Original Article

Sociotherapy in the Time of COVID-19: A Critical Position Paper on the Importance of Sociology

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Abstract

This paper contends that sociotherapy, a sociologically informed approach to therapy, is a viable alternative to the diagnostic model recognized by the College of Registered Psychotherapists in Ontario (CRPO). The Psychotherapy Act (2007) along with the Regulated Health Professions Act (1991) gives the CRPO authorization to regulate the practice of psychotherapy and to control titles affiliated with the act of psychotherapy. I offer a discussion of sociotherapy and socioanalysis as clinical alternatives to the conservative and normalizing approaches endorsed by the College. I situate sociotherapy and socioanalysis in the discipline of sociology and in relation to Freudian psychoanalysis. I offer my own sociotherapeutic practice as an illustration of how the societal and the psychological, the social, and the psychic must be engaged in concert. I underscore the importance of dialogue, as opposed to diagnostics, interpretation as opposed to assessments and psychosocial contemplation as opposed to cognitive-behavioral treatment in clinical practice.

Keywords

clinical, ethics, mental health, policy-politics-government, public soc, social psychology, social work, theory

Sociotherapy is a therapeutic practice informed by sociology. Unlike psychotherapy, which is focused on individual psychology, sociotherapy is based on a dialectical understanding of the client-subject in society. Sociotherapists have a greater appreciation for the way neo-liberal institutions, economics, politics, culture, pandemics (including, but not limited to COVID-19), effect individual well-being. Sociotherapy is important because it enables therapists to treat and interpret individual symptoms in social context. In this paper, I offer my thoughts on sociotherapy as an alternative to psychotherapies singularly focused on the individual. Although many psychotherapists attend to sociological factors relating to mental and emotional heath, it is, increasingly, difficult for them to do so because the controlled act of psychotherapy is narrowly defined in psychological terms and regulated by College of Registered Psychotherapists of Ontario (CRPO). Registered psychotherapists may find themselves subject to disciplinary investigation if their

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practice departs from increasingly narrow and formulaic psychotherapeutic treatment protocols insufficiently attuned to social context. Sociotherapeutic practice is a viable alternative to the more conservative and normalizing regulations, practices, and discourses relating to professional practice now governing psychotherapy in Ontario and in the international context.[1]

I begin with a brief discussion of my own sociotherapeutic practice, qualifications, and the legal-bureaucratic structures governing the controlled act of psychotherapy in my province. As a sociotherapist, I am in a unique position straddling the university and the clinic. I am a sociology professor at York University with a diploma from the Association for Applied and Clinical Sociology (AACS). I have been doing research in psychoanalytic sociology and attending seminars, workshops, and courses in psychoanalytic theory and practice for over 15 years. I have a private sociotherapy practice in Toronto and see approximately 10 clients per week. My sociotherapeutic approach is informed by the lectures on psychiatric power and normalization given at the Collège de France (1973–1974) by Michel Foucault, psychosocial studies,[2] feminist theory, and Lacanian psychoanalysis. I am not a member of what Foucault calls the "psych" professions. Nor do I belong to one of the five Colleges legally recognized by The Regulated Health Professions Act (RHPA) in Ontario. I do not call myself a psychotherapist because I am not a member of the CRPO. In Ontario, clinicians can work as therapists without belonging to one of the five Colleges affiliated with the RHPA as long as they do not call themselves psychotherapists or commit the controlled act of psychotherapy (which is distinct from supportive therapy, counseling, coaching, etc.). In 2020, the CRPO was given legal authority by the RHPA (1991) and The Psychotherapy Act (2007) to regulate the practice of psychotherapy and to control titles affiliated with the act of psychotherapy. Sociotherapy is not a title regulated by the CRPO. I am thus classified as an unregulated provider.

Despite what many clinicians view to be an interrelationship between the psychological and the sociological, it is, increasingly, difficult to do sociologically informed therapy under the designation "psychotherapist" in my province. Although the CRPO claims to act in the public interest by guarding against professional misconduct and enforcing what they believe to be "best practice," there is an unfortunate by-product of the legislation and associated work of the College. The RHPA and the CRPO are making it difficult to practice therapies inspired by the social sciences, the arts, humanities, and philosophy combined. Although I cannot do justice to the history, administrative, legal, and professional politics governing the formation of the CRPO, and the associated provincial legislation in this paper, I foreground the socio-legal institutional apparatus to provide context for my discussion. Like many professionals with interdisciplinary, international, and inter-institute qualifications that fall between and outside the boundaries of standard credentialing and licensing systems, my work with clients is not covered by the Ontario Health Insurance Plan (OHIP) (the province's government-run and tax-funded health care program). The stratification of the psych-health care professions and applied social sciences has, unfortunately, led to gaps in health care coverage. I write from the interstitial space between the university and the clinic to discuss the gap between the social and the psychological enabled by provincial legislation and the associated work of the CRPO.

This is not a research paper but, rather, a position paper informed by the literature and my own sociotherapy practice. I make a case for the importance of a sociologically informed approach to psychotherapy and reflect upon the negative clinical implications of a singular focus on psychology. I invite scholars and clinicians alike to imagine therapy as an applied sociology informed by intersectional theory and politics in the COVID-19 viral moment. Physical distancing protocols, underfunded health-care systems, poorly managed seniors' care-homes, economic uncertainty, institutional racism, environmental degradation, and social isolation all take a toll on mental and emotional health. Sociotherapists can offer insight into the relationship between social injustice and mental and emotional health along with the ways they are exacerbated during times of societal crisis.

In what follows, I offer an introduction to sociotherapy, outline the three sociological paradigms that inform the sociotherapeutic literature, consider the relationship between psychotherapy and sociotherapy as they relate to my own practice, and comment on the regulatory function of the CRPO. I discuss how sociological insight is marginalized by the psychological orientation of the College without forgetting that psychoanalysis[3] (which provides a historical foundation for psychotherapeutic practice) has been marginal to sociology. Sociologists often lament how psychologists do not incorporate sociological insight into their scholarly and clinical research. Disciplinary divides are not only regulated at the institutional and provincial level but enforced by academic sociologists and psychologists alike. As a clinician, I believe that what the CRPO calls the controlled act of psychotherapy will be hampered to the extent that it does not engage the interrelationship between the social and the psychological. Although I am critical of the way the sociological is excluded from the psychotherapeutic models recognized by the College, I do not believe that my concerns about therapeutic practice, its regulation and professionalization, would be addressed by developing a more inclusive and expansive model whereby, for example, sociotherapy would be recognized by the College as psychotherapy. My focus is not on assimilation but rather upon differentiation. I believe the public is best served by offering a range of non-diagnostic therapeutic supports irreducible to psychological normalization.

What Is Sociotherapy?

Sociotherapy is a sociologically informed therapeutic practice that dates back (at least) to 1936 (Bain 1936). Sociotherapy is informed by uniquely sociological insights into human experience. It has roots in the social sciences and has much in common with social work. In fact, there is much overlap between social work and applied sociology (Heraud 2016). All sociotherapists recognize an interrelationship between the social and the psychological but each sociotherapist understands this interrelationship differently. The same conflicts and debates concerning structure and agency dominating the discipline of sociology are evident in clinical sociology. Just as it is important to be critical of the monopoly psychology has on psychotherapy, it is important to be observant of the way sociotherapies are shaped by differing theories, methods, and field-based typologies that are not neutral with respect to power, capital, and politics. There are, however, three main sociological frameworks that inform the sociotherapeutic literature: functionalism, socialization theory, and psychoanalytic sociology.[4] In addition, there are critical theorists affiliated with the Frankfurt School who merge Marxism and psychoanalysis (Adorno, Marcuse, Fromm, etc.), but they do not use the term "sociotherapy." Nor do they focus on what a sociologically informed therapy looks like at a practical (clinical) level. Thus, I do not foreground them in this paper.

Sociotherapy is often associated with the social scientific researchers at the Tavistock Clinic in London. Established in 1920, the Tavistock Clinic comprised a group of social scientists who were concerned about the effect of military traumata on soldiers, shellshock in particular. They conducted what came to be known as the Northfield Experiments and Operation Phoenix. What sociologists now call the structure-agency debate was, in the work of Siegmund Heinrich Foulkes (1898–1976) and others in the Tavistock group, a dialectic that could be theorized using the socioanalytic method. The publications of the "Tavistock group" bridge sociology and psychoanalysis in an effort to understand post-war resettlement, anxiety, resistance and, ultimately, the "interdependence of social and psychological factors operating within a defined structural, organizational and cultural . . . field" (Rustin and Armstrong 2019:477).[5]

There is a relationship between sociotherapy and what many in Québécois and French academic circles call socioanalysis. The latter is more directly informed by psychoanalytic insight about unconscious processes. One of the earliest definitions of socioanalysis is "the activity of exploration, consultancy, and action research which combines and synthesises methodologies

and theories, derived from psycho-analysis, group relations, social systems thinking, organization behaviour, and social dreaming" (Bain 1999:14). We might say that sociotherapy is to socioanalysis what psychotherapy is to psychoanalysis. Socioanalysis and psychoanalysis involve attention to unconscious processes originally theorized by Sigmund Freud whereas sociotherapy and psychotherapy do not by definition engage Freudian insights relating to psychic life. In French sociology, the socioanalytic work of Vincent Gauljac is a good example of the socioanalytic focus on the social and the psychic in tandem.

What unites sociotherapists and socioanalysts is an agreement upon the relevance of the sociological context to the human condition. This is not to say that we do not actively create and repeat early life traumas as psychoanalysts note, but that not everything is a defensive projection, a fantasy, or a delusion. COVID-19 is, for example, an object of real and imagined anxiety. The corona virus cannot be seen by the naked eye but is, nevertheless, real. It is ripe for fantasy and defensive projection at the individual level, but the effects of the pandemic are all too real and global. We do not always know who has and does not have the virus or if it is outside or inside our own bodies. Imagined boundaries between self and other get confused. The pandemic is a social and psychologically invested emergency requiring a psychosociologically informed approach to health and well-being.

Sociotherapists understand people in societal context. It follows that sociologically informed clinicians consider individual experience in relation to the family (as many psychotherapists and psychoanalysts do) but, also, in relation to larger societal forces, institutions, communities, cultures, and histories mediating these experiences. Indeed, most sociotherapists agree that individual suffering has a social and environmental etiology.[6] The Society for the Furtherance of Sociotherapy, for example, defines the practice as involving attention to somatic, psychic, social, and spiritual factors affecting the whole person. There is, in this definition, a focus on holistic health and wellness in community, relationship, and environmental contexts. As the late American sociologist Neil Smelser explains,

> For psychoanalysts the external world has been what individuals make of it in terms of denial, distortion, rationalization, avoidance—all in relation to their intrapsychic struggles; for sociologists the external world has been conceived of as an independently existing reality that impinges on people. (Smelser 2014:107–108)

Sociotherapy is predicated upon both conceptualizations of the external world and regards them as more interdependent and dynamic than psychotherapists with psychological training, as opposed to psychosocial training, do.

Many sociotherapists work with vulnerable populations including, but not limited to, children, the elderly, those with disabilities, and those who have survived natural disasters, the ravages of war, genocide, military attack, and so forth. Sociotherapy has made its greatest and most important interventions in settings where communities on mass have been traumatized by natural disasters, war, genocide, colonialism, political turmoil, economic collapse, and pandemics. For example, Richters, Dekker, and Scholte (2008) discuss sociotherapeutic work in the aftermath of the genocide in Rwanda. They explain that the focus is on enabling people to

> regain self-respect, rebuild trust, feel safe again, overcome unjustified self-blame, re-establish a moral equilibrium, have hope, live without terror, forgive those who have harmed them, apologize to those whom they have wronged, and regain their rightful place in the community. (Richters, Dekker, and Scholte 2008)

Despite the history and international uses of sociotherapy, few North Americans are familiar with the clinical designation. M. Kubilay Akman of Uşak Üniversitesi in Turkey explains how the "individualistic discursive perspective [of most psychotherapies] has blocked the improvement of

sociotherapy until the 21st Century, although it has a history and background for decades" (Akman 2016). As a result, people are more familiar with psychotherapy than sociotherapy in the contemporary context. Yet, sociotherapy continues to be an internationally recognized therapeutic practice. See, for example, research on sociotherapy done in north Rwanda post-genocide (Richters, Dekker, and Scholte 2008), in the treatment of trauma and state-terrorism (Aron 1992), in the German mental health care system (Puschner, Kunze, and Becker 2006),[7] and by Franz Fanon (1952) where he applies "socio-therapeutic analysis to his examination of the colonial situation" (Parris 2011). It follows that sociotherapy has regional and international definitions and diverse geo-political applications.[8]

Although sociotherapy, like the discipline of sociology grounding the clinical practice, has its own slate of conservative and normalizing frames of reference, as I will discuss in what follows, critical and progressive approaches to sociotherapy are urgently needed. The World Health Organization (WHO) declared an international pandemic at the time of writing this paper and, like all socially conscious practitioners, I am acutely aware of the way the public health emergency effects my clients. People are struggling with unprecedented levels of anxiety, stress, and depression due to job-loss, lack of access to safe and affordable housing, attempts to combine paid work and childcare, fear of viral transmission, physical distancing protocols, isolation, lack of personal protective equipment, the dissolution of vibrant public communities, and so on. Domestic abuse, suicide rates, divorce, struggles with addictions, and opioid overdose are all escalating. The sociological dimensions of human suffering cannot be in doubt. Despite what may seem obvious during a pandemic, few people give serious thought to how and why sociology and psychology have come to be separate disciplines and with divergent clinical orientations.

Sociotherapeutic Paradigms: Functionalism, Socialization Theory, and Psychoanalysis

Sociotherapies are shaped by three theoretical and paradigmatic currents in the discipline of sociology. Most sociological writing on sociotherapy has been informed by (1) functionalist and systems-based approaches, (2) socialization theories targeting dysfunctional behavior through reform-oriented community and interactionist interventions, and (3) psychoanalytic sociology. Given my own psychosocial orientation, I see limitations to sociotherapies shaped by structural-functionalism and socialization theories, many of which do not attend to questions of power, culture, capital, neo-liberalism, and so on. I am guided by sociotherapeutic work that engages psychoanalysis, intersectional studies, critical race theory, feminism, and other progressive fields in the discipline of sociology. I provide a sketch of the three approaches to illustrate how my own clinical orientation departs from functionalist and social role learning theories.

In the functionalist approach, focus is placed on the relevance and utility of sociological knowledge (Akman 2016). Alex Swan, of Texas Southern University, published an often-cited book titled *The Practice of Clinical Sociology and Sociotherapy* in 1986. In this book, he develops an approach he calls Grounded-Encounter Therapy (GET). See also Swan (1985) for a good example of the functional and systems-based approach to sociotherapy. Swan wants sociology to be used by sociologists to solve real-world problems. Although I agree with Swan's (1985) contention that sociological knowledge is of great relevance to therapy, group therapy in particular, and that the psychological focus on the individual separable from societal context is untenable, I do not support the diagnostic and prescriptive model he develops under the auspices of GET. My concern is that sociologists, like all disciplinary "experts," do not always know best. It is up to the client to decide what is useful and relevant to their own experience. Whenever an "expert" assesses a problem independent of the client's own subjective experience and interpersonal needs, and prescribes courses of action with recourse to adaptation and conformity, the depth and potentiality of the socioanalytic dialogue is foreclosed.

Like Bain (1936) before him, Swan's orientation is primarily functionalist. He advocates for community integration, adaptation, and pro-social belief systems. As the current COVID-19 pandemic illustrates, there is value in cultivating functional systems and pro-social values. We must depend on institutions to ensure access to health care, food supply chains, shelter, and so on. But the values Bain and Swan endorse are white, Christian, patriarchal, capitalist and, seemingly, without attention to history, community, cultural, religious, and individual differences. Bain's (1936:214) functionalist approach to sociotherapy is more obviously worrisome from a social justice standpoint. Let us, for instance, consider the 4-point sociological plan for intervention into societal pathologies Bain refers to as "societal surgery." In Bain's plan sociotherapy/socioanalysis would involve forced rationalization as the "price we pay for . . . pseudo-sanity" (Bain 1936:214); the reinterpretation of a patient's "societal life to him" (Bain 1936:214); and the removal of individuals from "psychotic groups" like, for instance, "gangs, homosexual colonies, bizarre cults, and so on" (1936:214). Although I cannot do justice to the harm Bain's version of applied sociology would bring about to the populations subject to what he calls societal surgery, I hope we can agree that his functionalist approach is saturated by an anti-social morality at odds with social justice regardless of the historical context he was writing in.

The second sociotherapeutic approach is shaped by socialization theory. Like the functionalist and systems-based approach, it lacks critical attention to questions of history, culture, class, race, gender, sexuality, capital, and the state broadly defined. Rand L. Kannenberg (2003) equates sociotherapy with what he calls "resocialization." Dysfunctional behaviors and maladaptive social roles are replaced with more functional behaviors through social role modeling. In this modality, the sociotherapist becomes the teacher, the one who orchestrates more productive resocialization activities. "Sociotherapists take an active role, redesign and direct social environments for therapeutic purposes" (Akman 2016:14). Sociotherapists, like J. Stuart Whiteley (1986), emphasize behavioral change and enhanced interpersonal coping in social context. The problem with the resocialization approach is that it does not take questions of power and unconscious processes into account. We may try to punish "dysfunctional" behaviors like, for example, racism, sexism, and homophobia, and reward "functional" behaviors like, for example, equity and social justice initiatives, but psychoanalytic sociologists know that "re-socialization" does not work. The "problem" behavior is psychosocially rooted and must thus engage the societal and individual realities of aggression and, very often, unmetabolized histories of abuse, neglect, and poverty. The psychic investment in aggression and its vicissitudes in the social arena must be interpreted psychosociologically if the underlying structure at the individual and societal level is to be abated.

The third sociotherapeutic approach is psychosocial and attentive to unconscious processes. In my view, it has great sociotherapeutic promise. The underlying ideas were clinically evaluated by the sociologist and psychotherapist Estelle Disch at Boston State College. As early as 1979, Disch was developing a feminist and critical interdisciplinary approach to therapy informed by what we may now call psychosocial studies or psychoanalytic sociology. Although I do not believe Disch classified herself as a sociotherapist she did, as a sociologist, distinguish her clinical practice from both the functionalist and social-learning theories dominating the field by adopting psychoanalytic ideas. Disch's early work focused on the problem of normativity in ways that do justice to the Foucauldian critique of power, diagnosis, and case management in the "psych" professions. Unlike the abovementioned focus on integration and community conformity to pre-existing norms, Disch (1979:18) wrote that because "conceptions of normal behavior usually limit the expression of human feeling and behavior, the therapy process often involves challenging the norms which have been taught, particularly if they do not feel 'right' for various individuals." Her focus is on alleviating feelings of depression in women who chose not to marry by helping "them to feel less 'crazy' and to . . . assert what they really want for themselves (which usually includes building career plans which they have been encouraged *not* to do since

adolescence)" (Disch 1979:18, emphasis in original). In other words, Disch understood the effects of sexism and heteronormativity on the emotional lives of unmarried women. (She also recognized the effects of hegemonic masculine gender norms on men and the damaging effects of homophobia men are subject to when they depart from these norms. In addition, Disch questioned the societal pressure to consume alcohol and wrote about the effects of addiction on mental health.[9])

Although The Association for Psychosocial Studies was not formed until 2013, Disch's pioneering work should be recognized as central and foundational to the field in the American context. Psychosocial studies invite us to question the disciplinary divisions between sociology and psychoanalysis in precisely the ways Disch did. Although some sociologists have argued that Sigmund Freud (the founder of the talking cure) did not have a theory of the social at all, "only the individual writ large" (Frosh 2010:67), a close reading of his work suggests otherwise. The field of psychoanalytic sociology is, in fact, shaped by an interrelationship between the two disciplines. It could be argued that Freud ([1907] 1959) not only invented psychoanalysis but was a sociologist in disguise. His writings on *Obsessive Actions and Religious Practices* (Freud [1907] 1959), *Civilized Sexual Morality and Modern Nervous Illness* (Freud [1908] 2014), *Totem and Taboo* (Freud 1913), *Group Psychology and the Analysis of the Ego* (Freud 1921), *The Future of an Illusion* (Freud 1927), and *Civilization and its Discontents* (Sigmund 1930) are all commentaries on the interrelationship between neurosis, morality, and modernity. Let us also recall that Freud wrote, "For sociology too, dealing as it does with the behavior of people in society, cannot be anything but applied psychology" (Taft 1933:179). As contemporary social psychologist Donald Carveth (1984) notes, there has always been a social or object-relational component to psychoanalysis and it cannot be otherwise.[10]

Despite the relationship between the social and psychological, sociologists as a group have been uninterested in questions of internality, let alone psychoanalysis.[11] Harold Garfinkel (1963:190) made this clear when he wrote that "there is no reason to look under the skull since nothing of interest is to be found there but brains." But it is not only sociologists who take distance from psychoanalysis, many clinicians—psychologists and psychoanalysts alike—take distance from sociology. While some psychologists and psychoanalysts adopt social constructionist frameworks to understand their patients (Bass 2007; Bauknight and Appelbaum 1997; McLaughlin 1983; Spruiell 1983), this is certainly not the majority. Nancy Chodorow (2014:136), a sociologist and psychoanalyst herself, laments that too often psychoanalysts "operate as if the social sciences [did] not exist." She also writes that many psychoanalytic clinicians "do not notice that the clinical consulting room is always partly a psychodynamically inflected instantiation of society, culture, and politics, as is the transference-countertransference field" (Chodorow 2014:134).

The psychological and the sociological, the psychic, and the social are inseparable. Like a mobius strip, they cannot be separated and must be interpreted as a unit or assemblage. From a psychosociologically informed intersubjective perspective, one of the "goals of analysis is to help the analysand discover the extent to which he [she or they] is trapped in social and cultural systems" (Movahedi 2014:147). Although more classically trained psychoanalysts might resist the idea that the sociological should play a part in analytic work, it is, in fact, not a stretch to equate the "social and cultural systems" of concern to sociotherapists with the Lacanian notion of the Symbolic (inclusive of language, signs, and symbols). The Lacanian subject is shaped by the desire of the Other (m/Other) and by the Symbolic which is not distinguishable from the social. The late Parisian psychoanalyst who advocates a return to Freud was highly critical of ego-psychology. Today, many relational psychoanalysts concentrate on what sociologists like Siamak Movahedi (2014:149) refer to as the "sociocultural position that structures the person's desires and relationships to self and the other."

Sociotherapy and Psychotherapy

The disciplinary split between sociology and psychology provides an important context for the way psychotherapy has been defined by the CRPO as applied psychology, as opposed to applied sociology or social work. It is noteworthy that the original draft of the Psychotherapy Act did not include Ontario's social workers and social service workers. (The Ontario College of Social Workers and Social Service Workers [OCSWSSW] had to petition the province to have their members included in the legislation. Registered members of the OCSWSSW can now perform the controlled act of psychotherapy as defined by the CRPO.) The CRPO requires its registrants to interpret their clinical work in medical and psycho-psychiatric terms. Under the RHPA (1991) the controlled act of psychotherapy is defined as "Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning." The individual is, in this definition, diagnosed and said to be impaired. There is no recognition of the sociological context in which such an assessment is made.

Despite an exhaustive list of therapies now incorporated under the legal title psychotherapy, sociotherapy and socioanalysis do not appear on the CRPO Web site as therapies, let alone psychotherapies. This is not surprising given the way psychotherapy is understood to be distinct from clinical and applied sociology. I must stress that I see value and promise in progressive approaches to psychology and psychiatry. My concern is with respect to the way the College and provincial legislation eclipses sociologically informed clinical knowledge developed by generations of feminist, LGBTQ, anti-racist, and trauma-informed therapists (many of whom are no longer able to call themselves psychotherapists under the provincial legislation). Clinical expertise specific to these sociologically informed practitioners has been overwritten by the dominant discourses of psychology and psychiatry, neither of which pay sufficient attention to sociology, let alone social context. There are brilliant psychologists and psychiatrists in Ontario, some of whom recognize the societal etymologies of human suffering. My intention is not to cast psych-oriented therapists in a disparaging light. My point is that if there is to be something unique and important about psychotherapy, as a clinical practice deserving of recognition, the wisdom of its sociologically oriented practitioners must not be replaced by the already established approaches to treatment relevant to psychology and psychiatry.

It is a mistake to reduce human suffering to individual "disorders" distinct from modern societal configurations. It is worrisome that sociology, a discipline devoted to the study of modern life—including, but not limited to, advanced capitalist formations, liberal democracy, law, state policy, health care, bureaucracy, technology, labor, housing, poverty, addictions, urbanization, policing, incarceration, settler-colonialism, racialization, gender, sexuality, and so on, should be marginal to psychotherapeutic practices intended to treat people who suffer in uniquely modern ways. It is my contention that the professional divide between the social and the psychological is not only anti-intellectual but clinically untenable, particularly in the time of COVID-19. By separating psychology from sociology in, for example, the controlled act of psychotherapy we mitigate against the best interests of clients and set up a false binary between the individual and society. Worse still, we deliver the message to our clients that their struggles with mental and emotional health are personal failings, as opposed to ways of coping with adverse societal configurations. Anti-black racism and the escalating Sinophobia specific to the COVID-19 viral moment, for instance, not only exacerbate chronic conditions relating to anxiety, depression, post-traumatic stress, and so on, but can cause such conditions. Having said this, I want to be clear that one's experiences, trials and tribulations, dreams, and disappointments are intricately related to, but not determined by, social circumstances. Sociotherapy is not about social determinism (or consciousness raising). Nor is it about externalization (a defense mechanism whereby

an individual blames other people and "external" situations for their life circumstances). Everyone has some degree of agency, even in dire circumstances. We make our own histories, as Karl Marx (2008) wrote, but not as we please, we "do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted from the past."

The controlled act of psychotherapy is, unfortunately, focused on the internal life of the client without due attention to the social as point of reference and context. I am unconvinced that the individual and the social (the inner and the outer) are clearly separable domains. But even if we do abide by a distinction between the individual and the social what if the so-called "disorder" identified by the psychotherapist is not an "impairment" but, rather, a strategy enabling the client to cope with a situation that impairs their "judgement, insight, behaviour, communication or social functioning"? In other words, the client may be struggling to deal with a life situation that is untenable. Moreover, the same symptom configuration can be experienced as an impairment for one client and as a solution by another. Let us ask for whom something is a serious disorder and impairment: the client, the psychotherapist, or the CRPO? If, for example, black, indigenous and people of color (BIPOC) are more likely to be diagnosed as having anger management issues, as being resistant to authority, unable to adjust themselves to law and order might it be because they are disproportionately policed and incarcerated? Anger, civil disobedience, and public protest are, from a social justice perspective, rational responses to irrational life situations. Ways of coping with reality are sometimes diagnosed as pathologies whereas they may, in sociological terms, be understood as strategies of survival and catalysts for social change.

Psychotherapists who have undergone psychological training often encourage their clients to acquiesce, adapt, and adjust themselves to difficult life circumstances. Some degree of suffering and accommodation is part of the human experience, but sociologists know that suffering is complicated and made worse by prejudice, discrimination, and institutional barriers to life necessities. Sociotherapists are less likely than psychologists to focus on individual accommodation and adjustment to untenable life conditions. Although most psychologists, like sociotherapists, would support their clients in leaving abusive relationships, for example, they are less likely to understand the interdependence of the personal and the political, the psychic, and the societal in life situations that are damaging but rendered normal (or typical) like, for instance, escalating workloads, lack of affordable childcare, gender-based discrimination, and so on. Too much accommodation, adjustment, and submission to institutional structures can, over time, cause depression, anxiety, burn-out, and so on. While classical approaches to psychotherapy might focus upon strengthening a client's ego-defenses (to cope with reality as it is), sociotherapists are attune to the societal conditions that deplete subjective defenses. A client dealing with the deleterious effects of anti-black racism or Sinophobia during the present-day pandemic, for instance, may want to talk about identity, race, and racialization more so than family history. Therapy can involve identifying, working-through, and organizing against non-familial micro-aggressions, abuse, discrimination, war, poverty, and oppressive state systems; much of which goes unnoticed by white privileged majority groups with professional designations.

Psychologists, like psychoanalysts, have developed important insight into the formative role of the family in shaping individual experience. But where many psychotherapists trained in psychology go astray, from a sociological point of view, is with a lack of attention paid to the non-familial institutions impacting mental health. The family is not the only institution that shapes and impinges upon the life of the client. It is, of course, a key institution for the developing child and the quality of care and kinship relations central to the family have enormous impact on adult life. Psychotherapists are right to focus on early familial dynamics, childhood development, the quality of parental care, and so on. But the family does not exist independent of society and is, in fact, shaped by societal conditions. No matter how nurturing and supportive the family situation may have been it will not annul the effects of neo-liberalism, a capitalist free-market economic system that values profit over people. The quality of parental care a child receives is mediated by

economics, history, geography, citizenship, culture, class, gender, and a host of other societal factors.

Like clinical sociologists, many CRPO-registered psychotherapists work with vulnerable populations. But they are not required to have the training needed to understand the societal conditions that make these populations disproportionately vulnerable. Sociologists well versed in intersectional studies (Crenshaw 1990), institutionalization and Foucauldian theory, are highly critical of what counts as normal and the way socially disenfranchised peoples are rendered abnormal. People of minority groups are more likely to be incarcerated, given psychiatric diagnosis, medicated, sterilized, thought to be diseased, mentally and emotionally impoverished, and so on, than privileged majority groups. It should not be surprising that many clients seek out therapists who are not white, male, Christian, heterosexual, and/or able-bodied because they do not want their struggles with racialization, sexism, religious intolerance, homophobia, ableism, and so on, to be dismissed as superfluous.

While there are psychotherapists (and psychologists) who take societal inequalities seriously, sociology is marginal to psychotherapy training curriculums regulated by the CRPO and approved by the province. When psychotherapy courses do cover the societal experiences of diverse communities they are usually relegated to "special topics" marginal to the curriculum. Psychotherapists who incorporate sociological knowledge into their practice often have educational and clinical backgrounds in sociology, feminist, anti-racist, and/or trauma-informed counseling practices of no consequence or relevance to the CRPO's requirements for registration. Others have educated themselves about social injustice and affiliate themselves with feminist, LGBTQ, anti-racist, anti-poverty, prison abolitionist and migrant rights movements, associations, and related community organizations. None of these are central to the CRPO's entry to practice competencies.

This engagement with community organizing and critical sociology is at odds with the focus on psychological normality, diagnosis, and impairment enforced by the CRPO. Many psychotherapists with sociological training and community-oriented clinical experience now have to frame their clinical work in terms of normality and deviance. The discipline of psychology and, to a lesser extent, psychiatry informs the discourse and regulatory structures of the province. Psychologists are often required to assess their clients in relation to statistical norms. Psychological approaches to treatment uninformed by social psychology or sociology tend to view psychological normality and abnormality as psycho-neurological givens or, at least, biological predispositions.[12] It is rare to meet a psychologist well versed in the Foucauldian critique of the normalizing society or in how the psychiatric measures upon which they base their diagnosis are historical inventions (systems of thought particular to the modern era) (Hacking 2006b). It is difficult for sociologically informed clinicians to frame the work they do with clients in the psych-informed discourses of normality and abnormality, diagnosis, and deviance because their psychosocial orientation is dialectical (involving the individual and the social together). Just like psychotherapists are taught to challenge "black and white" thinking (cognitive distortions) in their clients, the critically informed sociotherapist will challenge the diagnostic approaches to human psychology camouflaging the nuances and vicissitudes of human experience. In addition, sociologically informed therapists, like myself, are more open to the way therapy can be about life exploration and discovery as opposed to treatment for a disorder or impairment.

Sociotherapists, community activists, and psychotherapists who consider the social etymologies of suffering are more likely to view statistical norms as societal constructions that change over time. More significantly, however, they understand how norms can be operationalized in harmful ways. The psych-clinic is no exception. Norms mirror the views of white privileged majority groups. As critical sociologists have noted (Pickersgill 2014), the diagnosis listed in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA] 2013) is, by no means, based on consensus. Foucauldian-inspired sociologists view norms against which psychological functioning is measured as instruments of governmentality, psychiatric power,

and as central to bio-politics (power over life). From a Foucauldian perspective, psychological diagnosis and assessment based on statistical norms, treatment, and evaluation are technologies of power at odds with the public good. Clients are not helped by enforced normalization. Certainly, psychiatric survivor movements organize against involuntary institutionalization and normalization (Adame and Knudson 2007). But one need not be Foucauldian or a psychiatric survivor to recognize that pharmaceutical companies, insurance agencies, hospitals (which are chronically underfunded), and so on are not neutral with respect to the question of normality, medico-psychiatric diagnosis, pharmaceuticals, and profit.

From a critical sociological perspective, normality is a societal problem to be analyzed (not enforced). Norms are based on the assimilation and reduction of human experience to statistics. Statistics are thought to be objective because they discount external (intervening) variables like society. Subjective experience is reduced to an objective numerical measure in the tradition of positivism, a methodology that has been subject to extensive critique in the neo-Foucauldian and psychological literature (Hacking 2006a, 2006b; McDonald and O'Callaghan 2008). As a Foucauldian-inspired clinical sociologist, I have significant concerns about the way the controlled act of psychotherapy functions as an instantiation of a legal-professional norm in Ontario. It encourages psychotherapists to negate the social and what may, ultimately, be in the best interests of clients. What the client has to say about their life experience becomes an indicator or measure of normality in the "best practice" protocols of the College, not an articulation of psychosocial experience to be heard and explored on its own terms. People want to explore foundational questions about life, what it means to be happy, to grieve, to love, to forgive, to take responsibility, and to survive and heal.

My concern is that the application of a norm under the auspices of psychotherapy can exacerbate the conditions of suffering leading people to psychotherapy to begin with. Social workers have recognized this in their own clinical work (Foote and Frank 1999). While we may cling to normative points of reference in times of crisis, we must recognize that normality has a history (Cryle and Stephens 2017) and is not a remedy. Societal norms impede individual creativity, negate viable life choices, foreclose upon individual differences and, ultimately, produce homogeneity in the name of mental health and well-being. Effective psychotherapy is not only impeded when the therapist is focused on normativity, but harm can result. Consider the paradigm-shifting work of sociologists like Judy Singer (2017) who theorizes neurodiversity. She helps us to understand that without respect for difference and neurodiversity we are in danger of "diagnosing difference" as Annalise Ophelian et al., (2009) showcases, in her award-winning documentary film by the same name ("Diagnosing Difference"), about the way gender variance is subject to medical and psychiatric diagnosis. Much therapeutic harm has been done in the name of psychological normality. I would also reference the devastating practice of "reparative" or "corrective" therapy targeting gender variant children in my province that is alleged to have occurred in the Gender Identity Clinic for Children at the Centre for Addiction and Mental Health (CAMH) under the supervision of Kenneth J. Zucker (Ashley 2019; Pyne 2014, 2015; Tosh 2011).

My sociotherapeutic approach is based on the principle that the "presenting issue" in therapy is not always a shortcoming or "problem" within the individual (as client): the problem may, at least in part, come from without. I believe that what are called "disorders" in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), a publication of the American Psychiatric Association, are, in fact, interpersonal differences, necessary accommodations, life choices, personality structures, and psychological orientations that need to be respected and interpreted in psychosocial context. I do not believe the goal of psychotherapy, or any therapy, should involve a neo-liberal rush to fix the client, to indoctrinate a more efficient and less symptomatic mind-set. In my practice, I replace normative diagnostics with thoughtful dialogue, ethical and critical contemplation and care.

Conclusion

As generations of scholars and clinicians have noted, the human condition is a complex psychosocial choreography calling for interdisciplinary specialization. Clinical sociotherapists have as much to offer therapeutic practice as do Ontario's registered psychotherapists (RPs). CRPO registrants, who, like me, oppose normalization, the focus on the individual separable from society, the hegemony of psychological diagnoses and treatment, the over-reliance on cognitive-behavioral therapies (CBT) and dialectical behavioral therapies (DBT),[13] and so on, will dwindle in numbers because we are not supported by the College. Moreover, we are in danger of violating "best practice" as defined by the CRPO and finding ourselves before a College disciplinary committee. The singular focus on psychological approaches to psychotherapy mitigates against the development of interdisciplinary, alternative, and non-diagnostic approaches to therapy. By adopting a single disciplinary approach to psychotherapeutic practice, the province is negating a wealth of clinical sociological insight, theory, and practice in Ontario and across the globe. Psychodynamic and socioanalytic synergies will be lost. What is, ultimately, in the best interests of clients and the public in the COVID-19 viral moment is a rich therapeutic eco-system where the social and the psychological can co-mingle.

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Notes

1. For a discussion of state regulation and therapeutic practice internationally, see *Psychoanalytic Practice and State Regulation* (eds.) Ian Parker and Simona Revelli. Routledge: 2018.
2. Psychosocial studies is a field that was developed in the early 1990s. The psychosocial scholarship coming out of Birkbeck, University of London and the University of Essex is exemplary. As defined by the Association for Psychosocial Studies, the field explores the interrelationship between psychical experience, unconscious sexuality, and society. Stephen Frosh (2010:196) explains that the "origins of this mode of psychosocial studies lie in psychoanalysis, sociology, applied social studies and social work, critical social psychology, postructuralist theory, social constructionism, queer theory and feminist social research."
3. Psychoanalysis is predicated upon a belief in the unconscious whereas psychology is more often focused on cognitive and behavioral treatment models.
4. I use psychoanalytic sociology and psychosocial studies interchangeably in this paper although distinctions between the two are made in the scholarly literature. Psychoanalytic sociology is a designation often used by sociologists who incorporate psychoanalytic theory into their research while psychosocial studies is a more contemporary designation for interdisciplinary social science scholarship informed by a wide range of psychoanalytic theories.
5. Rustin and Armstrong (2019:479) describe the Tavistock zeitgeist as "radical and anti-establishment in spirit," but this claim has been contested. Donzelot (1979), Miller and Rose (1988), and Rose (1989) contend that the Tavistock group was less radical and more regulatory, serving a governmental function in Foucauldian terms. Rather than seeing the Tavistock as leftist and progressive in the way that Rustin (2003) does, the neo-Foucauldian scholars view it as more consistent with the normalizing project of psychiatric power.
6. The Sociotherapy Association in the United States stresses the importance of interpersonal relationships, community integration, and the environment in understanding human suffering.
7. In Germany, sociotherapy involves attention to labor and social components of care.

8. Rand L. Kannenberg (2003), for example, studies sociological counseling and the community supports offered to those on parole and probation with addictions. In Sarasota Florida, the Kanner Academy and Community Schools uses sociotherapy to support and educate high-risk youth (Lee 2004).
9. There is more to be written about the marginalization of psychoanalytically informed sociotherapies, and the female sociologists who advocated for them, but suffice to say here that Disch had predecessors. Jessie Taft (1882–1960) (Deegan 1986), for example, graduated with a doctorate in philosophy from the University of Chicago under the supervision of George Herbert Mead. She went on to make significant contributions to feminism and to the development of a psychodynamic approach to case work and to child adoption in particular. In *The Dynamics of Therapy in a Controlled Relationship*, Taft (1933) wrote an important critique of psychoanalysis and simultaneous application of psychoanalytic ideas to the socially responsible clinical situation.
10. The sociological theories of Talcott Parsons are a good example of the way early American sociologists used and interpreted Freudian ideas. Erich Fromm of the Frankfurt School also used Freudian theorizations to develop his postwar critical theories. "In the 1950s, many sociologists in departments such as Chicago, Harvard and Columbia were being analyzed, and some, such as Smelser, Parsons, Inkeles, and Lindsey, also received psychoanalytic training" (Silver 2014:68). There are too many sociologists who have undergone a psychoanalysis and have, in fact, become psychoanalysts themselves to dismiss the associative, albeit strained, relationship between the disciplinary fields.
11. Sociologists are more likely to engage psychology than psychoanalysis in their work. The field of social psychology is a good example of the engagement with psychology as opposed to Freudian psychoanalysis (or more contemporary psychoanalytic theory) in the discipline.
12. I will concede that sociologists critical of biological determinism and essentialism often fail to account for elements of human experience that are irreducible to society. I agree that there are biological, neurological, hormonal, sensory, developmental, and cognitive differences between people. But the way we understand and interpret these differences is mediated by culturally specific ideas about normality and deviance.
13. While I acknowledge a place for cognitive and behavioral therapies along with the many progressive therapists who use cognitive behavioral therapies (CBT) and dialectical behavioral therapies (DBT), these approaches should not be valued above socioanalytic approaches to therapy (Dalal 2018).

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