FINDING A THERAPIST THAT 'SPEAKS YOUR LANGUAGE': HOW PSYCHOTHERAPISTS DISCURSIVELY CONSTRUCT THE PROBLEMS THEY TREAT

by

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ABSTRACT

Nearly 1 in 5 Americans experience a diagnosable mental illness every year (SAMHSA, 2019). Although this statistic may be alarming in conjunction with the escalating need for accessible psychotherapy services (Cohn, 2015), it does not account for all of the reasons outside of clinical diagnosis that individuals may seek these services. These reasons, or "presenting problems" in the verbiage of mental and medical health professionals, can act as mediators between an individual's current cognitive and emotional experience and their self-evaluated need for psychotherapy. The current study aimed to identify and explain the ways in which psychotherapists construct presenting problem discourse to their potential patients through the media where this discourse is most likely to be seen, the internet. An exploratory thematic analysis of 40 clinical psychotherapists' *Psychology Today* profiles and websites (208 webpages in total) was conducted to uncover the five major themes for the discursive construction of presenting problems. They are: (1) lay description, (2) clinical diagnoses, (3) ailing identities, (4) the enigmatic self, and (5) cosmetic psychotherapy. These themes represent the various types of presenting problem messages that individuals considering psychotherapy observe from the clinicians they are considering choosing. The findings highlight multiple ethical considerations for presenting problem discourse, such as the use of identity labels and vague phraseology in mental health marketing. Practical implications suggest a need for psychotherapists to be better informed on presenting problem discourse strategies and should practice awareness in their message construction.

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CHAPTER 1: INTRODUCTION AND RATIONALE

The greatest gatekeeper for mental wellness is the language that is used to describe the processes to becoming well. It is indisputable that, in the psychotherapist-patient relationship, the psychotherapist holds the power. Regardless of race, sex, sexual orientation, socioeconomic status, and/or life achievements, the therapist is ultimately the one responsible for the wellbeing and emotional safety of their patient in the therapy room. For a patient to even make it to their first session, they need to have some level of trust in therapy and, more notably, their therapist (Marshall & Serran, 2004). This trust is multifaceted and often begins long before the psychotherapist has a chance to ask the age-old question, "How are you feeling?" It begins with a Google search.

According to the Substance Abuse and Mental Health Administration (SAMHSA, 2019), 1 in 5 Americans experience a diagnosable mental illness at some point within a given year. Treatment for mental illness varies, but psychotherapy is still found to be the most effective in symptom reduction for both short- and long-term mental illness (De Maat et al., 2009; Leichsenring & Rabung, 2008). Although seeking treatment for mental illness is still stigmatized (Sarkin et al., 2015; Wu et al., 2017) roughly 30% of adults reported seeking psychotherapy treatment in the last two years, and this number is expected to increase as mental health stigma decreases (Cohn, 2015).

Although this rate appears high, it is important to keep in mind that it is impossible to distinguish *clinical prevalence* (i.e., how many people are being treated for mental illness in the community) from *true prevalence* (i.e., the actual rate of mental illness in the community) (Wakefield & Schmitz, 2010). The clinical prevalence does not account for those who go untreated and have disparities in access to healthcare. To meet the needs for mental healthcare in

the United States, there are roughly 327,500 mental health counselors currently practicing, with more starting every year (Bureau of Labor Statistics, 2020). The high prevalence of mental illness in the United States mandates steady job security for psychotherapists, coupled with the importance placed on the work that they do. Thus, the treatment that therapists provide to their patients is a captivating topic for scholarly research.

The term "psychotherapist" is a comprehensive occupational title referring to licensed mental health clinicians who practice psychotherapy to treat mental illness. This includes Marriage and Family Therapists, Licensed Professional Counselors, Licensed Clinical Mental Health Counselors, Clinical Social Workers, Psychologists, and Psychiatrists. Psychiatrists are unique in this category as they are the only psychotherapy profession to require medical school and have the capability to prescribe and/or manage prescription medication. Psychotherapists can work independently in private practice, or in a more organized and group setting, such as an agency or hospital. Contrary to their more traditional medical counterparts, professional therapy organizations are few in number compared to individual practicing clinicians (Wiita, 2021). Regardless of their workplace structure, the profession is also unique in that the execution of the job is most commonly performed in isolation from other professionals. That is, due to confidentiality laws, psychotherapists meet with their patients privately, behind closed doors, usually unrecorded. Thus, while important, these confidentiality laws can create challenges for studying the communication practices of clinicians.

The interactions between therapist and patient are most commonly studied in the fields of psychology, psychiatry, and medicine, as these are the disciplines that create and teach psychotherapy treatment interventions. However, communication scholars are also extremely well-suited to examine such professions since, after all, in the therapy realm, communication *is*

the profession. In other words, *communication* is the means by which psychotherapy is taught, conducted, delivered, and experienced. Even non-traditional trauma therapy modalities, such as Eye Movement Desensitization and Reprocessing (EMDR) and Neurofeedback, rely heavily on the verbal and nonverbal interaction between the therapist and patient (Shapiro, 2018). In short, communication is preeminent to psychotherapy as a profession. For this reason, the communication skills of the therapist are imperative to the delivery and effectiveness of treatment.

Communication occurs when we try to transfer what is in our minds to the minds of our audience. In the psychotherapy process, communication begins with the presenting problem(s), or description of the problem(s). In psychotherapy literature, the term "presenting problem" is used to describe patients' "perceived symptoms, emotional or cognitive disturbances, or difficult behaviors that lead them to seek mental health services" (Cheng, 2000, p. 1). The term is standard nomenclature for mental health professionals and assists healthcare collaborators to quickly identify the need and focus for treatment. Researchers have studied patients' presenting problems as they relate to numerous important aspects of treatment, including help-seeking behaviors, patient goals and expectations, treatment setting and modality, special populations and diagnostic categories, and psychotherapy processes and outcomes (Kunkel & Newsom, 1996).

Therapists become aware of their patients' presenting problem most commonly by their patient sharing it with them, either in their intake documentation, or orally in an intake call or meeting. Before interactions with a therapist even start, patients often use their own understanding of their presenting problem to find the right "fit" of therapist who specializes in their condition. For example, someone experiencing obsessive-compulsive disorder (OCD) may

specifically search for a provider who markets themselves as having extensive training or specialization in treating OCD before choosing to make contact.

Understanding the presenting problem is important because it "is the foundation for the effective treatment of mental health problems" (Nakash et al., 2018, p. 917). For example, in the medical field, if a doctor diagnoses a patient with a "broken ankle," that diagnosis might inform the doctor to treat the injury with a cast versus a "sprained ankle" diagnosis, which may only need a bandage wrap. In psychotherapy, a clinician identifying a patient as experiencing "borderline personality disorder" (BPD) may then choose to utilize Dialectical Behavioral Therapy (DBT) as the treatment modality, which was created to treat BPD and has been designated by the American Psychological Association (2013) and the Substance Abuse and Mental Health Services Administration (2014) as an empirically supported treatment for BPD. Unfortunately, not all presenting problems have a clear "best" modality for treatment, but diagnoses can help clinicians identify interventions that may be more effective than others, which may improve treatment outcomes.

Presenting problems are not always described in diagnostic terminology. It is not uncommon for patients to describe their mental health concerns using symptoms (e.g., major depressive disorder being described as "lack of motivation, lack of energy, lack of focus, and sleeping more throughout the day") or using other more socially common labels that align with disorders (e.g., "depression" for major depressive disorder, "anxiety" for generalized anxiety disorder, and "multiple personalities" for dissociative identity disorder). It is also not uncommon for patients to seek mental health treatment for presenting problems that are not diagnosable disorders such as grief, couples therapy, and/or identity work. How patients' and clinicians'

language (or talk about) the presenting problem can differ, but *how* it is communicated can help determine confidence in treatment outcomes.

Communicating confidence and trustworthiness as a mental health provider is no small challenge. Unless they happen to have had a rare face-to-face interaction with a prospective client before beginning treatment, they most likely will be acquiring clients via personal referral or their online presence. Online information sharing and promotion is not new for healthcare professionals. As the internet became increasingly more accessible at the turn of the 21st century, the architects of the first Health Information National Trends Survey (Hesse et al., 2005) described the changes that the internet created as a "tectonic shift" for health information seeking, which is evident today as most health-related information is found online. For example, in a study that measured how long participants looked at different elements on a social media profile using an eye-tracking device, researchers found that "although profile photographs are given attention and are likely to be influential in impression formation, people tend to focus on descriptive information for a significantly longer time" (Bacev-Giles & Haji, 2017, p. 51). In the online space, language choice for therapists becomes even more important as they are stripped from most of their nonverbal cues that would accompany them during in-person exchanges. To delve deeper into the complexities for mental health providers' specific language choices when marketing their practices, we must first understand how psychotherapists choose to discursively construct the presenting problems they treat.

To explore the discursive formation of presenting problems, it is important to recognize the significance of communication and language when constructing messages about mental health. Communication is central to any discussion concerning mental health because communication is the manifestation of meaning, as it is both a conscious and unconscious

process representing our cognitions and emotions in any given moment. Communication is complex, as it is both instinctual and learned, and can be spontaneous or planned. Communication is inevitable, and as much as we may try at times, we cannot not communicate (Watzlawick et al., 1967). The brain is a meaning-making machine that is constantly deriving meaning and interpretation from the verbal and nonverbal communication of others. In psychotherapy, patients are always assessing for safety, using the communication cues of the psychotherapist, such as their vocalics (e.g., tone, volume), nonverbal behavior (e.g., body positioning, facial expressions), artifacts and adornments (e.g., objects and layout of the therapy room, clothing choice, symbolism of a belief ideology), and their use of language (e.g., words, phrasing, framing).

If communication is the manifestation of meaning, language is then the means through which meaning is shared. This is likely why language is experienced both in the mind and in the observable world because meaning making is a mental process. Fodor (1975) supported this notion by crystalizing the idea that cognition occurs in a language-like medium. The language that is used can be verbal, nonverbal, spoken, or written; and as such, it constructs our social realities through the act of sharing and listening to personal interpretations of reality. As Gunthrie et al. (2013, p. 11) contend, "[t]he language one uses provides a window for others to observe the paradigms through which one sees the world." As these paradigms are shared, thought is influenced, and understanding is reached, they create salient points of reference for individuals to navigate within their social discourse.

The discourse surrounding mental health is complicated. Based on ones' own personal and broader historical narrative, mental health treatment can carry various "indexical" meanings. "Indexicality" refers to what connects language to cultural patterns (Blommaert, 2007).

Language use related to mental health is riddled with indexicals that can spark thoughts of stigma, fear, and/or curiosity. Indexicals are expressions that can shift meaning depending on the context in which they are used or viewed. For example, the phrase, “she has schizophrenia” for one person may bring up feelings of frustration and dismissal due to gender-directed misuse of this term against women in psychiatric wards in the early-to-mid 1900s, while for another person, it may bring up feelings of worry and fear due to their experience of this term in the media and its focus on chaos and violence. These meaning-oriented nuances can make it particularly difficult for patients and providers to feel that they are speaking the same language when talking about mental health.

Because language contributes to shaping mental representations (Bowerman & Levinson 2001; Gentner & Goldin-Meadow 2003; Hinzen 2017), it is therefore the best tool for therapists to tell patients who they are, what they do, and if they would be a good fit for their treatment needs. Language is a dynamic process that psychotherapists can use to control how they are represented, as well as open discourse about the presenting problem. According to Gorbatov, Khapova, and Lysova (2018), “Both individuals and the targets of their personal branding efforts engage in a process of reciprocal sense-making” (p. 10). Through socially/relationally negotiated construction and attribution of meaning, both the personal brander (i.e., psychotherapist) and the consumer (i.e., potential patient) create both the need and the provider. Psychotherapists have financial and ethical incentives to choose presenting problem language intentionally, to attract the most/“best” patients that they feel confident and comfortable treating.

Human-made environments where interaction takes place are malleable and evolving. They consist of the technologies and infrastructures we have invented that support our ways of life that link us together and make us interdependent (Sanders, 2021). The purpose of this study

is to understand the public portrayal of a private profession (i.e., therapy) by focusing on the language that psychotherapists use to explain the presenting problems that they treat in the online environment where this language is used. Their language use is imperative to treatment because their ability to communicate about presenting problems is where decisions for choosing the right provider begins for the patient. There is little research attention focused on the marketing of psychotherapists in general (Becker et al., 2018), and there has yet to be a study exploring this crucial communication event in the patient-provider matching process. The lack of knowledge in this area of health communication limits the discourse related to patient acquisition and provider approachability because we cannot have more meaningful conversations until we know the content of which we are discussing. Because language can be a barrier to treatment, *how* language is used in this context must be further explored.

Overall, this research aims to identify and analyze dominant themes in psychotherapists' presenting problem language used in online messaging. The data was collected from online directories and provider websites to mimic a common way in which patients find providers. The subsequent chapter (i.e., Chapter 2) offers a summary of the relevant research concerning presenting problem discursive considerations, language choice significance in emotional work, and communicating trustworthiness in online marketing. In Chapter 3, I provide details of the collected data and outline the methods and procedures utilized in this study. In Chapter 4, I provide the research findings from this study. Last, Chapter 5 offers a discussion and interpretation of the results, as well as the theoretical and practical implications of this research. Limitations of the current study, as well as directions for future research, are also presented.

CHAPTER 2: LITERATURE REVIEW

In this chapter, key concepts and relevant literature relating to presenting problem discourse, language use in emotional work, and communicating trustworthiness in online marketing are reviewed. Examining the relevant literature of these areas provides a richer understanding of the influences and considerations that affect how psychotherapists choose to discursively construct the presenting problems that they treat.

Presenting Problem Discursive Considerations

One of the most common ways to recognize a presenting problem is by using a formal diagnosis. The term "diagnosis" comes from the Greek word, *gnosis*, meaning "deep knowing" or "thoroughgoing knowledge" (McWilliams, 2016). In its broadest meaning, "diagnosis" may apply to any situation that needs better understanding, so that therapists can provide the best and most effective and/or meaningful care possible. According to McWilliams (2016):

> We can diagnose a problem with a car or a malfunction with a computer or a failure of some institution, political system, or economic process. 'Diagnosis' means trying to understand in as much depth as possible so as to guide practical intervention. (p. 31)

Diagnosing is a communication event. Identifying a diagnosis is a result of a sensemaking interaction between a therapist and a patient, wherein naming the problem assumes a level of certainty and control (Brown, 1990). Mental health diagnoses are often distinguished using the term "disorder," such as obsessive-compulsive disorder, social anxiety disorder, and avoidant personality disorder, to signify those symptoms have reached a clinical level of distress that is interfering with day-to-day functioning. With this language, and for most

psychotherapists, the process of diagnosing is essentially a “power-linguistic approach to categorization, in which subjectivity is sacrificed to clinical objectivity” (Brown, 1990, p. 400).

Ultimately, diagnoses themselves are subjective to the parties that create them (Parrott et al., 2020). The current approach to classifying and diagnosing mental illness can be attributed to the Diagnostic and Statistical Manual of Mental Disorders (DSM) III. Published in 1980 by the American Psychological Association (APA), the DSM-III was drafted in a time of conflict amongst mental health professions. Psychiatry, the dominant profession at the time, began to lose its privileged position in the field to clinical psychology. New research supported new treatments, and Dr. Robert Spitzer, an acclaimed psychiatry professor at Columbia University, was tasked to lead the efforts to create a new manual of mental disorder classification using psychiatric origins (Spitzer, 2001). Diagnostic criteria for the DSM-III were created by psychiatrists who were deemed the most qualified (by other psychiatrists) to make those decisions (Strand, 2011). Clinical psychologists, therapists, and psychoanalysts were notably left out, although small glimpses of their perspectives are arguably found throughout the manual. The DSM-III aimed to simplify diagnosing by connecting categorized illnesses with corresponding symptoms, giving the “diagnosis” full power over differentiating between illness and health.

With as much power that the DSM-III held, it also had problems, most notably with its usefulness outside of research. Clinical functioning was not prioritized in its design and was admittedly (by Spitzer, 2001) not given much thought before publication. Despite this, the DSM-III was widely adopted due to its popularity with insurance providers and pharmaceutical companies, supporting and advocating for their involvement in treatment. The reach of the DSM-III extended past the health field into areas such as law, education, and government. Notable

changes have been made between the introduction of the DSM-III and the current DSM 5 (APA, 2013), though much of the disorder classification schema and language remains the same.

Although clinical diagnoses are integral to healthcare, the use of them can be controversial in the mental health field. Definitions of mental illness and diagnostic classification systems determine who is "ill" and who is not, as well as who receives treatment, as well as the type of treatment. At a societal level, these labels (i.e., diagnoses) can stigmatize those who bear them, preserving a cycle of social inequality that privileges status-quo political and economic agendas (Goffman, 1963; Tyler & Slater, 2018). Conversely, these labels are valuable to the medical and mental health community by providing a common language that clinicians can use to discuss presenting problems and treatment for their patients. Just as a diagnosis of a broken wrist is valuable in determining if a cast is necessary, mental disorder diagnoses and classifications help to determine if interventions, such as medication or psychotherapy, are necessary.

Practically, diagnoses allow patients to use their insurance benefits for treatment which helps to increase financial accessibility to mental healthcare. Depending on the diagnosis, patients may also file for disability and/or be protected from discriminatory actions (e.g., at work). Therapeutically, therapists communicating patients' diagnoses directly to them can produce therapeutic and beneficial effects, such as improvement in self-esteem, relief from emotional distress, and/or increased compliance with treatment recommendations. Additionally, using a diagnostic system for mental illness allows for more empirical research into its causes and treatment options (Kelly, 2018), which equips providers to be more effective in their work.

As mentioned above, the stigma associated with mental health diagnoses is a serious consideration for psychotherapists. In fact, this stigma is one of the biggest reasons that a

clinician would choose to not diagnose their client, or at least not share their client's diagnosis with them (Milton & Mullan, 2014). This decision is controversial but has professional backing with ethical codes, such as the American Counseling Association's standard E.5.d, "Counselors may refrain from making and/or reporting a diagnosis if they believe that it would cause harm to the client or others. Counselors carefully consider both the positive and negative implications of a diagnosis" (ACA, 2014).

Clinicians understand and are empathetic to the reality that being stigmatized is a stressful experience. This stress can influence how stigmatized individuals respond to stigma messages, both voluntarily and involuntarily (Miller & Kaiser, 2001). Involuntarily, stigmatized individuals experience unpleasant physical and emotional arousal that can lead to impulsive action or isolation. Voluntarily, they can choose to detach or use a communication strategy that they feel best manages their stigmatized identity, such as using people first language (e.g., "a person with schizophrenia" instead of "schizophrenic"). In a profession dedicated to alleviating the stress response of their clients, many psychotherapists struggle with the idea that they may be adding to their patient's stress through seemingly immutable traditions of their occupation that they may not even agree with (i.e., diagnosing practices).

Not all patients experience stigma the same way or to the same degree. Many patients will come to therapy already diagnosing themselves from web searches and psychopharmaceutical commercials that *seem* to echo their symptoms. Self-diagnosis has become more prevalent as commercials for psychopharmaceutical drugs have shifted from advertising medication responding to an illness in need of treatment, to advertising symptoms presented as an illness with the goal of consumers seeking the medication themselves (Waite, 2012). Whereas this rise in self-diagnosis may not necessarily represent a steadfast decrease in

stigma, this symptom-first discursive construction may at least reflect a curious culture that is becoming more aware of, and perhaps more willing to talk about, mental illness, with a desire to put a name to the symptoms that negatively impact them.

According to the American Psychological Association's (2002) code of ethics standard 6.06, clinicians are required to provide accurate information concerning a patient's diagnosis to a third-party payer (like an insurance company). Moreover, they must also conduct their practice accurately, honestly, and truthfully. Regardless of personal conviction, outside influences embedded into the medical model that psychotherapy falls under can provide immense pressure and internal conflict for psychotherapists to diagnose their clients with mental disorders. To put it frankly, managed care (i.e., insurance companies) requires a diagnosis for payment, and many individuals cannot afford mental healthcare without the financial help that these companies provide.

Lowe, Pomerantz, and Pettibone (2007) conducted a study to test how managed care involvement impacts diagnosing with psychotherapists. They created two vignettes describing fictional patients that had symptoms of social anxiety disorder or symptoms of attention-deficit/hyperactivity disorder, but not enough symptoms to meet the diagnostic threshold (which provides the justification for a clinical diagnosis). The fictional patient vignettes also mentioned if they were paying with insurance or out of pocket. The researchers found that psychotherapists diagnosed patients paying through managed care nearly three times more than those paying out of pocket (Lowe et al., 2007).

The study by Lowe et al. (2007) highlights the ethical and moral dilemma many psychotherapists face when diagnosing a presenting problem. For example, a parent seeks therapy grieving a sudden loss of a child. They are experiencing intense emotional distress, sleep

disturbances, angry outbursts, and hopelessness. They are struggling financially and need to utilize their insurance benefits to attend therapy. In the first session, the therapist learns the tragic story of loss and the painful aftermath that has left the grieving parent feeling isolated and directionless. Towards the end of the session, the parent expresses that the therapy room is the only safe space they have in their life right now and is grateful to be taken on as a patient. It is clear to the therapist that the person in front of them is suffering, desperately wants to feel better, and is hopeful that therapy will help. This is where the dilemma begins. Although in any other circumstance, the intensity of this patient's distress would qualify for a clinical diagnosis, the "symptoms" that the patient is experiencing are considered natural responses to grief, which is not a DSM 5 diagnosis. Bereavement is, however, a "v code" listed in the "[o]ther conditions that might be the focus of clinical attention" section of the DSM 5 (2013), but the patient's insurance does not cover "v codes." Some of their symptoms could technically fit into major depressive disorder, which the therapist knows would be covered by insurance. However, major depressive disorder has some clear lineations separating it from bereavement. Most insurance companies require a diagnosis after the first session, so the therapist must decide very early on whether to diagnose their client inaccurately, authorizing their economic access to mental health services, or decide not to diagnose them, knowing that this decision would essentially prevent the patient from receiving the care that they need.

The example above illustrates some of the external considerations for communicating and/or documenting presenting problems as diagnostic disorders. Sometimes the cause of emotional distress is not so clear. This can complicate diagnosing, as people often make attributions about the cause of a person's behavior to understand the situation, as well as to understand what controls future events (Kelley, 1967). Highlighting this error in attribution,

Nakash et al. (2018) conducted a study comparing presenting problem perceptions of both patients and providers after a diagnostic (intake) session. They found that although providers were able to accurately identify the significant emotional and relational distress of their patients, they were not as consistent with understanding their patients' desired focus of therapy and underplayed the role their patients' physical illness/distress and financial issues. Furthermore, Elwy et al. (2007) found that *how* health professionals communicate with patients may be associated with the attributions they make for their patients' behavior. Therapy is a social interaction between therapist and patient, where the two can be conceptualized as a working team, each of them with unique roles and responsibilities, united together to reach treatment goals. This means that the discursive formation of the presenting problem between therapist and patient early on directly influences how the therapist communicates with their patient thereafter.

As therapists continue dialogue past the conceptualization of the presenting problem, they are responsible to avoid and prevent dignity injuries through non-ethical communication practices. In mental health professions, dignity has been defined as "the inherent and inalienable worth of all human beings irrespective of social status such as race, gender, physical or mental state" (Funk et al., 2015, p. 14). Dignity is "something intrinsic to individuals; it is a vulnerable and valued part of their being" (Lucas, 2015, p. 621). It can be found in individuals' self-conception, as well as the quality of their interactions with others. Thus, the kind of interaction required for clinical growth in psychotherapy would be classified as vulnerable.

According to Livingston (2004), vulnerability can be conceptualized as making oneself "susceptible to being wounded" (p. 443). When people drop their defenses, particularly contemptuous and shame-related behaviors, and share their vulnerable selves in a safe and nurturing atmosphere, such as a therapy office, self-development and self-awareness can be

enhanced (Livingston, 2004). This drop of psychological defenses is necessary for self-development leaves clients vulnerable to dignity injury through actions of the therapist, such as aggressive or microaggressive communication, unethical behavior, or enacted superiority. Ziedonis et al. (2016) recommend that therapists practice mindful communication, deep listening, and be transparent about treatment plans to help reduce the occurrence of dignity injury.

Therapists have a moral obligation to preserve and advocate for the dignity of patients due to the barriers of accessibility, education, and stigma surrounding mental health treatment (Sagar & Prakash, 2016). How psychotherapists choose to describe, define, or diagnose their patient's presenting problems are linguistic means to advocacy that directly influences the patient's sense of identity and tendencies towards resilience. Because of this ethical obligation, the language choices psychotherapists make are some of the most significant choices impacting the effectiveness of the work that they do.

Language Choice Significance in Emotional Work

Psychotherapy is a type of emotional work. The term *emotional work* refers to work that largely involves "authentic emotion in positions where intense emotionally charged interactions are common" (Miller et al., 2007, p. 235). Psychotherapy is centered around emotional talk (discussion about emotion) and emotional expression. Professionals in this type of work utilize emotional boundaries and emotional labor to manage relationships. *Emotional labor* refers to the intentional nonverbal expressions that professionals use or display to look and act in ways that comfort their patients (Hochschild, 1983). For example, in this context, emotional labor might play out with a therapist slightly furrowing their eyebrows to express sympathy or smiling to express warmth. Boundaries in emotional work are needed to prevent emotional contagion, such

as trauma therapists experiencing their patient's shame, grief, fear, and self-doubt (Sexton, 1999). These boundaries are largely internal but can also be asserted by the therapist's communication through language use, question choices, and nonverbal displays. For example, a therapist becoming overwhelmed from details shared by a grieving patient might try to create emotional distance for themselves by using euphemisms (e.g., "passed away" instead of "died") or use a question to direct the discussion towards a less triggering component of grief (e.g., "who is supporting you during this time?").

Psychotherapy is interactive in nature and positions emotion as a communication event. Although the orthodoxy of psychology asserts that emotions are a state of the individual, Harre and Gillet (1994) challenge this convention by describing *emotions* as being psychologically equivalent to *statements*. Further, Harre and Gillet suggest that emotion is socially purposeful and cultural. Conceptualizing emotion interactionally, and not just intrapersonally, reveals that emotions are constructed between people, and ultimately a social form of action (Fredman, 2004). Even as scientific leaps for understanding emotions are achieved, they create cultural stories from which humans take comfort and meaning (Watters, 2010). These stories are often shared with language.

Language is both the therapist's and patient's tool of communication in psychotherapy (Streeck, 2002). With a multitude of emotional and cultural interpretations, "linguistic competence does not solely depend on the knowledge of the language but is also associated with the culture in which this takes place" (Georgiadou, 2014, p. 14). Language can mean different things to different speech communities (or individuals from different cultures). For example, speech communities perceived as working class across the United States might share a similar linguistic system, including frankness, directness, expletives, and "straight-talk" (Chun, 2019).

These linguistic qualities may seem crass to outsiders but are part of how this speech community creates shared meaning and a sense of shared identity.

Internal conflicts for conceptualizing the presenting problem in therapy often manifest outwardly in discourse. Psychotherapists must consciously consider their own and their patient's language use as they frame their patient's presenting problem and treatment plan. Languaging these concepts is integral to the therapeutic modalities and interventions themselves. As De Shazer (1994) highlighted in their work, psychotherapeutic change happens within the limits of language. Additionally, they asserted that as psychotherapists, "what we talk about and how we talk about it makes a difference" (De Shazer, 1994, p. 10). This notion has been supported by researchers such as Demiray and Gençöz (2018) who found that a patient's language use naturally changes as they experience psychological and emotional changes in therapy.

For effective therapeutic change to take place, psychotherapists need to communicate in a way that meets a patient's needs while maintaining a sense of their emotional capacity (Thompson et al., 2011). Therefore, the words that psychotherapists use must be considered cautiously and carefully. For example, a sexual assault survivor may be emotionally triggered when discussing their assault based on the language the therapist uses to refer to the assault (e.g., "rape," "attack," "assault," "traumatic event"). A patient's response to a therapist's language use sends a message in and of itself. According to Rogers and Schmidt (2016), "Emotion is an invitation to others to respond rather than solely an internal experience. But this invitation is not always so clear" (p. 209). Thus, how the therapist forms thoughtful responses to emotional talk can promote safety, as well as encourage growth and healing.

Therapist/patient communication happens both consciously and unconsciously (Bass, 2019). Although there is research to support the importance of using "real world" discourse with

patients (Tay, 2014), without realizing it, therapists may use words attached to the cultural lexicon surrounding mental illness that evokes a negative emotional response, such as the use of labels and/or jargon. In a Washington Post article (2021), psychiatrist, Dr. Eve Byrd explains that linguistic shortcuts such as "schizophrenic" versus "a person with schizophrenia" adds to stigma and reduces a person down to their diagnosis. As Byrd (2021) notes, "an illness is a part of their life and experience and does not define who they are."

While reductionism may not be the intention in using the word "schizophrenic," it can have negative consequences on a patient's sense of self. Careless language use can also have consequences on a patient's sense of how their therapist views them. For example, the misuse of pronouns can have profound effects on patients. This type of mistake by a therapist can feel invalidating or even hostile to a patient, which is why Goldberg (2019) recommends that therapists only mention a patient's gender identity when it is clinically relevant.

Although psychotherapists may not intentionally try to express negative sentiments toward their patients, they may be harboring biases at the automatic, and often non-conscious, level. This level is referred to as "implicit bias" (Wilson et al., 2000). Implicit bias reflects more spontaneous attitudes that are relatively hard to monitor and self-regulate, but that can be exposed through microaggressions and other harmful communication practices. Microaggressions are "brief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults that potentially have a harmful or unpleasant psychological impact on the target person or group" (Sue et al., 2007, p. 273).

Davis et al. (2016) found that microaggressions hinder the treatment process by rupturing the therapeutic alliance between therapist and client and are more common than researchers

originally believed. In their study, Davis et al. (2016) found that most clients report experiencing at least one microaggression from their therapist. Nadal et al. (2015) also reinforces the importance for mental health clinicians to be cognizant of the intersectionality of both their own, and their client's identities, to avoid the use of microaggressions in their work.

Purposeful language use can not only promote emotional safety, but it can also help therapists promote their professional niche in working with specific presenting problems or populations that they prefer to work with. Whether they are using inclusive, direct, or tacit language, therapists can display their clinical and/or cultural competency through *how* they communicate about the work that they do. For example, a therapist passionate about working with gender minorities may use inclusive language throughout their marketing, such as using the pronouns "they/them," or referencing "mindful eating" and "body neutrality" when marketing for patients experiencing disordered eating. Although niching can help patients find a provider that they feel is the right fit for their needs, not all therapists agree with this marketing strategy. For example, Bradshaw (2020, p. 15) notes:

> If we view patients in terms of a niche, we could be reinforcing their story and excluding a fuller exploration of other, silenced parts of them. In specializing in a niche, we may be unconsciously contributing to the sense that a group identity (be it class, race, sexuality or type of issue) is the only identity that a person can have. In reality, we are all complex, multifaceted and messy in both our identities and our needs. Maybe it is helpful to have some idea of the issues that person presents with. Conversely, the idea that we may 'know' something of their experience before they have the chance to talk about it may buy into the idea that the whole of that person is that narrowly proscribed narrative.

Undoubtedly, emotional experience is tied to emotional talk, which is also tied to identity. Patients want to meet with a provider who they feel "gets" them. How therapists choose to communicate the type of patients they "get" can be a tricky process.

The key to psychotherapists' effective work is that they create a sense of safety for their patients, so that emotional talk is possible at the time when people feel unsafe (Rogers & Schmidt, 2016). Because the protection of the "self" is central to survival, vulnerability is pursued cautiously. The safer one feels, the less one is concerned to hide from others and oneself (Pocock, 2005). The lack of protection that vulnerability requires influences the perception of emotional acceptability and non-acceptability for any given circumstance and is especially relevant to psychotherapy. For patients to willingly express vulnerability with their therapist, the therapist must first earn their trust. Doing so requires thoughtful communication practices, both in and out of session, from the very beginning of the help-seeking process.

Communicating Trustworthiness in Online Marketing

Making the decision to seek out therapy is not easy. In fact, making that decision is identified as the hardest step in the whole therapy process (Elliott et al., 2015). Because societal health messages are largely blaming or shaming, responsibility for wellness is often placed on the "sick" person (Guttman, 2011), stigmatizing their efforts to become well. It is the responsibility of mental healthcare providers to help destigmatize this process by promoting messages of safety and hope for recovery in the therapy-seeking process. As noted earlier, patients are always assessing their therapist for emotional safety, which can often start with what is communicated on a mental health provider's website.

According to research on Health Information-Seeking Behaviors (HISBs), an internet search is the most common starting point for individuals wanting to learn more about health and

healthcare options (Jacobs et al., 2017). An HISB is a purposeful act intended to satisfy a perceived need for health information (Johnson, 1997), such as a Google search. HISBs can be triggered by an external stimulus (e.g., self or a loved one experiencing a disease or suspected symptoms of a disease) or an internal curiosity (Lenz, 1984). Finding information for health-related concerns can decrease anxiety and increase a sense of autonomy for taking action towards wellness (Lambert & Loiselle, 2007), such as seeking therapy treatment.

Psychotherapy websites are commonly visited by individuals with mental health concerns. According to a survey of psychiatry patients (Klackreuth et al., 2014), roughly 70% of patients use the internet to look up mental health information, including therapy options. Diving deeper into assessing emotional safety, Eichenberg and Sawyer (2016) found that over 80% of psychotherapy patients look up their specific therapist online, searching for both professional and personal information. It is clear that patients have a need and desire to feel like they know and trust their therapists.

Therapists, on the other hand, have struggled to identify how, or how much, they want to be known by their patients. As online interactions become increasingly more socially prevalent and important, how individuals present themselves online has become more complex. boyd's (2002) concept of "faceted identity" addresses this web-based complexity by explaining that different aspects of an individual's identity are relevant in different contexts. Those aspects are shared or hidden based on the specific context and how the individual feels they will be perceived by others. Psychotherapists must choose what aspects of their personal identity they include in the online presentation of their professional identity in order to attract patients that "fit" with them. When looking for a therapist online, patients may be more likely to choose someone who presents themselves in a way that resonates with their own identities, such as

shared cultural or social identities, creating a sense of empathy and understanding. Additionally, a psychotherapist who presents themselves as approachable and non-judgmental in online marketing may be more appealing to someone who values those qualities.

Online resources have been available for psychotherapists to connect with potential patients for decades, but the field of psychotherapy in general has not kept up with online evolutions in marketing. Therapists have a tendency to be critical of personal branding and struggle to carve out their own professional identity, while also emulating more established yet opaque fields, such as medicine (Wiita, 2021). Along with a lack of marketing education taught in psychotherapy training programs, the influence of psychoanalytic treatment techniques (famed by Dr. Sigmund Freud) has fostered a condemnation of self-disclosure, which "was considered an amateurish technical error," and set the expectation of maintaining clinician privacy for the perceived benefit of the patient (Zur et al., 2009, p. 26).

The stigma of personal marketing in this profession is well documented. In 1992, Gilchrist and Stringer advocated for psychotherapists to market themselves by outlining three primary benefits. First, to help therapists maintain their position as service providers. Second, to help enhance the image of therapy services. Third, to help meet increasing demands for therapist accountability. According to Becker et al. (2018), marketing psychotherapy services has helped enhance the image of therapy services by helping to reduce stigma and is a preferred way for some patients (i.e., college-aged individuals) to acquire information about therapy services. By meeting this preference with thoughtful online marketing materials, psychotherapists have an opportunity to build early trust with prospective patients by promoting their services in an accessible way.

Trust is arguably the most crucial factor when choosing a mental healthcare provider. Advising prospective patients on how to choose a therapist, the American Psychological Association (APA, 2017) lists factors on their website such as the therapist's experience treating the presenting problem(s), cost, location, and the specific type of therapy. At the end of this list, the APA reinforces the value of trust in making this decision by stating, "[r]emember that choosing a therapist is a very personal matter. No one therapist is good for every patient. It is important that you feel a sense of trust and that this therapist can help you." Along with the APA, other popular online sources for health information mention factors alluding to trust as being pivotal in the search for a psychotherapist. WebMD (Davis, 2004) published guidance for choosing a therapist from mental healthcare providers, quoting Psychologist and author, Dr. Geurin Weiss', advice:

> You find a therapist in the same way you choose any healthcare professional. They must be professional, credentialed, and competent, with no lawsuits against them. And they must be an intuitive fit – you can't underestimate the absolute value of feeling a good intuitive match with somebody.

What makes a provider trustworthy or not may be difficult to put into words at times, but that intuitive feeling of safety can make all the difference in finding the right fit.

Trust is an essential component of one of the most powerful predictors of therapeutic outcomes regardless of treatment modality – the quality of the therapeutic alliance (Hill & Knox, 2009; Horvath & Symonds, 1991, 1994). The therapeutic alliance refers to the bond between the therapist and patient (liking and trusting), and the agreement they have about therapy goals and therapy tasks (Bordin, 1979). Although the professional relationship does not begin until an interaction has been made (Smith et al., 2012), trust starts to build with the first encounter

prospective patients have with a therapist, most likely being the information the therapist shares about themselves online.

> According to Pera et al. (2016), when evaluating others on public online platforms: Parties in transactions are assessed to be trustworthy when they (i) have the required skill and characteristics that enable exerting influence within a specific domain, (ii) are believed to do good to trustors, setting aside an egocentric motive, and (iii) are perceived to adhere to a set of principles that trustors consider important. (p. 47)

When it comes to psychotherapists presenting themselves online, there are some trust-related factors that they have less control over than others. For example, one factor that is quick to qualify/disqualify a therapist is the observed or assumed sex of the therapist. The research on preferences for therapists' sex is extensive, but highly inconsistent. In earlier studies, when men dominated the therapy profession, individuals found unilateral preferences for male therapists (Bernstein et al., 1987); however, more recent research has observed a unilateral preference for female therapists (Landes et al., 2013) or no preference at all (Liddon et al., 2017). Furnham and Swami (2008) found that prospective patients prefer sex-matched therapists, whereas Anderson (2005) found a preference for opposite-sex therapists. More recently and most applicably, Black and Gringart (2019) found that regardless of the sex of the prospective patient, they are significantly less likely to begin psychotherapy if their sex preference of therapist is not available.

Other factors that can quickly earn or lose trust in a therapist for prospective patients is the language(s) that the therapist speaks and their cultural background (Kreuter & McClure, 2004). Shared cultural backgrounds can promote a sense of safety through lived, common

experiences between the patient and therapist and can also endorse a sense of credibility in the therapist. Barnett, Bernal, and Sanchez (2020) explored how language and the messenger impact therapy marketing. In their study, two versions of a promotional video featuring Parent-Child Interaction Therapy (PCIT) – one delivered by a parent/peer, and one delivered by a mental health professional – was shown to Spanish- and English-speaking parents in their natural language. They found that both sets of parents had similar intentions towards seeking out this therapy when the promotional messages were delivered in their native language. Only Spanish-speaking participants had higher intentions to seek out this therapy when the messenger was a therapist rather than a parent/peer. These findings highlight the influence of language use and cultural beliefs surrounding credibility when crafting messages related to mental health treatment.

One way that other professions can establish trust is by posting customer/client reviews. In the field of psychotherapy, it is statutorily unethical to post or solicit reviews from patients (American Psychological Association, 2017; Caldwell, 2020). Revealing that an individual is or has been a patient violates that patient's right to confidentiality. Psychotherapists are legally and ethically prevented from even responding to voluntary online reviews posted on third-party review websites (e.g., Google, Health Grades, Yelp, etc.). Because of the inherent power imbalance prohibitions against soliciting testimonials from clients are in place so that clinicians "do not solicit testimonials from those clients/patients who, due to their particular circumstances, are vulnerable to undue influence" (CAMFT, 2020, 13.6). These provisions, although necessary, limit online public interaction that may help to further inform a therapy-services-seeker.

Interaction and relationships, including those with mental healthcare providers, do not take place in a vacuum. The social interactions we take part in are in the context of the history of

the relationship, and the history of all our other relationships. Interactions take place within a cultural and historic context that shapes our understanding and interpretation of emotion, and our subsequent response (Matt & Stearns, 2014). Not all cultural aspects need to line up for therapists and patients to reach a level of trust and understanding. Contrary to their hypotheses, some research has found that matching therapists and patients on age, income, and gender did not have any measurable improvement on therapeutic alliance compared to unmatched therapists and patients (e.g., see Behn et al., 2018).

Although there are a few identity factors that can immediately affect a patient's trust, the perceived empathy, competency, and genuineness of the therapist have the greatest impact on building a therapeutic alliance (Jung et al., 2015). Empathy in this context refers to the degree to which therapists are successful in communicating their awareness and understanding of their patients' feelings in a language attuned to them (Rogers, 1957). Since learning how to build a therapeutic alliance is integral to psychotherapists' clinical training, it is expected that they would market themselves in a way that reflects these qualities.

Online marketing is a big undertaking for even the most confident of providers. "The increase in and diversification of users are matched only by the tremendous variety and scope of health information and services available online" (Sundar et al., 2011, p. 182). Given that patients frequently visit a healthcare provider's website before their first visit, website design potentially could facilitate a trusting relationship between the provider and patient (Erdem & Harrison-Walker, 2006). When appropriately designed, healthcare provider websites save both providers and patients time by answering frequently asked questions and offering information and tools to help patients identify a provider who meets their needs (Alpert, 2015). For example, due to the increased need for emotional safety, trans and gender non-conforming (TGNC)

patients often search provider's websites to find clinicians who would be a good fit for their needs.

In a recent study (Holt et al., 2019), even when explicitly searching for a therapist who specializes in gender-related issues, on Google and *Psychology Today*, roughly only 56% of the websites stated a provider specialty working with TGNC patients, and 32% of websites had no mention of services or resources for TGNC people at all. This lack of directness is significant because, in a qualitative study of the experiences of TGNC individuals who had sought psychotherapy, participants expressed that they would only select a therapist who is visibly supportive of TGNC people and who is active in the community (Benson, 2013). Because language has a direct impact on safety, it is not just the messages that therapists are sending through their online presence that is important, but also the messages they are not sending.

Along with trying to communicate clinical competency and trustworthiness, psychotherapists may also choose to explain their treatment modality. This can be beneficial to patients as pre-therapy outcome expectations have an impact on later treatment outcomes (Constantino et al., 2011). Due to the wide range of treatment modalities for patients to choose from (e.g., cognitive behavioral therapy, narrative therapy, brainspotting), some therapists feel the need to advocate for why their chosen modality is valuable and/or effective. For example, Boyle (2019) found that play therapy has declined in popularity and prestige with less concrete measurable outcomes, making play therapists less secure about how they describe their work. For prospective patients, it is not necessarily more impressive for therapists to dive into treatment modality details, as it is to speak in a language that the patient can understand. Emma Munro wrote a personal narrative for *Therapy Today* (2009) about her experience finding a psychotherapist online. She wrote:

> What I want is some kind of personal statement explaining in words that I can understand, where the therapist is coming from and what they are offering. There has to be professionalism – the therapist won't reveal personal details – but I have to know what I'm signing up for.

Emma also mentioned how confusing it is to have seemingly infinite options to choose from, and how the psychotherapy jargon used by many providers online did not feel inviting.

Emma is not alone in their confusion. Prospective patients are eager to find help but can struggle to find someone who seems like the right fit. Whether this is because their language use is too clinical, too lax, too vague, non-inclusive, or reads as disingenuous, psychotherapists are the ones liable for the help-seeking process they create, along with the potential patients they fail to connect with. When language, personality, and competency connect in online marketing, therapists are quite capable at fostering first impressions that attract their ideal clients.

Research Question

With so much to consider when crafting messages to achieve this goal, and no current research on what these messages consist of, it naturally leads to the following exploratory research question addressed in this dissertation research:

> **RQ:** How do private practice clinical psychotherapists discursively construct the presenting problems they treat for their potential patients?

In the following chapter (i.e., Chapter 3), I outline the methods and procedures I utilized to identify and analyze dominant themes in psychotherapist's presenting problem language used in online messaging and marketing.

CHAPTER 3: METHODOLOGY

This research project is an exploratory investigation that aims to contribute to the growing body of literature on psychotherapy discourse, specifically when that discourse is directly concerning the experiences that motivate individuals to seek out mental health services. In this chapter, I first address my relationship and positionality with this research topic. I then provide an overview of the methods and procedures I utilized in completing this project. This chapter concludes with a description of the data collection and analytic approaches I utilized to answer the research question posed for the study, before moving onto the chapter of results (i.e., Chapter 4).

Research Context – Positionality Statement

As Thornberg (2012) asserts, it is irresponsible to not include knowledge that you (the researcher) are aware of, as knowledge cannot be unlearned. The knowledge that I have of my research topic started years before I even considered being a researcher. During the first year of my graduate work at Southern Utah University, wherein I was working on my M.A. degree in Professional Communication is where the initial thoughts of becoming a therapist first entered my mind. I was sitting in a graduate seminar on interpersonal communication learning about step- and blended-family communication. We were discussing helpful and unhelpful communication strategies for stepparents who are assimilating into their new families when I thought to myself: *This is really interesting! There are so many families who would benefit from learning this information. This research could really help people.*

I realized that if I simply continued through the standard academic track to become a professor, I would be teaching this information to college students, who may or may not be interested in it, and at a stage of life where this information is likely not all that relevant.

Therefore, I wanted to *do* something with this knowledge, not just teach it. While I was taking this course early in my M.A. program, I was also pursuing a second B.A. degree in Psychology. I set up a meeting with one of my psychology professors, shared with them what I was learning, and asked if this information would be valuable in a therapeutic setting. My professor replied, "yes," and I started planning my new future as a psychotherapist that evening.

I chose to enroll in a Master's of Marriage and Family Studies program at Southern Utah University to become a Marriage and Family Therapist. It was in this program where I learned about the importance of presenting problem jargon and the language that typically goes along with treatment. My prior education in communication had a strong influence on my treatment approach, which was most evident when I was one of only two students out of 24 who gravitated towards Collaborative Language Systems (CLS) as a treatment modality for psychotherapy. In this social constructivist-rooted theoretical perspective, CLS posits that language and knowledge are interdependent of each other, centering language as the key factor for therapeutic change (Anderson & Goolishian, 1988, 1992).

The success of the CLS modality is dependent on the therapist's use of discursive flexibility, the quality of their questions, and their awareness of their client's language use. In CLS, a language change signifies a change within the client (e.g., the problem has been addressed, the problem has been reframed). Given that the therapist using CLS is expected to utilize their client's language during a psychological session, *discursive flexibility* is used to negotiate language use in a way that serves both the client and the therapist (Strong, 2007). I found this to be true even in my early interactions with clients, as they diversely shared their understanding of the presenting problem(s) that brought them to therapy.

Outside of sessions, as my M.A. program progressed, and my peers started to develop their own professional identities, I noticed that the ways in which we were talking about our client's presenting problems (e.g., describing that a client "has" depression, "suffers from" depression, or "experiences" depression) in class and supervision started to differ as well. Because communication is my first academic love, I chose to continue my passion for learning by obtaining a Ph.D. in Communication Studies just two weeks after graduating from my psychotherapy program.

Being reminded of the research on self-presentation, as well as facework (Goffman, 1967), coupled with the impact of framing (Goffman, 1974), is what initially sparked my interest in this dissertation project. Furthermore, while doing research for a paper in a seminar on Health Communication during the first year of my Ph.D. program, I realized that *how* psychotherapists explain the work that they do can be vague, confusing, and even problematic at times. I witnessed therapists present themselves as "specialists" with little to no training in the specialty, offer services that are more aligned with "coaching" than mental health treatment, and described the specific populations that they wanted to work with as a specialization in their identity. For example, it was not rare for straight, cis-gendered therapists to claim, nearly verbatim, *"I specialize in LGBT+ clients."*

Usually, when claiming a specialization, therapists are referring to a specific presenting problem (e.g., post-partum depression, PTSD, eating disorders, anxiety). I hold a strong stance that gender or sexual orientation should not be included in that type of categorization because these identities are not "problems," and allyship is not the same as specialization. I imagine what those therapists meant with those statements is to say, *"I have experience working with…"* or *"I enjoy working with LBGT+ clients."* Unfortunately, how these therapists present that intention

matters because no one has specialization in an identity that is not their own. It would be akin to a white therapist claiming to specialize in Blackness. These examples are not to claim that there is a widespread difficulty with presenting problem discourse, but the presence of these examples is part of the motivation to explore this topic.

My presenting problem discourse interests transitioned specifically to online communication quickly. In the first year of my Ph.D. program, I passed my national licensing exam, opened my own private practice, and started seriously thinking about how I planned to market my services. When writing the online marketing messages for my private practice, I was very intentional in my language use. I intended to attract my "ideal client" – a term often used in the psychotherapy field to describe the preferred characteristics and/or presenting problem that a therapist would most want to work with. My ideal client was vague: 15-50 years old, any gender, struggling with self-confidence, internalized anxiety, feeling that they don't "fit in," but who are also hopeful they can feel differently. I also wanted to give cues to my personality in my description so that potential clients could deduce from my language choice if they thought we would be a "good fit." As an example of this, I wrote the following paragraphs for my *Psychology Today* directory profile:

> Struggling is not meant to be a lifetime sentence. Whether you are struggling in a relationship or with yourself, I believe that with effective communication and inherent trust, everyone can become their favorite version of themselves. One of my favorite quotes is from Rose Fitzgerald Kennedy. She said, "Birds sing after a storm; why shouldn't people feel as free to delight in whatever sunlight remains to them." As a storm passes, we have two options – drown or take shelter. Even after it's gone, we may still

> have to clean up debris. Once that debris is out of our life, that sunlight feels pretty damn good.
>
> My approach is practical and honest. Trust is very important to me, and it starts with open communication. You can expect me to be straightforward, encouraging, and committed to achieving your goals.
>
> When I am not practicing therapy, I am earning my first Ph.D. and 4th college degree. As a firm believer in self-improvement and living a valued life, I have dedicated over 13 years of mine to learning how to help others communicate and feel better. Please feel welcome to reach out by phone or email with any comments, questions, or amusing quips.

Cursing in an online public directory for licensed mental health professionals (i.e., "pretty damn good") was a risky choice but ended up being the number one phrase that clients who found me through *Psychology Today* noted as to why they believed I would be the right therapist for them.

I put similar language intentionality towards writing the content for my website. I was conscious of using dis/ability and gender-inclusive language. In addition, I used an overall empathic, narrative approach in crafting my website. Although I was less forward on my website than in my *Psychology Today* profile, I still wrote to depict hope, confidence, and credibility on the presenting problems that I was treating. I even organized my home page by presenting problem for convenience. For example, a potential client interested in working on social anxiety could click on a picture on my website that reads, "social anxiety," and read more about that condition and the approach I tend to use in treating it. I only made these clickable pictures for the conditions I felt most confident in treating and hoped that highlighting these conditions in such a

way would help instill confidence and trust with my client before we even began the therapeutic relationship.

Another decision I made in the formal construction of my professional website was to try to "weed out" potential clients that would not be a "good fit" with my practice, or who had conditions outside of my scope of practice. I received validating feedback when clients would reach out with statements such as, "On your website, you mention that you treat depression. I think that that is what I have," or "What you wrote about chronic pain on your website is exactly what I am going through." Given all of my client acquisition experiences, it was clear to me that there was a direct correlation between the language I used in my online marketing and the clients who reached out for my services.

As a clinical psychotherapist earning their third college degree in communication, I am constantly balancing two professional identities. As a scholar in Communication Studies, I am privileged to consistently be intellectually challenged by experts in their field, grow as a teacher by educating college students in valuable communication principles, and access and contribute to innovative research that spans across disciplines. As a clinical psychotherapist, I am privileged to be trained in treatment modalities that help bring healing to emotional and often ambiguous circumstances. My training allows for me to have access to hidden parts of people's personalities that they do not readily show the world (i.e., vulnerability, insecurity) and bear witness to the resiliency of the human spirit repeatedly, with each client I meet.

Although it is clear to me how my communication scholar and psychotherapist identities are interdependent with one another, onlookers may often have misconceptions. For example, my psychotherapist identity allows me a higher level of occupational prestige – the level of social status attributed to members of an occupation based on that occupation's perceived

contributions to society (Hauser & Warren, 1997) – than my communication scholar identity. However, I would argue that my acquired education to complete a Ph.D. in Communication Studies has been equally influential in my role as a psychotherapist, as was my education in Psychology. After all, it was my love for communication that inspired me to become a psychotherapist.

I do not believe that these two professional identities (i.e., communication scholar and psychotherapist) are mutually exclusive, and feel that both are valuable in this dissertation research. Although a strength for this research topic comes from my tacit knowledge – understanding of the nuance of a culture – in the psychotherapy field, there is also a potential risk for bias. I am choosing to consciously put aside the bias that I have experienced regarding presenting problem discourse for the purpose of true exploration. The practice of non-biased and ethical conduct is intrinsic to both of my professional identities, and I am committed to the practice of bracketing throughout this study, as well as the other rigorous standards outlined in this chapter.

My hope for the outcome of this study is not necessarily for generalizability, but for transferability. I hope to provide enough thick and rich description so that other therapists can see themselves in the findings. It is my intention with this study to bring focus and reflection to the ways in which psychotherapists discursively construct the work that they do to the people who are seeking help. The results of this study may help psychotherapists better align their intentions with the words that they choose. I understand that this study will serve as only a starting point for a much larger conversation centering on therapists' communication responsibilities and considerations for mediating potential clients' preliminary therapeutic contact experiences.

Research Method

Due to the exploratory, qualitative nature of the research question, coupled with the limited knowledge currently published about this topic, a thematic analysis is an ideal method utilized to understand how psychotherapists choose to discursively construct the presenting problems they treat. Thematic analysis is a method for identifying, analyzing, organizing, describing, and reporting themes found within qualitative data (Braun & Clarke, 2006). Through its theoretical freedom, thematic analysis is an ideal choice for exploratory research. Its approach to data collection and analysis provides a rich and detailed description of large data sets by guiding the researcher in a structured process to produce a clear and organized final report (Braun & Clarke, 2006; King, 2004). This final report is presented through the use of "themes." Themes are patterns of shared meaning, united by a central concept, that address the research question in an insightful way (Braun & Clarke, 2013, 2014). Its inductive approach gives a truer picture of the underlying concept, compared to other more theoretically confined methods, by allowing the data to drive the organization and presentation of the research findings.

Without pre-established theoretical categories to guide the data analysis, thematic analysis can be adapted to any qualitative research that relies solely on researcher interpretation (Alhojailan, 2012). Researcher interpretation is often influenced by their personal experiences. These experiences are a strength throughout the entire research process as they provide a deeper understanding of the topic for the researcher (Nelson, 2017). This, in turn, enriches the quality of the study's findings, helping to explain in greater depth new concepts to others who are unfamiliar with the research topic.

Thematic analysis has been the method of choice for many scholars who are interested in studying online messages. Herrick et al. (2021) used thematic analysis to explore how TikTok

users expressed their personal experiences with eating disorder recovery on the platform by analyzing over 150 social media posts. Similarly, Faric et al. (2019) used this approach to explore how players of various virtual reality gaming systems express their opinions about the games they played on public review platforms.

Along with being a valuable tool to study how individuals share their lived experiences online, thematic analysis is also a valuable tool to explore web-based promotional communication. Crook and Nixon (2021) used this method to analyze how essay mill websites (i.e., sites where collegiate-level essays are available for purchase) portray educational practices and the student's experience of those practices. Adding a critical lens to their research, Grundy (2021) used thematic analysis to uncover how graduate programs in Communication Sciences and Disorders promote multicultural education by analyzing programs' website descriptions from across the country. They found that although many programs are headed in the right direction with offering multicultural courses, the content presented to be taught in these courses are institutionally lacking in both modernism and practicality.

Thematic analysis is a well-suited methodology for integration with critical perspectives. (Lawless & Chen, 2019). Critical approaches to research advance the ability to deconstruct the "archeology of knowledge" and identify how human discourse is linked to larger social constructions, grand narratives, and social ideologies (Foucault, 1972). This study presents itself not simply as a summary of potential patients' experiences, but intentionally moves to a macro-level analysis that links everyday digital discourse to larger ideologies.

Data Sample

According to Tompkins (1994), "[t]he basic unit of evidence in qualitative research is the word, written or spoken" (p. 44). The sample for this study was compiled of written messages

pertaining to mental health treatment on private practice psychotherapist websites, and personal statements written for the directory used to find them, from *Psychology Today* (see Appendix A). "Websites remain the mainstay of health information on the internet. Websites are remarkably versatile tools for mass communication of health information and advice" (Sundar et al., 2011, p. 192). I searched *Psychology Today*'s online directory for profiles from four large cities in the United States located in the Northeast, South, Southwest, and Midwest regions. These region labels are used in lieu of the therapists' specific cities and states to provide a layer of anonymity to their identities. These cities were selected because they span across a wide area of regions in the United States, allowing for a wide range of cultural representation in the presenting problem messages across psychotherapists' websites. Licensed psychotherapists of all genders, races, ethnicities, and ages practicing within these regional parameters were eligible for this study. I did not make assumptions about race, ethnicity, or gender while collecting this data, through some clinicians self-disclosed on their websites (e.g., "as a BIPOC therapist," "as a queer-identifying therapist," etc.).

Both *Psychology Today*'s personal statements and professional websites were used for this research. Personal statements on *Psychology Today* are three-paragraph, 1360-character maximum statements that psychotherapists write to promote themselves on their directory profile (see Appendix B). There are three prompts that the *Psychology Today* website gives the therapists to guide their statement. The official prompts include:

> (1) Imagine your ideal client. What are their issues, their needs, their goals? What do they want and why? (2) How can you help? Talk about your specialty and what you offer. (3) Build empathy and invite the potential client to reach out to you. Do not include contact details here.

The prompts do not specify any language or phrasing restrictions for what therapists can or cannot write on their profiles. It is stated on the *Psychology Today* terms of use webpage, "[w]e are under no obligation to monitor the conduct of our users, but we may investigate and respond when violations are reported" (Psychology Today, 2023). When contacted to clarify if there are any language/wording boundaries in place for therapists using their platform, and what would be considered a violation, a *Psychology Today* representative briefly responded, "[a]n example of a reported violation was that one of our members copied another member's personal statement" (Psychology Today, personal communication, October 18th, 2022).

Only websites and *Psychology Today* profiles associated with independently owned, private practices were selected for this study. If a website is only written and designed to represent one clinician, then that clinician will have the most autonomy over how they present themselves online, as compared to clinicians sharing a website for a group practice or an agency. For example, a clinician that works at a group practice may have all their online marketing content created by the group owner or a marketing company to align with the group marketing as a whole. In contrast, an independent, private practice clinician that owns their practice would only be writing or approving content that they feel is authentic to them because they do not have other clinicians to consider.

Another qualifier for inclusion in the study was that only independently, clinically licensed, private practice owners would be eligible. This qualifying strategy helped to ensure that I analyzed messages from actual licensed mental health professionals, discluding pre-licensed clinicians who are under clinical supervision, "coaches," and other non-licensed wellness professionals. All publicly accessible web pages on a qualifying therapist's website were analyzed for this study. Ultimately the data sample was comprised of 16 Licensed Clinical Social

Workers (LCSW), 12 (Psych) Psychologists, 6 Licensed Professional Counselors (LPC), 5 Licensed Marriage and Family Therapists (LMFT), and 1 Licensed Mental Health Counselor (LMHC). Specifically, I coded the profiles of 2 LCSW, 5 Psych, 2 LPC, and 1 LMFT from the South; 7 LCSW, 2 Psych, and 1 LMHC from the Northeast; 3 LCSW, 3 Psych, and 4 LPC from the Midwest; and 4 LCSW, 2 Psych, and 4 LMFT from the Southwest.

Data Collection

In qualitative research, the process of data collection, data analysis, and report writing are not always distinct steps; they are often interrelated and occur simultaneously throughout the research process (Creswell, 2007). For this study, my data was written messages found on private practice psychotherapist websites and personal statements written by psychotherapists for *Psychology Today* (see Appendix C). To protect myself and my IP address, I utilized my computer's "incognito mode" (private web browsing feature) when collecting my data. Websites were identified by searching profiles by the selected cities listed on *Psychology Today*, a public online directory service for mental health professionals. The order in which therapists are listed in on the directory is randomized when users visit the site based on location (Therapy Everywhere, 2021). This randomization process was confirmed by an email exchange with a representative for the directory:

> [w]hen a search is completed on our site, all the members with addresses within the search area are randomized on the page. Everyone has an equal chance to be at the top of a results page. Currently, there is no way to force profiles to the top of a specific results page. (Psychology Today, personal communication, August 1st, 2022)

Because of this, each of the four selected city's therapist data was collected on the same day.

Once a qualifying therapist's profile was identified, I then followed the "Website" button link from the *Psychology Today* profile to connect to the individual therapist's website (see Appendix D). Ten therapists' *Psychology Today* and website data were collected from each of the four city samples, totaling 40-time preserved data sets collected for analysis. I understood and considered the ethical commitments to my peers and institutions regarding who owns and is entitled to share data and materials generated in the discovery process (Humphreys, 2021, p. 861). Psychotherapists posting on *Psychology Today* choose to make their accounts public (accessible to everyone) or inactive (unviewable to anyone except themselves). Only profiles and websites that were publicly accessible (considered to be in the "public domain") were analyzed. No personal identifying information (i.e., names, physical descriptions, etc.) is included in this document to help protect the identity of the therapists.

Once collected, theoretical sampling (Strauss & Corbin, 1998) was used to develop, refine, and fill out the properties of tentative thematic categories that the data was defining. Through this process, categories became more precise and robust. With thematic analysis, "the cycle of comparison and reflection on 'old' and 'new' material can be repeated several times. It is only when new cases do not bring any new information to light that categories can be described as saturated" (Boeije, 2002, p. 393).

Of the 40 therapist websites and *Psychology Today* personal statements collected and analyzed, 32 were needed to reach saturation (Davis et al., 2013), though all 40 were still included in the analysis. Analysis was conducted systematically by numbering each data set as they were collected within their respective city group (e.g., "South 1", "South 2," etc.), then analyzed in numerical order, turn-taking evenly between the four cities (see Appendix E). For example, the first collected data set of each city ("South 1," "Northeast 1," "Midwest 1," and

"Southwest 1") would be coded before moving on to the second collected data sets ("South 2," "Northeast 2," "Midwest 2," and "Southwest 2"), and so on. This allowed each city (i.e., cultural region) to have equitable representation in the coding process. This amounted to the content of a total of 208 web pages (168 website pages and 40 *Psychology Today* profiles), and 40 therapists' online materials being analyzed for this study. Individual words/phrases were not totaled as myself and my advisor felt it would be too cumbersome to count.

Data Management

Data for this project was stored in two ways. First, the therapist's *Psychology Today* profile and individual pages of their website were downloaded and saved as a file for offline viewing. This preserved the date from the time of collection. Second, the *Psychology Today* profile and website pages were saved as HTML files as a backup, which preserved all written text. This data was stored on my personal computer and on KU's OneDrive as a backup. I also ensured that my dissertation advisor had access to all data collected as part of this research through a shared file.

Data Analysis

To analyze my data, I utilized an inductive, constant comparative technique (Charmaz, 2006; Strauss & Corbin, 1990), systematically organizing thematic coding into two primary steps: (a) open coding and (b) axial coding. Unlike other systematic methodologies, constant comparative analysis occurs simultaneously with data collection. One of constant comparisons' greatest contributions to exploratory thematic analysis research is its "stimulating process thought that leads to both descriptive and explanatory categories" (Lincoln & Guba, 1985, p. 334). It is used throughout the full coding process, making comparisons between: (a) different parts of the data, (b) data and concepts, and (c) between concepts (Miles & Huberman, 1994).

This technique is used to analyze many forms of data, including data pulled from interviews and focus groups (e.g., see Cipolletta, Votadoro, & Faccio, 2017) to online messages (e.g., see Knobloch et al., 2018; Crook & Nixon, 2021; Grundy, 2021). Regardless of the type of data being analyzed, the researcher makes the decision about which codes are most prevalent and important to the analysis (Engward, 2013). Because the researcher is the primary instrument of qualitative research (Rogers, 2018), I was sure to be diligent in the empirical rigor standards necessary for this type of research and was in constant contact with my advisor as I collected, analyzed, and made sense of my data.

When utilizing constant comparative analysis, the analytic process involves "immersion in the data, reading, reflecting, questioning, imagining, wondering, writing, retreating, and returning" (Braun & Clarke, 2021, p. 332). First, open coding was used while collecting data to generate as many ideas and concepts as possible (Strauss & Corbin, 1990). Open coding is the process of breaking qualitative data down into distinct parts in order to conceptualize and categorize the data (Saldaña, 2013). I coded all publicly accessible messages in my data sample related to the research question (i.e., communication about presenting problems and their treatment), leaving out unrelated messages (i.e., psychotherapist schedule and availability, contact information, etc.) in order to not over-exhaust the coding process (Elliot, 2018) and to develop more accurate themes (Mason, 2002).

During open coding, I developed substantive codes, which are codes directly from line-by-line analysis of the data (Charmaz, 2006). These codes acted as "meaning units," or words and sentences that conveyed similar meanings, for categorizing the data (Graneheim & Lundman, 2004). I handwrote my codes and analytical memos in a notebook to help organize my thoughts. Analytic memos are comparable to journals, lab notebooks, or blogs where researchers

can reflect and record their "coding processes and code choices; how the process of inquiry is taking shape; and the emergent patterns, categories and subcategories, themes, and concepts in your data" (Saldaña, 2016, p. 44). As I collected and coded my data, I then examined the codes closely and compared them for similarities and differences. Although I was becoming aware of emerging themes, I understood that these initial codes and categories were tentative and could change as the analysis progressed.

Open coding was a flexible process that transitioned into axial coding when I reached "conceptual depth" of the data, and my code categories became saturated (Nelson, 2017). Charmaz (2014) defines saturation as the point at which:

> your categories are robust because you have found no new properties of these categories and your established properties account for patterns in your data…you have defined, checked, and explained relationships between categories and the range of variation within and between your categories. (p. 213)

Different than simply experiencing repetition in the data, saturation is the test as to whether or not categories are rich and/or have conceptual depth.

Second, I used axial coding to link the relationships between the emergent code categories and sub-categories to establish themes (Corbin & Strauss, 2008). The goal of axial coding is to strategically reassemble the data that may have been split during initial coding. In this process, I also crossed out synonyms and redundant codes to develop dominant codes. In tandem with axial coding, I utilized the process of focused coding to identify the most frequent or significant codes in order to develop the most prominent categories (Saldaña, 2013). I continued to use memos as a site of conversation with myself (and my advisor) about my data (Clark, 2005, p. 202).

I questioned the codes, categories, and emergent themes about their accuracy, uncertainty, relevancy, and meaning related to the research question. When encountering "deviant cases" (Lindlof & Taylor, 2017), or anomalies found in my data arose, I examined whether they conformed to already coded categories or whether their deviance from established patterns offered more "holistic and meaningful" insight into what I may have not been thoughtfully considering enough at the time (Manning & Kunkel, 2014, p. 202). For example, when observing the early formation of dominant categories, I wrote a note to myself in my notebook page margins, *This may be something I overlooked in previous data – need to look back as I am noticing this [characteristic] more often*.

The relationships between categories and sub-categories were analyzed through axial coding (Corbin & Strauss, 2008) to establish more dominant themes. In qualitative research, themes are "an outcome of the coding process and analytic reflection" (Rogers, 2008, p. 889). They provide a framework for organizing and reporting the researcher's analytic observations. The themes were then tested for mutual exclusivity, meaning that they did not overlap. Defining and naming themes consists of determining the heart of what each theme conveys: knowing what it is, as well as what it is not (Braun & Clarke, 2006, p. 118). Deciding how to best illustrate the themes requires the researcher to make a selection of compelling examples that provide evidence of the theme and relate them to the research question. The results of this process are the most dominant themes found in the discursive construction of psychotherapists' online presenting problem messages and are elaborated on using rich descriptions in the next chapter.

Rigor of Data Collection and Analysis

Collecting and interpreting qualitative data relies on the researcher's commitment to rigor, or the thoroughness in which research is done, to protect the study's integrity, creativity,

and openness (Tracy, 2010). For this study, I committed to the use of bracketing and keeping detailed memos. *Bracketing* is a self-reflective process that challenges researchers to consciously set aside prior knowledge and assumptions related to their research with the goal of having an open mind (Starks & Trinidad, 2007).

Memo writing is used in constant comparison analysis to organize the thinking process of how data fits together, as well as to help articulate the emerging patterns and links between codes (Glaser & Strauss, 1967). Keeping reflexive and organizational memos increases the credibility and trustworthiness of research (Tracy, 2010) by documenting the internal coding process of the researcher, which eventually becomes the thematic findings of the study. When researchers reflect and write about data analysis and their thinking with the coding process, it increases their critical thinking and challenges their assumptions (Rogers, 2018, p. 890). Charmaz (2006) advises researchers that the best approach to memo writing is to "do what works for you," such as pen and paper, a computer program, or a voice recorder for memo writing (Clarke, 2005).

For the recording of my memos, I chose to use pen and paper because it is what feels most natural to me. Ultimately, I hand-wrote on approximately 78 notebook pages for coding, memos, and notes – not including notes from advisor meetings, which were both typed and handwritten, and span across multiple notebooks. I also periodically typed notes to myself on my phone or directly onto my document when I was away from my notebook and wanted to record a pertinent thought.

Through the use of bracketing and memo writing, I committed myself to practice transparency and thoroughness to support the rigor of this study. I shared these practices and the insights I gained from them with my advisor through each stage of the research process. The next chapter (i.e., Chapter 4) is a compilation of my dissertation findings and interpretation, to answer

the overarching research question for this study: How do private practice, clinically licensed psychotherapists discursively construct the presenting problems they treat for their potential patients?

CHAPTER 4: RESULTS AND INTERPRETATION

Through analysis of 40 psychotherapists' *Psychology Today* (*PT*) profiles and websites, I discovered five major themes, as well as several subthemes within a few of the major themes (described below). The five major themes include: (1) lay description, (2) clinical diagnoses, (3) ailing identities, (4) the enigmatic self, and (5) cosmetic psychotherapy. Together, these core themes represent the common discursive construction strategies that psychotherapists use to describe the presenting problems that they treat (RQ). First-name pseudonyms are used for the clinicians in the following descriptions and examples (again, see Appendix E).

Lay Description

The first major theme found in the discursive formation of presenting problem language amongst psychotherapists is lay description. *Lay* language, also known as "plain" or "non-professional" language, is an accessible way to discuss stressful cognitive and emotional experiences, as it does not require an understanding of medical terminology or jargon to participate. For example, lay description could constitute friends discussing the symptoms of seasonal affective disorder as the "winter blues," or substance use disorder as a "drinking problem." The theme of lay description includes messages describing emotional or lived experiences without the use of clinical language or phrasing. The theme is further divided into three subthemes: (a) emotional labeling, (b) figures of speech, and (c) identifying significant events. In this theme, therapists are often using less stigmatized, socially constructed nomenclatures to describe the presenting problems they treat. This strategy ranged from referencing specific emotions and experiences to more ambiguous and ineffable feelings.

Emotional labeling. The first subtheme within lay description is emotional labeling. Emotional labeling pertains to clinicians directly labeling emotional states or experiences (e.g.,

sadness, stress, anxiety) without a diagnostic marker (e.g., major depression disorder, post-traumatic stress disorder, or generalized anxiety disorder). This subtheme is likely validating to potential clients who are unsure if they are "sick enough" to necessitate therapy by utilizing the same working and phraseology that they are likely using for themselves. Though this subtheme is comprised primarily of singular words and short phrases, each statement or idea contributes towards understanding the issue, which leads to an appreciation of the whole picture (Alhojailan, 2012, p. 42). Emotional labeling was found throughout the research sample, weaved throughout paragraphs, as well as used categorically (i.e., used as treatment category headings or found in list form).

Most commonly, emotional labeling is found in specific words or sentences integrated throughout the clinician's marketing copy. For example, Jackie, a Licensed Marriage and Family Therapist (LMFT) from the Southwest used emotional labeling multiple times on their *PT* profile, writing that they treat adults "struggling with anxiety, depression, [or] trauma" in their opening paragraph. They later mention that they provide therapy "for a variety of issues, including anxiety, depression, trauma, [and] stress" in their second paragraph. Similarly, on their website, Jackie repeats the same emotion labels mentioning "anxiety, depression, and overwhelming stress" when referring to their clinical work with adults, and "depression or anxiety, emotional dysregulation, anger outbursts, or behavioral issues" when referring to their work with children. Similarly, Katrina, a Licensed Clinical Social Worker (LCSW) from the Northeast, used comparable emotional labeling on their website and *PT* profile stating that they treat clients with "persistent anxiety, depression, grief, and trauma."

The terms "depression," "anxiety," and "stress" were the most commonly observed emotion labels throughout the sample. Without any symptomology attached (e.g., hopelessness,

difficulty sleeping, forgetfulness, etc.), these labels are broad and vague enough to serve as umbrella terms that relate (at least in part) to most distressful emotional states. Whereas this broadness may be more inviting than the use of clinical diagnostic terminology, the ambiguous nature of the emotional labels themselves may inaccurately reflect the therapist's scope of practice for treatment. For example, not all depression is created (i.e., treated) equally. Just because a therapist claims to treat "depression" does not necessarily mean that they are clinically competent to treat experiences such as major depressive disorder, persistent depressive disorder, premenstrual depressive disorder, disruptive mood regulation disorder, or postpartum depression, symptoms from all of which a potential patient could understandably identify with under the lay description of "depression." The severity of symptoms can also necessitate different treatment modalities that emotional labels do not address. Linguistically addressing complex emotional and cognitive experiences in their most simplified form through the strategy of emotional labeling can be simultaneously both a strength in its familiarity, and a weakness in its accuracy.

Charlie, a Licensed Professional Counselor (LPC) from the South used questions directed at the reader of their online content to identify what emotional label best fits them. For example, in their *PT* profile, Charlie asked if unhealthy coping mechanisms have led to feelings of "guilt, shame or self-doubt?" Further, on their website, they ask, "Have you been experiencing feelings of sadness? Frequent mood swings?" Charlie also uses questions in this way when addressing parents looking for therapy services for their children. They ask, "Is your child or teen exhibiting abnormal feelings of sadness, or anxiety? Are they easily triggered or have problems with their temper and anger?" In their treatment discourse, Charlie is clearly describing emotions, including perceived emotions (i.e., parents observing children), as the presenting problem.

The other strategy utilizing emotional labeling was observed through the use of categorization on clinicians' websites. A good example of emotional labeling used categorically comes from Raven, a Psychologist from the South. On their website, they provided several broad presenting problem treatment categories for potential clients to quickly identify with, along with short anecdotes underneath. These categories had labels such as "anxiety," "eating problems," and "mood instability" in lieu of their DSM category counterparts (e.g., Anxiety Disorders, Eating Disorders, or Mood Disorders). Raven uses similar wording for their *PT* profile, but they interestingly substitute "mood instability" for "Mood Disorders" and capitalize the term "Anxiety." The de-clinicalization of Raven's website terminology compared to their *PT* profile may have been done to casualize their website, as websites tend to feel more personal than directories.

In line with the previous example, under the "services" page of their website, Lana, an LCSW from the Northeast, used the emotional labels "trauma," "anxiety," and "depression" on their treatment list, though without any accompanying anecdotes or descriptions. Similarly, Aaron, a Psychologist in the Midwest, has an "areas of specialty" page on their website where they list 19 different specialties, including, "anxiety," "depression," "social anxiety," "self-esteem" "loneliness," "anger," "stress," and "trauma." Emotional labels displayed in list form apart from any further elaboration encapsulate the ambiguous nature of this subtheme.

Figures of speech. It is not always easy to confidently identify an emotion with an experience. Fortunately, there are other means available to psychotherapists for communicating their emotional understanding of complex human emotions. Differentiating itself from emotional labeling, the subtheme of figures of speech is less concerned with labeling a distressful emotional experience as it is describing it through the use of more illustrative narratives, such as

analogies and euphemisms. Frankie, a Licensed Mental Health Counselor (LMHC) from the Northeast, incorporates multiple examples of this strategy. In their *PT* profile, referencing couples therapy, Frankie states, "[y]ou feel your relationship withering, month by month, and you can't seem to change it." The term "withering" not only alludes to the slow dissolving of a relationship, but the helplessness of what that could feel like as well. Additionally, on their website, Frankie used the metaphor of being "stuck in a loop" in a relationship to illustrate an undesired relationship cycle.

Metaphors can provide richness and depth to an experience that sometimes emotional language cannot. "Simply put, without metaphor it is difficult to adequately render the emotional richness and complexity of our lived experiences as told stories, especially in moments of crisis and distress" (Angus & Scott, 2011, p. 349). Aaron, a Psychologist from the Midwest wrote in their *PT* profile, "[m]aybe you're feeling disconnected from friends and loved ones who are usually your anchors." The use of the word "anchors" in this example illustrates the intensity of this feeling, potentially making it more powerful for the potential client than simply reading the emotional label, "disconnected." Although more ambiguous in comparison to its preceding subtheme (i.e., emotional labeling), the use of figures of speech in presenting problem messaging allows the potential patient to ascribe their own interpretation to the symbolism provided (i.e., what an "anchor" means in this context).

Similar to the previous examples, figures of speech were observed most commonly in tandem with the word "you," with the psychotherapist addressing the reader directly. For example, while discussing their specialty in working with life transitions on their website, Roma, an LCSW from the South, wrote, "[y]ou may feel like you are on an emotional roller coaster." This metaphor uses lay description to illustrate a visual representation of instability in the

reader's mind, which is the "you" that Roma is referring to. It is not life transitions themselves that are cited as the presenting problem, but the feeling of instability in response to them. Although typing the word "you" does not inherently make a message more personal, it may help it to feel more intimate or captivating to a potential patient. "You" invites transference of the reader's experience into the metaphor they are being presented with.

In some examples, clinicians were able to allude to the presenting problem more subtly while discussing the treatment they provide. Andy, a Psychologist from the Southwest, explained in their *PT* profile that "[c]onsulting a psychologist can help unblock your career…Therapy can be…all that's needed to get back on track." In this example, it is insinuated that the presenting problem would be feeling "off track" or aimless in some way. By not using an emotional label, the potential client reading this profile can fill in the blanks on what it means to "unblock" their career or be "off track" in any relatable way. Alternatively, if these euphemisms are perceived as too vague, they could be seen as not relatable enough, preventing a potential patient from reaching out to this therapist.

Identifying significant events. The final subtheme of lay description is psychotherapists identifying significant events in their presenting problem discourse. Whereas the two former subthemes of lay description (i.e., emotional labeling and figures of speech) tend to be broader and more ambiguous, in this subtheme, clinicians often refer to specific events or life transitions that someone could be experiencing that would lead them to seek therapy. These events are largely portrayed as stressful or traumatic (e.g., surviving abuse or traumatic birth) but occasionally neutral or positive (e.g., marketing pre-marital therapy for transitioning into married life). However, when not utilizing specificity, therapists refer more vaguely to significant events with broad terms such as "life transition" or "traumatic event." The events described in this

subtheme are positioned as the inciting incident for treatment consideration, validating external stimuli as "reason enough" to seek therapy.

Marty, an LMFT from the Southwest, advertised multiple events/transition-specific treatment specialties on their website including pre-marital therapy, perinatal therapy, postpartum therapy, and Coronavirus therapy. On their webpage offering "Coronavirus therapy," Marty addresses Coronavirus-specific concerns with statements such as, "…Therapy for Coronavirus related parenting challenges now that your kids are home 24 hours a day for an indefinite amount of time," "[t]he social distancing policy wisely recommended by the CDC can have profound mental health side effects," and "change and disruption of our normal routines can be difficult and may amplify feelings." In this section, Marty is able to clearly refer to specific struggles directly related to the home-restricted transition many had to make during and after the Coronavirus epidemic. There is a sense of helplessness that is conveyed through these anecdotes that removes blame from readers who identify with these examples. Marty's webpage offers distressful emotional responses to a global pandemic that are "normalized" by providing practical reasons for why someone would be distressed.

Whether marketing to individuals or couples, divorce was a common significant event psychotherapists addressed in their messaging. Jessica, a Psychologist from the Midwest, attempts to advertise treatment for all stages of divorce on their website by asking questions to the reader. Jessica asks:

> Is the decision to get divorced causing fear, doubt, or uncertainty? Do you worry about the impact the transition will have on your children, financial stability, or the connections you've developed with your partner's family and mutual friends?... Or maybe you are in

> the post-divorce phase and looking for someone who can support you as you rebuild and adjust to your new reality.

Jessica's use of practical examples and emotional labeling with the stages of divorce may increase perceived trust and credibility as they list validating, and likely common, questions and concerns. They identify the divorce as the catalyst for emotional distress, not the distress itself as the problem. It is as if they are saying, *You wouldn't have this stress if you weren't getting divorced*, similar to how a friend might respond to another friend in a similar situation.

Being less precise in how they identify significant events as the presenting problem, Maren, an LCSW from the Midwest, started their *PT* profile with, "life's challenges and transitions are often times when we feel greater anxiety and stress." This is followed with descriptions of treatment focusing on "struggling to cope with a loss" and "traumatic experiences." Continuing these vague presenting problem statements on their website, Maren mentions "loss" two more times, along with "life transitions." Significant external events are still positioned as the origin for seeking treatment, but with no further elaboration on what those events specifically are. "Life transitions" was the most common vague significant event listed, often mentioned as a specialty. Without elaboration, "life transition" could mean anything from welcoming home a new pet to adjusting to life as an amputee after a car accident. There is nearly no way to gauge what kind of life transitions the therapist is referring to without greater context, of which there often was none. Because presenting problems are so closely related to treatment modalities, this type of lay description may be overly "lay" or vague for potential patients to confidently identify if that therapist is the right fit for them. It is a "catch-all" phrase that has no general consensual meaning.

It is common practice that clinicians interweave lay description strategies in their messaging. For example, Ren, a Psychologist from the Northeast, incorporated emotional labeling, figures of speech, and identifying significant events in a sentence used both in their *PT* profile and their website, "[p]atients who come to me may be experiencing a broad range of concerns, including, but not limited to: grief, anxiety & depression, existential malaise, pregnancy loss, infertility, reproductive concerns, creative blocks, heartbreak, and relationship difficulties." Ren is labeling emotions, using figures of speech, and identifying significant events in one sentence. Similarly, Denice, an LPC from the Midwest incorporated both emotional labeling and identifying significant events on their *PT* profile, "I have helped my clients with; relationship issues, depression, low self-esteem, eating disorders, anxiety, life transitions, addictions, trauma and abuse." With this approach, these clinicians are filling the limited *PT* profile character space with a wide range of descriptive strategies for potential patients to identify with.

Summary of lay description. The first major theme of lay description encompasses the everyday "real world" discourse surrounding mental health. This discourse is recounted by psychotherapists to potential patients through the strategies they use to identify the presenting problems that they treat. The three subthemes under lay description (i.e., emotional labeling, figures of speech, and identifying significant events) sidestep clinical terminology for the use of more familiar and commonly used language. The first subtheme, emotional labeling, revealed the tendency for psychotherapists to utilize simple, often one-word labels to describe an emotional state/s that therapy-services-seekers would want to change. These labels are easily recognizable and commonly used. Whereas the first subtheme was restricted in its description, the second subtheme (i.e., figures of speech) showcased the creativity available to therapists when

constructing their presenting problem messages. Figures of speech allow for ineffable emotional and cognitive experiences to be illustrated and legitimized as presenting problems. The third subtheme, identifying significant events, moves the presenting problem from being within one's own mind to an external event or transition.

Clinical Diagnoses

The second major theme found in the discursive formation of presenting problem language amongst psychotherapists is the use of clinical diagnoses. As mentioned earlier in this research, the act of diagnosing is a naturally occurring process of understanding and treating an identified problem (McWilliams, 2016). Diagnoses differentiate between what is, as well as what is not, considered a "problem." A *clinical* diagnosis is an agreed-upon label given by a medical or mental health practitioner that represents a particular illness or disease (Jutel, 2019). It *represents* disease in the sense that "it presents the inside world of disease to an outside audience" (p. 2). The theme of clinical diagnoses includes the use of diagnoses from the Diagnostic Statistical Manual of Mental Disorders (DSM 5), associated clinical diagnostic terminology, non-DSM clinical diagnoses (physical health), and messages specifying symptomology of clinical diagnoses.

In stark contrast to the theme of lay description, presenting problems are constructed in this theme (i.e., clinical diagnoses) through the use of direct and precise medical language. For example, clinicians using the clinical delineation of "major depressive disorder" in lieu of the broader label of "depression." Whereas many clinicians promote that they treat "anxiety," Marty, an LMFT from the Southwest specified types of clinical anxiety they treat on their website, listing "generalized anxiety, specific phobias, panic disorder, and social anxiety." Marty also

promoted on their website the treatment of “obsessive-compulsive disorder (OCD)” and “post-traumatic stress disorder (PTSD).”

Using clinical diagnoses to construct presenting problems is likely most valuable to individuals who have researched their symptoms online and suspect that their experience aligns with a specific disorder. If they are looking for someone who treats that disorder, seeing clinicians use the same language from their online search may instill confidence in that therapist’s ability to treat that disorder. Identifying with symptoms online does not mean that a mental health clinician would diagnose them with that disorder but discussing it can be a good place to start. Deana, a Psychologist from the South listed on their website that they specialize in treating “attention-deficit/hyperactivity disorder” and “OCD [obsessive-compulsive disorder].” Similarly, Lana, an LCSW from the Northeast wrote on their website that they treat “individuals living with substance use disorder” and “PTSD [post-traumatic stress disorder].” Along with the written-out clinical diagnoses, both examples also used abbreviations (i.e., OCD, PTSD, etc.). When only the abbreviations for disorders are used, there is an assumption from the therapist that the reader already understands what that abbreviation means. It acts as a shorthand for those “in the know,” so to speak.

Along with abbreviations, non-DSM 5 diagnoses and clinical terminology associated with mental health were also utilized to construct presenting problems. Marty, an LMFT from the Southwest listed a specialization in treating “postpartum depression disorder (PPD),” “postpartum anxiety (PPA),” “postpartum OCD,” and “postpartum post-traumatic stress disorder” on their website. The DSM 5 does not recognize any anxiety, depression, or stress disorder that is related solely to the post/perinatal period, patients can be formally diagnosed with major depressive disorder with the peripartum onset specifier (APA, 2013). Although these

disorders are not recognized by the DSM 5 or insurance agencies, they are still diagnoses (i.e., they identify and provide a deeper understanding of a problem) that give language to clusters of distressful symptoms that warrant professional care. A commonly known example of this type of diagnosis comes from David, a Southern Psychologist who lists treating "dementia" on their *PT* profile and website. "Dementia" is known in the DSM 5 as a major neurocognitive disorder. "Dementia" is a general term for a group of symptoms including impaired ability to think and remember, with Alzheimer's being the most common type.

Whereas some clinicians used diagnostic labels, others wrote more broadly about the conditions they treat. Another type of clinical terminology found in this theme was the use of diagnostic categories. Melissa, an LCSW from the Midwest wrote on their website that they treat "Anxiety Disorders" and "Mood Disorders," both being diagnostic categories in the DSM 5. For example, the "Mood Disorders" category contains diagnoses such as bipolar I disorder, bipolar II disorder, and cyclothymia (a milder form of bipolar disorder). By listing the diagnostic category, it could be used as an umbrella term or phrase that encompasses all the diagnoses organized under that category as presenting problems that they treat. This does not necessarily mean that every clinician utilizing the term "disorders" is referring to a DSM 5 diagnostic category.

Applying similar terminology to non-DSM 5 diagnoses, Roma, an LCSW from the South advertised specializing in treating "Perinatal Mood and Anxiety Disorders (PMAD)" on their website. As mentioned earlier, there are no perinatal-specific disorders or categories in the DSM 5. This may not be an issue for potential patients who are informed about these disorders with a clear understanding of what symptoms these disorder categories are describing. This can become less clear when the term "disorders" is used too vaguely. For example, Leila, an LPC from the South specified on their website and *PT* profile that they treat "Attachment Disorders." Leila

explains, “[a]ttachment disorders are often the root of addiction, anxiety, and various other mood disorders.” This could be confusing because there are actually only two types of attachment disorders in the DSM 5 (APA, 2013) – reactive attachment disorder and disinhibited social engagement disorder. Both disorders are found under the Trauma and Stress-Related Disorders section of the DSM 5, neither of which must be present to experience addiction, anxiety, or “various other mood disorders” (which neither addiction nor anxiety is classified under). Oversimplifying presenting problems, by using professional jargon that appears more empirically sound than it is, risks perpetuating misinformation that contributes to mental health stigma.

Clinicians like Chelsea, an LPC from the Midwest seem to be aware of mental health stigma when describing presenting problems. Expressing weariness of clinical diagnostic labeling when discussing their work with children on their website, they wrote, “[l]ots of terms get thrown around by teachers and other paraprofessionals like ‘ADHD,’ ‘oppositional,’ and ‘Asperger’s.’” Chelsea’s use of the phrase “thrown around” implies a perceived inaccurate or overuse of these types of clinical diagnoses of children. Interestingly, on their *PT* profile, they list similar diagnoses such as “bipolar disorder” and “ADHD” as treatment specialties, seemingly without hesitancy. These statements at the surface level can read as mixed messages regarding how presenting problems are conceptualized by this therapist by in one way denouncing diagnostic terminology, while also using it to describe the “problems” that they treat.

Occasional contradictions being a rare occurrence, psychotherapists often congruently incorporated multiple facets of clinical diagnoses and terminology when describing presenting problems. Louie, a Psychologist from the Southwest wrote on their *PT* profile that they specialize in “psychological assessment of personality, development, and intellectual

functioning…early stages of depression…psychological assessment (ADHD, learning disabilities, developmental, personality)…bipolar mood disorders…and postpartum psychosis (PPP).” Similarly, Kenny, a Psychologist from the Northeast wrote on their *PT* profile that they work with patients experiencing “memory problems, traumatic brain injury, mood disorders or psychiatric conditions, learning disabilities, and ADHD.”

An extension of clinical terminology was found in messages that expanded on diagnoses by using symptomology to differentiate between “normal” and disordered distress. Deana, a Psychologist from the South, cited on their website that while anxiety is a natural emotion, it can become disordered when an individual develops symptoms such as:

> excessive worry, sleep problems, fear, panic, muscle tension, feeling awkward or self-conscious around others, cold or sweaty hands/feet, dry mouth, inability to stay still or calm, agitation, perfectionism, self-criticalness, intrusive thoughts, phobias, anxiety attacks, shortness of breath, chronic indigestion or ulcers, self-doubt, compulsive behaviors, numbness/tingling in hands or feet, nausea, and dizziness.

Mimicking a long, run-on sentence format like that of a side effects list in a psychopharmaceutical commercial, Deana listed symptoms directly from the DSM 5 (APA, 2013) for generalized and social anxiety disorders alongside associated psychosomatic sensations that could lead to a diagnosis of an anxiety-related mental disorder. David, from the South, similarly differentiates normalcy from non-normalcy when discussing their clinical treatment for insomnia on their website. David notes, “Most people have difficulty falling, or staying asleep, at some point in their life, but when these problems become the majority of nights for long periods of time, it warrents professional attention.” Though less thorough than the previous example

from Deana, David utilized DSM 5 symptom criteria to illustrate the presenting problem of insomnia.

The final instances of psychotherapists constructing the presenting problem with clinical diagnoses come from the observance of physical-health diagnoses listed as treatment specialties. Deana, mentioned above, lists “adrenal fatigue,” “irritable bowl,” and “fibromyalgia” as specialty areas on their website. On their *PT* profile, Deana wrote that they treat “chronic health issues such as fibromyalgia, chronic pain, and gastrointestinal disorders.” Lana, an LCSW from the Northeast listed “HIV/AIDS” under their treatment services on their website. Although psychotherapists are not medical doctors, nor qualified to treat these physical illnesses, they can help with the emotional and cognitive distress that can result from these types of diagnoses.

However, this distinction was not typically made clear. In those cases (i.e., the examples given above), one would need to piece together the fact that this is advertisement for a mental health professional, not a medical professional, and infer the intention of the services being offered for the mental health aspects of these conditions only. Some therapists did make this distinction in their content. For example, Paloma, a Psychologist from the South listed on their website under a webpage title “clinical psychological services” that they treat “diabetes,” “cardiovascular disease,” and “autoimmune disorders.” Unlike the examples, Paloma clarifies on another webpage that they treat the “overwhelming stressors” of having a “chronic illness or health crisis.” Clarifications like this affirm to potential patients who experience these health conditions that this therapist treats only the mental health features of these conditions, and not the medical conditions themselves.

Summary of clinical diagnoses. The second major theme of clinical diagnoses includes all references to DSM 5 clinical diagnoses, and related terminology to describe presenting

problems that would prompt individuals to seek out psychotherapy services. Fully written out or abbreviated diagnoses (i.e., attention-deficit/hyperactive disorder and ADHD) were observed frequently as treatment specialties. DSM 5-based symptomology was found in tandem with their correlating diagnoses, providing further elaboration on the criteria for qualifying for the disorder. This was used to distinguish between "normal" undesired cognitions and behaviors from those that would warrant clinical treatment. This theme also encompasses all mentions of non-DSM diagnoses, including those pertaining to physical health conditions (i.e., diabetes, HIV/AIDS, etc.) that can be accompanied by emotional distress.

Ailing Identities

The third major theme found in the discursive formation of presenting problem language amongst psychotherapists is ailing identities. Bucholtz and Hall (2005) define *identity* as "the social positioning of self and other" (p. 586). Identities are linguistically indexed through distinct styles, social category labels (such as "white," "Catholic," "elderly," etc.), implicatures, presuppositions, and other linguistic structures. There are two primary dimensions to identity: (a) one is who we are as we believe ourselves to be, or our "avowed identity" and (b) the other is who we are as others perceive us, or our "ascribed identity" (Collier, 1997). Unfortunately, not all identities are valued equally in the social world that constructs them. The term *ailing identities* represents the conceptualization of an individual's identity, or the social treatment thereof, as an ailment, or for the purpose of this theme, the "problem." The identity is not a problem because of any innate characteristics of the person avowed or ascribed to it, but because of the identity's adverse position in a hierarchical societal structure, and the stress or trauma endured by this type of social positioning. The use of the word "ailing" reflects this adverse

perception from those who are in positions of power in the social hierarchy, governing the classifications of who is "ill" (i.e., ailing) and who is not.

Unlike previous themes where emotions, events, or diagnoses defined the "problem" with a more general reach, and the ability to be experienced by large portions of the population, this theme conversely postulates that the population (i.e., identities) dictates the possibility of a problem to exist. For example, if a therapist were to say that they treat "trans issues" in their practice, they are not specifying that they treat "depressed" or "anxious" trans individuals or specifying the clinical diagnosis of gender dysphoria. They are insinuating that they treat the distress (and other cognitive and emotional experiences that could be perceived as an "issue") unique to individuals who identify as trans. The trans identity in this example is integral to the presence of a "problem" that would warrant psychotherapy treatment.

The theme of ailing identities includes discourse describing the unique experiences and distress associated with having an ailing identity, most notably minority identities. The theme is further divided into two subthemes: (a) affirming identity disclosure and (b) unaffiliated identity marker. This is also the only major theme where the characteristics of the therapist themselves can be integral to the construction and presentation of patients' presenting problems. In this theme, therapists' messages range from directly stating social identity category labels to describing broader abstracts of identity.

Affirming identity disclosure. The first subtheme within ailing identities is affirming identity disclosure. The two terms, "affirming" and "disclosure," pertain to the clinicians disclosing one of their own identities, or their personal relationship with the identity, that they treat (e.g., "woman," "queer," "Hispanic," etc.). This disclosure is integral to presenting problem discourse within this theme because the therapists are, in a way, disclosing that they are, or have

experienced, the presenting problem as well. Observing a licensed mental health professional intentionally bringing attention, with their words, to the identity they share with the defined "problem," validates (i.e., affirms) that ailing identity as a legitimate reason to seek psychotherapy services. This subtheme only substantiates self-disclosure that is transcribed. It does not rely on visual assumptions from clinicians' photos or sociolinguistics. Self-disclosure was found primarily on clinicians' websites, making their identities known to their potential patients either directly or indirectly.

Malia, an LCSW from the South, identifies themselves as the owner of a reduced-cost therapy program whose:

> goal is to provide access to and offer mental health services for BIPOC [Black, Indigenous, and People of Color] women who have either had limited, insufficient, or no access to psychological services AND have been impacted by the prison industrial complex (including all its tentacles).

On their website, this program is described to be developed "for BIPOC women" run by "a BIPOC woman." Malia, being the therapist who owns and runs the program, is self-disclosing this aspect of their identity in this statement. Identity is crucial to understanding the presenting problem that Malia's program is trying to address. To qualify for this service, applicants "must be a BIPOC woman who has been directly (former incarcerated individual) or indirectly (adult female family member or spouse/partner of a current or former incarcerated individual) affected by the prison system." Multiple social identities are referenced in this example, including racial/ethnic identities (BIPOC), those economically or resource-disadvantaged (limited, insufficient access to services), and returned citizens (formerly incarcerated). These identities are a "problem" in so much that they are constructed in a culture that unfairly burdens them with

disadvantages and stereotypes that are inherently stressful to bear, especially when support is inaccessible and not available.

Disclosing their identity less directly, Hanna, an LPC from the Midwest described themselves on their website as having a "multicultural background in the US, Canada, and China." Their treatment specialties on their website and *PT* profile include "cross-cultural topic (study abroad, immigration, assignment, separation)" and "trauma (immigration separation)." Something that stands out about their website is that it is written in both Chinese and English, with paragraphs in Chinese first with the English translation directly underneath. Even with the inclusion of the Chinese language, Hanna does not explicitly identify themselves as Chinese, but they do affirm their "multicultural background" and specialize in treating presenting problems specific to "cross-cultural" experiences. Together, statements like these reinforce the therapist's clinical credibility through familiarity, whereas that familiarity then reaffirms the legitimacy of these ailing identities as presenting problems.

Another indirect example of self-disclosure comes from Clyde, an LMFT from the Southwest. On their *PT* profile, their areas of specialty included "first responders/law enforcement professionals, Native American/Alaska Natives, [and] LGBTQ+." They do not mention the LGBTQ+ identities on their website, but they do re-language their treatment of Native American/Alaska Natives to "Native American populations." Clyde also shared on their website that they previously worked with "Indian Health Services," and are currently a Native American "subject matter expert for the California Board of Behavioral Sciences" and serve as an administrator for the "Native American Foster Family Agency." Similar to the last example, they are not explicitly stating that they identify as Native American, but their work history with Indian Health Services, and current work as a "subject matter expert," speaks to personal

experience and credibility that they have with one of the ailing identities they specialize in treating.

Last, a more subtle way of self-disclosing came with the declaration of allyship. Identifying as an ally alludes to a much more personal relationship with the ailing identity than simply offering a general "safe space" for patients. Kinsey, an LCSW from the Southwest identified as an "LGBTQIA+ ally" on their *PT* profile. They reinforce this with direct statements like, "I am queer affirming." On Kinsey's website, they list treating "issues specific to LGBTQIA+ identity," with possible subtle self-disclosure writing directly to the reader stating, "You deserve a therapist who 'gets it.'" In alignment with the theme of ailing identities, they discursively construct the presenting problem on their *PT* profile by writing, "I work with people…navigating the complex intersections of personal identity and relational structures that challenge the status quo." Kinsey is implying that the identities they treat are only actualized as a presenting problem because those around them do not accept them as they are.

Unaffiliated identity marker. Self-disclosure is a highly personal decision that, while some psychotherapists chose to do, most did not. The second subtheme of ailing identities is "unaffiliated identity marker," which encompasses discourse from psychotherapists who centered identity as the presenting problem, but who also chose not to self-disclose (i.e., "affiliate") any personal relationship with that identity. This does not mean that all or any of these therapists do not privately identify with these identities. For example, a therapist who claims specialization in treating "immigrants" and does not provide accounts of any further connection with that population does not mean that they themselves personally do not identify as, and/or have a family member (or members) that identify as, an immigrant. It does, however,

mean that psychotherapists who claim to “treat” someone’s identity, run the risk of conflating identity with disorder.

For starters, the general term “identity” was listed occasionally as a treatment focus. Outside of a more common list format, Charlie, an LPC from the South asks potential patients questions about distress in various aspects of their life such as relationships, emotional regulation, or life transitions, with the final question asking if they are experiencing “[f]eelings of anxiousness or self-identity?” It is unclear what they mean by this question by the way that it is worded, but their use of “self-identity” after “anxiety” reads like they are implying that identity is something that needs to be cured or fixed.

Without self-disclosure, presenting problems related to identity are presented in less personal ways, often in a list with other discursive construction theme strategies. The most common identity listed as a treatment specialization was some variation of the LGBTQIA+ community. For example, Aaron, a Psychologist from the Midwest listed “LGBTQIA+” as an area of specialty on their website alongside conditions such as “insomnia,” “social anxiety,” and “substance use.” Kamila, an LCSW from the Southwest listed “LGBTQ” as a treatment “issue” on their website alongside “Alzheimer's,” “anxiety,” “divorce” and “infidelity.” Examples like these highlight the risk of tokenism unique to this subtheme. It is fair for potential patients to question why these therapists consider themselves specialists in an identity that may not be their own, especially when no other context is given. It is also fair to question if therapists who utilize this particular subtheme view the identities they list in stereotypical ways, since not everyone who shares identities experiences life the same way.

Robbin, a Psychologist from the Midwest wrote on their website and *PT* profile, “I am especially effective with depression, LGBTQ, grief, [and] anxiety.” The use of “LBGTQ” in the

same sentence as emotion labels makes it look like *being* LGBTQ is the problem, similar to *being* depressed or anxious is the problem. Robbin continues a similar pattern on their website's "Area of Focus" section where they listed 24 treatment categories such as "Lesbian, Gay, Bisexual, Trans*, Queer Related (LGBTQ) Concerns," "identity concerns," "multicultural concerns," and "men's issues" interlaced amongst common emotional labels (e.g., depression, anxiety, anger) and significant events (e.g., life transitions). Notably, the addition of the words "concerns" and "issues" helps to clarify that being a lesbian or a man is not itself a problem, but it is the concerns or issues related to those unique identity experiences that might prompt someone to seek out to therapy. Similarly, Lana, an LCSW from the Northeast listed "women's issues" as a treatment specialization on their website, instead of "women."

Gender and sexual orientation were not the only identities that psychotherapists were singling out when conceptualizing identity as the presenting problem. For example, David, a Psychologist from the South described themselves on their website as a "geropsychologist." Elaborating, David wrote that a geropsychologist is:

> a clinical psychologist specializing in working with older adults, or within the area of geriatrics. I have both extensive education and training in working with older adults and a variety of topics of concern that can be experienced during this stage in life.

David's example describing their treatment of older adults evades the risk of tokenism other therapists have struggled with in this subtheme by elaborating on professional training and experience with this population in a seemingly sincere and credible manner.

Another good example of this comes from Elouise, an LCSW from the Northeast. They wrote on their website that they work:

> extensively with immigrants and others who have a connection to the immigrant experience, often through a partner or parent(s), and with people who are dealing with the psychological impacts of racism, xenophobia, sexism, homophobia, ethnocentrism, and other forms of oppression.

Providing examples of why immigrants are an ailing identity whose experiences justify the value of psychotherapy treatment, and acts as evidence against biases that could leak into this type of presenting problem discourse.

Summary of ailing identities. The third theme of ailing identities encompasses discourse alluding to underlying adversities that many face within social hierarchies. This discourse is constructed through the lens of social or ascribed identities using social category labels (e.g., BIPOC, man, elderly, etc.) and more general mentions of identity (e.g., noting this literally with statements like “identity” or “identity issues”). The two subthemes of ailing identities (i.e., affirming identity disclosure and unaffiliated identity marker) consider how the identity(s) of the psychotherapist can affect the impression of the presenting problem messages. The first subtheme, affirming identity disclosure, resulted in more personal and empathetic depictions of identity-related reasons for patients seeking psychotherapy services with more detailed explanations than most discursive strategies provided. In this subtheme, clinicians verbally self-disclosed their identities that bore relevance to the ailing identities they treated. In contrast, the second subtheme of unaffiliated identity marker involved identity-related presenting problem messages without therapist self-disclosure. This subtheme showcased how lacking self-disclosure risks discourse that can read as oversimplified, and even problematic, for a topic of this sensitivity.

The Enigmatic Self

The fourth major theme found in the discursive formation of presenting problem language amongst psychotherapists is the enigmatic self. An *enigma* describes "someone or something that is puzzling, mysterious, or difficult to make sense of" (Collins English Dictionary, 2023). "Self" in this context refers to the individual characteristics that are unique to a person, differentiating that person from others (Sedikides & Brewer, 2001). It is a felt sense (the connection between mind and body) of personal identity and self-governance that people refer to with first-person subject language such as "I," "me," or "myself." For example, if someone were to state, "I don't feel well," the "I" they are referring to is themselves or their "self." *The enigmatic self* is a term used here to represent the feeling of not knowing oneself. Whether this concept is perceived as an impediment, or sparks a desire for self-discovery, the "problem" presented in this theme is one of self-ignorance.

Distinguishing the enigmatic self from the previous themes is most notably the centering of the self as the "problem," not the emotions or experiences the self might be coping with. The previous themes externalized the presenting problem as conditions that are inflicted on the self, while this theme more-or-less internalizes the presenting problem as something that the "self" is doing (or not doing) that is causing a negative emotional response or stimulating an interest in deeper and more nuanced understanding. For example, what the themes of lay description and clinical diagnoses would be used to describe with labels such as "anxiety" or "general anxiety disorder," psychotherapists constructing the presenting problem applying strategies from the enigmatic self might use phrases like, "getting in your own way" or "forgetting what makes you 'you.'" In these examples, self, beliefs about self, or not knowing oneself, is the problem, not an emotion, event, or diagnosis. In contrast to the previous theme of ailing identities where social

identities and societal treatment of these identifies is constructed as the problem, the enigmatic self is solely referencing the individual self (not the collective/social self or how the self is treated by others). This theme includes discourse encompassing self-discovery, self-exploration, acceptance, self-love, self-sabotage, and nescience. These characteristics are often presented ambiguously, philosophically, and interlaced with each other in standard sentence format.

It is natural for individuals to be curious about themselves, their beliefs, and their behaviors. Featuring this desire for self-discovery, David, a Psychologist from the South wrote on their *PT* profile that they help patients "to obtain a more meaningful and deeper understanding of themselves." Similarly, on their website, Maren an LCSW from the Midwest wrote that a goal for therapy could be "developing greater self-understanding and acceptance." On their *PT* profile, they wrote that they work with patients who want to "develop different ways of understanding, coping, and relating to themselves and others," presenting the self as a nescient being who just needs to learn new ways of interacting with their world. Although vague in their descriptions, these clinicians use language such as "meaning" and "understanding" that underpin the philosophical nature of understanding knowledge and reality. These examples also allude to the idea that greater self-understanding is an achievable goal.

Hanna, an LPC from the Midwest wrote one of the most encouraging messages observed, stating, "I believe that you can discover yourself as a unique, precious, and shining individual." Statements like this create a positive incentive for patients to attend psychotherapy for self-exploration by describing what one could feel once they are no longer an enigma unto themselves. Lidia, an LCSW from the Northeast displayed a similar positive incentive on their website, writing, "Finding love within yourself, for yourself, leads to a strong foundation that can support one's growth and ability to cope with difficult life experiences."

Elouise, an LCSW from the Northeast boldly illustrated this theme by verbally differentiating the enigmatic self from other problems, presenting the problem ambiguously and positively, and using philosophical language to provide further elaboration. Elouise wrote on their website:

> Some people come to therapy to address a specific problem – a relationship, a job, a distressing thought, a repetitive behavior, a decision, a trauma, a loss. Others seek help for something more enigmatic…I can work with you to discover, strengthen, and reconnect with different parts of yourself, and access more of your innate vitality, creativity, and playfulness. In therapy, we will work together to cultivate compassion and curiosity about your experience, leading to awareness of aspects of yourself that might have been previously unknown to you and meaningful transformation in areas you define as important.

This example encompasses nearly every characteristic of the enigmatic self, with Elouise literally using the word "enigmatic" to validate this theme as a presenting problem warranting psychotherapy to the reader.

As introduced in the previous example, part of knowing oneself is knowing one's strengths and weaknesses. On their *PT* profile, Mikaela, an LSCW from the Northeast wrote, "I will help guide you through your journey of self-exploration…In therapy, I help my clients to identify their strengths…clarifying the issues that trouble you." Furthermore, Mikaela mentions on their website that "identifying your needs" is a common issue they address in therapy. In this example, the potential patient is presented as someone who does not know themselves well, their strengths, or even what their stressors or needs are. Understanding the enigmatic self is seen here as a first step for then being able to work through stressors and needs.

Continuing this first-step objective, Marty, an LMFT from the Southwest mentioned on their website that they "work collaboratively with [their] clients to help them identify obstacles…and to identify and change their problematic patterns of behavior." Identification of obstacles and/or behavior is necessary to establish first before furthering psychotherapeutic growth. With a more elaborate approach, Deana, a Psychologist from the South shared on their website:

> Together, we can explore the hidden barriers that prevent you from getting closer to the life of your dreams. As you practice working with these barriers, many of them become eliminated, while others may direct you to a deeper truth of something that you had not considered as important in your life. This work can be concrete and clear, such as identifying a goal and working toward it, or we can work in a deeper, more exploratory way. Working at a deeper level helps you begin to tap into aspects of yourself that had been forgotten or have not yet had a chance to grow.

The first step of understanding one's barriers is not a panacea in this example. Covering all their bases, Deana uses dualism in their discourse (i.e., "many become eliminated while others direct you to a deeper truth," and "work can be concrete and clear…or we can work in a deeper, more exploratory way") to establish a comprehensive treatment template for the enigmatic self.

Barriers within the self are not usually clearly defined by psychotherapists utilizing this theme, but generally are represented as thoughts or beliefs that the self (i.e., the patient) does not know are negatively impacting their life. For example, Carla, an MFT from the Southwest wrote on their website:

> My goal is to increase your self-awareness into how you are handling or processing aspects of your life in order to help you let go of thoughts or barriers that are holding you

> back…I desire to help you have corrective experiences and thoughts that will free you from old patterns and allow you to have a healthier view of yourself, others and your day to day life.

Carla's discourse depicts a thought-centric barrier to self-understanding; whereas Paul, an LMFT from the South similarly described the presenting problem as a belief-centered barrier. While describing negative beliefs from their perspective on their website, Paul wrote, "We carry this [negative belief] and project it into our primary relationships." Paul further describes the goal of therapy as "to discover what we can about these negative beliefs. To expose them for the untruths that they are. Help you learn to be kinder to yourself and others. To help you change unwanted behavior patterns and live peacefully." In these examples, the presenting problem is that the self is attached to harmful thoughts and beliefs that are acting as a form of self-sabotage and need to be explored, unlearned, and corrected.

Psychotherapists' personal treatment goals and beliefs related to the presenting problem are alluded to some degree in other themes, but this final example of the enigmatic self may be the most blatant of them all. Frankie, a LMHC from the Northeast wrote the following on their website:

> My core belief in therapy work is that we are all on a journey as we move through life. We come into this world with lessons to be learned, and throughout our journey, Divine Intention presents us with opportunities to learn those lessons time and time again. Our inability or refusal to fully accept these lessons is at the core of much of our pain. Through my work, I've witnessed that often the most important lesson people need to learn is to love and value themselves, just as they are...As I work with clients, I

> continually seek attunement with Divine Intention. I ask for the gift to share with clients the knowledge that they need at this moment to help them move forward.

Constructed here, the problem is that the enigmatic self is unable (nescient) or unwilling (ignorant) to learn the life lessons that "Divine Intention" laid out for it. Self needs to learn these lessons on how to love and value themselves in order to be released from their pain. Discourse like the example above likely land well for potential patients who have similar beliefs, and simultaneously repels those who are unfamiliar with this type of rhetoric.

Summary of the enigmatic self. The fourth theme of the enigmatic self encompasses the metaphysical construction of "the self," the innate desire to understand it, and its relationship with mental health. Psychotherapists centered the enigmatic allure of self-exploration through discourse that provided elaborative depictions of the presenting problems they treat. Using language aligned with the philosophical underpinnings of this theme (i.e., "meaning," "understanding," "deeper truth," etc.), clinicians were able to reference ambiguous treatment goals related to topics such as self-discovery, self-love, and self-sabotage. This theme, at times, revealed how a therapist's personal beliefs related to the presenting problems they treat can leak into their discourse of it.

Cosmetic Psychotherapy

The final major theme found in the discursive formation of presenting problem discourse amongst psychotherapists is cosmetic psychotherapy. The phrasing of this theme comes from the term "cosmetic psychopharmacology." Introduced by Kramer (1993), *cosmetic psychopharmacology* refers to the use of prescription psychopharmacological drugs to create changes in functioning for individuals *without* clinical diagnoses. In an interview with WebMD (Mann, 2003), Kramer refers to this concept as "taking someone from one normal, but less

desired or less socially rewarded state to another normal, but more desired or more socially rewarded state." Like the function of cosmetic surgery, cosmetic psychopharmacology is intended for individuals whose focus area is functioning just fine but feel that it could be better.

This idea is the basis for the theme of *cosmetic psychotherapy* – psychotherapy treatment for individuals who are emotionally and/or behaviorally functioning well enough but feel that they could be functioning better. The presenting problem is the space between where the patient currently is (i.e., emotionally, behaviorally, cognitively, etc.) and the potential (or belief thereof) of where they eventually can be. Unlike the previous theme of the enigmatic self, individuals whose problems are constructed in this theme already know who they are. Here, the problem is not associated with self-exploration, but with self-actualization (the process of an individual's personal capabilities becoming fully realized).

The discourse of this theme is characterized by messages that are improvement-focused, often with words such as "better," "more," "ideal," or "best," and depict the "problem" of not being currently self-actualized as a solvable one. The messages are simple, absent of illness, goal-oriented, and vague in describing the overarching goal of therapy. Occasionally, emotional labels are present, but when an emotion is mentioned, it is framed as a goal and not as a problem. For example, Robbin, a Psychologist from the Midwest wrote on their website that they provide psychotherapy to "help [patients] work toward building a happier, more authentic life." Melissa, an LSCW from the Midwest mentioned treating patients "not living to [their] fullest potential" on their website and *PT* profile. Elaborating, Melissa states, "My role as a therapist is to help you live a life that is more genuine, fulfilling, and aligns with your goals and desires for yourself." Illustrating this theme at its most basic principle, Katrina, an LCSW from the Northeast, wrote on their website that one of their areas of treatment is "for those who wish to simply feel better."

There is no mention of illness, the goal is vague, and the statement is written in an easily accessible and relatable fashion.

Because there is no impairment per se to correct, the idea of patients utilizing therapy to become their "best" or "ideal" self, occurred quite often in the data set. The profusion of this kind of language may be indicative of a bias held by some professionals in psychotherapy field suggesting that self-improvement is in some way virtuous, while complacency is not. Lidia, an LCSW from the Northeast described their therapeutic work on their website as "[m]y job is to help you…become your best self." They even separately wrote "[b]e your best self" in large font on their website welcome page. Lidia mirrored this notion on their *PT* profile with, "I focus on helping you to achieve your maximum potential." Bryce, an LCSW from the Midwest provides another example on their website, stating they help patients to "be [their] best self, alone and with others." The inclusion of the phrase "with others" introduces the notion that self-improvement cannot only benefit the individual, but their relationships as well.

Carla, an LMFT from the Southwest addressed relationship improvement as a preventative measure. While advertising their pre-marital therapy services, Carla wrote on their website, "[t]he first two years of marriage don't have to be so difficult if you build a foundation before you build a home together." In this example, there is nothing presented as being necessarily "wrong" or unhealthy with the relationship, and pre-martial therapy is offered as a means to prevent things from going wrong in the future. Offering therapy as a preventative service effectively works in the duality of both fears and hopes for the future.

Although relationship improvement was not a common focal point of cosmetic psychotherapy, it was occasionally mentioned in tandem with personal improvement messages. For example, Deana, a Psychologist from the South wrote on their *PT* profile that they work with

"people ready to create stronger skills for improving their mood, creating effectiveness in their lives, and growing better relationships." On their website, they added that pursuing psychotherapy services is "making a courageous choice to begin to have *more* in your life." Italicizing the word "more" emphasizes the abundance mindset-esque quality that this theme can inhabit, projecting the notion that constant pursuit of improvement is a more "courageous" (read as: "right") choice over *settling* for the life that they are currently living.

Echoing their patients' innate desire to improve comes with the belief in their patients' ability to *do* so. Shea, an LSCW from the Northeast shared on both their website and *PT* profile:

> I believe in the philosophy that YOU are the expert of your own life. My role…is to provide services that allow you to build upon some of the innate skills you already possess and to support you in the process that ultimately allows you to live the best life possible.

In this example, the potential patient is seen as capable, and the problem (as defined by the patient) as solvable. The word "YOU" presented in all capital letters and repeated (as "you" or "your") five times in two sentences may be a strategy to personalize an impersonal message. In alignment with the characteristics of this theme, Shea's message does not classify any known or perceived "problems," is focused on improvement, and outlines treatment goals vaguely. Describing cosmetic psychotherapy in second-person language (writing directly to the reader using words such as "you" and "your") may be the only way to imitate familiarity with the presenting problem.

Mimicking this strategy, Andy, a Psychologist from the Southwest who advertised a specialty in "Life Enhancement Strategies" on their website described providing "psychological empowerment that focuses on strengthening one's ability to live fully." Andy also asks questions

for their potential patients to consider on their website. Questions such as, “How are you doing, is your life working, is it what you want it to be?,” “Are you making good use of your strengths and personal resources?,” and “What areas of personal growth are most important to produce the results you want?” More second-person language is found on Andy’s *PT* profile, writing that they “empower you to live the life you envision,” and offer “mindfulness sessions to unlock your full potential. We will focus on your whole life, so you can get the most out of it.”

Charlie, an LPC from the South also asked a series of questions for their potential patients to consider regarding the presenting problem on their website. Charlie’s questions primarily centered on symptoms of depression and anxiety but ended by asking the reader if they want to “work towards building better self-esteem and or a better self-care regimen?” Having this as the final question endorses the idea that if the reader did not identify with the previously listed symptoms of distress, they can still be a fit for psychotherapy. Raven, a Southern Psychologist expressed this notion more directly at the end of a treatment focus list on their website, stating that they help with “ways to increase self-care and relaxation in your life. Everyone needs more of that!” The emphasis on “everyone” invites quite literally anyone to go to therapy, and more specifically, to work with this therapist.

Summary of cosmetic psychotherapy. The fifth and final major theme of cosmetic psychotherapy exemplifies the presenting problem that is absent of any identified “problems” to be solved. The discourse found within this theme validates the desire for individuals to seek psychotherapy for non-deficient reasons. The idea of simply wanting to be “better” is reason enough. Cosmetic psychotherapy is an expansive term that reflects the broad statements used by psychotherapists to describe broad treatment goals. Messages utilizing this theme were overall positive and encouraging towards potential patients in lieu of mentions of distress or illness.

Emotion labeling was only used as an aspiring destination (i.e., “happier,” “empowered,” etc.) and not framed as a problem. When found together with other themes, cosmetic psychotherapy was most often utilized towards, or near the end of presenting problem discourse (i.e., the final item on a list, or the last sentence of a paragraph), inviting a wide spectrum of clientele to consider themselves fit for psychotherapy services.

Overall Summary

The purpose of this chapter (i.e., Chapter 4) was to identify and explain the emergent themes found in psychotherapist’s online presenting problem discourse to answer the research question (RQ): How do private practice clinical psychotherapists discursively construct the presenting problems they treat for their potential patients? Using an exploratory thematic analysis of individually licensed clinicians' *Psychology Today* profiles and websites, I identified five distinct ways in which psychotherapists discursively construct presenting problems. They are: (1) lay description, (2) clinical diagnoses, (3) ailing identities, (4) the enigmatic self, and (5) cosmetic psychotherapy. Each theme offers unique discursive characteristics that expand the prospect of psychotherapeutic treatment. In Chapter 5, these findings will be discussed and interpreted in greater detail, followed by an exploration of their theoretical and practical limitations.

CHAPTER 5: DISCUSSION AND IMPLICATIONS

In this last chapter (i.e., Chapter 5), I further expand on answering this study's RQ by providing a brief summary and interpretation of its key findings. I then discuss the theoretical and practical implication of this research. Finally, I address this study's limitations and directions for future research.

Brief Summary and Interpretation of Findings

The culture of the United States has been scrutinized as being bio-materialistic, corporation-dominated, and even "hysterical" at times, causing individuals to act against their better instincts to achieve a "normal" identity (Burchell, 1996; Gardner, 2003; Schutzman, 1999). Cultural, state, commercial, industrial, and scientific health discourses circulate and inform one another, replicating certain assumptions about normality and illness. These assumptions create a pervasive script used to inform people that they are ill and outline a pathway to "good citizenship" (Guttman & Ressler 2001). These scripts are intended to reach a broad spectrum of individuals with an assortment of symptoms, which citizens (consumers) tend to follow and be governed by. At the same time, new health discourses have recently arisen that break slightly from the old, and sometimes even contradict them. Still, they tend to put the collective "social good" first, targeting stigma and self-esteem to promote the goal of becoming an ideal model citizen, being a "coherent, hyper-productive subject who is competitive in society and the marketplace" (Gardner, 2003, p. 5). The purpose of this study was to explore one major, often overlooked, aspect of these health scripts – presenting problem discourse constructed by the psychotherapists who treat them.

Because health and commerce are so interconnected, Guttman (2011) outlines five ethical precepts for persuasive health communication that can be applied to presenting problem

discourse. First, health messages should be *truthful*. Information should be accurate and not mislead the intended audience. Second, health messages should be *complete*, meaning that arguments are not presented as one-sided, and all relevant information is included. Third, health messages should be *sincere*. The message should be truly relevant to the intended population and not just superficially designed to appear that way. Fourth, health messages should be *comprehensible*. Information should be able to be understood by all members of intended audience. Finally, health messages should be *inclusive*. The message should reflect respect for an individual's right to autonomy and self-determination and be considerate of diverse members of the population that the message aims to influence. These precepts offer a check list for constructing presenting problem messages aimed to endorse psychotherapy treatment. In according with Pera et al.'s (2016) research on evaluating trustworthiness online (outlined in the literature review), following these precepts can help psychotherapists cultivate trust with their potential patients through ethical discourse.

As noted earlier in this study, 1 in 5 Americans experience a diagnosable mental illness each year (SAMHSA, 2019). Whereas this statistic could easily get misconstrued as "1 in 5 Americans experience a diagnosable mental illness warranting psychotherapy services each year," the results of this study show that a diagnosable mental illness is only one of many reasons individuals would recognize as warranting psychotherapy, particularly in the eyes of the psychotherapists themselves. In the previous chapter (i.e., Chapter 4), I identified five major constructions of presenting problems (i.e., reasons to go to therapy) that clinical psychotherapists promote treating in their practices. Next, I briefly discuss and further interpret each theme in accordance with their unique characteristics and compare them with relevant ethical precepts

(Guttman, 2011). Then, I provide a final comprehensive interpretation of the themes for a deeper understanding of their role in the larger construction of illness scripts.

Lay description. The use of lay language (i.e., "plain" or non-professional language) was the cornerstone of discourse found in this theme. *Discourse* refers to the use of language relative to social, political, and cultural formations (Jaworski & Coupland, 1999). It simultaneously shapes and reflects social order, both enabling and limiting ways of "seeing" and/or understanding objects (Tuominen, 1997, p. 352). The "objects" in this context are the presenting problems that prompt people to seek out psychotherapy. The theme of lay description utilized language, that on its face may appear simplistic, but after careful analysis, represents deeper indexical meanings that have social merit in defining emotional distress.

Emotions, aside from the stigma associated with many of them, are often difficult to put into words. According to John Seal's (1969) principle of expressibility, "whatever can be thought can be said." Seal proposed a notion that an individual's expressive means – *most centrally, language* – is an unrestricted channel of communication. However, that principle does not extend to feelings, as whatever can be *felt*, cannot necessarily be said. Emotions are a subject reality of neurotransmitters and hormones that heavily influence perceptions, thoughts, attitudes, memories, and other integral meaning-making processes. The effort to communicate about subject realities is "a core, distinguishing, beneficial, and unavoidable aspect" of human language (Sanders, 2021, p. 89). Because there is no true way to objectify emotion, modest labels such as "stress," "anxiety," and "depression" are used to symbolize these biopsychosocial constructs. Psychotherapists' use of these emotion labels allows a linguistic matching process to occur with potential patients through "object" familiarity.

Laclau and Mouffe (1985) suggest that humans only receive meaning through discourse, which by that account, is contextually sensitive and thus flexible. This flexibility is found in the quasi-interchangeability of illness labels related to presenting problems (i.e., “major depressive disorder” vs. “clinical depression” vs. “depression”). How illnesses are interchanged and communicated gives rise to a type of intentional or unintentional storytelling that creates a particular configuration of authority, identity, and entitlement (Jutel, 2019). For example, using lay language, as opposed to clinical language (i.e., “anxiety” vs. “generalized anxiety disorder”), can paint a proverbial picture of one’s relationship to that illness. These pictures can also be painted through the use of figures of speech, such as metaphors. One of the essential functions of metaphor is to express the otherwise inexpressible (Ortony, 1975). The data sample within this study provided dynamic examples of metaphors, with descriptors such as Roma’s use of “emotional roller coaster” or Frankie describing a relationship as “withering.” Psychotherapists’ construction of presenting problems through the use of lay description (particularly through the subthemes of figures of speech and identifying significant events) was the clinical embodiment of storytelling.

Expressing otherwise inexpressible neurocognitive experiences is a challenge in and of itself. Trying to do so responsibly and ethically is the challenge psychotherapists undertake when languaging presenting problems. Simple labels, such as “stressed” or “worried,” risk the communication ethical precept of completeness on a technicality, as not all relevant information is included. Psychotherapists use of presenting problem discourse may always struggle to be complete because language itself is not complete. This is why figures of speech are so valuable to illustrate what emotional language cannot. The methods in which emotional language is used in the DSM have even been criticized as often pathologizing natural emotions and reactions,

such as stress, as a mental disorder (Horwitz, 2007). Although this argument is important to have in how "illness" is defined, it does not address whether an emotional or lived experience is worthy of therapy. Language is ultimately where and how that argument is had. The ways in which psychotherapists can connect on the linguistic familiarity level of their potential patients governs the perceived accessibility of their services and may be the last validating factor that patients need to follow through on starting treatment.

Clinical diagnoses. Although not all ailments can be diagnosed, the use of diagnoses in presenting problem messaging can provide a sense of authority to substantiate that ailment. A clinical diagnosis is a name for an ailment or condition based on classifications that are embedded in extant medical knowledge. As the acclaimed psychoanalyst Dr. Michael Balint noted, diagnosis transforms seemingly random symptoms into an organized illness (Balint, 1964). From Balint's (1964) perspective, the most pressing and immediate problem for the patient is "the request for the name of the illness, for a diagnosis. It is only [then] that the patient asks for therapy" (p. 25). Diagnoses act as a cultural expression of what a society accepts as "normal" and what it constitutes as an "illness" in need of treatment (Jutel, 2011). Diagnoses offer permission for individuals to be "ill," and for their illness to be taken seriously. The diagnostic label of "post-traumatic stress disorder" carries an authoritative weight to it that the emotional labels of "fear" or "stress" alone do not.

Times have changed since patients were reliant on medical professionals for diagnoses, or reliant on diagnoses for accessing treatment. Because medical information is no longer controlled by medical institutions, most patients already have some knowledge of their illness before even stepping foot in a therapy office (Nettleton, 2004). Patients, now acting as more informed consumers, often self- and mis-diagnose themselves based on health information they

access online or see in advertisements, such as psychopharmaceutical drug commercials. With calls to action like, “ask your doctor if you’ve been experiencing…,” psychopharmaceutical drug advertisements present vague, commonly experienced emotions and behaviors (such as irritation, and a lack of motivation) as symptomatic of a mental illness (Waite, 2012). After all, profit is not found in healthy or dead people, only in ill ones.

Discursive practices like this were observed in presenting problem messages when therapists listed out potential symptomology associated with clinical diagnoses. For example, when Charlie from the Midwest wrote the following list of “depression, bipolar, and other mood disorders” symptomology: “low motivation, difficulty getting out of bed, too little or too much sleep, sadness, exhaustion, thoughts of self harm; or alternately inflated self-esteem, feeling on top of the world, and invincibility.” Without clarifying how many of these symptoms would need to be experienced, how severely, or how often, before they warrant professional attention, messages like this can appear superficial, risking the ethical precept of sincerity. Furthermore, this list of symptoms was written to represent three different diagnostic categories (i.e., “depression,” “bipolar,” and “other mood disorders”), which share some symptomology criteria. However, these categories are not the same and should not be presented as such.

That is not to say that psychotherapists are always incorporating clinical diagnostic discourse in their presenting problem messaging in an insincere or unethical way. In fact, diagnoses themselves exemplify the truthful precept of ethical health communication via their commitment to science and to an evidence base (Jutel, 2011). Therapists’ use of diagnostic labels such as “major depressive disorder” and “adjustment disorder” reflects decades of empirical research aimed at further understanding and treating these ailments. As long as diagnoses, and

any symptomology or neuroscientific research associated with them, are shared in a way that is consistent with current empirical data, it is considered ethical (Bott et al., 2016).

Clinical diagnoses do not just increase the credibility of the message, they also increase the credibility of the professional using them. They can be used by professionals to differentiate themselves from the layperson by virtue of the diagnosis itself; that is, the pursuit of that specific label (diagnosis), often prompting patients to seek professional help to begin with. Seeking that diagnosis is a result of a sense of "unwellness" that the lay person is unable to fully interpret on their own, and thinks is likely to be a treatable disease rather than an external or nonmedical factor (Leder, 1990). Diagnoses continue to differentiate clinically licensed medical and mental health professionals from tangential non-scientific services such as astrological readings, energy healing, or life coaching.

Credibility ascribed to a clinician's use of clinical diagnostic language is also affected by an individual's indexical meaning (i.e., personal and cultural relationship) with the diagnosis itself. As each iteration of the DSM has been released, the manual has become increasingly more culturally sensitive in its language use and instructions. For example, the current DSM 5 (APA, 2013) includes a Cultural Formulation Interview (CFI) which helps clinicians assess how an individual's culture may be affecting their mental health and suggests using terms that are acceptable and familiar to the patient's culture, avoiding terms that may be stigmatizing. The DSM 5 also includes specific cultural syndromes (e.g., "koro" and "susto") which were not previously included. However, the DSM 5 still has limitations as it primarily reflects Western cultural biases and may not be as relevant or suitable for non-Western cultures. This diagnostic manual does not fully capture the cultural landscape of mental health experience or language.

Ailing identities. In any illness-constructing discourse, there must be a classification system for differentiating illness from health (i.e., what is different from what is similar). Once classification is established, we are inclined to think of the categories as natural, when in fact, as Zerubavel (1996) reminds us, nature is a continuum that is only divided into categories based on our subjective understanding and conventions. There is no emergent theme more representative of this subjective classification of difference and similarity than ailing identities.

The languaging of this theme is inspired by Goffman's (1963) use of the term "spoiled identity," referencing the stigma attached to individuals who are "marked" due to a classified "defect" in their physicality, character, or tribal affiliation. Goffman believed that stigma was found in the relationship between the stigmatized ("marked") and non-stigmatized ("normals"), not in the mark itself. The power of this stigma makes the subtheme of affirming identity disclosure impressive feat in substantiating identity mistreatment as a problem in this country. It is as if therapists are bravely proclaiming, "*It is painful to be different. I know, because I have experienced it too*."

Goffman (1959) also had a stance on the development of identity. Goffman (1959) believed that identity develops through a performance of the self that changes based on the audience. According to Goffman's (1959) performance analogy, there is a "front stage" and "backstage" component to identity – the front stage being the chosen performance of identity that the audience sees, while the backstage represents the more intimate parts of identity that are protected and kept away from the audience. Because identity portrayal is based on the specific audience, the "actor's" (i.e., individual's) performance is not stable. In this conceptualization of identity (Goffman, 1959), identity is constantly changing, adapting to the specific audience and social situation, meaning that there are as many "selves" as there are opportunities to "perform."

boyd (2002) offers a slightly different strategy referred to as “faceted id/entity.” This approach focuses on managing representations of identity in online spaces where individuals actively manage their identity by using contextual information about the environment in those virtual spaces. Interaction in online spaces is unique from social interaction in the physical world, as individuals do not receive the same performance feedback and context that they are accustomed to (e.g., facial expressions, body language, etc.) and the audience is largely unknown (boyd & Heer, 2006). Without these cues, individuals manage their online identities through context, self-awareness, and faceting of their identities. Contextual differences found online are essential to how mental health professionals are constructing, deconstructing, presenting, and self-disclosing identities in presenting problem discourse.

Self-disclosure in this theme differentiates between the two subthemes, and its absence can risk ailing identity discourse in violating the ethical precept of inclusiveness. Self-disclosure occurs when a therapist reveals (or confirms) personal information to a patient. It is widely considered ethical to self-disclose in the field of psychotherapy if that information is believed to serve as a benefit to the patient (Zur et al., 2009). Self-disclosure can happen intentionally or unintentionally. When it happens unintentionally, self-disclosure has the potential to increase the risk of harm (e.g., transference, countertransference, projection, etc.) to therapists and their patients (Baier, 2019; Bratt, 2010). Psychotherapists may have personal beliefs and values, or demonstrate attitudes and behaviors, in their personal lives that patients would find to be nontherapeutic. Self-disclosure use in the subtheme of affirming identity disclosure is intentional (e.g., Malia’s use of “BIPOC women” and Clyde’s use of “Native American/Alaska Natives”), constructing discourse that is inclusive for the audience it is intended for. Conversely, some of

the presenting problem discourse found in the subtheme of unaffiliated identity marker did not reflect this level of consideration.

The ethical communication concerns that are found in the discourse of the subtheme of unaffiliated identity marker are similar to the concerns of tokenism. Ethical concerns are raised when "cultural themes or symbols are co-opted by detaching them from their original meaning and using them as a persuasive tactic" (Guttman, 2011, p. 637). When psychotherapists list "LGBTQ" (which is not the full initialism, to begin with) as a presenting problem, without any context, they conflate real people's identity, not the undue social treatment of that identity (embodied in the previous subtheme, affirming identity disclosure), with illness. Even with slightly more elaborate labels, such as "women's issues," therapists often over generalize and oversimplify the "problem" by branding (in the advertisement of a paid service) an individual's identity as their trauma.

The enigmatic self. In a world that can be harsh and filled with unknowns, there are unlimited opportunities for sensemaking. Sensemaking is a method whereby individuals cognitively "structure the unknown" in a way that they can comprehend (Weick, 1995, p. 104). Sensemaking promotes confidence and safety by attaching meaning to lived experiences, making the unknown feel more familiar and manageable. For example, when an individual travels to a new country, they use sensemaking to understand and navigate that culture's customs and norms by observing and connecting their experiences with the residents. When applied inward (towards oneself), sensemaking can "be understood as a coping mechanism involving the collection of information about the self (self-exploration)" (Zikic & Richardson, 2007, p. 60). This is the guiding conceptualization for psychotherapists' discursive construction of the enigmatic self as a presenting problem.

Whether therapists such as David and Carla advertised their services as a means for patients "to obtain a more meaningful and deeper understanding of themselves," or vowed directly to their audience to "help you let go of thoughts or barriers that are holding you back," it was always insinuated that now knowing (i.e., making sense of) "self" was the at the crux of the problem. Discourse centering the self as a problem is not revolutionary by any means. Colloquialisms like "Why am I like this?" or "It's not you, it's me," point to a sense of ownership over an individual's emotions and behaviors. Even the eleven-time, Grammy-winning, musical artist, Taylor Swift, currently has a song topping the charts called "Anti-Hero" (2022) beginning each chorus with the catchy lyrics, "It's me, hi, I'm the problem, it's me." Self-blaming messages can be distressful or empowering depending on how that message is framed. Sensemaking problems through the lens of personal ownership and responsibility may give someone a felt sense of accountability or control over their problem. If their emotional or behavioral problems are something that they have control over, they may perceive fewer barriers back to good citizenship, resulting in quicker, health-seeking behaviors. Conversely, this sense of control may dissuade individuals from seeking help because if their issue is something they feel they can control, they may feel that they can address it themselves.

In modern health discourse, personal responsibility is extensively promoted as "the key to good health" (Guttman & Ressler, 2001). Although not all health discourse overtly blames individuals for their illnesses, they often promote the notion that responsibility for disease prevention and recovery is "primarily under the control of individuals, when in fact, they may only have partial control" (Guttman, 2011, p. 638). This can be problematic as many mental illness symptoms can be dismissed or mischaracterized as "personality" or "attitude" issues (Kemp et al., 2023). When constructed through the characterizations of self-discovery or

acceptance (e.g., “finding love within yourself” or “developing greater self-understanding and acceptance”), the enigmatic self can depict a non-threatening, baseline approach of health seeking where patients can participate in self-exploration without blame. However, because self-discovery and self-correction are so intimately intertwined, both in this theme and in greater socio-economic motivations, it is understandable how individuals could conflate unique traits of their personality (i.e., their “self”) with symptoms of illness.

This notion of self-responsibility, including the presenting problems reliant on it, risks the ethical precept for completeness. By psychotherapists discursively constructing presenting problems by centering self as the problem, they are not providing the nuance necessary to discuss these issues comprehensively. The vagueness of the messages in this theme (e.g., Elouise’ use of “reconnect with different parts of yourself” or Mikaela’s use of “clarifying the issues that trouble you”) with very few explanations or anecdotes given, relies on the potential patients to accept and internalize those beforementioned colloquialisms at truth, taking advantage of already incomplete information regarding illness etiology.

Cosmetic psychotherapy. The final theme, cosmetic psychotherapy, may be the most controversial across all the results. Breaking away from the other themes, this theme’s marketing centers exclusively on mental wellness, as opposed to mental illness. Mental wellness refers to “the degree to which one is positive and enthusiastic about oneself and life” (Manderscheid et al., 2010, p. 1) and is often associated with discourse related to self-care and personal improvement. This presenting problem seemingly absent of a “problem” bares similar controversies to the concept from which it derives its name, cosmetic psychopharmacology (Kramer, 1993).

Prescribing psychopharmacological medications (e.g., Prozac, Wellbutrin, Adderall, etc.) to already moderate- or high-functioning individuals has been hotly debated amongst psychiatrists and medical professionals alike, weighing the risks and benefits of allowing the general public access to these medications. Risks include adverse side effects (e.g., sleep disturbances, heart complications, suicidal ideation, etc.), increased unsafe sharing or selling of medications (e.g., with family members or peers), and individuals developing a reliance and/or addiction to the medication. Benefits may include mood enhancement, increased cognitive performance and productivity (e.g., increased motivation or focus), and increased creativity. Ultimately, "the ethics of non-therapeutic psychopharmacology depends on the theory of emotions [medication prescribers] adopt" (Duncan, 2016, p. 78). The same sentiment is likely applicable to therapists' perspectives on cosmetic psychotherapy.

Although cosmetic psychotherapy does not share the same physiological risks that prescription medications bring to the cosmetic treatment debates, it does risk medicalization. *Medicalization* refers to the social phenomena that occurs when various life domains become incorporated within medical explanation and control (Verweij, 1999). Medical means of elucidation play a central role in the contemporary social discourse surrounding illness and wellness. This discourse contributes to individuals redefining emotions and life events in medical terms and turning health into the focus of human existence. According to the standard capitalist-incentivized social script, healthy human equals good citizen(ship). In the case of cosmetic psychotherapy, medicalization occurs in the discourse of the "ordinary," as it is framed as a type of complacency that potential patients then see substantiated by licensed professionals who are stating that they "treat" this complacency in their clinical (i.e., medical) practices. This complacency (i.e., lack of current ambition to be *more* productive) is only considered a

"problem" because good citizens are not complacent. Through the use of language, such as "best," "ideal," and "perfect," therapists may be contributing to pervasive societal and economic standards of excellence that reinforce stigmas of those viewed as "underperforming" in comparison, especially for already marginalized and underprivileged groups (Tyler & Slater, 2018).

Ethically, cosmetic psychotherapy risks the ethical precepts of truthfulness and inclusion. In regard to truthfulness, how accurate or informative can statements such as Bryce's, "I focus on helping you to achieve your maximum potential," or "My job is to help you be your best self" be? How can psychotherapists present the concept of self-improvement with pinnacle qualifiers like "maximum" and "best" so confidently? Questions like these reflect the risks of how the discursive construction of cosmetic psychotherapy could be unintentionally hyperbolic or misleading in its attempt to convey goals of mental wellness, conveying goals of mental perfection instead.

Regarding the ethical communication precept of inclusion (Guttman, 2011), the theme of cosmetic psychotherapy may be the most privileged. Without mentions of any mental or emotional barriers to wellness, no ethical therapist could charge an insurance company to cover cosmetic psychotherapy sessions, meaning that these sessions would all be private pay (out-of-pocket by the patient), which many people cannot financially afford to do. This aligns with a common fear of the medicalization process mentioned before related to equity. The assumption is that the more financially powerful groups could demand that the health care systems meet their escalating needs, whereas members of vulnerable groups will continue to receive relatively fewer services (Daniels, 1995; Meadowcroft, 2015). In this context, as financially well-to-do

individuals seek out clinical psychotherapy services for “life enhancement strategies” and “to simply feel better,” less treatment time will be available for those who are struggling the most.

In contrast to these criticisms of cosmetic psychotherapy, and to criticisms of all cosmetic treatments (i.e., psychopharmacology, surgery, etc.), lies the other key principles of the inclusion precept – self-determination and autonomy. People have a right to pay for services they believe will make their lives better. They do not have to qualify their purchases with proof of adversity. What is more autonomous than choosing something you do not need?

Final interpretations. Writing is one of the first communication mediums that humans invented and perhaps the most important one. The importance of the written word is that it gives language an alternative medium to speech. As Sander (2021) argues, “In speech, language is used in communicative items that are temporary and local…In writing, language is used in communicative items that are preserved over time and can be distributed across places” (p. 92). The written word is where ideas become immortal. As with any well-documented idea, presenting problems written today will exist through time and space, informing future discursive construction processes that will evolve in unison with the commonwealth.

Discourse is a human communication tool that individuals operate willfully and collaboratively to advance psychological, sociological, cultural, economic, and political interests. In malevolent hands, discursively constructing health-related risks can serve as a means of maintaining control over sick bodies in the interests of powerful institutions (Landqvist & Nikolaidou, 2020). Due to the position of power that psychotherapists are designated concerning their patients and their roles in society, their words are significant to the internalized incarceration or liberation of individuals. These individuals are thus influenced by illness scripts designed to manipulate their personal sense of health and normalcy. In extension, the discursive

construction of presenting problems could also have a direct impact on the participation of patients because presenting problems only become “real” as they are discussed. Reasons for attending psychotherapy are both created and validated, as psychotherapists expand their construction beyond traditional clinical diagnoses, simultaneously making the prospect of pursuing therapy services more approachable and accessible. However, this approachability must not cross over into disease mongering.

The term “disease monger” was introduced by Payer (1992) who argued that they identified a medical-industrial complex that has an invested interest in promoting the notion that the greater population is either (a) already sick or (b) at risk of becoming sick. This medical-industrial complex is comprised of institutions that stand to benefit from the proliferation of diagnostic labels, creating a need for their products and services, including medical researchers, medical and mental health providers, health educators and promoters, the pharmaceutical industry, lawyers, hospitals, the courts, and insurance companies. Payer’s (1992) focus was on the abuse of diagnoses as a mechanism for advancing political, social, and commercial interests. Disease mongering can be described as widening the boundaries of treatable illness in order to expand markets for those who sell and deliver treatments (Moynihan et al., 2002). Regardless of how illness is defined (clinically or non-clinically), once something is presented a “treatable” it also becomes profitable. As psychotherapists validate non-clinical reasons for pursuing clinical psychotherapy, they become increasingly responsible (and increasingly culpable) to uphold ethical communication and treatment practices.

An ethical health communication precept yet to be discussed in this chapter is the precept of comprehensibility. All of the themes discovered in this research had presenting problem messages that threatened the comprehensibility precept. Therapists struggled in their ad copy

writing with literary blunders, such as confusing questions (e.g., asking if readers are having "feelings of anxiousness or self-identity?"), misspelled words (e.g., "warrent"), and various other grammar mistakes (e.g., explaining a treatment modality as being "used to stop destructive such as smoking or nail biting"). Good grammar is not considered a clinical skill and likely has no implication on the value of the services being provided. However, poor grammar risks the perceived credibility of the message (and by extension – the messenger) and could plant a seed of distrust in a potential patient's mind that the therapist may unknowingly not be able to recover from.

Theoretical Implications

One of the guiding purposes of this study was to contribute to the growing body of literature on psychotherapy discourse centered in the scholastic field of Communication. The results of this study offer theoretical implications for emerging research in Health Communication and related processing theories, such as the Elaboration Likelihood Model.

Health communication scholarship. This study explored an under-researched topic pertinent to the field of health communication. Health communication refers to the way we seek, process, and share health information (Kreps & Thornton, 1992). It is "the singularly most important tool health professionals have to provide health care to their clients" (Kreps & Thornton, 1992, p. 2). This study of psychotherapists' online presenting problem discourse aims to do just that – help mental health professionals provide better healthcare to their patients by bringing awareness to language use that acts as a gatekeeper for the illnesses they treat. This study also contributes to the ever-growing communication scholarship regarding eHealth, or "the use of electronic means to transfer health information and resources" (du Pré, 2014, p. 233). Advances in eHealth communication and its use for health promotion are a driving force in

transforming healthcare, making some elements of care more accessible, faster, and often cheaper (Obuaku-Igwe, 2021). Improving eHealth communication is imperative for mental health professionals, the internet often being the primary, or sole, channel that they utilize for promoting their psychotherapy services.

Health information-seeking behaviors. Pertinent to the study of health care promotion, the findings of this study have implications for the study of Health Information-Seeking Behaviors (HISBs). As a reminder, an HISB is a purposeful act intended to satisfy a perceived need for health information (Johnson, 1997), with internet searches being the most common starting point (Jacobs et al., 2017). The five major themes that emerged from this study bring attention to the discourse surrounding the presenting problems that health information seekers are finding when exploring treatment options for these very concerns. That discourse ranges from concise, clinical terminology to more ambiguous, even metaphoric linguistic illustrations.

The stigma and vulnerable nature of psychotherapy can make it difficult to construct effective messages promoting it, which makes it even more imperative to get it right. For example, developing research on how to best promote psychotherapy services to individuals who suffer from depression has shown that depressed individuals are particularly difficult to persuade. Some health promotion messages have recently been shown to negatively influence factors of help-seeking behaviors, intensifying the urgent need for effective health communication strategies (Lueck, 2018). These strategies are particularly difficult to develop due to the symptomology researchers and clinicians are up against. For example, the negative feelings and cognitions inherent to the symptomology of depression can negatively bias views of help seeking, or that help seeking can lead to favorable outcomes as the disorder progresses (Lienemann et al., 2013). In other words, as the depression worsens, people become more

reluctant to seek help. Due to the complexity that depression entails, it has been a common focus of mental health promotion research (e.g., Christensen et al., 2006, Klimes-Dougan & Lee, 2010, Lienemann & Siegel, 2016). Because not all mental health conditions respond as depression can, and studying every diagnosis or presenting problem would be exceptionally time-consuming and unrealistic, more inclusive research, such as that presented in the current dissertation study, can practically add to the collective objective of improving discourse surrounding mental health.

The current study found five discursive construction strategies that psychotherapists use to language the presenting problems they treat. Although this study did not analyze the effectiveness of these strategies, it provides a secure jumping-off point for establishing practical and effective presenting problem communication strategies that mental health professionals can implement into their promotional materials. This jumping-off point is monumental for the development of these strategies. Previously, eHealth presenting problem analysis has only focused on user-led (non-clinician) online health communities (Giles & Newbold, 2011, 2013; Mo & Coulson, 2008; Owen et al., 2010), not on professional psychotherapy advertising or psychotherapist discourse.

Gain-and-loss framing. Another area of study that these findings have implications for is the health communication promotion model known as gain-and-loss framing (Rothman et al., 1999). This model posits that any singular health promotion message can have markedly different effects depending on how it is framed. For example, health messages can highlight the benefits of adopting the promoted health behavior (a typical gain frame) or the costs of failing to adopt the recommended health behavior (a typical loss frame) (Mavandadi et al., 2018; Rothman et al., 2006). In the current study, therapists who exemplify cosmetic psychotherapy were the most likely to utilize a gain framing approach, while those portraying lay description were the

most likely to use a loss framing approach. In contrast, therapists representing usage of the enigmatic self seemed to engage in a fair amount of both gain and loss framing. Equally important to understanding how a message is framed is how it is processed.

The Elaboration Likelihood Model. Although not utilized as a guide for this study, the findings of this research have implications for a fundamental, health communication processing model, the Elaboration Likelihood Model (ELM). The ELM, developed by Petty and Cacioppo (1986), theorizes that persuasive messages are processed through two different mental routes; the central route or the peripheral route. The *central route* involves elaboration, or the extent to which a person carefully thinks about and/or scrutinizes issue-relevant arguments. The *peripheral route* acts as a type of cognitive shortcut that quickly accepts and/or rejects a message based on superficial cues, as opposed to actively thinking about the issue itself. Which route is used is dependent on an individual's motivation (e.g., current attitude on the topic, personal interest, and importance of issue), ability (e.g., concentration, intelligence, time, lack of distraction, etc.), and the construction of the message itself.

If the language used in a persuasive message is clear, credible, and well-organized, it is more likely to be processed via the central route (Guttman, 2012). This is because clear language allows for easier comprehension and understanding of the message, which increases the likelihood that people will engage in deeper processing and critical thinking about the message's arguments and evidence. Persuasion aimed at invoking the central route often involves detailed and decision-relevant information. Conversely, the peripheral route relies on cues such as the source of the message or the message's emotional appeal to influence attitude. Persuasion intended for peripheral route decision making often appeals to simple heuristics, such as tradition, liking, and similarity. When individuals process messages through the central route,

their decisions are often more committed and longer lasting as they have engaged in deep processing of the message. Peripherally processed messages can be just as persuasive but are often more indicative of quick, "gut-level," heuristic decision-making that is less-committed.

The ELM is highly relevant to the field of Health Communication, as it provides a framework for understanding how people process and respond to health messages (Roberto et. al., 2011). The field of Health Communication aims to develop effective health messages that can persuade people to adopt healthy behaviors and avoid risky ones. The ELM can help health communication researchers and practitioners to identify the most effective strategies for designing and disseminating health messages. For example, Briñol and Petty (2006) found that health messages that have high involvement (relevance to the intended audience) are more memorable (privileging the central route) and more likely to be acted on than vague, detached messages.

In the context of discursively constructing presenting problems for psychotherapy, the ELM may explain how the therapist may affect potential clients' processing and responses to the presenting problem message. It may also provide insight about therapists' perceptions of, and intentions for, potential clients. Based on this model, therapists whose discourse promotes central processing may be interested in attracting patients who will commit to long-term therapy and engage in the hard work necessary for personal growth. In contrast, therapists whose discourse promotes peripheral processing may prioritize the successful initial recruitment of patients over their long-term commitment to therapy. Of the five themes that emerged from this study, two utilized discursive techniques promoting the central route of processing. They are clinical diagnoses, with discourse appealing to *more able* potential patients who are already informed on

the problem; and the enigmatic self, which appeals to *more motivated* patients who are driven to solve, or at least explore the problem.

The other three themes promoted peripheral processing. Lay description utilized simple, often one-word, discourse that appeals to *less able* potential patients. Discourse in cosmetic psychotherapy appeals to *less motivated* potential patients who are not driven to solve a problem but are only desiring the relatively vague goal of self-actualization. Finally, the theme of ailing identities is constructed of discourse using primarily peripheral cues, especially the subtheme of affirming identity disclosure, which relies on the affinity bias that the therapist is "like me" (i.e., has similarities to the potential patient) so they would be better as "my therapist." Further analysis of presenting problem discourse through the theoretical perspective of the ELM could provide practical strategies for psychotherapists to reference when constructing messages promoting their services.

Practical Implications

The findings from this dissertation study provide several practical implications for mental health providers. First, although psychotherapists are generally savvy with online engagement, "many continue to struggle with privacy, boundary, and identity issues while online" (Lopez & Robbins, 2022, p. 176). With so much at stake when advertising psychotherapy services, health care professionals should also be aware of how their languaging of presenting problems could be affecting their clients. Therapists can use the interpretations of the findings of this study to mindfully construct the presenting problems they treat in a way that reflects their intentions and positionality aligned with them. Because not all clinicians have the time or desire to read though this study in its entirety, I could offer a concise presentation or handout for therapists new to creating their online messaging or those interested in learning more about this topic.

Furthermore, this study has resulted in unexpected implications for the comprehensibility of private practice marketing. There were many examples in the data of unclear questions and statements, misspelled words, along with various other grammar mistakes. Being sure to spell and grammar-check their online presenting problem messages (and all of their marketing copy for that matter) will help psychotherapists boost their credibility and be better understood by their potential patients.

Finally, psychotherapists' understanding of how their treatment discourse engages potential patients online is more relevant than ever with the advancement of chatbot technology. Text-based conversational agents (i.e., chatbots) are considered promising digital technology in the future of mental health treatment (Abd-Alrazaq et al., 2020). Chatbots have the ability to support the early detection of symptoms, diagnostics, and treatment as they may improve access to mental health services using digital technologies such as computers, tablets, or cell phones (Uhlhaas & Torous, 2019). Most pertinent to this study, chatbots are being designed to interact with users through the use of natural language, keeping individuals engaged longer (Schick et al., 2022). Whether psychotherapists want to compete with this technology or integrate it into their businesses, they benefit from understanding what language use strategies are more likely to increase engagement. This all starts with how they language the presenting problems they treat (i.e., the very reason individuals are seeking them out to begin with).

Limitations

As with any research, this study is not without its limitations. First, the use of *Psychology Today* and website content as the only sources of data is a possible limitation. Incorporating a second method of data collection, such as therapists' professional social media accounts, could have yielded richer data about how this population discursively constructs the presenting

problems they treat to their potential patients. The sample was compiled from psychotherapists whose private practices are located in or near four major metropolitan areas in the United States. This study's findings depict presenting problem language from a Western perspective only and are not representative of all mental health professionals.

Next, there are limitations to the research method used for this study. Thematic analysis focuses on identifying and analyzing patterns and themes within data, not examining the relationships between variables in the way that other methods do. Thematic analysis is a subjective method that relies on the researcher's interpretation of the data. This method requires researchers to make decisions about which themes to prioritize and how to categorize data. As Rogers (2018) notes, "It is important to note that coding is not an exact science with right and wrong answers. All coding is considered a judgment call" (p. 889). As a result, different researchers may identify slightly different themes or interpret the same data in a different way.

Finally, an important limitation to consider inherent to the method and subject matter of this study is researcher bias. The power dynamics within the social sciences are such that participants' experiences (i.e., discourse) are filtered through the lenses of researchers, usually being the only side of the story that gets told (Hegarty & Rutherford, 2019). I am a unique researcher and interpreter for this study because I am both an academic researcher and a member of the larger population of focus, as I am a clinically licensed psychotherapist. Because of this, I have been diligent to identify my biases, subjectivities, and predispositions within the research process through practicing bracketing. However, bracketing does not alleviate me from holding subconscious assumptions about the research topic, the nature of reality, or what constitutes meaningful knowledge and knowledge production that may have influenced my research process (Braun & Clarke, 2006).

Directions for Future Research

This study was an exploratory investigation of psychotherapists' presenting problem discourse online. Now that five major discursive themes have been established, as well as several subthemes, there is much more to be understood about this topic. Future research might consider developing insight into why or why not psychotherapists utilize these discursive strategies using research methods such as interviews or focus groups to ask therapists about them directly. Similar methods could be used to study potential patients' impressions of how these themes play out in therapy, the results of which would be valuable because "beyond simply increasing awareness of services, marketing also needs to increase interest by presenting services in an appealing way" (Rith-Najarian et al., 2019, p. 381). Without knowing the impact these themes have on their intended audience, clinicians are limited to a trial-and-error-type strategy for constructing their presenting problem messages.

This study did not explore all means of psychotherapists presenting problem discourse. Social media, including video messages, could be a future consideration for the analysis of this topic. Moreover, addressing presenting problem discourse from other theoretical perspectives, such as Petty and Cacioppo's (1986) Elaboration Likelihood Model, or gain and loss framing (Rothman et al., 2006), could further connect the outcomes of this study to relevant health communication processes, most notably, health information-seeking behaviors.

Conclusion

This dissertation study was the first of its kind to explore psychotherapist-constructed presenting problem discourse. In light of these findings, it is important for mental health practitioners to consider the ways in which they language the problems they treat. Language acts as a gatekeeper for making sense of personal illness narratives, acting as a barrier or an advocate

for the purposes of seeking treatment. Through a thematic analysis of private practice advertising messages, five major themes emerged, along with several subthemes, to represent the various ways therapists attempt to explain the purpose of their profession to those outside of it. These themes remind us that there are many ways for therapists to describe feeling unwell, each of which hoping to find an audience who speaks the same language.

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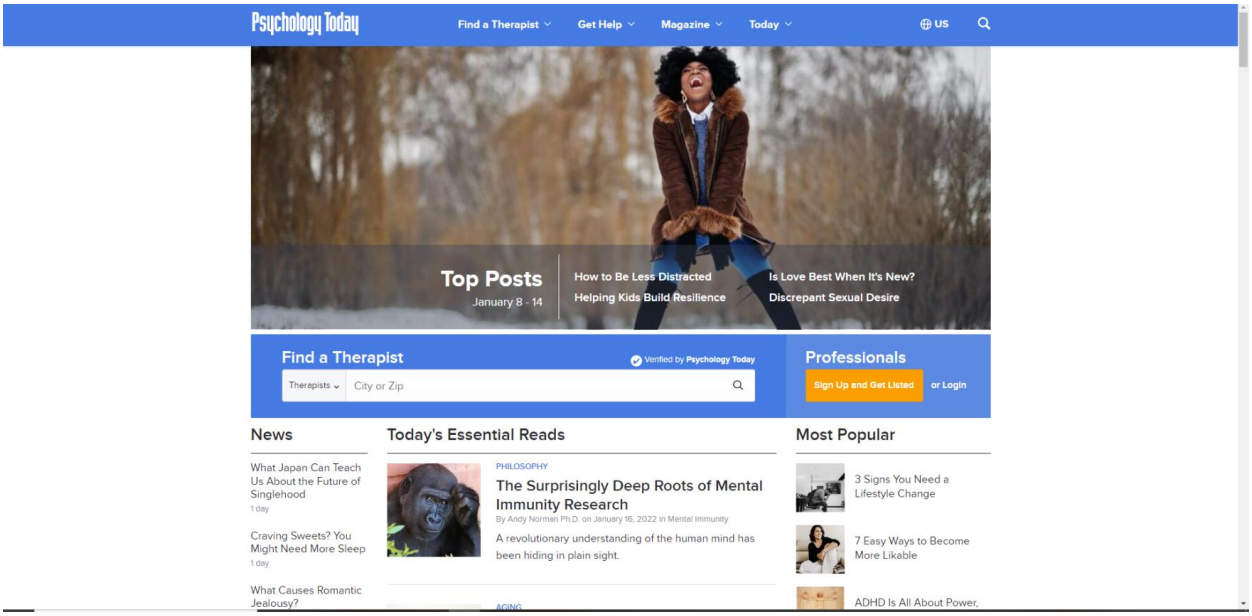
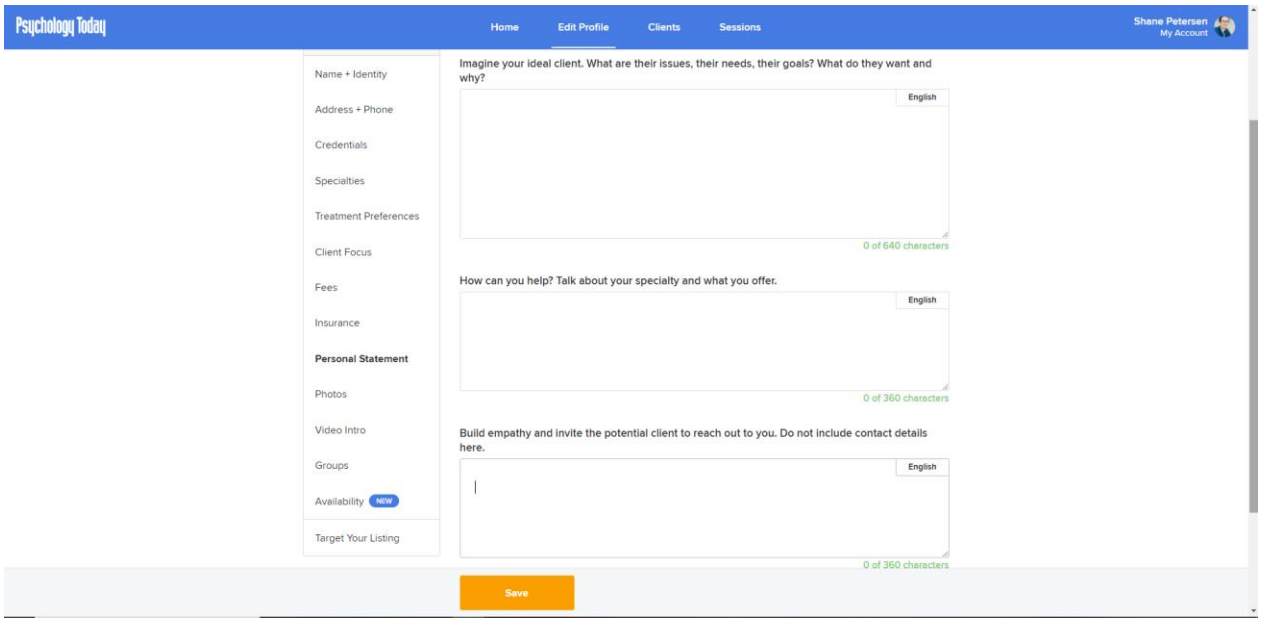
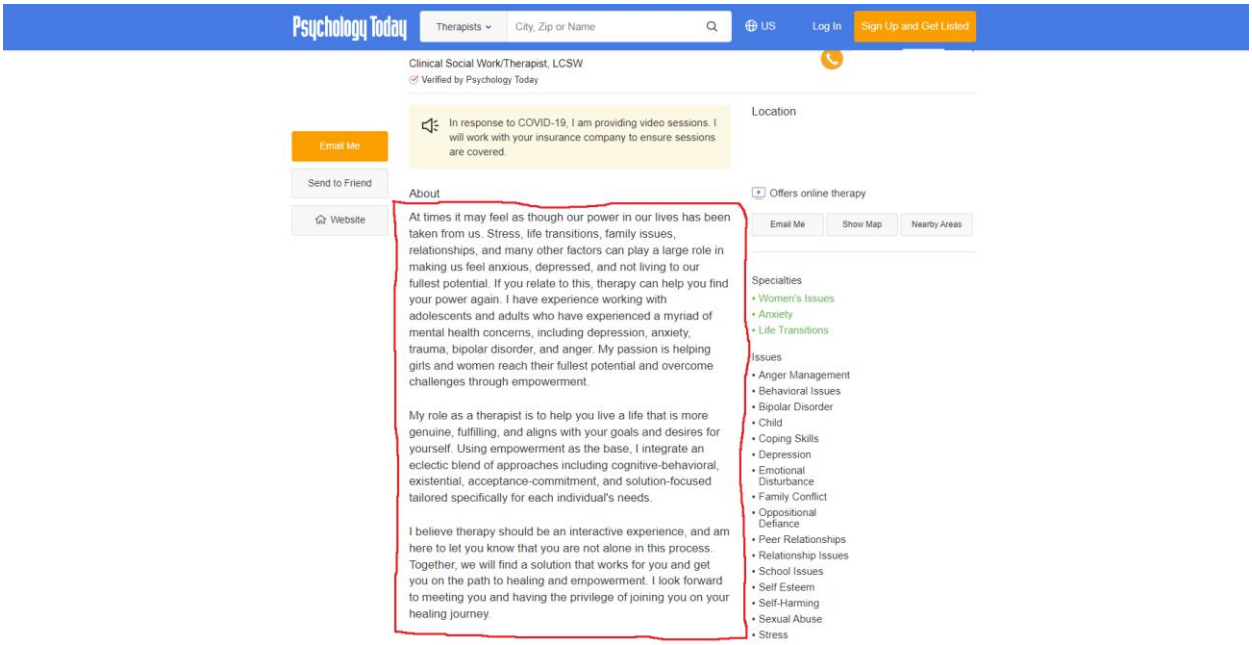
APPENDIX A: *PSYCHOLOGY TODAY* DIRECTORY HOME PAGE



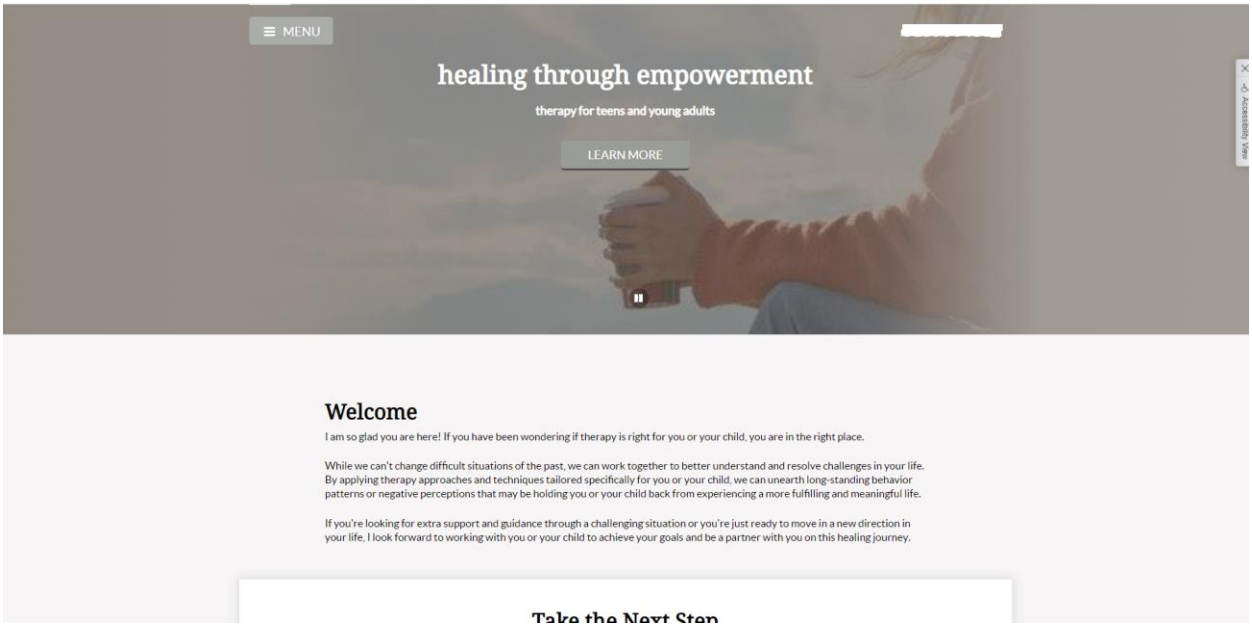
APPENDIX B: *PSYCHOLOGY TODAY* PERSONAL STATEMENT PROMPTS

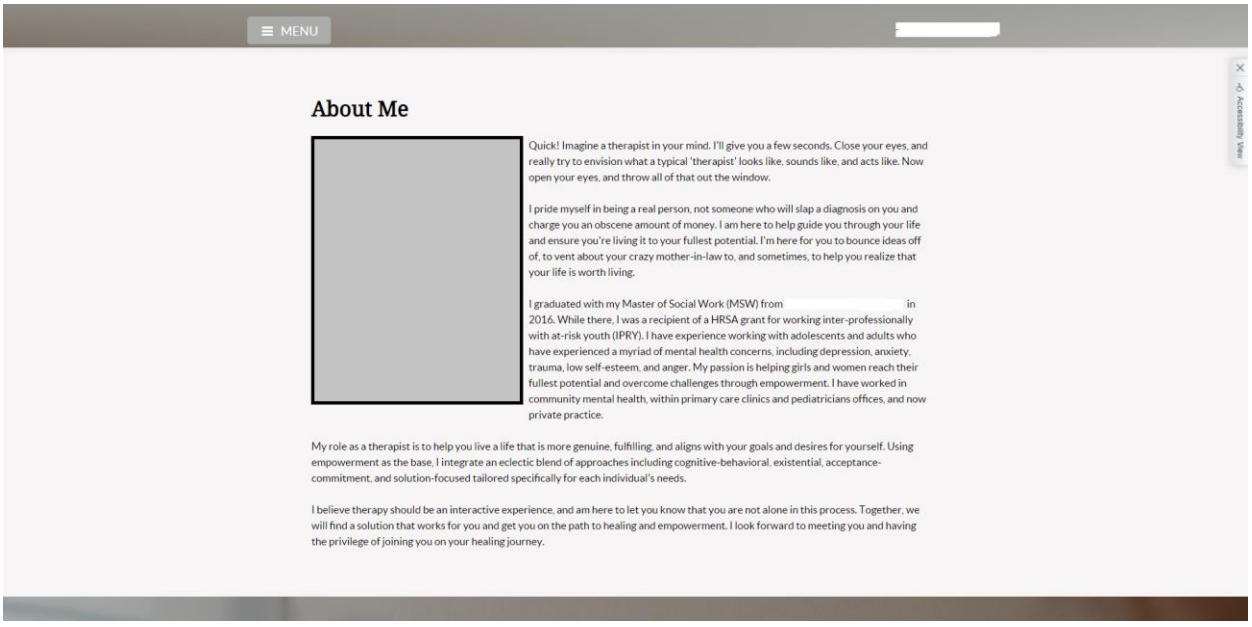


APPENDIX C: SAMPLE DATA SET EXAMPLE: *PSYCHOLOGY TODAY* PROFILE



APPENDIX D: SAMPLE DATA SET EXAMPLE: PSYCHOTHERAPIST WEBSITE PAGES





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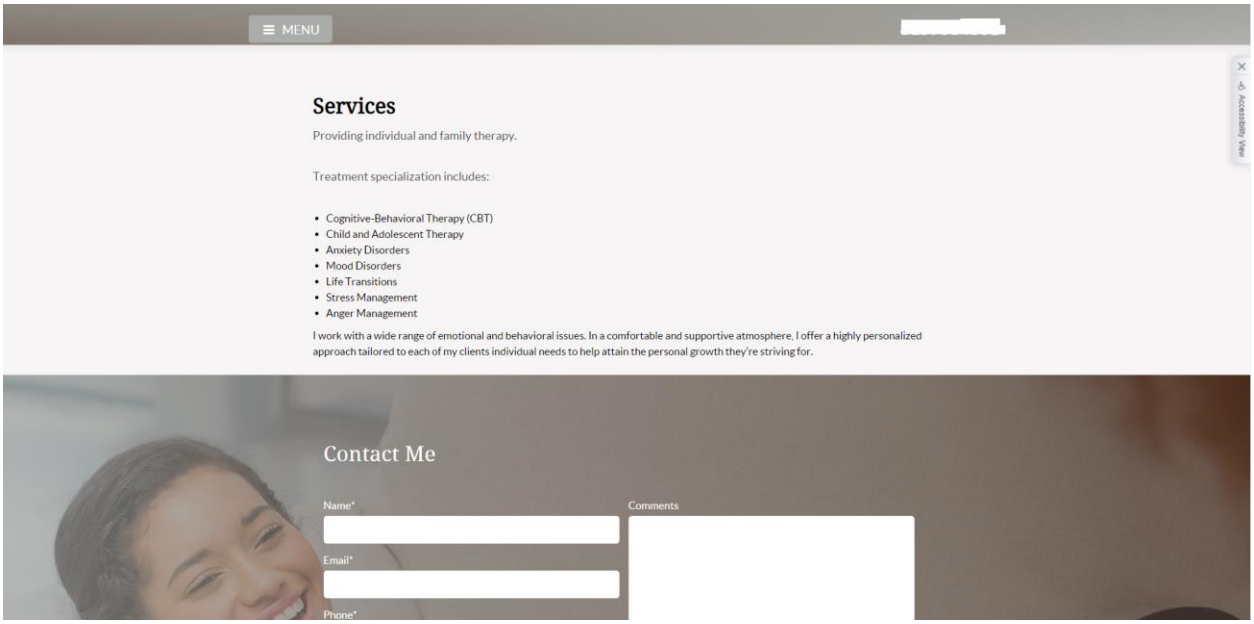

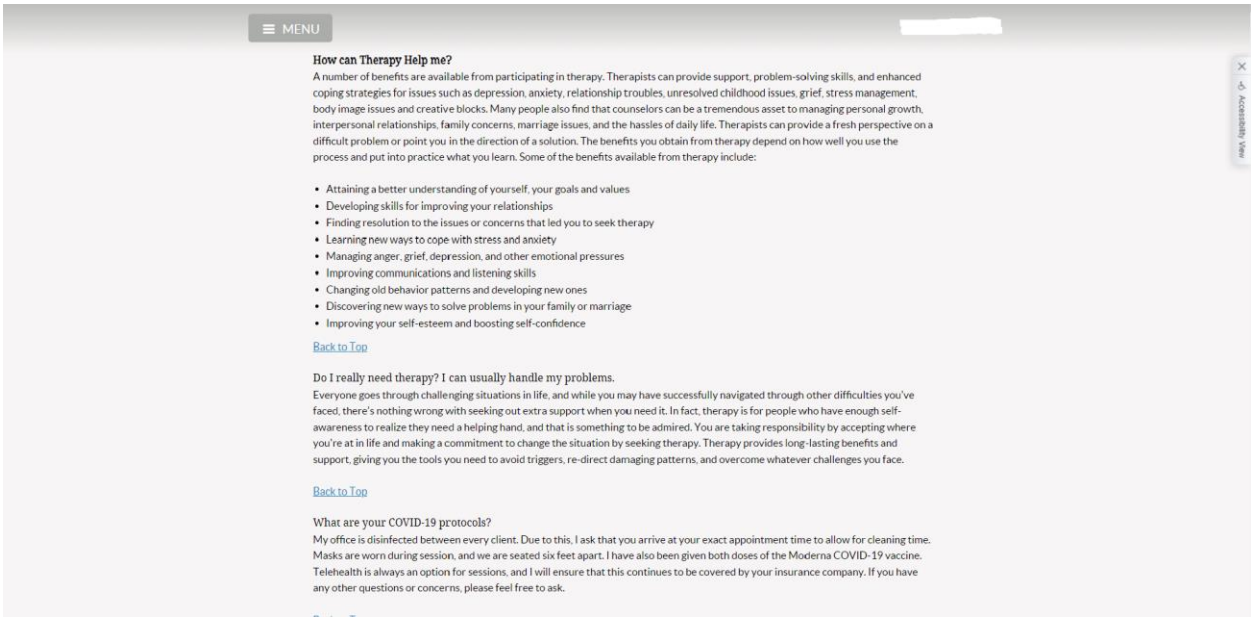

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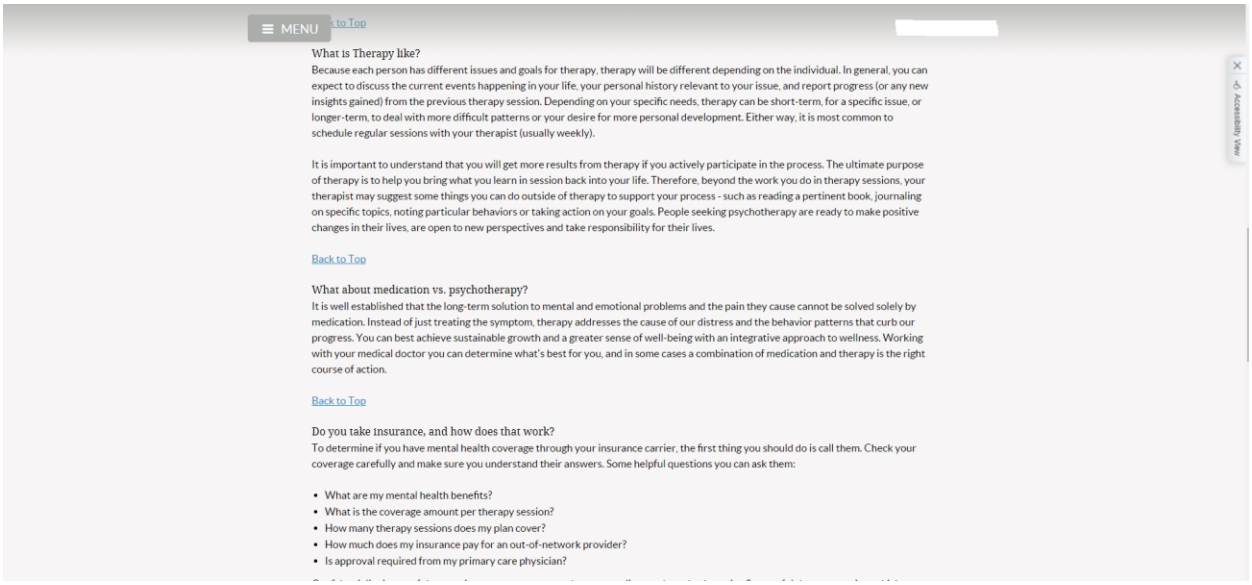

MENU

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What is Therapy like?

Because each person has different issues and goals for therapy, therapy will be different depending on the individual. In general, you can expect to discuss the current events happening in your life, your personal history relevant to your issue, and report progress (or any new insights gained) from the previous therapy session. Depending on your specific needs, therapy can be short-term, for a specific issue, or longer-term, to deal with more difficult patterns or your desire for more personal development. Either way, it is most common to schedule regular sessions with your therapist (usually weekly).

It is important to understand that you will get more results from therapy if you actively participate in the process. The ultimate purpose of therapy is to help you bring what you learn in session back into your life. Therefore, beyond the work you do in therapy sessions, your therapist may suggest some things you can do outside of therapy to support your process - such as reading a pertinent book, journaling on specific topics, noting particular behaviors or taking action on your goals. People seeking psychotherapy are ready to make positive changes in their lives, are open to new perspectives and take responsibility for their lives.

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What about medication vs. psychotherapy?

It is well established that the long-term solution to mental and emotional problems and the pain they cause cannot be solved solely by medication. Instead of just treating the symptom, therapy addresses the cause of our distress and the behavior patterns that curb our progress. You can best achieve sustainable growth and a greater sense of well-being with an integrative approach to wellness. Working with your medical doctor you can determine what's best for you, and in some cases a combination of medication and therapy is the right course of action.

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Do you take insurance, and how does that work?

To determine if you have mental health coverage through your insurance carrier, the first thing you should do is call them. Check your coverage carefully and make sure you understand their answers. Some helpful questions you can ask them:

- What are my mental health benefits?
- What is the coverage amount per therapy session?
- How many therapy sessions does my plan cover?
- How much does my insurance pay for an out-of-network provider?
- Is approval required from my primary care physician?

APPENDIX E: SAMPLE DATA DEMOGRAPHIC TABLE

	Participant Pseudonym (Alphabetical Order)	Clinical Licensure Type	Practice Location
1	Aaron	Psych	Midwest
2	Andy	Psych	Southwest
3	Ava	LPC	Midwest
4	Bryce	LCSW	Midwest
5	Carla	LMFT	Southwest
6	Charlie	LPC	South
7	Chelsea	LPC	Midwest
8	Clyde	LMFT	Southwest
9	David	Psych	South
10	Deana	Psych	South
11	Denise	LPC	Midwest
12	Elijah	Psych	South
13	Elouise	LCSW	Northeast
14	Frankie	LMHC	Northeast
15	Gerry	LCSW	Southwest
16	Hanna	LPC	Midwest
17	Jackie	LMFT	Southwest
18	Jaime	LCSW	Northeast
19	Jenna	LCSW	Southwest
20	Jessica	Psych	Midwest
21	Karla	LCSW	Southwest
22	Katrina	LCSW	Northeast
23	Kenny	Psych	Northeast
24	Kinsey	LCSW	Southwest
25	Lana	LCSW	Northeast
26	Leila	LPC	South
27	Lidia	LCSW	Northeast
28	Louie	Psych	Southwest
29	Malia	LCSW	South
30	Maren	LCSW	Midwest
31	Marty	LMFT	Southwest
32	Melissa	LCSW	Midwest
33	Mikaela	LCSW	Northeast
34	Paloma	Psych	South
35	Paul	LMFT	South
36	Raven	Psych	South
37	Ren	Psych	Northeast
38	Robbin	Psych	Midwest
39	Roma	LCSW	South
40	Shea	LCSW	Northeast

Clinical Licensure Type Key:
Psych – Clinical Psychologist (*n* = 12)
LMFT – Licensed Clinical Marriage and Family Therapist (*n* = 5)
LCSW – Licensed Clinical Social Worker (*n* = 16)
LPC – Licensed Professional Counselor (*n* = 6)
LMHC – Licensed Mental Health Counselor (*n* = 1)