

# **THE EROSION OF OUR PROFESSION**

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Two interlocking problems account for much of the erosion and demoralization we are experiencing in the profession of psychoanalytic psychotherapy. The first problem is the undermining of traditional professional relationships, as a result of profound social and economic forces affecting all of the professions. These changes are particularly critical in the service industries. (I say “industries” here to stress both the scale that our work has assumed and its role in the economy. I might have said “growth industries.”) The psychological care we provide in our intimate relationships with patients is increasingly dominated by pressures for economy, efficiency and control -- pressures that place us at variance with traditional arrangements with clients we once were able to take for granted.

The second underlying problem has to do with the relationship between psychotherapy and health care in general. Having come under the jurisdiction of medicine, psychotherapy now finds itself increasingly restricted in virtually every aspect its work. On one level, we suffer from current draconian efforts to curtail the costs of health care. The alliance with medicine, that once enhanced our professional authority, now has become something of a handicap. On another level, we are often pressured into misrepresenting the nature of the work we do to fit expectations that our medical identity arouses.

We cannot simply decide to alter our professional identity, of course, but at least we might reflect on how that affects our ability to be understood and to be effective.

## **Problem One: The Professions**

Professions as we know them have not always existed – and, very likely, they will not always continue to exist. The medieval world recognized three professions, law, medicine and teaching, but the system of professions we know today was established during the later half of the nineteenth century during the flowering of industrial capitalism. It was a means whereby providers of expert services, services based on esoteric knowledge and skills, were able to band together to gain control over the conditions of their work and establish a greater measure of autonomy and security for themselves.

Physicians, dentists, lawyers, accountants, architects, teachers and others established professional associations in order to negotiate for themselves special relationships between their clients, the market, on the one hand, and government, on the other. In exchange for agreeing to regulate themselves stringently, setting up and monitoring standards for competence as well as ethical behavior, they were granted a considerable degree of autonomy, essentially a monopoly over the provision of services. Governments

agreed to license professionals, prohibiting non-licensed professionals from practicing, turning over to the professions themselves the setting of standards, the management of training, the establishment of fees, and the monitoring of malfeasance.

Thus a middle ground in our economy was established that was relatively immune to the more destabilizing and destructive aspects of unbridled competition. Professionals came to enjoy a certain amount of economic security along with a pride in their ability to regulate themselves. And along with this came a certain social status. Educated, relatively independent, prosperous, needed and valued for their skills, they came to occupy a privileged station. Government could stay aloof from attempting to control matters they did not understand. And the public was able to enjoy relatively well-managed professional services with reasonable confidence.

This is the basic model. Different professions varied, of course, in how they worked this out in different countries, based on the specifics of local traditions and conditions. In Germany, for example, the independence and prestige of universities gave the medical profession a means of regulation and a status that no professional organization could compete with at the start of the 'twentieth century. Being a "doctor" conferred far less prestige than holding an academic position – a fact not lost on Freud who always preferred the title of "Professor." In America, on the other hand, where universities lacked such status, physicians had a more difficult time establishing themselves as respected professionals. It was not until standards of education and practice were established in the early twentieth century, that the American Medical Association came to have unprecedented authority over the field (see Starr, 1982). This belated but highly successful development for American medicine helps to account for the tenacious insistence of the early American psychoanalysts, almost uniformly psychiatrists, that psychoanalysis had to be grounded in the newly prestigious profession of medicine. Without that, they feared, it would be associated with quackery, as were medical doctors before the profession had succeeded in establishing itself (Eisold, 1998).

Thus in different ways in different countries, the professions developed. But as this was happening, it came to seem that certain practitioners were inherently entitled to the privileges and status of a professional by virtue of their specialized knowledge. It was not seen as a bargain that had been struck, or an achievement that had been negotiated, but a reflection of the fact that professional services could be organized no other way.

The early theoreticians of professions, such as Max Weber, assumed so. And I think that most of us still do, assuming that by virtue of the kind of work we do we are "professionals." It is only in the last 25 to 30 years that sociologists of the professions began to examine more closely how professions came to be organized, reflected in the account I just gave (Larson, 1977; Macdonald, 1995). No doubt this new understanding of the "creation" of the current system of professions became possible because changes in the stability and structures of the professions themselves were well underway, as a result of which it was easier to see that the model was far from inevitable or sacrosanct.

But many of us, inside the professions, still tend to see the professions as fixed or essential. When we speak about what is happening to our profession, we tend to bring to the discussion an assumption that something pure, stable and strong is being worn away, threatened, compromised. It may be the case that something valuable is being slowly debased, but I think it is important to see this in context. The economic forces that enabled the professions to establish themselves in the last century are now moving on, creating the conditions that make that way of providing services no longer feasible.

What is happening to our profession is happening to all professions, at different rates of change and in different ways, but inexorably. The market forces to which the model of the professions was originally a response have evolved so that economies of scale and the management of costs have become mandatory. Professionals no longer control the economics of their work. If we look at the professions of law or architecture or accounting, for example, increasingly we see huge multinational firms, recruiting “professionals” directly from graduate schools at competitive salaries. The legal structure of these enterprises may still bear some resemblance to the partnerships they started out being, but they no longer actually function as those partnerships did. Those professionals are now, by and large, employees. To be sure, there are the “boutique” firms, which have been able to carve out for themselves a market niche, remaining small and distinctive; but they are the exception, not the rule.

In short, the idea of protecting or preserving an established profession is no longer an adequate defense against these developments. Our identity as professionals provides us no leverage. To claim that some established professional ideal is being compromised carries no weight.

This is particularly true where costs are associated with social entitlements, such as workplace benefits and insurance coverage. Increasingly physicians, do not go into private practice as they once did; either they join a group practice, which frequently evolves into a kind of clinic or specialized center, or they become employees of outpatient hospital services. The choice is to be entrepreneurial, if you can figure out an opportunity that has not already been exploited, or a worker in someone else’s shop.

A recent article in The Wall Street Journal described a dramatic example of the economic benefits of medical entrepreneurship: “In a 2000 speech, neurosurgeon Larry Teuber rhetorically asked why doctors would want to open a hospital dedicated to surgery. ‘Profit, profit, profit,’ ran his answer. When it comes to taking business from general hospitals, ‘you can’t believe how easy it is,’ he said.” The Journal went on to note that he made 9 million dollars when his company went public, while the local hospital, where he used to practice, posted an 8.3 million operating loss. The hospital claims that the “surgery center has siphoned away healthier – and more profitable – patients. Dr. Teuber says his rival’s problems stem from poor management and inefficiency.” (WSJ, August 2, 2005, p.1)

This may strike us as an extreme example, but put it beside what has become a standard practice in psychotherapy: relatively affluent patients end up in private practices, paying

decent fees, while others are left to public services increasingly strapped to meet this need.

There is another aspect of this development that we need to take into account: what has become known as the “commodification” of services. That is, the treatments we provide, under the pressure of the marketplace, are increasingly viewed as products to be measured against other products rather than as unique, specialized relationships with clients. These commodities are broken down into components in order to be analyzed for cost, effectiveness, and consistency. In the more crude language of the market, this is known as “pricing,” “value” and “quality control;” the total package is promoted as a “brand.”

In our field, psychodynamic psychotherapy or psychoanalytic psychotherapy is in competition with cognitive behavioral therapy, psychopharmacological treatments, rational emotive therapy, EMDR, group therapy, etc. etc. Thus the relevant questions that are raised are about comparative outcomes, expense, and reliability. Increasingly we have treatment protocols, manualizations, best practices -- all the bureaucratic apparatus that takes professional judgment out of the hands of practitioners, putting decisions into the hands of managers who are charged with implementing policies that seek to reconcile quality and profit.

Managers too must now inevitably raise the question of how much expensive training is required to provide adequate care. Do we really need Ph.D.'s or prolonged apprenticeships? What is the evidence for the effectiveness of traditional trainings? Can cheaper labor do the work?

This is a radical departure from the traditional autonomy of the professional, exercising his or her own judgment about the needs of the patients, the skills he or she possesses to provide for them, and the training required to acquire them. The judgment of practitioners is no longer privileged. Decisions not only exist within narrow guidelines (such as length or frequency of sessions) but also often need to be justified to managers who have no specific competence apart from the formulas they must adhere to. At least this is the situation in America.

But no matter how insulting such procedures are to the self-esteem of the “professional,” if we may still use the term, and no matter how liable they are to abuses in the name of profit, we have to acknowledge that these developments are not entirely bad. They stress efficiency and accountability, something our profession has tended to be lax about. The traditional complaint about professionals, in general, has been that either through self-interest or ignorance they abuse their trust, often too willing to promise what they cannot or will not actually deliver.

Psychoanalysis has a somewhat embarrassing history in this respect. I am sure we recall the days, if they are indeed over, when psychoanalysis was considered the treatment of choice for all patients, so long as they were “analyzable.” Three, four or five times a week, for an unspecified number of years, regardless of the complaint, was not only

preferred and often mandated by professional organizations that viewed any other approach as a form of deviance or apostasy. Today, lengthy and frequent treatments will not be supported by insurance companies or the state, even if we could manage to find the way to rationalize them to ourselves as an ideal for most forms of mental distress.

On the other hand, or course, it is hardly better to have decisions about mental health driven by “profit, profit, profit,” in the words of the American medical entrepreneur, or to have those who provide the service largely excluded from the decision-making process. I do not think that the abuses of the past account for these new developments, or justify them, but they do help us to understand some of the arguments used against traditional practices.

To summarize: the professions that we knew, that we grew up understanding, that we thought we joined – those professions no longer exist. We have licensure regulated by the state, but that no longer insures a professional monopoly over the provision of services. Increasingly, the state now takes on the role of gatekeeper to the profession and has its own agenda in seeking to insure that costs are contained. The definition of essential services is no longer in the hands of practitioners. Increasingly, fees are set by others.

As a result, along with losing control over our economic conditions, our ability to make clinical judgments about treatment, and determine schedules, we have also lost much of the status and social respect we once enjoyed. We still have the ideas – if not ideals – of professional knowledge, skills, and ethical standards, but, to a large extent, we have become workers, mental health workers.

A blunt way of putting this is that now we still have the responsibilities and obligations of professionals but not the autonomy and privileges that once were part of the package. We are suffering from the cutbacks and economies that increasingly characterize all employees, particularly those providing social services. In the increasing gap between the richer and poorer members of society, we ourselves are among the losers.

### **Problem Two: The Link with Medicine**

My second point is about the link between psychotherapy and medicine. Psychotherapy has come under the jurisdiction of medicine. Even if we are trained and licensed as psychologists, social workers, pastoral counselors, nurses, etc., as psychotherapists we are part of the health care industry, regulated by its procedures and expectations, reimbursable under medical insurance plans, covered by malpractice insurance, etc.

This was by no means inevitable. I am not at all sure that, at this stage of the process, it is reversible, but it is useful, I think, to grasp the fact that it is not essential. It is worth our while to reflect upon the professional space within which we now find ourselves housed.

The link with medicine was there in the beginning with Freud, a neurologist, developing psychoanalysis as a treatment for hysteria, a disorder that, under the influence of Charcot and others, had come to be generally considered a medical problem. Very quickly, Freud saw the danger of psychoanalysis becoming “a mere handmaiden of psychiatry,” as he put it, and tried to set it up as an independent profession. But many of his medical followers combated him on the subject of “lay analysis,” insisting that psychoanalysis needed to be under the control of physicians.

Freud lost on this issue, with the result that medicine gained jurisdiction over the new field, servicing the growing array of personal problems that the dislocations and stresses of industrialization helped to create. As a result, though we do now have many “lay” psychoanalysts and psychotherapists, all of us have become providers of medical services, adjuncts to the medical industry.

Earlier in the century, the greatest competition for the claim staked by neurologists, such as Freud, came from the clergy, whose social role as advisor and consolers to their parishioners inevitably suggested that they were the logical choice to take on this work. But other groups, as well, joined in the battle to assert jurisdiction.

As the sociologist Andrew Abbott (1988) pointed out: “The jurisdiction of personal problems was created, split, reattached to other jurisdictions, split in new ways, and reconceptualized a dozen times between 1860 and 1940. Groups associated with it subdivided, joined, then divided along new lines, both ideological and organizational” (p. 281). Neurologists competed with psychiatrists; Christian Scientists competed with evangelicals, electrotherapists competed with hydrotherapists; psychologists and social workers made concerted efforts to claim specific areas of work. At stake was the opportunity to get into a rapidly growing business and claim social importance.

In the twenties and thirties, the battle was joined by the newly established mental hygiene movement, developed to bring the benefits of scientific thinking to social problems, free from ideological and moralizing judgments. Framing mental problems as forms of disease, mental hygienists believed, helped patients to accept them as objective problems they needed to face not as moral failings to be ashamed of. The concept of illness promised to take the stigma out of mental suffering, making it a problem, not a failing. But it also provided a boost to medicine as it competed against the clergy to establish jurisdiction over this burgeoning new field.

My point here is not to dwell on these historical developments but simply to make the point that the jurisdiction of medicine over psychotherapy was not inevitable. And just as it was by no means pre-ordained that medicine should triumph in this battle, it is by no means required that it should continue to prevail. Indeed, now, there are powerful reasons for us to combat the identity that medicine fought so hard to achieve, and there are significant social factors to make change seem somewhat more likely.

Throughout our history, powerful critiques have been waged against this medical identity. In 1961 Thomas Szasz attacked the Myth of Mental Illness, arguing that

psychotherapists are “shackled to the wrong conceptual framework and terminology” (p. 4). And many have continued to protest what is frequently referred to as “the medical model,” urging us to refer to “clients” instead of “patients,” “problems in living” instead of “diseases,” etc.

The medical concept of disease is actually complex and multifaceted, reducible to no simple physical condition, according to medical doctors who have wrestled with this problem. Indeed, one scholar has plausibly suggested a “sociopolitical definition” of disease, in which a disease is an “undesirable” condition that “it seems on balance . . . physicians (or health professionals in general) and their technologies are more likely to be able to deal with it effectively than any of the alternatives, such as the criminal justice system (treating it as a crime), the church (treating it as a sin) or social work (treating it as a social problem).” (Kendell, 2004, p. 35) This pragmatic if not somewhat self-serving definition may be the best that can be offered, but certainly not without its shortcomings.

The concept of mental health is misleading for a number of reasons. It introduces the idea of normative functioning into human behavior, replacing traditional morality with a new set of standards about the “healthy personality” that we are hard put to justify. It also suggests a similarity between organic diseases, treatable by surgery and drugs and the kinds of difficulties that clients experience. The increasing array of psychotropic medications reinforces that implication, arousing false hopes of palliatives if not actual cures. Moreover, in emulating medical procedures, we find ourselves often engaged in a collusion of bad faith, finding a diagnosis that will make a patient eligible for the care he has come to expect, that we think he should have, and that our managers want us to be able to provide.

More recently, the hermeneutical critiques of psychoanalytical claims to scientific status have reinforced the idea that the primary focus of our work is interpretation or understanding: narratives not diseases. Much of our work is about meaning: false beliefs, misconceptions, inadequate stories, unknown motivations, confusions, misattributions, etc. etc.

Let me take a moment to briefly survey the range of problems that are now addressed by psychotherapy, the range of issues under our jurisdiction.

Some problems are entirely about meaning: the work we do helping clients through difficult life transitions: the death of a spouse or close friend, divorce or other forms of separation, job loss, illness and so forth. Though such problems of adjustment may provoke intense anxiety and depression, suggesting the temporary use of medication, by and large these problems are clearly not “illnesses,” in any sense of the term, requiring medical attention. Closely related are family problems: marital disputes, child/parent conflicts, ageing parents, etc. People need considerable help in managing these issues or reaching painful decisions.

Here our old professional adversaries, the clergy, have a distinct advantage. No one would question the relevance of their interest in such matters or the appropriateness of their concern and desire to help, though their current levels of competence may leave much to be desired.

Our expertise as interpreters of experience becomes more clearly relevant with clients who suffer from self-defeating behaviors: the incapacity to sustain intimate relationships, the failure to pursue their own self-interests, to follow through on projects, to feel worthy of achievement, to confront others. There is a related set of clients who are unable to lead authentic lives.

Many of the problems we face in our daily work suggest that the body is profoundly involved in the symptom picture, and that, therefore, we are somewhat closer to the traditional concept of disease. Anorexia, for example, or OCD implicate the neurological and endocrine systems. It is hard to assert the sufficiency of working with narratives or interpretations when we know that drugs will often be powerfully effective in relieving depression or panic and that behavioral approaches are required to counteract deeply entrenched habits or powerful cravings.

And then there are patients who require more active management, severely depressed patients who cannot care for themselves or who are suicidal, schizophrenic, sociopathic.

This list is far from comprehensive, but sufficient, I think, to make the point that the complexity of what we are learning and discovering about human behavior suggest that there is no single approach that is adequate. This, in turn, implies that there is no single set of competencies, no single discipline that can hope to encompass all that is required. Neurologists have come back into the picture by virtue of the new discoveries being made into the functioning of the brain and nervous system. Behavioral psychologists have a role to play in reshaping destructive habits. Psychopharmacologists clearly have a powerful role to play by virtue of the complex array of new medications being developed for anxiety and depression. Traditional social workers often provide essential support. And, of course, psychotherapists continue to be essential, with their interpretive skills.

We have come full circle: beginning by questioning the location of psychotherapy in medicine, we are now questioning the location of psychotherapy in any single discipline, the adequacy of any existing profession to encompass the knowledge and skills required to deal with the realm of personal problems. Thirty years ago, a group of sociologists (Henry, Sims, & Spray, 1971) argued in The Fifth Profession that social workers, psychologists, psychiatrists, and psychoanalysts together constitute the beginnings of a new emergent profession of psychotherapy. They found that not only did the work of the four professions overlap, but also that there was significant overlap in their attitudes, values and socio-economic backgrounds.

Professional jealousies and ideological differences kept that from happening, but it may be that now, in the face of adversity such a radical idea may have more appeal. If so, it would not be an autonomous profession, as in the old model of the professions. The



complexity of the work of psychotherapy suggests it would have to be a matrix organization drawing on an amalgam of skills, prepared to adapt to constantly changing conditions.

I doubt that what I am saying here is particularly new to those who struggle on a daily basis with these complexities. What would be new is reorganizing our profession to promote cooperation among relevant disciplines and to find the means to pay for it.

### **Some Concluding Thoughts**

Let us assume that the economic forces reshaping our profession – and our society -- cannot be challenged. The market is too strongly entrenched as our dominant ideology. Competition will prevail, services will continue to be commodified, and costs will continue to be questioned and cut.

We will have no choice but to become entrepreneurial in our thinking. That does not mean we have to be like the American surgeon with his battle cry of “profit, profit, profit,” gleefully putting competing services out of business; but it does mean that we will need to decenter from our traditional orientation as professionals, defending our familiar privileges. Difficult and distasteful as it may be for many of us, we will have to think about ways of improving value and cutting costs.

Some trends in the commodification of services, can be readily joined without compromise. It would be possible to set up specialized services to deal with complex clinical entities like eating disorders, OCD, phobias, etc, where different sets of skills are brought together: psychopharmacology, behavior modification, nutrition, neurology, endocrinology, as well as psychotherapy. Such services could utilize best practices as well as perform on-going research in order to establish and maintain a competitive advantage in the market. Services such as these ought to be managed by psychoanalytically oriented psychotherapists, I think, as they will have the best overview of the patient’s relationship to the treatment process. But this would require, in turn, that psychotherapists develop managerial skills in coordinating teams.

Another set of commodities that could be developed is services for executives or managers contending with the complex and contradictory demands of their work. Frankly, I believe well-trained psychotherapists are best suited to do this work because they readily detect signs of unconscious anxiety and emotional conflict, but they can also help in grasping and reframing the meaning that clients attribute to their behavior and that of others. And they are less likely to be taken in by their client’s own pre-conceptions about their problems.

Much of this work today is in the hand of “coaches,” who know the world of organizational life and business better than most of us, but do not know the intricacies of personality and behavior as we do. To compete in this field would require additional training, but there is no inherent reason why psychotherapists should not be able to grasp

the cultural and psychodynamic issues pervading organizational life sufficiently to understand the context of work issues for clients.

Might it also be possible to provide “advisory services” to those facing disconcerting transitions in their lives: deaths, divorce, empty nests, etc. I deliberately use the term “advisory” here because of the well-known aversion in our field to offering advice. But people want advice – or at least advice is what they seek, even though they usually still do not want to be told what to do. Can we envisage sophisticated “advice” that does not specify answers but helps clients think through their problems, clarifying their thoughts, assessing their strengths, becoming aware of some of the choices others have made in similar circumstance? Groups might be an option here.

Similar services might be made available for those who require counseling for problems with children, spouses, colleagues, friends, or parents, or for those going through difficult career transitions. Much of this kind of work now is lumped together under psychotherapy, but such problems can be separated out into particular services and characterized in ways that make them more readily accessible and acceptable to clients. If they were more clearly non-medical, they could be easier for clients to accept.

There will be continued pressure to make services broader and cheaper by minimizing the costs of training. Inevitably that will lead to the development of two tiers of competence: those who know enough and have the basic skills to provide direct services and those who can provide supervision, deal with thorny problems, and manage. There are many citizens who could provide useful services dealing with “problems in living” but who would profit immensely from having guidance and supervision: mothers, retired businessmen, refugees. To be in the supervisory tier in the provision of such services would require some additional training for psychotherapists.

All of these suggestions, however, would require reinvigorating our professional identity. I noted earlier that as professionals we have lost much of the control over the conditions of our work, along with the status, that have been the traditional hallmarks of professions. What has been left to us is the responsibility – but also the expertise. Society needs us because we have essential knowledge and skills that we have the obligation to protect and to employ. No matter how degraded and manipulated we may feel, we still know something that others do not know – and that they need.

Let me summarize. The problem we face now is twofold: First, we need to help the public understand better what it is we do, what the skills are that we employ in the service of alleviating emotional distress, that knowledge we have acquired and that we refine and use to train others. Linking it with medical skills may have seemed useful to us at one point in the past, but that point has gone. The link with medicine makes us seem relevant in emergencies, oriented to suffering and disease, part of pathology, not part of life.

The second has to do with our relationship with the public itself. Earlier I stressed our need to come to terms with the market in an age of heightened competition, and I think that that is an essential aspect of the economic reality we face. But the public is our

market; our consumers are people who are confused and desperate, often frightened and helpless. It is true that we need to think of providing useful commodities to those consumers, but we also need to develop their trust in us so that they trust the services we provide.

Part of that is being clear about the first point, what it is we do. But part of that is also convincing the public that we are not indifferent and aloof, primarily concerned with our own status, salaries, working conditions, rather than their needs. In our present condition, mourning the erosion of our profession, preoccupied with losses of our social standing and control over our work, we do not present an attractive picture.

We do need decent working conditions, good salaries, respect and a significant say in the work we perform. All workers are entitled to that, and our work is uniquely sensitive to those factors. Even if the model of the professions no longer holds as it did, the nature of our work itself requires these things. But times have changed, and we have to look to ourselves to make it happen.

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