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Towards gender awareness in couple therapy and in treatment of intimate partner violence

Gender is the most pervasive classification of individuals and thus strongly defines couple relationships. Cultural discourses on couple relationships reproduce hierarchical gender differences, and couple distress is often linked to gendered power inequalities. At worst, gender is the basis for intimate partner violence (IPV). Generally, however, therapeutic interventions do not address the issues of gender and gendered power. This paper discusses the meaning and functions of gender in the context of couple therapy, in particular for IPV. It is argued that the therapist needs to be skilled 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. Addressing the gendered positioning of others and themselves is a clinical tool of potential value in therapeutic conversations.

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

The article is based on the doctoral dissertation of the first author.

Key messages:

- Gender and power play a part in couple's motivations to seek therapy and need to be addressed by the therapist
- Positioning may work as a clinical tool for therapists working with couples in general and in particular with IPV
- Attention to and skill in addressing gender and power should be supported in therapist training and supervision

Introduction

Over the past thirty years, feminist thinking has gained a central place in family therapy (Leslie & Southard, 2009). However, according to Leslie and Southard, this has led to a diminution in the original critical awareness of injustice and development of therapy practice that feminism brought with it. Indeed, family and couple therapies have been criticized for not addressing the gendered imbalance of power (Knudson-Martin, 2013), and instead couple conflicts are often handled at the private, individual level without addressing the cultural, political and social context (Sinclair & Monk, 2004). This approach entails the possibility that social injustice and oppression are reproduced in the therapy room (Dickerson, 2013; Hare-Mustin, 1994; Parker, 2009). This paper discusses the current state of couple therapy, and treatment of intimate partner violence (IPV) in particular, with respect to gender and power, and, based on the literature and the authors' own contribution to research in the field, argues that a discursive approach to therapy can help in this challenging task of addressing gender and power in therapeutic conversations.

Gender is not a static and finite characteristic of an individual, but an evolving, nuanced and negotiable part of a person's identity. Gender refers to something that is constructed through performance by individuals in their everyday lives (Butler, 1990; Magnusson & Marecek, 2012). Everyday performance is informed by the cultural resources of being male or female (Wetherell, 2007). In social constructionist terms, identity comprises a constellation of subject positions that we adopt in social interaction (Harré & Van Langenhove, 2003). Thus, identity is a social process involving not only our own endeavors to act from a preferred position but also other people's positioning of us and themselves along with the cultural resources that the participants in such interactional positioning can draw on. Positions are not freely negotiable but are subject to cultural expectations. This means that not all positions are equally available to everyone (Henriques, et al., 1998). Gender categorization is hierarchical, including the unequal distribution of power, meaning that men and women do not have the same possibilities or limitations. Like the gender division itself, the discrepancies in the 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.

The ideal of equality between partners may be strong and explicit. However, the cultural discourses surrounding couple relationships continue to be gendered and involve hierarchic power dynamics (Fishbane, 2011; Knudson-Martin, Huenergardt, Lafontant,

Bishop, Schaepper, & Wells, 2015; Ward & Knudson-Martin, 2012). Hence, even if equality is an ideal for couples, and it has been connected to relationship satisfaction (Whisman & Jacobson, 1990), greater marital happiness (LeBaron, Miller, & Yorgason, 2014) and well-being (Knudson-Martin, 2013), 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 themselves and build up their relationships (Knudson-Martin, 2013; Knudson-Martin & Huenergardt, 2010; Sinclair & Monk, 2004). Thus, couple relationships lack support for breaking down gendered hierarchies. Furthermore, inequality between partners has been linked to distress and problems in couple relationships (Harryson, Novo, & Hammarström, 2012), and an unequal distribution of power to relationship dissatisfaction (Whisman & Jacobson, 1990). It is likely, therefore, that gender and power hierarchies are linked to treatment-seeking by individuals and couples.

If seeking treatment is linked to inequality and heterosexual relationships are the primary site for constructing the gender order (Henriques et al., 1998), couple therapy presents a fruitful site on which to challenge and reconstruct the gender order and the cultural discourses supporting it. The distribution of power between the two partners is an important starting point for couple therapy, since tackling the issue of inequality in couple therapy may lead to positive changes in the couple relationship. While the importance of this is acknowledged by therapists, it has been found difficult to accomplish (Parker, 1997).

Given the dominant role of the gendered cultural discourses, it is clear that gender will also play a part in the construction the therapeutic relationship. Even if it has been shown that the gender of the therapist is not linked with the therapy outcome (Blow, Timm, & Cox, 2008; Okiishi et al., 2006), this feature may nevertheless carry certain expectations and assumptions with it for the client. Contemporary psychotherapy research highlights the importance of the therapeutic alliance as a key factor in successful treatment (Lambert & Barley, 2001). In the alliance, the client's experience of empathy, understanding and acceptance is essential for a positive therapeutic outcome. It is important that the therapist can relate to the client and tailor the relationship to that individual's needs. Thus, it may be that how the therapist deals with gender issues in the therapy session is more significant than gender per se (Blow, Timm, & Cox, 2008).

Gender and power in couple therapy

Words spoken by the therapist may have an influence and significance that go beyond the utterances of family members (Guilfoyle, 2001). Psychotherapy which is performed within

given therapeutic domains and discourses (Parker, 1998) has been criticized for reconstructing the western cultural ideal of personhood (Guilfoyle, 2002) and gendered relations (Hare-Mustin, 1994). Indeed, research on practitioners' views on women and men has found these to be stereotypical (Huntington & Black, 2014; Trepal, Wester, & Schuler, 2008). This leads to suspicions that gender bias and maintenance of the hierarchical gender order may affect therapy practice.

Parker (1997) has argued that even self-identified feminist practitioners find it difficult, albeit important, to deal with the question of asymmetries of power. Moreover, in their study of family therapists' use of feminist interventions, McGeorge, Carlson, and Guttormson (2009) found that practitioners view patriarchy and social position as important factors that affect relationships and should therefore be addressed. Nevertheless, the therapists studied rarely raised these issues in their own work with clients. Hence, discussion of power issues may not take place in therapeutic conversations unless therapists know how best to raise the issue and have the tools for doing so.

Some couple therapy approaches and guidelines explicitly aim at addressing the couple's cultural and social context, especially gender order and power hierarchies, in their clinical practices. These therapy models include, among others, Socio-Emotional Relationship Therapy (Knudson-Martin & Huenergardt, 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) has 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) has further argued that orienting to discourse in therapeutic interventions can lead to socially responsible therapy practice.

Generally, in clinical training and supervision, instruction in how to deal with gender issues and inequality is lacking (Huntington & Black, 2014; Scher & Good, 1990; Stevens-Smith, 1995). It seems, then, that there is not only a need for the wider acceptance and inclusion of feminist ideas in therapeutic theory and guidelines, but also the continuous development of therapy training curricula as well as monitoring practicing therapists and supporting them in putting these ideas into practice.

IPV as a gendered problem in therapy

Since IPV can be viewed as stemming from stereotypical, fixed and limited gender roles (Holma, Partanen, Wahlström, Laitila, & Seikkula, 2006) and the dominant patriarchal discourse (Dickerson, 2013), deconstruction of gender stereotypes and the embedded imbalance of power needs to be at the core of IPV treatment. Traditionally, IPV victims and perpetrators have been treated separately. Today, the number of such intervention programmes globally is large (Geldschläger, Ginés, Nax, & Ponce, 2013; Saunders, 2008). Perpetrator programmes typically start with individual meetings followed by group treatment. Various approaches are used in different programs (Gondolf, 2004). However, the safety of the victim of IPV has to be the first rule of any such programme (Work with Perpetrators of Domestic Violence in Europe, 2008).

IPV perpetrator group discussions commonly focus on violence-related issues, such as expanding the definition of violence, taking responsibility for one's violent behaviour and learning alternatives to this behaviour. Research on perpetrator programmes has shown that male perpetrators do not initiate gender-based explanations for their violence (Partanen, 2008). Furthermore, when raised by the therapists, the topic of male identity was not seen as important by the group participants. However, the men's views about women may have relevance for their violent acts (Kapanen, 2005). When perpetrators talk about women as impossible to understand or biologically different from men, the speaker is simultaneously constructing a position for himself as a man. The perpetrators and victims of violence were observed to struggle when asked about the influence of gender in their lives (Kelly & Westmarland, 2015). Gender 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 therapist, and quite explicitly.

Treatment groups for IPV perpetrators are usually conducted by a co-therapist dyad, and it has been considered important that one therapist is female and one male. It has been argued that a female therapist can bring a woman's perspective and experience to bear in an otherwise all-male context (Päivinen & Holma, 2012; Tyagi, 2006; Wilson, 1996). A male therapist, in turn, can model a more flexible and modern masculinity to the male client (Deering & Gannon 2005). Having both female and male group facilitators has also been deemed important because it enables the dyad 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). Thus, to accomplish this aim in IPV treatment

requires that the therapists acknowledge the power embedded in the gender order, which then enables them to reflect on their own gendered position and to reconstruct the client's detrimental assumptions about gender.

Working with IPV perpetrators has been considered demanding because the clinician has to balance between empathetic and confrontational approaches. For example, the therapist's 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).

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 but instead locates violence in the intersections and shifting structures of power (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 in female perpetrated violence towards her male partner (Babcock, Miller, & Siard, 2003). Hence, 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.

Following this evolved view of IPV, successful attempts have been made to develop IPV-specific couple therapy models which acknowledge the specific features of IPV and focus on safety (for example, 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, Päivinen, & Holma, 2017; Vall, Seikkula, Laitila, & Holma, 2016; Vall, Seikkula, Laitila, Holma, & Botella, 2014). According to a recent meta-analysis of couple therapy for IPV, this treatment modality can be considered suitable in selected cases (Karakurt, et al., 2016). For each prospective couple, it is essential to assess whether couple treatment appears to be a suitable treatment modality or whether other options would suit the couple better. Couples have to be carefully selected, paying attention to the following criteria: 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 safe and able to talk there; the couple wants to end the violence as well as stay together; and the perpetrator is ready to take responsibility for the violence (Bograd & Mederos, 1999).

Addressing gender in couple therapy and IPV treatment

Therapy, as an institution, is in a good position to contribute to reviving and updating the dominant cultural discourses that influence how people live their lives. This in turn requires that therapists take a broad view of what may work for people and help them in deconstructing the “truths” they live by and constructing better-fitting story lines (Päivinen & Holma, 2016). 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. Active and explicit engagement by the therapist in bringing up the topics of gender and power is needed, and a discursive approach may be fruitful for the therapist in this task.

Critical discursive analyses on couple therapy conversations have demonstrated how the dominant cultural discourses that couple relationships are embedded in inform couple therapy conversations (Päivinen & Holma, 2016; Päivinen, et al., 2016; Sutherland, LaMarre, Rice, Hardt, & Jeffrey, 2016). These traditional cultural discourses offer people an acceptable storyline on how to behave as a male or female partner in heterosexual couple relationships, or as a mother or father in a family with children. The partners may for example draw on dominant cultural discourses in gendered talk about how they should, e.g., behave, communicate with each other, show their commitment and be involved, and this way justify why their partner has to change (Päivinen & Holma, 2016). Thus, using positioning of self and other, the partners seek to redistribute rights and duties in their relationship. Sutherland and colleagues (2016) demonstrated how in couple therapy, patterns of interaction supporting subordination are constructed with reference to the hierarchical gender order. Furthermore, the findings of Päivinen and colleagues (2016) indicated that discourses about, for example, loyalty and the prioritizing of the love relationship, require certain acts of commitment and place the love relationship at the top of the hierarchy along with certain expectations, such as taking the partner’s side over that of others. Moreover, the same study focused on the possible contradiction between the gendered position offered to the subject and the subject’s preferred identity, and also on the importance for clinicians of addressing and exploring identity blaming, which may also be gendered.

Positioning has been shown to be useful approach in exploring identity work in therapy (Avdi & Georgaca, 2009; Drewery, 2005; Guilfoyle 2001, 2002). Päivinen and Holma (2012) demonstrated how gendered positioning can be used as an intervention tool by therapists

working with IPV to change a dominant cultural discourse that can be used to justify violence. The findings demonstrated how a female therapist was invited to take up gendered positions in the group conversations. The positions offered often reflected cultural understandings of women and men as profoundly different, assumptions that can be used as a justification for violence. Such gendered positioning presents the therapist with the challenge of dealing with the cultural discourses around gender and expectations embedded in them. However, a therapist invited to occupy a gendered position may reject that position and by drawing attention to it promote discussion on the topic of gendered expectations and understandings and in this way seek to reconstruct the assumptions, generalizations and justifications of the men who had committed violence towards their female partner.

The findings further underline the importance of understanding both the gendered nature of IPV in efforts to treat it and the fact that awareness of gendered positioning can have a positive effect on affect the therapeutic relationship. While the acknowledgement of gendered positioning may benefit treatment, unacknowledged it may put at risk the goals of the treatment, the co-operation between the female and male therapist, the quality of the intervention, and 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.

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). However, sensitivity is required when dealing with gendered positioning as a tool in therapy. Cultural discourses about gender are limited, dual and individuals may feel constrained by them. Gendered positioning can also be experienced as uncomfortable and a poor fit with the preferred identity of the person (Reynolds, Wetherell, & Taylor, 2007) In such cases, drawing attention to gendered positioning may be interpreted by clients as a way of shaming and blaming them and assigning responsibility to them (Päivinen, et al. 2016). Addressing attributions of blame via their positioning of one another may be an appropriate place for intervention by the therapist. A recent multi-case study showed how gender and gendered expectations informed partner blaming in couple therapy for IPV (Päivinen, et al. 2016). Moreover, such blaming showed as physiological arousal in the couple, and also in the therapist, indicating the strong affective influence of acts of blaming. One powerful gendered blaming episode targeted the partner’s parenting. In couple therapy, gendered positioning occupies central role in the relationship of partners with children, and thus offers a good example of how to work with gendered positioning and dominant cultural discourses. The

centrality of this issue shows in research on IPV treatment, in both perpetrator programmes and couple therapy, in which fatherhood has been seen as a strong motivation for male perpetrators to take responsibility and to work towards changing their violent behaviour (Cooper & Vetere, 2005; Hakala, Jalava, & Holma, 2014; Råkil, 2006; Veteläinen, Grönholm, & Holma, 2013). The therapist can and should 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.

Promoting therapists' awareness of gender

Therapists themselves will also encounter gendered positioning and dominant cultural discourses with gendered expectations of them in their work. 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. 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). For a female therapist it may be especially difficult to strike a balance between these positions (Caoyette, 1999). The therapist also has to acknowledge their own position in the gendered power hierarchy. Quek and colleagues (2016) highlight the possible gender-role conflict of cis-female therapists elicited by notions of reenacting a submissive gender role in their own lives. On the other hand, for cis-male therapists, working with gender means that they have to acknowledge their position as members of the dominant gender group (Quek, Eppler & Morgan, 2014). It is important to acknowledge gender in therapist training and supervision so that gendered issues in treatment can benefit and not hinder a successful outcome.

It is also 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 that may manifest in therapeutic conversations. However, addressing gender requires seeing it as intertwined with the other social categories in which the individual may be positioned. The meaning of gender is constructed in relation to other categories of identity (George & Stith, 2014; Shields, 2008). Sensitivity to the intersection of socio-demographics and gender is needed. For example, in group treatment for IPV therapists are required to adapt their way of working according to the characteristics of their clients (Räsänen, 2013).

Directions for future research

More research is needed to develop ways of incorporating a gender perspective into therapist training and supervision. Research on therapy practices that represent the full gamut of gender, relationships, and forms of IPV is needed for the development of more individually tailored and sensitive interventions. The intersection of socio-demographics and gender also merits more careful attention. 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.

Future studies could also devote more attention to the gender identity of the therapist and working with gender to foster the introduction of gender theory into therapy conversations. For example, taking a more detailed look at male therapists constructing and modelling masculinity in IPV treatment could benefit from understanding how they can best challenge traditional notions, as suggested by Deering & Gannon (2005). Then again, a more detailed look at the gendered positioning of a therapist dyad would also be interesting and useful for developing collaboration in co-therapist teams.

Mixed-method research may provide a more holistic view of social encounters as well as highlight bodily aspects in doing therapy, and in therapist training and supervision (Author citation, 2016). Further analysis of uncomfortable gendered positioning, also targeted at the therapist, could provide useful information in training therapists to work, for example, with alliance ruptures. Such research would also highlight the embodied aspects present in doing therapy, and in the supervision and self-care of clinicians doing this challenging work. Incorporating the embodied level in discursive analyses may help understanding of how a safe and productive therapeutic context can be constructed that enables dominant gender discourses to be challenged and reformed.

Conclusions

The aim of this paper was to promote the development of a sensitive and socially just therapeutic practice. Specifically, the goal was to further understanding of the workings of gender and gendered power in therapeutic conversations by reviewing the current literature. It was argued that the gendered discourses of society are embedded in therapeutic conversations pertaining to couple relationships, and the meanings and role of gendered positioning in the treatment process. The purpose was also to increase understanding of the phenomenon of IPV as a gendered problem and how acknowledging this can make a crucial difference in couple and group treatment conversations. Working with the gendered positioning of the clients and

of the therapists themselves was offered as an intervention tool for therapists to use. However, to use this tool efficiently, the therapist needs to understand the gender order and embedded intersections of gender and power.

In sum, this paper underlines the importance of recognizing the role of gender in therapeutic conversations. It is argued that to perform sensitive and socially just therapy, clinicians should acknowledge and address the gender order and embedded gendered power which may manifest as gendered positioning, of both therapist and client, in therapy conversations. This argues for the inclusion in therapist training and supervision ways of encouraging professionals' self-reflection on gender and power and for supporting their efforts to address these issues in clinical practice.

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