done is only done to benefit the patient.

Psychotherapy as interaction: 'Translation' and 'othering'

In the encounter between a patient and therapist, following Schütze (1993, 1996), different lifeworlds meet, and thus, one of the challenges for the therapist is clarifying what the encounter is about – in other words, 'what is the actual case?' (Gildemeister, 1995, p. 31). Clearly, there are standardised manuals for diagnosis used in psychiatric and psychosomatic hospitals, but only the various interactions between therapist and patient create 'the case'. The concrete definition of the case starts the treatment process, which follows a standardised procedure. However, the single case always sets the epistemic foundation for psychotherapy. Therapists as professionals claim a broad licence and mandate to work on specific cases. Following Hughes (1971, the concept of *licence* refers to the activities society grants a profession to carry out; the *mandate* refers to the jurisdictional claim the profession makes. Moreover, therapists have knowledge (diagnostic criteria, the accompanying treatment, etc.) that distinguishes them from their patients. In that sense, according to Hughes (1971), it is an 'esoteric' knowledge. By mandate, therapists not only have the legitimacy to execute treatments, but they can also define what affective conditions are treatable in the first place and in what way the outcomes of the treatment should result in. As Hughes (1971) notes, 'Professionals do not merely serve; they define the very wants which they serve' (p. 424). Therapists as

professionals always create the 'case' by interpreting – and within this interpretation, translating – the patient's illness narratives (Davis, 1986; Kleinman, 1989) into a medical framework (Callon, 1984). At least at the beginning of treatment, as Freidson argues (1986), the professional applies official knowledge about the profession to an individual case. Of course, standardised manuals exist to make a diagnosis, but each case always sets the epistemic foundation for psychotherapy. The interpretive process, in which the psychotherapist engages in creating the case, can also be described as a practice of professional appropriation: Psychotherapists produce a description of suffering that legitimises psychotherapeutic treatment. Again, this could be understood as the process of translation, as Callon (1984) argues for a different context. Rather than a translation in the service of intelligibility, the psychotherapeutic translation is an active attempt to bring suffering into the purview of the profession. Kleinman (1989) describes this as the transformation of the patient's illness narrative into the professionals' concept of a disease (1989). This always involves a transformation of formal knowledge into working knowledge (Freidson, 1986).

This transformation of knowledge, as well as the process of appropriation, mostly implies another dimension – the 'othering' of the patient, along with what Strong and Zeman (2007) introduced as the 'selving' of the therapist. Othering, a concept that details the process of creating homogeneity by identifying he self and 'others,' was best described in postcolonial theory (Spivak, 1988) and is not only related to psychotherapy. It is a process that identifies those who are thought to be different from oneself or what is considered mainstream, and it can reinforce and reproduce positions of domination and subordination (Johnson et al., 2004). However, in the context of medical records, othering is therapists' 'operation of making things intelligible to the reader' (Brown et al., 1996, p. 1573), and in doing so, deflecting attention away from them by simultaneously legitimising their professional role in the treatment. Furthermore, in therapeutic conversations, othering and selving describe the processes of referring to the therapist's 'normal self' as being distinct from the 'pathological other', that is, the patient. In this sense, psychotherapy offers individuals the opportunity to transform their personal histories into coherent narratives (Illouz, 2008; Kühnlein & Mutz, 1996). However, this transformation is preceded by a re/interpretation of the patient's suffering into the frame of the medical diagnoses.

In medicine and psychiatry, there have already been numerous studies analysing these difficulties in the early stages of treatment (Goffman, 1961). Goffman's (1961, p. 11) thesis on the 'total institution' as formulated for psychiatry is well known. Following Goffman's characterisation, the main purpose of clinical psychiatry here understood as a total institution is not to treat and heal patients but to turn them into patients in the first place.

Power and the claim of jurisdiction

If one centres autonomy for an analysis on the sociology of professions, this autonomy relates to empowerment. Medical sociologist Freidson argues that professions claim their autonomy and power to self-direct based on three points: First, the claim is that professions need such an incredible amount of knowledge and skill that non-

professionals could never value this knowledge; second, they claim that professions act with discernment so that no outer control is necessary. Third, the claim is that the profession can identify and exclude those members who are not following the ethical standards or are not competent. These three arguments have immediate consequences for decisions about what is seen and treated accordingly as health or illness (Freidson, 1970).

If an occupation is entitled to have ultimate control over the content of its action, the psychotherapy profession does have a strong influence on what conditions are considered normal or ill. The sociological analyses of Illouz (2008) or Furedi (2003) on therapeutic culture extract a new understanding of health. In the therapeutic setting, health has started to mean self-actualisation (Rogers & Dymond, 1954). What Freud started continues today, with more and more syndromes needing therapeutic treatment. Seen from that angle, therapists do not – other than in the logic of Parson mentioned above – control the observance of social norms and deviance, but instead, they expand the scope of what is considered 'deviant' in the first place (e.g. Castel et al., 1982; Foucault, 1965; Frances, 2013). From this perspective, one can integrate the professional action of therapists in the debate on medicalisation if affective conditions are increasingly diagnosed as pathological (Frances, 2013; Horwitz & Wakefield, 2007; Horwitz, 2002). The translation of an increasing amount of suffering in a narrative of conditions that require treatment and simultaneous claim that there is a treatment for those conditions opens unknown possibilities and a never-ending expansion of the conditions psychotherapists could be responsible for (Freidson, 1970, 2001). Following a power–knowledge approach, one can speak of a successful professionalisation if the profession manages to produce a demand for its treatment and a monopolised jurisdiction (Abbott, 1988). The idea of 'constructing the case' that was mentioned above seems to exacerbate this.

Following Abbott, the development of professions is based on a competitive struggle between occupations for jurisdiction in realms of expertise that are vacant. If this perspective is applied to psychotherapy, it shows two things – the clergy surrender, as Abbott (1988, p. 308) calls it, and the rise of clinical psychology. For a long time, pastoral care was the central space for people to discuss themselves and their moral breaches, but this has changed immensely given the contemporary dominance of psychotherapy. Abbott (1988, 300 f.) claims that jurisdiction is responsible for this, arguing that, once doctors and pastors had the licence and mandate to care for the mental and spiritual well-being of their patients – at least for the European and North American countries – the clinical psychologists and psychiatrists took over this jurisdiction for any mental crisis.

The power–knowledge angle also tackles gender relations that are produced and reproduced by professions. Every profession is gendered, and gender is a crucial characteristic of professional processes (Gildemeister & Wetterer, 1992; Kuhlmann, 1999). This is especially true for the psychotherapy professions. If we consider the required skill set that is implicitly formulated for the profession, the gendered dimension becomes clear: Empathy, an ability to listen, communicative skills in general and a caring attitude towards the client/patient are commonly known 'feminine skills'. This is especially interesting because the founders of psychotherapy were all male, although most of their patients were female. While there are a lot of female coryphées in the field of

psychoanalysis and psychotherapy, such as Melanie Klein and Anna Freud, the public perception of a medical psychotherapist is still male, as research on media appearance and public representation of psychotherapy has shown (Robinson, 2013). Yet, there are rising numbers of women entering the profession. The numbers show that a feminisation of the profession is occurring, and with this, a change of gender of the profession in general (Willyard, 2011).

A lack of professionalism?

After the brief classification of the psychotherapy profession given above, I analyse the challenges and predicaments for the profession in the next section. The remaining question is: Are we facing a decline of professionalism, or is there still an ongoing professionalisation process? I start with the deficits that can be identified regarding the professionalism of the psychotherapy professions.

The lack of a stringent concept of health and illness

A *stringent concept of health and illness* is lacking. Although empirical studies show that therapists often combine different paradigms and methods in their day-to-day practice, the concepts of health and illness vary in the paradigm (Luhrmann, 2001). If a patient seeks treatment because of recurring anxieties, for example, which therapeutic paradigm the therapist will apply and how this is connected to an understanding of health and the outcome of the treatment are crucial issues. Should the patient be confronted with the anxiety and adjust his or her behaviour over time accordingly? Is he or she considered 'healthy' when it is possible to be in a situation that would have previously caused anxiety without having anxious feelings? Or should she or he turn to childhood memories, associations and internalisations that may be the causes of the anxiety in triggering situations? If the individual can reflect on that, is she or he 'healthy'? In addition, the particular training depends on the training institute that fundamentally shapes the professional's self-understanding of psychotherapists (Davies, 2009; Heinonen & Orlinsky, 2013). Another challenge that comes along with the professional self-understanding is a changing society, and with this, the predicaments of working with outdated diagnostics. From within the profession, to name one example, the discussion around gender norms and the norms for setting up romantic relationships has developed and shown that the idea of heteronormativity is strongly underlying a lot of therapeutic approaches and understandings of a 'healed' patient (Hodges, 2011; Ruti & Cocking, 2015). It remains open whether and how changing notions of normalcy will affect the future of training institutes and diagnostic manuals. Another field of examples for this is the heteronormative framework in which psychotherapy is mostly embedded. Reich (1984), among others, shows that psychotherapists follow an implicit family ideal that they develop based on their familial biographical experiences (Buddeberg-Fischer, 1997).

Diffuse skillset

One of the central questions is, who is a good therapist and how is this determined? Unlike in most professions, a clear skillset for psychotherapists is not formulated, and this brings problems of differentiation from other professions (Wampold, 2006). After all, psychotherapists work with their whole person, their subjectivity and their feelings, and this often implies a normative idea of good therapy, which varies greatly. Suitability is also discussed differently depending on the therapeutic paradigm, but standardised procedures for aptitude testing are not available.

Of course, there are legal definitions for licencing that vary in different countries, from a strong legal restriction, as in Germany, to a broad definition, as in the United States. The regularities and accredited trainings are transparent in each specific organisation. However, regarding the overall skill set, eligibility for practicing the profession is not clearly defined, and with this, the demarcation from other occupational skills is problematic. It seems there is an established implicit skill set, as mentioned above, that is strongly connected to the normative representation of being a woman – empathy, the ability to listen carefully and care, to name just a few characteristics. Nevertheless, it remains unclear whether those skills are necessarily important for being a good psychotherapist. Moreover, eligibility strongly depends on the psychotherapeutic paradigm one follows, but at the same time, there is no standardised procedure to test aptitude at the beginning of psychotherapy training (Davies, 2009). Aside from personal traits, one could name competencies that are more connected to analytical thinking, self-reflexivity and experience in the field of mental health, but it remains open why these competencies are especially important for psychotherapists, and more, whether there are limitations that should prevent some personalities from becoming therapists. Moreover, what affective and emotional conditions of the therapists are required to be able to practice are not standardised. Mental health issues of psychotherapists remain crucially understudied (Jaeggi, 2001).

Studies have shown how the therapist's social milieu of origin and family biography affect their explicit and implicit ideas about their profession, where therapists run the risk of 're-infecting' themselves later in self-directed therapies (Reich, 1984, p. 62). Aptitude becomes an attitude, and as mentioned above, this is above all characterised by a reflexive reflection on oneself. This lack of specificity is also seen when it comes to the agenda of therapy. Especially in the field of psychodynamic psychotherapy, a clear ending point is never articulated, and psychoanalysis is considered a never-ending process. This diffuse agenda not only of psychodynamic approaches but also in evidence-based psychotherapies, such as 'cognitive behavioural therapy' or 'interpersonal psychotherapy', entails the danger of the patient's dependency as an adverse outcome of the treatment (Berk & Parker, 2009). This leads to the next dilemma.

Side effects of psychotherapy

Other than the huge debate on the consequences of pharmaceutical treatment, *side effects of psychotherapy* are still not sufficiently discussed (Mohr, 1995). This topic is rarely considered in the field of the psychotherapy profession that every treatment that has an

effect on the patients also comes with potential side effects (Kleiber, 1990; Kleiber & Kuhr, 1988). A change of self-awareness after going through psychotherapy can have widespread consequences not only for patients but also for personal relations; yet, this potential change is rarely discussed at the beginning of a treatment (Kächele & Schachter, 2014; Strauß, 2015a). Illich's (1976, p. 3) concept of iatrogenesis comprises all inadvertent and preventable induction of disease or complications from the medical treatment. Given the tendency of the professions, and especially the psy disciplines, to escalate the line of action, this becomes trickier for the potential side effects. One iatrogenic outcome of the professional's creation of the necessity for psychotherapeutic treatment is that more people consider themselves as 'a case for a therapist'. Illich differentiates the concept of iatrogenesis into the three following categories: (1) clinical, (2) social and (3) cultural iatrogenesis.

Clinical iatrogenesis is the harm done to people as the result of actions taken to restore health or prevent illness, such as an adverse drug event, hospital-acquired infection or perforated bowel from a screening colonoscopy. For the field of psychotherapy, this could mean that patients could fixate on specific afflictions caused by inaccurate behaviour of the therapists, for example, distressing, alarming or even offensive remarks. With *social iatrogenesis*, Illich refers to the harm societal arrangements for healthcare can inflict on people they are meant to help. Social iatrogenesis describes the development of a health system oriented towards a welfare system that leaves the patients as passive consumers of medical services and, in doing so, undermines the healing potential and the will of the patient to cope with their disorder independently or to create solidarity with others. The result of this is the 'medicalisation of life' (Illich, 1976, p. 41). Thus, in social iatrogenesis, the social arrangements of healthcare are the pathogens. In the field of psychotherapy, social iatrogenesis relates to an increasing therapeutic culture that is even advancing social iatrogenesis. The patient's autonomy is debilitated and not promoted by the dominance of the therapeutic knowledge. Increasingly, individuals tend to delegate their individual responsibility to experts in the psy disciplines (Illich, 1976). Finally, Illich's *cultural iatrogenesis* occurs when societies capitulate to 'professionally organised medicine [that] has come to function as a domineering moral enterprise that advertise industrial expansion as a war against all suffering' (p. 127).

The lack of structural competencies

Several studies have shown that, although there is an ongoing discussion on cultural competencies, this has neglected to account for social structures (Hansen, 2019; Metzl & Hansen, 2014; Waitzkin, 1989). Not only is a distinct boundary between health and illness lacking, as shown above (e.g. Schützeichel, 2010), but a methodological individualisation is also part of the therapeutic treatment. Therapists claim to have no means of 'treating' their patient's social situation or even the social–structural causes of their patient's suffering (Flick, 2016, 2019). There is a robust body of studies in epidemiology arguing that social determinants of health are the most important ones (Barr et al., 2015; Hoven et al., 2015; Waitzkin, 1981), and in contrast, there are several studies that show how the clinical gaze tends to neglect the social–structural aspects of health and illness by either naturalising them or linking them to the patient's lifestyle (anonymous, 2016,

2019; Holmes, 2013). Based on a summary of studies, Wampold (2015) argues that the common factors between the therapist and patient in therapy are crucial; however, it is mostly neglected that, when it comes to social commonalities, therapists hardly bond with their patients on an eye-to-eye level. There is simply not much in common when it comes to certain patient groups (Wampold, 2015).

Tendencies of deprofessionalisation?

Above all, in addition to the mentioned missing professionalisation, one can also see tendencies towards a decline of the profession – in other words, a tendency towards deprofessionalisation. There are four tendencies in this regard in the field of psychotherapy, which are as follows: (1) therapy culture and proto-professionalism, (2) deficient fulfilment of demand and simultaneous increase of demand, (3) the feminisation of psychotherapy and (4) a marketisation of psychotherapeutic practice.

Therapy culture and proto-professionalism

Not only for psychotherapy but also for all medical professions, one can state a rise in what Schützeichel (2010) has called a self-expertisation of patients. Patients interpret their suffering as 'a case for psychotherapy', and this is based on knowledge that the psychotherapy professions have spread out into the public arena (Schützeichel, 2010, p. 138). In the interaction with the therapist in the therapeutic setting in inpatient or outpatient care, this can lead to a consumerist approach to the patient: They come for help with a self-diagnosed disease and a precise idea of the treatment they would like to receive (see Schützeichel, 2010 as well as the discussion around job burnout, see Neckel & Wagner, 2013). This development is often described as proto-professionalism and found widely among professions; nevertheless, it implies some paradoxical tendencies for psychotherapy: Therapists establish a therapeutic culture that can have a destabilising effect on the profession. What do I mean by this? An increased attention to psychic and mental crisis in general and a strong emphasis on the urgency of psychotherapeutic treatment by the professional chambers in public potentially enhances a discourse that claims a need for the treatment of mental problems, but at the same time, allows other professions to make the claim of jurisdiction. The widespread offers for counselling in the psychosocial field, as well as the rising number of employees seeing a coach, can give a hint in that direction. Although these occupations work within the knowledge system of psychotherapy, at the same time, they become competitors in the 'battle for the souls' (Abbott, 1988, p. 300; Illouz, 2008). From the perspective of epidemiology, this development is broadly discussed as an increase of 'mental health literacy' (Jorm et al., 2017). Especially, the alleged paradox of an increased amount of support for mentally ill patients on the one hand, and a ceaseless prevalence of disorders like depression on the other hand, can be explained with this concept: mental health literacy describes the knowledge about the preservation and advancement of mental health as well as the knowledge about disorders and its treatment. Associated with this are non-stigmatising opinions towards the mentally ill and competencies for one's search for help (Wei et al., 2015). The increase of mental health literacy among the public can be related to an

increase in patients' willingness to interpret their own experience as pathogenic. Jorm et al. (2017) showed, for example, that the increase of mental health literacy of the population of Australia correlates with the prevalence of depression for the same period of 1998–2008.

Changed logic of action through economisation

An important aspect of a potential decline in professionalism for psychotherapy professions is the rising marketisation of the therapeutic practice (Scheid, 2001). If professional practice is no longer geared to ethical and medical criteria but only financial and economic factors, this will lead to a decline of professionalism. In the medical field, we face a rising tendency towards marketisation in general that implies new logics of efficiency that influence therapists' concrete practice. Financial guidelines determine the treatment, and this thwarts the ethos of psychotherapy at its core – the focus of psychotherapy is no longer the patient's recovery but rather the financial guidelines for efficiency of health insurances and hospitals, and with this, a reduction of quickly treatable symptoms. If therapy claims to operate on the foundation of an intersubjective relationship between the patient and the therapist, as claimed by the profession itself, this certainly needs time to develop, which may not be allocated by insurance programmes. Moreover, the treatment could face the risk of becoming more standardised; this is also evident in the increased usage of manuals (Keller, 2016). This again thwarts the core idea of psychotherapy – to be a personalised approach to human suffering within the frame of a trustful relationship between two people.

Organisational integration and loss of autonomy

The next dimension addresses the increasing organisational embeddedness of medical psychotherapists in different fields: Job centres, schools, universities or companies hire more and more psychotherapists, but they have a clear assignment that they expect the psychotherapy professionals to be subordinate to. This also includes taking over organisational structures, bureaucracy and hierarchy (Evetts, 2014). If we follow the annual publication of health insurers on the work satisfaction of the therapists, the latter at least gives a hint that a loss of autonomy is standing in the way of satisfaction. At the same time, and opposingly, there are programmes established within companies that access psychotherapeutic knowledge and psychotherapists and in which the professionals increasingly engage. The so-called Employee Assistance Programme is one example, as is the role of therapists in job centres (Lees, 2016, p. 4; Loewenthal, 2015).

Conclusion: Deprofessionalisation through professionalisation?

This article analysed the psychotherapy profession from the point of view of the sociology of professions and, from this understanding, followed an approach that understands the psychotherapy professions within a frame of power and knowledge and not merely an occupation that serves public health. Two consequences could be drawn from this analysis: First, professionalism is a never-ending process, including for the

psychotherapy profession. Second, the professionalism of psychotherapy is challenged by several developments, and these lead to a decline of the profession, in other words, to tendencies of deprofessionalisation. Whereas some findings vary in different countries and imply a potential process of professionalising, the paradoxical development and the tendencies of deprofessionalisation mark a real challenge to the professionalism of psychotherapy. However, the claim in this article is that a theoretical perspective on the sociology of the professions can help understand these processes from within the profession. Again, this is not meant to be an argument against analysing psychotherapy from either a Foucauldian approach or the perspective of the sociology of deviance, but rather, it is intended as a third dimension for theorising the psy professions.

Although convincing and influential, one could criticise a Foucauldian perspective for being too hermetic and being implicitly highly normative without explicitly defining the normative foundations of the critique. Moreover, a Foucauldian perspective neglects the various professional settings and the professionals themselves by looking only at the effects of subjectivation of the patient. The potential contradictions of the professional practice can hardly be explained by this approach. Yet, the sociology of deviance approach is highly convincing on different levels. Nevertheless, given the rising numbers of depression diagnoses, it would be too simplistic to explain them by the logic of controlling deviance only. My argument is that an understanding of psychotherapists as a professional group with interests that do not necessarily serve the public or the patient's interest but follow a different professional logic helps theorise the psychotherapy professions.

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