Article

International Journal of Qualitative Methods
Volume 19: 1–11

DOI: 10.1177/1609406920922002
journals.sagepub.com/home/ijq
SAGE

Politico-Critical Analysis: A New Research Framework Applied to Psychiatry

Paulann Grech, PhD[1] and Reuben Grech, MD, MSc[2]

Abstract

Background: This article presents a new framework called politico-critical analysis based on the contentions of Foucauldian discourse analysis. The framework was developed to address a number of shortcomings and assess further aspects of importance to fields such as mental health and psychiatry. **Aim:** To present the main principles and steps of the politico-critical analysis framework and, subsequently, to demonstrate its application to a study on the therapeutic alliance in psychiatry. **Method:** The rationale and main principles of politico-critical analysis are described and applied to a study, the aim of which was to explore the knowledge and power interface in the therapeutic alliance in a psychiatric hospital in Malta. Data were collected during two phases; in the first phase, 10 care receivers, who were selected through purposeful random sampling in a psychiatric hospital in Malta, were interviewed to explore their perception of the knowledge–power balance in the psychiatric therapeutic alliance. The second phase consisted of collecting data from and analyzing a 60-page sample of medical records pertaining to the study participants interviewed in Phase 1. **Results:** Four themes emerged from the politico-critical analysis of care receivers' interviews, depicting the knowledge–power interface within therapeutic alliances. From the analysis of medical records, three themes emerged, which shed light on the knowledge–power matrix within the alliances under study. **Conclusions:** The politico-critical analytical framework was regarded as a helpful agent in facilitating the exploration of the knowledge–power matrix within the psychiatric therapeutic alliance. Strengths and limitations were acknowledged, and the framework might help guide similar potential research.

Keywords

Foucauldian discourse analysis, politico-critical analysis, critical mental health, sans-serif">therapeutic relationship, power, knowledge, psychiatry

Introduction

This article presents politico-critical analysis, a framework, which while building upon Foucauldian theories regarding knowledge and power, explores connections between entities that are characterized by a power imbalance. Emphasis is on the identification of factors or forces in specific scenarios that might contribute to any injustice under examination. Additionally, this framework prompts the researcher first to critically analyze the situation at hand and then to move beyond critique to focus on eliciting potential practical solutions that might require changes in practice or the environment or a transformative positive discourse identified during the research itself. The framework depicted and described is intended to offer an easy-to-read, step-by-step guidance to researchers attempting to undertake this type of research. As a starting point, Foucault's contentions as applied to Foucauldian discourse analysis are explored.

Foucauldian Discourse Analysis

Foucauldian discourse analysis is best suited to a situation in which the researcher is interested in exploring knowledge and power issues—in other words, an analysis of how knowledge and power are intertwined through discourse to produce a certain type of situation and reality (Graham, 2005). This research method is suited for researchers who are

- willing to question the status quo (Walkerdine & Arribas-Ayllon, 2008),

[1] University of Malta, Msida, Malta
[2] Mater Dei Hospital, Msida, Malta

Corresponding Author:
Paulann Grech, Falling Waters, Triq Josef Kalleya, Swieqi, Malta.
Email: paulanngrech@gmail.com

- interested in critical evaluation of traditional systems or practice (Jansen, 2008), and
- concerned about knowledge–power imbalances in a particular system (Powers, 2007).

The principle authors in the field of Foucauldian discourse analysis frameworks are Willig (2008), Parker (2014), Burman (1996), Kendall and Wickham (1999), Hall (2001), and Walkerdine and Arribas-Ayllon (2008). While Foucauldian discourse analysis is a powerful method to explore critical situations, as in any other method, a number of limitations have been described. First, while the definition of discourse allows for exploration beyond the actual language itself, often, other forces in a given situation are not given enough prominence within the method. Also, in this type of analysis, critique is the main strength, with less emphasis on actual pragmatic solutions identified during the research process (Fendler, 2014). The methodological framework for critical discourse analysis presented by Chouliaraki and Fairclough (2007) has attempted to address the generation of solutions. However, it seems as if the tendency is to solve problems by removing that which is negative rather than coming up with radical alternatives (Bartlett, 2009). Subsequently, the introduction of positive discourse analysis (Martin, 2004) has focused on the identification and promotion of alternative voices in a given problematic situation. Finally, criticism has been leveled at the use of complex language that renders the process rather difficult to follow and the findings not as accessible as they might otherwise be (Martinez, 2018). The development of the politico-critical analysis framework to apply Foucauldian perspectives attempted to address these shortcomings and to assess further aspects as described in the following section.

Method

Politico-Critical Analysis Framework: An Introduction

Politico-critical analysis aims to elaborate on Foucault's theories by exploring the interaction of knowledge and power in a connection between entities in which a perceived power imbalance causes injustice. Here, "connection" refers to alliances or relationships between individuals as well as to broader interactions, for instance, to politicians and the citizens under their governance. Politico-critical analysis obviously has two components: political and critical.

Primarily, the political component refers to the need for an in-depth exploration of politics as practiced in the given area of study, including both "small-p" and "big-P" politics. Janks (2012, p. 151) defined small-p politics as the "micro-politics of everyday life . . . the minute-by-minute choices and decisions that make us who we are." Additionally, the political component includes power relationships within a specific context or relationship. In big-P politics, Janks explained that the focus is on government, world trade agreements, and global capitalism.

While aspects of big-P politics are important because they shed light on why the overall status quo is as it is, in politico-critical analysis, equal emphasis should be placed on aspects of small-p politics because the latter are often more discreet in their enforcement and their effect on the knowledge–power interface in connections between entities. Since interactions do not take place in a vacuum, the researcher needs to take into account and explore with the participants other dynamic factors apart from words and actions that might contribute to the status quo. These might be the environment, economic influences, legal factors, and social forces (i.e., attitudes, values, ethics, and lifestyles; Goryakin et al., 2015).

Within the niche of politico-critical analysis, politics is not viewed as solely governed by politicians but rather as an area that should ideally belong to citizens. In this view, the process of politico-critical analysis needs to be as transparent and accessible as possible. In essence, this refers to the need to simplify the process so that it can be easily followed and broadly accessed by people in different areas of life. Thus, throughout the process, it is crucial to avoid heavily loaded academic nomenclature and instead use easily understood language in reports of findings. Thus, while politico-critical analysis is based on Foucauldian theories, a contrasting feature is that the Foucauldian method tends to use "a cryptic philosophical," complex style (Martinez, 2018) that can usually be understood only by those in the field. This has, in fact, been the target of criticism. Simplicity of process and wording may be frowned upon in academic circles. However, if the aim of politico-critical analysis is to expose power imbalances and injustices, then it is counterproductive to render findings accessible only to the elite few. Additionally, bearing in mind the ground-up political approach embraced in this method, politico-critical analysis concludes with potential solutions following exploration. These solutions need to be teased from participants themselves during the research process as well as from the researcher's reflections. This is an addendum to the Foucauldian method that has been criticized as failing to propose pragmatic solutions to identified problematic social and political issues (Fendler, 2014). Once again, including this step within the politico-critical analysis framework is faithful to the desire to give something tangible back to the people. Simply, this method denounces the idea that critique alone can lead to change. While critique is obviously important, its impact is perceived as greater if researchers immersed in the process immediately put their insight into use by proposing pragmatic solutions.

Apart from the politics component, this method involves the critical aspect. Foucault (2002, p. 456) contended:

> A critique does not consist in saying that things aren't good the way they are. It consists in seeing on just what type of assumptions, of familiar notions, of established and unexamined ways of thinking the accepted practices are based . . . to do criticism is to make harder those acts which are now too easy.

This does not necessitate the process of metaphorically reinventing the whole wheel—but of taking the wheel apart and carefully examining and describing the resulting picture. The resulting critical description needs to be sharp enough to make an impact yet controlled enough to be credible. Realistically, it is often a fine balance between sharpness and an emotional

outburst, which is not easy to maintain. A helpful exercise may be to write the initial report of the findings freehandedly, without any boundaries or control. Revisiting and revising the document after a cool-down period might then allow necessary editing to maintain the previously mentioned balance.

Principles and Steps of the Framework

To facilitate explanation, Figure 1 describes in detail each step and respective rationale of the politico-critical analysis framework. Figure 2 presents a reflective process that can be followed.

The main principles of politico-critical analysis can be summarized as follows:

- The two main sides contributing to the power imbalance must be involved in exploration of the situation, specifically in the data collection process.
- Sole reliance on examination of texts is not ideal since this might be a limited, flat, and one-sided representation of the situation. Thus, human contact in the field itself is desirable.
- Focus is on (1) "big-P" politics as well as on "small-p" politics; (2) examining knowledge possessed by both sides in relation to the power imbalance; and (3) bringing to the forefront economic, social, legal, and environmental forces contributing to the status quo.
- While interacting with participants, the researcher needs to concentrate not only on understanding the situation and critiquing it but on eliciting rationales and potential solutions from participants themselves. This might necessitate offering insights to participants different from those they depict as well as engaging in counterarguments. It has to be acknowledged that in the context of power balance, the participants can perceive the interventions of the researcher as a source of irrefutable knowledge, and therefore, they will adapt their speech to this situation, so the decisions/solutions will be biased by that information. This could interfere with the proposed solutions. Such bias may be addressed by the researcher's attempt to ensure that during the contact, the power balance within the interview itself is evenly distributed by, for instance, avoiding the use of technical jargon, using open body language, avoiding physical barriers and taking the time to build a rapport with the participant prior to engaging in counterarguments. Furthermore, it may be wise to engage in counterarguments only after the participant has been given ample time to freely present their own views and proposed solutions.
- The process culminates in practical solutions elicited from participants, the researcher, and referral to existing literature.
- In the report of findings, it is crucial to use easily understood terms and avoid heavily loaded academic nomenclature.

Step	Explanation
1). Determine if Politico-Critical Analysis (PCA) is applicable to the situation to be investigated	PCA is appropriate if the researcher: - Is concerned about knowledge-power imbalances in a connection between entities -Suspects that latent politics within the system are shaping reality whilst creating the power imbalance in the connection - Is willing to challenge assumptions - Has adequate resources to explore and access representatives of both sides of the argument Note: It is advised that the researcher engages in the reflective process in Fig. 2 before proceeding to Step 2
2). Data Collection	Use a qualitative approach to data collection e.g. interviews. May not be ideal to rely on texts alone but include actual human participants. Representatives of both sides of the argument need to be included as participants (separate data collection for each side). Ideally the perceived "underdog" is interviewed first so that the findings can then be used during the data collection with the perceived "oppressor". The researcher needs to focus on: -exploring the situation at hand in particular the power matrix - unearthing knowledge possessed by each of the "sides" - seeking rationale from the participants as to why they do what they do -unearthing solutions from the participants
3). Data acquaintance	A process of becoming familiar with the data by multiple reviews and ongoing reflection about connotations and meanings.
4). Primary analysis: General thematic coding	Codes are generated by a process of open coding that involves the coding of data chunks based on the meaning that emerges from the data. Codes are then collapsed and listed. They are then analyzed for possible further reduction or addition of new codes (Braune & Clarke, 2006). At this stage, codes are of a generic nature and not exclusively related to knowledge-power. This process is carried out in order to organise data and to get a general idea of the main ideas that were highlighted by the participants.
5). Secondary analysis: Main themes related to knowledge-power	A process of scrutinizing the data and the codes that emerged from the primary analysis. This is done in order to identify themes based on the knowledge-power interface in relation to the situation being explored. These should be presented as
	the main thematic sections in the research report.
6). Descriptions of the situation	For each knowledge-power theme: How is the situation being described by the participants? This needs to include i). What is actually stated ii). What is implied iii). What is not said – silences.
7). Dominant concepts	For each knowledge-power theme: Reflection on the descriptions provided in step 6 and identification of their location within wider concepts (such as Inequality or Authoritative Positioning). These may comprise the sub-themes in the research report.
8). Possible rationale	For each knowledge-power theme: Presentation of possible reasons why the participants are doing what they are doing.
9). Identification of practical solutions	Possible solutions that were described by the participants and that the researcher comes up with after being immersed in the process are presented and elaborated on by referral to existing literature.

Figure 1. Steps in carrying out politico-critical analysis.

Application of Politico-Critical Analysis

Use of this framework is described in the context of a mental health research study with the aim of exploring the knowledge and power interface within the therapeutic alliance in a psychiatric hospital in Malta. Prior to the data collection process, a research proposal was submitted for review and approval by the local ethics committee.

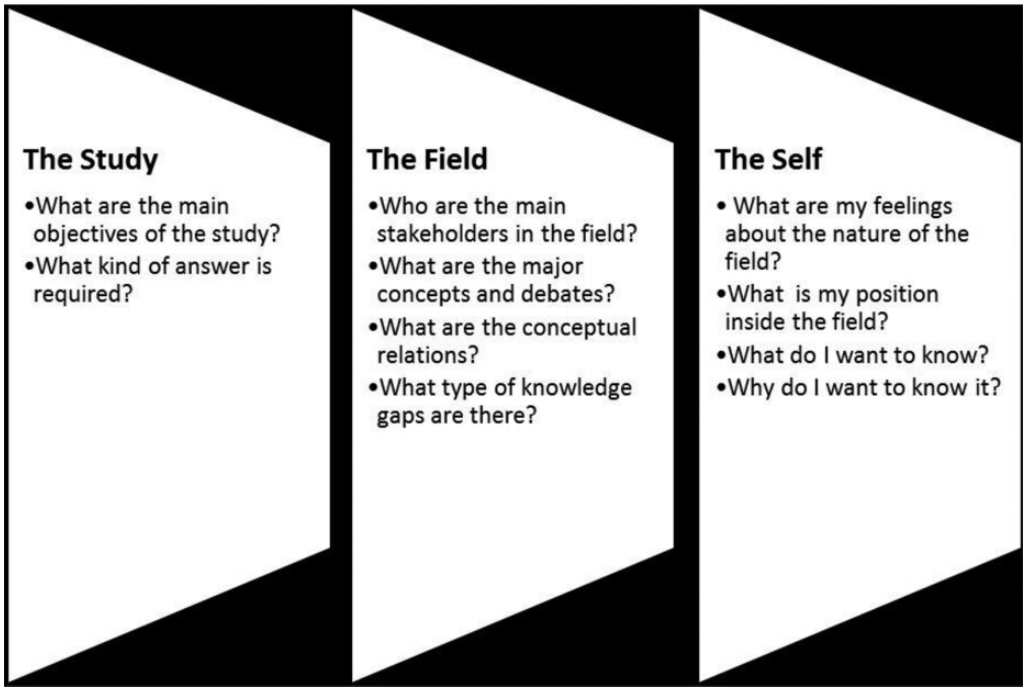

Figure 2. The reflective process (Authors' own).

Sample and procedure. Data were collected during two phases. The first phase's aim was to interview 10 care receivers, selected through purposeful random sampling, in a psychiatric hospital in Malta to explore their perception of the knowledge–power balance in the psychiatric therapeutic alliance. In the second phase, data collection consisted of exploring and analyzing a 60-page sample of the medical records of participants interviewed in Phase 1. These consisted of the person's medical file and the respective nursing registries. In this manner, Phase 1 involved recruitment of human subjects in order to collect verbal data, as opposed to, but also complementing collection of written data from existing documents in Phase 2. Essentially, the two phases were targeted at allowing data and methodological triangulation through use of differing data sources and methods during each phase. The politico-critical analysis framework depicted in Figure 1 guided the research process.

Results and Discussion

This article aimed to introduce the framework of politico-critical analysis. The findings that emerged when the framework was applied to the research study helped provide important insights into the knowledge–power interface of the therapeutic alliances being explored. To enhance clarity, overviews of findings that emerged from interviews with care receivers and from analysis of medical records are provided in Figures 3 and 4, which depict main themes as well as subthemes. The following section summarizes the findings. (The corresponding author can be contacted for a more detailed version of the report.)

Findings: Care Receivers

Four themes were identified from care receivers' transcripts, and these served as a classification system of therapeutic alliances based on the type of knowledge–power balance in each alliance.

Theme 1: Satisfaction–acceptance. This featured a therapeutic alliance characterized by a knowledge–power balance in favor of the care provider. Notably, it seemed as if most care receivers were satisfied with this power imbalance and partially compliant with it. Their descriptions of this relationship highlighted concepts of compliance and romanticism. That is, care receivers seemed to regard it as a lifeline, an important clinical tool, and a loving bond between them and the professionals. Thus, they were eager to participate in care and, semi-blindly, to follow professional guidance. This theme illustrates dependence on traditional care systems not considered to promote independence and autonomy. However, care receivers in this alliance type appeared satisfied and viewed their relationships with professionals in a positive light. The rationale for subscribing to this type of alliance primarily included affinity for traditional perceptions that view the medical professional as the ultimate expert who must be obeyed. Locally, this is not relevant only to mental health but to other areas of health, and it seems to be somewhat ingrained in the culture. In view of this knowledge, participants felt as if they were expected to submit, at least partially, to this higher power, thus exhibiting a degree of self-induced paternalism—this was something that did not bother them at all and which they were only too glad to do. However, this is not to say care receivers in this position

Knowledge-Power themes	Descriptions (of the therapeutic alliance)	Dominant Concepts	Rationale
Satisfaction-Acceptance Key features: *Knowledge-Power imbalance* *Acceptance of imbalance* *Overall satisfaction* *Some degree of care receiver independence*	Life-line Clinical tool Loving bond	Compliance Romanticism	Affinity for tradition Self-induced paternalism Professional love Excitement and purpose
Dissatisfaction-Compliance Key features: *Knowledge-Power imbalance* *Acceptance of imbalance* *Overall displeasure* *Moderate-high dependence on care provider*	A means of care receiver obedience A medium of fear A catalyst to the employment of sanctions Related to displeasure or discomfort	Discontentment Compliance	Affinity for tradition Fear Dissatisfaction Sick role
Resentment-Opposition Key features: *Mostly one-sided* *Unacceptance of imbalance* *An angry/irritated care receiver*	A struggle A punishment tool A mystery An unwanted burden A non-therapeutic temporary relationship	Discontentment Anarchism	A survivor role Rebellion Resistance Oppression Displeasure and anger
Collaboration Key features: *Knowledge-Power balance* *Both entities on same plane* *Mutual contribution*	A collaborative agreement (partnership) A beneficial and gainful system A system that needs to be managed by the care receiver	Assertiveness Equality	Pride Satisfaction Involvement A balanced, two-way connection

Figure 3. An overview of the analysis process—care receivers' interviews.

receive no gains, and, here, romanticism comes to light. In discussions, these participants readily attributed deity status to professionals and regarded them in an aura of awe and adoration. This seemed to lead to excitement and purpose during their interactions within the therapeutic alliance. In this type of alliance, it might be worthwhile to measure actual care

Knowledge-Power themes	Descriptions (of the therapeutic alliance)	Dominant Concepts	Rationale
A Pathological Lens Key features: *Use of the medical model as the sole explanatory framework* *The authority of the professional as the "gatekeeper" of the normal and the acceptable*	A clinical package A series of professionally determined interactions A gauge of the care receiver's readiness to behave and follow orders	Pathology Conservatism Authoritarian positioning	Authority Safety/ self-protection Expertise
Depersonalization Key feature: *Removing the person from the patient*	One-way nonparticipant observation Task oriented	Minimalism (Providing the bare minimum amount of information) Depersonalization	Authority Learned ways of writing/practice Time management Mindlessness Lack of knowledge regarding person-centered care Safety/ self-protection
Humanism Key features: *Mutual involvement* *Collaboration*	A medium for collaboration A method of mutual involvement Patient focused	Humanism Equality Recovery	A holistic viewpoint Partial Knower Humbleness Partnership

Figure 4. An overview of the analysis process—medical records' analysis.

outcomes because, possibly, this reported serenity actually results from a form of covert institutionalization.

Excerpts describing the satisfaction–acceptance alliance:

> With the nurses, I feel good. Sometimes I buy things for them too. There are some nurses who give you psychological therapy themselves because they explain to you, speak to you gently, and make sure that you understand. Even during their break time.
>
> I feel calm when I am with the psychiatrist, if I am pain free. First, he asks you how you feel. So you have to answer in a way that you tell him everything in those few minutes: "I feel this, this, and that." Because when you stop talking, he starts.
>
> I am satisfied that I am at a lower level than the consultant psychiatrist. The most important thing is that he understands my problem and helps me.

Theme 2: Dissatisfaction–compliance. This alliance type depicts those alliances described by the participants that, in a similar way to those that featured in the first theme, presented passive care receivers who seemed quite dependent on their care providers. While in this second theme, most care receivers in this alliance type did not seem satisfied, they accepted that professionals held most of the power. Similar to the first theme (*satisfaction–acceptance*), the concept of compliance was evident. Contrastingly, while in the first theme, care receivers were happily compliant, those in Theme 2, were not in awe of their professionals but simply felt that they had no other option but to obey and follow orders. Thus, the relationship was viewed as a medium of fear, a catalyst to employment of sanctions, and commonly related to displeasure and discomfort. Once again, affinity for tradition was one reason contributing to this type of alliance. However, this was accompanied by pure fear, as expressed by participants themselves—fear that disobedience would lead to punishment, for instance, the care receiver who was threatened with not being allowed to listen to mass if he did not obey the professionals. On the other hand, assuming the sick role might also explain why participants readily gave up any power in the alliance. This situation refers to participants' belief that their sickness disables them completely, so they need to depend on professionals. This knowledge might actually be linked to some gains since it excuses care receivers from participating actively and making recovery-related decisions. Additionally, it may be hypothesized that absence of sickness awareness that is commonly created by the mental pathology itself may be another justification for the discomfort that was present within this type of therapeutic relationship. However, this could not be thoroughly explored during the interviews. This study did not attempt to measure long-term outcomes of the dissatisfaction–compliance alliance. Possibly, however, such states might eventually lead to chronic care and institutionalization resulting from excessive dependence on professional care.

Excerpts describing the dissatisfaction–compliance alliance:

> They [the nurses] are ok, but I think that most of them are not really interested . . . you sort of realize when they speak to you . . . even the way they speak, the tone of voice. Like I am bothering them, and they want me to leave them in peace. That is not nice, it makes me feel uncomfortable.
>
> With the nurses, I am down there, one of many. It is the system. It is the way it has to be.
>
> If I do not agree with something that the nurses say, I do not always tell them because I am afraid. I am afraid that they will stop something—stop one of the permissions. It has never happened to me, but I have seen it happen to other patients.
>
> I am scared when I am with the psychiatrist. I am scared about what he is going to tell me. He tells me what is needed, and I try to do what he says. What he says goes because it is for my own benefit.
>
> I do not know whether anyone had given me information about the pills. Sometimes the nurses explain to me though—they tell me what each pill is for. But sometimes when I ask, they say: "That's what the doctor has prescribed!"

Theme 3: Resentment–opposition. This type of alliance featured angry, irritated care receivers due to knowledge–power imbalance, with full control in the care provider's hands. In this theme, the alliance was described as a mysterious struggle, a punishment tool, an unwanted burden, and a nontherapeutic temporary relationship. In this light, anarchism and discontentment were identified as leading concepts. Deeper analysis of the resentment–opposition theme reveals the possibility to expand further by considering whether each entity in the therapeutic partnership is acting or reacting to its counterpart. Thus, do care recipients respond to an oppressive system by displaying rage and fighting for power? Or, do they act in this way for other purposes, with practitioners' actions a direct reaction to this hostility? While this study's findings suggest a mixture of these two possible scenarios, the answers to these questions also seem unclear. It is clear, however, that this form of alliance tends to be marked by aggression and intense focus on maintaining power, thus indicating an unhealthy relationship. Consequently, a major concern is long-term impact on rehabilitation. The main rationale for this position was centered on the feeling of being a psychiatric survivor in an oppressive system. The participants' conviction that the professional is wrong and abusive was accompanied by a rebellious attitude and displeasure with the situation. This is concerning in many ways especially in relation to concordance to treatment since it is indeed possible that one way to rebel against such perceived oppressions and lack of information provision may be to not adhere to treatment. In fact, such a dangerous situation is clearly depicted in the first excerpt that follows which features an individual who is clearly unhappy with his treatment plan.

Excerpts describing the resentment–opposition alliance:

> I am not satisfied with the treatment that I am receiving here. I try to speak to the doctor about it but he ignores me. He does not wish to speak to me. Nothing. He does not pay attention. The junior doctors visit but they say that they cannot give me any permissions because they speak to the consultant psychiatrist, and he does not wish to give me permissions. He does not even come to see me once weekly. I speak to his doctors. They tell me that they speak to him about me. Now, I do not know if they really do.
>
> I was not involved in the care plan. Actually, [the psychiatrist] just changed my pills without informing me about it. I wish that I'm involved. Because they think that you do not know how to do anything. They decide everything for you. That's not right.
>
> They throw you into this room, as if you are in prison—seclusion—and you feel even more down than you already are.
>
> I am not satisfied with the power balance in my relationship with the nurses. This is because they are not people who interact with care receivers in a gentle manner rather than a savage-like manner. This is my opinion, although I know that some others share the same opinion as I do. You cannot speak—only what they say is right. Mind you, there are some nurses who are nice, if you ask them to give you X, they would try to give that to you. I think this is caused by the fact that they become big-headed.

Theme 4: Collaboration. In this final theme, the care provider and the care receiver are depicted as being more or less on the same level, with no significant knowledge–power imbalance in the relationship. Thus, the alliance was described as a collaborative, beneficial, and gainful agreement. Featuring the main concepts of assertiveness and equality, all parties can be seen as contributing knowledge to the partnership and working together to promote the recovery process. This balance led to feelings of care receiver pride, satisfaction, and involvement. Such an alliance might resemble the recovery model's principles, featuring most care recipients in it as satisfied with the balance of knowledge–power and the alliance. It might be worth paying some attention to the efficacy of this form of alliance, which, if presented against a postmodern context and an approach based on the contemporary sense of rehabilitation, it would likely be an appropriate example. Notably, this partnership shares characteristics with those promoted in the recovery model, especially because it is influenced by optimism—a sense that the recovery process is presented in a positive light.

While testing various alliance models' effects was not within this study's scope, interestingly, the recovery model's efficacy has been extensively studied. For example, Warner (2010) conducted a review of published research outcomes that demonstrated the efficacy of interventions based on the recovery model. In another study, Tilsen and Nylund (2008) described how the recovery model's effectiveness strongly depends on the therapeutic alliance. To this extent, Wampold's (2015) meta-analysis showed that the alliance accounted for 54% of therapy variance. This prompted the researchers to conclude that to promote rehabilitation, care providers must be responsive to care recipients' needs in a cooperative partnership. Thus, it seems as if the Collaboration alliance can lead to positive outcomes.

Here are excerpts describing the collaboration alliance:

> In the relationships that I have with the professionals, the power is positive. Whenever I asked for something, it was ok. Like reasonable things—if I ask for four Valium pills instead of one, they obviously cannot meet my demand! But the professionals and I always got along. The power is shared in the relationships. We are equal.

> Like he (a nurse) said: "You have relapsed AGAIN?" And my answer was: "Don't you think that it is a good thing that I came here for treatment instead of staying outside in a bad way?" I did not answer rudely or whatever. I do not want to be rude. I wish to be good mannered. Listen, I may look "soft" but I stand up for myself—what's right is right, what's wrong is wrong.

> I feel ok with the nurses. They talk to me, about my problems. If I am not feeling well, I have to go to talk to them. If I disagreed with something that they said or wanted to give suggestions and feedback, I would do that to the nurses.

Findings: Care Providers

From the medical records, three themes emerged: the pathological lens, depersonalization, and humanistic.

Theme 1: The pathological lens. This theme described a way of interacting that seemed clinical, influenced by the medical model. In this view, the alliance seemed to be regarded as a clinical package, a series of professionally determined interactions and a gauge of the care receiver's readiness to behave and follow orders. Conservatism and authoritarian practices were the prominent concepts, accompanied by strong reliance on pathological explanations. This resembled a metamorphosis during which most of what the care receiver said and did was then restructured to suit a pathological interpretation. In general, this alliance reflects overuse of medical jargon and a phenomenon we called "automatic wording." The latter refers to words frequently used in the analyzed documents, possibly resulting from professional autopiloting—these include "comfortable day/night" and "treatment given as per chart"—terms that might not really provide useful descriptions of the care receiver's condition. A potential consequence is that the care receiver might be placed in a vulnerable position while simultaneously providing the practitioner with superior knowledge and power. One might then wonder if such medical dominance theoretically serves as a catalyst for coercive practice, especially covert acts of the 21st century, such as overprescription of psychiatric drugs and nonaction/reinforcing actions in the light of care receivers' passive attitude (Szasz, 1970). With reference to these unwelcome acts, a care provider's custodial and patronizing behavior is also known to come within the scope of such coercive activity. This can be demonstrated by written phrases such as "Patient needs to have things their way"—a single assertion contained in a practitioner's report, with no underlying facts or explanation. Thus, through this lens, the care recipient can be expected *not* to possess valuable knowledge but is expected to practice submissiveness, while this scenario simultaneously places the professional in a position of power, authority, and exclusive expertise. The presence of such text may be surprising when viewed against a backdrop of the contemporary focus on the practice of a person-centered approach. This includes a communication style adapted to the person affected by the pathology, trying to leave behind the traditional medical model based on medical paternalism. It is clear that such an approach does not feature in the texts explored.

Excerpt examples related to this theme—The pathological lens:

> Patient grandiose.

> Denies auditory or visual hallucinations.

> Patient not overly psychotic.

> Patient compliant to treatment.

> When patient was confronted re stalking another patient, blames another woman. Attention seeking

Theme 2: Depersonalization. This theme defined the medical records that appeared to remove the person from the patient. This might have resulted from or in a care provider's belief that they have an association with a nonperson, with all the negative

effects this might lead to. For instance, some clinicians' written words did not provide any information indicating that the patient was actually a person, not an object. Most professionals opted to use the word "patient" or the third-person pronoun instead of the person's actual name. For a professional to engage in such cold, mechanical writing, while describing an alliance that is supposedly care-centered and recovery-oriented seems quite strange. In practice, is the care recipient simply a chess pawn transferred to other wards, sent on leave, and brought back as needed? Is this the "subjected body" to which Foucault referred?

Nonetheless, we refer here to Foucault's argument that power might not always be negative and does not necessarily lead to oppression. This is because reality, ritual, and knowledge can also be produced (Foucault, 1980). Thus, such a task-oriented alliance might actually be a ritual that evolved over time and is accepted by those in the system. Undeniably, ritual and routine often offer safety and security. This might mean that depersonalization does not necessarily result in care recipient dissatisfaction, as some care recipients actually confirmed. Further, care providers might have various reasons for demonstrating such a mechanical attitude. Glorified authority may be at the peak of the potential rationale. Learned ways of writing/practice, time management, mindlessness, and lack of knowledge regarding person-centered care may be other contributors. However, depersonalizing care receivers might also serve as a self-protection measure preventing over-involvement and potential burnout by professionals.

Excerpt examples related to this theme—Depersonalization:

> House chores done. Treatment given as prescribed.
>
> Patient found in ward. Treatment given and taken as per chart. Calm and cooperative. Slept.
>
> Level 1 not covered. Treatment refused a.m. and p.m.
>
> Comfortable day.
>
> Increased appetite. Feels irritable. Claims that she has been sleeping more.

Theme 3: Humanism. This final theme refers to alliances apparently based on a somewhat holistic and person-centered approach. It indicates a degree of importance given to using the care recipient's name and their words, instead of attempting to restructure the entire rapport. In this way, the guiding principle for interactions within the alliance might be collaboration, mutual involvement, and sharing of knowledge rather than simple compliance. This is the only instance in the collected data where the care recipient's actual name and direct words found their way into the medical records. Such additions might provide color to a black-and-white portrait and a breath of life to what might otherwise be a cold and morbid scripture. The concepts of recovery and equality seemed to be in practice: The professional took up the position of a partial knower and a humble partner. For others, in contrast, this style and attitude in writing might be considered unprofessional, perhaps too personal, or generally undesirable. This might explain its limited presence in our review of medical records.

Although definitive comparisons cannot be made, it might be that the study's two sources have complemented one another by defining the balance of knowledge–power in the therapeutic alliances. For example, the theme of depersonalization that emerged from the medical records might shed light on the resentment–opposition alliance. Similarly, the theme of humanism may be related to alliances classified within the theme of collaboration.

Excerpt examples related to this theme—Humanism:

> [Care receiver's name] claims that she has been having very bad days as well as days when she feels well but not elated. She complained of lethargy. No change in appetite. She feels anxious over minor things and feels that she cannot open up with anyone even though she has a good relationship with her husband.
>
> Would like to go back home although unsure. Talks about her husband, hurt that he threw away her things but then justified his actions and anger. When he brought her home, his friends were telling him: "Għalfejn gibtha lura? Għax ma ħallejtiex fejn kienet?" (Why have you brought her back? Why didn't you leave her where she was?) When she envisions her future going back home, she feels anxious.

Knowledge Required and Tentative Solutions

In view of the findings, several solutions may be proposed to promote change. These solutions have been proposed by some of the study participants themselves during the data collection process with further elaboration from the researcher following reflection on the process. Since the care providers' "voice" could be elicited from the medical records only, solutions in this regard were extracted through the researcher's reflection on the written material. However, this was regarded as a limitation of the study which is why it was earlier emphasized that for the thorough application of this framework, it is best to seek human contact with both sides rather than exploring texts.

As identified during the care receiver interviews, training related to communication, self-worth, mindfulness, and assertiveness might provide these individuals with the necessary tools to be active care participants and build more balanced alliances. Potential sources include reflective exercises, role-plays, and assertiveness coaching. On the other hand, care providers need to be consciously aware of their words and actions in efforts to interact with care receivers in a more humane, person-centered way. Reflective practice, involvement of care receivers and care providers in joint educational efforts, and interactions based on person-centered care might be a good start for reaching this target. Furthermore, quality assurance and outcome measures should be in place to audit the quality of provided care since these factors might identify further areas needing improvement. It may be a good starting point to introduce a person-centered model of communication between the two entities and explore the resulting effect on the relation between the use of this

language and the unequal distribution of power that exists in some of the scenarios that featured in this study.

However, there seems to be a need for potential solutions beyond the perimeters of the microenvironment constituted by individual therapeutic alliances in mental health. In particular, public education is needed to change the prevalent local perception of mental illness. As Grech (2019) discussed, the local tendency to favor a custodial approach might instill a passive attitude in some care receivers. This might lead to overdependence on and provision of excessive power to care providers, as reflected in some alliances encountered during the study. Thus, consideration of cultural norms and values is of crucial importance. Public awareness can be enhanced by sharing ways of relating to people with mental health problems that do not portray them as weak or too vulnerable. A recent anti-stigma campaign and introduction of a new Mental Health Strategy show promise in this regard. Additionally, mental health has finally found its way onto the political agenda, and this augurs well for funding and innovation of services. However, infiltrating deeper to change every day lay discourse is definitely a challenging task that will take time. A pragmatic, in-the-field approach based on involvement of people with mental health difficulties in educational activities and in general community life is needed.

Conclusion

This article introduced politico-critical analysis, as applied to an exploration of the knowledge–power matrix within the psychiatric therapeutic alliance. This framework seemed beneficial in facilitating a dual-sided exploration of the connection identified and in enhancing in-depth analysis of multifaceted forces contributing to the status quo. Additionally, and most importantly, the analysis fostered generation of rational, pragmatic solutions. These emerged during interactions with participants and with data analysis, along with the researchers' reflections. As described earlier, the framework itself and the presentation of findings were aimed to be as easy as possible to access and understand, in order to facilitate the framework's application to other scenarios and to maximize distribution of findings. Despite these strengths, a number of limitations must be acknowledged. The main limitation is felt to be exploration of medical records. While data from this source were beneficial in shedding light on the therapeutic alliance, direct interviews or a focus group with professionals would have probably allowed for a fairer, more well-rounded, and dual-sided exploration. These methods would have enabled the researcher to probe and challenge professionals in a manner not possible through simple access to medical records. To this extent, a note was later added to the framework in Figure 1 to advise the ideal inclusion of human subjects when exploring each side of the connection. Another possible challenge to this framework's application is thorough analysis of multifactorial forces affecting the status quo (social, political, legal, economic, and so on). To address this challenge effectively, researchers need to immerse themselves truly and deeply into the field by accessing any available information on the area under study. This would likely demand resources that might not be readily available such as ample time and an adequate financial budget. Finally, the task of writing the research findings might also prove challenging since reporting needs to be a fair, passionate, political, critical, controlled, and diplomatic account of the situation, inevitably requiring multiple revisions to achieve the right balance.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Paulann Grech, PhD https://orcid.org/0000-0001-5485-0893

References

Bartlett, T. (2009). Towards intervention in positive discourse analysis. In C. Coffins, T. Lillis, & K. O'Halloran (Eds.), *Applied linguistics and (con)text: Systemic functional linguistics, critical discourse analysis and ethnography*. Routledge.

Braune, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77.

Burman, E. (1996). Constructing and deconstructing childhood: Images of children and charity appeals. In J. Haworth (Ed.), *Psychological research* (pp. 170–194) Routledge.

Chouliaraki, L., & Fairclough, N. (2007). *Discourse in late modernity*. Edinburgh University Press.

Fendler, L. (2014). *Bloomsbury library of educational thought*. Bloomsbury Academic.

Foucault, M. (1980). *The history of sexuality*. Vintage Books.

Foucault, M. (2002). So is it important to think? In P. Rabinow & J. Faubion (Eds.), *Power: The essential works of Michel Foucault, 1954–1984* (pp. 454–458) New Press.

Goryakin, Y., Lobstein, T., James, W. P., & Suhrcke, M. (2015). The impact of economic, political and social globalization on overweight and obesity in the 56 low and middle income countries. *Social Science & Medicine (1982)*, *133*, 67–76. https://doi.org/10.1016/j.socscimed.2015.03.030

Graham, L. (2005). *Discourse analysis and the critical use of Foucault* [Conference session]. Australian Association for Research in Education. Queensland University of Technology. https://eprints.qut.edu.au/2689/

Grech, P. (2019). The case of mental health. *Times of Malta*.

Hall, S. (2001). Foucault: Power, knowledge and discourse. In M. Wetherell, S. Taylor, & S. Yates (Eds.), *Discourse theory and practice: A reader* (pp. 72–81) Sage.

Janks, H. (2012). The importance of critical literacy. *English Teaching: Practice and Critique*, *11*(1), 150–163.

Jansen, I. (2008). Discourse analysis and Foucault's. *International Journal of Caring Sciences*, *1*(3), 107–111.

Kendall, G., & Wickham, G. (1999). *Using Foucault's methods*. http://search.proquest.com/docview/60045030/

Martin, J. (2004). Positive discourse analysis: Power, solidarity and change. *Revista Canaria De Estudios Ingleses*, *49*, 179–202.

Martinez, M. (2018). *(2018) Foucauldian discourse analysis—Miguel Ángel Martínez*

Parker, I. (2014). *Discourse dynamics* (*psychology revivals*)*: Critical analysis for social and individual psychology*. Taylor and Francis.

Powers, P. (2007). The philosophical foundations of Foucaultian discourse analysis. *Critical Approaches to Discourse Analysis Across Disciplines*, *1*(2), 18–34.

Szasz, T. (1970). *The manufacture of madness*. Harper & Row.

Tilsen, J., & Nylund, D. (2008). Psychotherapy research, the recovery movement and practice-based evidence in psychiatric rehabilitation. *Journal of Social Work in Disability & Rehabilitation*, *7*(3-4), 340–354. https://doi.org/10.1080/15367100802487663

Walkerdine, V., & Arribas-Ayllon, M. (2008). Foucauldian discourse analysis. In C. Willig & W. Stainton-Rogers (Eds.), *Qualitative research in psychology* (pp. 91–108), Sage.

Wampold, B. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.) Routledge.

Warner, R. (2010). Does the scientific evidence support the recovery model? *Psychiatrist*, *34*(1), 3–5.

Willig, C. (2008). *Introducing qualitative research in psychology. Adventures in theory and method* (2nd ed.). McGraw-Hill.