JYVÄSKYLÄ STUDIES IN EDUCATION, PSYCHOLOGY AND SOCIAL RESEARCH
569

Helena Päivinen

Gendered Positioning

Addressing Gendered Power and Cultural Discourses in Therapeutic Conversations

JYVÄSKYLÄN YLIOPISTO

JYVÄSKYLÄ STUDIES IN EDUCATION, PSYCHOLOGY AND SOCIAL RESEARCH 569

Helena Päivinen

Gendered Positioning

Addressing Gendered Power and Cultural Discourses in Therapeutic Conversations

Esitetään Jyväskylän yliopiston yhteiskuntatieteellisen tiedekunnan suostumuksella
julkisesti tarkastettavaksi yliopiston vanhassa juhlasalissa
joulukuun 10. päivänä 2016 kello 12.

Academic dissertation to be publicly discussed, by permission of
the Faculty of Social Sciences of the University of Jyväskylä,
in building Seminarium, auditorium S212, on December 10, 2016 at 12 o'clock noon.

UNIVERSITY OF JYVÄSKYLÄ

JYVÄSKYLÄ 2016

Gendered Positioning

Addressing Gendered Power and Cultural Discourses in Therapeutic Conversations

JYVÄSKYLÄ STUDIES IN EDUCATION, PSYCHOLOGY AND SOCIAL RESEARCH 569

Helena Päivinen

Gendered Positioning

Addressing Gendered Power and Cultural Discourses in Therapeutic Conversations

UNIVERSITY OF JYVÄSKYLÄ

JYVÄSKYLÄ 2016

Editors
Timo Suutama
Department of Psychology, University of Jyväskylä
Pekka Olsbo, Timo Hautala
Publishing Unit, University Library of Jyväskylä

Cover Photo: Helena Päivinen

URN:ISBN: 978-951-39-6855-7
ISBN 978-951-39-6855-7 (PDF)

ISBN 978-951-39-6854-0 (nid.)
ISSN 0075-4625

Jyväskylä University Printing House, Jyväskylä 2016

ABSTRACT

Päivinen, Helena
Gendered positioning: Addressing gendered power and cultural discourses in therapeutic conversations.
Jyväskylä: University of Jyväskylä, 2016, 63 p.
(Jyväskylä Studies in Education, Psychology and Social Research
ISSN 0075-4625; 569)
ISBN 978-951-39-6854-0 (nid.)
ISBN 978-951-39-6855-7 (PDF)

This research examined gendered positioning in therapeutic conversations, especially in treatment of intimate partner violence (IPV). A feminist-informed reading combined with a discursive psychological approach was applied in three studies on positioning in therapeutic conversations. This reading focused on gendered positioning, gendered power and cultural discourses. Thus, the aim of this research was to examine how gender is constructed in therapeutic conversations that deal with couple relationship issues, and how the power distribution this entails is addressed in these conversations. The data consisted of videotaped and transcribed couple therapy sessions and group treatment sessions for men who have been violent in their intimate relationship. Language-based analyses drawing on discourse analysis, discursive psychology and a narrative approach were conducted. Study I focused on gendered positioning of the female therapist in an IPV treatment program. Study II analyzed the construction of dominant stories in couple therapy and focused on the mutual positioning and distribution of power in these dominant stories. Study III looked at blaming micro narratives in couple therapy for IPV and participants' responses, particularly to identity blaming. The findings of this research foreground the gendered basis of intimate relationships and how couple distress is linked to the distribution of power manifested in the gendered positioning of the partners. The discursive analysis showed how the participants in the therapy session, including the therapists draw on gendered cultural discourses when positioning each another. Thus, it is argued that the therapist needs skill in discursive deconstruction to be able not only to address the client's situation as an individual experience but also to locate it in the wider social and cultural context. Attention to positioning is one such clinical tool of potential value in therapeutic conversations.

Keywords: positioning, gender, power, discourse, narrative, couple therapy, group treatment, intimate partner violence

Author's address

Helena Päivinen
Department of Psychology
P.O.Box 35
40014 University of Jyväskylä
Finland
helena.paivinen@jyu.fi

Supervisors

Professor Juha Holma
Department of Psychology
University of Jyväskylä
Finland

Professor Jarl Wahlström
Department of Psychology
University of Jyväskylä
Finland

Senior Lecturer Marita Husso
Department of Social Sciences and Philosophy
University of Jyväskylä
Finland

Reviewers

Professor Arlene Vetere
Section for Family Therapy
VID Specialized University, Oslo
Norway

Associate Professor Evrinomy Avdi
School of Psychology
Aristotelion University of Thessaloniki
Greece

Opponents

Professor Arlene Vetere
Section for Family Therapy
VID Specialized University, Oslo
Norway

TIIVISTELMÄ (FINNISH ABSTRACT)

Päivinen, Helena
Sukupuolittunut positiointi: Sukupuolittuneen vallan ja kulttuuristen diskurssien huomiointi terapeuttisissa keskusteluissa.
Jyväskylä: University of Jyväskylä, 2016, 63 p.
(Jyväskylä Studies in Education, Psychology and Social Research
ISSN 0075-4625; 569)
ISBN 978-951-39-6854-0 (nid.)
ISBN 978-951-39-6855-7 (PDF)

Tässä tutkimuksessa tarkasteltiin sukupuolittunutta positiointia terapeuttisissa keskusteluissa, erityisesti parisuhdeväkivallan hoidossa. Tutkimuksessa selvitettiin, miten sukupuolta rakennetaan terapeuttisissa keskusteluissa, ja miten sukupuolittuneeseen positiointiin sisältyvää valtaa käsitellään terapeuttisissa keskusteluissa. Tutkimuksen kolmessa osatutkimuksessa analysoitiin positiointia terapeuttisissa keskusteluissa. Lopuksi näitä osatutkimuksia tarkasteltiin feministisesti orientoituneesta diskursiivisen psykologian lukutavasta käsin, jolloin päähuomio kohdistui positioinnin sukupuolittuneisuuteen, ja positiointiin sisältyvään valtaan. Osatutkimusten aineistona käytettiin videoituja ja litteroituja pariterapiaistuntoja sekä parisuhteissaan väkivaltaan syyllistyneiden miesten ryhmäistuntoja. Aineiston lukutapa pohjautui diskurssianalyysiin, diskursiiviseen psykologiaan ja narratiiviseen lähestymistapaan. Ensimmäisessä osatutkimuksessa tarkasteltiin naispuolisen terapeutin sukupuolittunutta asemointia parisuhdeväkivallan hoito-ohjelmassa. Toisessa osatutkimuksessa analysoitiin dominanttien tarinoiden rakentumista pariterapiassa sekä valta-asetelmaa näihin tarinoihin sisältyvien positioiden välillä. Kolmannessa osatutkimuksessa tarkasteltiin syytösnarratiiveja parisuhdeväkivallan hoitoon toteutetussa pariterapiassa ja erityisesti sitä, miten osallistujat reagoivat identiteettiin kohdistuviin syytöksiin. Tutkimuksen tulokset kiinnittävät huomiota parisuhteiden sukupuolittuneisuuteen sekä siihen, miten parisuhdeongelmat liittyvät valta-asetelmaan sukupuolten välillä. Diskursiivinen analyysi osoitti, miten asiakkaat ja terapeutit käyttävät sukupuolittuneita kulttuurisia totuuksia positioidessaan itseään ja toisia keskusteluissa. Tulokset korostavat terapeutin asemaa ja kykyä tarkastella asiakkaiden tilanteita, ei vain henkilökohtaisena kokemuksena, vaan myös suhteessa laajempiin kulttuurisiin diskursseihin. Tutkimus esittää positiointia hyödylliseksi näkökulmaksi ja työvälineeksi terapeuttisissa keskusteluissa.

Asiasanat: positiointi, sukupuoli, valta, diskurssi, narratiivi, pariterapia, ryhmäterapia, parisuhdeväkivalta

ACKNOWLEDGEMENTS

This research has now reached completion, and it is time to thank the numerous people who have influenced its progress at various stages along the way.

First, I am immensely grateful to my supervisor Juha Holma. Without his encouragement I would not have started this research in the first place, nor would it have been possible to finish it. Juha has offered me his extensive knowledge as well as pointed out interesting possibilities for networking and growing as a researcher. He has been the most inspiring mentor, a great colleague and a dear friend. My special thanks also go to Jarl Wahlström and Marita Husso, my other supervisors, for their insightful comments on my research. Moreover, I am thankful to Evrinomy Avdi and Arlene Vetere for reviewing this research. Their thoughtful and detailed comments were of great value in improving the final version of this report.

I have been fortunate to work in some very interesting and groundbreaking research projects during these years. In the complex and sensitive field of intimate partner violence research, and treatment practice, it is essential to have a well-functioning team. I am thus deeply grateful to my great colleagues. Doing, developing, and talking about our work has been inspiring. I am indebted to the European Family Therapy Research Group for allowing me to participate in their collaborative research. It has been a great privilege to work as part of such an experienced and proficient, yet warmhearted group of researchers. My appreciation also goes to all the members of the Relational Mind research project and its national and international collaborators. Working in this team has greatly widened my perspective on interaction and therapy. In the end, it would not be possible to research and develop therapeutic practices without the willing participation of the clients involved. Thus, my foremost thank you goes to the people who kindly permitted the use of their therapy sessions in research.

I thank the whole personnel of the Department of Psychology, and especially those in the psychotherapy research and training clinic, for creating such a good working atmosphere. I want to thank all the younger researchers for peer support, above all: Berta Vall, Petra Nyman-Salonen, Anu Karvonen, Laura Pesu, and Heli Siltala. Good discussions and laughter in Sohwi, several university restaurants and conference trips have brightened this, sometimes rocky, road of becoming a researcher. Further, my thanks go to Raija Mehto for guiding the practicalities of my research training and to Timo Suutama for taking care of the final steps of the research process. Michael Freeman kindly collaborated in reviewing the language of the whole research project, for which I am very grateful.

I am very thankful to many people in my other workplaces during these years: these include clients, colleagues, and clinical supervisors, from whom I have learned a lot about people, therapy, and myself. I am also highly appreciative for the financial support that this research has received from the Emil Aaltonen Foundation, the Department of Psychology at the University of Jyväskylä, and the Relational Mind research project, funded by the Finnish Academy.

Finally I want to thank my friends and family who have played an essential part in putting research into perspective in my life. I thank all my friends for valuable conversations and showing interest in my research, but even more for taking my mind off research-related thinking. In this connection, special thanks go to Noora, Reetta, Elisa and Jaana for sharing times of fun and times of trouble with me during these years. I would be lost without you. I am truly grateful for my family. I want to thank my parents, Anne and Juha, for always encouraging and supporting me in whatever I have chosen to do. I owe huge thanks to my siblings, Kaarina, Maria and Pekka. You have always been the great companions, support and joy in my life. I also want to thank all my relatives, as well as Heli and Mikko for kindly taking me into your family. Finally, I am deeply thankful for my partner Jarkko, who has always been there to share the ups and downs of this journey. Your patience, care and encouragement have been invaluable. You are my highway.

Jyväskylä 12.11.2016
Helena Päivinen

LIST OF ORIGINAL PUBLICATIONS

I Päivinen, H. & Holma, J. (2012). Positions constructed for a female therapist in male batterers' treatment group. *Journal of Feminist Family Therapy, 24*, 52–74.

II Päivinen, H. & Holma, J. (2016). Dominant story, power and positioning. In M. Borcsa & P. Rober (Eds.), *Research perspectives in couple therapy: Discursive qualitative methods* (pp. 89–104). Cham: Springer.

III Päivinen, H., Holma, J., Karvonen, A., Kykyri, V. L., Tsatsishvili, V., Kaartinen, J., Penttonen, M., & Seikkula, J. (2016). Affective arousal during blaming in couple therapy: Combining analyses of verbal discourse and physiological responses in two case studies. *Contemporary Family Therapy, 38*, 373–384.

Taking into account the instructions given and comments made by the co-authors, the author of the thesis applied previously collected data, conducted the analyses, and wrote the reports of the three studies. In Study III, the statistical analyses were conducted by V. Tsatsishvili and M. Penttonen.

CONTENTS

1 INTRODUCTION

This research addressed gender and power in therapeutic conversations. In the three studies reported, I analyzed positioning in therapeutic conversations, in couple therapy and in treatment for intimate partner violence (IPV). I then took a feminist-informed standpoint and focused on gender and gendered power in the findings of these studies. The purpose of the research was to show how gender and gendered power function in social interaction in the institutional context of therapy. Under scrutiny were such issues as the construction of gender in therapeutic conversations and what its meanings and functions are. Special attention was given to the distribution of power embedded in gendered positioning. Finally, consideration was given to how the therapist participates in the construction of the gender order, and how gendered power is addressed in this specific institutional context.

Even if this research highlights gender and power in therapeutic conversations, it has to be acknowledged that to construct a safe and productive therapeutic relationship, factors like negotiating goals, emotional bond, and cooperation are at the core of the encounter (Bordin, 1979). Empathy and trust are key ingredients in such an alliance. However, it can be presumed that gender and power are likely to influence this process of constructing this alliance and thus require closer investigation in process research on therapy. In particular, in treatment for IPV, which is often based on an imbalance of gendered power, these issues may become explicit in the therapeutic relationship and the treatment process.

During the course of this research both the understanding and treatment of IPV and the understanding and application of feminist theory have developed, as also has my own position as a researcher. This research was started as part of a research project on an IPV group treatment program in the psychotherapy research and training clinic at the University of Jyväskylä. During the past few years, another IPV project, on couple treatment for IPV, has also been under way at the clinic. This development accords with the broadening of view of violence, to be introduced later in this introduction. I started this research as a student of psychology and gender studies and I wrote the final report as a

junior researcher, clinical psychologist and feminist. Feminist theory is often misunderstood. According to George and Stith (2014), there are many feminisms. Although mine was based on the gender essentialist second wave of feminism, the deeper I dug into the issues of gender, power, oppression and inequality the more my analysis became informed by third-wave feminist ideas. My aim was to combine a feminist perspective with discursive psychological research on therapy conversations and thereby further the development of therapeutic practice in the field of couple therapy and of IPV treatment in particular.

1.1 Why study gender in therapy?

Gender is a much theorized and contested concept. It predominantly concerns male-female difference, which is often either over-emphasized or overlooked in psychology research (Hare-Mustin & Marecek, 1988). Generally, gender can be conceptualized as the state of being a female or a male person based on either biology or environment, or both (Stevens-Smith, 1995). A more nuanced description of gender includes "sexuality and reproduction; sexual difference, embodiment, the social constitution of male, female, intersexual, other; masculinity and femininity; ideas, discourses, practices, subjectivities and social relationships" as stated by Ramazanoglu and Holland (2002, 6). From a constructionist perspective, gender is something that is constructed through the performance by individuals of gendered categories in their everyday lives (Butler, 1990; Magnusson & Marecek, 2012). These performances are informed by the cultural resources of being male or female (Wetherell, 2007). However, studying gender requires seeing it as entwined with the other social categories in which the individual is positioned. The meaning of gender is constructed in relation to other categories of identity (Shields, 2008). In the third wave feminist view, this intersectionality (Crenshaw, 1991) is the site where oppression, violence and inequality meet (George & Stith, 2014).

While the understanding of gender has developed, so that currently a more complex viewpoint is taken with respect to individuals, gender remains the main divider in society. It seems to have remained what feminist scholars postulate: gender is the most pervasive categorization of individuals (Crawford & Marecek, 1989; Eckert, 1989; Henriques, Hollway, Urwin, Venn, & Walkerdine, 1998; see the whole special issue of Sex Roles, 5-6/2008). It is also hierarchical in that men and women do not have the same possibilities or limitations. Like the gender division itself, the discrepant value of these categories is a cultural construction supported by various discourses that reproduce the gendered asymmetries of power and privilege. Social encounters of everyday life are gendered, including interaction in intimate relationships.

In the western countries, the traditional and still dominant idea of the couple relationship is that between members of the opposite sex. The heterosexual nuclear family continues to hold dominant position as the norm of the

family form. Alternative cultural discourses challenging these dominant discourses around family structure and functioning easily remain marginalized. Thus, other forms of family— same-sex couples, couples without children, single parents, blended families, etc. — lack supportive cultural discourses concerning their functioning and distribution of duties and rights. In fact, the cultural discourses around these alternative forms of family may be unsupportive and even critical, thereby affecting how people see their lives.

The cultural discourses surrounding couple relationships continue to be gendered and thus involve hierarchic power dynamics (Fishbane, 2011; Knudson-Martin, Huenergardt, Lafontant, Bishop, Schaepper, & Wells, 2015; Ward & Knudson-Martin, 2012), even if equality in the couple relationship has been connected to relationship satisfaction (Whisman & Jacobson, 1990), greater marital happiness (LeBaron, Miller, & Yorgason, 2014) and well-being (Knudson-Martin, 2013). Thus, lack of equality may be linked to couple relationship distress and reasons for seeking treatment. Indeed, it is argued that cultural discourses supporting equality in couple relationships have not developed to the point of achieving a dominant position in western cultures (Knudson-Martin, 2013; Knudson-Martin & Huenergardt, 2010; Sinclair & Monk, 2004). Thus, heterosexual relationships also lack support for breaking down gendered hierarchies.

From the feminist standpoint, one aim of therapeutic practices should be to enhance equality between people, between partners, and between genders. The ethical guidelines for psychologists working in Finland require clinicians to take into account individual, role and cultural differences based on clients' ability to function along with their gender, sexual orientation, ethnicity, national identity, age, religion, language and social position. The psychologist is to take account of the limitations set by their own cultural, societal and gendered position. These guidelines conform to the ethical meta-code of the European Federation of Psychologists' Associations (EFPA) and the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (APA). From a feminist perspective, a social justice approach also requires that clinicians remain actively aware of how these social locations intersect with power and privilege in people's relationships (Parker, 2003; 2009).

It has been shown that the gender of the therapist does not predict the outcome of the therapy (Blow, Sprenkle, & Davis, 2007; Blow, Timm, & Cox, 2008; Bowman, Scogin, Floyd, & McKendree-Smith, 2001; Okiishi et al., 2006). Yet, given the dominant position of gendered cultural discourses, it can reasonably be hypothesized that gender plays a part in the construction of relationships, including the therapeutic relationship. Psychotherapy research has highlighted the importance of the therapeutic alliance as a key factor in treatment success (Lambert & Barley, 2001). Common factors, including the client's experience of empathy, understanding and acceptance seems to be essential in a successful therapy process. It is important that the therapist is able to relate to the client and tailor the relationship to individual needs. Thus, it may be that the way the therapist deals with gender issues in the therapy session may be

more crucial than gender per se (Blow, Timm, & Cox, 2008). This assumption raises the questions at issue in this research: how do gender and gendered power work, and how these are constructed and addressed in therapeutic conversations?

1.2 Discursive approach

This research approached therapeutic conversations from a post-positivist, post-structuralist research paradigm (Smith, Harré, & van Langenhove, 1995a, b). This rather new paradigm in psychology is language- and discourse-oriented, studies psychological phenomena in situ, observes life as a set of dynamic interactions and processes, and focuses on individuals rather than making generalizations. By concentrating on understanding and meaning instead of, for example, measurements and frequencies, this research approach comes close to the clinical practice of psychologists and psychotherapists; in other words, the research findings have pragmatic value.

Specifically, in this research gender and power were approached from the perspective of discourse analysis or, more precisely, discursive psychology, which highlights the theoretical rethinking of psychological ideas from within a discursive methodology (Edwards & Potter, 1992). These discursive approaches to gender and power have their roots in the social constructionist epistemology (Burr, 2003; Gergen, 2009). For psychotherapy research this epistemological basis means that not only the psychological understanding of clients' problems and their treatment, but also the social and institutional aspects of therapy become the object of examination (Wahlström, 2016). The target of analysis is not the clients' inner world and its reformulation but, instead, the way therapeutic interactions; in other words, talk in therapy, produces change. Thus, social and psychological phenomena are seen as co-constructed through discursive acts in the various social encounters in which people participate. Use of language is the focus of interest in discursive research. Accordingly, gender is understood as discursively constructed in social encounters.

Discourse as concept covers both the process of talk and interaction and the outcome of that interaction (Sinclair, 2007). Discourse is action-oriented, situated, and both constructed and constructive (Potter, 2004, 2012). Thus, discourse is performative, contextual and constructed though use of various rhetorical devices, choices of words and metaphors that connect the local discourse to larger systems of meaning as well as at the same time reconstruct these larger discourses.

Discursive research, then, is interested in the local construction of meaning, that is, micro discourse, and/or the cultural, macro level of discourse reflected by the micro level (Avdi & Georgaca, 2007a). At this macro level, some cultural discourses are more supported and approved than others. These dominant discourses are familiar and feel natural to us. They are the stories that are taken for granted about life, ourselves and our relationships and they are hard to ques-

tion. Thus, how life, experience and problems are understood is shaped and defined by cultural discourses (Dickerson & Crocket, 2010; Winslade, 2005). In this research, discourse was viewed at the local level of interaction and meaning making, at the same time acknowledging the cultural macro level of discourse and its effect on the local discourses.

From the discursive viewpoint, the self is not stable by nature, but individuals as subjects are constantly constructed and reconstructed in each discursive encounter that they participate in (Burr, 2003). Hence, the formation of identity is seen as a fluid and dynamic, ever continuing process (Avdi & Georgaca, 2009). In this light, therapy can be conceptualized as an institutionalized context of identity-work; construction and reconstruction of identity. This process involves various societal categories. Identities are not individual in the sense that they reflect the dominant cultural discourses available and are constructed in relation to the identities of others. However, the traditional concepts used to describe this kind of identity construction, such as role, have for some time been considered too static and formal to serve this purpose (Davies & Harré, 1990). Hence, a more dynamic concept of position has been introduced in the social sciences, including psychology.

1.3 Positioning and power

Positioning is a concept which highlights the contextual and relational aspects of how people construct identities. In this research, positioning was conceptualized following Rom Harré and his colleagues (Davies & Harré, 1990; Harré & van Langenhove, 1991, 2003; Harré & Moghaddam, 2003), who define positioning as a discursive process in which people are given parts or are assigned locations in an ongoing discourse. Accordingly, a position is an interactional location that is taken up by oneself or offered to another person. The act of positioning defines the participants' place in the local moral order (Harré & van Langenhove, 1991; Kurri, 2005; Wahlström, 2016). In other words, positioning outlines the rights and duties between the interlocutors. In this research, this division of rights and duties was conceptualized as discursive power. As a discursive product, discursive power is dynamic, interactional and a contextualized achievement (Avdi & Georgaca, 2007a). Such power is also relational (Fishbane, 2011; Knudson-Martin et al., 2015; Ward & Knudson-Martin, 2012), making some actions possible for one interlocutor but less so for another.

Positioning the self and others may be explicit, as in utterances deliberately constructing specific positions, or it may be implicit in that the positioning is not explicitly uttered as such, but is more subtly constructed. Positioning can also be intentional or it can be unintentional and unconscious (Harré & van Langenhove, 1991). According to Harré and van Langenhove (1991), positions are fluid and ephemeral points from which the world is viewed. The position currently occupied by a person makes particular metaphors, story lines and concepts available to that person. Thus, positioning sets the limits to what are

considered socially and logically possible actions for a person (Harré & Moghaddam, 2003; Henriques et al., 1998).

Positions, although constructed in the local discourse, also reflect the larger, macro cultural discourses and the subject positions available in them. As people draw on various cultural discourses to account for, justify, and validate their view and themselves, the positions they adopt are multiple and shifting. Moreover, positions are also relational (Harré & van Langenhove, 1991; Harré & Van Langenhove, 2003; Henriques et al., 1998; Winslade, 2005). By taking up a certain position, one inevitably positions other persons in relation to this position, that it, in a counter-position. In this sense, our identities are always interdependent, bound up together. Change in one person's position challenges the existing positions of others, causing them to change as well (Gergen, 2001).

Different sides of one's identity are called upon in different social encounters. The concept of positioning neatly illustrates the situational variability of our being. In our western society, the way being a person is done or performed is predicated on the notion of a historically continuous and unitary self. This means in turn that contradictory positions are experienced as problematic and in need of reconciliation. Investment in certain positions more than in others has been one way to explain the sense of self as something unitary or at least continuous (Henriques et al., 1998; Wetherell, 2007). Psychological distress has been seen as stemming from a limited or too widespread and disorganized use of discourses and subject positions (Avdi, 2005; Frosh, Burck, Strickland-Clark, & Morgan, 1996; Georgaca, 2001; Madill & Barkham, 1997). Others argue that developing a more agentic position should be the main goal of therapy (Avdi, 2012; Burck, Frosh, Strickland-Clark, & Morgan, 1998; Guilfoyle, 2015; Wahlström, 2016). Being positioned not in line with one's preferred identity narrative may be experienced as uncomfortable, leading to efforts to change the situation by repositioning oneself or by drawing on alternative cultural discourses that enable a change in one's position (Reynolds, Wetherell, & Taylor, 2007).

1.4 Gendered positioning

Positioning does not involve the discursive production of selves solely as individuals in relation to other individuals, but also as members of groups or classes (Tan & Moghaddam, 2003). Social categories bear cultural meanings, as they are based on a shared language and framework (Magnusson & Marecek, 2012). As a member of certain groups and classes a person sees the world through certain discourses and constructs her or his identity through these discourses. For a member of a given category, group or class, this means that certain other possible positions are limited. This limitation is due to the power of the cultural discourses that define the social order and exclude some of the possible alternatives (Burr, 2003). The dominant cultural discourses about, for example, being a woman or a man offer different possible positions for the members of these two categories (Henriques et al., 1998). Other social categories,

including sexuality, ethnicity, age, social class, (dis)ability and geographical location intersect with gender to help or hinder individuals in taking up certain positions. However, in the current social order, gender continues to be the most pervasive category that constructs asymmetries of power between people, including in their intimate relationships (Eckert, 1989; Henriques et al., 1998).

Gendered positioning refers to positioning based on cultural discourses concerning gender. The dominant cultural discourses around gender remain dichotomized, although gender variability is increasingly being acknowledged. These dominant gendered discourses deal with gendered category memberships (Widdicombe, 1998) like women and men, girls and boys, mothers and fathers, husbands and wives, girlfriends and boyfriends, and how these categories should act and talk, and what they should look like. Also, the relationship between these positions is embedded in cultural discourses in which the distribution of power is gendered, meaning that possibilities and limitations for women and men are not equal. Positions are not freely negotiable but are subject to cultural expectations; which means that not all positions are equally available to everyone to take up. However, gender is not a static and finite characteristic of an individual, but an evolving, nuanced and negotiable part of one's identity. Thus, it may be that the dominant dualistic, gendered cultural discourses are experienced as constraining and discomforting. Furthermore, inequality between intimate partners is often linked to distress and problems in their relationships (Harryson, Novo, & Hammarström 2012). Therefore, gendered positioning may be linked to treatment-seeking by individuals and couples.

1.5 Gender, power and positioning in couple therapy

Family and couple therapies have been critiqued for not addressing the gendered imbalance of power (Knudson-Martin, 2013). This in turn means that, for example, couple conflicts are often handled at the private, individual level without addressing the cultural, political and social context (Sinclair & Monk, 2004). Feminist scholars have argued such an approach entails the possibility that social injustice and oppression are reproduced in the therapy room (Dickerson, 2013; Hare-Mustin, 1994; Parker, 2009). In her critical paper, Hare-Mustin (1994) showed how the discourses that may be drawn on in therapy and become heard in therapy sessions are limited to those that the clients and the therapist acknowledge. Indeed, psychotherapy has been argued to be performed within the constraints of given therapeutic domains and discourses (Parker, 1998), and has also been criticized for reconstructing the western cultural ideal of personhood (Guilfoyle, 2002) and gendered relations (Hare-Mustin, 1994).

It has been argued that the therapist's words have an influence and significance that the utterances of family members do not have (Guilfoyle, 2001). In the therapy context, the institutional role of the therapist can be performed in multiple ways (Wahlström, 2016). In any case, therapists inevitably have to take

up a position in the therapy conversation, as they have to choose from which discourse to speak from (Sinclair & Monk, 2004) and thus take a moral stance on their clients' situation (Kurri & Wahlström, 2005). Yet, Lynn Parker (1997) has shown how, for therapists, bringing up power issues is experienced as difficult, albeit important, even among feminist scholars. Hence, discussing power issues may not emerge in therapeutic conversations.

There are a few couple therapy approaches and guidelines which aim at explicitly addressing social context issues, especially gender and power issues, in their practices. These approaches include, for example, Socio-Emotional Relationship Therapy (Knudson-Martin & Huenergadt, 2010; Knudson-Martin et al., 2015), the Power Equity Guide (Haddock, Zimmerman, & MacPhee, 2000), Gender Aware Therapy (Good, Gilbert, & Scher, 1990), the Feminist/Emotionally Focused Therapy practice model (Vatcher & Bogo, 2001) and the Relational Justice Approach (for working with infidelity) (Williams, 2011). In her research, Parker (1997, 2003, 2009) found several interventions useful for therapists in addressing gendered power issues with couples. Furthermore, scholars have paid attention to hierarchical power-over, which leads to power struggles, and its reconstruction into relationship empowerment through the development of emotion regulation and empathy (Fishbane, 2011). Sinclair (2007) further argues that orienting to discourse in therapeutic interventions can lead to socially responsible therapy practice.

However, researchers focusing on practitioners have noticed the prevalence among therapists of stereotypical views of women and men (Huntington & Black, 2014; Trepal, Wester, & Schuler, 2008). This in turn leads to suspicions that gender bias and maintenance of the hierarchical gender order may affect therapy practice. In their study of family therapists' use of feminist interventions, McGeorge, Carlson, and Guttormson (2009) found that practitioners seem to hold the view that patriarchy and social position are important factors that affect relationships and should therefore be addressed. However, the therapists studied rarely raised these issues in their own practice. This finding is in line with reports that practitioners find it difficult to deal with the question of asymmetries of power (Parker, 1997). It seems that practitioners lack clinical training in how to deal with gender issues and inequality (Huntington & Black, 2014; Scher & Good, 1990; Stevens-Smith, 1995).

Over the past thirty years, feminist thinking has gained a central place in family therapy (Leslie & Southard, 2009). However, according to Leslie and Southard, the fact that feminist thinking has become part of the dominant discourse of psychotherapy has led to a diminution in the critical awareness of injustice and development of therapy practice that it originally brought with it. It seems, then, that a need remains for the wider acceptance and inclusion of feminist and discursive ideas in therapeutic practice, as well as theory, and constant monitoring of how these ideas are actually put into practice.

1.6 Intimate partner violence as a gendered issue in therapy

From a feminist perspective, intimate partner violence is viewed as stemming from stereotypical, fixed and limited gender roles (Holma, Partanen, Wahlström, Laitila, & Seikkula, 2006) and the dominant patriarchal discourse (Dickerson, 2013). This gender dichotomy then serves as a justification for perpetrators of IPV (Holma et al., 2006). Thus, deconstructing the imbalance in gendered power is central in treatment for IPV. However, IPV can also be perpetrated by both partners, by the female partner only, and in same-sex relationships. Indeed, an updated, third wave, feminist perspective sees IPV as located in the intersections and shifting structures of power (George & Stith, 2014). To achieve the objective of deconstructing power imbalances requires a close look at identity construction and gendered positioning in the treatment of IPV in situ.

Traditionally, treatment for IPV has been implemented separately for victims and perpetrators. This preventative work was started by the women's movement and the development of women's shelters in the USA, in the 1970s. The Northern European countries followed this development a decade later, and today the number of programs is vast (Geldschläger, Ginés, Nax, & Ponce, 2013; Saunders, 2008). Perpetrator programs typically include initial individual meetings followed by group treatment. Different programs use different approaches (Gondolf, 2004). However, the safety of the victim has to be the first rule of any such program (Work with Perpetrators of Domestic Violence in Europe, 2008).

IPV group discussions commonly focus on violence-related issues, such as expanding the definition of violence, taking responsibility of one's violent behavior and learning alternatives to this behavior. Treatment groups are usually conducted by a co-therapist dyad and it has been considered important to have both a female and a male leader in the groups. It has been argued that a female leader can bring a woman's perspective and experience in an otherwise all male context (Tyagi, 2006; Wilson, 1996). Then again, a male therapist can model a more flexible and modern masculinity to the male client (Deering & Gannon 2005). Having both a female and a male leader in the group has also been deemed important because it makes it possible to model co-operation and the sharing of leadership between women and men (Adams & Cayouette, 2002; Austin & Dankwort, 1999; Caoyette, 1999; Tyagi, 2006; Wilson, 1996). Working with IPV perpetrators has been considered demanding because the clinician has to balance between empathetic and confrontational approaches. For example, gender may influence the client's perceptions of the therapist's understanding or empathy (Caoyette, 1999). Another challenge concerns the heterogeneity of perpetrators and thus how to apply individually oriented and flexible interventions in a group context (Räsänen, 2013).

Johnson (2006) has defined four different patterns of IPV: intimate terrorism, violent resistance, mutual violent control and common/situational couple violence. Since there are different types of IPV, different kinds of treatment mo-

dalities are needed (Bograd & Mederos, 1999; Johnson, 2006; Räsänen, 2013). Recently, understanding of IPV has evolved to looking at the phenomenon from an updated feminist view which sees it as a problem that does not stem solely from the patriarchal power position of the male gender (George & Stith, 2014). This third-wave feminist view makes it possible to address different forms of IPV with appropriate interventions, and also to acknowledge and intervene in violence between same-sex partners (Baker, Buick, Kim, Moniz, & Nava, 2013; Linville, Chronister, Marsiglio, & Brown, 2012; Ristock, 2003) and female perpetrated violence towards her male partner (Babcock, Miller, & Siard, 2003).

For a long time, couple therapy for partner abuse was criticized and not recommended in any situation (Kaufman, 1992). Traditional family systems approaches, in particular, were criticized for blaming the victims and making them mutually responsible for the violence (Hansen, 1993). Furthermore, victims of violence reported not being heard or understood in couple therapy, and not daring to speak about violence in the presence of their spouse (Husso, 2003; Kaufman, 1992). This may certainly be the case, especially among couples in which only one partner is both violent and controlling towards the other (see Johnson, 2006, for a discussion on intimate terrorism). Yet, from the third-wave feminist viewpoint, power is acknowledged as a multidimensional phenomenon, thereby enabling a more nuanced analysis of IPV (George & Stith, 2014). In current research, for example, dominance in couple therapy sessions has been divided into different forms (quantitative, semantic and interactional) (Seikkula, Laitila, & Rober, 2012). In case studies on couple therapy for IPV, it has been found that male clients uses more quantitative dominance whereas female clients use more semantic dominance (defining what is talked about) (Keltinkangas, Kulta, & Kyrö, 2014; Vall, Seikkula, Laitila, & Holma, 2016). Moreover, the therapist in turn seeks to promote dialogic conversation through the use of interactional dominance and in this way prevent emotional escalation (Vall, Seikkula, Laitila, & Holma, 2016; Vall, Seikkula, Laitila, Holma, & Botella, 2014).

Recently, attempts have successfully been made to develop IPV-specific couple therapy models which acknowledge the specific features of IPV and focus on safety (Cooper & Vetere, 2005; Goldner, 1998; Hrapczynski, Epstein, Werlinich, & LaTaillade 2012; LaTaillade, Epstein, & Werlinich, 2006; McCollum & Stith, 2008; Stith, McCollum, Amanor-Boadu, & Smith, 2012; Stith, Rosen, & McCollum, 2003; Vall, Seikkula, Laitila, & Holma, 2016; Vall, Seikkula, Laitila, Holma, & Botella, 2014). For each prospective couple, it is essential to assess whether couple treatment appears to be a suitable treatment modality or if other options would suit better the couple. Minimizing risk and optimizing safety are priorities. The criteria for selecting couples with a history of IPV for conjoint treatment include the following: the violence (both physical and psychological) has been situational and mild to moderate in its seriousness; both partners are willing to attend couple therapy and feel that it is safe; the couple wishes to end violence as well as stay together; and the perpetrator is prepared to take responsibility for the violence (Bograd & Mederos, 1999).

1.7 Aims of the research

The goal of this research was to further understanding of the workings of gender and gendered power in therapeutic conversations. Each of the three studies focused on different aspects of positioning in the local micro discourse which is surrounded by and linked to the larger cultural discourses. Also in each analysis, the position and discursive actions of the therapist were acknowledged. The purpose of Study I was to increase understanding of the phenomenon of IPV as a gendered issue and how this aspect makes a difference in group treatment conversations. Specifically, the interest was in how the female therapist is gender-positioned in the therapy discourse. Study II focused on the power imbalance between counter-positions and asked how the positioning between the couple was constructed and how it changed during couple therapy. Study III examined how discomforting positioning of the other was carried out through attributions of blame and how such blaming was experienced both by the couple and by the therapists in couple therapy for IPV.

The larger aim of the research was to promote the development of a sensitive and socially just treatment practice. The main objective was to analyze gendered positioning and to examine how gender is socially constructed in therapeutic settings that deal with issues connected to couple relationships. It was demonstrated how the gendered discourses of the society are embedded therapeutic conversations and what meanings and functions such gendered positioning has in the treatment process. Specifically, the research questions were:

(1) How is gendered positioning performed in relation to the dominant cultural discourses in therapeutic conversations?
(2) What are the meaning and functions of gendered positioning in therapy discourse?
(3) How are gendered positioning and the power issues embedded in it dealt with by the therapists?

2 METHODOLOGY

2.1 Methodological choices

This research followed in the tradition of qualitative, discourse oriented therapy process research (McLeod, 2011), which has become a strong branch of research in the Department of Psychology, at the University of Jyväskylä. Language-based analysis of session transcripts of the kind performed here has gained a place in psychotherapy research and its clinical implications have been greeted as particularly useful (Avdi & Georgaca, 2007a; Madill & Barkham, 1997; Sinclair & Monk, 2004; Winslade, 2005). While the philosophical basis of discursive approaches is broadly social constructionist, these approaches focus on different aspects of social construction. These methodological stances also vary in their emphases and themes (Avdi & Georgaca, 2007a; Georgaca & Avdi, 2009; McLeod, 2011; Parker, 2013). The analyses in the studies comprising this research were guided by discourse analysis (Banister, Burman, Parker, Taylor, & Tindall, 1994; Potter, 2004, 2012; Potter & Wetherell, 1995; Wetherell, Taylor, & Yates, 2001; Willig, 1999; Wood & Kroger, 2000), discursive psychology (Edwards & Potter, 1992; Potter, 2003, 2012; Potter & Wetherell, 1987; Wetherell, 2007) and a narrative approach (Avdi & Georgaca, 2007b; McLeod, 1997, 2004, 2011). Ideas from a more critical tradition of discourse analytic research (Avdi & Georgaca, 2007a; Parker, 1998, 1999, 2002) were also drawn on.

The discursive methodologies are more of an approach and orientation to text than a method with specific tools (McLeod, 2011). Hence, no specific, "ready" method was used in the analysis of the studies. Instead a discourse- and narrative-informed and oriented reading was conducted. Discourse analysis and discursive psychology focus on meaning construction through use of language at different levels. Some discursive scholars focus on local meaning making through the use of language (micro discourse) (e.g., Edwards, 1995) and others take a critical stance towards the power of different cultural discourses and deconstruct these by examining people's identity-work (e.g., Parker, 1999). These latter studies also take a more critical stance to, for example, therapeutic

practices and focus on issues like power, culture and institutions (Avdi & Georgaca, 2007a). However, what these approaches share is their interest in the use of language, in discourse.

In this research, the concept of discourse stands for both the construction of meaning in local interaction as well as for larger, macro-discourses about how things are and what they mean. It is acknowledged and highlighted that these cultural discourses are drawn on in local meaning making. Discourse is seen as active and purposive in constructing realities and meaning on these two levels, both of which were included in the analysis. On the level of local discourse, the interest was in how clients and therapists use words in such discursive actions as blaming, justifying, critiquing, validating, confronting, eliciting empathy and so on. On the macro level, therapeutic conversations were seen as meeting points for cultural discourses and the focus was on how these discourses are deconstructed and reconstructed in these local conversations.

Ian Parker (2013) states that discourse analysis should not be conducted by strictly following a set of methodological steps. Instead, new ways of combining analytical tools should be devised. To inquire into development of the therapy discourse in detail, a narrative approach was applied in two of the studies. Methodologically, the narrative frame makes it possible to place sequences of discourse into the larger perspective of the whole session or whole therapy process. Like the language-based approaches, which vary in their focus but not basis, the embedded concepts highlight different aspects of social construction. The narrative approach takes a narrative or story as a frame in which lived experience and the meaning of this experience are structured (Polkinghorne, 1988; Sarbin, 1986).

Stories enable people to link their experiences through the dimension of time. In this way, the world, and they themselves, become coherent and continuous, or meaningful. The stories people tell about their lives reflect the prevailing cultural narratives (Bruner, 1987, 1991; Polkinghorne, 1988) of which some are more dominant than others. Also, in the local storying of experience, some stories become dominant while others become silenced (McLeod, 2004). The stories that become dominant often reflect the culturally dominant narratives and values in the teller's society (Hare-Mustin, 1994; McLeod & Lynch, 2000). However, narrative research in the field of psychotherapy has focused more on the local level of client micro-narratives to the relative neglect of the cultural level (Avdi & Georgaca, 2007b). The studies reported here sought to capture both these levels by linking them through the concept of positioning.

The theory of positioning (Harré & van Langenhove, 2003) was used in this research as the conceptual apparatus for the analysis of the discursive and interactional dynamics that characterize therapeutic conversations. Positioning has particular value in revealing in detail how discourse operates in the construction of relationships. In the studies comprising this research, the term positioning was used to describe both the interactional act of offering and taking up diverse positions in the local conversation, as well as their links to discursive positions embedded in cultural discourses. The concept of positioning was not

perhaps as closely specified as it could have been in each study. Distinguishing between interactional and discursive positioning could have raised the level of elaboration of the analyses. Nevertheless, each study investigated and discussed different aspects of positioning. In Study I the focus was on gender positioning. In Study II, counter-positioning was introduced to highlight the relational nature of positioning and in Study III, the analysis concerned troubled positioning.

Many scholars have acknowledged and argued for the advantage of positioning theory in analyzing psychotherapy discourse (McLeod, 2011; Sinclair, 2007) and the construction of identity or subjectivity in this context (Avdi, 2015; Avdi & Georgaca, 2009; Drewery, 2005; Guilfoyle 2001, 2002; Karatza & Avdi, 2011). In her recent paper, Avdi (2015) has shown how discourses around developmental psychology are drawn on in family therapy with a blended family and how these discourses support the nuclear family ideal. Winslade (2005), in turn, has demonstrated how positioning can be used by the therapist in helping the client find suitable alternatives to a problematic discourse and positioning. Other scholars have also argued for the usefulness of a discursive viewpoint and positioning in highlighting the role of cultural meanings in local meaning making in psychotherapy (Madill & Barkham, 1997) and in leading conversations away from attributions of blame in couple therapy (Sinclair & Monk, 2004). Earlier studies by the Jyväskylä discourse group have looked at victim positioning in the treatment of IPV perpetrators (Partanen & Wahlström, 2003), construction of the moral order through positioning shifts (Kurri, 2005), and construction of parent positioning in family therapy (Suoninen & Wahlström, 2009).

A criticism of discursive research and positioning is that they neglect the embodied level of interaction and focus solely on language and discourse. However, following the recent effort to combine embodied aspects with the analysis of discourse in psychotherapy research (Cromby, 2012; Lyons & Cromby, 2010; Seikkula, Karvonen, Kykyri, Kaartinen, & Penttonen, 2015), and in positioning research specifically (Avdi, 2016), a tentative combination of discursive and narrative analyses and physiological responses was conducted in study III with the aim of attaining a new level in understanding how positioning occurs and is experienced in couple therapy.

In this research, the focus of analysis was on aspects of gendered power in therapeutic conversations. The analysis followed a similar line to that adopted in the three studies; in other words, combining a discursive psychological approach with a more critical reading of the underlying cultural discourses. This reading was informed with ideas from critical discursive psychology (Parker, 1998, 1999, 2002) and critical discourse analysis (Parker, 2013; Wodak & Meyer, 2001). These critical discursive approaches focus on social inequality and injustice by analyzing unequal social arrangements that are sustained through discursive practices. Both cultural patterns and proximal interaction were explored. Moreover, a political stance was taken towards the object of research (Parker, 2013). More specifically, a feminist-informed reading was conducted (Lazar, 2005, 2007; Magnusson & Marecek, 2012; Ramazanoglu & Holland, 2002). Femi-

nist analysis acknowledges that gender inequality lies in the power structure at the societal level. Thus, the focus was on gender inequality and how it is constructed in discursive practices at the levels of local and cultural discourse.

2.2 Data

The data of the three studies originated from different research projects implemented by the Jyväskylä University Psychotherapy Training and Research Centre. The Centre protocol includes the video-recording of therapy sessions conditional upon the clients giving their written consent. In Study I, video-recordings from treatment groups in an IPV perpetrator program were analyzed. Study II used data from couple therapy sessions conducted at the Psychotherapy Training and Research Centre. The data analyzed in Study III were collected in connection with the ongoing research project Relational Mind, conducted at the department of Psychology, University of Jyväskylä.

In Study I, group discussions recorded during a treatment program for men who have been violent in their relationships were analyzed. The treatment program was established in 1995 in Jyväskylä, Finland in collaboration between the Mobile Crisis Centre and Jyväskylä University Psychotherapy Training and Research Centre. The program is influenced by a Norwegian treatment program called Alternative to Violence (ATV). The treatment consists of individual meetings with a male worker at the Crisis Centre after which the men are referred to a treatment group run at the Psychotherapy Training and Research Centre. In the program, psychotherapeutic principles are combined with a feminist perspective and IPV-specific interventions such as safety planning (Holma et al., 2006; Raakil, 2002).

Videotaped sessions of five treatment groups were selected for analysis in accordance with the criterion that the group was facilitated by a female-male therapist dyad. The therapist dyad was different in each group, and each therapist had many years' experience of working with IPV. The five groups were run in Jyväskylä between spring 2000 and spring 2002. At that time, the group format was closed, meaning that each group gathered once weekly for 15 weeks. The duration of a group session was one and a half hours. In total, conversations from a total of 75 sessions (112.5 hours) were analyzed. The groups contained from three to seven participants each, making a total of 26 men. Participation varied across sessions. The participants were aged between 25 and 56 years. Most of them were still in a relationship (marriage, common law or dating) with the target of their most recent violent acts. All but one man was living in a family with children. According to their own report, most of the men (22) had acted violently for longer than a year; and half of these for longer than three years. Sixteen men reported having been violent one to three times during the preceding 12 months. Six men reported 4 to 10 violent incidents and the rest (four) described having behaved violently over 10 times within the last year.

Police contact had been made for 14 of the men due to their violent behavior. Seven men were facing charges for, or had been convicted of, violence.

In Study II, a case study of one couple in couple therapy was conducted. This study formed part of a collaborative research project organized by the European Family Therapy Research Group, a group of researchers and clinicians who, in this case, studied the same data by applying different discursive qualitative methodologies (Borcsa & Rober, 2016). The data analyzed were transcripts of four couple therapy sessions with the same couple. The couple in question was a young, heterosexual, multicultural couple who had been living together for three years, in the female partner's home country. The therapy sessions were conducted in English. Two therapists worked with this couple: an experienced male family therapist and a younger female family therapy trainee.

Study III formed part of a research project under the title Relational Mind in Events of Change in Multi-actor Therapeutic Dialogues (Seikkula et al., 2015). This research project, funded by the Finnish Academy (Grant Number 265492), focuses on attunement and synchrony between participants in couple therapy. In the project, attunement and synchrony are studied at various levels of interaction, including verbal dialogue, body movements, gestures, gaze and the autonomic nervous system. Also, a stimulated recall interview method is applied to capture the participants' inner dialogue and experience. The focus of Study III was on verbal dialogue and autonomic nervous system. Stimulated recall interview data were also investigated.

In Study III, two cases were analyzed. These cases were selected based on the history of IPV in these couples' relationship. At analysis start, these two cases were the only ones with a relational history of IPV in the data corpus of the Relational Mind project. In Jyväskylä University Psychotherapy Training and Research Centre, where the project data were gathered, couple therapy is not started if the violence has been especially serious or life-threatening. Also, the violence has to have stopped before couple therapy is started. Here, violence includes psychological coercive control, which has to be considered as an exclusion criterion for conjoint treatment. A non-violence contract is made with the clients. Both partners have to be willing to start couple therapy and feel able to speak openly in the presence of their partner. Should any threatening issues arise in the therapy discussions, the process will be interrupted, safety practices discussed and, if necessary, the partners can be directed to individual services.

The analysis focused on the second therapy session, since this was first occasion in which the physiological data were also gathered (the second occasion was the fifth or sixth session). The first case was a heterosexual couple with children. The female partner was also pregnant during the analyzed session. Ten therapy sessions in total were conducted with this couple. The couple were attending conjoint therapy owing to relationship problems and violent behavior by the male partner. He had been physically violent towards his partner, the most serious instance of which had been attempted strangulation. This couple wished to have conjoint treatment, the partners felt that they would be able to speak openly in each other's presence, and they both wanted to continue their

relationship. For these reasons and after the male partner had attended long-term individual treatment for IPV, this couple were admitted to couple therapy. A male-male experienced family therapist dyad was working with this case. The second case was a female same-sex couple who had sought conjoint treatment for IPV. IPV had been committed by one partner only, and it had included both physical (e.g., striking with the fist) and emotional forms of violence. The couple had a child together and were currently living separately. Their therapy process comprised a total of five sessions. A female-male experienced family therapist dyad was working with this couple.

In addition to using therapy transcripts and video-recordings for the qualitative analysis, recordings of the participants' electrodermal activity (EDA) were also investigated in Study III. EDA describes skin conductance, the level of which is connected to the involuntary sympathetic nervous system that prepares the body for action. An increase in EDA suggests emotional arousal (Kreibig, 2010). However, an increase in EDA may also accompany cognitive work, movement and rapid changes in respiration. Thus, interpreting EDA responses has to be done with caution. Information gained through the stimulated recall interview method was used in the interpretation of EDA arousal. However, validation through a stimulated recall interview remains partial as it is based on participants' interpretations of what took place.

2.3 Heterogeneity issues

It is easily noticed that the data in all three studies were drawn from multiactor therapeutic conversations. Nevertheless, the data in the three studies differed according to the format and model of treatment. Study I explored feminist-informed group treatment for IPV. The model combines different therapeutic ideas and interventions related to a gender-based view of IPV. Shifting between empathy for and challenging the client is characteristic of the work of these therapists. The therapists facilitating these groups had training in trauma psychotherapy, family therapy, or integrative therapy, and had many years' experience of working with IPV. Study II centered on couple therapy, where the therapist was a trained and experienced family therapist using a dialogical approach in tandem with a trainee therapist. Study III was on couple therapy for IPV in two cases. In the psychotherapy training and research clinic, the initial focus in couple treatment for IPV is always on safety. Different post-structural forms of therapy are used and these are combined with IPV-specific interventions. Safety issues are brought up and discussed in the sessions, for example by discussing both previous violent acts and possible future abuse. In the two present cases, the therapists were all experienced family therapists.

The data also offered diversity in the socio-demographic characteristics of the clients and therapists. The gender distribution of the participants varied across the three studies. In Study I, the treatment specifically targeted at male perpetrators, from three to seven in each group, was facilitated by a female-

male therapist dyad. The couple therapy cases varied in gender. The female-male couple whose therapy discourse was analyzed in Study II was counseled by a male therapist and a female trainee. In Study III, the female-male couple were counseled by a male-male therapist dyad and the female-female couple counseled by a female-male therapist dyad. It should also be noted that in each study the participants' gender has been given, as it was made explicit in the therapy discourse.

At this juncture, it should be admitted that the conceptual choices for describing the participants greatly reflect the prevailing cultural discourse around gender and relationships. In this research, I chose to use concepts like woman, man, she, he, heterosexual couple, and same-sex couple. The choices in interpreting the participants' gender were made on the basis of the concepts used by the participants when describing themselves and other people. However, during the course of this research I became increasingly more sensitive to the multiplicity and nuances of gender, to the extent that using this terminology came to feel reductionist. The gender identification of the participants may be more subtle than this binary division allows for. When referring to the relationship status of the participants, I chose to use heterosexual and same-sex in accordance with the dominant ways of conceptualizing couple relationships between persons of the opposite sex and relationships in which the partners identify with the same gender. It is thus important to emphasize that this choice of binary concepts is inevitably too limited to capture the true gender diversity characterizing different couples and families.

Finally, the focus of analysis was different in each study. Study I looked at gendered positioning in five treatment groups. How gendered positioning was realized in a particular group or by an individual participant was not studied. In Study II, the entire therapy process of one couple was analyzed and the focus was more on the shifts and changes in the positioning of the individual participants. Study III focused on positioning in two separate cases. The process and evolution of positioning were studied during a single session, along with autonomic nervous system responses. Thus, the analysis of positioning in each of three studies remained rather limited; however, when considered as a whole a more nuanced understanding of this concept emerged. Moreover, the use of this research tool became increasingly refined during the research process.

Clearly, the findings were context-bound. For example, the IPV treatment group studied here represents a specific model of IPV treatment which combined therapeutic and psychoeducational modes. Cultural discourses and gendered power issues, for example, may work quite differently in other modes of IPV group treatment and in, for example, individual therapy settings, which were not under scrutiny in this research. However, in any qualitative analysis, including the present instances, the aim is to gain a detailed understanding of the phenomena of interest rather than a generalization that can be applied to a larger population. That said, a diversity of data and analytical approaches, such as those used here, offer fruitful scope for discussion on gendered power in the treatment of issues pertaining to couple relationships.

2.4 Analysis

This research was data-driven throughout. However, the analyses in this research included development of the chosen methodological tool of positioning. Also, even though I was using such naturalistic data as video-recorded therapy sessions, it is inevitable that, as the researcher, I influenced the course of the analysis. Thus, it is appropriate that I also reflect on my position as a researcher in this section. When I started the research project, I was finishing my Master's degree in psychology and doing gender studies at the intermediate level. Through these studies I was also gaining familiarity with the phenomenon of IPV. At this point I already had some clinical insight into the phenomenon of IPV, having worked as a psychologist intern in a psychiatric hospital. This phase of research and education was perhaps the time of my strongest awakening to feminism in the sense that I found feminist analysis a powerful tool for understanding not only how inequality is constructed, but also how it can be deconstructed. Thus, the focus on gender was present from the outset. I believe that interventions for gendered social problems like IPV should be more widely understood, researched and designed. This wider understanding can only be achieved by paying attention to issues of gender and power.

My master's thesis was produced within the IPV treatment program at the University of Jyväskylä and completed in 2010. That study was the starting point for this research. Based on the literature and earlier research conducted on the IPV treatment program, especially by Partanen's (2008) research on the interventions implemented in this treatment modality, and Kapanen's (2005) study focusing on the participants' images of women, I became interested in the role of the therapist's gender in IPV treatment. Grounded Theory was used as the method of analyzing and classifying the gendered positioning of the female therapist (Glaser & Strauss, 1967; Strauss & Corbin, 1998).The analysis started by watching twice over video-recorded therapy sessions of five IPV treatment groups facilitated by a female–male therapist dyad. The data comprised 75 sessions, or 112.5 hours of video-recordings. This analytical process, although time-consuming, was needed to gain an overall picture of the discourse in the groups, and whether there was sufficient material to warrant studying the female therapist's position in particular. Also, the second viewing of the videos was conducted parallel with theory-building, which kept me close to the research context for an extended period. Such a large database made it possible to capture a more all-encompassing view of the position of the female therapist, a low visibility issue in the IPV literature. From this extensive body of data, sequences of interest were selected and transcribed for more detailed analysis and classification.

During the analysis of the session conversation, I kept a research diary in which I made various notes and recorded the emotions that arose in me. The purpose of the diary was to help me maintain my neutrality towards the data,

and to change the focus from a traditional psychological view towards a discourse-oriented one. Reflecting on ideas and emotions related to the data was helpful in this task. IPV is a sensitive topic, and to be able to work with it, either clinically or as an object of research, requires strategies for dealing with, one's sometimes strong and negative, responses to it. As a woman researching violence against women, it was all the more important to reflect on the emotions and thoughts that it aroused. Moreover, I was able to talk about these things with the research group at any time. Later in the research process I gained more clinical experience, including with IPV, and this work with victims and perpetrators helped me to develop my view on the issue and to work through the accompanying emotional load. Throughout the research process, I found it of great importance to do clinical work alongside research, both with the perpetrators and victims of IPV. Such dual positioning keeps research close to practice, and helps in balancing one's attitudes and ideas about IPV as phenomenon.

Although Study I described the advantages and challenges of gendered positioning in IPV treatment, the choice of methodology did not enable answers to clinically interesting questions like "How did changes in positioning occur during treatment?", and "To what extent was possible positional change related to a successful process?". Moreover, the shifts in interactional positioning could have been studied in more detail. Thus, the next study focused on a single case, to enable a more elaborate analysis of the shifts in positioning.

In Study II, the interest was in power as embedded in gendered positioning, and in interactional positioning in the case of a heterosexual couple. The concept of counter-positioning was developed to describe the relational nature of positioning. This study also focused on the therapy process, which was not captured by the methodology used in Study I. Thus, all four sessions with this couple were analyzed using a narrative approach to identify storylines and changes in positioning in them. The analytic procedure included multiple readings of the therapy session transcripts and identifying the cultural discourses used by the partners in their storylines. Applying the criterion that the dominant story was accepted by everyone present, sequences where such stories were constructed were marked in the transcripts and studied in more detail using positioning theory. I and my co-author first conducted this phase of the analysis separately, after which we compared the storylines and related cultural narratives we had found in order to enhance the validity of the findings. This study was conducted in collaboration with the European Family Therapy Research Group (Borcsa & Rober, 2016), and thus the data were discussed in many meetings.

The findings of Study II revealed the use of a type of positioning that does not accord with the preferred identity narrative of the target. Such a troubled mode of positioning challenges the dominant storyline of a couple, an aspect that I felt was in need of further analysis, particularly in the context of couple therapy for IPV. In Study III, it was possible to take the investigation of positioning one step further, as the research design of the Relational Mind project enabled interaction to be explored not only at the verbal, but also at multiple,

embodied levels. This study challenged me as a discursive researcher to re-evaluate how social orders are constructed and how meaning-making can and should be studied. This study was one of the first to combine qualitative analysis with participants' physiological responses. This process involved multiple viewings of video-recorded therapy sessions of two couples, and intensive reading of the transcripts of these sessions. During this process, the main research question started to clarify and blaming was chosen as the unit of analysis for choosing sequences for more detailed analysis. Blaming sequences around specific themes were translated into micro narratives, and the transcripts fore-read to identify more implicit attributions of blame around such themes. The sequences so identified were then verified in consultation with the second author, and the findings presented in the research seminars of the research project. Finally, together with the second author, I carefully integrated the electrodermal activity data into the qualitative analysis. The calculation of momentary skin conductance responses was conducted by two other co-authors and all this information was put together by me.

Overall, the research process required spending much time with the data, videotapes and transcripts. Owing to the existence of the large data corpus already collected at the clinic, I did not need to collect data myself. However, I became familiar with data collection during the research process via meetings with clients and couples in the Psychotherapy Research and Training Centre, where such recordings are customary. I also became a facilitator of IPV group treatment in January 2015 and have also been a co-therapist in couple therapy for IPV. The research process included breaks during the periods when I was working as a clinical psychologist outside the university. In my view, these phases enriched the analytical process, and enabled me to maintain close links between research and clinical practice, a matter of especial importance in therapy research.

3 OVERVIEW OF THE ORIGINAL STUDIES

3.1 Study I

Positions constructed for a female therapist in male batterers' treatment group

Intimate partner violence (IPV) can be viewed as a gendered issue that stems from a gendered power differential based on patriarchy. Violence towards women is often justified by reference to gender differences by perpetrators. In treating IPV as a gendered issue, it has been argued that the gender of the therapist may play an ambivalent role (Tyagi, 2006). In this study, this hypothesis was studied qualitatively by investigating the gendered positions that were constructed for a female therapist in groups for male IPV perpetrators. The data were drawn from an IPV perpetrator program conducted in Jyväskylä, Finland. Group discussions from five treatment groups were analyzed discursively using positioning as a tool of analysis. The gendered positions were found and classified using Grounded Theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998) as a method.

Three categories of gendered positions emerged: the female therapist as a representative of women in general, of a specific woman, and of herself personally as a woman. In the first, the female therapist was positioned as a representative of the female gender in general. The female therapist was counted among the class of women in these discourses, and because of her gender she was expected to have a different viewpoint from that of the men. This difference was seen as either interesting or negative. Women as a group were seen as strange and unpredictable, as different biologically, mentally, and in their needs, and the female therapist was positioned as representing this group. In the second, the female therapist was positioned as representative of the point of view of the men's (ex)partners. The female therapist took up this positioning on her own initiative, especially when referring the men's partner's feelings of fear. In the third, the men invited the female therapist to take up gendered positions

personally as a woman. In this category, she was positioned as weak, "a potential man-hater", and was invited to give her point of view not only as a representative of women in general or of men's (ex)partners, but also personally as a woman in the group meetings.

The findings of this study support the view that in the treatment of IPV as a gendered phenomenon the gender of the therapist may become an issue. The gendered positioning offered the female therapist was found to carry both positive and negative implications. These positions were primarily based on constructed gender differences. The therapists' goal seemed to be to challenge this difference discourse and to generate positive attitudinal change towards women. Being positioned by her gender as different, as 'other', presents the female therapist with a challenge. She may have to try to strike a balance between the different expectations and conflicting positions constructed for her. However, when offered gendered positions, the female therapist was also able to reject them by re-positioning herself and thus change the storyline that sought to construct a difference between men and women and that reproduced the traditional male constructions of women. Thus, the use of gendered positioning also functioned as a tool for the female therapist in her clinical work. The male therapist in turn was also able to make use of the gendered positions that were offered to his colleague. Yet, the male therapist's positioning per se was not analyzed, and although discourse was analyzed in five different groups, the findings remain context-bound.

3.2 Study II

Dominant story, power and positioning

The stories people tell about their lives reflect the prevailing cultural narratives (Bruner, 1987, 1991). During these tellings, some stories become dominant while others become silenced (McLeod, 2004). These local dominant stories reflect culturally dominant discourses and values (Hare-Mustin, 1994; McLeod & Lynch, 2000). This study investigated how dominant stories are constructed in couple therapy conversations between the participants, including the therapists, and how these local stories are constructed with reference to larger cultural narratives. Moreover, it was studied how the partners construct and reconstruct their positions in these local dominant stories. The focus was on the resulting distribution of power, or the rights and duties that the positions assigned to them entailed for each partner. The four sessions of couple therapy attended by a young multicultural heterosexual couple was analyzed by applying a narrative approach. The couple was living in the home country of the female partner, which was also where the couple therapy took place. The stories identified as dominant were studied using positioning as a discursive tool of analysis.

Two dominant stories were found, and in the course of the couple therapy these stories evolved to the point that both partners were able to accept the po-

sitions they had adopted or been assigned in the story. The first dominant story stated that in a love relationship the partners should share experiences and feelings with one another. This story offered the female partner the position as a free talker and the male partner the counter-position of a patient listener. The story started to evolve when the male partner, drawing on a trauma discourse, began sharing his experiences and feelings, for which he received support from his partner. The positions of talker and listener were transformed into more flexible and reciprocal positions. The second dominant story concerned the special, primary value of the love relationship and positioned the male partner as uncommitted to this relationship while his partner adopted the counter-position of the committed partner. This story evolved with the acceptance by the male partner of the cultural discourse supporting this dominant story. Thus, he adapted his behavior to his partner's expectations and demonstrated commitment to their relationship.

The way these dominant stories evolved increased the level of equality between the partners and was in line with Northern European cultural discourse about couple relationships, as well as with the view of the psychotherapy world. In these stories, then, the female partner had a more powerful position in defining the rules of the relationship and the male partner had to accommodate to her wishes and to the broader cultural expectations pertaining to such relationships. It has been suggested that how a story functions may serve as a criterion for whether or not to support it (Hare-Mustin, 1994). In the present case, acceptance of the cultural discourses seemed to work for this couple, since acting in line with them increased the partners' mutual understanding and eased the problems that had led them to seek therapy. In this process, the therapist's reflexive awareness of the dominant cultural discourse and acknowledgement of the possible marginalized discourses was also important, as the therapist was able to help the client couple construct an alternative dominant story. Such awareness is especially important in the context of multicultural couple therapy where the positioning of the couple is influenced by several intersecting sociodemographic features that may induce an imbalance in power between the partners. Discussion of the intersections of, for example, gender and cultural background, as well as the specificities of multicultural couple therapy remain, however, limited in this study and warrant attention in the future.

3.3 Study III

Affective arousal during blaming in couple therapy: Combining analyses of verbal discourse and physiological responses in two case studies

Casting blame is an action that contains a moral comment and puts the target in a questionable position. The aim of this study was to investigate how blaming the other is displayed and responded to in the embodied dialogue of couples with a history of intimate partner violence. As well as discourse analysis, re-

sponses of the autonomic nervous system, measured as electrodermal activity, were also studied. In addition, data from a stimulated recall interview were used in interpreting the electrodermal activity responses of the participants during blaming. The two cases analyzed for this study were selected from ten couples receiving therapy in the Relational Mind project. For these two couples, intimate partner violence was one of the reasons for seeking therapy. One of the couples was a heterosexual and the other a same-sex couple. Each couple's second therapy session was analyzed using discursive psychological and narrative approaches. Blaming centered around specific themes was constructed and studied as a micro narrative that evolves over the course of the session.

The first couple's blaming micro narrative coalesced around loyalty issues. The second couple allocated blame relating to parenting and trust. These three themes can be considered central for couples contemplating becoming or already forming a family (with children). The main finding was that blame, especially when targeted at the partner's identity, was accompanied by arousal at the level of the autonomic nervous system in most of the participants. Furthermore, the identity blaming referred to gendered cultural discourses about parenting and the couple relationship. Gender was used as part of the justification for expressing expectations about how things should be in the relationship. These gendered expectations and identity blaming were also found in the case of the same-sex couple. This couple was negotiating the responsibilities of parenting, for which, in cases where when both parents share the same cultural gender role, more explicit negotiation is perhaps needed.

Characterological blaming challenges the identity of, and attributes full responsibility to, the target (Stratton, 2003). In such identity blaming, being assigned a position not in line with one's preferred identity narrative may be experienced as uncomfortable, and lead to attempts to reposition oneself. The findings of this study indicated that criticizing one's partner's identity in couple therapy is an instance of alerting positioning. In both the cases analyzed, the conversational acts of the therapists indicated that they found the themes contained in the blaming micro narratives important for the therapy process. The findings highlight the fact that, as more implicit and smooth identity blaming may arouse affects in the target, there is a case for intervention by the therapist, for example by reformulating the issue. Even if exploratory, the analysis and its findings also point to the importance of embodied aspects in therapy conversations. Physiological markers have been successfully used in some of the prominent couple therapy models (Gottman & Gottman, 2008; Greenberg & Goldman, 2008). Thus, further studies combining discursive and embodied levels of interaction are encouraged.

4 DISCUSSION

4.1 The main findings

This research examined therapeutic conversations from a feminist-informed discursive perspective with the aim of illuminating the meaning and functions of gendered positioning in identity-work and interventions in multiactor therapeutic conversations concerning couple relationship issues. The analysis focused on how gendered positioning is implemented and the meaning and functions of gendered positioning in therapeutic conversations. Also of interest was how gendered positioning and the distribution of embedded power are addressed by therapists. The overall findings highlight the importance of recognizing the role of gender in therapeutic conversations. It is argued that the ability to perform sensitive and socially just therapy requires that clinicians acknowledge and address the use of gendered positioning, both their own as well as that of their clients, and the cultural discourses that inform local conversations in the therapy session. Furthermore, gendered positioning is a useful tool that can be used by the therapist in dealing with gender-based issues.

The three studies demonstrated how positioning functions in therapy interaction as well as its potential as an analytic tool in studying such interaction. In study I, it was shown how a female therapist leading a group for male IPV perpetrators was offered and took up gendered positions. These positions reflected cultural understandings of women and men as profoundly different, which may be used as a justification for violent behavior. However, the female therapist was able to change the positions offered her in a way that promoted the deconstruction of such gendered discourse. The main finding of this study demonstrated how gendered positioning can be used as an intervention tool by therapists in changing a dominant cultural discourse that can be used to justify violence. However, this study did not look at the gendered positioning of the male therapist, while the analysis of the positioning of the therapist dyad and their mutual collaboration was also rather limited. A more detailed analysis of the positioning invitations and responses to them could have illuminated the

use of gendered positioning as a therapeutic intervention tool. Nevertheless, the findings of this study highlight the importance of understanding the gendered nature of IPV in efforts to treat it and that gendered positioning may affect the therapeutic relationship. When acknowledged, gendered aspects may profit treatment, but unacknowledged they may put at risk the goals of the treatment, the co-operation of the female-male therapist dyad, the quality of the intervention and also the work-related well-being of the therapists. Thus, the role of gender and gendered positioning should be taken into account in the training and supervision of therapists working with IPV.

Study II focused on the construction of local dominant stories and positioning in relation to larger cultural discourses. The findings underline the importance of awareness of the relational aspects of positioning as well as the power arrangements that are constructed through the division of rights and duties between positions. The interdependence of identities becomes especially noticeable in the context of couple therapy. The study demonstrated how the dominant, problematic story of a couple may change as a result of the participants in the therapy situation taking up and offering new positions and alternative cultural discourses. However, certain cultural "truths" about, for example, love, relationships, commitment, and communication, are easily accepted in couple therapy. In this instance, the female partner had a more powerful position in setting the rules for the relationship. She was more experienced in psychotherapy discourse, having had individual therapy earlier, and the present therapy was taking place in her cultural context. Moreover, the therapists shared this Nordic culture. The study demonstrated not only the interdependence of identities, but also the intersectionality of identity and, particularly in this case, multicultural issues. The analysis started with a focus on power in positioning in a heterosexual relationship, and was based on rather gender essentialist assumptions. However, during the analysis, cultural background and resources emerged as strongly intersecting with power in this specific case. A more intersectional approach to this analysis from the outset might have stimulated a more illuminating discussion of gender, power and identities in this study. Literature on multicultural couple therapy would also have enriched the discussion in this study. However, this reading highlights the importance of the fact that to promote change, it is essential that the therapy discourse is open to a variety of alternative discourses. This requires the therapist to engage in self-reflection and make space for possible alternatives.

Study III focused on identity work in couple therapy for IPV and showed how being positioned in certain ways can be alerting and experienced as troubling. The analysis of blaming dialogue during therapy demonstrated that criticism that targets the identity of the partner was affectively arousing both for blamer and blamed, and sometimes also for the therapists. This finding supports the earlier view that characterological blaming is the most damaging form of blame as it places full responsibility on the agent (Stratton, 2003). Changing who you are is not as possible as changing your behavior. Furthermore, the blaming micro narratives in the cases studied here also included gendered posi-

tioning. Gendered expectations of parenting, loyalty and commitment were placed on the partner and gender was used as part of the justification for expressing expectations about the way things should be in the relationship. Gendered discourse and expectations were also present in the case of the same-sex couple. Thus, this study draws attention to the effects of the social construction of gender and the importance of awareness of the pervasiveness of gendered cultural discourses in couple relationships. Although each of the cases analyzed had a history of IPV, the findings cannot be generalized to all such cases; moreover, they may not be restricted to IPV cases only. The methodology has its limitations and this study should thus be seen as an exploratory attempt to combine physiological data with language-based analysis. Nevertheless, this methodology, which included the tracking of affective arousal, allowed the researcher to detect more subtle attributions of blame. This finding may be of value in improving sensitive clinical practice. Importantly, this study also draws attention to the embodied aspects of therapy. Paying attention to the embodied signs of affect arousal either in oneself as a therapist or one of the clients may point to an important aspect of the therapy process.

When the findings of the three studies were seen from a feminist-informed viewpoint, certain details relating to the construction of gender and its significance stood out. First, it was noticeable that gendered positioning takes place both explicitly and implicitly in therapeutic conversations. For example, a therapist can be positioned as a woman, or the partners may gender-position each other as parents, in line with specific cultural discourses. Alternatively, positioning may be accomplished without referring to the other or oneself with a gendered term. Gendered positioning can be delivered by referring to dominant cultural "truths", expectations and obligations among other more implicit means. In whichever way it is done, certain expectations will be embedded in such interactional positioning. Nevertheless, the target also has the possibility to challenge such expectations stemming from the cultural discourse in question, and thus change how self and other are positioned in the local interaction.

Furthermore, in reading the data it became very evident how strongly couple relationships are embedded in gendered cultural discourses. These traditional cultural discourses offer us an acceptable storyline on how to behave as a male or female partner in couple relationships, or as a mother or father in a family with children. The reading of the data indicated that discourses about, for example, loyalty and the prioritizing of the love relationship require a certain acts of commitment and place the love relationship at the top of the hierarchy along with certain expectations, such as sharing experiences and processing issues via talking. The findings of this research demonstrated how these cultural understandings of women and men, partners and parents are at play in the positioning of the self and others in therapy conversations.

Next, the reading of the data foregrounded some of the meanings and functions of gendered positioning. We do things with words to each other. One key finding of this thesis is that the dominant cultural discourses, particularly where these are gender-related, may not show an unproblematic fit with the

identity narrative of one or both partners. Thus, positioning someone not in line with their preferred identity narrative may alert them and cause them to feel discomfort. Using gendered positioning in the therapeutic discourse may function in multiple ways that cannot be predicted. This in turn means that it is possible to use gendered positioning both as a way of showing empathy and understanding of a person's situation and experience and also as a way of challenging the status quo, for example, an unequal distribution of responsibilities in the relationship.

The findings also drew attention to the gender identity of the therapist, especially when dealing with gendered social problems like IPV. From a discursive viewpoint, the therapist inevitably participates in the construction of the "truths" and identities of clients by accepting, focusing, exploring and challenging what the latter produce in their narratives. Thus, the therapist also holds a measure of power in the construction of gender and gendered couple relationships. Another key finding of this research was that gendered positioning can be used as a therapeutic intervention in therapeutic conversations. By repositioning oneself, or rejecting the stereotypical assumptions offered in the cultural discourse about, for example, women, the therapist can promote change. However, sensitivity to gendered issues is a prerequisite for an intervention of this kind. It is argued that gender and gendered power issues have to be addressed in therapy research, practice, training and supervision. Furthermore, it is stressed that the use of discursive ideas, in this case positioning, provides a valuable resource for such a socially sensitive and equitable research and clinical approach.

4.2 Therapy as a discursive and gendered practice

The findings of this research demonstrated how identity-work — taking up and placing others in various positions — is a gendered issue. Society's dominant gender discourses direct and limit the possibilities of individuals in constructing their identity and in seeking for change in life. Thus, therapeutic conversations are neither gender- nor power-neutral. Instead, power embedded in gendered discourse is dynamically and variously distributed among all the participants in therapeutic conversations, including both clients and therapists, through acts of positioning. It has been argued that the fact that feminist ideas have become part of mainstream psychotherapy practice may have brought with it the disadvantage that socially just practice is taken for granted and a critical eye no longer cast at what actually takes place in the different forms of therapy (Leslie & Southard, 2009). Whether a valid criticism or not, while society continues to embed unequal, gendered orders, such a critical eye is warranted.

It has been stated that heterosexual relationships are the main site for reconstructing gender difference (Henriques et al., 1998). Thus couple therapy as the context for gendered positioning is interesting as there the relational posi-

tioning of intimate partners happens in situ. The distribution of power between the two partners is an important starting point for couple therapy practice, since a more unequal distribution of power has been shown to link with relationship dissatisfaction (e.g., Whisman & Jacobson, 1990). Thus, tackling the issue of equality in couple therapy may lead to positive changes in the couple relationship. Yet, scholars have argued that cultural narratives in support of equality are lacking (Knudson-Martin, 2013; Knudson-Martin & Huenergardt, 2010; Sinclair & Monk, 2004), causing people to struggle in constructing more power equal relationships. The ideal of equality may be strong and explicit. However, ways of realizing this ideal in every-day life are not properly supported. Instead, the old, traditional ways and gender roles may continue to govern how people understand and live their lives. Therapy, as an institution, is in a good position to contribute to renewing, refreshing and updating the dominant cultural discourses that influence how people live their lives. It is essential that therapists hold a broader view of what may work for people and help them in deconstructing the "truths" they live by and reconstruct better-fitting story lines.

The therapist is not a neutral bystander. Instead, the therapist has a duty to take part in moral discussions (Kurri & Wahlström, 2005; Stancombe & White, 2005). This participation may manifest in, for example, offering clients certain positions, supporting some positions or story lines and not others. Not taking a stance against a dominant cultural practice is to sanction that practice (Hare-Mustin, 1994). Thus, by not questioning gendered cultural discourse when they come into play in clients' lives, the therapist reproduces and confirms these "truths". Active and explicit engagement by the therapist may be needed in issues that are generally taken for granted and not brought up in everyday conversation. In her research, Partanen (2008) noticed that the men in an IPV perpetrator treatment group did not offer gender-based explanations for their violence on their own initiative. Partanen found that when raised by the therapists, the topic of male identity was not seen as important by the group participants. In the Mirabel Research project, it was found that the perpetrators and victims of violence struggled when asked about the influence of gender in their lives (Kelly & Westmarland, 2015). This viewpoint was not something the interviewees had thought about before. These observations indicate that gender and its meanings and effects are not spontaneously brought up by clients in IPV treatment. Instead, gender has to be introduced into the conversation by the therapists, and quite explicitly.

However, therapists themselves may encounter gendered positioning and dominant cultural discourses, for example gendered expectations in their work, as was shown in Study I. For example, being a woman in a group of men may mean that gender becomes a stronger defining feature than it would be in the case of a woman therapist in a group of women. Also, in the treatment of gendered problems like IPV, the gender of the therapist may be invested with special meaning (Tyagi, 2006). In treating violence, the therapist also needs to be able to shift flexibly between psychological and moral standpoints (Partanen, 2008). Showing empathy towards and challenging men in IVP treatment alter-

nate in the work of the therapist. For a female therapist especially, it may be difficult to find a balance between these positions (Caoyette, 1999). Too empathetic a female therapist may be considered weak and a too challenging one a man-hater. Yet, the gender of the therapist has been found to be a poor predictor of therapy outcomes for both male and female clients (Blow, Sprenkle, & Davis, 2007; Blow, Timm, & Cox, 2008; Bowman et al., 2001; Okiishi et al., 2006). Instead, how the therapist handles gender issues in the therapy session seems to be more crucial than gender per se (Blow, Timm, & Cox, 2008), and may lay the foundation for a good therapeutic relationship. Studying how gendered positioning impacts the process of constructing safety, trust and client-experienced empathy merits further attention. However, gendered positioning is already an issue that has to be acknowledged and dealt with by the therapist.

To conclude, gender and power are present in our everyday lives as well as in therapeutic encounters, and thus gender is part of the accounting and identity work that takes place in therapeutic conversations. However, certain gendered discourses hold a dominant position in society and thus are easily taken for granted. It is, therefore, important that gender is acknowledged in couple therapy and IPV treatment and actively brought up and addressed by the therapist.

4.3 Gendered positioning as a therapeutic tool

A discursive approach to psychotherapy processes both in research and clients' problems in clinical practice has been found useful (Avdi & Georgaca, 2007a; Madill & Barkham, 1997; Sinclair & Monk, 2004; Winslade, 2005). This approach makes it possible to place clients' individual problems in a larger cultural context, and to work at both the therapeutic and research levels. In the three studies that comprise this research, a discursive viewpoint and positioning were found to work as tools in therapy practice in acknowledging and addressing issues of gendered power in therapeutic conversations.

Gender order and gendered positioning can be taken as self-evident due to the pervasiveness of gendered cultural discourses. Thus, the therapist has explicitly to raise gendered power issues in therapeutic conversations. Due to their institutional position, therapists have the possibility and power to question and ponder cultural "truths" that would otherwise be taken at face value. The therapist is in a strong position to suggest or support new, alternative discourses since, owing to the institutional setting, the therapist's words may carry more weight (Guilfoyle, 2001). This kind of discursive work can be done by bringing these alternative cultural discourses into the conversation and offering or taking up new positions.

The therapist inevitably participates in the positioning of clients. Even if the aim is to stay neutral, the therapist has to make choices about which discourses to follow. By so doing, the therapist is also supporting, validating or dismissing some of the positions or alternative discourses on offer. This re-

search has shown how the therapist can use gendered positioning of the client as an intervention tool. In the couple therapy context, the presence of both partners makes it possible to explore; deconstruct and reconstruct their relational positioning in situ. Others have shown how, for example in IPV treatment, talking to clients "in roles" can ease their resistance, common at the beginning of treatment, to accepting responsibility (Vetere, 2011). Positioning can also be done in relation to people not actually present in the therapy situation. This kind of positioning is used as an intervention in many therapy models, for example through applying the empty chair exercise or by asking questions like "What would he say if he were here?"

In couple therapy, gendered parent positions occupy a central position in the relationship of partners with children, and thus offer a good example of how to work with gendered positioning and dominant cultural discourses. The centrality of this issue shows in, for example, earlier IPV research, in which fatherhood has been seen as a strong motivation for male perpetrators to take responsibility and to work towards changing their violent behavior (Cooper & Vetere, 2005; Hakala, Jalava, & Holma, 2014; Råkil, 2006; Veteläinen, Grönholm, & Holma, 2013). The therapist can be active in spotting parent positioning in clients' accounts and take part in the construction and reconstruction of the gendered arrangements of power in parenting. It is also important to pay attention to transition phases in parenting: for example becoming parents and the construction of relationship positions after the children have moved away from home. These transition phases may turn out problematic for couples and require identity work as the range of available positions changes. On the other hand, working with couples whose choices or possibilities are not in line with the dominant cultural discourses, for example with respect to having children, requires sensitivity and a willingness to be open to alternative ways of life on the part of the therapist. Gendered positioning can be experienced as troubled, as was shown in Study III. Paying attention to gendered positioning as possible blaming or shaming may be useful. Observing physiological markers both in the client and in oneself can help the therapist to save the client's face, as well as help clients learn to cope with and soothe their affective arousal (Gottman & Gottman, 2008; Greenberg & Goldman, 2008), particularly in treatment for IPV (Vetere, 2011). Thus, sensitivity is required when engaging in gendered positioning as a tool in therapy.

This research also argues for acknowledging and carefully using the position of the therapist. The power therapists hold in the institutionalized context of therapy has to be acknowledged along with the responsibility that accompanies this position. Alongside their institutional role, therapists can also take various positions in the therapy conversation, including gendered ones. The findings of the research clearly show that the therapist is not a genderless in the therapy situation, but like everyone else is also positioned within the gendered spectrum. For example, in a group of male IPV perpetrators, the gender of the female therapist became an issue and she was explicitly offered gendered positions by the clients. A male therapist could also explicitly raise the female gen-

der of his colleague as an issue. In the context of an IPV treatment program with a partly feminist ideology, invitations to take up specific positions were quite explicit. However, it remained unclear from reading of the session transcripts whether this was a strategy or to what extent the therapists acknowledged the possible role played by their gender. In other treatment contexts, gendered positioning of and by the therapist remains an open question. Also, the positioning of the male therapist in a male-female therapist dyad, and how gendered positioning and power influence collaboration between the therapists in such a dyad were only touched upon in the analyses of this research, and thus require further attention.

The gendered position of the therapist may limit or facilitate the discursive acts open to them. According to the therapist's gendered position, certain behavior may be expected from them, for example directness, or empathy. Also, the therapist's behavior can be interpreted through gendered discourses. However, as a trained professional, the therapist should have the skill to use the various positions embedded in their personal identity as intervention tools. The therapist should also be alert to gendered expectations by clients (e.g., relating to power issues) in the therapeutic discourse and work with them. Thus, the therapist's gender can be beneficial for therapy since aspects of power that lead to dissatisfaction in the couple relationship may also become explicit in the therapeutic relationship. It seems, however, that, for example, the gendered nature of IPV has to be explicitly raised by the therapist (Kelly & Westmarland, 2015; Partanen, 2008). One way to do this is for the therapist to assign them a gendered position.

4.4 Promoting socially sensitive and just therapy practice

The findings of this research highlight the usefulness and the need for the explicit inclusion of gender and gendered power issues in the education, training and supervision of therapists. Although feminist principles of equality have become part of mainstream couple and family therapy practice, focusing on these issues has to be continuous. Also, feminist-oriented practices, like some of the IPV treatment modalities, require constant reflection by the therapists themselves so that the deconstruction of gendered discourses and inequalities of power remain in focus. However, such reflection is also needed in other therapeutic practices in which gendered positioning as a basis of problems while less explicit may nevertheless exist due to the cultural dominance of gendered discourses.

Doing socially sensitive therapy means, among other things, the deconstruction of hierarchies and power relations. The therapist is in a position to help clients to see how cultural discourses and entailed power hierarchies function in their relationships. However, this is not an easy task; it requires active measures and skills from the therapist, since acknowledging the role of power issues in one's relationship may be rejected by the client (Parker, 1997, 2003).

Being able to deconstruct the discourses operating clients' lives requires understanding of the considerable power of these cultural discourses in the lives of individuals and couples. Furthermore, it has to be acknowledged that these discourses entail a division of power and hierarchies, and that positions related to this discursive power are differently available for, for example, men and women. The therapist brings to the therapy conversation the cultural discourses and the psychotherapeutic discourses that they have acquired through the psychotherapy frame adopted during training (Hare-Mustin, 1994). Earlier research has shown that therapists themselves hold gendered stereotypes about men and women (Huntington & Black, 2014; Trepal et al., 2008). Thus, gendered issues should form an essential part of therapist education.

Reflexive awareness of the dominant cultural discourses, one's personal position and one's institutional position are needed for the therapist to be able to make space for marginalized discourses and positions in constructing alternatives for the client (Hare-Mustin, 1994). To attain this awareness, the therapist needs to be aware of their own gendered positioning and gendered cultural understandings. For example, in the treatment of IPV perpetrators it has been argued that a male therapist can model more flexible and modern masculinity to the men (Deering & Gannon, 2005). However, this requires that the male therapist acknowledges his own masculinity and how it is constructed. Only then can this position can be used to confront clients' violent behavior and encourage men to take responsibility of their actions (Orme, Dominelli, & Mullender, 2000). The same reflexivity about one's gender identity is also needed by the female therapist. By meeting these criteria, the female-male therapist dyad can genuinely model co-operation and shared leadership between men and women in IPV treatment (Adams & Cayouette, 2002; Austin & Dankwort, 1999; Caoyette, 1999; Tyagi, 2006; Wilson, 1996).

Thus, the gendered positioning of the therapists offers an interesting prospect for the further development of therapeutic practices as well as educating and supervising therapists in their work with gendered issues like IPV. As stated earlier, gendered positioning can induce feelings of discomfort, not only in clients but also in the therapist. The findings of this research also encourage therapists to increase their awareness of bodily and physiological changes both in themselves and in their clients during the therapy interaction. Also, it is important to be sensitive to the kinds of assumptions we make about the persons we are interacting with, including in therapy, on the basis of their assumed gender. Since gender is a nuanced and varying construction linked to other aspects of identity, gendered positioning can also be a sensitive issue with special loadings which may emerge in therapeutic conversations.

The present research leaves uncertain the issue of whether such gender awareness actually developed in the therapists involved in the cases studied. In the data gathered for Study I, the therapists were active in bringing up the issue of gender and addressing gendered positioning by the clients. This may be due to the IPV setting, in which interventions include explicit talk about clients' gender identity. Then again, in Study III, the issue of gendered identity blaming

was not addressed by the therapist. However, the male therapist who brought up the issue of gender roles in the session reported in his stimulated recall interview that he gave thought to how to ask about the topic. This can be read as indicating sensitivity towards the clients' gender. Study II, on the other hand, highlighted multicultural issues and demonstrates that gender cannot be viewed as a single variable. Thus, sensitivity to intersecting positions is also needed. For example, in group treatment for IPV such intersections requires that therapists to adapt their way of working according to the characteristics of their clients (Räsänen, 2013). A research design including, for example, a stimulated recall interview, or a focus group interview with therapists talking about gender and power issues might advance understanding about how clinicians view these aspects in their work. However, such interviews may not necessarily illuminate what actually happens in practice.

It has been argued that, for therapists, one way of becoming sensitive and reflexive to gender and power issues and their effect on clients' lives is through gaining familiarity with the discursive analysis of real-life therapy sessions (Avdi, 2005, 2015; Avdi & Georgaca, 2007a; Sinclair, 2007). Being able to deconstruct client's stories and the influence of cultural discourses in them can be developed through immersing oneself in the detailed analysis of discourse. In clinical practice, supervision with video recordings of what actually happened in treatment may be useful in shifting the focus onto discourse, and in promoting acknowledgement of gender issues. Through video-recordings, the bodily level of interaction may also be rendered more visible in supervision practices. Thus, I argue that couple therapy and the treatment of specific gendered issues like IPV should be developed by incorporating discursive and feminist ideas into therapist education and supervision. This would contribute to the realization of gender-sensitive and socially just therapeutic practices.

4.5 Evaluation of the research and directions for future

This research showed, by applying a feminist-informed discursive analytical approach, how gender, gendered power and cultural discourses operate in couple therapy and IPV treatment. Like all studies, the present ones have their strengths and limitations. The value of the qualitative methodology used in this research lies in its ability to highlight both the level of local interaction in identity construction and its relation to larger cultural discourses. We are bound to each other and to larger cultural meanings in constructing who we are. Positioning was used as an analytic tool in showing and analyzing the construction of these relations. In future research, distinguishing between, for example, discursive, interactional, and subject positioning would yield more detail on how identity-work is collaboratively accomplished in therapeutic conversations. Such knowledge would have useful implications for both theory and practice.

Language-based approaches in psychotherapy research have also been found useful in understanding the therapy process (Avdi & Georgaca, 2007a, b)

and in evaluating different aspects of psychotherapy (Georgaca & Avdi, 2009). The benefit of developing and using an unstructured method allows the data to guide the analytic choices of the researcher. While such a methodological choice leaves the data room to guide the analysis, the reliability of the findings may be questioned. However, the analytic process and criteria were specified in the reports to enable the reader to understand how the findings were arrived at. In this research a combination of discourse and narrative analysis was found of value in describing the whole therapy process or an entire therapy session. The narrative approach used in this research enabled the evolution in clients' positioning to be charted and also understanding of the meaning of utterances that would have remained undetected by looking solely at unrelated sequences of talk. Reporting the formation of client micro narratives, however, is somewhat problematic. In Study II, this was done by including in the report conversational excerpts that were considered the most representative of the unfolding of the narrative. Nevertheless, this approach to reporting easily becomes fragmented, making the storyline difficult to follow. Study III adopted another strategy in which the positioning sequences related to a specific theme were written up in the form of micro narratives, thereby highlighting specific themes, positioning, and the development of the storyline. This approach may make the unfolding of the story line easier for the reader to follow. Then, again, the actual voice of the participants is less well heard and the reader does not have the original data with which to judge the findings.

The use of naturalistic data adds to the validity of the analysis by providing information on what actually happens in the therapy encounter in situ. However, this data-drivenness also limits the possible questions that may be asked, while the representativeness of the data is also called into question. Due to the heterogeneity of the data and foci of analysis the representativeness of the cases, and hence generalizability of the findings, remains limited. For example, the participants in this research did not range across the whole socio-demographic spectrum and the couples studied do not represent the full range of intimate relationships. Thus, the findings do not represent the gamut of gender, relationships, forms of IPV, and so forth either. It was acknowledged throughout the studies that a variety of socio-demographic characteristics limits and widens the repertoire of cultural discourses of use in therapy conversations. The specificity of multicultural and of gender and sexual minorities in couple therapy as well as IPV in same-sex relationships was discussed in the studies. However, the intersection of these socio-demographics and gender was not a focus of discussion in this research. Hence, these intersections need more careful attention in the future research. Research on gendered positioning and identity construction among, for example, perpetrators and victims of dating violence or IPV among the elderly, immigrants, sexual minorities and so on, would help in designing interventions for IPV. More research is also needed on gender and power in non-violent couple relationships across different couples and family forms in different phases of life.

Also, therapist gendered positioning requires more attention in future studies. As acknowledged earlier, gendered positioning of the male therapist in the IPV treatment group or of the therapists in the couple therapy cases was not studied in this research. It may be that in the IPV treatment, the gender of the female therapist, especially if she is the only woman in a group of men, becomes more explicit than in other contexts. However, a focus on the deconstruction of masculine identity would also require analysis of how male therapists construct and model modern masculine identity in the group setting, as this has been seen as one way of working with men who adhere to the traditional notion of masculine identity (Deering & Gannon, 2005). Then again, a more detailed look at the gendered positioning of a co-therapist pair would also be interesting and useful for developing collaboration in co-therapist teams. Linking gendered positioning to client-experienced empathy and to the construction of the working alliance would also be important in light of the importance of such factors to the outcome of therapy.

McLeod (2011) has argued that the value of case study methodology in psychotherapy research is in highlighting issues that earlier have been marginalized in research. Gender, gendered power, and intimate partner violence are issues that were foregrounded by the case studies in this research. Study I did not look at gendered positioning at the case level, however. Instead a theory of gendered positioning was built that was based on talk in five different groups. A possible strength of this analysis is its generalizability, although this is inevitably limited in such a qualitative analysis. Nevertheless, gendered positioning of the female therapist was found in each of these five groups, and this together with support from the literature indicates that the phenomenon can also be expected to be present in other IPV perpetrator group programs. However, this analysis does not capture the development process of the gendered positioning of the female therapist at the individual or group level. Since the idea in IPV group treatment is to diminish the gender difference used as justification for violence, such process research might provide important information with respect to treatment outcome.

This research also included an exploratory attempt to combine qualitative analysis of positioning with autonomic nervous system responses. Such mixed-method research may provide a more holistic view of social encounters as well as highlight the bodily aspects in doing therapy, and in therapist training and supervision. Also, as brought up earlier, even if the findings of the analyses highlight the ways gender and power are at play and can be addressed in the therapeutic process, how they are linked to a successful treatment alliance or, for example, to the repair of alliance ruptures is an important topic for future studies. Further analysis on troubled (gender) positioning, also targeted at the therapist would be useful. Such analyses would provide useful information in training therapists to work, for example, with alliance ruptures and also in highlighting the embodied aspects in doing therapy, which should also be remembered in the supervision and self-care of clinicians. Incorporating the bodi-

ly level in discursive analyses may help understanding of how a safe and productive therapeutic context is constructed.

The limitations in the representability of the findings also inevitably link with the researcher bias which needs reflection (Hollway, 1989; Parker, 2013). Although I as the researcher did not participate in constructing the data with, for example, specific interview questions or choices of questionnaires it is inevitable that the researcher with her personal views and positions becomes part of the analysis and its findings. In this research I started the analyses alone, yet my reading was always triangulated with that of another researcher. The selections from the data rely on my reading, or on a consensus between my own and second author's reading. The conclusions drawn in this research are influenced by my identity as an academically educated Nordic woman living in a heterosexual relationship, and so on. Working as a clinical psychologist with people from various backgrounds has expanded my view of alternative discourses, yet, such a perspective eventually reaches a limit. This subjectivity is an inevitable and acknowledged part of knowledge formation rather than a bias. The pre-existing assumptions, language system and worldview of the researcher are part of her reading of the data. The validity of the research resides in the detailed description of what was actually done with the data and acknowledging the position of the researcher in the formation of the findings. In this type of analysis, however, the last word rests with the reader, who is able to participate in the meaning-making process through the data extracts given in the study reports. Future alternative readings are to be welcomed rather than rejected.

With respect to the language system, this research can be viewed as limited in two ways. First, writing in English and not in one's mother tongue can be regarded as a limitation as reporting is part of the analytical process. Also, in Study II, the therapy process analyzed was conducted in English, which was not the mother tongue of any of the participants. Moreover, as was acknowledged in the study, the limitations of the cultural understanding of the researchers became explicit as the case was multicultural. However, researcher triangulation and careful attention was paid to language in an effort to minimize these language- and culture-based limitations in meaning making.

Finally, the dualist definition of gender used in this research, although based on careful analysis of the participants' talk, and thus grounded in the data, can be criticized. Here, I refer to Hare-Mustin and Marecek (1988, 8), who state "as observers of gender we are also its creators". From the very beginning of the research project I have been critically reflecting on this dualist definition of the participants' gender. Acknowledging the intersectional view of third wave feminism, and moreover a more nuanced view of gender, has made it difficult to draw conclusions about the findings. Also, writing about genders, men and women has sometimes caused me to feel that I am reinforcing the binary categorization. However, to reconstruct first requires deconstruction. In this research my aim was to render visible the gender discourse that the participants draw on as well as how this discourse evolves during conversation, and how it can actively be changed by the participants through modifying the manner in

which a gendered position is occupied. In future studies, it would be important to pay attention to the flexibility and nuances of the social characteristic of gender and its intersection with other categories of identity.

Psychotherapy as a social institution functions in between the levels of the individual and society (Wahlström, 2016), and thus both levels have to be acknowledged also in clients' narratives and positioning. Since couple relationships are informed by strongly gendered social orders, gender and power in these relationships should be addressed in therapy practice. The analyses presented in this report encourage future research into therapeutic processes from a feminist standpoint as a way of contributing to individual's and couples' wellbeing and a socially sensitive and just society.

YHTEENVETO (SUMMARY)

Sukupuolittunut positiointi: Sukupuolittuneen vallan ja kulttuuristen diskurssien huomiointi terapeuttisissa keskusteluissa

Tässä tutkimuksessa tarkasteltiin sukupuolen sosiaalista rakentumista terapeuttisissa keskusteluissa: pariterapiassa ja parisuhdeväkivallan hoitoryhmässä. Tutkimuksessa analysoitiin sukupuolittuneen positioinnin tapoja, merkityksiä ja tarkoitusta. Huomiota kiinnitettiin erityisesti sukupuolittuneiden positioiden väliseen valta-asetelmaan ja asetelman muuttumiseen terapeuttisissa keskusteluissa. Lisäksi tarkasteltiin terapeuttien osallistumista sukupuolittuneeseen positiointiin. Osatutkimuksissa käsiteltiin positioiden rakentumista ja muuttumista suhteessa toisiin vuorovaikutustilanteeseen osallistujiin sekä laajempiin kulttuurisiin diskursseihin. Näiden osatutkimusten tuloksia arvioitiin positioinnin sukupuolittuneisuuden kannalta, feministisestä näkökulmasta. Tutkimuksen laajempana tavoitteena oli edistää sukupuolisensitiivisen ja sosiaalisesti oikeudenmukaisen terapiatyön toteutumista.

Tutkimuksen teoreettisena viitekehyksenä oli sosiaalinen konstruktionismi ja analyysimenetelmä pohjautui diskursiiviseen psykologiaan, diskurssianalyysiin ja narratiiviseen lähestymistapaan. Tutkimuksessa siis yhdistettiin erilaisia laadullisen puheentutkimuksen lähestymistapoja. Positiointi toimi tutkimuksen erityisenä diskurssinaalyyttisenä analyysivälineenä. Ensimmäisessä osatutkimuksessa posoitioita luokiteltiin Grounded theory -menetelmällä. Kahdessa jälkimmäisessä osatutkimuksessa käytetty narratiivinen lähestymistapa auttoi tavoittamaan asemoinnin tilannesidonnaisuutta ja positioinnissa tapahtuvaa muutosta terapiaistunnon tai koko prosessin aikana.

Osatutkimuksissa analysoitiin erilaisia terapia-aineistoja. Ensimmäisessä osatutkimuksessa analysoitiin viiden hoitoryhmän keskusteluja parisuhdeväkivaltaan syyllistyneiden miesten hoito-ohjelmassa ja keskityttiin siihen, millaisia sukupuolittuneita positioita naisterapeutille näissä terapiakeskusteluissa rakennetaan. Tutkimuksen tulokset havainnollistavat sukupuolittuneen positioinnin käyttöä työvälineenä parisuhdeväkivallan hoitoryhmässä. Toisessa osatutkimuksessa aineistona toimivat yhden pariskunnan pariterapiakeskustelut koko terapiaprosessin ajalta. Analyysi kohdistui terapiassa rakentuviin dominantteihin tarinoihin ja näiden tarinoiden suhteeseen kulttuuristen diskurssien kanssa, sekä siihen, millaisia positioita näissä dominanteissa tarinoissa tarjotaan pariskunnan osapuolille. Tutkimuksen tulokset toivat esiin positioihin sisältyvää valtaa ja valta-asetelmassa tapahtuvaa muutosta pariterapian aikana. Kolmannessa osatutkimuksessa analysoitiin kahden, parisuhdeväkivallan vuoksi pariterapiaan hakeutuneen pariskunnan yhtä terapiaistuntoa. Tutkimuksessa tarkasteltiin syytöspuheen rakentumista terapiaistunnon aikana ja sitä, miten yhden puolison asettaminen hankalaan positioon näkyy osallistujien autonomisen hermoston tasolla. Tutkimuksen tulokset korostavat erityisesti identiteettiin kohdistuvien syytösten voimakkuutta.

Feministisestä lähestymistavasta käsin tutkimuksen tulokset kiinnittävät huomiota identiteettityön sukupuolittuneisuuteen terapeuttisissa keskusteluissa. Löydökset havainnollistavat sukupuolittuneiden kulttuuristen diskurssien vaikutusta terapeuttisissa keskusteluissa tapahtuvaan identiteettityöhön. Tutkimustulokset näyttävät, miten sosiaalinen sukupuoli ja kaksijakoisesta sukupuolijärjestyksestä kumpuava valta-asetelma rakentuvat terapiakeskusteluissa suhteessa kulttuurisiin diskursseihin. Toisaalta tulokset havainnollistavat tällaisen asetelman purkamista ja vaihtoehtoisten tarinoiden rakentumista. Tutkimuksen tuloksissa sukupuolittuneisuus näyttäytyi tärkeänä ja esiin nostettavana näkökulmana terapeuttisissa keskusteluissa, jotka liittyvät parisuhteeseen tai sukupuolittuneiden ongelmien, esimerkiksi parisuhdeväkivallan hoitoon. Tutkimuksen tulokset viittaavat lisäksi siihen, että terapeuteilta vaaditaan aktiivista otetta sukupuolen ja valta-asetelmien esiin nostamiseksi terapiakeskusteluissa.

Tutkimus havainnollistaa positioinnin käyttökelpoisuutta sekä analyyttisenä että terapeuttisena työkaluna, jolla voidaan tarkastella identiteetin monitasoista rakentumista paikallisissa vuorovaikutustilanteissa, mutta samalla suhteessa laajempiin kulttuurisiin diskursseihin. Positioinnin näkökulma tekee näkyväksi vuorovaikutuksen valta-asetelmia ja positiointia voidaan käyttää vuorovaikutuksellisena keinona, jolla voidaan pyrkiä muutokseen terapeuttisissa keskusteluissa. Sukupuolisensitiivisen, oikeudenmukaisen ja valtasuhteita purkavan terapeuttisen toiminnan toteuttaminen vaatii terapeuteilta sekä oman, että asiakkaiden sukupuolittuneiden positioiden tiedostamista. Sukupuoleen ja valtaan liittyvät kysymykset ja interventiot tulisikin sisällyttää selkeästi osaksi terapiakoulutuksia ja terapeuttien työnohjausta.

REFERENCES

Adams, D. & Cayouette, S. (2002). Emerge: A group education model for abusers. In E. Aldarondo & F. Mederos (Eds.), *Programs for men who batter: Intervention and prevention strategies in a diverse society* (pp. 1–25). New York: Civic Research.

Austin, B. A. & Dankwort, J. (1999). Standards for batterer programs: A review and analysis. *Journal of Interpersonal Violence, 14*, 152–168.

Avdi, E. (2005). Negotiating a pathological identity in the clinical dialogue: Discourse analysis of a family therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 493–511.

Avdi, E. (2012). Exploring the contribution of subject positioning to studying therapy as a dialogical enterprise. *International Journal for Dialogical Science, 6*(1), 61–79.

Avdi, E. (2015). Discourses of development in the consulting room: Analysing family therapy with children. *Feminism & Psychology, 25*, 363–380.

Avdi, E. (2016). Positioning as embodied interaction: Commentary on Guilfoyle. *Journal of Constructivist Psychology, 29,* 141-148.

Avdi, E. & Georgaca, E. (2007a). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy and Counselling, 9*, 157–176.

Avdi, E. & Georgaca, E. (2007b). Narrative research in psychotherapy: A critical review. *Psychology and Psychotherapy: Theory, Research and Practice, 80*, 407–419.

Avdi, E. & Georgaca, E. (2009). Narrative and discursive approaches to the analysis of subjectivity in psychotherapy. *Social and Personality Psychology Compass, 3*, 654–670.

Babcock, J. C., Miller, S. A., & Siard, C. (2003). Toward a typology of abusive women: Differences between partner-only and generally violent women in the use of violence. *Psychology of Women Quarterly, 27*, 153–161.

Baker, N. L., Buick, J. D., Kim, S. R., Moniz, S., & Nava, K. L. (2013). Lessons from examining same-sex intimate partner violence. *Sex roles, 69*, 182–192.

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide*. Buckingham: Open University Press.

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy, 33*, 298–317.

Blow, A. J., Timm, T. M., & Cox, R. (2008). The role of the therapist in therapeutic change: Does therapist gender matter? *Journal of Feminist Family Therapy, 20*, 66–86.

Bograd, M. & Mederos, F. (1999). Battering and couples therapy: Universal screening and selection of treatment modality. *Journal of Marital and Family Therapy, 25*, 291–312.

Borcsa, M. & Rober, P. (Eds.) (2016). *Research perspectives in couple therapy: Discursive qualitative methods.* Cham: Springer.

Bordin, J. L. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16*, 252-260.

Bowman, D., Scogin, F., Floyd, M., & McKendree–Smith, N. (2001). Psychotherapy length of stay and outcome: A meta–analysis of the effect of therapist sex. *Psychotherapy, 38*, 142–148.

Bruner, J. (1987). Life as narrative. *Social Research, 54*, 11–32.

Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry, 18*, 1–21.

Burck, C., Frosh, S., Strickland-Clark, L., & Morgan, K. (1998). The process of enabling change: A study of therapist interventions in family therapy. *Journal of Family Therapy, 20*, 253–267.

Burr, V. (2003). *Social constructionism* (2nd ed.). London: Routledge.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.

Caoyette, S. (1999). Safety issues for women co-facilitating groups for violent men. In J. Wild (Ed.), *Working with men for change* (pp. 153–165). London: Routledge.

Cooper, J. & Vetere, A. (2005). *Domestic violence and family safety. A systemic approach to working with violence in families*. London: Whurr.

Crawford, M. & Marecek, J. (1989). Psychology reconstructs the female: 1968–1988. *Psychology of Women Quarterly, 13*, 147-165.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1299.

Cromby, J. (2012). Feeling the way: Qualitative clinical research and the affective turn. *Qualitative Research in Psychology, 9*, 88–98.

Davies, B. & Harré, R. (1990). Positioning: The discursive production of selves. *Journal of the Theory of Social Behaviour, 20*, 43–63.

Deering, C. G. & Gannon, E. J. (2005). Gender and psychotherapy with traditional men. *American Journal of Psychotherapy, 59*, 351–360.

Dickerson, V. (2013). Patriarchy, power, and privilege: A narrative poststructural view of work with couples. *Family Process, 52*, 102–114.

Dickerson, V. C. & Crocket, K. (2010). "El Tigre, El Tigre": A story of narrative practice. In A. Gurman (Ed.), *A casebook of couple therapy* (pp. 153–180). New York: Guilford.

Drewery, W. (2005). Why we should watch what we say: Position calls, everyday speech and the production of relational subjectivity. *Theory & Psychology, 15*, 305–324.

Eckert, P. (1989). The whole woman: Sex and gender differences in variation. *Language Variation and Change, 1*, 245–267.

Edwards, D. (1995). Two to tango: Script formulations, dispositions, and rhetorical symmetry in relationship troubles talk. *Research on Language and Social Interaction, 28*, 319–350.

Edwards, D. & Potter, J. (1992). *Discursive psychology*. London: Sage.

Fishbane, M. (2011). Facilitating relational empowerment in couple therapy. *Family Process, 50*, 337–352.

Frosh, S., Burck, C., Strickland-Clark, L., & Morgan, K. (1996). Engaging with change: A process study of family therapy. *Journal of Family Therapy, 18*, 141–161.

Geldschläger, H, Ginés, O. Nax, D., & Ponce, A. (2013). *Outcome measurement in European perpetrator programmes: A survey. Working paper 1 from the Daphne III project "IMPACT: Evaluation of European Perpetrator Programmes"*. Retrieved from http://www.work-with-perpetrators.eu/index.php?id=62.

Georgaca, E. (2001). Voices of the self in psychotherapy: A qualitative analysis. *British Journal of Medical Psychology, 74*, 223–236.

Georgaca, E. & Avdi, E. (2009). Evaluating the talking cure: The contribution of narrative, discourse, and conversation analysis to psychotherapy assessment. *Qualitative Research in Psychology, 6*, 233–247.

George, J. & Stith, S. M. (2014). An updated feminist view of intimate partner violence. *Family Process, 53*, 179–193.

Gergen, K. (2001). Self-narration in social life. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse theory and practice* (pp. 247–260). London: Sage.

Gergen, K. J. (2009). *An invitation to social construction* (2nd ed.). London: Sage.

Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory. Strategies for qualitative research.* Chicago: Aldine.

Goldner, V. (1998). The treatment of violence and victimization in intimate relationships. *Family Process, 37*, 263–286.

Gondolf, E. W. (2004). Evaluating batterer counseling programs: A difficult task showing some effects and implications. *Aggression and Violent Behavior, 9*, 605–631.

Good, G. E., Gilbert, L. A., & Scher, M. (1990). Gender aware therapy: A synthesis of feminist therapy and knowledge about gender. *Journal of Counseling & Development, 68*, 376–380.

Gottman, J. M. & Gottman, J. S. (2008). Gottman method couple therapy. In A. S. Gurman (Ed.) *Clinical handbook of couple therapy* (pp. 138–164). New York: Guilford.

Greenberg, L. S. & Goldman, R. N. (2008). *Emotion-focused coupes therapy: The dynamics of emotion, love, and power*. Washington, DC: American Psychological Association.

Guilfoyle, M. (2001). Problematising psychotherapy: The discursive production of a bulimic. *Culture and Psychology, 7*, 151–179.

Guilfoyle, M. (2002). Rhetorical processes in therapy: The bias for self–containment. *Journal of Family Therapy, 24*, 298–316.

Guilfoyle, M. (2015). Listening in narrative therapy: Double listening and empathic positioning. *South African Journal of Psychology, 45*, 36–49.

Haddock, S. A., Zimmerman, T. S., & MacPhee, D. (2000). The power equity guide: Attending to gender in family therapy. *Journal of Marital and Family Therapy, 26*, 153–170.

Hakala, V., Jalava, S., & Holma, J. (2014). Vanhemmuuden rakentuminen pariterapiassa [Construction of parenthood in couple therapy]. *Perheterapia, 30*(3), 33–46.

Hansen, M. (1993). Feminism and family therapy: A review of feminist critiques of approaches to family violence. In M. Hansen & M. Harway (Eds.), *Battering and family therapy: A feminist perspective* (pp. 69–81). Thousand Oaks, CA: Sage.

Hare-Mustin, R. T. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. *Family Process, 33*, 19–35.

Hare-Mustin, R. T. & Marecek, J. (1988). The meaning of difference: Gender theory, postmodernism, and psychology. *American Psychologist, 43*, 455-464.

Harré, R. & Moghaddam F. (2003). Introduction: The self and others in traditional psychology and in positioning theory. In R. Harré & F. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political, and cultural contexts* (pp. 1–11). Westport: Praeger.

Harré, R. & van Langenhove, L. (1991). Varieties of positioning. *Journal of the Theory of Social Behaviour, 21*, 393–407.

Harré, R. & Van Langenhove, L. (Eds.) (2003). *Positioning theory: Moral contexts of international action*. Oxford: Blackwell.

Harryson, L., Novo, M., & Hammarström, A. (2012). Is gender inequality in the domestic sphere associated with psychological distress among women and men? Results from the Northern Swedish cohort. *Journal of Epidemiology and Community Health, 66,* 271-276.

Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1998), *Changing the subject: Psychology, social regulation and subjectivity*. London: Routledge.

Hollway, W. (1989). *Subjectivity and method in psychology: Gender, meaning and science*. London: Sage.

Holma, J., Partanen, T., Wahlström, J., Laitila, A., & Seikkula, J. (2006). Narratives and discourses in groups for male batterers. In M. Lipshitz (Ed.), *Domestic violence and its reverberations* (pp. 59–83). New York: Nova Science.

Hrapczynski, K. M., Epstein, N. B., Werlinich, C. A., & LaTaillade, J. J. (2012). Changes in negative attributions during couple therapy for abusive behavior: Relations to changes in satisfaction and behavior. *Journal of Marital and Family Therapy, 38*, 117–132.

Huntington. J. & Black, L. L. (2014). Women, you've come a long way, baby; or have you? Male clinicians-in-training's perceptions of women. *Journal of Feminist Family Therapy, 26*, 55–72.

Husso, M. (2003). *Parisuhdeväkivalta: Lyötyjen aika ja tila* [Violence in intimate relationships]. Tampere: Vastapaino.

Johnson, M. P. (2006). Conflict and control: Gender symmetry and asymmetry in domestic violence. *Violence Against Women, 12*, 1003–1018.

Kapanen, K. (2005). Naiskuvat miesten puheessa [Men's discursive constructions of women]. In J. M. Holma & J. Wahlström (Eds.), *Iskuryhmä. Miesten puhetta Vaihtoehto väkivallalle –ryhmissä* [Discourses in groups for male batterers] (pp. 71–89). Helsinki: Helsinki University Press.

Karatza, H. & Avdi, E. (2011). Shifts in subjectivity during the therapy for psychosis. *Psychology and Psychotherapy: Theory, Research and Practice, 84*, 214–229.

Kaufman, G. (1992). The mysterious disappearance of battered women in family therapists' offices: Male privilege colluding with male violence. *Journal of Marital and Family Therapy, 18*, 233–243.

Kelly, L. & Westmarland, N. (2015). *Domestic violence perpetrator programmes: Steps towards change. Project Mirabel final report*. Retrieved from https://www.dur.ac.uk/resources/criva/ProjectMirabalfinalreport.pdf.

Keltikangas, M., Kulta, H., & Kyrö, H. (2014). *Dialogical conversations on power abuse in couples treatment for intimate partner violence. A qualitative analysis of positioning and dominance used in the conversations*. Master's thesis. Department of Psychology, University of Jyväskylä.

Knudson-Martin, C. (2013). Why power matters: Creating a foundation of mutual support in couple relationships. *Family Process, 52*, 5–18.

Knudson-Martin, C. & Huenergardt, D. (2010). A socio-emotional approach to couple therapy: Linking social context and couple interaction. *Family Process, 49*, 369–384.

Knudson-Martin, C., Huenergardt, D., Lafontant, K., Bishop, L., Schaepper, J., & Wells, M. (2015). Competencies for addressing gender and power in couple therapy: A socio emotional approach. *Journal of Marital and Family Therapy, 41*, 205–220.

Kreibig, S. D. (2010). Autonomic nervous system activity in emotion: A review. *Biological Psychology, 84*, 394–421.

Kurri, K. (2005). *The invisible moral order: Agency, accountability and responsibility in therapy talk*. Jyväskylä Studies in Education, Psychology and Social Research, 260.

Kurri, K. & Wahlström, J. (2005). Placement of responsibility and moral reasoning in couple therapy. *Journal of Family Therapy, 27*, 352–369.

Lambert, M. J. & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy, 38*, 357-361.

LaTaillade, J. J., Epstein, N. B., & Werlinich, C. A. (2006). Conjoint treatment of intimate partner violence: A cognitive behavioral approach. *Journal of Cognitive Psychotherapy, 20*, 393–410.

Lazar, M. M. (Ed.) (2005). *Feminist critical discourse analysis: Gender, power and ideology in discourse*. Hampshire: Palgrave MacMillan.

Lazar, M. M. (2007). Feminist critical discourse analysis: Articulating a feminist discourse praxis. *Critical Discourse Studies, 4*, 141–164.

LeBaron, C. D., Miller, R. B., & Yorgason, J. B. (2014). A longitudinal examination of women's perceptions of marital power and marital happiness in midlife marriages. *Journal of Couple & Relationship Therapy, 13*, 93–113.

Leslie, L. A. & Southard, A. L. (2009). Thirty years of feminist family therapy. In S. A. Lloyd, A. L. Few, & K. R. Allen (Eds.), *Handbook of feminist family studies* (pp. 328–339). Los Angeles: Sage.

Linville, D., Chronister, K., Marsiglio, M., & Brown, T. B. (2012). Treatment of partner violence in gay and lesbian relationships. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 327–342). New York: Brunner-Routledge.

Lyons, A. C. & Cromby, J. (2010). Social psychology and the empirical body: Rethinking the relationship. *Social and Personality Psychology Compass, 4*, 1–13.

Madill, A. & Barkham, M. (1997). Discourse analysis of a theme in one successful case of brief psychodynamic-interpersonal psychotherapy. *Journal of Counseling Psychology, 44*, 232–244.

Magnusson, E. & Marecek, J. (2012). *Gender and culture in psychology: Theories and practices*. New York: Cambridge University Press.

McCollum, E. E. & Stith, S. M. (2008). Couples treatment for interpersonal violence: A review of outcome research literature and current clinical practices. *Violence and Victims, 23*, 187–201.

McGeorge, C. R., Carlson, T. S., & Guttormson, H. (2009). The feminist couple therapy scale: A measure of therapists' ability to promote equality in couple relationships. *Journal of Feminist Family Therapy, 21*, 198–215.

McLeod, J. (1997). *Narrative and psychotherapy*. London: Sage.

McLeod, J. (2004). Social construction, narrative, and psychotherapy. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 351–365). London: Sage.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy* (2nd ed.). London: Sage.

McLeod, J. & Lynch, G. (2000). "This is our life": Strong evaluation in psychotherapy narrative. *European Journal of Psychotherapy, Counseling and Health, 3*, 389–406.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*, 1157–1172.

Orme, J., Dominelli, L., & Mullender, A. (2000). Working with violent men from a feminist social work perspective. *International Social Work, 43*, 89–105.

Parker, I. (1998). Constructing and deconstructing psychotherapeutic discourse. *The European Journal of Psychotherapy, Counselling & Health, 1*, 65–78.

Parker, I. (1999). Tracing therapeutic discourse in material culture. *British Journal of Medical Psychology, 72*, 577–587.

Parker, I. (2002). *Critical discursive psychology*. New York: Palgrave Macmillan.

Parker, I. (2013). Discourse analysis: Dimensions of critique in psychology. *Qualitative Research in Psychology, 10*, 223–239.

Parker, L. (1997). Unraveling power issues in couples therapy. *Journal of Feminist Family Therapy, 9*, 3–20.

Parker, L. (2003). Bringing power from the margins to the center. In L. B. Silverstein & T. J. Goodrich (Eds.), *Feminist family therapy: Empowerment in*

social context (pp. 225–238). Washington, DC: American Psychological Association.

Parker, L. (2009). Disrupting power and privilege in couples therapy. *Clinical Social Work Journal, 37*, 248–255.

Partanen, T. (2008). *Interaction and therapeutic interventions in treatment groups for intimately violent men*. Jyväskylä Studies in Education, Psychology and Social Research, 332.

Partanen, T. & Wahlström, J. (2003). The dilemma of victim positioning in group therapy for male perpetrators of domestic violence. In C. Hall, K. Juhila, N. Parton, & T. Pösö (Eds.), *Constructing clienthood in social work and human services* (pp. 129–144). London: Kingsley.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany, NY: State University of New York Press.

Potter, J. (2003). Discursive psychology: Between method and paradigm. *Discourse & Society, 14*, 783–794.

Potter, J. (2004). Discourse analysis. In M. Hardy & A. Bryman (Eds.), *Handbook of data analysis* (pp. 607–624). London: Sage.

Potter, J. (2012). Discursive psychology and discourse analysis. In J. P. Gee & M. Handford (Eds.), *The Routledge handbook of discourse analysis* (pp. 104–119). London: Routledge.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behavior*. London: Sage.

Potter, J. & Wetherell, M. (1995). Discourse analysis. In J. A. Smith, R. Harré, & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 80–92). London: Sage.

Raakil, M. (2002). A Norwegian integrative model for the treatment of men who batter. *Family Violence & Sexual Assault Bulletin, 18*, 8–14.

Ramazanoglu, C. & Holland, J. (2002). *Feminist methodology: Challenges and choises*. London: Sage.

Reynolds, J., Wetherell, M., & Taylor, S. (2007). Choice and chance: Negotiating agency in narratives of singleness. *The Sociological Review, 55*, 331–351.

Ristock, J. L. (2003). Exploring dynamics of abusive lesbian relationships: Preliminary analysis of a multisite, qualitative study. *American Journal of Community Psychology, 31*, 329–341.

Råkil, M. (2006). Are men who use violence against their partners and children good enough fathers? The need for an integrated child perspective in the treatment work with the men. In C. Humphries & N. Stanley (Eds.), *Domestic violence and child protection* (pp. 190–202). London: Kingsley.

Räsänen, E. (2013). *Dialogues in group interventions among partner-violent men: Different approaches for different clients*. Jyväskylä Studies in Education, Psychology and Social Research, 472.

Sarbin, T. R. (1986). The narrative as a root metaphor for psychology. In T. R. Sarbin (Ed.) *Narrative psychology. The storied nature of human conduct* (pp. 3–21). New York: Praeger.

Saunders, D. G. (2008). Group interventions for men who batter: A summary of program descriptions and research. *Violence and Victims, 23*, 156-172.

Scher, M. & Good, G. E. (1990). Gender and counseling in the twenty-first century: What does the future hold?. *Journal of Counseling and Development, 68*, 388–91.

Seikkula, J., Karvonen, A., Kykyri, V.-L., Kaartinen, J., & Penttonen, M. (2015), The embodied attunement of therapists and a couple within dialogical psychotherapy: An introduction to the Relational Mind research project. *Family Process, 54*, 703–715.

Seikkula, J., Laitila, A., & Rober, P. (2012). Making sense of multiactor dialogues in family therapy and network meetings. *Journal of Marital and Family Therapy, 38*, 667–687.

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*, 301-311.

Sinclair, S. L. (2007). Back in the mirrored room: The enduring relevance of discursive practice. *Journal of Family Therapy, 29*, 147–168.

Sinclair, S. L. & Monk, G. (2004). Moving beyond the blame game: Toward as discursive approach to negotiating conflict within couple relationships. *Journal of Marital and Family Therapy, 30*, 335–347.

Smith, J. A., Harré, R., & van Langenhove, L. (1995a) (Eds.), *Rethinking methods in psychology*. London: Sage.

Smith, J. A., Harré, R., & van Langenhove, L. (1995b) (Eds.), *Rethinking psychology*. London: Sage.

Stancombe, J. & White, S. (2005). Cause and responsibility: Towards an interactional understanding of blaming and 'neutrality' in family therapy. *Journal of Family Therapy, 27*, 330–351.

Stevens-Smith, P. (1995). Gender issues in counselor education: Current status and challenges. *Counselor Education and Supervision, 34*, 283–293.

Stith, S. M., McCollum, E. E., Amanor-Boadu, Y., & Smith, D. (2012). Systemic perspectives on intimate partner violence treatment. *Journal of Marital and Family Therapy, 38*, 220–240.

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2003). Effectiveness of couples treatment for spouse abuse. *Journal of Marital and Family Therapy, 29*, 407–426.

Stratton, P. (2003). Causal attributions during therapy I: Responsibility and blame. *Journal of Family Therapy, 25*, 136–160.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Suoninen, E. & Wahlström, J. (2009). Interactional positions and the production of identities: Negotiating fatherhood in family therapy talk. *Communication & Medicine, 6*, 119–209.

Tan, S. & F. M. Moghaddam (2003). Positioning in intergroup relations. In R. Harré & L. van Langenhove (Eds.), *Positioning theory* (pp. 178-194). Oxford: Blackwell.

Trepal, H. C., Wester, K. L., & Shuler, M. (2008). Counselors'-in-training perceptions of gendered behavior. *The Family Journal, 16*, 147-154.

Tyagi, S. V. (2006). Female counselors and male perpetrators of violence against women. *Women & Therapy, 29*, 23–44.

Vall, B., Seikkula, J., Laitila, A., & Holma, J. (2016). Dominance and dialogue in couple therapy for psychological intimate partner violence. *Contemporary Family Therapy, 38,* 223-232.

Vall, B., Seikkula, J., Laitila, A., Holma, J., & Botella, L. (2014). Increasing responsibility, safety, and trust through a dialogical approach: A case study in couple therapy for psychological abusive behavior. *Journal of Family Psychotherapy, 25*, 275–299.

Vatcher, C. A. & Bogo, M. (2001). The feminist/emotionally focused therapy practice model: An integrated approach for couple therapy. *Journal of Marital and Family Therapy, 27*, 69–83.

Veteläinen, A., Grönholm, H., & Holma, J. (2013). Discussions of fatherhood in male batterer treatment group. *Sage Open, 3*(2). doi: 10.1177/2158244013492083.

Vetere, A. (2011). Family violence and family safety: An approach to safe practices in our mental health services. *Partner Abuse, 2*, 246-256.

Wahlström, J. (2016). Constructing the moral order of a relationship in couples therapy. In M. Borcsa & P. Rober (Eds.), *Research perspectives in couple therapy: Discursive qualitative methods* (pp. 149–165). Cham: Springer.

Ward, A. & Knudson-Martin, C. (2012). The impact of therapist actions on the balance of power on the couple system: A qualitative analysis of couple sessions. *Journal of Couple and Relationship Therapy, 11*, 1–17.

Wetherell, M. (2007). A step too far: Discursive psychology, linguistic ethnography and questions of identity. *Journal of Sociolinguistics, 11*, 661–681

Wetherell, M., Taylor, S., & Yates, S. J. (2001). *Discourse as data: A guide for analysis*. Milton Keynes: Open University.

Whisman, M. A. & Jacobson, N. S. (1990). Power, marital satisfaction, and response to marital therapy. *Journal of Family Psychology, 4*, 202–212.

Widdicombe, S. (1998). ´But you don't class yourself': The interactional management of membership and non-membership. In C. Antaki & S. Widdicombe (Eds.), *Identities in talk* (pp. 52–70). London: Sage.

Williams, K. (2011). A socio-emotional relational framework for infidelity: The relational justice approach. *Family Process, 50*, 516–528.

Willig, C. (Ed.). (1999). *Applied discourse analysis: Social and psychological interventions*. Buckingham: Open University Press.

Wilson, M. (1996). The CHANGE men's programme. In K. Cavanagh & V. Cree (Eds.), *Working with men. Feminism and social work* (pp. 28–44). London: Routledge.

Winslade, J. M. (2005). Utilising discursive positioning in counselling. *British Journal of Guidance & Counselling, 33*, 351–364.

Wodak, R. & Meyer, M. (2001). *Methods of critical discourse analysis*. London: Sage.

Wood, L. A. & Kroger, R. O. (2000). *Doing discourse analysis. Methods for studying action in talk and text*. Thousand Oaks, CA: Sage.

Work with Perpetrators of Domestic Violence in Europe (2008). *Guidelines to develop standards for programmes working with male perpetrators of domestic violence*. Retrieved from http://www.work-with-perpetrators.eu/index.php?id=29.

ORIGINAL PAPERS

I

POSITIONS CONSTRUCTED FOR A FEMALE THERAPIST IN MALE BATTERERS' TREATMENT GROUP

by

Helena Päivinen & Juha Holma, 2012

Journal of Feminist Family Therapy, 24, 52–74

Journal of Feminist Family Therapy, 24:52–74, 2012

ISSN: 0895-2833 print/1540-4099 online
DOI: 10.1080/08952833.2012.629132

Routledge
Taylor & Francis Group

Positions Constructed for a Female Therapist in Male Batterers' Treatment Group

HELENA PÄIVINEN and JUHA HOLMA
Department of Psychology, Psychotherapy Training and Research Center, University of Jyväskylä, Jyväskylä, Finland

How the gender of the therapist affects the treatment of intimately violent men has been little researched. In this study we examined the positions that batterers construct for a female therapist in batterers' group treatment. The data consisted of five videotaped therapy groups for male batterers. Three positions of a woman were constructed: woman in general; woman as spouse and woman personally as herself. These positions were often based on a constructed difference between men and women. The female therapist repositioned herself to diminish the difference constructed between the genders and to make fear of the spouse visible.

KEYWORDS gendered positions, male batterers, intimate partner violence, female therapist, group therapy, grounded theory, gender conscious therapy, co-operation between the therapists

In psychotherapy research the gender of the therapist has been found a poor predictor of therapy outcome for both male and female clients (Bowman, Scogin, Floyd, & McKendree–Smith, 2001; Okiishi et al., 2006). It has been suggested that how the therapist deals with processing gender issues in the therapy session seems to be much more important than the therapist's gender itself (Blow, Timm, & Cox, 2008). Psychotherapy research has consistently demonstrated that the strength of the client–therapist alliance is significantly related to positive outcomes in therapy (Blow, Sprenkle, & Davis, 2007; Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008).

Received April 7, 2011; accepted June 30, 2011.
Address correspondence to Juha Holma, Department of Psychology, University of Jyväskylä, P.O.Box 35; Jyväskylä, Finland, 40014. E-mail: juha.m.holma@.jyu.fi

The gender of the therapist, like other demographic characteristics, has only a minor, if any, effect on the alliance (Dinger et al. 2008).

If intimate partner violence is considered as a gendered issue involving attitudes and power-relations it may be assumed that the gender of the therapist has some affect on group functioning and on the alliance (Tyagi, 2006). It has been considered important to have a female leader in the group to bring a woman's perspective and experience to bear in an otherwise all-male group (Tyagi, 2006; Wilson, 1996). She can also confront the men with the impact of their behavior better than a man (Wilson, 1996). Building an alliance with batterers in a treatment program may be difficult because the therapist's task is seen as one of confronting and challenging the men (Babcock, Canady, Graham, & Schart, 2007).

Working with batterers is considered challenging for women (Banks 2008; Dominelli, 1999; Tyagi 2006). The female therapist may encounter objectification and invisibility (Caoyette, 1999). Her comments may be accorded less value by their being generalized to all women or she may not be noticed at all; she may be rendered invisible. The men may also more readily express their negative attitudes toward women when there is a female therapist in the group (Adams & Cayouette, 2002). The participants may interrupt, challenge, or ignore the female therapist. She may be made responsible for the way the men express their feelings and a controller of sexist speech as well (Long, 1987).

The female therapist may become an object of over-protectiveness or other approach from the group participants' side (Caoyette, 1999; Deering & Gannon, 2005). This may reach even outside the group setting, which is why the female therapist has to draw clear lines for the group participants. Experiences of exceeding limits, generalizations about women, and not being respected because of one's gender may cause feelings of being depreciated, insulted, and objectified (Banks, 2008). However, such negative behavior toward the female therapist is also seen as useful (Adams & Caoyette, 2002). Because it occurs in the group setting, it can be pointed out, brought into the discussion, and compared to the men's negative behavior and attitudes toward their spouses. Female therapists have been observed to encourage men to talk about their intimate relationships; however, the female therapist may also become the target of sexist expectations (Holma, Partanen, Wahlström, Laitila, & Seikkula, 2006).

It has been stressed that in treatment programs for intimately violent men, the therapist should take a strong leadership position over the group (Partanen & Wahlström, 2003; Tyagi, 2006). In particular, the female therapist is expected to assume an active role in psychoeducation and in the therapeutic process. In treating violence the therapist also needs to be able to shift flexibly between the psychological and moral standpoints (Partanen, 2008). Empathetic understanding of and challenging men alternate in the work of the therapist. For a female therapist especially, it may be difficult to find a

balance between these positions (Caoyette, 1999). Too empathetic a female therapist may be considered weak and a too challenging one a man-hater. Representing both her gender and authority requires special skills in the case of the female therapist.

It has been argued that having a male therapist in the group is also important as he can model modern masculinity and exemplify more flexible role expectations to the men, which may facilitate the change process of the group members (Deering & Gannon 2005). For male workers, working with male batterers requires that they acknowledge their own masculinity in order to be able to confront the men's violent behavior and bring men to take responsibility of their actions (Orme, Dominelli, & Mullender, 2000). The male therapist must be able to share leadership with a woman and to behave respectfully with a female therapist and treat her as an equal (Caoyette, 1999; Dominelli, 1999). The male therapist may face challenges in his work in situations where the group participants try to ally with him or strongly offer him and not the female therapist the role of leader. One of the greatest benefits of having a female and a male therapist in a group is that it offers a model of co-operation and sharing of leadership between the sexes (Adams & Cayouette, 2002; Austin & Dankwort, 1999; Caoyette, 1999; Tyagi, 2006; Wilson, 1996). When it works well, the model gives the group members an opportunity to observe how a man and a woman can get along with each other and share power. However all this is not easily accomplished nor is it self-evident that the men would relate what they see to their own lives (Wilson, 1996).

Discursive Approach and Positioning

This study lies within the tradition of researching speech in treatment groups of intimately violent men from the discursive psychological standpoint. On this view language is not taken to be simply a tool for description and a medium of communication, but as social practice, as a mode of doing things (Wood & Kroger, 2000). The discursive perspective on language differs from conventional orientations in three major ways: it sees talk and language as action, as behavior; it emphasizes talk as the event of interest in social and psychological research, meaning that the phenomena of interest are constituted in and through discourse; and thirdly, the discursive perspective emphasizes variability. Talk constructs different versions of the world and is oriented toward different functions; variability is therefore to be expected not only between persons, but within persons. Participants use variability to construct their talk for different purposes, for different audiences, and on different occasions.

Discourses make available positions for subjects to take up (Hollway, 1984). Positioning means a process in social interaction where individuals become produced over and over again in the various discursive practices

in which they participate (Davies & Harré, 1990). It is nevertheless the very same person who is experiencing and displaying these different aspects of self. It is one and the same person who is positioned in different ways in conversations and who at the same time can negotiate new positions within the same discursive practices. Position can be viewed as a loose set of rights and duties that limit the possibilities of action (Harré & Moghaddam, 2003). Compared to conventional views of self, positions can be multiple and shifting. Position helps to focus on the dynamic aspects of encounters rather than on the static, formal, and ritualistic aspects that the use of, for example, role would serve (Davies & Harré, 1990). Talking of positions instead of roles fits within the framework of the idea of social phenomena as socially constructed and reconstructed (Harré & van Langenhove, 1991).

In this study the concept of positioning is used by the authors to analyze interaction in the group context. Positioning can be interactive, meaning that what one person says positions another (Davies & Harré, 1990). It can also be reflexive in that one positions oneself. Positioning another person happens when that person is given a part in the discourse, whether explicit or implicit. Positioning can be intentional but also unintentional and even unconscious (Harré & van Langenhove, 1991). The current speaker in a way invites another person present in the discourse situation to take part in the story line of the discourse by taking up the offered position. In taking up an offered position, the person in question inevitably sees the world from the perspective of that position. Positions are always relational, that is positioning someone in a certain way means that someone else is thereby positioned relative to that person (Harré & Moghaddam, 2003; Hollway, 1984). One can also refuse the position offered and reposition oneself or others. Given that individuals understand themselves as continuous and unitary, it is clear that contradictory positions are experiences as problematic and thus to be reconciled. Nevertheless, normative expectations exist at every level of positioning (Davies & Harré, 1990).

Positioning does not solely involve the discursive production of selves as individuals, but also selves as members, representatives, and mediators of groups (Tan & Moghaddam, 1999). One belongs to the world as a member of certain classes and not others, and sees the world through these positions (Davies & Harré, 1990). For example, taking up a position as a subject or an object is not equally possible for women and men in gender-differentiated discourses (Hollway, 1984). Specific positions for the categories of "woman" and "man" exist in traditional discourses. Other dimensions of social difference, such as age or race, also intersect with gender to advantage or disadvantage individuals taking up certain positions. In this study special interest is paid to how gender affects the positions offered to a female therapist in a treatment group for male batterers.

Aim of the Study and the Research Questions

This study deals with the positions that are constructed for a female therapist in male batterers' group treatment. The interest is in how gendered positions are offered: how the female therapist is invited to take up a position in the discourse at hand, and what these positions are like. Also of interest is how the female therapist reacts in these situations. Does she take up the offered position or reject it and so change the discourse? Attention is also paid to the male therapist who is also present in these discourses.

METHODS

Data and Participants

The data for this study are drawn from a batterers' treatment program which was established in Jyväskylä, Finland, in 1995 by the Mobile Crisis Centre in collaboration with the Jyväskylä University Psychotherapy Training and Research Centre. The model for the program has been influenced greatly by a Norwegian treatment program called Alternative To Violence (ATV). The program combines various treatment approaches by integrating specific knowledge of violence and safety planning, a feminist perspective, and psychotherapeutic principles in the eclectic, broad sense of the concept (Holma et al., 2006; Raakil, 2002). Treatment of male perpetrators begins with an intervention and individual sessions with one of the male workers at the crisis center. This phase lasts from one to six months. Men need to complete the individual sessions before entering the group treatment, which is organized in the Jyväskylä University Psychotherapy Training and Research Centre. There is no system of mandatory treatment in Finland and the men who come to this program do so voluntarily. The group sessions are conducted by two therapists, including female/male dyads. The group meetings are unstructured, but the group facilitators direct the discussion toward specific topics such as past and present different modes of violent behavior, security of the victim, violence as a choice, and masculine identity (Holma et al., 2006).

The data in this study consist of videotaped group sessions arranged for five groups of male batterers according to the Jyväskylä model. The group sessions took place in Jyväskylä between spring 2000 and spring 2002. Each of the groups gathered once weekly for 15 weeks, and each session lasted 1.5 hours. In total the data comprise 75 sessions, or 112.5 hours of videotaped material. Written consent for the recordings was obtained from all the participants at the beginning of the group treatment. The recorded material is securely stored at the Psychotherapy Research and Training Centre, and all members of the research team are committed to complete confidentiality.

These five groups were chosen because one of the two therapists was a woman. In the groups held since, then all the therapists have been men.

The groups comprised a total of 26 men, of whom two (in different groups) dropped out during the first half of the treatment. Each group contained from three to seven participants. The female therapist was absent from five of the 75 sessions. The men were aged between 25 to 56 years. Over half of the men (14) were married to the woman toward whom they had acted violently. Four were living in a common law relationship and two were dating the woman they had battered. Three men were undergoing a divorce process at the time of the group treatment and in three cases the relationship the men had been violent in had broken up. Thus most of the men were still together with the woman they had battered (the last time). All but one man was living in a family with children, either their own or children from their spouse's previous relationships.

The majority (22 men) reported that they had acted violently for longer than a year, and half of them estimated that the violence had lasted longer than three years. Sixteen of the men described having been violent one to three times during the preceding 12-month period. Six of the men had been violent 4 to 10 times. The rest (four) described having been violent over 10 times within the last year. The police had been called for half (14) of the men when they had been behaving violently. Seven of the men were facing charges for their violence or they had been convicted of it.

The therapist-dyads varied in the groups. The female therapist in the first group was an employee of the Mobile Crisis Centre. The female therapist in the remaining groups was employed in the Psychotherapy Training and Research Centre. There were also two different male therapists. One attended the first three groups and the other the last two groups. Both the male therapists were employees of the Psychotherapy Training and Research Centre. All the therapists had training in trauma psychotherapy, family therapy, or integrative therapy, and many years experience of working with intimate partner violence-related issues.

Method and Research Process

The method of analyzing the data was Grounded Theory (GT) (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The original inventors of the method, Glaser and Strauss (1967), describe GT as discovering theory from data that are systematically obtained from social research. Generating a theory from the data means that most hypotheses and concepts not only develop out of the data, but are systematically polished in relation to the data during the course of the research. It can also be considered as a way of thinking about and conceptualizing the data of interest (Strauss & Corbin, 1998). GT as an approach and a method suited the purposes of this study by providing appropriate tools for classifying the data. The operation underpinning the

process is the combined collection, coding, and analysis of data. This process is called the constant comparative method of analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1998). In practice this means that data are constantly collected and analyzed and the results compared to those of previous analyses in order to further clarify the relationships between the variables and to render the classification more precise.

Data Collection

There are contrary opinions on whether the researcher should (Payne, 2007) or should not (Glaser & Strauss, 1967) review the literature at the beginning of the research process. In this study the literature was reviewed at the beginning of the process. The analysis started by watching the group sessions, focusing on the positioning of the female therapists, in other words, how she is invited to take up positions, what these positions are like, how the female therapist reacts in these situations, and on the impact of the presence of the male therapist in these discourses. The exact criteria for determining the importance of parts of the discussions (discourses) were formed during this data collection process. The criteria were the following:

- Female therapist is asked something as a woman. "As a woman, what do you . . . ?
- Female therapist comments on something as a woman. "I think as a woman that . . . "
- Female therapist differentiates herself or is differentiated from the other group members because of her gender.
- Female therapist's attendance in the group is taken up for discussion. "We have a woman sitting here!"
- The positions taken by the male therapist in discourses in which the female therapist was offered positions.

In all cases the discursive context was written down.

Only the extracts considered to be significant were transcribed. As GT research does not demand that the prosodic, paralinguistic, or extralinguistic elements of the data be studied (Payne, 2007), speech at the word level was deemed sufficient for the analysis. However, to capture the participants' voices their speech was written down word-for-word. The transcriptions comprised 75 pages of data.

Coding and Analysis

The next step was start the open coding phase according to the principles of GT (Payne, 2007; Strauss & Corbin, 1998). This was done by reading the

notes repeatedly and classifying the extracts under one or more themes as these arose from the reading process. The data were coded with a word-processing program (Microsoft Word). Initially, this resulted in 35 classes, which overlapped each other in many respects, and did not strictly match the criteria.

After this open coding phase, the original video sessions were watched a second time. When watching the videotaped data for the second time, the classes were studied more carefully, some new extracts were coded, and overlapping classes were integrated. Sub- and upper categories were formed by paying attention to the 'goodness of fit' of the categories, which means they were not forced but applicable to the data (Glaser & Strauss, 1967). Also, when watching the tapes the second time, saturation of the data was sought, meaning that no additional data would be found to create new categories. The categories can confidentially be held to be saturated when the researcher observes similar instances over and over again.

When performing this constant comparison of the data, the concept of positioning was taken as a tool to conceptualize the phenomenon. The kinds of positions that were constructed for the female therapist and if and how she accepted the positions offered her were studied. Invitations to take up a position were examined in relation to the extent to which they left the female therapist with the possibility to reject the offered position and to reposition herself. Three categories of positioning were constructed and named. Subcategories of these core categories were formed during this constant comparison. The positions taken by the male therapist were also studied in these situations.

RESULTS

Three core categories of woman were found. The female therapist was invited in the group discourses to represent women in general, a specific woman (in this context a spouse or a girlfriend), or herself personally. The categories are presented with illustrative extracts from the transcribed data. The extracts have been selected to best describe the category that they represent. The extracts have been drawn from different groups, sessions, and group participants to best cover the data. The five therapy groups have been numbered from I to V, with the sessions numbered from 1 to 15. The approximate starting time of the extracts is given in minutes and seconds after the group/session information. Thus, II/3/30:00 means the third session of group two, thirty minutes after the beginning of the session. The abbreviation FT refers to the female therapist and MT refers to the male therapist. The participants' and their spouses' as well as the therapists' names

have been changed to ensure anonymity. Round brackets () are used to signal communicative elements other than speech. Notes on the researcher are given in double brackets (()).

Representative of Female Gender in General

One way the female therapist was positioned as a woman was as representative of the female gender in general. The female therapist was counted among the class of women in these discourses, and because of her gender she was expected to have a different viewpoint. This difference was seen as interesting or negative. Women were seen as strange and unpredictable, as different biologically, mentally, and in their needs.

Negative View on Female Gender: One of "You Women"

In positioning the female therapist in this way the men clearly included her in the class of women. The invitation to take up this position was sometimes tacit but mostly explicit and demanding.

Extract 1 (IV/14/83:05-)

Aki: You have to make such goddesses of yourselves, damn it, that we always have to beg you for everything.
MT: This was directed at you Maija ((FT)).
FT: (laughter) Yes, clearly.
MT: So would you like to give some answer to this? (Laughing)
FT: It comes into my mind at least that I can't imagine that your wife is always forbidding you from doing things. Do you hear the other side of it?
MT: What would the other side be?
FT: Well, I wonder why it is, or how you always get the experience of, or why the situation always ends up with the other person forbidding and forbidding and forbidding. Perhaps she in other ways . . . like that you go and do and things. Then the other side is often left out here in the group a bit like that you don't hear it. We don't hear her side.
Aki: I could do some homework for the last session. I could carry a recorder in my pocket and do some homework I'd have this kind of a little plan with the lads, I could even negotiate for a while.

In Extract 1 Aki accuses the women of being goddesses with whom one has to plead for everything. Before the extract Aki had explained that he would like to travel with his friends but his wife refuses to allow him to go. Aki uses the pronoun *"you"* (plural in Finnish) when he talks about women. Aki's outburst makes a strong reference to a quarrel at home before the group session; however, he uses the plural "you". The male therapist takes

part in discourse and by explicitly directing the accusation toward the female therapist invites her to take up the offered position as a representative of women in general. The female therapist tries especially to bring up the wife's point of view, but Aki maintains his stance.

Explicit positioning happened when the men were annoyed either about events at home or about a discussion with the female therapist during the session. Levelling explicit accusations was not common in the group discourses. Positioning the therapist as a representative of women in general was usually constructed more sensitively and indirectly than by talking about "you women".

Strange and Different Gender Biologically, Mentally, and in Their Needs

Women were seen as behaving unpredictably and unintelligibly because of their biology, especially because of their menstruation and hormonal changes. The female therapist became positioned in a positive way as a specialist on this topic because of her gender.

Extract 2 (I/6/64:30-)

MT: Do you think it's hard to understand women? (Laughing)
Janne: A bit like that.
MT: Strange things happen in a woman elsewhere too. (Laughing)
FT: Yeah, yeah (laughter) do women explain?
MT: It hasn't been possible to bring this up in the group in this way before.
FT: Do women take advantage of their periods? Do you get that impression?
Vesa: Dunno, many things are so incomprehensible. Women are so individual—one behaves oddly, another doesn't.
MT: Does this incomprehensibility create a distance? I would feel like that at least.
Vesa: Well yes, then relations tighten up.

Janne could not understand his girlfriend's behavior. She had later explained her behaviour as due to her having her period. In Extract 2 the male therapist joins in with the construction of women as acting strangely to make Vesa's point of view explicit. When the female therapist takes part in this discourse the male therapist notices the novelty of the situation. He invites the female therapist to join the discourse. The female therapist is offered a special position also by the group members in this discourse. Vesa individualizes the differences between women, but the male therapist continues by making a personal statement. The female therapist then starts to explain about the premenstrual syndrome. Both therapists take a personal position

in this discourse. Vesa explains his violence by reference to his spouse's odd behaviour, which causes tension between them.

Extract 3 (I/6/85:10-)

FT: When it comes to the men's menstrual cycle, observe yourselves now. Don't you experience any hormonal changes, not the same as we women have but, for example, being on edge. Our female hormonal functioning is a bit like over-advertised, I think.

(Silence)

MT: Do you think that it gives motives for many things?

FT: Well, yes.

(Silence)

FT: And then I thought I'd give you some relief from the nightmares that you have here too.

MT: Yes, and if someone is cross, there may be some other reason too.

Later in the same session the female therapist takes up the position offered as a biological woman, as one of "us". She uses the pronoun "you" (plural in Finnish) in addressing the men and adds herself to the group of women by speaking about "we". By making the men think about their own hormonal changes the female therapist is trying to lessen the gap between men and women. In this biological discourse the difference has increased. The group members did not take up the position offered them and kept silent. The male therapist was the only one to comment and support the idea put forward by the female therapist. The male therapist supports his co-worker's view here. Both therapists attempt to change the men's image of women as unpredictable and hard to understand. In the subsequent group sessions the topic was raised again but only one of the men started to notice hormonal changes in himself as well. However, this narrowed the gender gap compared to what it had been at the beginning of this discussion. Menstruation and women's hormonal changes during the course of a month were not discussed elsewhere in the data to the extent they were discussed in this group.

Men also constructed women as thinking differently than men. "Women's logic" was how the men designated women's peculiar way of thinking. The men referred to women's logic when their spouse had said or done something that they could not understand. When talking about women's logic some of the men started to apologize to the female therapist for what they had said. The same thing happened with the men's generalizing about women. The men started constructing a position for the female therapist as a watchdog for sexist speech in the group.

Extract 4 (V/2/79:20-)

Jaakko: So like the one who causes the violence, actually that person himself is afraid in that situation and this fear then causes fear in the other as well and, and then that person provokes back

so that both are afraid and one uses violence and the other her mouth in that situation. So that's women's logic (shows nagging with his hand). Sorry ((Looking at the FT with laughter)).

FT: An apology was called for (laughing). I'm fed up with hearing these stories about women's logic.

Jaakko: No, I didn't really mean that, but well somehow a man's logic is more the logic of action, you have to give vent to your feelings somewhere. When you realize that you take second place verbally, at least I do.

FT: Do you feel like that?

Jaakko: That I got totally jerked in that situation. And it starts to make me furious that damn it I have the means, I'm not gonna take second place to women, again I'm being jerked, that what is this. Doesn't a man have right to be angry?

MT: Is there a difference between being angry and being violent?

Jaakko: Yes of course there is. You can be angry and you should be but you mustn't cross the line to being violent in your behavior.

MT: So the answer to the question whether a man may be angry is yes.

Jaakko: Yes, yes but you mustn't lift your hand against anyone. For example I should have said yesterday that now I'm really pissed off 'cause of what you said. That I'm angry, but I couldn't say that.

In Group V one of the men has proposed that a man's spouse provokes a man into behaving violently. Extract 4 shows how Jaakko takes this idea further and suggests a man reacts physically with violence and a woman with her words. This is what Jaakko designates women's logic. He realizes that this demeans women and apologises for using this expression to the female therapist whom he positions as representing the female gender. Here the female therapist reacts by conceding that an apology was in order and by doing so accepts the position offered as a representative of the female gender and as a woman personally. After that the conversation turns to power issues and the male therapist points out the difference between feeling angry and being violent. Because the female therapist's presence halts Jaakko's attempts to justify violence, he has to start giving reasons for his statements.

Sensitivity toward the female therapist was not always a rule in the group discussions. The female therapist also reacted to the men's comments herself without a specific invitation to represent her gender. As the data show, differences between men and women were often introduced into the discussion.

Extract 5 (III/6/50:30-)

Eero: ((Eero has read that men and women are built differently)) A man has basic needs that should be satisfied—respect from the wife,

sex, and so on. A woman has different needs, such as tenderness, a desire to nurture.

FT: At least I say as a woman that it sounds very sexist to think like that. That someone would deny that I for example have similar sexual needs to some man, or different sexual needs. It sounds very sexist to divide men and women according to different needs.

Eero: I don't, I've read somewhere, not that, that all women should be categorized under the same label. Everyone is an individual.

MT: I'd like to steer the discussion into the direction, whether you as men have different standards from those surrounding you? Do the expectations of being the head of the family and so on come from outside?

Eero: It's not difficult to say that I do cleaning at home. It came into my mind when you said the head of the family. One of women's basic needs it to experience security.

FT: I see, and men don't have this?

Eero: Yes they have but it creates security for women if the man is the head of the family, like in balance. In the end the man takes responsibility of the decisions that are made together. That creates security for his wife and children.

MT: Last time we spoke about insecurity in a relationship. It went quite differently. You were afraid of losing your spouses.

In Extract 5 the female therapist reacts to Eero's statement about gender differences in sexual needs. The female therapist positions herself as a representative of the class of women and judges Eero's comment as sexist. She takes a personal position and denies differences in sexual needs between the genders. This confuses Eero and he tries to be conciliatory. The male therapist tries to go back to discussing cultural standards but Eero sticks to his argument and starts to argue for different needs concerning security. The male therapist shifts the discussion from general level to the personal level on the topic of security and reminds the men that previously they have been talking about feeling insecure and fear of losing their partner.

Representative of the Spouses

The female therapist assumed the spouses' point of view in discussions of gender differences. She was directly invited to represent the point of view of the men's spouses: in other words, wives and girlfriends. This was done especially when there was a reference to spouses' feeling of fear.

Extract 6 (V/1/74:30-)

MT: Is Liisa ((spouse)) afraid of you nowadays? ((FT tries to say something here too))

Jarno: What if I ask her (points at FT with his hand). Would you be afraid of me, of what you've been listening to now, what I've been telling you.
FT: Yes I'd be afraid, I was just about to say that it must have been quite a scary situation for Liisa, the kind of, when you described that, that you've pulled her up by her hair and called her names in a certain way. What you said 'look at yourself now slut,' it must have been quite a humiliating and scary situation.
Jarno: Yeah, certainly it doesn't go away in a couple of months.

When talking about fear in Group V, the male therapist asks Jarno whether his girlfriend is still afraid of him. Jarno passes the question to the female therapist and asks her whether she personally would be afraid of him after hearing about his violence. In this example Jarno is explicitly offering the female therapist a position as a fearful girlfriend. The female therapist accepts the position and offers the spouses' perspective.

Representing Herself Personally

The female therapist was positioned as weak, "a potential" man-hater, and was invited to give her point of view not only as a representative of women in general or as a specific woman, but also as a person in the group meetings. The men constructed their discourses in such a way that the female therapist was strongly offered gendered positions she would have to take up personally as a woman. Erotic or sexualized positions were also strongly constructed for the female therapist in the groups for male batterers.

Weak or a Man-Hater

At times the men regarded the female therapist's gender sensitively and protectively. It was seen possible that discussing a topic like intimate partner violence might harm her personal life.

Extract 7 (II/10/95:00-)
FT: I'm really interested in that do you think that you don't need to worry about Matti ((MT)) even though he always hears the same things as I do, and you have to be worried about me?
Kalle: You are weaker.
FT: In what way am I weaker?
Kalle: In your strength, in a way, I don't know.
FT: If I'm physically . . .
Kalle: Then you can be mentally stronger, okay I admit that.
FT: If I'm physically weaker does it mean that I'm also mentally weaker?
Kalle: No, no.

MT: It came into my mind that they are afraid that you'll start to hate men.
(Lots of overlapping speech)
FT: Apparently this was the right interpretation as everyone woke up.

The female therapist brings up her curiosity as to why the men are not afraid the group discussions might harm the male therapist too instead of only her. She does not accept being positioned as a weak person and contests the generalization. The male therapist suggests that the men might be afraid that the female therapist will start to hate men, become a man-hater. Later in the session the female therapist repositioned herself as a professional, not solely as a representative of female gender in the group.

Extract 8 (II/10/95:00-)
FT: May I say here at the end, that when, as a woman, one listens to violence, it cannot leave you unaffected, or anyone. Of course it's a tough topic. Anyhow I consider myself a professional, who can think about these things in her mind. It's pleasing and good that you're worried about me as a woman, because then I can assume you're worried about other women as well and don't want to be violent towards them. If through me you can think how it might feel.

The female therapist is pleased that the men are worried about her as a woman as it can be inferred from this that they are concerned about other women as well and do not want to hurt them.

Sexual Partner or Object

The female therapist was also positioned as a possible sexual partner. This occurred not only on the level of speech but also physically and it reached outside the group setting too. Sexualized positions were constructed in every group but the first. The men talked about charming women and referred to the female therapist as an example of such a focus of conquest, but also as a possible dating partner.

Extract 9 (II/9/67:36-)
Pasi ((to FT)): I should ask you, since we've been here, that if we were a little younger and handsome, would you dare to start dating any of us?
FT: Well that's a good question.
Kalle: But we are still handsome, right.
FT: It's a good question really. Sometimes when one listens to those stories of yours, one can understand why for example Kaija ((Pasi's spouse)) has been afraid or, Kalle,

your ex-girlfriend. I would think about whether I would dare.
Kalle: Fairly well said.
MT: So it's not so sure at all that you would dare?
FT: I'm not sure, I would surely think that.
Kalle: But you have education, right. You could train the man. (Laughing)
FT: Is that what you think?
Kalle: Yeah, but it's a good question really.
FT: I would think about whether I'd dare.
Esa: I have a friend who has just left her ex-husband because he's been violent.

The female therapist was positioned as a possible dating partner. The female therapist responds by putting herself in the men's spouses' position and raises the issue of fear and then falls back on her personal position by saying that she would be afraid. The male therapist highlights the issue of fear in his comment. Kalle's solution is that he offers the female therapist a position different from that occupied by the kind of women who would be afraid because of her education. This positioning enables him subsequently to position the female therapist as a possible dating partner.

The female therapist also became a target for a physical approach and the exercise of charm. One of the men asked if he could hug the female therapist at the end of the session. After another group the female therapist was given a bucket of flowers which can be interpreted as attempting to charm her as a woman, as the male therapist was not approached in this way.

One of the men in Group V approached the female therapist outside the group sessions by means of a SMS message. This approach was taken up for discussion in the group.

Extract 10 (V/9/61:00-)

Jaakko: I can tell you, I sent Maija ((FT)) an SMS. What do you think about it?
FT: Can you tell us what the message contained?
Jaakko: I asked if we could meet outside the group, that it would be nice to chat. And Maija answered that it's inappropriate. I thought you would either answer or not.
FT: What was the idea behind that?
Jaakko: That we could chat and so on.
MT: Was that the whole message?
FT: There was also the bit that if I'm like single, so it was also aimed at me personally as a woman. So it had a somewhat different content than you are telling us now.
Jaakko: Well, it was.

MT: For me it would have meant that if you had met, someone's coming to the group, possibly Maija's would have been impossible.
FT: Would have changed from an equal leader to a dating partner. What were you thinking when you broke this kind of a basic rule?
Jaakko: Weakness, as it's been so tough.
FT: From my point of view it included belittling as a group leader as I was approached as a woman. I work here, so it was offensive to me personally.
Jaakko: I apologize and can quit the group if need be.
MT: It's not about that, what's interesting is how handling this now affects things, and what would have happened if the date had occurred.

The female therapist brought up the topic. Jaakko did not disclose the whole SMS message. The female therapist explains that she was positioned as a possible dating partner by Jaakko's message. She explained that she felt undervalued and offended. She rejected the offered position by repositioning herself as an employee. The male therapist supports his co-worker in her re-positioning and setting boundaries for the group sessions.

DISCUSSION

It has been argued that because intimate partner violence is a gendered issue the gender of the therapist may play a part in its treatment (Tyagi, 2006). In this article the authors studied this qualitatively by paying attention to the positions constructed for a female therapist in groups for male batterers. The results support this view, although this positioning had both positive and negative aspects.

The gendered positions offered to the female therapist were based primarily on constructed gender differences. These specific positions are available in traditional gendered discourses (Hollway, 1984). The female therapist was positioned to represent biologically, logically, and in its needs a different gender. This is in accordance with the findings of Kapanen (2005) and Holma et al. (2006) that batterers see women negatively in many ways, especially at the beginning of group treatment. Kapanen found that batterers construct women as different from men, as oddly behaving and hard to understand. The female therapist was positioned as such a woman in this study. The female therapist was considered weaker than men, who were constructed as strong. Difference on the personal level was also constructed when the female therapist was sexualized in the group sessions or even outside them. These results are in accordance with the

view that man and masculinity are constructed on the basis of difference to the female gender (Boonzeier & de la Rey, 2004; Skeggs, 1993) or difference to an 'other' (de Beauvoir, 1970). Constructing women as different and impossible to understand is also one way of justifying violence against them (Holma et al., 2006). Sexualization in therapeutic relationships has been studied as transference, especially within psychoanalytic approaches (Deering & Gannon, 2005; Gornick, 1986; Koo, 2001; Potash, 1998; Russ, 1993). Men may feel unaccustomed to self-disclosure and to feel in control they may objectify their female therapist and relate to her as a girlfriend or a lover.

Being positioned as different, as an 'other' and according to the constructions the batterers had of women presented a challenge for the female therapist. The female therapist had to try to balance between the different expectations and conflicting positions constructed for her. *S*ometimes the positions offered also changed very quickly. The variety of positions offered to her as a woman were also an advantage to the female therapist. When offered gendered positions, the female therapist was able to reject them by re-positioning herself. This shows that positions are dynamic and allow persons to move between them (Davies & Harré, 1990). She was able to re-position herself in the discourses and change a storyline that sought to create a difference between men and women and that reproduced the men's constructions of women. The therapists' goal seemed to be to challenge the differences constructed between the genders and generate attitudinal change toward women. When invited to represent women in general or herself personally the female therapist often took the spouses' perspective to render visible the fear the violence had caused. When the men engaged in sexist discourse the female therapist positioned herself as a representative of women in general, as a spouse, or as a person. She also repositioned herself as a professional group facilitator to remind the group members that she was not present solely as a representative of the class of women, thus reminding the group of the rules.

Repositioning is a useful and functional means for a female therapist in seeking to change the discourses and attitudes of male batterers and narrow the difference constructed between the genders and render visible the fear experienced by spouses. It has been stated that maintaining stereotypical images of men and women that correspond to the values of hegemonic masculinity is in part to legitimize the position of power that men hold in society (Adams, Towns, & Gavey, 1995). Change toward more positive attitudes to women has been connected with striving at a nonviolent relationship with one's partner (Schmidt et al. 2007). Kapanen (2005; Holma et al., 2006) describes the more positive constructions of women that emerge toward the end of batterers' group treatment.

The results of this study are in line with the literature on the challenges that face the work of a female therapist in male batterers' groups. Caoyette

(1999), Potash (1998) and Tyagi (2006) have noticed that a female therapist has to uphold the boundaries set for the group members as they are likely to try to break them. In this study the female therapist was especially vulnerable to sexualized positioning and possible rule-breaking. Because of her gender, finding a balance between an empathetic and a challenging approach may also be difficult, as she is easily judged as either weak or a man-hater (Caoyette, 1999). Invitations to defensive positions were the most challenging in this respect.

The male therapist took different positions in the discourses where his co-worker was variously positioned as a woman. He took part in the position construction by explicitly directing the men's invitations to the female therapist and asking her to respond as invited. He invited his co-worker to take up a special position by initiating discussion about her being in the group. The male therapist often brought up her gender as an issue in the group sessions. On the other hand, the male therapist supported the female therapist in difficult situations. For example, he showed his agreement with his co-worker or tried to lead the conversation away from a general level toward the situations in the men's own lives, often in heated discussions. The male therapist was also able to use the positions offered to his colleague. He could bring up the female therapist's dual position as a leader and a woman. He was able to discuss and emphasize the positions taken up by the female therapist that reduced the gender gap. Gendered positioning led to co-operation between the therapists. It was noticeable in this data that a good relationship and co-operation between the therapists is very important in leading male batterers' groups, as has also been noted in earlier research (Adams & Cayouette, 2002; Austin & Dankwort, 1999; Caoyette, 1999; Dominelli, 1999; Tyagi, 2006; Wilson, 1996).

For a practicing female therapist it may be challenging to cope with the expectations she is confronted with, especially if she is working alone. The positions offered her can negatively affect a female therapist's empathetic understanding. She may adopt a too challenging position, which widens the gender gap and promotes even more rigid attitudes toward women. Understanding the phenomenon of intimate partner violence can make it easier to tolerate the men's behavior in the therapy situation (Banks, 2008). Therefore therapists, both female and male, should be given enough education and support by their organization, and taking into account the relationship between co-workers, especially their personal gender attitudes and how these effect their co-operation.

To enable the reader to gain familiarity with the application of the theory and to judge the reliability of the study, the research process is described in detail and the results of the study are represented with illustrative and authentic extracts from the data. This kind of thick description was used to gain transferability. In this way the voices of the participants and not only that of the researcher are heard. The limitations of this study include the

lack of research triangulation and possible researcher subjectivity, which is a known characteristic of qualitative investigations. It must also be borne in mind that qualitative research aims at understanding and representing social phenomena, not making generalizations. Nevertheless, it can be assumed that the results from five different groups can also be transferred to processes in other batterers' programs. While the lack of researcher and method triangulation can be seen as a weakness of this study, credibility and dependability of the analysis was improved by keeping research diary and peer debriefing. The trustworthiness of the results was also strengthened by prolonged engagement with the analysis and persistent observation of the data.

In this study the concepts of woman and man have been used dichotomously, as the men in the groups use them. It is worth emphasizing women and men are not all the same. Other demographic characteristics, like race, age, or status may also affect the interactions in groups like these. There were differences between and within the groups. Some men, more than some others, invited the female therapist to take up a position as a woman. Also, some positions were more prevalent in certain groups. However, this study did not set out to compare the men or groups. Further research is needed to explore how, for example, one man's constructions of the female therapist changed during the group process and how the repositioning of the female therapist functioned in that process. This proposed study might yield new understanding about the treatment process and the position of a female therapist in it. The change in the positions offered may reflect the change observed in the man's attitudes toward women and the development of his new masculine identity.

The therapists' experience and actions would also merit further study. Leading a batterers' group is unproblematic for neither a female nor a male therapist. It would be important to know more about the role played by the gender of therapists in batterers' group treatment so that it could be used to assist and not hinder treatment. Studying the processes from the point of view both of male and female therapists could give useful information on how to support them and develop their work. This study supports the model of having a female leader in male batterers' group treatments.

REFERENCES

Adams D., & Cayouette S. (2002). Emerge: A group education model for abusers. In E. Aldarondo and F. Mederos (Eds.), *Programs for men who batter: Intervention and prevention strategies in a diverse society* (pp. 1–25). New York, NY: Civic Research.

Adams, P. J., Towns, A., & Gavey, N. (1995). Dominance and entitlement: The rhetoric men use to discuss their violence towards women. *Discourse and Society, 6*, 387–406.

Austin, B. A., & Dankwort, J. (1999). Standards for batterer programs: A review and analysis. *Journal of Interpersonal Violence*, *14*, 152–168.

Babcock, J. C., Canady, B. E., Graham, K., & Schart, L. (2007). The evolution of battering interventions: From the dark ages into the scientific age. In J. Hamel and T. L. Nicholls (Eds.), *Family interventions in domestic violence* (pp. 215–244). New York, NY: Springer.

Banks, G. L. (2008). *Taking the bait: Countertransference among female clinicians who work with men who batter*. Smith College School for Social Work Northampton, Massachusetts.

Blow, A. J., Timm, T. M., & Cox, R. (2008). The role of the therapist in therapeutic change: Does therapist gender matter? *Journal of Feminist Family Therapy*, *20*, 66–86.

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, *33*, 298–317.

Boonzaier, F., & de la Rey, C. (2004). Woman Abuse: The Construction of Gender in Women and Men's Narratives of Violence. *South African Journal of Psychology*, *34*, 443–463.

Bowman, D., Scogin, F., Floyd, M., & McKendree–Smith, N. (2001). Psychotherapy length of stay and outcome: A meta–analysis of the effect of therapist sex. *Psychotherapy*, *38*, 142–148.

Caoyette, S. (1999). Safety issues for women co-facilitating groups for violent men. In J. Wild (Ed.), *Working with men for change* (pp. 153–165). London: Routledge.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal of the Theory of Social Behaviour*, *20*, 43–63.

de Beauvoir, S. (1970). *The second sex*. New York, NY: Random House, Vintage Books.

Deering, C. G., & Gannon, E. J. (2005). Gender and psychotherapy with traditional men. *American Journal of Psychotherapy*, *59*, 351–360.

Dinger, U., Stack, M., Leichsenring, F., Wilmers, F., & Schauenburg, H. (2008). Therapist effects on outcome and alliance in inpatient psychotherapy. *Journal of Clinical Psychology*, *64*, 344–354.

Dominelli, L. (1999). Working with men from a feminist perspective. In. J. Wild (Ed.), *Working with men for change* (pp. 17–38). London: Routledge.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory. Strategies for qualitative research*. Chicago, IL: Aldine Publishing Company.

Gornick, L. K. (1986). Developing a new narrative: The woman therapist and the male patient. *Psychoanalytic Psychology*, *5*, 299–325.

Harré, R., & Moghaddam, F. (2003). Introduction: The self and others in traditional psychology and in positioning theory. In R. Harré and F. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political, and cultural contexts* (pp. 1–11). Westport, CT: Praeger.

Harré, R., & van Langenhove, L. (1991). Varieties of positioning. *Journal of the Theory of Social Behaviour*, *21*, 393–407.

Holma, J., Partanen, T., Wahlström, J., Laitila, A., & Seikkula, J. (2006). Narratives and discourses in groups for male batterers. In M. Libshitz (Ed.), *Domestic violence and its reverberations* (pp. 59–83). New York, NY: Nova Science.

Hollway, W. (1984). Gender difference and the production of subjectivity. In: J. Henriques, W. Hollway, C. Urwin, C. Venn and V. Walkerdine (Eds.), *Changing the subject: Psychology, social regulation and subjectivity* (pp. 227–263). London: Routledge.

Kapanen, K. (2005). Naiskuvat miesten puheessa [Discoursive constructions of women]. In J. M. Holma and J. Wahlström (Eds.), *Iskuryhmä. Miesten puhetta Vaihtoehto väkivallalle –ryhmissä* [Discourses in groups for male batterers] (pp. 71–89). Helsinki, Finland: Helsinki University Press.

Koo, M. B. (2001). Erotized transference in the male patient–female therapist dyad. *The Journal of Psychotherapy Practice and Research*, *10*, 28–36.

Long, D. (1987). Working with men who batter. In M. Scher, M. Stevens, G. Good and G. A. Eichenfield (Eds.), *Handbook of counselling and psychotherapy with men* (pp. 305–320), Thousand Oaks, CA: Sage.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology*, *62*, 1157–1172.

Orme, J., Dominelli, L., & Mullender, A. (2000). Working with violent men from a feminist social work perspective. *International Social Work*. *43*, 89–105.

Partanen, T. (2008). *Interaction and therapeutic interventions in treatment groups for intimately violent men*. Jyväskylä Studies in Education, Psychology and Social Work, 332. Jyväskylä, Finland: Jyväskylä University Printing House.

Partanen, T., & Wahlström, J. (2003). The dilemma of victim positioning in group therapy for male perpetrators of domestic violence. In C. Hall, K. Juhila, N. Parton and T. Pösö (Eds.), *Constructing clienthood in socialwork and human services. Interaction, identities and practices* (pp. 129–144). London and NewYork: Jessica Kingsley.

Payne, S. (2007). Grounded theory. In E. Lyons and A. Coyle (Eds.), *Analysing Qualitative Data in Psychology* (pp. 65–86). London: Sage.

Potash, M. S. (1998). When women treat men: Female therapists / male patients. In W. S. Pollack and R. F Levant (Eds.), *New Psychotherapy for Men* (pp. 282–307). New York, NY: John Wiley.

Raakil, M. (2002). A Norwegian integrative model for the treatment of men who batter. *Family Violence & Sexual Assault Bulletin*, *18*, 8–14.

Russ, H. (1993). Erotic transference through countertransference: The female therapist and the male patient. *Psychoanalytic Psychology*, *10*, 393–406.

Skeggs, B. (1993). Theorizing masculinity. In P. Ahokas, M. Lahti and M. Sihvonen (Eds.), *Mieheyden tiellä. Maskuliinisuus ja kulttuuri* [On a way of masculinity. Masculinity and Culture] (pp. 13–35). Jyväskylä: University of Jyväskylä, Research Centre for Contemporary Culture.

Schmidt, M., Kolodinsky, J., Carsten, G., Schmidt, F., Larson, M., & MacLachlan, C. (2007). Short term change in attitude and motivating factors to change abusive behaviour of male batterers after participating in group intervention program based on feminist and cognitive-behavioural approach. *Journal of Family Violence*, *22*, 91–100.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Tan, S., & Moghaddam, F. M. (1999). Positioning in intergroup relations. In R. Harré and L. van Langenhove (Eds.), *Positioning Theory* (pp. 178–194). Oxford, UK: Blackwell.

Tyagi, S. V. (2006). Female counselors and male perpetrators of violence against women. *Women & Therapy*, *29*, 23–44.

Wilson, M. (1996). The CHANGE men's programme. In K. Cavanagh and V. Cree (Eds.), *Working with men. Feminism and Social work* (pp. 28–44). London: Routledge.

Wood, L. A., & Kroger, R. O. (2000). *Doing discourse analysis. Methods for studying action in talk and text*. Thousand Oaks, CA: Sage.

II

DOMINANT STORY, POWER AND POSITIONING

by

Helena Päivinen & Juha Holma, 2016

In

M. Borcsa & P. Rober (Eds.) (2016), *Research perspectives in couple therapy: Discursive qualitative methods* (pp. 89–104). Cham: Springer.

Chapter 7
Dominant Story, Power, and Positioning

Helena Päivinen and Juha Holma

From a narrative perspective, how we understand our life, experience, and problems is shaped and defined by cultural discourses (Dickerson & Crocket, 2010; White & Epston, 1990; Winslade, 2005). In these cultural discourses, power is also present, as these discourses constitute our "truths" and normality (Foucault, 1977). Love relationships are also embedded in these discourses. In psychotherapy, what constitutes normality and truth in love relationships is constructed via discursive practices. These psychotherapy discourses in turn are affected by larger cultural discourses.

Narrative psychotherapy research has been conducted from a wide variety of approaches and has focused mainly on client micro-narratives (Avdi & Georgaca, 2007b). Along with Avdi and Georgaca (2007b), we see a need for narrative studies that acknowledge the broader sociocultural processes involved in narrative production and transformation. In this study, we look at narratives from one such broader, discursive perspective. The analytic tools that we have chosen allow us to place the stories that are constructed in psychotherapy within these larger cultural discourses. We investigate how dominant stories are constructed in couple therapy sessions in the interaction between the participants, including the therapists. We study how participants in couple therapy construct and reconstruct their positions and focus on the resulting distribution of power or the rights and duties that these positions entail. We are also interested in the way people make changes in identity by differently positioning themselves and others (Winslade, 2005).

H. Päivinen (✉) • J. Holma
Department of Psychology, University of Jyväskylä, Jyväskylä, Finland
e-mail: helena.paivinen@jyu.fi

M. Borcsa, P. Rober (eds.), *Research Perspectives in Couple Therapy*,
DOI 10.1007/978-3-319-23306-2_7

Review of the Literature

Narrative Approach and Dominant Story

The narrative approach postulates that a narrative or story offers a frame in which lived experience is structured. It is in stories that we situate our experience and give meaning to our experience. A narrative or a story has a beginning, middle, and an ending as well as a plot that holds the story together (Sarbin, 1986). Stories enable persons to join aspects of their experience through the dimension of time (White & Epston, 1990). In this way, the world and they themselves become coherent, which invests life with a sense of continuity and meaning. Thus, stories are constitutive and shape our lives and relationships.

The stories people tell about their lives reflect the prevailing cultural narratives (Bruner, 1987, 1991). During these tellings, some stories become dominant while others become silenced (McLeod, 2004). These storied dominant narratives reflect the culturally dominant discourses and values in the teller's society (Hare-Mustin, 1994; McLeod & Lynch, 2000) and therefore often seem to be appropriate and relevant when we want to express our experience (White & Epston, 1990).

Nevertheless, a story, even a dominant one, can only partly cover the individual's lived experience (Bruner, 1986). When the dominant story does not sufficiently represent the individual's lived experience or when there is contradiction between the dominant story and the lived experience, the person may experience unease, and seek therapy (White & Epston, 1990). Getting stuck with problematic stories has been seen to affect relationship problems (Rosen & Lang, 2005; Sween, 2003; Zimmerman & Dickerson, 1993). In their paper, Sinclair and Monk (2004) illustrate how couple conflicts can be approached discursively in couple therapy; this, according to them, leads to a more open and less blame-attributing therapy practice.

Power in Psychotherapy

Cultural discourses are present in forming the stories narrated about and the positions taken in love relationships. Feminist family therapists argue that owing to patriarchal discourse there is always an imbalance of power in heterosexual relationships (Dickerson, 2013). However, at least in our Western culture equity between the partners is usually a premise in love relationships and in couple therapy. Others have approached inequality in heterosexual couples by concentrating on mutuality for which, they argue, cultural discourses are not properly established (Knudson-Martin, 2013; Knudson-Martin & Huenergardt, 2010).

According to Foucault (1977), power works in psychotherapy and other psychological domains through taking people's minds as objects of professional knowledge. It is argued that therapists are participants of a specific kind, as their institutional position offers them more influence and significance than the family members

(Guilfoyle, 2001). The cultural and psychological discourses that are used in meaning making in psychotherapy are limited to those that are familiar to client and therapist (Hare-Mustin, 1994; Parker, 1998). If therapists are not aware of their position and the possible oppressive nature of the cultural discourses that are drawn on, there is a risk that social injustice and oppression will be reproduced in the therapy room (Dickerson, 2013; Hare-Mustin, 1994).

Discourse Analysis and Positioning

There are significant differences within the discourse analysis tradition (Avdi & Georgaca, 2007a; Parker, 2013; Potter, 2004). However, what these approaches share is their interest in the use of language in discourse. Discourse is seen as active and purposive in constructing realities. Parker (2013) states that discourse analysis should not be conducted by strictly following certain methodological steps. Instead, new ways of combining analytical tools should be devised. In this present study, we use the concepts of position and positioning as our main discourse analytic tools. Positioning can be described as the discursive process in which people are given parts or are assigned locations in the discourse (Davies & Harré, 1990; Hollway, 1984). Position is a central concept in studying discourse (Sinclair, 2007). It has particular value in studying the detail of how discourse operates in the production of relationships (Winslade, 2005) and in the changing responsibilities and interactive involvements of the members of a community (Linehan & McCarthy, 2000).

Positioning occurs within the context of a specific moral order of speaking (Harré & van Langenhove, 1991; Chap. 10) and, as well as reflecting cultural discourses, these local stories also reflect the positions embedded in these discourses. The concept "position" focuses on the dynamic aspects of encounters (Davies & Harré, 1990). Positions change and shift as we draw from the various cultural discourses available. Positioning can also be resisted, which also changes the discourse. Furthermore, a change of positioning, and hence in the discourse, can be accomplished by repositioning: taking up or offering another new position.

Positions are always relational (Harré & Moghaddam, 2003; Hollway, 1984; Winslade, 2005). This means that the act of positioning someone in a discourse inevitably entails positioning the other participants relative to that initial positioning. In our analysis, we use the term "counter position" to refer to these entailed positionings to highlight the relational nature of positioning. Positioning may be explicit or implicit. Explicit positioning refers to deliberately constructing certain uttered positions while implicit positioning occurs when positions are taken for granted and thus they are not uttered as explicitly. In either case, positions set the limits of what are considered socially and logically possible actions in the discourse (Harré & Moghaddam, 2003; Hollway, 1984). In other words, one's position defines one's rights, duties, and obligations and thus the distribution of power between the participants in a discourse.

Data Analysis and Method

In this present study, we analyze the course of four therapy sessions attended by Victoria and Alfonso, a young, multicultural couple. We focus on how dominant stories are constructed in these sessions and how power is distributed in the positions entailed by these dominant stories. Our analysis started with multiple readings through the transcribed therapy sessions. Next, a narrative approach was used to organize the experience of the clients into stories. Our units of analysis were the dominant stories constructed in the therapy discourse. A dominant story was identified as a narrative that was accepted by all the other participants in the therapy session. That means none of the others participating in the conversation criticized that particular narrative. The dominant stories were identified and marked in the transcripts. The evolution of these dominant stories and new emerging stories was followed throughout the therapy process. The stories identified as dominant were studied using positioning as a discursive tool of analysis. We looked at what kinds of positions were constructed for the clients and what kinds of power aspects were entailed by these positions.

Findings

We illustrate the construction of each dominant story as it evolved in the couple therapy sessions. The findings are presented with selected data extracts in which the story construction and the positioning in each dominant story become explicit.

Session 1

Dominant Story 1

At the outset of the therapy session, Victoria relates how in the past she was depressed and how this greatly affected their relationship. At that time, Alfonso was a caregiver, supportive, and understanding towards Victoria. Now, the couple see that the situation has changed. Victoria says she is feeling better but that she still has a strong need to talk. Alfonso says he does not have the patience to listen like he used to when Victoria was depressed.

Extract 1

Session 1, turns 18–22

18 A But then I think that I, somehow I react too strongly like if it would be something bigger

19 T So you are saying that meanwhile Victoria was down you could support her but now when things are better, in some way,}

20 A Yeah, now if there is something small maybe that somehow I feel I kind of get like how'd you say aaa irr}
21 A } Irritated? Yeah?
22 V } Like he's afraid that every time I need to talk about something, something a bit negative or whatever that it will get again to this kind of awful situation where I am crying in bed for 2 days like that, kind of, he doesn't believe kind of that that I'm better and that I I'm able to talk about things and that I really need to talk about things.

Victoria positions herself as free talker and by this act she constructs for Alfonso the counter position of being a patient listener. Alfonso is not satisfied with this position but becomes irritated when Victoria wishes to talk about something. Victoria relabels Alfonso's emotion fear and emphasizes that there is no reason to be afraid, since she is strong enough to talk about things without collapsing. In this way Victoria constructs her behavior as unproblematic. The relabeled emotion fear is later accepted by Alfonso himself and by the therapist. The current problem is constructed as Alfonso being afraid and not able to talk but instead reacting with panic and anxiety when Victoria starts a conversation on certain topics. This leads the couple to quarrel.

Victoria and Alfonso validate their positions by reference to their needs. Alfonso needs to rest and Victoria needs to talk.

Extract 2

Session 1, turns 74–80

74 A } I think it can be because like, I, somehow now maybe now that she got better, so somehow I have used a lot of, let's say energy, maybe I kind of feel now that, [Laughter] I kind of need a rest
75 T You need a rest, yeah
76 A I think somehow, I mean that's the explanation that I
77 T You have used so much energy that now you need rest
78 A Yeah, I think, like I would need … some positive experience, like that if for some time there wouldn't be this kind of discussion, then maybe we could then (.) get like normal
79 T Yeah
80 V but this is difficult because in a relationship there has to be talking about things if there is anything that bothers me I need to share it, I need to talk about it but since that's impossible

Extract 3

Session 1, turns 91–93

91 T And how have you tried to solve this problem?
92 V We have been talking about it like we both know the situation like, we know why is it like this and we think that time would make it better but the problem seems to be that, as long as we can't talk how can anything get better? There is always something in a relationship that you need to talk about, but then we we can't, it always gets like the same, he feels bad, then I get very frustrated and I start feeling more bad, it's like, never ending
93 T Mm have you ever managed to have a good talk that you both liked (V: yes) during the last half a year?

Alfonso positions himself as exhausted, a person in need of rest because his earlier position as caregiver has demanded a lot of energy. By positioning himself in this way, he constructs for Victoria the counter position of a sympathizer, which Victoria has not taken up, as she is not giving Alfonso a positive discursive experience without arguing. Victoria strongly repositions herself as a free talker. This position is no longer explained as a result of depression but as part of a normal relationship. Victoria here refers to a cultural discourse on what constitutes a normal love relationship: "there has to be talking." She also constructs her emotions as something one has to deal with by sharing and talking.

Alfonso's new positioning and the story he refers to are not accepted by Victoria. Instead, the normality that is constructed reflects the cultural discourse that talking is important in love relationships. This discourse prescribes to the couple the positions of a free talker and a patient listener. In Victoria and Alfonso's relationship this means that Victoria talks and Alfonso listens. Thus, Alfonso's inability to talk is constructed as problematic. This problem formulation also fits in with culturally shared discourse of psychotherapy as a talking cure where the participants share and reveal their thoughts and feelings.

The therapist supports Alfonso in constructing his story about the situation. However, later the therapist accepts the formulation of the problem according to the dominant story constructed by Victoria by asking how the couple have tried to solve the problem, as well as the implied cultural discourse by asking whether they have ever managed to have a good talk. Later, when the therapist asks Alfonso's opinion, Alfonso shares this problem formulation and accepts the dominant story. Alfonso would like to be able to listen but says that he does not decide to react in the way he does. The dominant story that in a good love relationship you have to share your experiences and feelings with your partner is now constructed and shared, although it assigns Alfonso the position of a listener, which he is not satisfied with.

Dominant Story 2

In the first therapy session, another dominant story also emerges. Alfonso's visits to his home country create a problem for the couple. Victoria says that she feels that they are not a couple when Alfonso is abroad visiting his family. Victoria has been asking Alfonso to contact her every day when he is away so that she would know that he is thinking of her.

Extract 4

Session 1, turns 133–138

133 V	… I think that the relationship should be, the most important thing in your life or at least one of the most important things
134 T	Yes
135 V	I think it should be the number one because otherwise what's the point

136 T Mmmm
137 V And, somehow, I feel like that, still when he is there alone, I feel like, I'm also very alone I feel like kind of like we're not together while the time he's there, I would need something like one text message like per day sent without my me asking for it, but he doesn't need that, he doesn't need to contact me, like
138 A Well I

Victoria validates her request for messages by pointing out that the love relationship should take first priority in one's life. Here she reflects a cultural discourse about the special value attached to a love relationship. The therapist signals agreement with this cultural discourse. Victoria says the relationship is the most important thing for her, but not for Alfonso. By this utterance she positions herself as a fully committed partner in their relationship and Alfonso in the counter position of an uncommitted partner.

Extract 5

Session 1, turns 140

140 A Yes for me just that, for the thing that I'm there just a few, few weeks per year and in (home country) it's not like this, there's all the family and there's many people that you always have to go to see and to meet, to meet your friends or, so when I'm there I'm really just busy and anyway at the end I always like manage to send a message or to call

Alfonso tries to resist this counter positioning as an uncommitted partner by referring to his other obligations when visiting his family. He says that being in his home country is different and he is busy there. When talking about his visits to his home country, Alfonso refers to a cultural discourse related to the concept of family relationships and their value. In his home country, one's relationships with one's family members are very important. Alfonso repositions himself as a son of his family of origin and also as a committed partner, stating that he does want to keep in contact with Victoria, and that he does in fact do this. The repositioning he proposes is not accepted by other participants in the therapy session; neither by Victoria nor by the therapists. Victoria sticks to her story and the therapists do not actively take part in the story construction at this point. The discussion continues with Victoria positioned as a committed and Alfonso as an uncommitted partner in their relationship.

The division of rights and duties becomes explicit over the session and is illustrated in the following extract.

Extract 6

Session 1, turns 203–206

203 T and what about if you are the first one sending sms saying 'hello how are you?'
204 V Yes that's fine yeah but but mostly because we always have to talk about this thing I feel I have to kind of see if he does it or not
205 T Uhuh can you say something more about why, why is this?
206 V Kind of like testing or something

Victoria says she is testing Alfonso to know whether he is thinking of her. From her position as a committed partner Victoria has the right to ask for proof of this kind. From the counter position of an uncommitted partner, Alfonso has the duty to prove his commitment, which Victoria sees as uncertain.

Session 2

Dominant Story 2

In the second session, there is a return to dominant story 2. Alfonso's visits to his home country are discussed, as Alfonso will be going there soon. Alfonso is planning to send Victoria text messages just as she has asked him to. He asks for Victoria's understanding if for some reason he is unable to send her a message.

Extract 7

Session 2, turns 162–163

162 A	no, I told you that, I can send you like I told you, and there are like a week, if there is during this week one day, even if we call, for one day maybe, it can be that or maybe not, it can be that (.) I am really busy (.) I can like do it, I can send you message I can do this, but if for one day it will happens once, like that maybe I can't send you a message (.) once (.) I don't, maybe if you try to understand a little, it can just happen
163 V	Yeah, I try (.) I just think that it is quite easy thing to do, if you want to

Extract 8

Session 2, turn 234

234 V	But, also I don't want it to feel like work, like I think it should be a bit natural, I don't know, maybe I feel like you, you are not really committed or something because to me it's natural that, I am like interested in what's going on with you or some-

Alfonso attempts to reposition himself as a committed partner despite the fact that he might not be able to send Victoria a text message every day. Alfonso's repositioning is not accepted by Victoria. By uttering that keeping in contact is possible even when busy, if one wants to, she is referring to the cultural discourse of the priority of a love relationship over other family relationships.

Victoria positions herself as committed to their love relationship. She says this commitment comes natural to her. In uttering "natural" she is referring to a cultural discourse that assigns priority value to the love relationship, a discourse that is dominant in her home country, which is also where the therapy meeting is taking place. Finally, Alfonso accepts this cultural discourse and the corresponding duty to send messages. By agreeing to send messages, Alfonso positions himself as a committed partner in the love relationship with Victoria.

Session 3

Dominant Story 2

At the beginning of the third therapy session, there is a brief return to dominant story 2. Alfonso reports that, as agreed, he has sent Victoria text messages during his visit home, and Victoria agrees that keeping contact has worked well. Alfonso has acted in accordance with the cultural discourse brought forward by Victoria, and in this way the problem has been solved. Alfonso is no longer positioned as uncommitted, as he seems to have accepted the discourse of the special value of the love relationship that is dominant in Victoria's home country.

Dominant Story 1 Starts to Evolve

In the session 3, the conversation shifts back to dominant story 1, i.e., in a good love relationship experiences and feelings have to be shared. Victoria says, at the start of this conversation, that Alfonso is continuing to react negatively to the basic premise of dominant story 1. Alfonso's reaction is then explored by the therapists. From their institutional position, the therapists actively ask detailed questions to help the couple in reconstructing the dominant story that has been constructed during the therapy. By doing this exploration, they accept the dominant story constructed by Victoria and acted in accordance with the dominant discourse of the psychotherapy world: experiences and feelings have to be shared.

Extract 9

Session 3, turns 144–148

144 V	like usually it's really some simple question that I would need like one word for an answer, but then I don't get it, I get only this awful, like (.) this very bad reaction
145 T2	What kind of a reaction those are? What do you mean by that?
146 V	Alfonso's reaction is like, his face gets like this and like, I don't know, I think I have explained it but I don't know if you were here(.) but he gets like really suffering (..)
147 A	Yeah, it's a bit like, when you are kind of disappointed, you are a bit down, a bit
148 V	and then for very small reasons I think this happen like, like I think that in every relationship there is times that you, you want to talk about your relationship, it doesn't work like if you never talk about it, and even if I try to talk about positive things (.)

Victoria defines Alfonso's reaction as apparent feelings of suffering. Alfonso himself relabels his emotions as disappointment and feeling down. Disappointment has an object, and hence by saying this Alfonso is assigning the blame to Victoria and resisting the position Victoria is constructing for him. Victoria strengthens her position as a free talker by referring to cultural discourse about the importance of talking about the relationship: "it doesn't work if you never talk about it."

A little later in this session, Alfonso starts reframing his reaction. He says that it is kind of opposite to Victoria's feelings of depression, and at the same time he says that it is the same: like she could not control her depression then, he can not control his reaction now.

Extract 10

Session 3, turns 164–166

164 A it's, in a way I have this reaction and I (.) can't like help it, … it just comes like this I don't can't control it, and then I can't, don't want to have this kind of reaction but it's just how it is, I don't control it (.) so I was trying to explain to her that this kind of thing, as it would be the exact kind of opposite of how it was for you, that you had this reactions, strong reactions that you couldn't, you couldn't control, and you were just feeling like bad for a long time so

165 T I don't quite follow you, when you said that first Victoria was feeling bad and you was ok but now it is the opposite you are feeling

166 A … I think that now maybe when I have this reaction that it's not exactly the opposite because I think that she can't deal with it

Here Alfonso positions himself as a person in need of understanding. Through this positioning, he invites Victoria to take the counter position of a sympathizer. Alfonso validates his position by referring to his uncontrollable emotions.

Extract 11

Session 3, turns 179–181

179 A Because I was thinking like when you were getting, when you were getting like this kind of things and I was understanding you and I was kind of, there like, so I was just trying to say so if you could try to think it as the opposite way, that what I do it's not something that I decide to do maybe (.) that time if you could understand me like

180 V but there is the sadness because, because all this happened, because I got like sick, like depressed (.) and now it has ruined everything, that I can never get it back just because I got this, because

181 A but sadness it's like, of course, I was feeling sad too, it wasn't about, I was feeling sad also when you were having this, this thing, but I think that when you feel like that it's more than just sadness, it's like when you start crying, and then, when I have the thing it gets again to the other side…

Alfonso continues to construct for himself a position as a person in need of understanding, and for Victoria a counter position as a sympathizer. Victoria resists the constructed counter position of a sympathizer by speaking of her feelings of sadness, and now again refers to her depression, first as a justification for her feelings of sadness that prevent her from taking up a sympathizer position, and second as something that has affected their relationship in a negative manner. Alfonso sticks to his view that he too needs understanding. Thus, the couple are negotiating who is allowed to show feelings, to be weak and to be understood.

Next, the therapist frames the issue as expectations of one another and describes how expectations in a relationship change and develop. Victoria accepts this framing but she also sticks to her position as talker and constructs it as problematic that

Alfonso refuses to take up the counter position of a listener. Victoria refers to her individual therapy as validation of her ability to talk and to cultural discourse about talking as central in love relationships as validation of the dominant story.

The therapist takes up an active position and turns the discussion back to Alfonso's reaction, asking whether it has occurred on some other occasion in his life.

Extract 12

Session 3, turns 258–262

258	A	Yeah, that's maybe always can be, in some situations of course, in different situations, but in anyways, in situations of, feeling bad or anger or something like that
259	T	Yeah.
262	A	And now we understand that maybe can be, how, how I have been like, in my family, in [home country] can be a little bit different than in [Victoria's home country] I am not sure but (.) I was thinking I don't know, when I was young I, sometimes, maybe, aaah, how to say, my mother was hitting us, not like badly but [laughs]

Alfonso connects his reaction to feeling bad or angry. He tells about his background with experience of domestic violence and growing up in another culture. In this way, Alfonso's position as a person with uncontrollable emotions and who needs understanding gets validation. Victoria confirms Alfonso's childhood experience as serious after this extract and this way takes up the counter position as sympathizer that Alfonso has offered her.

It is at this point that the dominant story "in a good love relationship both parties have to share their experiences and feelings" evolves: Alfonso is sharing his feelings and experiences and thus obtains validation of his feelings and behavior. This new dominant story offers Victoria the counter position of a sympathizer.

Later in the session Alfonso's reaction to Victoria starting a conversation is analyzed further. Victoria states that in general she responds to Alfonso's negative reaction by crying. The therapist points out that they have constructed a circle with each responding to the response of the other and emphasizes that Victoria and Alfonso have learned how to let things calm down before discussing something. In this way, the therapist validates the new dominant story and positions.

Session 4

In the fourth session, the couple report that they have not quarreled during the previous weeks and that for both of them life has been good. Alfonso says there has been the usual amount of questioning by Victoria and reacting by him. Nevertheless, fewer situations have led to an argument.

Victoria is no longer accusing Alfonso of being unable to listen to her or of being uncommitted. Instead, Victoria constructs the current problem as her individual project. She explains her reactions by reference to her emotions, which arise from

the old way of thinking, not from Alfonso's behavior. Alfonso says he too has tried to take it easier, but that there has not been much need to do this, since Victoria has made things easier. The therapist suggests that the couple have learned to do something different together and both partners accept this suggestion. They seem to be satisfied with their relationship and decide to end their couple therapy.

Discussion

In this study, we looked at the construction of dominant stories in couple therapy and aspects of power in the positions constructed for clients in these dominant stories. Furthermore, the evolution of these dominant stories was studied. Two dominant stories were constructed in the case of Victoria and Alfonso. The first dominant story stated that in a love relationship partners should share the experiences and feelings with one another. Victoria positioned herself as a free talker, and by doing so she positioned Alfonso in the counter position of a patient listener. In the second dominant story, Victoria positioned Alfonso as uncommitted to their relationship, as he did not keep in contact as often as Victoria would have wanted. This second dominant story about the special value of the love relationship counter-positioned Victoria as a committed partner

In the course of the couple therapy, the two dominant stories evolved such that both Victoria and Alfonso were able to accept the positions they had taken or been given in the story. The first dominant story evolved when Alfonso started to behave according to the cultural discourse subscribed to by both Victoria and by the psychotherapy world. He started to share his experiences and feelings and by doing so gained acceptance to his positioning of himself as a person in need of understanding. This also changed Victoria's position from being the only one who needs to be supported and listened to into a more equal partner who in turn has to listen to her partner's experiences and feelings. The way this story evolved increased the level of equality between the partners. The second dominant story evolved when Alfonso accepted the cultural discourse to which Victoria subscribed and which was dominant in her home country, where the couple are living. Alfonso adapted his behavior accordingly to that cultural discourse and by doing so positioned himself as a committed partner in this love relationship.

Cultural discourses are normative about life and relationships (Foucault, 1977). Our results showed how the power of cultural discourses works in couple's dominant stories. The importance of speaking of one's emotional experiences is a well-accepted discourse in psychotherapy and in western culture generally (Parker, 1997). In this couple's therapy, Victoria referred to this cultural discourse, and her story in line with it became dominant in the couple's discussions. Emotion talk has been found to construct, for one person, the privileged position of laying down the rules of the relationship (Kurri & Wahlström, 2003). This person's emotions and needs then become the focus of the relationship and the responsibility for these states is attributed to the other party (Silverstein, Buxbaum Bass, Tuttle, Knudson-Martin, &

Huenergardt, 2006). In Victoria and Alfonso's therapy, Victoria talked about her and Alfonso's emotions from the beginning. From her position as a free talker, Victoria expected Alfonso to be there to listen to her and sooth her emotions. Moreover, naming and relabeling emotions can be used as a means in positioning and repositioning either oneself or another person (Parrott, 2003), and this seemed to work in the construction of the dominant story in Victoria and Alfonso's therapy.

The first dominant story only started to evolve when Alfonso had begun acting in line with it: He started sharing his experiences and emotions. When asked by the therapist, Alfonso told about his childhood experience which led his reaction be seen in a new light. Victoria stressed the seriousness of Alfonso's experience of domestic violence. This view is in line also with northern European cultural discourse as well as with the view of the psychotherapy world. Trauma discourse is strongly embedded in our everyday understanding of how certain experiences affect us (Parker, 1997). In the psychoanalytic psychotherapy discourse, childhood trauma is understood to explain and moderate our present behavior (Parker, 1998). Victim positioning has even been found to be an effective way to avoid responsibility in therapy discourse (Partanen & Wahlström, 2003). Even though Alfonso was mitigating his experience, Victoria seemed to accept this psychological and cultural discourse about trauma and the positions it offered Alfonso and her. These new positions in the story line offered Alfonso and Victoria the possibility to take turns in being understood and sympathizing, talking and listening.

Less polarized and more flexible positions have also been reported at the end of the family therapy by others (Frosh, Burck, Strickland-Clark, & Morgan, 1996). Frosh et al. suggest that this greater equality may lead clients to a better understanding of one another's perspectives and emotional states. In Victoria and Alfonso's therapy discourse, the evolution of the first dominant story and the potential positions of mutual support were in some way already present in the earlier sessions. However, at those stages, these aspects remained more in the background of the therapy discourse, as some stories are always left unheard in psychotherapy (McLeod, 2004). For a dominant story to evolve or to change, validation through negotiation is needed. It has been argued that cultural discourses of equity, such as mutual support and sharing, do not have as strong an effect on heterosexual relationships as do, for example, patriarchal discourses that are characterized by an unequal power arrangement (Knudson-Martin, 2013; Sinclair & Monk, 2004).

Psychotherapeutic discourse is one of the discourses in which the clients and the therapist are already positioned in their interaction. From her/his institutional position, the therapist has the right and the duty to help the clients find out how cultural discourses work in their relationship. In the therapy of Victoria and Alfonso this help was provided by the therapists as they were actively taking part in the construction and reconstruction of the dominant stories. However, the institutional and personal position of the therapist limits her/his ability to be of help in this search (Hare-Mustin, 1994). The therapist brings into the therapy her/his cultural discourses and the psychotherapeutic discourses s/he has learnt through the psychotherapy frame that s/he has adopted. Thus, psychotherapy has also been criticized for reconstructing western cultural discourses of personhood (Guilfoyle, 2002).

The cultural discourses referred to in Victoria and Alfonso's therapy were in line with the idea of psychotherapy as a talking cure and the dominant discourse about the values attached to the romantic relationship in north-western society. Therefore, these stories had strong potential validation for emerging as dominant in couple therapy in a Northern European country. Hare-Mustin (1994) emphasized the importance of the therapist's reflexive awareness of the dominant cultural discourse as well as of the marginalized discourses that could help clients construct an alternative dominant story. For example, gendered discourses may be present in psychotherapy (Dickerson, 2013; Päivinen & Holma, 2012), and may have an effect on the therapy process if left unacknowledged.

The therapist's awareness of the marginalized and silenced cultural discourses is central in cross-cultural couple therapy, especially when the therapist shares a cultural background with one of the partners. In our results, the second dominant story also required that Alfonso changed his behavior in line with the cultural discourse that Victoria subscribed to and which is dominant in the country in which the couple live. However, acceptance of the story dominant in Victoria's home country seemed to prevent the couple from arguing and to solve the problems that lead them to seek couple therapy. Hare-Mustin (1994) suggests that how a story functions may serve as a criterion for which stories to support. In this case, these accepted cultural discourses seemed to work for this couple, since acting in line with them increased mutual understanding between the partners and eased the problems that had been constructed.

When studying power and positioning in psychotherapy, there is yet another level of positioning to be addressed—that of researcher (Parker, 2013). The present study was conducted by a female doctoral student and an experienced male researcher from a north European country. It may be argued that their reading of the data is limited to the cultural discourses of these researchers, despite their objective of reflexivity.

Conclusions

In psychotherapy and in love relationships, what constitutes normality and a good life refers to larger cultural discourses. Psychotherapy and therapists also refer to particular discourses that may structure what stories are accepted as dominant in therapy. The power of these normalizing truths may leave other possible discourses marginalized. In couple therapy, it is essential that both clients are able to narrate their experiences and that the therapist accepts these stories. Reflexivity and acknowledgement of power issues are required of the therapist in order for the therapist to be able to bring alternative, silenced, and marginalized stories into the therapy conversation. This is especially important in intercultural couple therapy, where cultural differences in discourse may be present.

Narrative and discourse analyses have been shown to be applicable to process research in psychotherapy (Avdi & Georgaca, 2007a, 2007b). These analyses are

also of value to clinicians in increasing both their awareness of the power of cultural discourses in their clients' stories and their reflexivity on their practice and institutional power position in the therapy setting.

References

Avdi, E., & Georgaca, E. (2007a). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy and Counselling, 9*, 157–176.

Avdi, E., & Georgaca, E. (2007b). Narrative research in psychotherapy: A critical review. *Psychology and Psychotherapy: Theory, Research and Practice, 80*, 407–419.

Bruner, E. M. (1986). Ethnography as narrative. In V. Turner & E. Bruner (Eds.), *The anthropology of experience* (pp. 139–155). Chicago: University of Illinois Press.

Bruner, J. (1987). Life as narrative. *Social Research, 54*, 11–32.

Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry, 18*, 1–21.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal of the Theory of Social Behaviour, 20*, 43–63.

Dickerson, V. (2013). Patriarchy, power, and privilege: A narrative poststructural view of work with couples. *Family Process, 52*, 102–114.

Dickerson, V. C., & Crocket, K. (2010). "El Tigre, El Tigre": A story of narrative practice. In A. Gurman (Ed.), *A casebook of couple therapy* (pp. 153–180). New York: Guilford Press.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. London: Penguin Books.

Frosh, S., Burck, C., Strickland-Clark, L., & Morgan, K. (1996). Engaging with change: A process study of family therapy. *Journal of Family Therapy, 18*, 141–161.

Guilfoyle, M. (2001). Problematising psychotherapy: The discursive production of a bulimic. *Culture and Psychology, 7*, 151–179.

Guilfoyle, M. (2002). Rhetorical processes in therapy: The bias for self-containment. *Journal of Family Therapy, 24*, 298–316.

Hare-Mustin, R. T. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. *Family Process, 33*, 19–35.

Harré, R., & Moghaddam, F. (2003). Introduction: The self and others in traditional psychology and in positioning theory. In R. Harré & F. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political, and cultural contexts* (pp. 1–11). Westport, CT: Praeger.

Harré, R., & van Langenhove, L. (1991). Varieties of positioning. *Journal of the Theory of Social Behaviour, 21*, 393–407.

Hollway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques, W. Hollway, C. Urwin, C. Venn, & V. Walkerdine (Eds.), *Changing the subject: Psychology, social regulation and subjectivity* (pp. 227–263). London: Routledge.

Knudson-Martin, C. (2013). Why power matters: Creating a foundation of mutual support in couple relationships. *Family Process, 52*, 5–18.

Knudson-Martin, C., & Huenergardt, D. (2010). A socio-emotional approach to couple therapy: Linking social context and couple interaction. *Family Process, 49*, 369–384.

Kurri, K., & Wahlström, J. (2003). Negotiating clienthood and moral order of a relationship in couple therapy. In C. Hall, K. Juhila, N. Parton, & T. Pösö (Eds.), *Constructing clienthood in social work and human services* (pp. 62–79). London: Jessica Kingsley.

Linehan, C., & McCarthy, J. (2000). Positioning in practice: Understanding participation in the social world. *Journal for the Theory of Social Behavior, 30*, 435–453.

McLeod, J. (2004). Social construction, narrative, and psychotherapy. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 351–365). London: Sage.

McLeod, J., & Lynch, G. (2000). "This is our life": Strong evaluation in psychotherapy narrative. *European Journal of Psychotherapy, Counseling and Health, 3*, 389–406.

Päivinen, H., & Holma, J. (2012). Positions constructed for a female therapist in male batterers' treatment group. *Journal of Feminist Family Therapy, 24*, 52–74.

Parker, I. (1997). *Psychoanalytic culture: Psychoanalytic discourse in western society*. London: Sage.

Parker, I. (1998). Constructing and deconstructing psychotherapeutic discourse. *The European Journal of Psychotherapy, Counselling and Health, 1*, 65–78.

Parker, I. (2013). Discourse analysis: Dimensions of critique in psychology. *Qualitative Research in Psychology, 10*, 223–239.

Parrott, W. G. (2003). Positioning and the emotions. In R. Harré & F. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political, and cultural contexts* (pp. 29–43). Westport, CT: Praeger.

Partanen, T., & Wahlström, J. (2003). The dilemma of victim positioning in group therapy for male perpetrators of domestic violence. In C. Hall, K. Juhila, N. Parton, & T. Pösö (Eds.), *Constructing clienthood in social work and human services. Interaction, identities and practices* (pp. 129–144). London: Jessica Kingsley.

Potter, J. (2004). Discourse analysis. In M. Hardy & A. Bryman (Eds.), *Handbook of data analysis* (pp. 607–624). London: Sage.

Rosen, L. V., & Lang, C. (2005). Narrative therapy with couples: Promoting liberation from constraining influences. In M. Harway (Ed.), *Handbook of couples therapy* (pp. 157–178). Hoboken, NJ: Wiley.

Sarbin, T. R. (1986). The narrative as a root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology. The storied nature of human conduct* (pp. 3–21). New York: Praeger.

Silverstein, R., Buxbaum Bass, L., Tuttle, A., Knudson-Martin, C., & Huenergardt, D. (2006). What does it mean to be relational? A framework for assessment and practice. *Family Process, 45*, 391–405.

Sinclair, S. L. (2007). Back in the mirrored room: The enduring relevance of discursive practice. *Journal of Family Therapy, 29*, 147–168.

Sinclair, S. L., & Monk, G. (2004). Moving beyond the blame game: Toward as discursive approach to negotiating conflict within couple relationships. *Journal of Marital and Family Therapy, 30*, 335–347.

Sween, E. (2003). Accessing the rest-of-the-story in couples therapy. *The Family Journal: Counseling and Therapy for Couples and Families, 11*, 61–67.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Winslade, J. M. (2005). Utilising discursive positioning in counselling. *British Journal of Guidance & Counselling, 33*, 351–364.

Zimmerman, J. L., & Dickerson, V. C. (1993). Separating couples from restraining patterns and the relationship discourse that supports them. *Journal of Marital and Family Therapy, 19*, 403–413.

III

AFFECTIVE AROUSAL DURING BLAMING IN COUPLE THERAPY: COMBINING ANALYSES OF VERBAL DISCOURSE AND PHYSIOLOGICAL RESPONSES IN TWO CASE STUDIES

by

Helena Päivinen, Juha Holma, Anu Karvonen, Virpi-Liisa Kykyri, Valeri Tsatsishvili, Jukka Kaartinen, Markku Penttonen, & Jaakko Seikkula, 2016

Contemporary Family Therapy, 38, 373–384.

Contemp Fam Ther (2016) 38:373–384
DOI 10.1007/s10591-016-9393-7

ORIGINAL PAPER

Affective Arousal During Blaming in Couple Therapy: Combining Analyses of Verbal Discourse and Physiological Responses in Two Case Studies

Helena Päivinen[1] · Juha Holma[1] · Anu Karvonen[1] · Virpi-Liisa Kykyri[1] · Valeri Tsatsishvili[2] · Jukka Kaartinen[1] · Markku Penttonen[1] · Jaakko Seikkula[1]

Published online: 22 August 2016

Abstract Blaming one's partner is common in couple therapy and such moral comment often evokes affective arousal. How people attune to each other as whole embodied beings is a current focus of interest in psychotherapy research. This study contributes to the literature by looking at attunement during critical moments in therapy interaction. Responses to blaming in verbal dialogue and at the level of the autonomic nervous system (ANS) were investigated in two couple therapy cases with a client couple and two therapists. Video-recorded couple therapy sessions were analyzed using discursive psychology and a narrative approach. The use of positioning, a discourse analytic tool, was also studied. ANS responses of the participants, including the therapists, were measured as electrodermal activity. The findings demonstrate how identity blaming, i.e. positioning the other person in ways counter to their preferred identity narrative, was accompanied by increased electrodermal activity in most participants. In the two cases studied, blaming centered on the themes of loyalty, trust and parenting. It is argued that identity blaming in these thematic domains increases the arousal level of the partners, since disloyalty, unfaithfulness and irresponsible parenting threaten the stability of the relationship.

✉ Helena Päivinen
helena.paivinen@jyu.fi

[1] Department of Psychology, University of Jyvaskyla, P.O. Box 35, 40014 Jyvaskyla, Finland

[2] Department of Mathematical Information Technology, University of Jyvaskyla, P.O. Box 35, 40014 Jyvaskyla, Finland

Keywords Couple therapy · Discourse · Narrative · Positioning · Autonomic nervous system · Electrodermal activity

Introduction

In couple therapy, the partners face and discuss challenging issues pertaining to their relationship. Blaming the other is typical at the beginning of joint therapy, and, even if their objective is to remain neutral, the therapists will also find themselves involved in these moral judgments (Kurri and Wahlström 2005; Rober 2015; Stancombe and White 2005). Therapist directive approach at the beginning of conjoint treatment process can be helpful in making both partners accountable (Vall et al. 2016). Blaming and resisting criticism involve emotions which may be manifested not only in the partners' verbal and non-verbal responses (Edwards 1995) but also in their responses at the level of the autonomic nervous system (ANS). The aim of this exploratory paper is to combine the levels of verbal dialogue, ANS and the inner dialogues of the participants to illuminate the experience of blaming in the couple therapy context.

Blame can be conveyed through explicit accusations or complaints (Buttny 2004), or through more implicit expressions of needs and wishes (Edwards and Potter 1995). Either way, blaming someone always contains a moral judgement. Thus, being blamed may elicit moral affects of shame and guilt. Blaming has traditionally been studied within an attributions framework (Stratton 2003). Findings from couple relationship interaction studies by the Gottman group show how criticism in conflict resolution is one of the major predictors of relationship instability (Gottman and Gottman 2008). The authors define criticism

as the declaration by one partner that the conflict is attributable to a deficit in the character of the other partner. Character blaming of this kind is considered the most damaging form of blame since while changing one's behavior is possible, changing oneself as a person is less conceivable. Characterological blaming places full responsibility on the agent and targets their identity (Stratton 2003).

From the discursive perspective applied in this study, the self is not a stable entity, but is constantly being constructed and reconstructed in social encounters (Burr 2003). The formation of identity is thus a fluid and dynamic, ever continuing process (Avdi and Georgaca 2009). Couple therapy in turn presents an institutionalized context for the construction of identity. This identity work is carried out through various discursive acts, such as ways of speaking about oneself and others. From a discursive viewpoint, casting blame is understood as constructing a questionable position for the target in the local discourse. A position is a moral place with certain rights and duties, which can be given and taken up in the course of the interaction (Davies and Harré 1990). Being assigned a position not in line with one's preferred identity narrative may be experienced as uncomfortable or troubling (Edley 2001; Wetherell 1998), and hence attempts to reposition oneself may be performed. As well as being flexible and subject to change, positioning is also relational (Harré and van Langenhove 1991). In this study, blaming is defined as the making of critical positioning statements concerning something that one of the partners did or did not do, or what kind of a person s/he is or is not.

This paper forms part of a broader research project, *The Relational Mind in Events of Change in Multi-actor Therapeutic Dialogues*, which aims at increasing understanding of attunement and synchrony in couple therapy at various levels, including both verbal and non-verbal interaction and ANS responses (Karvonen et al. 2016; Seikkula et al. 2015). The project is being conducted at the University of Jyvaskyla, Finland in collaboration with three other European universities. According to the dialogical perspective taken in the project, people are attuned to each other not only in their speech acts but in their whole embodied being (Bakhtin 1984). Research on embodiment in psychotherapy has previously been done, for example, at the levels of facial expressions (Bänninger-Huber 1992), nonverbal behavior (Ramseyer and Tschacher 2011), and neurobiology (Fishbane 2011). Physiological synchrony has been observed when negative emotions are expressed in high conflict exchanges between dissatisfied couples (Levenson and Gottman 1983). On the other hand, synchrony has been linked to empathy between client and therapist (Marci et al. 2007). Recently however, Karvonen et al. (2016) found the strongest sympathetic synchrony in the therapist dyad in a multiactor couple therapy setting. The authors speculated that this finding was related to the training and position of the therapists in the therapy situation. To our knowledge, Relational Mind is the first research project to use a naturalistic couple therapy design with two clients and two therapists to study attunement at multiple levels (Seikkula et al. 2015).

Currently, efforts are being made to extend qualitative analysis by measuring the embodied aspects of dialogue (Cromby 2012; Lyons and Cromby 2010; Seikkula et al. 2015). Here, the embodied level is approached by measuring the electrodermal activity (EDA) of the participants. EDA refers to changes in skin conductance (SC) that are connected to involuntary changes in sympathetic nervous system activity, which in turn prepare the body for action (Boucsein 2012). Generally, SC indicates psychophysiological arousal, which is linked to psychological processes. An increase in EDA suggests emotional arousal, since most emotions induce an increase in SC (Kreibig 2010). However, cognitive work, movement and rapid changes in respiration may also effect changes in SC (Boucsein 2012). Moreover, orienting and attention may include SC arousal. Taking into account the uncertainties in interpreting EDA arousal, the present study is an exploratory attempt to increase understanding of the experience of blaming in couple therapy. Our hypothesis is that blaming in couple therapy involves affective arousal on the level of the ANS, and hence we ask the following research questions:

1. How do the partners position each other when casting blame in couple therapy? In what ways are the therapists involved in this discursive process?
2. What responses are evoked at the levels of verbal dialogue and EDA by all the participants during blaming?

Methods

Design

In the Relational Mind project, couple therapy is conducted and studied with couples who have sought therapy for various reasons. The Ethical Board of the University of Jyvaskyla approved the research and the participants gave their written informed consent.

The therapy sessions are run by a co-therapist dyad and the treatment is non-manualized. Various modes of therapy—e.g. dialogical, narrative and reflective—are used. All the sessions are video-recorded. Each participant's ANS measurements (SC, respiration and heart rate) are recorded during the second and the fifth to seventh therapy sessions. A stimulated recall interview (henceforth SRI)

method is applied within one day of these measurement sessions to capture participants' self-reports of their thoughts, feelings and sensations. Both the two clients and the two therapists are interviewed in turn. These individual interviews center on four video clips of important moments during the measurement session selected by the researcher. A sequence can be considered important on the basis of the topic or passages of dialogue, visible emotion or observed signs of ANS arousal. The same physiological measurements, along with finger pulse volume and speech muscle movements, are also recorded. The interviewees are asked about the thoughts/feelings/bodily sensations they had at that moment in the therapy session. After discussing all the four extracts the interviewer asks if the interviewee would have selected some other moments from the session for the interview. If the participant names some moment the thoughts/feelings/bodily sensations that the participant recalls from that moment are discussed.

The Cases

The two cases analyzed for this report were drawn from the ten couples receiving therapy in the Relational Mind project. These two couples were selected since intimate partner violence (henceforth IPV) was one of the reasons for their seeking therapy. This selection was also made to facilitate possible future comparisons with couples whose histories do not include IPV. However, in this particular study, no such comparisons were made, nor were the findings generalized to all IPV couples. In the Relational Mind project, joint therapy with IPV couples is only started if the IPV has been mild to moderate and has ended. Both partners have to be willing to attend the therapy meetings and be able to speak openly in them. The partners in both couples had previously attended individual meetings at the local crisis center. Two of the present authors were working as therapists in these cases and two other therapists were also involved. All the therapists were experienced psychotherapists specializing in family therapy.

Case 1 was a heterosexual couple, Heli and Lasse (pseudonyms), with children. Heli was pregnant at the time of the measurement session. They were attending couple therapy owing to relationship problems and Lasse's violent behavior. Lasse had been physically violent towards Heli, the most serious instance of which had been attempted strangulation. Even if this instance of violence had been severe, both partners wished to have couple therapy, felt that they can speak openly in conjoint session, and wanted to continue their relationship. For these reasons and after Lasse having attended long term individual IPV treatment, this couple had been included in couple therapy for IPV. Their course of therapy lasted for 10 sessions. A male-male therapist dyad (T1, T2) worked with this couple. The same case has also been studied by others in the project (Itävuori et al. 2015; Kykyri et al. manuscript in preparation). Case 2 was a same-sex couple who had sought couple therapy for IPV. Tina and Jenny (pseudonyms) were parents of a toddler and were currently living separately. Jenny's violent behavior towards Tina had included both physical (e.g. striking with the fist) and emotional forms of IPV. The therapy comprised a total of five sessions, each conducted by the same male-female therapist dyad (T3, T4).

Analysis

A multi-method qualitative analysis was performed. The spoken dialogue was analyzed using both discursive psychology (Edwards and Potter 1992, Potter 2003; 2012) and narrative approach (Avdi and Georgaca 2007; McLeod 1997, 2004). From the viewpoint of discursive psychology, blaming was conceptualized as a speech act of positioning that ascribes moral responsibility to the target (Davies and Harré 1990). The narrative approach, in turn, adds the temporal and contextual elements into the analysis of the blaming sequences (Sarbin 1986). In other words, the flow and evolution of the themes around which the blaming forms, were rendered more visible. The methodological concept of micro narrative (Bamberg 1997; Kraus 2006) was developed and tested in this analysis to link the blaming sequences in the flow of the therapy session. Basically, in the therapy dialogue, a micro narrative is a story line that forms around a particular theme.

The analysis was started by the first author viewing all the videotaped therapy sessions featuring the two couples to gain an overall picture of the cases and what was talked about in the sessions. In each case, the data for the study were restricted to the second therapy session, as this was the first measurement session in the project design. Blaming was chosen as the unit of analysis for defining and selecting the sequences of the therapy conversation to be taken for further analysis. A blaming sequence in the therapy session was defined as a sequence of dialogue in which one of the partners is explicitly positioned as responsible for doing or not doing something, or being or not being something. The blaming sequences were classified thematically and the blaming dialogue around a specific theme was written up as a micro narrative. The blaming themes and micro narratives were identified by the first and second author for triangulating the findings.

EDA was measured from the palm of the participants' non-dominant hand, using two electrodes. The EDA of all four participants was examined visually from the raw SC data during the instances of blaming. SC responses were also detected using the Ledalab program (Benedek and Kaernbach 2010). The signals were standardized for each participant. The raw skin conductance recordings were

converted into skin conductance responses (SCR) and skin conductance level (SCL) using continuous deconvolution analysis (Benedek and Kaernbach 2010). In the same paper, it is suggested that SCR is directly linked to the sympathetic activity and it was therefore selected for further analysis. The extracted SCRs were standardized and peak detection was applied. Peaks that were two or more standard deviations above the mean were selected as statistically significant SCRs. These statistical procedures were carried out by the fifth and seventh authors.

The micro narratives along with the EDA responses were studied, first, by the first author and the results then negotiated with the second author. Together, they identified which sequences of the blaming micro narratives were accompanied by an increase in the level of arousal, i.e., an observable increase in the raw EDA, and later incorporated the calculated statistically significant SCRs into the analysis. The micro narratives and blaming sequences found were subsequently confirmed by the research group. Finally, the participants' thoughts, emotions, and sensations, self-reported in the SRIs, were used as information to gain insight into the observed physiological arousal. Since blaming was not the criterion for the selection of the video clips in the SRIs, this additional information was only available for some parts of the blaming micro narratives.

Findings

The three blaming micro narratives drawn from the two cases are presented along with the participants' EDA responses. The instances of blaming, i.e. moments in a session when a blaming incident occurred, are given in brackets (hours: minutes: seconds). The findings from the SRI's are presented after each micro narrative. The observed changes in EDA are shown in figures (Figs. 1, 2, 3) and statistically significant SCR activity in each participant during an instance of blaming is presented in a table (Tables 1, 2, 3) after each figure.

Case 1: The Micro Narrative of Loyalty

The theme of loyalty, disentangling from one's family of origin and forming the new family together with one's partner, constituted a blaming micro narrative in couple 1's therapy dialogue. Commitment as a partner and a parent was linked to this micro narrative. In this micro narrative, Heli blamed Lasse for not being on her and their family's side, thereby positioning him as being loyal to his family of origin instead of to his new family with her.

The micro narrative begins when the couple describe an argument in which Lasse had taken his sister's side instead of supporting Heli. About ten minutes later, T1 asks Heli whose view Lasse shares: hers or his sister's (time 1, 00:17:09). Heli shows SCR activity and her EDA remains elevated when she explains how Lasse takes the side of his family of origin. With this utterance, Heli positions Lasse as not committed to their joint family. At the moment of this positioning, Lasse's EDA does not rise. T1 shows a rise in EDA before he asks for Heli's view. In T2, EDA decreases.

T1 shows high EDA before he next asks the couple to evaluate themselves as a team. During T1's question (time 2, 00:21:27), EDA increases in both clients, and, as they tell and listen to each other's evaluations, both also show SCR activation. In T2, EDA falls. Three minutes later, the therapists together reflect on the reasons for Lasse's loyalty to his family of origin. Lasse describes his relationship to his family of origin when requested by T1. Heli listens to Lasse's account and then, as she explicitly points out that Lasse is not ready to risk his relationship with the most important family members of his family of origin (time 3, 00:34:11), shows SCR activation. In blaming Lasse in this way, Heli clearly positions him as a member of his family of origin. Lasse's EDA manifests no obvious changes. T1 shows an increase in EDA. T2 shows no clear EDA response.

About eight minutes later, T2 asks Heli if she could somehow help Lasse to choose her side in conflict situations. Heli points out that when it comes to the children alarm bells should ring for Lasse about which side to choose (time 4, 00:46:59). Here, when explicitly blaming Lasse as a father, Heli shows SCR activation. Lasse's EDA in turn remains unchanged. As T2 asks this question, his EDA begins to rise and his SCR activation shows two peaks during Heli's account. In T1, EDA shows no change.

Fourteen minutes later, T2 reflects on the couple's situation and the loyalty theme. During his reflections, T2 shows a rise in EDA rises and Lasse, Heli and T1 show SCR activation (time 5, 01:01:41). The discussion then turns to Lasse's loss of his grandmother and his sorrow over her passing. Lasse is visibly moved during this discussion. In this discussion, Lasse is positioned as a member of his family of origin. T1 asks Heli how she feels when Lasse reflects aloud on his feelings of longing. Heli answers (time 6, 01:12:11):

> Yeah, it's difficult to say. You somehow wish like that like I can't say, I thought that Lasse is anyway like a grownup man and a father even though like the like the what how do you call the family there the family of origin or the like (…) That even though it is like in a big role and important like someway that he could see that like life is anyway at this moment like with us, we are like a nuclear family

Besides seeing Lasse as a member of his family of origin, Heli also positions him as an adult, partner and

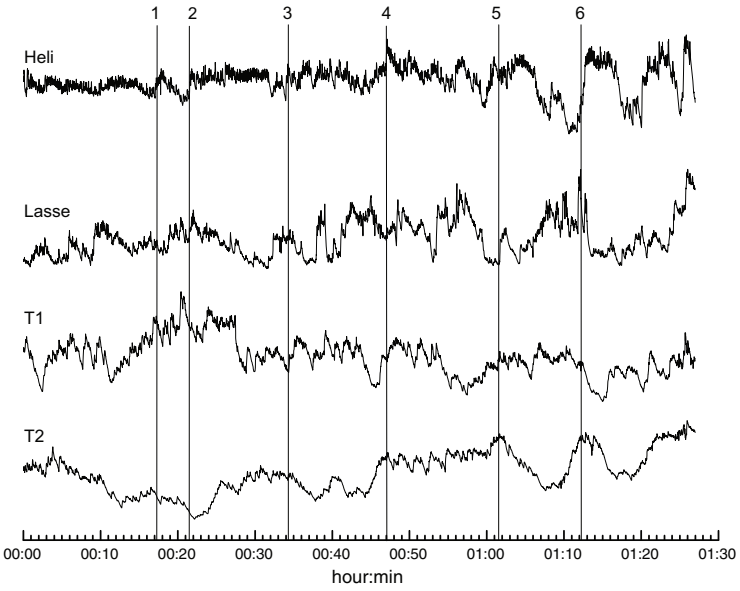

Fig. 1 Raw EDA of the participants over the entire session of couple 1. Range is scaled separately for each participant. The vertical lines indicate the instances of blaming in the micro narrative of loyalty

Table 1 Case 1, loyalty: SCR activation of each participant during blaming

Instance of blaming	Heli	Lasse	T1	T2
1. 00:17:09	00:17:41			
2. 00:21:27	00:21:37	00:21:47		
3. 00:34:11	00:34:14			
4. 00:46:59	00:47:05			00:47:05, 00:47:13
5. 01:01:41	01:01:58	01:01:46	01:01:42	
6. 01:12:11	01:12:44	01:12:45, 01:12:55		01:12:49

father, and by expressing her wish she blames Lasse for not taking up this position. Heli again shows SCR activation. Lasse shows increased EDA during the discussion about his loss, and now also SCR activation. The video shows that Lasse also touches and scratches his face while listening to Heli. In T2, EDA peaks and he also shows SCR activation. In T1, in contrast, EDA decreases.

In summary, Heli manifested SCR activation each time that she blamed Lasse for not being loyal to their family and not taking up the position she offered him as a partner and a father in the family. Lasse responded to Heli's blame only at the end of the session when she explicitly targeted his identity and strong emotions were involved. At that point, one of the therapists also showed high EDA.

Stimulated Recall Interviews

In the SRIs, two of the four clips covered the discussion on Lasse's sorrow over his late grandmother (before and after time 6). In their individual SRIs, both Lasse and T2 reported having felt a strong sense of longing at this moment in the session. In her SRI, Heli reported having felt sorrow but also insensitivity to her partner's grief. In his SRI, T1 stated that he did not relate to Lasse's sorrow.

Case 2: The Micro Narrative of Parenting

Responsible parenting was at the center of one of the two blaming micro narratives of couple 2. This micro narrative was also linked to a loyalty conflict between the family of origin and the current family. First, Jenny blamed Tina (the birth mother) for her way of parenting; later Tina accused Jenny of not taking responsibility as parent. Thus Tina positioned Jenny as an irresponsible parent.

The blaming micro narrative begins when Jenny criticizes Tina for complying too much with her parents' wishes. She accuses Tina of not listening to her opinion in these situations. Tina's family relations are explored by the

therapists and she explains her behavior by reference to her motherhood. During this talk, Jenny shows a gradual rise in EDA and on two occasions she verbally challenges Tina's account. Jenny shows SCR activation when she explicitly accuses Tina of keeping up relationships that are hurtful to her and thus also to their child (time 1, 00:29:06). With this accusation, Jenny positions Tina as a parent but further questions Tina's parenting, how Tina acts as parent. Tina shows a rise in EDA when she is positioned in this way, along with SCR activation when she starts to justify her behavior. The therapists show no EDA response to Jenny's positioning of Tina.

Soon after, Tina describes how Jenny does not take as much responsibility for their child as she does. By accusing Jenny of being irresponsible, Tina questions Jenny's position as a parent. Tina shows SCR activation when she blames Jenny for irresponsibility (time 2, 00:30:43). EDA remains elevated in Jenny and also shows an increase in the therapists. Tina's positioning of Jenny is underscored by T4, who restates Tina's view that she is bearing all the responsibility for the child. T4 shows SCR activation when she verbally echoes Tina's words.

Five minutes later, T4 asks Jenny what she thinks about Tina being burdened by the partners' unequal distribution of responsibilities in parenting (time 3, 00:45:31). In putting this question, T4 is following Tina's positioning of Jenny as an irresponsible parent, and her SCR peaks. Jenny manifests SCR activation when presented with T4's question, as also does Tina as Jenny answers it. Tina also becomes tearful. SCR activation is also apparent in T3. Jenny accepts being positioned as an irresponsible parent by saying that she agrees that the situation isn't right. Jenny then justifies her irresponsibility by saying that she is neither able nor willing to give ground. Tina voices her doubts about Jenny's parenting again (time 4, 00:47:24) during which her SCR peaks. EDA in Jenny continues to fall. In the therapists, EDA also declines.

Next, T3 asks Tina how the couple share Mother's and Father's Day (time 5, 00:50:12). Tina has mentioned

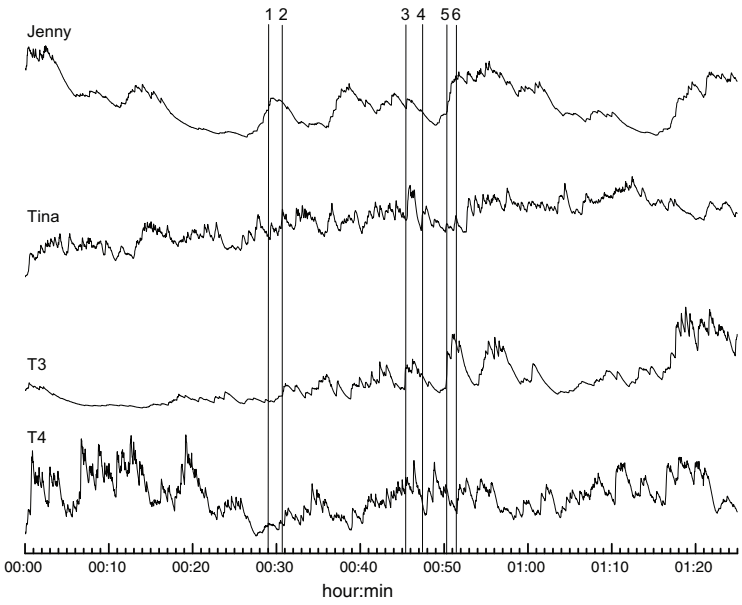

Fig. 2 Raw EDA of the participants over the entire session of couple 2. Range is scaled separately for each participant. The vertical lines indicate the instances of blaming in the micro narrative of parenting

Table 2 Case 2, parenting: SCR activation of each participant during blaming

Instance of blaming	Jenny	Tina	T3	T4
1. 00:29:06	00:29:06	00:29:24		
2. 00:30:43		00:30:43		00:31:04
3. 00:45:31	00:45:36	00:45:48	00:45:36	00:45:26
4. 00:47:24		00:47:25		
5. 00:50:12	00:50:26, 00:50:43, 00:50:52		00:50:23	
6. 00:51:18	00:51:26	00:51:24		

Mother's Day a little earlier and in posing this question, T3 is confirming Tina's position as the primary mother of the child. Jenny shows SCR activation. SCR is also activated in T3 when raising the topic and remains elevated while the topic is discussed. In T4, EDA falls. Tina manifests a smaller increase in EDA and she describes their gender roles, positioning Jenny as the more masculine and herself as the more feminine partner. In Jenny SCR activation is visible once again when Tina positions her as an irresponsible male by saying (time 6, 00:51:18):

> Jenny Even Looks Like a Twelve-Year-Old Little Boy…

Tina also shows SCR activation. Here, Tina also laughs a little and Jenny smiles and scratches her forehead. In T3, EDA is high. In T4, EDA is falling.

In summary, blaming that questioned Jenny's identity as a responsible parent was accompanied by SCR activation in both clients and in one of the therapists. Linking her parenting to gender identity was also accompanied by SCR activation in both clients.

Stimulated Recall Interviews

The sequence in which the unequal distribution of responsibilities in parenting was talked about (time 3) belonged to one of the sequences shown to the participants in their SRIs. All the participants reported emotional arousal in their individual SRIs. Jenny said that she felt ashamed and thought of herself as a bad person. Tina reported having felt frustrated and apprehensive. T3 reported having felt involved and curious. T4 said she felt sad for Tina's sake.

Another sequence shown in the SRIs concerned the gender roles of the couple (Time 5 and time 6). Jenny did not comment on this topic at all. Tina said that the theme of gender roles is one that she is used to discussing with people. T3 says that he had to think how to ask the question and that he felt apprehensive about how the question would be received. T4 says that she was surprised but felt happy about the raising of this topic.

Case 2: The Micro Narrative of Trust

Another blaming micro narrative in the therapy session of couple 2 centered on trust and commitment. Jenny had had an affair and had also been unfaithful in her previous relationship. In this micro narrative Tina positioned Jenny as an uncommitted partner; this Jenny did not accept.

Immediately after the parenting theme, T4 asks Tina what it meant for her to hear about Jenny having been unfaithful in her previous relationship. This topic had initially been brought up in the previous session. Both clients manifest SCR activation simultaneously when T4 finishes the question (time 1, 00:52:48). In T4, EDA is high when she asks the question, whereas in T3 EDA falls.

Jenny's infidelity is discussed and T3 focuses on how it has affected trust between the couple. Tina describes how Jenny's cheating has affected their relationship, and thus blames Jenny for causing problems of trust (time 2, 00:54:58). In this way, Tina positions Jenny as an unfaithful and uncommitted partner. Jenny and T3 show SCR activation. Tina continues describing how uncertainty about Jenny's commitment makes her feel like an independent single parent. By positioning herself in this way, Tina connects the micro narrative of trust to the micro narrative of parenting. T4 asks Jenny about her commitment, and Jenny answers that she can see that in Tina's eyes she is untrustworthy, yet she is sure that she wants to stay in her relationship with Tina. By this means, Jenny repositions herself as committed.

However, Tina again brings up her doubts about Jenny's commitment. Both the clients and therapists show a slight increase in EDA (time 3, 00:59:08). Jenny, who is blamed, shows SCR activation. She also touches her face at this point. T4 asks Tina what she thinks Jenny could do to ease this uncertainty. Tina describes how Jenny has not announced their reconciliation to her relatives (time 4, 01:03:29). Tina shows SCR activation as she elaborates this issue, positioning Jenny as uncommitted. In Jenny at this point, EDA is already falling and neither of the therapists show any EDA responses. Finally, Jenny accepts that, as Tina wishes, she has to tell her family about their relationship.

In summary, bringing up the theme of infidelity was accompanied by simultaneous SCR activation in both clients and in the therapist taking the lead. This topic, which threatened the couple's relationship, brought Jenny's partner identity into question and, when the direct target of identity blame, she showed SCR activation.

Stimulated Recall Interview

The sequence in which T2 brought up the topic of infidelity (time 1) was shown in the individual SRIs. In her SRI, Tina reported that this topic raised no emotions in her since she sees Jenny's previous cheating as an issue that she will never understand. Jenny, in her interview, said that she had not wanted to talk about this topic, as it had made her feel embarrassed, uneasy and tense in the session. In their individual SRIs, both therapists reported having had many thoughts about the topic and the therapy process.

The discussion about announcing the relationship to the larger family (after time 4) was also shown in the SRIs. Jenny said she felt uncomfortable about the topic and irritated by being assigned this task by Tina. Tina reported

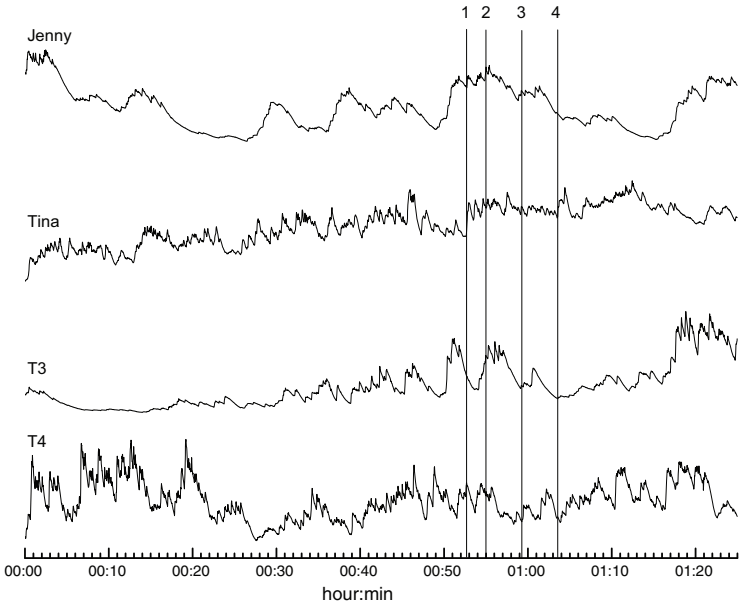

Fig. 3 Raw EDA of the participants across the entire session of couple 2. Range is scaled separately for each participant. The vertical lines indicate the instances of blaming in the micro narrative of trust

Table 3 Case 2, trust: SCR activation of each participant during blaming

Instance of blaming	Jenny	Tina	T3	T4
1. 00:52:48	00:52:48	00:52:48		
2. 00:54:58	00:54:59		00:54:58	
3. 00:59:08	00:59:13			
4. 01:03:29		01:03:45		

having felt sad, and in their interviews both therapists report having felt empathy for Tina and her sadness.

Discussion

In this study, we examined the positioning of one partner by the other in instances of blaming in couple therapy, showing how blaming evolves during the session, and involves physiological responses on the part of both client and therapist. Drawing together the results of the two case studies, our main finding is that blame, especially when targeted at the partner's identity, was accompanied by SCR activation both in the clients and also, on some occasions, one of the therapists. We would argue that in couple therapy such identity blaming is an instance of troubled positioning, as is shown by affective arousal in the target. We propose that identity blaming around certain themes may also be arousing for other participants than the target alone since the stability of the relationship is at risk. This paper aimed at developing a methodology for investigating and treating these situations by combining language-based analysis and physiological measures. Below, the meaning, implications and limitations of the findings of this exploratory paper are discussed.

From the discursive viewpoint, identity is constructed via the various positions we take up and are offered in social interactions (Davies and Harré 1990). Not all positions feel fitting or acceptable as part of one's identity (Edley 2001; Wetherell 1998). Blaming, criticizing or even commenting on one's partner as a person in a neutral tone may construct a position that is troubling for them and challenges their preferred identity narrative. The findings of this study demonstrate how troubled positioning is accompanied by affective arousal in the blamer, the blamed, and in those who are witnessing the attribution of blame. It was further shown that in couple therapy troubled positioning is constructed around such themes as loyalty, parenting and trust.

These blame-ascribing micro narrative themes concerned central issues that people face and have to negotiate in their intimate relationships when contemplating becoming or forming a family. These themes also relate to responsibility, safety and trust, which have been considered the main goals of conjoint IPV treatment (Vall et al. 2014). To begin with, the theme of loyalty involves setting boundaries, which is a basic task for any new family

(Minuchin 1974). For couple 1, this task had become a loyalty issue that involved blaming. This theme, and the blame it gave rise to, was present throughout their one-and-a-half-hour session. The theme of loyalty was more arousing for Heli, in whom SCR activation was present when she was blaming her partner. Lasse in turn manifested SCR activation when Heli explicitly questioned his identity as an adult father in their family. In T2, EDA became elevated at this point. Bearing in mind the context of a history of IPV, it can be hypothesized that blame targeted at one's partner on a familiar topic may remind the partners of the incidents of violence and activate the sympathetic nervous system.

Furthermore, in both cases, the blaming micro narratives were intertwined with parenting. Parenting, and the new responsibilities that come with it, adds to the necessity and possibilities for positioning in the couple relationship. Parenting also means building a new component into one's identity. In couple treatment for IPV, parenting is a central theme, as it has been shown that being a parent may furnish perpetrators with a strong motivation to take responsibility and work to change their violent behavior (Cooper and Vetere 2005; Råkil 2006; Veteläinen et al. 2013). For couple 1, parenting was part of the broader loyalty issue. Couple 2, in turn, was explicitly negotiating the responsibilities of parenting. SCR peaked in Jenny when Tina portrayed her as a little boy, i.e., Tina's blame encompassed Jenny's identity as a responsible parent, female and adult. SCR activation was also observed in T1 and Tina at this point. For both couples, parenting was linked to the target's gender identity. Parenting places partners in new, unequal positions, as they now have to negotiate their caregiving responsibilities (Ciano-Boyce and Shelley-Sireci 2003). For same-sex couples this negotiation also means that one of the partners fails to fulfil yet another of society's normative gender expectations (Ciano-Boyce and Shelley-Sireci 2003; Mazor 2004).

Finally, for couple 2, a micro narrative of blaming on the theme of trust was introduced towards the end of their session. Security, intimacy and trust are generally considered the basis of love relationships. Violence and infidelity challenge this basic premise and may damage the attachment of the injured partner (Johnson et al. 2001). It is possible that such damage leads to the enactment of a negative blame-withdraw cycle that pulls the couple further apart and thus puts the stability of the relationship at risk (Gottman and Gottman 2008). In the case of couple 2, Jenny was positioned as unfaithful, and thus her partner identity was questioned. She showed SCR activation when blamed and in her SRI she stated that this theme was something she didn't want to talk about in the therapy session and that she found it embarrassing. Visual observation of the raw EDA data showed that all present seemed to have an increased level of arousal during the discussion on this theme. The therapists also defined this theme as important and thought-provoking in their SRIs.

In each theme, the therapists were closely involved in the construction of the client micro narratives of blame. By means of, for example, questions and voiced reflections the therapists validated and took some of the attributions of blame further and thus participated in the moral negotiations of the couples. Their participation indicated that the therapists found the themes of the micro narratives of blame important for the therapy process. This was evident in their SRIs, where the therapists explicitly evaluated the topics of the micro narratives as important, and also reported on the evoking of emotions.

The therapists often showed opposed EDA responses during the clients' identity blaming. We propose that this may be due to the therapists at times following different story lines, engagement in diverse conversational tasks or experiencing empathy for different clients. Earlier research on couple treatment for IPV has found that the clients, both women and men, appreciate having male-female co-therapists (Lechtenberg et al. 2015). It would be interesting to study how the gender of the therapists might impact the quality of therapeutic alliance and consequently their physiological responses. However, the data of this study is limited for such research. Also, in the findings of this paper, therapists of same gender respond differently to blaming. For example, the two male therapists working with couple 1 mentioned in their individual SRIs that important issues were talked about in the clips shown; however, they saw and felt the situation in different ways, which could explain the differences in their EDA responses. Differences in the agendas and tasks of the therapists in this particular case have been studied in another paper in the Relational Mind project (Kykyri et al. manuscript in preparation). Along with Seikkula et al. (2015), we suggest that variation in synchrony may be a positive phenomenon in a multiactor therapy setting in that more perspectives are taken into consideration.

In the cases studied, blame was mainly cast by the same partner. During identity blaming, the target, who did not necessarily respond to other types of blame, showed SCR activation. At the same time, the therapists showed affective EDA. This finding is in line with Levenson and Gottman (1983), who reported the highest levels of physiological linkage during the expression of emotions by distressed couples in conflict discussions. For example, in case 1, in which Lasse's identity was the target, the SCR that accompanied Heli's criticism was framed by strong emotions of longing and sadness. It may be argued that this kind of an emotional atmosphere renders the attribution of blame even more effective. Moreover, Heli's blaming utterance was explicitly targeted towards Lasse's identity

as a man and a father. Closer scrutiny of the SRIs revealed that the participants did in fact report opposition and emotional arousal during some of the identity blaming sequences. Furthermore, the therapist's physiological responding when witnessing clients' blaming highlight an important aspect of couple therapy: namely the viewpoint of the children. Based on the findings of this study it can be suggested that like the therapists when listening to their clients' blaming, also children who witness their parents' conflicts, respond physiologically in these situations. Being exposed to parental violence has been linked to trauma symptoms including emotional and behavioral problems in children (Evans et al. 2008; Wolfe et al. 2003). Hence, developing treatment for children who are exposed to violence should also focus on physiological responses.

Nevertheless, drawing any firm conclusion about the stimuli evoking parallel SCR activation is complicated. In addition to the emotional value of the blame content, other factors may be linked to EDA arousal (Boucsein 2012). Movements by the participants can increase their level of arousal, and such movements were indeed observed in the video-recordings during some blaming moments. However, preparing to act causes the level of arousal to rise before the actual body movement (Burgoon et al. 1989). Self-touching has also been linked to emotion regulation (Grunwald et al. 2014; Ekman and Friesen 1969), and thus observations of hand movements may rather enrich the analysis than interfere with the findings. However, a more detailed analysis of attunement in body movements is beyond the scope of this study and is left for future research. Also, orienting responses and cognitive effort in, e.g., preparing one's utterance may include affective arousal. Some themes were raised by asking a direct question or making a comment. It should also be mentioned that SCRs were not activated only during blaming but were also observed in each participant outside of the blaming micro narratives.

In both the cases studied, blaming one's partner was done in particular by the victim of the IPV. Blaming that targeted the abusive partner was in most cases accompanied by SCR activation in the accuser, possibly suggesting activation of the flight-or-fight response caused by fear or uncertainty over the perpetrator's reaction. However, the possible links between arousal and IPV are hypothetical in this study, since no comparison with couples with no history of IPV was conducted. Blaming the other is a sensitive issue and may also be accompanied by emotional arousal in couples with no history of IPV.

Implications for Practice

This paper argues that when targeting the other person's identity, blaming is a strong discursive act which also shows at the level of the ANS. The findings of this study draw attention to more implicit and subtle blaming, the moral load of which becomes visible only when the utterance is placed in the context of the blaming micro narrative as a whole. Commenting on the other person's identity may be a cue for the therapist to expect blaming. Paying attention to comments of this kind about the other person present may help the therapist in addressing serious criticism. Reformulating identity blaming to target behavior instead of the person may work as an intervention in couple therapy. In the Gottman couple therapy model, blame is reformulated as a positive, contextualized wish for a change in one's partner's behavior (Gottman and Gottman 2008).

Furthermore, the findings highlight the embodied aspects of therapeutic interaction. Reciprocal physiological responses have been seen as part of transference—countertransference processes (Schore 2001; Schore and Schore 2008). Paying attention to and noticing physiological changes in clients or in oneself may signal to the therapist that something emotional or important is going on. Such signals can be brought up in the verbal dialogue and may benefit clients' learning to soothe their affective arousal (Gottman and Gottman 2008; Greenberg and Goldman 2008). Recognizing physiological changes in oneself may increase therapist reflexivity, and such observations should be encouraged and addressed also in supervision.

Limitations of the Study

In this study, a qualitative methodology was developed which combines discursive psychological and narrative ideas. The aim was to contribute to understanding how interaction takes place on different levels in couple therapy. The limitations of the qualitative reading include lack of dual coding in the initial phase of the analysis. However, researcher triangulation was used when selecting the most explicit blaming sequences and in writing micro narratives around these blames. Moreover, the intention of the present case study is not to make general assumptions about responses to blaming. Any such endeavor would require larger data, whereas the aim of this study was rather to investigate some aspects of blaming dialogue. Also, the aim of this study was not to compare couples with a history of IPV and couples with no such history. Data were selected with an eye to the possibility of such comparative research in the future. Finally, the use of EDA as the only physiological measure of affective arousal is a limitation of this study. To tackle the problem caused by the possible links between EDA arousal and multiple stimuli, the analysis was supplemented with the use of SRIs. However, the SRIs did not cover all the blame sequences, and the participants' reports have to be interpreted in their context,

which is not the same as the actual therapy interaction. Identifying the affective arousal during therapy conversations could be further enhanced by analyzing nonverbal behavior, e.g. gaze and facial expressions (Patterson et al. 2012).

Future Research

An important question for future research is the evolution of blame in the course of the couple therapy process at both the verbal and embodied levels. A fuller understanding of positioning and identity work in couple treatment would require combining multiple sources of ANS and nonverbal interaction with qualitative analysis. However, based on this analysis we would highlight the importance of the embodied aspects of therapeutic interaction. The analytic choices made in this study may prompt future research on the value of physiological data in understanding interaction phenomena. Furthermore, the analysis demonstrated the clinical value of discursive analysis. The findings encourage clinicians to intervene in comments and criticisms targeting the other's identity and which may include attributions of blame.

Acknowledgments This study was funded by the Academy of Finland (Grant Number 265492).

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

References

Avdi, E., & Georgaca, E. (2007). Narrative research in psychotherapy: A critical review. *Psychology and Psychotherapy: Theory, Research and Practice, 80*(3), 407–419. doi:10.1348/147608306X158092.

Avdi, E., & Georgaca, E. (2009). Narrative and discursive approaches to the analysis of subjectivity in psychotherapy. *Social and Personality Psychology Compass, 3*, 654–670. doi:10.1111/j.1751-9004.2009.00196.x.

Bakhtin, M. (1984). *Problems of Dostojevskij's poetics: Theory and history of literature* (Vol. 8). Manchester: Manchester University Press.

Bamberg, M. G. W. (1997). Positioning between structure and performance. *Journal of Narrative and Life History*, *7*, 335–342. Retrieved from http://www2.clarku.edu/~mbamberg/Papers/Positioning%20Between%20Structure%20and%20Performance.pdf

Bänninger-Huber, E. (1992). Prototypical affective microsequences in psychotherapeutic interaction. *Psychotherapy Research, 2*, 291–306. doi:10.1080/10503309212331333044.

Benedek, M., & Kaernbach, C. (2010). A continuous measure of phasic electrodermal activity. *Journal of Neuroscience Methods, 190*, 80–91. doi:10.1016/j.jneumeth.2010.04.028.

Boucsein, W. (2012). *Electrodermal activity*. Boston: Springer.

Burgoon, J. K., Kelley, D. L., Newton, D. A., & Keeley-Dyreson, M. P. (1989). The nature of arousal and nonverbal indices. *Human Communication Research, 16*(2), 217–255. doi:10.1111/j.1468-2958.1989.tb00210.x.

Burr, V. (2003). *Social constructionism* (2nd ed.). London: Routledge.

Buttny, R. (2004). *Talking problems: Studies of discursive construction*. Albany, NY: State University of New York Press.

Ciano-Boyce, C., & Shelley-Sireci, L. (2003). Who is mommy tonight: Lesbian parenting issues. *Journal of Homosexuality, 43*, 1–13. doi:10.1300/J082v43n02_01.

Cooper, J., & Vetere, A. (2005). *Domestic violence and family safety. A systemic approach to working with violence in families*. London and Philadelphia: Whurr Publishers.

Cromby, J. (2012). Feeling the way: Qualitative clinical research and the affective turn. *Qualitative Research in Psychology, 9*, 88–98. doi:10.1080/14780887.2012.630831.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal of the Theory of Social Behaviour, 20*, 43–63. doi:10.1111/j.1468-5914.1990.tb00174.x.

Edley, N. (2001). Analysing masculinity: Interpretative repertoires, ideological dilemmas, and subject positions. In M. Wetherell, S. Taylor, & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 189–228). London: Sage.

Edwards, D. (1995). Two to tango: Script formulations, dispositions, and rhetorical symmetry in relationship troubles talk. *Research on Language and Social Interaction, 28*, 319–350. doi:10.1207/s15327973rlsi2804_1.

Edwards, D., & Potter, J. (1992). *Discursive psychology*. London: Sage.

Edwards, D., & Potter, J. (1995). Attribution. In R. Harré & P. Stearns (Eds.), *Discursive psychology in practice* (pp. 87–119). London: Sage.

Ekman, P., & Friesen, W. V. (1969). The repertoire of nonverbal behavior: Categories, origins, usage, and coding. *Semiotica*, *1*, 49–98. Retrieved from http://boccignone.di.unimi.it/CompAff2011_files/EkmanFriesenSemiotica.pdf

Evans, S. E., Davies, C., & DiLillo, D. (2008). Exposure to domestic violence: A meta-analysis of child and adolescent outcomes. *Aggression and Violent Behavior, 13*(2), 131–140. doi:10.1016/j.avb.2008.02.005.

Fishbane, M. (2011). Facilitating relational empowerment in couple therapy. *Family Process, 50*, 337–352. doi:10.1111/j.1545-5300.2011.01364.x.

Gottman, J. M., & Gottman, J. S. (2008). Gottman method couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (pp. 138–164). New York: The Guilford Press.

Greenberg, L. S., & Goldman, R. N. (2008). *Emotion-focused coupes therapy: The dynamics of emotion, love, and power*. Washington, DC: American Psychological Association.

Grunwald, M., Weiss, T., Mueller, S., & Rall, L. (2014). EEG changes caused by spontaneous facial self-touch may represent emotion regulating processes and working memory maintenance. *Brain Research, 1557*, 111–126. doi:10.1016/j.brainres.2014.02.002.

Harré, R., & van Langenhove, L. (1991). Varieties of positioning. *Journal of the Theory of Social Behaviour, 21*, 393–407. doi:10.1111/j.1468-5914.1991.tb00203.x.

Itävuori, S., Korvela, E., Karvonen, A., Penttonen, M., Kaartinen, J., Kykyri, V. L., & Seikkula, J. (2015). The significance of silent moments in creating words for the not-yet-spoken experiences in threat of divorce. *Psychology, 6*(11), 1360–1372. doi:10.4236/psych.2015.611133.

Johnson, S. M., Makinen, J. A., & Millikin, J. W. (2001). Attachment injuries in couple relationships: A new perspective on impasses

in couples therapy. *Journal of Marital and Family Therapy, 27*, 145–155. doi:10.1111/j.1752-0606.2001.tb01152.x.

Karvonen, A., Kykyri, V. L., Kaartinen, J., Penttonen, M., & Seikkula, J. (2016). Sympathetic nervous system synchrony in couple therapy. *Journal of Marital and Family Therapy, 42*(3), 383–395. doi:10.1111/jmft.12152.

Kraus, W. (2006). The narrative negotiation of identity and belonging. *Narrative Inquiry, 16*, 103–111. doi:10.1075/ni.16.1.14kra.

Kreibig, S. D. (2010). Autonomic nervous system activity in emotion: A review. *Biological Psychology, 84*(3), 394–421. doi:10.1016/j.biopsycho.2010.03.010.

Kurri, K., & Wahlström, J. (2005). Placement of responsibility and moral reasoning in couple therapy. *Journal of Family Therapy, 27*, 352–369. doi:10.1111/j.1467-6427.2005.00327.x.

Kykyri, V. L., Karvonen, A., Nyman-Salonen, P., Kurri, K., & Wahlström, J. Changes in participants' affiliation, bodily synchrony and attunement while handling of allegiance problem in couple therapy—a mixed method case study (manuscript in preparation).

Lechtenberg, M., Stith, S., Horst, K., Mendez, M., Minner, J., Dominguez, M., et al. (2015). Gender differences in experiences with couples treatment for IPV. *Contemporary Family Therapy, 37*(2), 89–100. doi:10.1007/s10591-015-9328-8.

Levenson, R. W., & Gottman, J. M. (1983). Marital interaction: Physiological linkage and affective exchange. *Journal of Personality and Social Psychology, 45*(3), 587–597. doi:10.1037//0022-3514.45.3.587.

Lyons, A. C., & Cromby, J. (2010). Social psychology and the empirical body: Rethinking the relationship. *Social and Personality Psychology Compass, 4*, 1–13. doi:10.1111/j.1751-9004.2009.00219.x.

Marci, C. D., Ham, J., Moran, E., & Orr, S. P. (2007). Physiologic correlates of perceived therapist empathy and social-emotional process during psychotherapy. *The Journal of Nervous and Mental Disease, 195*, 103–111. doi:10.1097/01.nmd.0000253731.71025.fc.

Mazor, A. (2004). Same-gender couple therapy: Creating new objects in intimacy and parenehood transition. *Contemporary Family Therapy, 26*(4), 409–423. doi:10.1007/s10591-004-0644-7.

McLeod, J. (1997). *Narrative and psychotherapy*. London: Sage.

McLeod, J. (2004). Social construction, narrative, and psychotherapy. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 351–365). London: Sage.

Minuchin, S. (1974). *Families and family therapy*. London and New York: Routledge.

Patterson, J., Gardner, B. C., Burr, B. K., Hubler, D. S., & Roberts, K. M. (2012). Nonverbal behavioral indicators of negative affect in couple interaction. *Contemporary Family Therapy, 34*(1), 11–28. doi:10.1007/s10591-011-9170-6.

Potter, J. (2003). Discursive psychology: Between method and paradigm. *Discourse & Society, 14*(6), 783–794. doi:10.1177/09579265030146005.

Potter, J. (2012). Discursive psychology and discourse analysis. In J. P. Gee & M. Handford (Eds.), *The Routledge handbook of discourse analysis* (pp. 104–119). London: Routledge.

Råkil, M. (2006). Are men who use violence against their partners and children good enough fathers? The need for an integrated child perspective in the treatment work with the men. In C. Humphries & N. Stanley (Eds.), *Domestic violence and child protection* (pp. 190–202). London, England: Jessica Kingsley.

Ramseyer, F., & Tschacher, W. (2011). Nonverbal synchrony in psychotherapy: Coordinated body movement reflects relationship quality and outcome. *Journal of Consulting and Clinical Psychology, 79*, 284–295. doi:10.1037/a0023419.

Rober, P. (2015). The challenge of creating dialogical space for both partners in couple therapy. *Australian and New Zealand Journal of Family Therapy, 36*, 105–121. doi:10.1002/anzf.1090.

Sarbin, T. R. (1986). The narrative as a root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology. The storied nature of human conduct* (pp. 3–21). New York: Praeger.

Schore, A. N. (2001). Minds in the making: Attachment, the self-organizing brain, and developmentally-oriented psychoanalytic psychotherapy. *British Journal of Psychotherapy, 17*(3), 299–328. doi:10.1111/j.1752-0118.2001.tb00593.x.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*(1), 9–20. doi:10.1007/s10615-007-0111-7.

Seikkula, J., Karvonen, A., Kykyri, V. L., Kaartinen, J., & Penttonen, M. (2015). The embodied attunement of therapists and a couple within dialogical psychotherapy: An introduction to the relational mind research project. *Family Process, 54*, 703–715. doi:10.1111/famp.12152.

Stancombe, J., & White, S. (2005). Cause and responsibility: Towards an interactional understanding of blaming and 'neutrality' in family therapy. *Journal of Family Therapy, 27*, 330–351. doi:10.1111/j.1467-6427.2005.00326.x.

Stratton, P. (2003). Causal attributions during therapy I: Responsibility and blame. *Journal of Family Therapy, 25*, 136–160. doi:10.1111/1467-6427.00241.

Vall, B., Seikkula, J., Laitila, A., & Holma, J. (2016). Dominance and dialogue in couple therapy for psychological intimate partner violence. *Contemporary Family Therapy, 38*(2), 223–232. doi:10.1007/s10591-015-9367-1.

Vall, B., Seikkula, J., Laitila, A., Holma, J., & Botella, L. (2014). Increasing responsibility, safety, and trust through a dialogical approach: A case study in couple therapy for psychological abusive behavior. *Journal of Family Psychotherapy, 25*, 275–299. doi:10.1080/08975353.2014.977672.

Veteläinen, A., Grönholm, H., & Holma, J. (2013). Discussions of fatherhood in male batterer treatment group. *Sage Open,*. doi:10.1177/2158244013492083.

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and poststructuralism in dialogue. *Discourse & Society, 9*(3), 387–412. doi:10.1177/0957926598009003005.

Wolfe, D. A., Crooks, C. V., Lee, V., McIntyre-Smith, A., & Jaffe, P. G. (2003). The effects of children's exposure to domestic violence: A meta-analysis and critique. *Clinical Child and Family Psychology Review, 6*(3), 171–187. doi:10.1023/A:1024910416164.