& PROFESSIONS PROFESSIONALISM

ISSN: 1893-1049 Volume 3, No 2 (2013) http://dx.doi.org/10.7577/pp.559

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Social Integration as Professional Field: Psychotherapy in Sweden

Abstract: The present article describes and analyses the emergence and development of a professional field called social integration. Ideas, theories, and occupational practices forming this field are explored, particularly those related to the development of a new discipline, that of psychotherapy. The development of three occupations (psychiatry, psychology and social work) and their professionalisation is described through their qualitative and quantitative take-offs in particular historical periods. Three periods are identified: *formation,* 1850-1920, when psychiatry was defined as a medical sub-discipline; *consolidation,* 1920-1945, with the institutionalisation of psychiatric care, and with psychoanalysis and mental hygiene as qualitatively new cognitive bases for practitioners; and *professionalisation,* 1945-1980, with the deinstitutionalisation of psychiatric care and the professionalisation of psychologists and social workers. New ideas on subjectivity and individualism, new welfare state institutions, as well as collaborative professionalism all favoured the creation of psychotherapy as professional knowledge, and a possible new profession of psychotherapists.

Keywords: social integration, professions, professional, psychotherapy, mental hygiene, psychiatrists, psychologists and social workers

The present contribution depicts the emergence of psychotherapy and the ideas, actors and institutions involved in this historical process, and the development of a profession of psychotherapists in the field of social integration, one of the professional fields identified in the introduction to the present special issue. Social integration is considered as a field in the sense that there have been (and certainly still are) contested contentious and controversial ideas, theories, methods, resources, positions, and actors, which allows for particularly interesting professional analyses. The case of Sweden in professional research is of international interest, firstly as an alleged elaborated general welfare state, and secondly as a state with exceptionally strong relations to its individual citizens as objects suitable for professional diagnoses and intervention measures.

In a broad sense, social integration is concerned with the production and reproduction of individuals as persons and citizens through processes of socialisation that are undertaken by parents, peer groups, schools, churches, media, work places, the health sector and other institutions. In a narrower sense, social integration involves processes for readjusting individuals or groups with personal or social problems into societies, communities, schools, families, or other social contexts. In this sense, social integration is a tool for taking care of what are perceived as various kinds of deviance from established norms. It is close to, and often overlaps with, the field of social regulation (see article by Svensson and

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Received:
12 March 2013

Accepted:
25 November 2013

Åström, this issue). However, while social integration involves various kinds of therapies to readjust individual behaviour and understanding of reality, social regulation deals with discipline, coercion, punishment and separation (see the introductory article). Ultimately, social integration and social regulation are the two major institutional means of maintaining social order and normality. There is also an overlap with and a demarcation toward the field of health, and in particular mental health and psychiatry (see article by Carlhed in this issue).

The field of social integration revolves around the distinction and opposition between normality and deviance that constitutes the very foundation of the field. However, definitions of normality, and hence implicitly also of deviance, alter with the passage of time and with cultural change. Moreover, the concept of normality has several dissimilar definitions. For instance Ian Hacking (1991) identifies three key conceptions of normality found in discourses and practices of social integration: the statistical normal distribution, the absence of deficiency, and the ideal condition. For these reasons there can be no trans-historical definition of the field of social integration; its 'essence' implies that there is no essence, merely culture-bound distinctions between what is regarded as normal and deviant in particular socio-historic truth-regimes.

This article focuses on three major professions within the field of social integration: psychiatrists, psychologists, and social workers. These professions make up the main part of what has sometimes been summarised as the psy-complex (Foucault, 1973; Ingleby, 1983; Rose, 1993). The psy-complex emphasises the construction of the self via a set of psychological accounts such as counselling and psychotherapy (Pilgrim & Rogers, 1999).[1] There are a great variety of (psycho-) therapies and psychotherapists. This study includes only those that are currently licensed by the Swedish state.[2] Psychotherapy is defined as:

> The treatment of or interventions with psychic, relational or existentialistic problems by psychological methods, directed toward a client, patient, family or group. Psychotherapy aims to increase the client's mental and psychic health or wellbeing (Cullberg, 1999, p.420).

Historically, the theories and practices of psychotherapies have been of vital importance for the professionalisation and the delimitation of the three occupations (i.e. psychiatrists, psychologists, and social workers), in terms of their relations to other professions and occupations through field-internal stratification, closures, and jurisdictional claims. By focusing on the cognitive and social bases of psychotherapies, the present article describes and analyses the emergence and development of the professional field of social integration, to explain in particular how and why there is a possible new profession of psychotherapists. Our ambition is also to explain the emergence of particular historical periods and qualitative and quantitative take-offs within this field (the analytical concepts are presented in the introductory article by Brante).

[1] Pilgrim & Rogers (1999, p. 105) identify two types of discourses, the one mentioned above and the discourse of segregation and acting of the body (physical treatment). Together they represent two ways of understanding the activities of mental health professionals.

[2] Psychoanalytic and psychodynamic individual psychotherapy, cognitive psychotherapy, behavioral psychotherapy, family therapy, group psychotherapy, child and parent centered psychotherapy and existential psychotherapy (Högskoleverket, 2010).

The analysis is supported by secondary data for psychiatrists, psychologists, social workers, psychotherapists and institutions. These data emanate mainly from sociological and historical studies, public documents and statistics dating from the mid-19th to late-20th century. The selection of social workers is restricted to those working in different kinds of psychiatric and counselling clinics and psychiatric institutions, that is, voluntary treatment.[3]

Formation of the field: 1850-1920

Since the middle of the 19th century psychiatric institutions have been a foundation for professionalisation processes within the field of social integration. There are a number of factors involved. For instance, organisational changes in health institutions during this period led to greater specialisation within the hospitals (Qvarsell, 1996; Åhman, 1976) and asylums were appointed as mental institutions for the regulation of mental care in 1858, which was a prerequisite for psychiatry becoming a medical specialisation (Sjöström, 1992). According to Sjöström (1992, p. 157) this regulation initiated psychiatry as a scientific discipline. Professors were appointed in the 1860s and the subject became compulsory in medical training from 1860. The inauguration of the Association for General Psychiatry in 1905 came next. This provided a social base for psychiatrists, as well as the introduction of psychiatry as a compulsory subject in medical training, demonstrating the increasing demand for psychiatrists in mental institutions. The number of psychiatrists increased and a social base for psychiatry was settled.

This period is defined as a first take-off for psychiatrists. The cognitive base for psychiatrists was twofold: 1) the idea of correction was deeply anchored in psychiatric institutional care based on observation and analyses of the patients, which were the foundation for diagnoses; 2) new influences from biomedical models emerged, where psychic disturbances were considered as caused by biochemical changes within the nervous system (Beronius, 1994; Bűlow, 2004). The latter implied new classification systems for diagnoses and medical treatment methods (Sjöström, 1992; Qvarsell, 1996) and has been defined as the 'physicality discourse' by Prior (in Bűlow, 2007:37) or as the first biological psychiatry (Shorter, 1997). Thus, psychiatry as a defined subject was at the same time rather weak, and psychiatrists had low status within the medical profession. Some doctors, however, turned to the new psychology and psychiatry which had started to emerge in Europe. This represents the first minor qualitative take-off for the field of social integration, separated from the field of health. Psychiatrists were so far the only profession in an emerging field, even though social work was on the verge of becoming an occupation. Psychology remained a discipline within philosophy until the end of the 19th century, when experimental psychology in laboratories was established parallel to the human-oriented non-experimental stream (Nilsson, 1978; Goodwin, 1999).

[3] Social workers within municipalities are analysed in the field of social regulation (see Svensson & Åström).

Significant new influences

Two movements slowly started to spread their influences during the beginning of the 20th century: the mental hygiene movement and psychoanalysis. Both of them were significant for the construction of the field of social integration beyond health and regulation. What did these new ideas imply? The mental hygiene movement originated from the United States as a reaction to the inhuman care of patients at mental hospitals. [4] As a general idea, psychic problems originated from environmental factors and human interaction, and implied an outlook towards society. The movement advocated *preventive* psychiatric care in non-institutional clinics, i.e. counselling and fostering with the aim to create a mentally healthy population (Piuva, 2005; Qvarsell, 1997). Philanthropic movements striving for social policy reforms founded the National Association for Social Work (CSA) in 1903. The CSA was a union for socially engaged associations. It was inspired by the two new movements and managed by their pioneers. Both movements offered new epistemological foundations for understanding the origin of psychic problems and treatment, and eventually constituted a knowledge-field of social integration.

Psychoanalytical theories and ideas were constructed and invented by Sigmund Freud in the late 19th century and offered a new 'Theory of Mind', emphasising the subjective and unique emotions and experiences of individuals. Freud created a theoretical, topographic and structural model of the mind. This model consisted of psychosexual development, unconscious processes, and the interpretation of free associations. It eventually entirely changed the notion of psychic suffering and mental illness (Cullberg, 1999; Gieser, 2009; Haugsgjerd 1972; Luttenberger 1989; Makari, 2009).

Psychiatrists and neurologists started to conduct psychoanalysis in continental Europe, and later on in Sweden (Johansson, 2003; Luttenberger, 1989; Makari, 2010; Reeder, 2006). Psychoanalytic theories and methods slowly gained a foothold in Sweden during the first decades of the 20th century. Dr Poul Bjerre's introduction of psychoanalysis in the Swedish Society of Medicine in 1911 is often considered a significant starting point, and two years later the term 'psychotherapy' was accepted as a specialty by the Swedish Medical Society. A handful of pioneers fought for the acceptance of psychoanalysis during the first decades of the 20th century (Gieser, 2009; Luttenberger, 1997; Johansson 2003). These pioneers were mainly doctors working at private clinics, several of whom were also active within the CSA.

Psychoanalytical theory can be described as a theory about human beings within social cultures, as well as a practice for treatment of mental suffering. It defined the 'subjective' as a scientific area. This was controversial and signified a paradigmatic shift in relation to the predominant positivistic psychiatric paradigm. The new ideas of psychoanalysis and the mental hygiene movement gradually started to influence the cognitive base in the field of social integration. However, it took decades before these ideas were accepted and integrated into professional practices.

[4] The American National Committee for Mental Hygiene was established 1908.

Cognitive and social consolidation: 1920-1945

In this period the field of social integration began to be socially strengthened by the establishment of professional associations. This stage was in general characterised by social liberalism and by construction of the welfare state, urbanisation, the growth of the working-class movement and changes in the organisation of care in mental institutions. New institutions and nursing homes for minor psychic disturbances, e.g. neuroses, opened for voluntary treatment (Qvarsell, 1997; Åhman 1976) and new professional associations were established. In the 1920s and 1930s the ideas and theories from psychoanalysis and mental hygiene gradually infiltrated the practices in the field, affecting professional groups and the organisation of psychological care. The so-called new psychology (including psychoanalytical theory) represented both scientific knowledge and new ideals for human relations, including expectations of a new moral order (Kollind, 2002, p.65).

Representatives of psychoanalysis and psychotherapy, as well as mental hygiene ideas, founded associations during this period. The Nordic Psychotherapeutic Collegium was inaugurated in 1933 and became the first comprehensive professional association for psychotherapists in Scandinavia. The Swedish Psychoanalytical Association (SPA) was constituted in 1934 and became a member of the International Psychoanalytical Association (IPA), established in 1926, and in 1936 the Foundation for Medical Psychology and Psychotherapy was established. Swedish psychotherapists participated in international conferences and were active in discussions in international journals. Psychotherapeutic associations were also established in the 1930s, opposing some of the fundamental aspects of psychoanalytical theories (Johansson, 2009). These associations aspired to attain the acceptance of psychotherapists as an occupational group and the recognition of psychotherapeutic methods.

The mental hygiene ideas were manifested in the Association for Psychic Health Care (Sfph), which was established in 1931 with the purpose of promoting psychic healthcare. The association was managed by prominent founders such as Viktor Wigert, Emilia Fogelklou and Kerstin Hesselgren. Ideas of preventive intervention were closely connected to actual social policy and to new ideas in psychiatric care (Piuva, 2005; Qvarsell, 1997). The ambition was to extend not only psychiatric science and pathology, but also definitions of psychic health. This ambition implied that notions of deviance *and* normality were formulated in a psychiatric context (Piuva 2005:121). Representatives for mental hygiene tried to reach all people in society with information on psychiatric and psychological explanations for social success and social difficulties. They did not fight for any exclusive professional groups. Instead their strategy was based in fusions between psychiatric science and social, pedagogical and caring professions (Kollind, 2002; Piuva, 2005; Sfph, 1991). Thus, the professionalisation processes for the occupational groups increased and new working practices emerged, founding a social base for the field.

Expansion of occupational groups

The small group of psychoanalytic and psychotherapeutic pioneers in Sweden was mainly made up of neuropathologists and a few psychiatrists. Several of them were active members of the CSA and Sfph. They had taken their psychoanalytic training

mainly in continental Europe before World War I. The first psychotherapeutic courses in Sweden were arranged by the Stockholm University College in 1925, for both medical doctors and the public (Gieser, 2009). A further course was arranged solely for medical doctors at the Serafimer Hospital. Initially psychoanalytic training was based on both oral and written curricula, where the former has been the major part in therapeutic knowledge mediation (Johansson, 2009; Makari, 2010). This educational structure was controversial compared to traditional university education (Johansson, 2009).

The professionalisation process for psychiatrists continued during this period and the number of psychiatrists increased (from 71 in 1920 to 113 in 1939). Psychiatrists and neurologists working at the mental institutions belonged to academic medicine and had a critical attitude to, and demarcated themselves from, psychoanalysis (Geiser, 2009; Johansson, 2003; Luttenberger, 1989). Psychoanalysis was conceived of as a 'defective and morally unacceptable method without practical value that posed a threat to established medicine' (Luttenberger, 1989, p.343). Critical discussions continued during the 1920s and 1930s within the Psychiatric Association.

The criticism concerned both psychoanalytical theories and methods, and the term psychotherapy was excluded by the Swedish Medical Society in 1924 (Johansson, 2003). Treatment methods used within psychiatry were used instead; for example, electroconvulsive treatment (ECT) and surgical lobotomy (Olofsson, 2008), both of which were based on the biomedical perspective within academic psychiatry. The critical debates reflected the aim of psychiatrists and neurologists to preserve their jurisdiction, which emphasised biomedical explanations for mental diseases. However, child psychiatry was separated from adult psychiatry in the 1940s, implying the start of specialisation. A need for clinical psychologists emerged with the establishment of child psychiatry.

Though psychoanalysis almost faded away within academic psychiatric medicine, there was an increased interest among the general public, above all in discussions among intellectuals. Authors and philosophers discussed and emphasised 'the self', psychology, and motives for good and evil – issues which were greatly influenced by the effects of World War I. Left-wing political parties considered psychoanalysis as an instrument for human emancipation and as a means for class struggle (Johansson, 1999; Luttenberger, 1989). Thus, public debates contributed to a basis for accepting psychoanalytic theories outside the circles of the established medicine.

Social work emerged as a new occupation and appeared in the arena as a way of readjusting individuals into society by means of practical care and dialogue with the patients. The education of social workers had started in 1921 at the Social Policy Institute in Stockholm, and several of the pioneers in the National Association for Social Work (CSA) were teachers at this institute. The first social worker in mental care was employed in 1914[5], and in 1944 roughly 70 social workers were employed in somatic and psychiatric hospitals (Kollind, 2003; Olsson, 1998). The boundaries with other professionals were vague and social workers were initially regarded as assistants to physicians. In 1944 the first professional association was established for social workers in medical care, and

[5] She had no education in social work.

one of the first issues addressed was the skills and knowledge base for social workers (Fredlund, 1997; Olsson, 1999).

Psychiatric social workers were employed and struggled for legitimacy within the psychiatric-medical context. At the same time, a Mental Hygiene course at the Social Policy Institute, which included psychoanalytical theories, became compulsory for employment (Kollind, 2002; Olsson, 1999; Pettersson, 2001; Piuva, 2005). This also meant the differentiation and specialisation of social workers, who were roughly divided into those working with social integration and those working with social regulation (see article by Svensson & Åström, this issue). Thus, the social base for social workers was founded.

New practices

New practices emerged, influenced by psychoanalytical theories and mental hygiene ideas. The separation of psychoses from neuroses contributed significantly to the discussion around normality and deviance during the 20th century (Piuva, 2005, p.24). The interest in neuroses during the 1930s presupposed interpersonal problems and interaction between individuals and between individuals and society. The predominant understanding of mental illnesses as neuropsychological disturbances was considered inadequate for diagnosing neuroses and required new treatment methods. Psychological and psychoanalytic theories slowly started to have an impact for diagnoses, inference and treatment. Although the professional groups working with psychotherapy were small, new kinds of therapeutic facilities opened during the 1920s and 1930s; for example, the first institute in Sweden offering psychotherapeutic treatment for children and adolescents, the Erica Foundation, (Egidius, 1976; Gieser, 2009; Johansson, 2009). Some years later, the St Lukas Institute was established, based on psychoanalytical as well as theological theories. In 1940 the Institute for Medical and Psychotherapy was established. These institutions were external to and independent of the universities and mental health institutions.

Counselling bureaus opened in the 1930s, inspired by mental hygiene ideology and pedagogy. The Mental Health Child Service started in 1933, and in 1945 a state sponsored clinic for child and adolescent guidance was established for the prevention and cure of mental disorders in young people. The attention given to psychology, pedagogy and methods for children's upbringing contributed to an increased professional as well as general public interest, and the first clinical psychologists were established in the school system (see article by Nilsson-Lindström & Beach, this issue).

Amalgamation of cognitive and social aspects

A more differentiated psychiatric care emerged during this period and psychoanalytical and mental hygiene perspectives were gradually established, creating a qualitatively new basis to integrate individuals into society instead of controlling and separating them. However, this occurred more as an individual reception among certain physicians and psychiatrists than a collective one, as the criticism was strong. But support was given by public debate and interest, and several minor professional associations were eventually inaugurated, providing some education in psychoanalysis.

Institutions for prevention and counselling were established. New occupational groups emerged in the field, such as social workers at psychiatric hospitals and a few clinical psychologists in child and youth psychiatry as a result of a government commission. The professional associations, the new treatment services, and the moderate start of psychotherapeutic education can be interpreted as emerging professional claims within this field.

Professionalisation of the field: 1945–1980

Processes of professionalisation were evident in the field during this period; for example, by systematic education and training for professional groups and by seeking monopoly status from the government. Concurrently, psychic health prevention and psychotherapeutic and counselling methods received greater legitimacy and became the ideological ground for the field.

At this time society was characterised by the expansion of the welfare state and comprised major social policy reforms and legal and institutional changes. These conditions contributed to the professionalisation of the field initially. However, the 1960s was an ideologically and politically turbulent period with hefty debates and demonstrations concerning inequality and poverty in society. The democracy debate was in focus and left-wing movements protested against oppression and imperialism, such as the Vietnam War. Empowering patients and clients was emphasised. This influenced fields of health and social integration, and numerous psychotherapeutic societies were established. Attention turned to social circumstances, and it was asserted that personal problems should be solved by structural methods, not individual ones (Pettersson, 2001).

Institutional changes

Different public guidance clinics opened in the 1940s, and in the next decade child and adolescent psychiatric guidance clinics developed. The Bureau for Mental Health was established (Gieser, 2009). The medical service expanded in 1950s and 1960s and psychiatric clinics opened in somatic hospitals, but still most beds were to be found in asylums and mental institutions (Sjöström, 1992). The new legislation, 'Act on the preparation of psychiatric care in some cases' (1966, p.293), was effected in 1967 for incarceration, separate from the Health Act for voluntary care. Patients suffering from psychoses were, as before, treated at mental institutions while those with other psychiatric and neurotic problems were treated at psychiatric clinics in institutional as well as in non-institutional care.

A major change was the introduction of new psychopharmacological drugs in the 1950s, which was a major qualitative take-off for psychiatry in the health field. The effects of the medication diminished psychotic symptoms and patients could be discharged from mental hospitals. According to Reeder (2006), this is the most significant factor behind the breakdown of the dominance of traditional psychiatry. It led to a shift in the approach to psychiatric illness and treatment. Other significant factors were economic considerations, a changed psychiatric discourse and critique of the mental institutions (Bűlow, 2004).

These factors led to a deinstitutionalisation of psychiatric care and implied a focus on prevention. Psychotherapeutic methods in psychiatric services and

practices were thus introduced, with demands for qualified professionals trained in psychosocial and psychotherapeutic methods. At the same time dynamic psychiatry was established, inspired by both psychotherapy and the mental hygiene movement, and psychiatric services were developed in housing areas, close to the citizens, in order to make psychotherapy available to everyone (Cullberg, 1999; Elisasson & Nygren, 1981). From the vantage point of political ideology, psychiatric science and mental health were placed in social contexts, signifying major organisational changes, such as the dismantling of mental institutions into sites of non-institutional social care (Bűlow, 2004; Markström, 2003; Qvarsell, 1997). This differentiated psychiatric care, and also created a differentiation among the professionals.

Professional occupations in the field

During this period more pronounced professionalisation took place in the concerned occupational groups: psychiatrists, social workers, psychologists and psychotherapists. We will start with the expansion of psychiatrists, social workers and psychologists before moving on to the development of psychotherapy and psychotherapists.

The period involved differentiation and specialisation for *psychiatrists* into the areas of general psychiatry, child and youth psychiatry, and forensic psychiatry (Ottosson, 2009). Guidelines for the classification of diseases had existed since the 19th century (http://www.who.int/classifications/icd/en/HistoryOfICD.pdf), in order to legitimate professional action and expertise. They had a great impact on Swedish psychiatry. The first Diagnostic and Statistical Manual for Mental Disorders (DSM) was published in 1952 by the American Psychiatric Association. This and the following version (DSM II, published in 1968) were mainly based on psychodynamic thinking, contrary to later versions.

According to the DSM, normality and abnormality were perceived as existing on a continuum, and the abnormal as well as neuroses were caused by same kind of traumatic events or by suppressed child experiences. Diagnoses were made from underlying causal mechanisms, and symptoms were understood as cultural conditions (Brante, 2006, p.73).[6] There was still an ambivalent attitude towards psychotherapy among psychiatrists and the majority strove for neuropsychiatric closure, while some incorporated psychotherapy as a method for the treatment of psychological and psychiatric disorders (Johansson, 2009). Several of these psychiatrists were driving forces for the establishment of dynamic psychiatry (Cullberg, 1999; Eliasson & Nyberg, 1981). This signified a change in the approach to understanding the causes and treatment of mental disorders. The psychosocial paradigm replaced to a certain degree the neurological one.

During the 1950s the number of *social workers* in medical services had increased threefold and their work focused essentially on issues of mental hygiene (Fredlund, 1997; Piuva, 2005). The importance of an accurate social investigation as a complement to the medical investigation for a basis for diagnoses and treatment was emphasised during the 1950s and 1960s (Fredlund, 1997; Olsson,

[6] Another classification system is the International Statistical Classification of Diseases and Related Health Problems (ICD) by WHO (Cullberg, 1999).

1999). Social casework methodology inspired by psychotherapy, which was widespread in the US, was introduced in Sweden during this period, but with the exception of psychiatric and child psychiatric social workers and family counsellors very few adopted the method (Olsson, 1999; Pettersson, 2001; Piuva, 2005).

Interest in therapeutic methods, family therapy and methods for crises interventions increased towards the end of the period. Two other significant ideals for counsellors were the rationalistic and psychological ideals, which were also incorporated by social workers. These ideals were based on science; in the rationalistic ideal, the counsellor was the expert who should guide and control individuals, while the psychological ideal was based in non-directive counselling (Kollind, 2002). In 1958 the Professional Association for Social Workers (SSR) was inaugurated, and the association for social workers in the medical services cooperated on several issues. The question of licensing this group of social workers was discussed without success.

Education in social work developed and a process of academisation was initiated by the University Reform of 1964, when social work educational institutes were merged into the university system and changed into schools of social work. Training was expanded from five to seven semesters. Social Work Methodology was introduced as a subject in order to give the training a specific academic core, and in 1977 social work was completely integrated within the university system as a new academic discipline: Social Work (Sunesson, 2003).

This period saw a breakthrough for social workers. The number of employed social workers in the medical services increased during the period from 500 to more than 2,000, implying a quantitative take-off (see article by Svensson & Åström, this issue). Simultaneously, a qualitative take-off appeared when social work was established as an academic discipline.

The clinical *psychologists* emerged in the field during this period and the first professional education in psychology was established in 1955. Psychologists received a state governed licence in 1978. The title ‘psychologist’ was protected. It qualified individuals to exercise the profession according to reliable scientific experience and granted the authority to diagnose and treat patients using varying psychological methods (SOSF, 2008, p.34).

The Psychological Association was a driving force in developing education and in licensing from the beginning of the 1950s (Göransson, 1997). However, a process of re-professionalisation started in the 1970s. At that time, professional psychologists developed the areas of education, organisation and health, which implied a further qualitative breakthrough. The Association adopted prophylactic work as its objective in established areas in 1971 as well as in new ones. These areas included social work, occupational and public healthcare and public childcare, which all were situated at the core of the expansive social welfare society. Earlier areas such as industrial and organisational psychology were suppressed in debates in favour of social problems. Psychologists could then return to ‘pure’ psychology, which was defined as psychotherapy and psychodynamic theory (Rigné, 2002, p.35).

Psychoanalysis and other therapeutic trends, previously outside academic psychology, now made an important entry and were adopted into the longer training course from 1982. In part there was a paradigmatic shift in the discipline.

The professional role was intended to be that of the practising psychotherapist. Correct psychological treatment became equivalent to psychotherapy, which was also demarcated as the specific area for psychological expertise, in contrast to traditional psychiatry and psychosocial work. Psychotherapists should have a basic education in psychodynamic theory and diagnostic psychology. These demarcations applied to psychiatrists and social workers gradually became more intense across the 1980s. Regarding psychiatrists, this was caused by the need for specialist functions such as psychotherapy (parallel to the medical hierarchy). Regarding social workers, it was caused by the alleged difference between psychotherapy and psychosocial work (Rigné, 2002, p.41). Psychologists were supposed to work with prophylactic intervention and therapeutically with clients, through supervision, personnel and organisational development, research and teaching. This led to a quantitative breakthrough for the three professional groups in the 1970s (see figure 1).

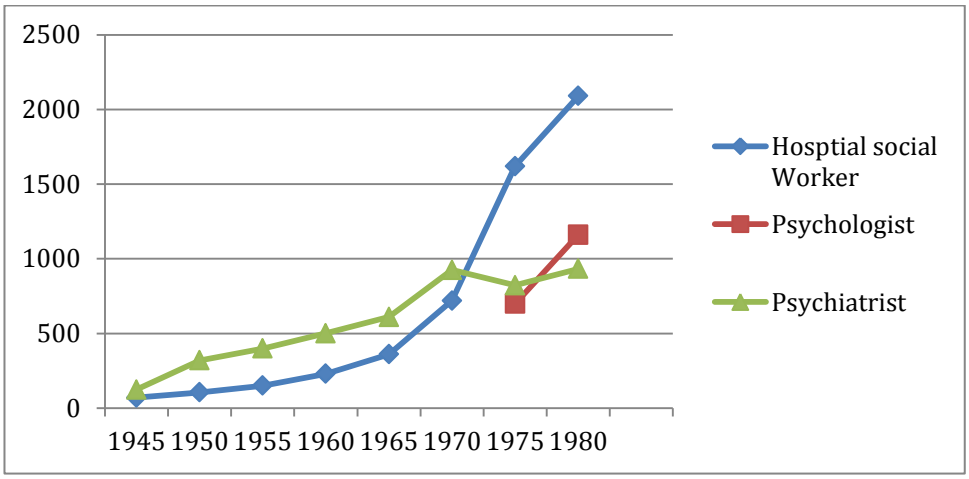

Figure 1. The emergence of the professions in the field of social integration.
Note: The figures include only social workers and psychologists employed in healthcare and emanate from official statistics; Statistics Sweden (SCB), historical database and from Annual Statistics in Swedish Regions.

Progress of psychotherapy

The continued development of psychotherapy was connected to societal and institutional changes, the psychopharmacological revolution, and a new approach to psychiatric illness and disturbances. The expansion and acceptance of psychotherapeutic methods was, in Sweden as in other European countries, dependent on the organisation of mental healthcare (Pilgrim et al, 2011). However, the progress of psychotherapy was also enforced by actions among psychiatrists, social workers and psychologists.

Therapeutic theories and methods developed in different directions after World War II, placing emphasis on various aspects of how to understand psychological processes and the human mind. Followers of the psychoanalytical tradition were Melanie Klein and object relation theory (Igra, 1984), Carl Roger's humanistic-experiential psychotherapy from the 1940s, Skinner's behaviour therapy, and Ellis and Aaron Beck's cognitive psychotherapy in the 1950s and 1960s (Larsson, 2010). In the 1970s new family therapy methods were introduced in Sweden (Carlssson, Schubert, Sandell, Blomberg, Lazar & Broberg, 2000; Egidius, 1976) and new

directions and elements from different psychological theories and schools merged into a common frame of reference called the psychodynamic approach (Luttenberger, 1989). According to Luttenberger, this was an important approach because it diminished Freud's dominance and made it easier for psychiatrists to integrate psychological and psychotherapeutic theories into their cognitive base.

Luttenberger divided the psychodynamic approach in Sweden into three phases. The first is called the preparation phase (1940s to 1950s), when psychodynamic therapy slowly grew in small isolated groups. In the development phase (1960-1975) the psychodynamic approach was responded to more strongly within medicine and psychology, and was applied as a technique in psychiatric care. It was also applied in medical and psychological education and as specialist training for psychiatric social workers. The breakthrough phase started in the middle of the 1970s when psychotherapy was granted a state governed education and when research and therapy were merged into the cognitive base of academic psychology and psychiatry (Luttenberger, 1989, p.364-373).

Breakthrough for psychotherapy and psychotherapists

The fight for recognition was manifested in the establishment of an educational system for psychotherapists. Different therapeutic institutes were founded during the second half of the 20th century; for example, the Institute for Medical Psychology and Psychotherapy, which included training courses. In 1955 the Erika Foundation was accepted as an institution for educating child psychotherapists. Therapeutic education and training was carried out by private organisers (different psychotherapeutic associations), and in 1971 the Mental Bureau started a two-year psychotherapeutic course for personnel within the psychiatric and medical services.

The idea that psychotherapeutic education was necessary for various professional categories was stated at the Hook symposium in 1970, concerning education for psychiatrists, psychologists and social workers. The so-called Hook manifest suggested a basic psychotherapeutic education for all nursing professions with education in both general and specialised psychotherapy, as well as education for supervisors and teachers. As a result the Centre for Psychotherapy was established with the purpose of promoting the development of Swedish psychotherapy.

The investigation and planning for state governed psychotherapeutic education started in 1970. This commission was carefully carried out by scrutinising the need for psychotherapy, scientific evidence of the effects of psychotherapeutic methods, the estimation of target groups, the number of psychotherapists needed, and of course the curriculum for the course (Egidius, 1976). Training and studies in teamwork were considered important. The commission also discussed psychosocial work as preventive and supportive work, emphasising social skills and psychological understanding. Thus, the first state governed psychotherapeutic education was established at the universities in 1978.

The training was divided into two parts. Step 1 was an introduction course for basic knowledge in psychological theories, methods and supervised training. It was designed for professionals who required this knowledge in their education, e.g. social workers, nurses, clergy and psychiatrists. One interesting aspect was that occupations such as psychiatric nurses without academic training were allowed to take part in the education. Only psychologists had direct access to step 2, which was the certifying psychotherapeutic course.

Psychologists lay claim to the training and suggested a coherent specialist education for psychologists and psychiatrists, implying the exclusion of social workers. This was a struggle for territorial and jurisdictional rights between psychologists and social workers, which ended with admittance for social workers. The emphasis on a common psychotherapeutic education for different professions was conclusive for the professionalisation process of psychotherapists (Reeder, 2006, p.32). The process from the Hook manifest to a state governed psychotherapeutic education is an important qualitative take-off or breakthrough in the field of social integration. Both cognitive and social aspects of psychotherapy were now situated in the field. The psychoanalysts stayed outside the academic world protecting their psychoanalytical education (Johansson, 2009).

Establishment of the field

This period was characterised by the strong development of the welfare state and its institutions. The mental hospitals were, however, dismantled and a new drug-based, differentiated psychiatry was formed, which tended to divide the profession. Psychiatrists were driving actors in formulating dynamic psychiatry. The earlier neurological paradigm was partly replaced by the psychosocial paradigm, which was and still tends to be contested by the biosocial, and particularly the biomedical, paradigm. This is explicitly reflected in later editions of the diagnostic manuals for mental disorders (DSM).

The psychodynamic approach developed strongly, and there was a breakthrough in the 1970s which caused a redefinition and a paradigmatic shift in Swedish psychology at the same time that there was a strong quantitative advance. State governed education in psychotherapy was established on two levels and an important qualitative breakthrough took place the same year as psychologists received a state licence in 1978. However, recurrent efforts—particularly in the 1980s and especially from psychologists—to use psychotherapy for another form of social closure failed, and all three occupations were then entitled to study psychotherapy as further professional education.

Conclusions

During the early 20th century the field of social integration was formed, thus separating it from the private sphere of families and households and from the fields of education, health, and social regulation. Major social changes such as industrialisation, urbanisation and democratisation including social rights and welfare institutions influenced the formation of the field. Three major periods can be identified. The first was the period of *formation* (1850-1920). This period provided the first qualitative breakthrough when psychiatry was defined as a medical sub-discipline. Diagnoses started to be systematised and personal problems gradually began to be defined as psychological. The next period was *consolidation* (1920-1945). It developed by the institutionalisation of psychiatric care and by psychoanalysis and mental hygiene forming qualitatively new bases for groups and individual practitioners in social integration. Finally, we can describe a *professionalisation* period (1945-1980), with the deinstitutionalisation of psychiatric care. This was caused by the introduction of new drugs, the emergence

of the eclectic psychodynamic approach, a paradigmatic shift in Swedish psychology, a professionalisation of psychologists, a quantitative take-off for them as well as for social workers, and a systematic education in psychotherapy.

Psychoanalysis and the mental hygiene movement were fundamental for the formation of the field of social integration, though the impact was weak to begin with. The cognitive base changed when the mind and emotions of individuals became an area for science and practice. Psychoanalytical theories in understanding unconscious psychological conflicts and new treatment methods for neurotic symptoms eventually influenced the understanding of personal psychic and psychological problems.

In particular, the construction of subjectivity and self–reflection and the idea of prevention constituted a qualitative take-off for the professions in the field of social integration and separated it from social regulation. Ideas from mental hygiene for the prevention of mental illness through counselling and fostering methods were other parallel influences contributing to mental healthcare during the first half of the 20th century. There was a growing demand for psychotherapy. This came from the anti-psychiatric movement from the 1970s, the deinstitutionalisation of psychiatry, and new attitudes to psychotherapy among the general public, not least furthered by public discussion among the cultural elite and mass media. Ideas about mental hygiene founded a base for a new way to organise psychiatric healthcare, which implied new forms of treatment. Counselling and preventive psychosocial work together with psychotherapeutic treatment composed the cognitive base, which constituted the doxa in the field. The mental hygiene movement and psychotherapeutic theories were highly interdependent in the course of establishing the professional field of social integration. These ideas were integrated into professional practices before World War II by single entrepreneurial enthusiasts and minor groups in private institutions for therapy and counselling. After World War II the ideas were usually initiated by the government through commissions.

Psychotherapy as a subject was first studied in continental Europe and appeared later on in private institutes and foundations in Sweden. In the 1970s systematic university education was established in Sweden, directed towards a number of occupations in the field. Basic therapeutic training has been and still is compulsory for specialised psychiatrists and for psychologists. Social workers, clergymen and nurses were obliged to take this basic course at some institute or university in order to get access to the licensing education in psychotherapy. Currently, this is a specialisation for psychiatrists, psychologists and social workers.

In summary, three major structural conditions favoured the emergence of the field. Firstly, personal problems were identified according to new ideas on subjectivity and individualism and elaborated by the psychoanalysis and mental hygiene movements. Secondly, the welfare state institutions took over and reconstructed integrating functions from the private sector, offering a demand and a labour market for professionals. Thirdly, the classic psychiatric profession, the new profession of social worker, and the new profession of psychologist with successful classic professional ambitions all appeared in the field. There was collaborative teamwork as well as recurrent jurisdictional competition between the occupational groups. Thus, the field emerged with a new cognitive base and with social conditions set by the welfare state and by the three professional occupations in question.

Psychiatry was professionalised early on as a medical specialty. Psychiatrists as a whole have in all three periods demonstrated ambivalence towards psychotherapeutic diagnosis and treatment methods. This has partially splintered the profession. It left space for psychologists, particularly after their reprofessionalisation by psychotherapy in the 1970s, and for social workers in the field of social integration. Through the professionalisation of social workers as counsellors and their entry into the health institutions, the field of social integration was reintroduced into the field of health.

In the field of social integration, individuals, their personality and their mental and psychosocial health, have been objects of practice. This is a kind of lowest common denominator in the field. The professional trilogy of diagnosis-inference-treatment is a general professional method, which was imported to the field from medicine and health by psychiatrists and elaborated by psychoanalysts and psychologists. The right to diagnose patients invoked many negotiations and border conflicts between psychiatry and psychology. Psychiatrists were ambivalent to and splintered by psychotherapy, partly leaving this area to psychologists, who tried without success to create a monopoly on psychotherapy. Counselling is another method created in the early 20th century on similar cognitive bases and practiced by psychologists and social workers. Together these two methods contain what is the most distinguishing skill in the field: conversation or dialogue for adaptation, adjustment and emancipation.

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