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Research Advances: Work-Related Suffering as Social Suffering

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In recent decades, significant changes have occurred in the world of employment. The notable expansion of service occupations, the growing impact of information technology, digitalization, and automation, and the profound impact of economic globalization are increasingly challenging traditional structures and opportunities for work and labour. With the advent of economic globalization, free market principles and technological innovations have spread around the world, resulting in large flows of transnational capital, trade, and labour forces (Siegrist & Li 2018). Given growing competition and the pressure for sizeable returns on investment, a general intensification of work is observable, as is an increase in flexible forms of employment (Eurofund 2015). Major transformations of the social and economic context are accompanied by significant changes in work organization methods. The generalization of individualized and quantitative performance evaluation procedures like benchmarking (Bruno & Didier 2013), total quality management, lean management, and performance-based contracts has spread to most professional sectors (Siegrist & Wahrendorf 2016). Most studies show that these changes significantly alter the relationship of individuals to their work (Thébaud-Mony, Davezies, Vogel, & Volkoff 2015).

These transformations have an impact on the mental health of workers, which is threatened by distinctly stressful psychosocial work environments (Schnall, Dobson, & Landsbergis 2016). In a recent publication, Dejours, Deranty, Renault, and Smith (2018) map out the main work-related worries of modern societies as follows: unemployment, precariousness or insecurity in relation to work, heavy work demands that can lead to burnout, various forms of disrespect shown at work, and unfulfilling or meaningless work. The economic crisis associated with the COVID-19 pandemic will likely increase the depth and breadth of precarious and highly demanding work. It is not merely that work can influence the onset of mental health problems; the conditions of work make it difficult to behave in a health-conscious manner and be aware of health impairments and signs of illness in a timely and appropriate fashion. Even diseases that have their "cause" in the private sphere or a person's life story can manifest themselves at work, so their "treatability" is also influenced by the conditions of work (Voswinkel 2019). The blurring of boundaries between work and life, which has long been discussed in the sociology of work, has been exacerbated by the COVID-19 pandemic. Working from home is the new normal for many people, and there is already evidence that it comes with new psychological stress. There is evidence, at least in Germany, that this stress is heavily influenced by gender and social status (KKH 2020). The gender care gap is aggravated by these new requirements, which means that many women carry the weight of a double load at home (Allmendinger 2020). On the other hand, the ability to work from home is connected to level qualifications: Highly qualified employees are more likely to work from home than workers in fields that lack this option (Möhring et al. 2020). The increase in suffering at work has resulted in new clinical conditions like burnout, which was recently added to the International Classification of Diseases (ICD-11) under QD85 (WHO 2018; Maslach & Jackson 1981; Maslach, Schaufeli, & Leiter 2001), mobbing (Leymann 1993), and workplace suicides (Waters 2017).

Thus, suffering at work, which was once considered a strictly private matter, has gradually become a public issue. The evolution of the public debate on work-related suffering and the adoption of related legal provisions have altered the social context and favoured the development of new practices. In Germany, a few specialized therapists now offer psychotherapeutic consultations

in the workplace (Barrech et al. 2018), and a variety of private institutions offer services with a special focus on work-related suffering. This, again, is related to the broad expansion of the burnout concept in the public debate in Germany and to research in general (Heinemann & Heinemann 2015; Maslach et al. 2001). The urgency of this problem has led to increased social demands, particularly in terms of care. The growing public sensibility regarding this issue goes hand in hand with an increase in treatment and a rising demand for psychotherapy, whether inpatient or outpatient (Strauß 2015; Olfson et al. 2002; Dornes 2015). In Germany, the established institution to treat work-related suffering, such as affective disorders like depression, anxiety, and somatoform disorders is a psychosomatic (Herzog, Beutel, & Kruse 2013: 66) rather than a psychiatric hospital, with costs covered either by health insurance or pension insurance. How is the issue of work addressed within the scope of psychotherapeutic treatment in psychosomatic hospitals?

Studies that focus on the return to work have shown that the less effectively the issue of work is addressed during the clinical treatment, the less likely it is that the patient's return to work will be successful (De Vries et al. 2017; Weikert, Fishta, & Wegewitz 2017). Moreover, although a real "anti-suffering market" (Dujarier 2009) has been created – mainly in the entrepreneurial sector – the creation of alternative mechanisms to prevent this new suffering does not appear to have spread to public mental health institutions. As a starting point for this project, we identify a gap between the public and scientific discourses on work-related suffering that also informs and influences both patients and their subjective theories of illness and the health professionals who work in a given professional arena. Given the circumstances and the attention that suffering from work has received over the last decade, this needs explanation. To what subjective or collective theories of work-related suffering do mental health professionals refer?

Previous work shows that work as an important dimension within treatment is often neglected and can even disappear in the course of professional appropriation and translation into the psychotherapeutic patterns of interpretation. Moreover, the therapeutic practice as a practice of *translation* is individualizing and privatizes the patient's work-related suffering. Lastly, the way that work is addressed in the course of the treatment is heavily biased; gendered ideas about "normal" work and heteronormative patterns of interpretations guide the way therapists look at the working conditions of their patients, as do assumptions of the patient's social class background. Moreover, ideas and knowledge – or rather the lack of knowledge – about different occupational fields are shaping the concepts of work and the very idea of what is considered "work" at all (Flick 2016, 2017, 2018b, 2019a, 2019b, 2020). What has yet to be analysed is precisely how this turning away from the issue of work and the ways that suffering is attributed to gender, class, and occupation are taking place. How does the psychotherapeutic process turn out to be so individualizing in practice? What roles do the different therapeutic paradigms play in this phenomenon, and what differences, if any, do we find among the various professional groups? Are there differences when it comes to psychotherapeutic institutions, and can we identify collective treatment ideologies in those?

The project addresses these questions within a qualitative empirical research frame. We focus on health professionals as members of the institution's multi-professional teams and on their theories of work. Answering these questions offers enormous potential (in both theoretical terms and for the diagnosis of current suffering at work treatment) for understanding the current therapeutic logics of the treatment of people suffering from and at work. The general aim of our research is to examine theories of practice of psychotherapeutic teams with regard to work in order to develop a typology of psychotherapeutic concepts of work. We locate the project in four areas that are outlined below and upon which our hypotheses are built.

A. Psychotherapeutic treatment ideologies as professional translation

A sociological understanding of psychotherapeutic treatment is crucial for our main research interest. Sociological theories of the profession consider psychotherapy to have primarily a specific jurisdictional claim and its own particular interests, but they fail to differentiate the various therapeutic paradigms (Foucault 1965; Abbott 1988). Following Strauss et al. (1964), we regard psychotherapy professions as sharing a specific *treatment ideology*, which is understood as a set of beliefs and ideas that professionals hold about the possible causes and aetiology of their patients' mental illnesses. This ideology also includes the principles behind the role of patients and psychotherapists and ideas about the efficacy of the interventions and treatments applied (Scheid 1994). While therapy offers space for various models of subjectivity, it typically favours those that emphasize increased reflexivity and self-orientation (Schützeichel 2010: 138). At least at the beginning of treatment, as Freidson argues (1986), the clinician applies the profession's official knowledge to an individual case. There are, of course, standardized manuals for diagnosis. The single case, however, always establishes the epistemic foundation for psychotherapy. The interpretative process in which the psychotherapist engages to create the case can also be described as a practice of professional appropriation: psychotherapists produce a description of suffering that legitimizes psychotherapeutic treatment.

In her preliminary work, Sabine Flick developed the understanding of psychotherapy as *translation* and *othering*, publishing two papers on her insights (Flick 2018a, 2019b). Psychotherapy in this view could also be described as a process of translation, as Callon (1984) argues for in a different context. Rather than a translation in the service of intelligibility, the psychotherapeutic translation is an active attempt to bring suffering into the purview of the profession (Callon 1984). Kleinman describes this process as the transformation of the patient's illness narrative into the professionals' concept of disease (1989), which inevitably entails a conversion of formal knowledge into working knowledge (Freidson 1986). This transformation of knowledge and the process of appropriation imply another dimension: the "othering" of the patient and what Strong and Zeman (2007) call the "selving" of the therapist. It is a process that identifies those who are thought to be different from oneself or what is considered mainstream and can reinforce and reproduce positions of domination and subordination (Johnson et al. 2004; Spivak 1985). In the context of medical records, however, othering is the therapists' "operation of making things intelligible to the reader" (Brown, Nolan, Crawford, & Lewis 1996: 1573) and thus deflecting attention away from themselves by simultaneously legitimizing their professional role in the treatment. Furthermore, in therapeutic conversations, othering and selving describe the process of referring to the therapist's "normal self" as distinguished from the patient, the "pathological other." Those descriptions are not yet developed with a focus on working conditions. The hypothesis resulting from this area is that the professional appropriation of the case always includes a specific process of translation. How are processes of translation and othering to be described in the case of work? Can we identify a specific treatment ideology? What notions of work and work-related suffering are "translated" at all? What is considered "work" and what factors shape the translation? We assume, based on the state of the art and Sabine Flick's preliminary research, that the therapeutic paradigm, the institution, the patient's background (gender, status, and occupation), and the various professions that participate in the treatment have an immense effect on the process of translating and othering.

B. Institutions of psychotherapeutic treatment in psychosomatic hospitals in Germany

Mental health care in Germany is mainly offered through either outpatient or inpatient treatment. For the latter, four variants of clinics exist: hospitals for psychiatry and psychotherapy, hospitals for

psychosomatic medicine and psychotherapy, general hospitals with appropriate specialist departments, and psychosomatic rehabilitation clinics. In contrast to most countries, Germany has an established tradition of psychosomatics as an independent speciality (Strauß 2015). Since its beginnings, psychosomatics in Germany has always tried to set itself apart from psychiatry. Psychosomatics claims jurisdiction over somatopsychic disorders and psychosomatic illnesses, which imply disorders with organic symptoms caused by psychosocial factors (Alexander 1950; Zipfel, Herzog, Kruse, & Henningsen 2016). Indication for inpatient psychosomatic treatment is provided if outpatient treatment is not yet or no longer possible. Today, inpatient treatment is considered to a complex treatment in the catalogue of medical procedures of the diagnosis-related group (DRG). In 2016, there were 223 *psychosomatic hospitals* with more than 10,000 inpatient beds in Germany, with a mean duration of stay of 40 days covered by health insurance, along with 141 centres for *psychosomatic rehabilitation* medicine, which provided about 16,000 additional inpatient beds and an average treatment duration of 37 days (Zipfel et al. 2016). In both kinds of institutions – acute hospitals and rehabilitation clinics – the patients have the right to request a return-to-work tool (*Betriebliches Wiedereingliederungsmanagement*, or BEM), a legal instrument that organizes the return-to-work process; usually, it is based on a timely and organized reintegration to work (Schneider, Linder, & Verheyen 2016). This is individually organized at the former workplace, with the social work duties falling mainly on the relevant staff of that employer.

Psychosomatic rehabilitation clinics, though they use the same therapeutic approach, are situated differently in the public health system; their explicit mandate is to bring patients back to employment (return to work), and this mandate is covered by pension insurance, not health insurance. According to the German Social Law (SGB IX), all negative health states which last longer than six months and are associated with present or impending restrictions in social or occupational participation are considered disabilities and are the subject of rehabilitation (Linden 2014). Thus, rehabilitation clinics focus particularly on work-related aspects of disability prevention. Nevertheless, research on the psychotherapeutic approaches and outcomes in these facilities also supports the hypothesis that work is addressed in a way that is individualizing and privatizes work restraints, rather than taking into account the structural conditions in which the patients are embedded (de Vries et al. 2017; Weikert et al. 2017).

So, it may be possible to state that both these institutions turn away from the issue of work; at the same time, the concepts of work among the psychotherapeutic team and in the treatment ideology might differ. Our **hypothesis** in this area is that, while there are differences in addressing the issue of work, there are potential similarities when it comes to gendered conceptions of work and patterns of interpretations of work as such.

C. Psychodynamic, cognitive-behavioural, and systemic therapy

Although most institutions offer an integrative therapeutic approach, there are still differences in the therapeutic paradigms they employ. The project is thus especially interested in identifying potential differences in the notion of work. The notion of the mind as a dynamic system with an unconscious that is shaped by conflicts and defence mechanisms is built into the idea of *psychodynamic therapy* (Müller-Pozzi 1991, Mentzos 2009) The assessment of personality structure forms the basis of the psychotherapeutic work. The second paradigm is *cognitive-behavioural therapy* (CBT). The term "behavioural therapy" does not imply a uniform therapeutic approach; rather, it refers to a group of different psychotherapeutic procedures. The underlying theory is that mental disorders are based on learned behaviour and can therefore be unlearned. Thirdly, *systemic therapy* (Schlippe & Schweitzer 1996), which developed out of family therapy, looks at the person and his or her illness in the

context of the social environment. Symptoms and illnesses are not only seen intrapsychically with regard to their development but also in their effects on the interpersonal level. Systemic therapy only received approval by the scientific boards of the health and pension insurance agencies in 2018; it is now slowly gaining acceptance in different institutions. Nevertheless, systemic approaches have been applied in most hospitals over the past few decades as part of a multi-professional treatment strategy. All three approaches are largely based on procedures of skilled listening, which is regarded as a process of understanding, and on processing the patient's narrative. This, as described above, is understood in our project as the process of interpreting and translating.

Previous work shows that, for the psychodynamic and CBT approaches, the issue of work is addressed either in the frame of a biographization (analysing early childhood memories in psychodynamic therapies) or with a focus on potential boundary management, like "the ability to say no" in CBT (Flick 2018b, 2019a, 2019b, 2020; Engelbach, Flick, & Alsdorf 2018). Our **hypothesis** in this field is that the different therapeutic paradigms operate with different hermeneutics when it comes to the issue of work. Given the paradigms themselves, there may be a spectrum from highly individualizing interpretations (psychodynamic) to more reflective of the "outside" (CBT) to a strong reflection of structures. Nevertheless, our assumption is that all three paradigms overlap when it comes to working conditions.

D. Multi-professional teams in the treatment process

Following the literature on psychosomatics, the multi-professional *team* is at the centre of psychotherapy in psychosomatic hospitals (Janssen, Martin, Tress, & Zaudig 1998; Storck 2016). An interdisciplinary therapeutic team and multimodal therapy are available to the patient in an inpatient setting, with the treatment always understood as group and team treatment (Janssen et al. 1998). But how do professional hierarchies interfere with this idea of a team? In contrast to psychiatry, medical doctors are not the only ones to conduct therapy in psychosomatic hospitals and departments of hospitals; so do clinical psychologists, who have degrees in psychology and further training in one of the three methods of psychotherapy recognized by German health insurance providers. In addition to these professionals, the multi-professional team includes social workers, nurses, and complementary therapists who use non-verbal approaches like art therapy, music therapy, physiotherapy, and approaches to mindfulness. Even though individual and group therapy led by a psychologist or medical psychotherapist is offered, one of the key institutions is the case conference. Following Storck (2016) and Küchenhoff (1998), the process of "understanding" is crucial in case conferences, which again makes them and all team meetings a central locus of the process of translation in the therapeutic process. According to Küchenhoff, the team acts like a "treatment subject" (1998: 51)

There are robust studies showing that the "psychotherapeutic team" is essential for the success of the patient's recovery and reintegration into the workplace (Janssen 1987; Janssen et. al. 1998). Following these studies, the notion of work and ideas around the connection of work and the patient's suffering that can be identified on the institutional (the hospital), collective (the team), and subjective (the single professional) levels play a significant role in not only the sensitivity to the complex relationships of work and mental health within the professional groups but also lead (or do not lead) to better preparation of the patient's return to work. The notion of work in those teams also strongly contributes to the process of translating the issue away from work.

The **hypotheses** that result are as follows. We assume that these communities of practice (Wenger 1998) create their own normative frameworks and their own procedures for translating work-related suffering but, in doing so, are shaped by professional hierarchies. What theories of

work are related to the specific normative framework of each team? Moreover, we assume that differences in professional backgrounds play a significant role in the interpretation of patient suffering but disappear in the face of a common treatment ideology. We further assume that the therapeutic paradigm powerfully influences the overall interpretations, even among those professions that are not really involved in the process of talk therapy, such as social workers, art therapists, and nurses. Which perspectives are heard, which are combined, and which ones disappear in creation a common interpretation by the team?

1 Objectives and work program

1.1 Objectives

As our first and leading hypothesis is that the professional appropriation of the "case" always results in a translation of the patient's stories, symptoms, and suffering that includes a turning away from work, the empirical study focuses on these processes of translation and seeks to analyse the dimensions that contribute to this turning away from work.

Objective 1: Typology of psychotherapeutic concepts of work

Our main objective is to analyse the implicit and normative conceptualizations of work, which should lead to the development of a typology of the psychotherapeutic understanding of work-related suffering based on the reconstruction of theories of practice. We assume that there are gendered assumptions about work that drive these ideas, along with assumptions about a patient's social status. The notion of work is varied and differs more or less along a number of factors. Our project addresses the following questions: How is the process of translation described for each therapeutic approach? Are there differences amongst the members of each psychotherapeutic team? How do the subjective and collective theories of work differ in terms of different factors like the gender, age, and professional background of the patients? Aside from this overarching goal, there are several project aims, described in Objectives 2–4 below, which are necessary steps for the development of our typology of concepts of work.

Objective 2: Understanding collective theories of work and work-related suffering within the context of clinical treatment and potential differences between acute hospitals and rehabilitation clinics

As our guiding hypothesis in this area is that there are differences in addressing the issue of work and potential similarities when it comes to gendered conceptions of work and patterns of interpretations of work as such, our research aims at better understanding collective theories of work and work-related suffering within the context of clinical treatment and potential differences between acute hospitals and rehabilitation clinics. We assume that the notions of work, what is considered work, and what is considered work that could cause suffering will all differ due to the primary legal assignment of each institution.

Objective 3: Understanding potential differences within the psychotherapeutic paradigms (psychodynamic, behavioural, and systemic)

Our hypothesis in this area is that the different therapeutic paradigms operate with different hermeneutics when it comes to the issue of work. Although most hospitals understand themselves as multi-professional, not only with regard to the different professions but also to their therapeutic

backgrounds, therapeutic paradigms play a significant role due to hierarchical processes of communication. Given the paradigms themselves, one could assume that there is a spectrum ranging from highly individualizing interpretations (psychodynamic) to those more reflective of the "outside" (CBT) to a strong reflection of structures (systemic). Nevertheless, our assumption is that these paradigms overlap when it comes to working conditions. The project aims at the development of a systematic understanding of the different paradigms.

Objective 4: Understanding the potential differences within the therapeutic teams
We assume that the clinical teams, as communities of practice (Wenger 1998), create their own normative frameworks and procedures of translation and that, in doing so, are shaped by professional hierarchies. Moreover, the hypothesis is that the team's different professional backgrounds play a significant role in the interpretation of the patient's suffering but disappear in the process of the common treatment ideology, for two reasons. The first is the hierarchical processes of communication, and the second is the collective interpretation of each case within the framework of the teams. We assume in addition that the therapeutic paradigm strongly influences overall interpretations, even among those professions that are not really involved in the process of actual talk therapy, such as social workers, art therapists, and nurses. Our aim is to analyse potential differences among the professions that make up the therapeutic teams (medical professionals, psychologists, social workers, nurses, and creative therapists).

Study design and methods
The issue of work can be addressed in different forms and with various kinds of data: implicit theories of professional practice of the individual therapists, collective theories of work-related suffering of the profession, and materialized theories of psychotherapeutic practice in institutions, such as specific cultures of either the hospital or the therapeutic paradigm. Methodologically, this project is oriented towards the research style of ethnography and the documentary method, which is related to the sociology of knowledge (Bohnsack 2010). Since we aim at "natural situations" that were not initiated by us as researchers, ethnographic research is most appropriate (Bruyn 1966). Because we seek to reconstruct theories of work-related suffering, mental health, and psychotherapeutic practice, the research uses a multi-centred qualitative research design (Denzin 1978).

The sample: We intend to work with nine medical institutions in Germany. Why these institutions? We follow the patient! Following Marcus' ethnographic and theoretical imperative to "follow the people" (1995, 1998), we seek to follow the patient to analyse the treatment of work-related suffering. This means investigating the field of psychotherapeutic treatment of a "normal" case. In Germany, such a patient typically first seeks help from his or her general practitioner. After consultation, no matter what cause is identified, the general practitioner can admit the patient to a facility like a psychosomatic hospital. Therefore, we plan to analyse the therapeutic theories of practice in these institutions as case studies (Burawoy 1998). Many people see a psychotherapist or psychiatrist in private practice for intense, even years-long psychotherapy. For several reasons, we do not investigate those therapeutic settings in this research project. First, we are researching collective theories of work with regard to the treatment teams; second, we assume the grade of institutionalized theories is stronger in hospitals; and third, the severity of suffering and reasons for seeking help in outpatient treatment settings vary so widely that it is too complicated to

operationalize our scientific objectives within this frame. In addition, the psychiatric sector offers an overly broad array of options – sometimes covered by the public health system, sometimes not – that we would not be able to adhere to our logic to follow the "average" patient.

Hospital ethnography:[1] Since we seek to gain access to subjective, collective, and institutional theories of work and work-related suffering, ethnographic fieldwork is the most suitable approach for our research. Ethnographic research involves observing people while they are conducting their habitual practices in their genuine situational contexts and describing these practices analytically (Goffman 1961; Marcus 1998). For us, this means attending staff meetings, case conferences, informal conversations, and even some forms of therapy. The aim is to attend as many of the meetings of the therapeutic team as possible. Though the classical understanding of ethnography includes fieldwork as participant observation, ethnographies in hospitals pose the question of how the participatory aspect can, or should, be realized. A researcher in a hospital who wants to be viewed as a "natural" person whose presence in the ward can be continuous has three options: joining the staff, becoming a patient, or being a visitor (Geest & Finkler 2004). We decided to take the point of view of an untrained intern. Since we are aiming to analyse not only the staff but also their "natural" treatment of patients, no other role was realistic. We are aware of the specific ethical issues of this research and have already received preliminary IRB approval. In addition to classical fieldwork, we apply other methods from an ethnographic perspective, as outlined in the following paragraphs.

Ethnographic interviews: Although we are aware of the risk of potential bias that interviews can entail (Jerolmack & Kahn 2014), there is good reason to address the issue of work through ethnographic interviews (Spradley 1979). This method opens access to implicit, subjective theories of work-related illnesses and theories of the meaning of work for mental health. Interviews allow for reconstructing semantics on work and suffering and help disclose existing discourses. In addition, other than in-group situations or staff meetings, we assume that individual interviews would offer a different perspective on the therapists' interpretations. There may be some aspects that are never addressed in staff meetings; some are entirely unspoken, while others may not be revealed in public. Therefore, the interviews will offer a space for therapists and other team members to elaborate on their notions of work and suffering. The interviews will be conducted in a narrative style and guided by stimuli addressing the work issue (Spradley 1979).

Group discussions: Group discussions are used to expose collectively shared patterns of the interpretation of work and its consequences for performing work. The goal is to understand the therapists' and other professional team members' conceptions of work and mental health within their professional group and hierarchy level and to observe which of these conceptions prevail and which are discarded over the course of the discussion. The group discussions should lead to understanding whether the actors use work as a dimension for mental health and for certain forms of suffering. Group discussions are particularly suited for this task because they offer insights into the collective opinions of a group (Bohnsack 2010) and reveal normative patterns of interpretation (cf. Dröge, Neckel, & Somm 2005). Furthermore, observing the flow of discussion demonstrates decision-making processes and how arguments are weighed. Group discussions differ from methods

[1] We are aware that the current situation in these hospitals, due to COVID-19, does not allow visiting researchers but are optimistic that this will be overcome by the time fieldwork begins, which is not likely to be before June 2021.

like focus groups or group interviews, both of which offer speedier access to certain information. Group discussions, however, more strongly emphasize the implicit knowledge of the group members and their collectively rooted orientations. The plan is to conduct group discussions with each professional group (i.e. doctors, psychologists, social workers, nurses, and complementary therapists) in each hospital According to Lamnek (2010: 408), group discussions are divided into six distinct phases: planning and guidance, entry into discussion, discussion rules, basic impetus, stimulation of discussion, and meta-discussion. In addition to this general outline, we will also respect the "rules for the detection of collective orientation patterns" (Lamnek, 2010: 407). The analysis will identify the modes and patterns of translation of patients' theories of illness and the othering of patients.

Medical records: The medical progress reports will be treated as artefacts and analysed with regard to the descriptions of the patients' working conditions or, rather, the interpretation of what the noted syndrome was and the crisis from which the patient suffered. Some data will be handwritten notes on specific therapy sessions, while others will be completely digitalized and include standard questionnaires. Perhaps shockingly but not surprisingly, medical records are often not fully completed (cf. Garfinkel 1967; Berg & Bowker 1997). Although documents, "even those that expressly operate as factual reports" should "basically be treated and analyzed as methodologically created communicative features" (Wolff 2000: 303), for reasons of practicability and research focus, we will analyse the medical reports with particular regard to the therapeutic and medical perspectives on labour in the language of the records.

Supervision protocols: Another potential way to collect data is supervisions. As part of quality management, therapeutic teams are provided with monthly supervisions. Supervision protocols could help confirm or contrast with the outcome of the interviews and field notes, following the assumption that an interview situation could potentially reveal different, more socially desired answers (Hess 2008; Watkins 2012). We intend to analyse supervision protocols where we can access them.

Analytical method

The evaluation of the collected data is based on the project's aim: to understanding the various concepts of work and develop a typology of the potential differences in therapeutic paradigms, treatment institutions, and treatment ideologies among teams and their participating professions. As we assume that the process of translating and othering the patient's suffering into the realm of the therapeutic field is influenced by more than the just the background of the institution, we will pay particular attention to analysing the concepts of work with regard to the following dimensions: work and gender, work and social status, work and meaning, and work and fields of occupation. As noted above, we follow an ethnographic methodology enhanced with the documentary method. As a methodological approach, the documentary method (Bohnsack 2011, 2014: 33 ff.) helps provide in-depth exposure of the context of the investigated therapists. It assumes that the knowledge of the actors revealed in the interviews is not uniform but qualitatively differentiated. Our analytical strategy seeks to broaden the comparative analysis by differentiating through the documentary method and exposing the actors' latent entanglements in their milieus and culture-specific contexts. The overall goal of the analysis is to reveal subjective theories of work and collective and institutional concepts of work. This interpretation, again, will be brought together in the

comparative analysis following the three dimensions of subjective, collective, and materialized theories as a frame of reference (Burawoy 1998).

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