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# "If she had helped me to solve the problem at my workplace, she would have cured me": A critical discourse analysis of a mental health intake

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**Abstract**
Critical approaches in psychology and social work criticizing the current mainstream psychotherapy discourse have been gaining more ground in recent decades. Yet, little empirical research has, to date, explored therapy in regular practice to identify the discursive resources employed during the clinical encounter and the way such discourses create and maintain power differences and the boundaries of the therapeutic interaction. This paper is rooted within a post-structural perspective based on Foucauldian analysis which sees power as dispersed throughout the social field and emphasizes the multiple ways in which power differences are created and maintained through accepted forms of discourse and knowledge. Data were drawn from a large study of mental health intakes in clinics in Israel working with culturally diverse populations. We conducted critical discourse analysis on a single dyad including transcription of a recorded intake session and post-intake interviews with the client and the therapist. Based on existing critique of psychotherapeutic discourse for its individualistic and apolitical view, we explored how the hegemonic psychotherapy discourse is negotiated in real practice, the ideology it carries, and the power differences it perpetuates. We shed light on the way this discourse conceals social injustice and contributes to the disempowerment of the client and ultimately to a poorer quality of services.

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Critical methods, discourse analysis, health care disparities, marginalized populations, mental health and illness

## Introduction

Critical approaches in therapeutic professions (such as psychology and social work) have been gaining more ground in recent decades (Avissar, 2013; Fook, 2003; Nakash et al., 2010; Prilleltensky et al., 2008; Sucharov, 2013; Totton, 2006). These approaches are committed to social justice and focus on exposing mechanisms of social oppression (Clark, 2002). Critical approaches tend to be based either on structural perspective or post-structural perspective in relation to how power differentials shape social interactions. The structural perspective is mainly based on Marxist analysis and emphasizes the role of social structure in the determination of class and power differences. Post-structural perspective is often based on Foucauldian analysis which sees power as dispersed throughout the social field and emphasizes the multiple ways in which power differences are created and maintained (Ife, 1997; Morley and Macfarlane, 2012).

This paper is rooted within the post-structural perspective suggesting that "power is everywhere"—it is constantly constituted through, and embodied in, accepted forms of discourse and knowledge (Foucault, 1971). In this paper, we offer a critical discourse analysis (CDA) of one mental health intake session. CDA is a cultural-social analysis that aims to identify dominant constructed ways of knowing, expose the ideological assumptions on which they are based, and the ways by which this constructed knowledge creates and maintains power differences and identities. CDA focuses on the discursive resources people use in written text and social interaction to construct versions of reality and knowledge and their subject position (Avdi, 2005; Fairclough, 2001). Little empirical research has, to date, explored how the hegemonic psychotherapy discourse is negotiated in real practice, the ideology it carries, and the power differences it perpetuates (Georgaca, 2013).

### *Current criticism of mainstream psychotherapy discourse*

The hegemonic psychotherapeutic discourse has been criticized for emphasizing intrapersonal processes while ignoring—or at best underestimating—the socio-cultural context in which the individual lives and through which suffering emerges (Avissar, 2009; Cushman, 1990; Masson, 1988; Nakash et al., 2009; Parker, 1999; Prilleltensky et al., 2008). This is despite the accumulation of research attesting to the impact of social determinants of mental health inequities (Alegria et al., 2009; Braveman et al., 2011; Nakash et al., 2012, 2013, 2014a).

By accepting the ideology of individualism and ignoring the social and historical context, psychotherapy discourse can perpetuates social problems that brought

about the clients' wounds in the first place. The individualistic decontextualized discourse undermines the work of therapy and might lead to "blaming the victim" because the therapist might attribute client's problems to inherent internal factors rather than to complex or external circumstances (e.g. exposure to prejudice as part of their disadvantaged group membership). The decontextualized discourse disregards different mechanisms of social oppression (Clark, 2002), which are rooted in the inherent struggle between social groups over resources and interests (Mullaly, 2002). This structure of social power that contributes to the suffering in the client's life can be replicated in the clinical interaction (Cushman, 1990; Parker, 1999).

From a critical perspective, psychotherapy can no longer be viewed as politically neutral, in the sense of "political" as related to distribution of societal power and resources (Sucharov, 2013). On the contrary, psychotherapy is "a field of political action, a place where power is exercised and contested, as therapists try to affect clients' lives and clients acquiesce, resist or do both at the same time" (Totton, 2006: XV).

## *Current critical approaches to psychotherapy*

Over the last three decades there has been a prosperity of critical approaches in social work and psychology including feminist (Chester and Bretherton, 2001; Morley and Macfarlane, 2012) and critical psychology (Parker, 1999), political sensitive therapy (Avissar, 2009; Sucharov, 2013), and radical, anti-oppressive, and human right-based social work (Fook, 2003). There is a debate in the literature whether these approaches should be grouped together (Fook, 2003; Morley and Macfarlane, 2012); yet, for the purpose of this paper, we identified common aspects shared by many of these new approaches toward the shaping of a critical discourse in psychotherapy.

*Ecological discourse.* The ecological discourse sees the person as part of the sociocultural systems that largely shape people's identity and lives, and resist the separation between the social world and the personal world. The daily personal reality is understood as an expression of social structure (Ife, 1997; Morley and Macfarlane, 2012; Sakamoto and Pitner, 2005).

*Standpoint discourse.* Critical discourse's challenge to universality is often based on a feminist standpoint (Morley and Macfarlane, 2012), which highlights the importance of multiple and diverse perspectives, particularly, those of marginal groups in society (Chester and Bretherton, 2001; Fook, 2003; Parker, 1999). Working from this position, the therapist should honor the knowledge of the client, assume that the client is the one that has solutions to his/her difficulties, and critically reflect on the inherent power relations between the therapist and the client (Sakamoto and Pitner, 2005).

*Political discourse.* A political discourse to psychotherapy includes an ongoing social critique of social exclusion and oppression (Avissar, 2013; Chester and

Bretherton, 2001; Fook, 1993; Prilleltensky et al., 2008), and an acknowledgment of the political context of psychotherapy (Fook, 1993; Morley, 2012; Prilleltensky et al., 2008). The basic assumption is that it is not possible to properly understand and address wellbeing and suffering without looking at the context of the power relationships in which suffering occurs (Totton, 2006). This discourse defines therapy not as a neutral action but rather as one that is value-led. Values such as social justice, protection of human rights and equity are in the basis of critical discourses to psychotherapy (Avissar, 2013; Fook, 2003; Morley and Macfarlane, 2012). It is argued that psychotherapists can be more effective if they integrate the understanding of how power influences oppression, liberation, and ultimately wellbeing into their practice (Prilleltensky et al., 2008; Totton, 2006).

Parker (1999) suggests that critical perspectives in social work and psychology should link theory and practice to offer a systematic examination of how dominant accounts of psychotherapy operate in the service of power. These processes are often hidden from view and can be brought to light using discourse analysis. Yet, the critique of the hegemonic psychotherapy discourse tends to be theoretical and the actual discourse analyses of psychotherapy sessions, and specifically intake sessions, published to date are few (Georgaca, 2013). In the current study, we use discourse analysis of one mental health intake to explore the tension between hegemonic and critical discourses in the clinical interaction between a therapist and a client.

The mental health intake is usually the first point of contact between clients and therapists. Therapists' observations during intake directly impact clients' treatment retention (Samstag et al., 1998) and guide therapists' decisions regarding diagnosis, treatment planning, and strategies to facilitate the establishment of good therapeutic alliance (Darghouth et al., 2012; Nakash et al., 2015a, 2015b; Nakash and Saguy, 2015; Rosen et al., 2012).

## Method

The intake referred to in this article was part of a larger study on mental health disparities (see Nakash et al., 2014a, 2014b) and took place in a community mental health center in a major Israeli city. The clinic offers free services to a diverse and socio-economically disadvantaged adult client population under the provisions of the extant health care law.

### *Data collection*

Therapist participants in the study were recruited at the clinics through introductory informational meetings. Client participants' recruitment was conducted through direct person-to-person solicitation on presentation for intake. Client inclusion criteria were adults aged 18 or older who did not require interpreter services, and for whom the intake was their first contact for a new episode of care. Exclusion criteria included clients identified as psychotic or suicidal by

providers, and those who otherwise lacked the capacity to consent. All clients who sought mental health treatment at participating clinics were invited to participate in the study.

The appropriate Institutional Ethics Committees at each participating clinic approved all aspects of the study and data collection complied with all human subject protocols. These protocols included a detailed informed consent process (which included an assessment of the capacity to consent) and assurances of patient care and confidentiality throughout the participation in the study. After consent was obtained, both clients and therapists participated in three separate components of the study: (a) audiotaping the intake, (b) participation in a post-intake semi-structured interview, and (c) completion of a demographic measure. Post-intake interviews with the therapist and client occurred immediately following the intake, and focused on the evaluation of the clinical encounter. Questions included the presenting issue, nature of the client—therapist rapport, and the role of socio-cultural factors during the meeting. The post-session interviews included in this current article were conducted by two graduate students in clinical psychology. The intake and interviews were fully transcribed. In our analysis, we used these three sources of information which allowed us to triangulate data from the session itself, as well as the respective post-session accounts by the client and therapist.

Following Parker's (1999) advice for critical research to focus on particularity, we chose to focus on one intake out of the 129 intakes that were recoded. Detailed analyses of language using qualitative methods often examine only a small number of texts due to the intensive nature of the work (Lamb, 2013). This intake was not meant to be representative of intakes in general, or of the intakes in this study. Rather, the intake was selected because it contained explicit discourse disagreement. The client resistance of the hegemonic discourse gradually emerged in her interaction with therapist. The explicit nature of the disagreement between the therapist and the client and the client's open criticism of the hegemonic psychotherapy discourse enabled us to highlight the nature of this discourse and for our analysis to be rooted in the experience of those who are marginalized by the hegemonic discourse (Parker, 1999).

## *Data analysis*

Central to the analysis in this paper is the notion of discourse as it is used in CDA. Discourse can be thought of as taken-for-granted "truths" that "systematically form the objects about which they speak" (Foucault, 1972: 49 as cited in Luke, 1997). Discourse enable, delimit, and govern what can be said and thought in a specific context (Luke, 1997). CDA, is a research approach rather than a specific method, in which text and talk are analyzed for the details of their linguistic and grammatical choices and rhetorical features in order to reveal what are the broader discourses from which speakers draw from and the versions of reality they construct (Cooper and Burnett, 2006; Fairclough, 2001).

As Cooper and Burnett (2006) argue, discourses cannot be identified because they are not "real" objects we can find. CDA is not, and cannot be, neutral. Indeed, the point of CDA is to take a position (Van Dijk, 1993). In this case, we take a position of critical psychologists who believe in the importance of expending the focus of psychotherapy to include an ecological understanding of human suffering and a political understanding of therapy as a social institution that tends to reproduce rather than challenge mental health disparities.

The analysis of the intake included examination of various properties of the context such as access patterns (e.g. in the diagnosis stage only the psychotherapist is allowed to provide her version of "facts"), setting, and participants (positions and roles). Then, we analyzed the properties of every segment of the talk itself, such as speech acts (e.g. assertions, accusations, or questions), participants' lexical and syntactic style of speech (e.g. the words they use and the words they emphasize), role-taking throughout the intake (e.g. who is talking and who is asking questions at each stage of the intake), and at the macrosemantic level of their speech—its topic and local meaning (e.g. implicit presuppositions) (Fairclough, 2001; Van Dijk, 1993).

## *Intake participants and structure*

Rivka,[1] the therapist, is a 54-year-old *Ashkenazi* (Jews of European/American origin, considered advantaged ethnic group in Israel) senior clinical psychologist. Sima, the client, is a 53-year-old *Mizrahi* (Jews of North African/Asian origin, considered disadvantaged ethnic group in Israel) woman. Sima completed 12 years of formal education, and had worked in the post-office in different clerical and managerial positions for 34 years, since she graduated from high school. Eighteen months prior to the intake session she got divorced and eight months after her divorce she was removed from her managerial position at work, and placed back in a more junior position as a cashier. She refused to accept the downgrading in her position at work, even though she was very eager to continue working in the post-office. She saw the change as deterioration in her employment status and attributed it to systematic "corporate injustice." For the preceding 10 months, she had been in a legal battle with the post-office and on sick leave. Although she had seen a psychiatrist for an evaluation as part of the legal battle, this has been her first visit to a mental health clinic.

Sima self-presented at the intake in a state of crisis following deterioration in her employment status, which occurred at a time growing social isolation due to major changes in her social status as her grown children left the house and she divorced. The changes at work and in her family circumstances left her feeling lonely and isolated, devoid of the sense of meaning and structure that she has known throughout her life.

The intake session lasted 55 minutes. Table 1 presents a flow chart of the main topics discussed during the session.

**Table 1.** Flow chart of the intake session by content units and duration.

| | Topic of discussion | Time and Duration |
|---|---|---|
| 1 | Short introduction of the therapist and the aim of the meeting | 0:00–0:43 43 s |
| 2 | Presenting problem and exploration of the reason to seek care at this time: The history of Sima's current crisis at work and its current status. | 0:44–18:46 18:02 min' |
| 3 | History of utilization of mental health services: The visit to the psychiatrist and his recommendations as part of the legal battle | 18:47–22:08 3:21 min' |
| 4 | Goal of intake reinstated: The therapist asked Sima what she wanted from the meeting. | 22:09–22:40 21 min' |
| 5 | Exploration of psycho-social background and history: Sima's current familial situation at home; quality of her relationship with her ex-husband, children, sibling, parents, friends, and colleagues; her developmental history and key events during childhood; and review of her physical health condition. | 22:41–38:29 15:47 min' |
| 6 | Returning to presenting problem: Sima discusses her current crisis at work. | 38:30–41:15 2:45 min' |
| 7 | Returning to evaluation of symptomatology: Focuses on therapist's evaluation of risk assessment (mainly self-harming behaviors) and physical health status. | 41:16–43:36 2:20 min' |
| 8 | Treatment recommendations: Focuses mostly on a discussion about therapist's recommendation to use psychoactive medication and short discussion on short-term crisis intervention at the clinic. Finally, a short discussion on forms and paperwork. | 43:36–54:45 11:10 min' |

## Findings

We identified two discursive disagreements between Sima and Rivka which related to the construction of Sima's main problem and the mandate of psychotherapy as a profession. In the following sections, we elaborate on the two discursive disagreements.

### *The construction of the main problem: Ecological versus essentialist discourse*

The main discourse that Sima used throughout the session was, what we named, "the system is unjust." She described the post-office as a corrupted and unjust system; herself as a victim of an unjust system as well as a fighter and self-advocator for her rights. For example, at the beginning of the intake she said:

> I worked as a registration clerk, it is called registration clerk, you give registrations to the public and sometimes received and . . . for all kinds of reasons they have decided to

> move me, and this includes all kinds of irrelevant considerations, you know, when they want to put someone in a place, so they start to look for someone with . . . I have noticed in the last months that I was there that they were after me and every day they sent me a complaint letter with all kinds of false complaints and I felt that they are planning to move me.

In this extract, Sima situated herself in opposition to the system. There were no specifics with which to represent the system, but rather a general vague powerful entity, ''they.'' Throughout the interview, she consistently referred to ''them'' in a general manner, without ever mentioning someone specific. Noticeably, she also tried to invite her listener, to acknowledge her case as being an example of a general pattern of unjust system saying: ''**you know**- when they want to put someone in a place.'' Then she quickly went back to the specific details of her case. However, her listener, the therapist, did not acknowledge an awareness of such a pattern. Throughout the intake she questioned Sima's narrative, while looking for alternative explanations to the post office's actions. For example:

> Sima (S): ''Until today, I insist, for more than 10 month, not to work in this position [a cashier position]. I have tried to receive help from all kinds of sources, I got to the union, the Histadrut labor federation, whomever I could and no one helped me''.
> Rivka (R): ''Why? What were their arguments that they don't help?''

In this extract, Sima positioned herself as fighting alone for her rights against the unjust system. Again, she did not refer to specific people but to ''sources'' and organizations. Rivka's response was to look for the plausible arguments and relevant considerations that preclude Sima's sense of being unjustly persecuted by the ''system.'' This extract is an example of the pattern of their discussion during the first 18 minutes, in which Sima told her story as a victim and a sole fighter against an unjust system. Rivka allowed her to tell her story, nodded and asked a few questions that challenged the ''unjust system'' discourse and seemed to be intended as a search for an alternative rational explanation. This dynamic went on until Rivka seemed to lose her patience at 15:11 and said: ''ok let's, let's move on, ok you have received exemption . . . onward!'' to which Sima answered: ''to put it shortly, I received exemption from work with physical effort''. This extract highlights the power differential within the interaction. The therapist, the more powerful participant in this interaction, controlled and defined the boundaries, and constrained the contribution of Sima, who was the less powerful participant (Fairclough, 2001).

Soon after this comment, Rivka shifted the discussion away from the chief complaint to a series of questions about Sima's psycho-social history and current functioning. Rivka asked Sima many questions about herself outside the realm of work, e.g. her relationships with her family, friends, her physical health, and the history of her mental health. Again, Rivka was the powerful participant, navigating and controlling the progression of the session. At this part of the conversation,

Sima continued to position herself as a victim of external factors. She mostly used an ecological discourse—a discourse that sees the person as part of the socio-cultural-political systems that mold his/her life and identity (Bronfenbrenner, 1979). The self is seen in the ecological discourse as a multidimensional system that incorporates physical, emotional, and political socio-cultural components (Arredondo et al., 1996). Rivka continued to question Sima's discourse and seemed to look for a more internal one dimensional, essentialist explanation to the story. For example:

> S: "Now for me to leave my work place and change a role is a very very big and meaningful crisis in my life; unspeakable crisis you know why?"
> R: "Why?"
> S: "Because my role was unique, I worked in it for a long time, I am in an age that it is not easy for me to get used to other roles. Anyway, it is difficult for me, it is the menopause, I suffer from all kinds of health problems, all kinds of moods and all kinds of extreme weakness, also because of my health state, and also because of my age and all these things together and exactly at the period that I remained alone at home, and I got divorced a year and a half ago, and my youngest daughter got married and all my children got married, thank goodness, but this created a situation that I remained alone completely at home, a situation I wasn't used to. And also I stopped working exactly at the same time, so this for me was an extreme change in my life. At once I remained alone. Also alone, lonely, at home and also without a job, that is to say this is a situation that from morning to night I am simply alone. And this is a very extreme change in my life. This is what has caused my depression."
> R: "I understood, and do you have friends?"
> S: "And also I have no friends"
> R: "Maybe"
> S: "I have maybe one for short phone calls, but also no one that suits me so much and no one that I can go out to get some air and it is very very hard for me."
> R: "How come you don't have any friends?"

In this extract, Sima offered a complex explanation to her depression, one that included interplay between internal and external reasons for her suffering. In this explanation, Sima did not utilize the "unjust system" discourse but rather the "ecological discourse," connecting her depression not only to work but also to physical and social states. The menopause, together with a feeling of "empty nest," the break of her marriage, and the loss of her position at work left her feeling lonely. She highlighted the influence of the external "real" contexts on her wellbeing. Rivka did not challenge the ecological discourse explicitly, but by not discussing any of the issues that Sima raised in this section she did not support it. Her question diverted discussion toward friends' social support and the inquiry as to why Sima would not have friends, implying an internal attribution to her loneliness. Furthermore, in choosing what to inquire about of all the things that Sima mentioned, Rivka implied that there is an individualistic internal explanation

to Sima's suffering. The internal discourse was more explicit later in the interview after Sima described how she tried not to upset her family and so did not share her problems with them. Rivka said "in general you describe yourself as someone very insulated from society and also from family very much to yourself." Hence, what Sima saw as a valuable social behavior that took into account the needs of others over her own interests, Rivka saw as a negative internal personality characteristic and choice to self-isolated.

These differences were most obvious in their formulation of the problem and decision about psychiatric diagnosis. As opposed to the complex explanation Sima offered to her suffering, Rivka diagnosed her as having a personality disorder not otherwise specified, and an adjustment disorder with prolonged depressive reaction.

In her interview after the intake, Rivka did not ignore the external explanations Sima gave but thought that Sima's reaction was inappropriate to the circumstances she described:

> Because she [Sima] relates a lot to the concrete aspects of it, I am not sure she is ready to see also her parts in it, what brought her to this situation, she really put all the blame on the system, I don't doubt what she says, it is entirely plausible that there is something . . . but her reaction is so difficult and extreme that she doesn't check at all how it is connected to her because right now she is in a crisis.

In this extract—as in the interview as a whole—Rivka did not ignore the role of external factors in Sima's suffering. Nevertheless, by defining Sima as "relates a lot to the concrete aspects" and her reaction as "so difficult and extreme" she positioned the external factors as almost irrelevant to the psychological diagnosis and recommend intervention. By focusing on Sima's reaction, the external factors were discussed only through an interpretative lens, i.e. looking at the external reality to explore an internal pattern. By that, their political nature was rejected. The external factors were appended into an essentialist discourse and an inherent personality-based explanation.

Hence, we identified different discourses held by Sima and Rivka on two dimensions. The first dimension was the "the system is unjust vs. the system is just and has a logical rational" and the second dimension was "ecological discourse vs. essentialist discourse." The presented gulf between the discourses was mostly implicit during the intake. The two different discourses were also connected to different perceptions regarding the mandate of psychotherapy in general and the current session as we next describe.

### *The mandate of psychology as a profession—internal pathology or the person as an ecological system*

Rivka and Sima, during their post-intake interviews, described vastly different aims for the intake session. These aims, however, were not openly discussed between

them. In her interview after the intake, Rivka said that she had four aims for the meeting:

> First of all I wanted to get to know her and check what the problem is. To try and reach a diagnosis, to see what she would want from us, from the clinic . . . and to think if we are the right place for her, what is the ultimate treatment to offer her.

Rivka continued to say that she saw all four aims as inseparable. This extract highlights the basic assumption in current mainstream psychological discourse that conceptualizes emotional difficulties as located "inside" the individual (Avdi, 2005); hence, the inseparable connection between problem, diagnosis, and treatment. In the meeting itself, Rivka offered an abbreviated version of her aims for the meeting. At the beginning of the session, after introducing herself she informed Sima that it was going to be an introductory session "so we will see if we are the right place for you to help you, and if so how can we help you." Sima, on the contrary, said in her interview following the intake that she hoped to receive help in her battle with her workplace.

> S: "So I thought that here there could also be assistance to receive medical opinion from a psychologist with some specific recommendation with some opinion that maybe will determine my fate"
> Interviewer (I): "the external fate of your work"
> S: "The external fate, because I am going to an appeal committee. Now, in the appeal committee they will bring their doctors and my workplace will bring, among others, they will bring a psychiatrist and I brought a recommendation of a psychiatrist so they bring doctors that suit the fields I turn to. They bring their own psychiatrist and now it is important for me that she [the psychiatrist that the committee will bring] will see that indeed I turn to psychological treatment as my psychiatrist recommended".

This extract highlights very clearly the political power of psychotherapy as a social institution. Sima explained that both she and her work-place use the mental health professionals in a legal struggle to define reality—is the workplace unjust, or is Sima a problematic worker? Sima describes how, to secure her rights at work, she needs to use the political power of psychotherapy in two ways: first to use the psychological diagnosis to prove she has suffered as a victim of external circumstances, and second to prove she is a "good subject" that follows the psychiatrist's orders. She hopes both methods will help to establish her account of reality. However, therapists usually do not acknowledge the political aspect of their professional practice. By doing so, they limit their own practice because they ignore the political aspect of human lives and the implication for people's well-being (Avissar, 2013). By asking political help, Sima unknowingly challenges the "last taboo" of psychology (Altman et al., 2004).

Rivka and Sima's discussion of the aims of their interaction was limited by their different discourses. Twenty-two minutes into the session, Rivka asked Sima directly about her goals for the meeting:

> R: "So actually what would you want from us? Sima"
> S: "I, I, look at the recommendation of the psychiatrist, I do what he said, I try, he recommended that I come for psychological counseling, he recommended me, so I looked for a psychological treatment"
> R: "But what do you want? Ok this is his recommendation but what would you like? Is there something that you feel you need therapy for?"

In this extract, Sima said explicitly that she came following the psychiatrist's recommendation. Rivka did not understand or did not accept this as an answer for her question; she was searching for Sima's internal motivation for her visit. Hence, she asked again, reframing her question in three different ways: "but what do you want? Ok this is his recommendation but what would you like? Is there something that you feel you need therapy for?" In the third version of the question, she defined the limits of the possible outcome of the session to therapy desired by the client. She did not allow for the possibility of participating in therapy as a political act. She did not want to acknowledge the political power of psychotherapy as a social institution—and hence, the aim of Sima to act as a "good subject"—within the social expectations dictated to her, as a worthy aim.

Up until this point, Sima had mentioned twice that she visited a psychiatrist two months earlier; he had prescribed psychopharmacological treatment, but she was not enthusiastic about it. At minute 43:36 Rivka started to wrap up the session by asking Sima "is there anything else that you think, is important that I will know about you, about the past, the present?" This question was followed by a 10-minute discussion mainly about the aim of their session and the use of psychiatric medication. We bring here a short extract from this discussion with our analysis.

> Sima answered: "No in my past there were no, I told you, in general I had no special events in my life. That's it. I never thought that I will be thrown into this situation (starts crying) I just looked for help because I see that nothing helps my position at work. Undoubtedly not, I think that if I go back to work, this will change my life in a significant way and if not, this will deteriorate my life and I will go downhill. I say it honestly, and no I am not coming to pretend or act and I am not coming to do, ah nothing, there are no games here I am a very honest person, I don't play any games, I don't do any shows, this is the situation now".
> R: "So let's, let's stop for a moment here, in terms of work, I have no way and capability to help you because, you know, we have no mandate"
> S: "I understand"
> R: "More personally to you, first of all I really recommend that you will start somewhere. There is no doubt that I see the depression. The deep sadness, as you said, there are many changes in the last year, everything happened at the same time. The

> adjustment to a new way of living is not easy from all respects. I am very much in favor of starting medication, very, because you have no idea how much these medication start to influence, they influence with the Cipramil or Cipralex that they gave you, it takes three to four weeks before it starts to influence and to accumulate some basic energy to help yourself. You see?"
> (Two minutes discussion about the other medication Sima takes)
> R: "Now I am really in favor that you will start [psychiatric medications] and that's it for me. I return the question to you again, and because we already need to stop, so let's do it short, what would you like from us? What are you asking from us?"
> S: "I repeat myself again, I think that if my problem at work would have been solved"
> R: "Ok, this, let's"
> S: "I know that you cannot help"
> R: "Assuming that this is not solved, or assuming that"
> S: "This is not solved, I don't know, right now I really do not want to use medication".

In this extract, Sima clearly reiterated that she came to ask for help in her legal battle with her workplace. Rivka limited again the boundaries of her practice and said that it was not in her authority to help her in the way Sima needed. Taking into account Rivka's introduction to the meeting and her statement that its purpose was to "see if we are the right place for you to help you," they could both agree that this was not the right place for Sima, and concluded the meeting at this point. Instead, 2 minutes later they were repeating almost the same dialogue. Their discussion became immobilized because of the limits of psychotherapy dominant discourse and practice.

Their discussion highlighted the argument of critical approaches in social work and psychology, which urge therapist to include a structural analysis of personal problems and social critique regarding oppressive functions in their practice with the goal for personal liberation and social change (Fook, 1993; Parker, 1999). The discussion with Sima shed light on Rivka's inability to help her; Rivka was not ready to face the last taboo of psychotherapy (Altman et al., 2004). As long as Rivka did not acknowledge the political blindness of her practice, Sima's narrative and aims—given her position as the less powerful participant—could not be validated. Sima could not determine that the session was over. She had to continue to follow the medical discourse directed by Rivka's questions. In doing so, she tried to balance the expectation to be a "good client" and not challenge the medical internal discourse while retaining her right not to accept the treatment recommendations (i.e. psychiatric medications). In the interview following the intake, Sima felt more comfortable to challenge the boundaries of the essentialist psychotherapist discourse. When asked in the post-intake interview what advice she could offer other therapists to help people like herself, Sima said:

> I think that instead of insisting and, as they say, get locked on psychiatric medication, one could think beyond that, even though that might be unacceptable in this kind of

> settings. To consider some, some different things from what they have learned so far. To consider, for example in my specific case what is needed is a medical evaluation [to the committee] so maybe . . . now if she had helped me to solve the problem at my workplace, she would have cured me!

Sima's advice echoed critical perspectives in social work and psychology that urge therapists to expand the context of their work to embrace social, cultural, and political issues (Avissar, 2009; Fook, 2003; Prilleltensky et al., 2008; Sucharov, 2013). Moreover, more critical views of the use of psychiatric diagnosis suggests that medicalizing psychiatric nosology and discounting the political context in which psychopathology emerges—is used to justify predetermined social structures, and at the same time, it serves to control and contain disturbed behavior and provide care for dependents while maintaining the social power structure and oppression (Moncrieff, 2010; Pilgrim, 2007). Here, the dominant essentialist discourse used by the therapist effectively reduces the client's experience of mental distress, while also serves to maintain oppressive power relations within society.

## *Discussion and concluding remarks*

In the current paper, we used discourse analysis to explore how the hegemonic psychotherapeutic discourse in regular mental health practice is characterized and shaped by an individualistic and apolitical view. This psychotherapeutic discourse emphasizes personal pathology, while underestimating the socio-cultural context in which the individual lives and through which suffering emerges. By ignoring socio-cultural systems in general and societal power relationships (those mirrored within the clinical encounter) in particular, therapists can be blinded to social injustices and may err through "blaming the victim" (Cushman, 1990). Blaming the victim inevitably contributes to a poorer ability to emphasize with clients, and to poor rapport. Poor rapport further contributes to the disempowerment of clients and ultimately to the poorer quality of services. This is particularly important in light of recent research highlighting the impact of social determinants of health. Intersectionality among different dimensions of social identity such as gender, race, and social class are critical in the shaping and perpetuation of mental health service disparities (Darghouth et al., 2012; Nakash and Alegria, 2013; Nakash et al., 2012; Rosen et al., 2012).

Our analysis shows that the individualistic discourse is powerful. It constructs a pathological identity by providing simple attributions to suffering and representing emotional difficulties as located only "inside" the individual. While at the same time, the individualistic discourse does not address the obdurate, persistent social structures and forces with which clients must engage, thus stripping the person of their socio-cultural-political context (Avdi, 2005). The apolitical nature of the discourse precludes discussion of the impact of socio-political factors on suffering that are particularly important for socially disadvantaged populations.

More specifically, psychotherapy is a socio-cultural institution where power is exercised and contested, as therapists try to affect clients' lives (Totton, 2006), and as they construct knowledge through the establishment of psychiatric nosology that defines psychopathology as a set of symptoms and internal personality structures. The exercise of power can reflect varying degrees of awareness with respect to the impact of one's actions. As argued by other researchers—and as suggested by this analysis—by ignoring the power they possess and the political aspects of their practice, therapists are oblivious to their own role in perpetuating the status quo, and the suffering that derive from the status quo (Altman et al., 2004; Samuels, 2006; Totton, 2006).

The role of the unequal power relations during the clinical encounter becomes even more pronounced when the client is from a disadvantaged social group. Gender, ethnicity, class, and other social identity dimensions often translate to asymmetric power relation in society, that seep into the therapeutic encounter. The therapist has to acknowledge the power discrepancy, and to find ways to diminish its affect. Clinical empathy is not enough. What is needed is *political empathy*. In this example, the therapist did her best to be empathetic: to be aware of the thoughts and feelings of the client, to understand her state of mind. Still, what was missing is an understanding of social marginalization as an everyday process embedded in unequal power relations in society (Prilleltensky et al., 2008), as well as awareness to the unquestioned psychological, social, and cultural discourses, and the structural features of bureaucratic hierarchies (Deutsch, 2011). A political empathy urges us to constantly reach for inclusion of the other by taking into account the whole person as an ecological system within specific, often unequal socio-political-economical context (Samuels, 2006).

Finally, as this analysis shows, discourse analysis is an important method for the study of the ways in which meanings are constructed within the diagnostic process and the institutional and ideological context of psychotherapy (Georgaca, 2013). Little empirical research has, to date, used discourse analysis focusing on the discursive interchange between clients and therapists within actual diagnostic process. Such analysis is in line with the contemporary emphasis on therapists to deepen their critical reflexivity of their practice.

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