A SOCIAL CONSTRUCTIONIST INFORMED THEMATIC ANALYSIS OF MALE CLINICAL PSYCHOLOGISTS EXPERIENCE OF WORKING WITH FEMALE CLIENTS WHO HAVE EXPERIENCED ABUSE

Omar Timberlake

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Doctor of Clinical Psychology

May 2015

Acknowledgements

I would like to thank all those who have supported me in my endeavours to complete this research project and the doctorate in clinical psychology. I would also like to thank my mother and grandmother for all their support and my supervisor Pippa Dell for 'hanging in there' with me, even when I was a pain.

Abstract

This research sought to explore how male clinical psychologists talked about their experiences of working with women who have experienced abuse and whether such gender difference in the context of therapeutic work problematized them or had implications for their practice and subjective experiences.

Eight male clinical psychologists were recruited and interviewed using a conversational style and co-constructed interview schedules. All participants had experience of working with clients who had experienced abuse and were working in the National Health Service (NHS) in a variety of different settings, which included psychosis teams, child services and learning disability services. The data corpus was analysed using a social constructionist thematic analysis (Braun & Clarke, 2006) also informed by the work of Michel Foucault (1972), set within critical realist ontology.

From the analysis two main themes were generated (*Gender difference in trauma work; Male clinical psychologists' perspectives in the wider context*) and six sub-themes (*Male clinical psychologist as associated with the abuser; Gender difference as therapeutic; Female clinical psychologists as problematized by gender; Supervision and peer support; Service constraints; Maleness as a minority in clinical psychology*). These themes represented the various ways from their accounts in which the participants were problematized in their work with female clients who had experienced abuse. These themes highlighted the various difficulties and constraints placed upon participants in their work with female clients and with the wider discipline, particularly in regards to a lack of support in addressing issues of gender difference and accessing suitable spaces to talk about their experiences. These themes also showed the different ways in which they are constrained by a lack of available discourses that legitimises their experiences and perspectives as men in the wider field of clinical psychology.

The research recommends the importance of creating safe spaces for the consideration of gender difference and for this to also be included in clinical psychology training.

Table of Contents

Acknowledgements

Abstract

Table Of Contents

CHAPTER 1: INTRODUCTION

In my first year of clinical training I was allocated a female client to work with as part of the psychology team. I offered an appointment with the client and met for an initial assessment, which was routine in the service I was placed in. Before meeting with the client I was made aware that she had experienced multiple sexual assaults in her life and the team felt that she could benefit from talking about those experiences. It was a difficult session for me and for the client. She expressed very early on in the session that she was not keen to meet with me and stated that this was due to the fact that I was a man. I acknowledged her concerns and we agreed that I would take it back to the team that she would like to work with a female clinician.

To begin with, I felt confident with acknowledging her concerns regarding talking about her experiences with a male practitioner and acting to ensure her request was met. I was however left feeling uncertain and worried that by even asking her to meet with me I may have done some harm and felt annoyed about the referral process in the team. I felt a better referral process might have helped avoid such an uncomfortable scenario for the client and perhaps for me also. It could have been checked with her beforehand whether she was comfortable speaking to a man. I was mostly keen that she had access to meet someone with whom she could have such conversations with but mostly my frustrations were my own acknowledgement that men often are the perpetrators of such abuse. I was in that sense, as a man already problematized. I felt associated with the abuser. I myself felt constrained by this. I felt apologetic and wondered if there was something I could have done that could have got around this painful fact.

In my contact with the surrounding team, I encountered a number of different ideas about why this client did not want to meet with me and how I should feel in

response to this. These ranged from the client being difficult, not ready to acknowledge that she needed help, to ideas around whether my personal characteristics as a tall man were in many ways too similar to the perpetrators or even that all female clients who have been abused by men should only see female practitioners. I found these various different ideas about why she wanted to speak to someone else and the different ideas around whether a female client should see a man very interesting. I recognised in my conversations with other male psychologists that they too had experienced similar situations and I aimed to further explore these experiences and the challenges that they brought.

1.1 Research aims

I felt encouraged to carry out this research not necessarily as an attempt at gaining access to solutions or how best to manage such situations. Rather it was an attempt to explore if gender difference in the context of trauma work can be problematic for male psychologists' subjective experiences and how this may be informed by available discourses regarding gender difference and 'expert' therapeutic models of working with female clients who have been abused. This will be achieved through exploring how male clinical psychologists construct their work with female clients who have experienced various forms of abuse and whether or not they are problematized as a result of the gender difference. This will also aim to explore the implications of such constructions of trauma for therapeutic work. In addition to this, the research aimed to identify the various subject positions that were offered through these constructions and subsequent subjectivities (Arribas-Ayllon and Walkerdine, 2008). This was done in order to understand the challenges they were facing and to learn from them.

1.2 Outline

In this chapter I will introduce the analytic approach chosen for the analysis. This will situate the approach taken towards the research, regarding the impact of abuse and how the psychological consequences and treatment of abuse are

'constructed' in mainstream literature. The term 'constructed' is used here to make clear my epistemological and analytic position. This analysis drew upon social constructionist ideas, mainly more of Michel Foucault (1982), therefore psychological models and proposed research evidence will be treated as discourses, which construct the objects and subjects of which they speak (Parker, 1992). Within such a social constructionist position, mainstream science becomes another discourse among many with no greater claim to truth or validity. Adopting this stance allows for curiosity as to how practitioners and clients are constructed and positioned by traditional models and approaches to trauma work and the implications this has for gendered experiences. A summary will be presented at the end of the chapter along with the rationale for the research.

1.3 Analytic Approach

I will be discussing epistemology further in section 2.1 but this research takes a critical realist social constructionist epistemology. The kinds of assumptions a researcher makes about the relationship between their data and the world are referred to as epistemological assumptions (Harper, 2012). A critical realist social constructionist stance positions our perceptions and sensations of the 'real world' as not directly caused by it or seen as a true mirror image but rather as referencing the world in some way (Hruby, 2001). Therefore, our ability to make sense of the world is mediated through our symbolic systems and the material world is constructed as offering constraints and limitations on the possibilities of what can be said (Sims-Schouten, Riley & Willig, 2007).

From this I have chosen to utilise a social constructionist thematic analysis (Braun & Clarke, 2006), which is informed by the work of Michel Foucault (1985). This is concerned with the function of discourse in the constitution of social and psychological life and a focus on the mechanisms of power relations. This analysis will involve a consideration of the availability of discourses (discursive resources) within the culture and how they construct the objects and subjects of which they speak (Parker, 1992) and therefore has implications for how people see and experience the world through the offering of subject positions which affect

subjectivity and experience (Hollway, 1989). For the literature review I will be presenting discourses that attempt to make sense of trauma work in clinical psychology. I will be looking at the different models and approaches to doing trauma work with this client group and considering the implications this may have for male clinical psychologists.

1.4 The Use of Language

For this research I have used the term 'abuse' generally to refer to physical, sexual, emotional and psychological forms of abuse. In doing so, I recognise that I am incorporating a wide variety of different concepts. This was chosen to capture the wide variety of clients who present in the context of therapeutic services. The use of the term 'trauma work' is here used to represent any therapeutic work carried out specifically with clients who have been identified as having experienced abuse and of which is the focus of the therapeutic work.

1.5 Impact of Abuse

Within the research base, abuse, such as physical, sexual and psychological abuse, is constructed as highly prevalent in the general public and service user populations. It is constructed as potentially having a number of consequences in its impact (Boonziaser & Rey, 2004). For example, Child Sexual Abuse (CSA) is increasingly constructed as a major cause of morbidity and mortality (Chouliara et al, 2011). Research has proposed that psychological, physical and relational difficulties are experienced by survivors of abuse (Cawson et al, 2000), with tendencies towards re-victimisation, substance abuse and post-traumatic symptoms (Johnson, Pike & Chard, 2001) as well as being linked with psychosis (Read, Rudegeair & Farrelly, 2006; Johnstone, 2011). With repeated and high levels of trauma, Herman (1998) has proposed that the impact of such experiences can also include guilt and shame with regards to abuse, issues in trusting others and low self-esteem, which may in turn affect the ability to form and sustain non-abusive relationships in adult life.

1.6 PTSD as a Consequence of Abuse

Researchers and clinicians have increasingly used the diagnosis of Post-Traumatic Stress Disorder (PTSD) to construct the psychological consequences of abuse (American Psychiatric Association, 2000). For example, sexual abuse is highlighted as being strongly associated with PTSD (Bremner & Vermeeten, 2001), although this is not exclusively the only way in which the impact of abuse is constructed (Hegadoren et al, 2006). The concept of PTSD emerged and was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM III; American Psychiatric Association, 1980) following the Vietnam War. This was a response to social and political pressures as opposed to being the result of scientific inquiry (Yehuda & McFarlane, 1995; Patel, 2011). This concept developed with regards to efforts by campaigners to highlight the impact of war on veterans and to help in acquiring funding for psychological support.

In the context of abuse, the DSM IV-TR (American Psychiatric Association, 2000) constructs PTSD as a diagnosis that highlights the impact of abuse with a list of twenty symptoms that an individual may be experiencing following such trauma (Calhoun et al, 2012). Such symptoms were constructed as being indicative of PTSD when they are present for four or more weeks following the 'traumatic' incident. These symptoms can include re-experiencing or flashbacks, avoidance of stimuli associated with the trauma, anxiety difficulties and low mood (Dunleavy & Slowik, 2012). Thus, PTSD had become a construct wherein the experience of abuse could be seen as something that can be quantified and categorized through the presence of symptoms (Patel, 2011) and further to this, psychologized as something that needs to be treated through psychological therapy (Patel, 2011).

In the context of CSA, studies have been carried out identifying PTSD as a consequence of the experience of CSA in early life (Saunders et al, 1992). However, with acknowledgement of CSA and other types of abuse often involving multiple traumatic experiences (Trickett & Putnam, 1998), questions have been raised as to whether a diagnosis of PTSD can appropriately capture the impact such repetitive and long standing abuse can have on individuals. Such critique is

informed by research that suggests the majority of trauma survivors encounter multiple traumas as opposed to single incidences (Kessler, 2000). The conceptualisation of PTSD in the DSM IV-TR (American Psychiatric Association, 2000) concerns discrete and circumscribed incidences of trauma, covering 'events' such as single incidents of sexual assault, disaster and combat as opposed to long standing and repetitive abuse.

Herman (1994) and Van der Kolk et al (1996) proposed that those who have undergone multiple and chronic experiences of trauma are not fully captured by such a construction of PTSD and suggested the symptomatology of such individuals as more complex. Such difficulties captured within this complex construction of PTSD include relational and identity difficulties and Herman (1994) proposes that this be identified as 'complex PTSD'. Difficulties associated with 'complex PTSD' include social and interpersonal, functioning in the work environment, and overall adjustment (Herman, 1998). Such a focus on CSA as a particular type of trauma associated with 'complex PTSD' has developed through research suggesting the high prevalence of CSA and its multiple, repetitive nature in those identified as experiencing it (Finkelhor & Dziuba-Leatherman, 1994), alongside its association to other types of traumas (Coid et al, 2001; Dong et al, 2004).

Herman (1994) identified three areas of potential disturbance that were not fully captured by the traditional PTSD diagnosis (American Psychiatric Association, 2000), which included a more complex symptom presentation (including dissociation, somatic and affective symptoms), impact on personality and a vulnerability to repeated harm from others and self. Thus, 'complex PTSD' was constructed as capturing a variety of the effects of trauma rather than just a dominant set of symptoms and includes alterations in emotional regulation, perceptions of self and perpetrator, difficulties in interpersonal relations, systems of meaning and identified as often being co-morbid with PTSD (Resick et al, 2012). In the new edition of the DSM V (American Psychiatric Association, 2012) PTSD is no longer listed as an anxiety disorder and is now constructed as a new category of trauma stressor-related disorders with three new symptoms added. In

this new construction of PTSD, the expansion of the diagnosis is now conceived as having a closer fit to Herman's (1994) concept of 'complex PTSD', which includes identity disturbance, difficulties with emotional regulation and a dissociative subtype. However, it can be argued that the impact of both singular and repetitive traumatic experiences are still constructed and pathologised as a way of rendering such individuals as amenable to psychological and psychiatric intervention.

1.7 Psychological Approaches to Trauma

Psychological approaches to understanding the effects of abuse, constructed as trauma effects, have been developed with a focus on addressing PTSD symptoms using a Cognitive Behavioural Therapy (CBT) framework (Bisson et al, 2007; Bennett-Levy et al, 2004; Stewart & Chambless, 2009). Such trauma-focused CBT approaches have been proposed, following research, to lead to significant improvement in PTSD symptoms and recommended as treatments (National Institute for Health and Clinical Excellence, 2005; Foa et al, 2005; American Psychiatric Association, 2004). Research has proposed that on average, up to 67% of clients who engage with trauma-focused CBT treatments will see a reduction in their PTSD symptoms resulting in no longer meeting the threshold for such a diagnosis. PTSD here is constructed as a common consequence of traumatic events including physical and sexual abuse (Dunmore, Clark and Ehlers, 1999) and recovery from trauma is positioned as being the reduction of associated symptoms.

1.7.1 Trauma-Focused Cognitive Behavioural Therapy

Symptom severity is typically used to assess the outcome of treatments for PTSD and research has suggested that trauma-focused psychological treatments are efficacious in addressing PTSD symptoms (Ehlers et al, 2010). Foa and Rothbaum's (1998) manualized treatment for PTSD is organized around the concept of prolonged exposure as its main intervention and is regarded as having a high effectiveness in the reduction of symptoms (Foa, 2001; Foa et al 1999; Rothbaum et al, 2005). Situated within a CBT framework, the prolonged exposure

intervention is based upon classical and operant conditioning. This approach constructs the concept of PTSD as deriving from associations of neutral stimuli with the emotional response of fear consequently becoming a conditioned stimulus. The conditioned stimulus subsequently produces fear in similar situations. Avoidance in the experience of PTSD is understood through negative reinforcement, avoiding aversive conditioned stimuli thus maintaining the fear and other PTSD symptoms. Intervention is understood as breaking the negative reinforcement of avoidance through the prevention of an avoidance response thus breaking this 'vicious circle' (Foa and Rothbaum, 1998). This also leads to the breaking of the connection between the conditioned stimulus and a fear reaction due to the absence of the feared for consequences following exposure to the conditioned stimulus.

The therapeutic programme involves three main components. Psychoeducation involves learning about the causes of PTSD and common responses to trauma. This is followed by imaginal exposure to the traumatic memory and in vivo (real life) exposure to reminders of the traumatic experience (Kramer, 2009). This approach has also been accompanied by research aiming to identify such processes at the neurological level suggesting that it helps to develop an inhibitory control from the medial prefrontal cortex of the fear circuit, leading to reduced PTSD symptoms (LeDoux, 2002).

In this approach, the devastating effects of abuse are being understood as something that can be measured with regards to symptoms that are experienced and constructed as being indicative of trauma related pathology. Alongside this, the effects of abuse are constructed as the result of faulty connections and associations that lead subsequently to the experience of fear and distressing symptoms in seemingly non-threatening situations therefore rendering the response of the person as unhealthy and pathological. Here the individual who has experienced trauma is constructed as in need of treatment and subsequently offered the subject position of 'victim'. This can be argued as offering a position wherein 'treatment' is necessary in order to 'fix' the individual who has

experienced abuse, further cementing the expertise and need for expert psychological and psychiatric discourses.

Some treatments generally share in common a focus on addressing the traumatic memories of events and the meaning of such trauma as constructed by clients'. For example, current cognitive behavioural approaches to working with PTSD highlight the role that cognitive factors and the nature of trauma memory play in its development and persistence (Ehlers & Clark, 2000). For example, there has been much research suggesting the manner in which traumatic life events are remembered as having significant psychological effects (Kleim et al, 2013; Stewart & Chambless, 2009; Bradley et al, 2005). This consequently places the alleviation of distressing symptoms within the need to make sense of traumatic experiences for one's wellbeing. Such approaches, which lean towards the positioning of effective interventions as the making sense of an event, have a number of variations including, placing the thoughts and feelings of an event under evaluation, developing a narrative, reframing of an event and seeking resolution or new insights (Park, 2010). Much emphasis is given to the application of such approaches which include Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001) and meta-analyses of research have proposed these as efficacious in the reduction of symptoms (Bisson et al, 2007; Seidler & Wagner, 2006; Kleim et al, 2013). However, it can be said that there appears to be a considerable absence of other factors such as the context that abusive experiences occurs within, wider social factors and the impact on relationships.

In Ehlers and Clark's (2000) trauma focused approach, persistent PTSD is understood to develop if the individual processes the traumatic event, along with its sequalae, in a manner that brings about a sense of current threat. This model stipulates that individual differences in how trauma and its sequalae are appraised, along with individual differences in the nature of the event memory and how it links to other autobiographical memories are key processes that lead to persistent PTSD. Activation of such memories with the perception of threat is accompanied by re-experiencing symptoms, such as intrusions and arousal. Through the perception of threat and its associated symptoms, individuals are identified as

having both cognitive and behavioural responses that are driven towards reducing the perceived threat and distress. This, however, is constructed as a short term strategy that may result in temporary alleviation of distress but results in preventing cognitive change, therefore maintaining the disorder (Kleim et al, 2013). An individualised formulation is developed for each client, serving to illustrate the unhelpful appraisals, triggers and characteristics of memories along with behavioural and cognitive strategies that provide temporary alleviation (Ehlers et al, 2010).

This trauma focused approach is concerned with attempting to address and change maladaptive appraisals. This also occurs as a central feature in Cognitive Processing Therapy for Sexual Assault (CPT-SA), another trauma-focused CBT intervention (Chard et al, 1997). This was adapted from CPT for victims of rape who experienced PTSD (Resick & Schnicke, 1993). In this intervention, clients were expected to complete a twelve week course of treatment involving one to one and group based work. This draws upon information-processing theories and proposes that individuals have a number of 'reactions' to a traumatic event that may prevent the integration of the event due to an inconsistency with pre-existing beliefs. Thus, what follows is either a process of assimilation (changing the meaning of an event to fit current beliefs) or a process of accommodation (changing prior beliefs to allow for inclusion of an event). Through assimilation it is considered that there would be an increased chance of experiencing PTSD symptoms such as intrusions and avoidance. The intervention involves a seventeen week model also combining one to one and group work.

In this trauma focused approach, CPT-SA additionally draws upon developmental and self-trauma theories and aims to address cognitive appraisals, helping to develop connections between thoughts and feelings and supporting clients in moving towards accommodation. This can involve retelling of the traumatic incident in a way that allows for the feelings associated with the event to become attached (Chard et al, 1997). It can be said here that distress following traumatic events such as abuse are reduced to a number of symptoms, something quantifiable, measurable and amenable to psychological therapy (Patel, 2011).

1.7.2 'Complex PTSD'

As mentioned above, there have been questions raised towards the adequacy of a PTSD diagnosis to capture the experience and features of chronic abuse, termed as 'complex PTSD'. Many models of treatment are based upon former constructions of PTSD (DSM IV; APA, 2004), which are deemed as failing to address the varied and complex symptomatology of PTSD. An alternative model towards understanding the impact of traumatic experiences has been developed by Herman (1994). This conceptualizes the impact of traumatic experiences as disempowerment and disconnection from others. Through constructing the impact of abuse and other traumatic experiences in such a way, in Herman's model, intervention becomes one of re-connection and empowerment as the route to recovery. Thus, the impact of abuse is constructed as one of 'damage', whereby the individual has become 'deformed' by the abuse and in need of recovery (Herman, 1998). Further to this, through constructing generically the concept of abuse as situated in the experience of disempowerment, the road to empowerment becomes one that only the 'victim' can take:

"Trauma robs the victim of a sense of power and control over her own life; therefore, the guiding principle of recovery is to restore power, and control to the survivor. She must be the author and arbiter of her own recovery. Others may offer advice, support, assistance, affection, and care, but not cure." (Herman, 1998 p3)

This constructs a 'survivor' story, one wherein the 'victim' of abuse must take control of her own recovery. Further to this position as a survivor, the client is positioned as needing to go through a set process before recovery is achieved. This challenges more traditional models such as the medical model, whereby the patient plays a more passive role as the receiver of expert intervention. Abuse and traumatic experiences are constructed within this model as leading to 'damage' and subsequently requiring intervention and 'recovery' (Herman, 1998). This emphasises the need for those working with the survivor to ensure that 'empowerment' is at the forefront of their work. This follows the work of feminists in playing a key role in raising the visibility of those who have been abused. The

notion of survivor works to move away from ideas of pathology whilst still acknowledging the suffering, misery or damage it may cause. This also served to situate the abusive experiences of women within the wider context of subordination and oppression and thus the term 'survivor' had become the result of much second wave feminist action (Worrell, 2003).

Constructing survivors as damaged positions therapeutic work as requiring taking into account a number of factors in building up a therapeutic relationship. This is understood as problematic given the very aspects or 'psychological damage' assumed to be inflicted upon the survivor is that which is required in developing 'healthy' relationships, which includes trust and feelings of safety. Already here the survivor is constructed as one who can be quite easily re-traumatised in therapeutic work if there is coercion, force and the reenactment of power dynamics in the therapeutic relationship (Lister, 1982). In addition to this, techniques such as physical therapy are also positioned here as holding the potential for re-traumatising effects (Schachter, Stalker & Teram, 1999). Thus, the political move to raise awareness of the experiences of women who have been abused also served to render them subject to expert discourses of healing, recovery and cure.

Through a construction of the 'damaged' survivor, developing a therapeutic relationship is positioned as a difficult and 'painstaking' task (Chu, 1988). The emphasis on developing 'sensitive' practice becomes very important in order to achieve both empowering the client in their own 'survivor' story and ensuring that therapy doesn't serve as a trigger for re-traumatisation. This includes emphasis on general counselling skills such as building good report, establishing partnerships, transparency and sharing information to further develop a therapeutic context of control and safety (Schachter et al, 2009). But abuse is not just constructed as a potentially damaging force upon a person's own capacity to enter into a therapeutic relationship it is also constructed as holding powerful effects upon the therapist themselves. Herman (1998) describes this as traumatic countertransference and others have labelled this as a form of PTSD amongst therapists themselves (Wilson & Lindy, 1994), whereby hearing and learning of traumatic stories experienced by clients can be traumatizing in and of itself.

Trauma becomes 'contagious', where the therapist can feel overwhelmed and be subjected to comparably distressing symptoms as that of the client and their own personal experiences of trauma can also be evoked.

This constructs the very nature of trauma work as potentially hazardous for both client and therapist. The National Institute for Clinical Excellence (NICE) notes that healthcare professionals should be mindful that those considered to have PTSD can be anxious about engaging in treatment (NICE, 2005). Thus, the clinician is positioned as having to take into account a variety of factors in engaging in therapeutic work with those deemed as experiencing distress following abuse and identified as meeting a diagnosis of PTSD. Thus, the strong emphasis on the damaging nature of traumatic experiences backgrounds alternative stories, creating a notion of what a victim of an abusive experience must be like and what working with them 'should' therefore entail.

Within Herman's (1994) model this led to the construction of recovery as occurring through the process of three stages; safety and stabilization, remembrance and mourning, and reconnection. In the first stage Herman (1994) notes that safety is central to the recovery process. Victims of chronic trauma are positioned as experiencing a sense of betrayal from their experiences and their bodies, with associated symptoms potentially resulting in re-traumatization. Therapeutic work is therefore the rebuilding of both internal and external control for the client. They are educated on skills and strategies to help in managing and reducing the distressing symptoms (internal control) and if they are currently in environments identified as abusive then clients are supported in leaving and finding safe places (external control). This facilitates a move towards reliable safety within the client and their immediate environment.

The second stage of recovery involves the therapist facilitating the reconstruction of the trauma experience in detail. Stories clients tell of their experiences are considered rarely linear and invite a sense of reliving for the client. This is underlined by the assumption that this has not occurred in those identified as having 'complex PTSD' following traumatic experiences. A safe place then is

created within which clients can begin to make sense of what has happened and the therapist can serve as a witness to these experiences whilst supporting them in the 'healing process' (Herman 1994). At this stage, the use of trauma focused CBT techniques (Kleim et al, 2012) can be integrated to further the therapeutic work.

The final stage of recovery (reconnection) involves the redefining of oneself in the context of meaningful relationships. This speaks to the importance of helping clients who have experienced trauma to move to a position wherein their traumatic experiences no longer define their identity, thus allowing for a sense of closure to emerge. This helps clients to experience liberation from the trauma in helping them to connect with a mission to continue their healing, despite what has happened to them. However, such a clear defined notion of healing may offer little space for the valid consideration of those who choose not to undergo such a process but may otherwise find other useful ways of managing their traumatic experiences without significant disruption to their lives.

Following the development of thinking towards the potential consequences of chronic abuse, Chu (1998) developed a model for survivors of such experiences. The 'SAFER' model also proposes that survivors of chronic abuse may need prolonged periods of therapeutic support. This is in aid of acquiring necessary skills that underpin the development of meaningful relationships along with skills constructed as important in managing symptoms of traumatization to help an individual to function in everyday life and thus develop a positive self-identity. This is carried out under the assumption of the necessity of developing a strong foundation of 'ego development' before moving onto more difficult therapeutic work into one's childhood experiences of abuse (Chu, 1998). It is posited here that although a depth of therapy is important in the recovery process through addressing symptoms, to do so before individuals have reached a state of readiness is highlighted as unhelpful and potentially re-traumatizing. To do so prematurely is characterized through a persistent sense of fear regarding the trauma experiences including symptoms of distressing flashbacks and intrusions, which may be unmanageable for the client. Thus, Chu (1998) here is emphasizing

the need for therapeutic work that builds a strong 'ego' to enable one to 'confront' and gain 'mastery' over their trauma history. Creating a sense of stability for the client in the beginning of therapeutic work is captured through; self-care, symptom control, acknowledgement, functioning, expression and relationships (SAFER). This draws on Herman's criteria for 'complex PTSD', focusing the work towards building a sense of stability before undergoing further therapeutic work and has inspired other similar models drawing on the same principles (Resick et al, 2012). This holds some similarities to narrative approaches to working with trauma whereby 'creating a safe place to stand' before discussing or returning to traumatic experiences are a vital part of therapeutic work (Yuen, 2009).

1.7.3 Psychodynamic approaches

CBT treatments are well known for being positioned as having a strong evidence base in their application to PTSD (Roth & Fonagy, 2005). However, research has highlighted rates of 'non-response' and dropout for these treatments as high and subsequently has made space for other approaches to trauma work that involve different ways of conceptualizing both symptoms and interventions (Schottenbauer, et al, 2008). Psychodynamic approaches have limited empirical evidence for PTSD, with some early research on a brief form of psychodynamic psychotherapy being equally 'effective' as systematic desensitization for PTSD and effective in addressing associated personality difficulties (Brom et al, 1989). The evidence base has subsequently grown for psychodynamic psychotherapy but more research is needed in regards to its application to PTSD. Several short-term psychodynamic approaches have been developed for example, Horowitz (1997) and Krupnick (2002) developed a 12 session intervention specifically for those experiencing PTSD following a traumatic event. Within this approach, emphasis is placed upon supporting inner conflicts in becoming conscious along with a focus upon the role of defenses in keeping emotions out of conscious awareness. This approach also emphasizes the importance of establishing a good therapeutic relationship along with psychoeducation and proceeds in three stages; developing a working alliance through hearing the individual's story and helping to build towards a therapeutic relationship; 'working through'; addressing loss in regards to

the trauma and the therapy (Schottenbauer et al, 2008). Earlier forms of the model were tested on small numbers of participants and found good outcomes in showing an increase in control over ones thoughts and emotions along with a reduction in associated PTSD symptoms (Krupnick, 1980).

A similar three stage model also utilizing Psychodynamic psychotherapy was developed by Lindy (1993) wherein there is a focus on developing a strong therapeutic relationship with the intention of supporting the client to identify and dispatch defenses that prevent confronting memories and emotions associated with the traumatic event. This is followed by a stage of the treatment focused upon the 'working through' of such emotions and memories and leading to a type of restructuring of the memory of the event. As with Horowitz' (1997) and Krupnick's (2002) model, this treatment approach was tested on small numbers of participants identified as combat veterans and reported positive outcome rates in the reduction of distressing symptoms and improvement in their ability to trust and manage further stress although more research is needed alongside bigger sample sizes.

Both models are based on short-term interventions utilizing psychodynamic psychotherapeutic ideas but are mainly positioned as being suitable for those who are experiencing PTSD following a single traumatic event. Some have proposed that because of the 'complex' nature of PTSD, its presumed impact on personality, relational skills and development, psychodynamic approaches may be 'best equipped' at offering intervention due to its focus upon underlying personality factors and attachment (APA, 2004; Harvey & Harney, 1997). Psychodynamic approaches focus upon the interpersonal relationships of the client utilising the relationship between the therapist and client in supporting the development of insight into relational patterns and using interpretations to help make links between the therapeutic relationship and relationships in the individual's lives (Schottenbauer et al, 2008). A study by Krupnick (2002) identified that treating interpersonal problems within this approach led to a reduction of PTSD symptoms offering its potential utility in this area of work.

In drawing upon a psychodynamic and psychoanalytic framework, the importance of safety in the therapeutic context becomes positioned as necessary in order for change to occur (Herman, 1998; Briere, 1992). Safety in the therapeutic relationship is constructed in the literature as highly important. Such importance on the nature of safety within the therapeutic relationship has in some circles raised the profile of the concept of countertransference in regards to how such safety can be achieved (Dalenberg, 2004). In the earlier forms of psychodynamic and psychoanalysis, countertransference was constructed as something that needed to be overcome to ensure the status of the therapist as one that is objective, in many ways like a 'blank slate' that could then provide the practitioner with an objective view of the client (Freud, 1957; McGuire, 1974). Others have noted the important and therapeutically advantageous role that countertransference can offer in trauma work and that being able to recognise it requires a sense of 'knowing oneself' (Yalom, 1995).

1.7.4 The self-aware clinician

Dalenberg (2010) constructs the unsafe aspect of therapy that a client fears as stemming from fear of the therapists countertransference, such as disapproval or rejection. Safety here is constructed as the ability to allow the client to become vulnerable within the therapeutic relationship without a fear of judgment from the therapist. Therefore, the therapist is positioned as needing to pay close attention to their own countertransference in order to make therapy safe enough and in doing so offer a number of possible advantages. This includes, offering reinforcement of a client's ability to reality-test, enabling a sense of honesty and genuineness and thus better rapport, increased tolerance of emotional affect and many more (Dalenberg, 2010).

A consideration of countertransference offers approaches such as psychoanalytic and psychodynamic models to operate on the assumption that the therapeutic relationship is primarily where change in therapy can occur. This is a feature of both Horowitz (1997), Lindy's (1993) and Krupnick's (2002) models. Although, the nature of how transference is utilised to bring about therapeutic change is widely

contested (Dalenberg, 2010). One school of thought offers the idea of a corrective emotional experience (Alexander, 1944; Palvarini, 2010) wherein the therapeutic encounter holds the opportunity of providing a new emotional experience that can be internalized and disconfirming of previously held assumptions about the self and the other (Lemma, 2003). This constructs the role of therapy as offering the possibility of new experiences with an 'object' that responds differently, therefore correcting previous assumptions. Here the client is constructed as one that has developed unhelpful assumptions or internal working models that need to be disconfirmed alongside the therapist as the one who provides that. However, despite the assumptions of what are useful 'beliefs' or 'working models', within this idea there appears to be little scope that 'new experiences' can 'naturally' occur within a person's own environment and instead further promotes the necessity of therapeutic work.

It can be said here that the subject position of therapist is one of needing to govern their own experiences and conduct in order to achieve the status of a good clinician who is self-aware. This can be said to be regulated through 'expert' discourses of what a good clinician is and the requirement to routinely demonstrate such awareness in one's professional role as a therapist, such as through supervision and in some therapeutic domains, the requirement for personal therapy. Foucault (1985) proposed that this shapes the subjective personal experiences of the individual, a form of subjectification through the process of governmentality. The concept of governmentality is less about the restriction of freedoms through processes of discipline but instead incorporated into the mechanisms that guide a person's behaviour. By government, Foucault is referring to techniques or technologies that are constructed as governing and guiding people's conduct (O'Farrell, 2005) such as through supervision. Therefore, the exercise of power that regulates a person is seen here as operating at a distance, through the individual conducting their own conduct and that of others voluntarily. Power becomes a subjectivising force and is seen as operating in a number of ways, most notably through pastoral power and technologies of the self.

Foucault's (1985) notion of pastoral power is connected to the Christian idea of the confessional. This is identified by Foucault as a technology whereby to show the truth of the self, one must first renounce themselves through confessing their sins. This can be argued as central to the practice of psychological work, a form of pastoral power that aims to produce the truth of a subject that they must achieve through verbalization of their inner thoughts and experiences. It can be argued that practices such as supervision reflect the need of the governing to know the minute details of the governed in order to regulate and guide their development and actions. It requires the building of trust and a form of both obedience and dependence. Foucault notes that technologies of the self:

"…permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality." (Foucault, 1988 p18).

Speaking the truth about oneself can be seen as the obligation that practitioners engage in through self-disclosure. These technologies of the self, offer the regulation of the self at distance by expert discourses (Banks et al, 2013). Such 'self-steering mechanisms' shape one's experience, conduct and relation to themselves, producing individuals that attribute a particular type of subjectivity to themselves, which in turn can be used to evaluate the self and regulate the self to its norms (Rose, 1996).

1.7.5 Feminist considerations

Many second-wave feminist approaches within psychology have leaned towards dominant positivist mainstream positions. Gavey (1999) situates this within a 'liberal humanist' tradition and one that is implicitly accepted and rarely challenged. Within this 'liberal humanism' people are constructed as sharing a human nature, an essential quality and such a tradition is highlighted as dependent upon a sense of rationality and positive values. Various feminist initiatives within this tradition have positioned their aims as privileging the voice of women and simultaneously treating this in an essentialist manner as though it

transparently reflects the truth of women's experiences. This differs from a post-structuralist position, moving away from essentialism and whereby experience cannot be 'got at', understood or expressed independent of language (Weedon, 1987). However, such traditional essentialist initiatives have played a political role in placing particular experiences in the spotlight and gaining awareness and recognition. This includes the oppression of women in society and in particular has played a role in bringing the presence of CSA and its impact into public awareness. However, this in turn may continue to reproduce essentialist discourses that serve to construct rigid positions that regulate and delegitimise constructions of gender that fall outside this constructed norm.

In the context of CSA, Warner (2003) notes that it represents a 'key site' for gendered unequal power relations to operate and so becomes a key area of concern for feminists. In thinking about the popular psychological constructions of abuse, trauma, 'simple' and 'complex' PTSD, O'Dell (2003) proposes that mainstream discourses around abuse, particularly CSA, produces a sense of coherence and a persuasive story that speaks to the 'professional discovery' of the abuse of children. Such a 'harm story' (O'Dell, 2003) is positioned as representing a kind of progress wherein the truth of such abuse is discovered or unearthed for analysis and consideration. In doing so it can be argued that the constructions of such 'facts' about abuse may serve to warrant and justify psychological and scientific interest. This may be seen as encouraging the development of such interventions or 'cures', as mentioned above, for the identified pathology that abuse is constructed as causing. Further to this, it may serve to position survivors and their experiences as quantifiable, measurable by way of tests, screening tools and other measures taken to look out for the 'symptoms' constructed as representing indication of pathology such as PTSD or borderline personality states. This 'harm story' may implicitly construct a singular narrative of the effects of abuse on those who experience it, subjugating alternative stories.

However, as noted above, this 'harm story' can play a political role, with feminist critics such as Macleod and Saraga (1988) arguing that drawing upon mainstream psychological research of the harmfulness of CSA can be used to bolster feminist

political claims. O'Dell (2003) notes the success of this approach in changing laws such as in regards to rape (Gavey, 1999) but argues that second-wave feminist action, in drawing upon such research to challenge systems such as society and popular discourses around gender, may serve to reify the dominant construction of the psycho-medical 'harm story'. This again offers a rigid and regulating construction of those who have experienced abuse, which can serve to silence background and delegitimise alternative identities and responses to abuse. With this comes the concern of co-opting such second wave feminist aims into a dominant mainstream understanding of CSA and other types of abuse, subsequently marginalizing the political aspect of feminist theorising.

The 'harm story' draws upon the idea of development, whereby this is identified as a linear process, stage building upon another stage as reflecting the process of childhood in a causal way. Childhood becomes causally linked to later adult life (Morss, 1990) and is considered key in understanding childhood and the impact of abuse such as CSA. Here, childhood is constructed as an early immature state wherein abilities, skills and knowledge are as yet fully developed. For example, O'Dell (2003) notes that this is drawn upon to construct CSA as something which a child cannot 'fully comprehend' and with this subsequently has implications of constructing the impact of CSA as disrupting what otherwise is presumed to be 'normal' developmental processes. This can lead to stories of loss of a childhood that may never be regained. 'Storying' such effects and consequences for those who have experienced abuse may serve to 'other' them as significantly and qualitatively different from those positioned as 'normal'. Although this again brings light to the potentially powerful effects abuse can have on childhood, it also serves to create a dominant 'singular' story of harm that leaves little space for any alternatives (O'Dell, 2003).

As mentioned above, effects of various types of abuse serve to create a 'damaged' person in need of treatment to mitigate such effects through techniques, skills, grieving and mourning processes (Herman, 1994). O'Dell (2003), in the context of abused children, notes that this can serve to 'mark' and make 'visible' the abused child from the non-abused child through the 'looking out

27

for' visible signs of trauma, subsequently reifying what is deemed to be normal (Reavey & Warner, 2001) and seen as continuing its effects throughout the course of one's life. Ideas of those who have experienced abuse in early life being more vulnerable to abuse later in life (Jehu, 1989) are thus positioned as 'eternally scarred' and potentially in need throughout their life.

It is argued that mainstream understandings, in the wider context of abuse, constructs the effects of such abuse as inevitably leading to distressing symptoms and that this may itself produce 'victims' through such a construction (Lamb, 1999). This proposes the ever suffering victim, irrespective of whether they construct themselves as such, shutting down the possibility of alternative subject positions. Many feminist writers have challenged assumptions regarding gender and CSA proposing that gender differences are regulated and interwoven within beliefs about the impact of CSA (Levett, 1994). Female survivors can often quite easily be portrayed as vulnerable, which can be interpreted as strengthening pre-existing ideas of passivity and submissiveness amongst women (O'Dell, 2003). The use of the 'heterosexual matrix' (Butler, 1990) within which to construct the 'harm story' also can be evident in positioning 'damaged women' as unable to have relationships with men, placing heterosexuality as the 'norm'. This can also speak to discourses that construct non-heterosexual identities as products of abuse as opposed to a deliberate choice (Kitzinger, 1992). Positioned as either an effect of abuse or a coping mechanism, it becomes a deviation from an assumed norm (O'Dell, 2003).

1.7.6 A more 'Visible therapy'

Warner (2000) highlights the importance of taking into consideration the social contexts within which therapy and recovery take place. This is to acknowledge that there are good reasons for the usefulness of both community and hospital based services for those who have been abused, depending on a variety of factors such as risk. Therapeutic work may be needed outside of an individual's familiar setting, potentially giving respite. This adopts a provisional stance to therapy recognising that whether it occurs or not must remain open and subsequently challenging

ideas that therapy or talking about abuse itself is always a good thing or necessary for 'recovery'. In addition to this, it is also noting the importance of acknowledging the models that we use to make sense of abuse and how this may further construct the client, such as a victim or a survivor, and the role of services.

In making sense of individuals' experiences and distress, Warner (2000) positions services as needing to not only consider the abusive relationships that clients may have had but equally the impact current relationships, such as within services themselves, may have on clients. This invites us to hold in mind the way services and practitioners themselves can sometimes replicate the 'tactics of abuse' particularly through a lack of transparency and potentially coercive actions within 'risk management'. Holding this in mind invites practitioners to consider how they themselves impact on the client, which therefore simultaneously challenges narratives which locate the 'problem' within clients, instead now locating the problem within the context of a relationship. Diagnoses such as PTSD may particularly invite locating the 'problem' as within clients. This may lead practitioners and services to respond to the diagnosis, distancing the impact or responsibility of services and other social factors on the problem seen through emphasis on the symptoms of PTSD as the site of intervention as well as the 'yard stick' by which interventions are measured for utility. This may close down opportunities to acknowledge the role of factors such as gender, race, class and others.

Warner (2000) argues for survivors to be supported in making sense of this and developed 'Visible therapy' within a narrative framework for those who have experienced CSA. This draws on ideas from Feminism and post-structuralism. By adopting a post-structuralist framework, one can begin to challenge the unquestioned acceptance of any identity (Warner, 2000). A feminist position here encourages the consideration and recognition of the strategic use of taking up certain 'identifications' and the importance of privileging the perspectives of those who are marginalized in some situations when needed. Thus, 'Visible therapy' aims to problematize the assumption of categorical identity. This serves to make visible the tactics involved in the taking up of certain 'strategic identifications'

(Warner, 2003), such as the efforts of second wave feminists to privilege the voice of those who have experienced abuse over that of 'professional experts' (O'Dell, 2003) as a political strategy.

Drawing on a post-structuralist perspective, identity is placed as a form of social practice made possible through relationships. This challenges traditional 'interiorising' and essentialist models of gender, whereby such an identity is placed as a property within a person or that they possess. From a post-structuralist perspective, meaning given to our experiences constructs particular identities and shapes our experience of the world. Warner (2003) proposes that reality is a function of relationships between understanding, experience and identity. Through the experience of CSA, particular negative versions of identity and experiences are performed, produced and maintained. 'Visible therapy' therefore aims to support women in making sense of their own sense of self that may have developed through abuse by drawing out and examining assumptions that are produced through the experience of abuse.

This approach therefore positions problems as not located within individuals but in the narratives that are drawn upon in making sense of the present and past experiences in their lives. Warner (2003) notes that it is through 'reiteration' that such narratives obscure their own social production. Through 'Visible therapy', those who have experienced abuse can explore the narratives they have drawn upon in making sense of the abuse and situate these within wider societal discourses. This brings forth the diverse tactics of abuse that are in support of abusive practices. Problems are constructed as residing within powerful social narratives that can be drawn on to situate relationships of the past and present, which give rise to ideas of a fixed identity. Reconstructing the 'problem' of abuse as socially constituted as well as constitutive of gendered western ideas of identity can offer the position of challenging both routine ways women are constructed as pathological and fixed notions of routes to recovery through making space for alternative constructions of the meaning of abuse.

1.7.7 Gender difference

Herman (1998) notes the importance of considering gender difference between client and therapist as having an influence on how male practitioners' may position themselves, highlighting potential pitfalls that may arise in such a context with the inclusion of boundary violations. This constructs recovery as taking place in the context of relationships and the potential transference and counter-transference experiences. Jones (1991) also highlights the relevance of considering the gender of the therapist in the therapeutic relationship and how this may affect subsequent work. Both draw from feminist approaches to considering power relations within gender and the wider socio-political context that privileges men over women. However, introducing gender as an important factor into the work of clinical psychologists brings about a number of assumptions as to what gender is assumed to be and how this exerts influence on the conduct of practitioners working in a therapeutic capacity.

In the context of reproductive difference, Connell (2002) reflects on the controversy surrounding the significance of this through identifying three influential approaches to how it is made sense of. These are labelled; body as machine, the two realms and body as canvas. The 'body as machine' discourse focuses upon biological reproductive differences between men and women. This is thought of as reflecting a variety of other differences including strength, physical skills, sexuality and character. Men are defined as stronger, more aggressive, having powerful urges and desires as opposed to the weaker and nurturing positions given to women. As an essentialist idea this is seen as reflective of a true nature inherent within the male sex and has been taken up by many to argue or justify men's dominance in society. These ideas are often situated heavily within scientific discourses as the truth (Connell, 1995).

This differs from discourses that draw distinction between sex and gender with the former constructed as a biological fact and the latter a social one (the two realms). Thus, gender roles, positioned as 'constructed', become a choice wherein reform could be made possible through making new choices to form an alternative gender

31

pattern, mixing both masculinity and femininity (Bem, 1974). Thus, society could change oppressive gender arrangements, which were positioned as the result of past societal choices, for a new arrangement through sex role socialization. However, positioning gender as a cultural choice failed to account for the higher value of masculinities over femininities (Pringle, 1992). Separating gender from bodies could be seen as encouraging a dualism similar to mind and body that was not taken up by feminists at the time, particularly as feminist approaches were placing high emphasis on the body as this was seen as a focus of oppressive acts (Connell, 2002). Feminists were particularly focused on how the female body was portrayed in popular media. Connell (2002) notes research on gendered imagery of women's bodies and how this shaped changes in gender over time and in defining what is constructed as desirable and beautiful.

The work of Foucault (1977) has been a significant influence in regards to the body and discourse. Foucault (1977) proposed that it is through modern systems of knowledge that people can become knowable and assigned to categories through which things can be done to them and their bodies. He notes that such discourses gives rise to a kind of disciplining and policing of the body and professions such as psychiatry and psychology play a role in applying this, for example, discourses of mental illness and the asylums (Foucault, 1961). Foucault's ideas have been applied through the work of feminists in treating the gendered body as the product of disciplinary practices (body as canvas), which include physical training regimes found within education, connected to competitive sport, imagery of the masculine body found in body-building competitions and role of cosmetic surgery in producing the gendered body (Connell, 2002).

Within the women's liberation movement patriarchal power is identified as involving control over women by men both directly and indirectly and also through state actions (Banner, 1983). Power and resources are positioned as unequally distributed between men and women, favouring the former (Coltrane, 1998). This has been highlighted in a range of legal procedures surrounding rape cases (Mackinnon, 1983) and the employment practices of organisations (Burton, 1987). Power here is conceptualised as a property held by one group over another and

an integral aspect of gender relations. However, this can be additionally approached from a post-structuralist position informed by the work of Foucault (Connell, 2002). Power also can be thought of as widely dispersed, operating through discursive practices. These are the ways through which reality comes into being through the practices of institutions and their ways of establishing 'truth' or what is accepted as 'truth' or 'reality' in society, such as through 'scientific discourses' and the construction of 'objective facts'. Thus, power is not deemed to be a specific entity but instead constructed as a relation. This also positions power as productive in micro social relations between people. Within Foucault's work, the mechanisms of power produce different types of knowledge that gather information about the activities of people and their existence to both produce and reinforce discursive and material practices. The term masculinity has been defined as the representation of a place in gender relations, and the practices by which men and women engage that place (Connell, 2005). Thus masculinities are constructed as being socially produced, changeable and significantly influenced through social contexts (Collinson & Hearn, 1996).

In considering discourse, seeing the practice and use of discourses within the therapy room as distanced from discursive practices outside of the therapy context is in many ways to construct what happens in therapy (what is being discursively produced) as cut off from the wider societal context (Hare-Mustin, 1994). Discursive constructions in therapy are not 'newly' created but are drawn from the discursive community in which individuals find themselves. Hare-Mustin (1994) speaks of the dangers of 'context stripping' in that doing so leads to viewing clients as equal despite their very different positions in other social hierarchies.

Here one can apply the same concept to the position of therapists themselves in that they too cannot be stripped of context in the positions that they hold within the therapy room and outside of it. This offers a need for consideration of how wider discourses regarding gender play a role within the therapy room for both clients and practitioners. With the knowledge of a large number of perpetrators of abuse towards women in society being men (Black et al, 2011), and the connections this is deemed to have in regards to hegemonic masculinity, namely the practices that

promote the dominant social position of men over women (Connell, 2005), this raises important questions about implications for the subjectivities of both clients and practitioners. In other contexts, Cross and Baglihole, (2002) suggest that the impact of wider discourses on the construction of gender has led to a form of reconstruction and in some instances a form of gender role conflict. The navigating of dominant discourses regarding masculinity has been identified within men who work in areas described as 'non-traditional' and the subsequent and continuous re-negotiation of their gender identities that arises as a result (Cross & Bagilhole, 2002). This potentially has implications on how male clinical psychologists may construct their gender identities in their therapeutic work, particularly with women who have experienced abuse, taking into account issues of power and already existing dominant discourses of hegemonic masculinity that they may indeed be continually renegotiating or challenging. Alongside this, how they conduct their own conduct in line with the 'expert' discourses surrounding trauma work. This acknowledges the role that such 'expert' discourses have in making considerations of gender difference both possible and a useful thing to do. In doing so, it allows us to ask questions of particular constructions of trauma work, such as trauma-focused CBT, and whether absence here of a consideration of gender in the therapeutic context may possibly lead to subjugating experiences and ideas around the role of gender difference.

In the trauma literature, emphasis has been placed on the importance of working towards and establishing a good therapeutic relationship with clients who have experienced abuse (Herman, 1992). Currently there has not been any research exploring the impact that gender difference may have on clinical psychologists' constructions of their work with such clients. This may be the result of differing approaches to trauma work such as cognitive behavioural approaches, whereby the therapeutic relationship is defined through both therapist and client working together towards an agreed goal (Beck, 1995) but not giving attention to the factors that may affect the building of a therapeutic relationship, such as gender difference. Alongside this, therapeutic change here is constructed as not dependent upon such a relationship but instead upon the model and technique

(Westbrook et al, 2007). This is further highlighted within the Improving Access to Psychological Approaches model (IAPT, 2007) core competencies framework, which lacks competencies regarding the therapist's relational skills and self-awareness (Chahal, 2013). I feel this undoubtedly 'frames' the consideration of factors like gender difference in the therapeutic relationship as secondary to 'therapeutic techniques', which emphasise the 'expertise' of the model rather than the therapist or client in effecting therapeutic change.

<u>1.7.8 Resistance</u>

Taking such ideas into consideration leads one to the issue of power in therapy. To 'context strip' both client and therapist is to deny the different 'positions' from which either may be coming to the therapy space. For example, gender is inextricably linked to poverty and various other structural inequalities (Bradshaw et al, 2003) and as a result 'brings' issues of power into the therapy room. Afuape (2011) draws attention to the relationship between power and discourse, noting discourse as implicated in upholding various structural inequalities. How various groups are constructed and represented in society allows certain things to be done to them. Having control over 'meaning making' therefore becomes an important resource for those in power (Hare-Mustin, 1994). Afuape (2011) gives as an example the various ways in which discourses that serve to represent and construct women as desirable sexual objects for men can legitimise sexual violence and exploitation of women. Thus, various structural inequalities in society are made possible through such discourses. However, power is complex and can have both creative and destructive possibilities (Afuape, 2011). For example, a complex appreciation of power has been considered in the context of therapy, notably its possible role in upholding and reproducing the interests of dominant groups through serving to 'fit' clients into acceptable fixed norms in society (Nylund & Nylund, 2003). This positions therapy as a form of social control (Afuape, 2011) but also serves to challenge assumptions of therapy as separate from the wider social world, as a place where power dynamics found in wider society can be avoided or renounced by therapists in their work.

Afuape (2011) notes generalised assumptions of a monological and dialogical division between therapies. A monological approach is constructed as the holding of 'expert' positions, distance and hierarchy between therapist and client. Meanings that are generated in therapy are positioned as a reproduction of the 'experts' already existing knowledge of the client, entrenching the therapist in an established system of knowledge. This is in contrast to a dialogical perspective, which constructs therapy as the constant interaction between different forms of expertise, co-creating new stories and where both participants are influencing each other, playing an active role in meaning making (Afuape, 2011). Afuape (2011) draws attention to assumptions about some therapies holding either monological or dialogical features, masking the utility and the various ways any type of therapy may take up features from either approach. This may particularly be evident when addressing issues of risk or when an 'expert' position is desired by the client. However, through associating monological positions with power and its contrasting dialogical approaches as an absence of such, may serve to position some therapeutic approaches as being able to step away from the issues associated with power (Guilfoyle, 2005 as cited in Afuape, 2011).

The influence of wider systems and discourses can serve to create the expert therapist who is positioned as the one to treat or cure and the client as one who behaves in a manner that allows the therapist to do so. Afuape (2011) argues that essentially all therapies contain such fixed positions and thus continues to be modelled by and reproductive of dominant discourses in culture. Drawing from Foucault (1980), power does not necessarily mean domination. Domination instead reflects the absence of power due to the inability to resist. Domination in therapy is subsequently a reflection of the absence of the possibility to resist the therapist/therapy through a lack of legitimacy. Acknowledging the possibility of and legitimacy of resistance in therapy can lead to dynamic interactions and which are reversible, making a dialogical approach one that does not require the removal of power (Afuape, 2011).

Dominant discourses co-exist with alternative discourses that may oppose them hence power/resistance (O'Farrell, 2005). Resistance becomes a form of power in

its own right and we can construct for example, the refusal of a female client to see a male therapist or to even engage in 'evidence-based' therapies as an exercise of power itself (as resistance). It can be argued that in doing so, leads us away from pathological understandings of clients who refuse or resist therapy or their therapists and instead towards an approach that may utilise it such as is found in narrative and solutions-focused approaches (Wade, 1997). Client resistance can often be subject to pathologising and individualistic attempts to explain them whereby conclusions such as ambivalence, denial, lack of psychological mindedness, refusal to change and many more are common parlance. This can be further explored through attempts from particular therapeutic approaches to make sense of client resistance such as the concept of homeostasis in family therapy (Afuape, 2011).

Afuape's (2011) proposal of re-conceptualising resistance as essential to thinking in regards to power in both therapy and wider society is a radical shift, offering here a construction of resistance where being open to it can provide creative options for a collaborative and dialogical approach to therapy. This involves seeing resistance as an opportunity to further understand and explore the clients world but also to identify what is not 'helpful' or what they are seeking to resist. With power already made present in therapy due to the institutional context that positions those involved differently as either client or therapist, acknowledging resistance and making it central may make therapy more dynamic and reversible (Afuape, 2011).

This also highlights the need to identify resistance away from more traditional pathologising ways such as the general tendency to view resistance as a defence against unconsciously threatening material or as a way of making sense of individuals' refusal to engage in therapy (Wade, 1997). Acts of resistance can instead be constructed as a healthy response to oppression. Wade (1997), positions therapists as playing an important role in both acknowledging and honouring the varying acts of resistance carried out by those subjected to oppression, forms of abuse and others.

1.8 Summary

The prevalence of various forms of abuse (Boonziaser & Rey, 2004) and the significant impact that they can have on people's lives demonstrates the need for thinking about trauma work in the context of mental health service provision. This is important as a large number of those who seek out psychological support and interventions in mental health services have experienced abuse such as CSA (Warner & Wilkins, 2003). It has been argued that PTSD and diagnoses such as Borderline personality disorder have increasingly been used to construct the potential psychological consequences of abuse as a diagnosis (Calhoun et al, 2012; Warner, 2003). The use of diagnosis lends itself to psychologising the experience of abuse as one that needs to be spoken about and worked through in the context of psychological therapy and at the level of the individual (Patel, 2011). It also assumes that PTSD as a term is something that can be quantified and categorized through the presence of such symptoms coming from within the client and that this is a meaningful thing to do (Patel, 2011).

From within a CBT framework, there is an emphasis upon symptom reduction with research suggesting the need for psychological interventions to be focused on the trauma specifically (Ehlers et al, 2010). Interventions here have increasingly used exposure to trauma related stimuli in addressing the memories of abuse (Foa & Rothbaum, 1998; Ehlers & Clark, 2000) with concern regarding the way in which meaning making of traumatic events is carried out (Bisson et al, 2007). Other approaches have given greater prominence to the experiences of disempowerment and disconnection that often occurs in abuse and the need to position clients in a 'survivor' story as a route to recovery (Herman, 1998).

In these approaches, greater emphasis has been placed on the importance of the therapeutic relationship as a contained and safe space for healing to emerge. I discussed the role that constructing 'survivors' as damaged can have in leading to the importance of building therapeutic relationships. This may cause difficulty in that the damage that is constructed to have been inflicted upon the 'survivor' is one of trust and feeling safe in the context of relationships, which therefore sets

out the clinicians attempt to develop a therapeutic relationship as a problematic task. The term survivor, emanating from the work of feminists, has become widely used in mass media (Plummer, 1995) and can be seen as a positive one in providing a discursive resource for women to draw upon, promising a sense of understanding and agency over one's life. However, the use of this term has been suggested as constructing a unified identity and not all women are the same. Thus, carrying an implicit assumption that there is something stable about women and their experiences of abuse (Worrell, 2003) and as a result, closes down the multiple meanings that can be applied to experiences of abuse such as CSA. Worrell (2003) highlights that such taken for granted assumptions have the additional function of obscuring the discursive work involved in making such a 'survivor' identity both intelligible and a desirable subject position.

I have proposed that practitioners engaging in trauma work cannot be stripped of their social context when in the positions they hold within the therapy room. This offers the need for a consideration of how wider discourses regarding gender and the material reality of large numbers of men being perpetrators of abuse (Walters, Chen & Brieding, 2013), play a role within the therapy room for both clients and practitioners. This offers the opportunity for practitioners to consider how their work may be implicated in wider political narratives regarding gender. This may have implications on how clinical psychologists construct their own identity when working with women who have experienced abuse and have consequences for their own subjectivities.

1.9 Rationale for the Research

From the literature, there has been attention and focus given to the need to consider a number of factors in trauma work. This includes the importance of building therapeutic relationships alongside the consideration of countertransference. Given the significant emphasis upon the therapeutic relationship, it is surprising that there has been very little consideration given to how gender difference impacts on the therapeutic work, especially given the highly gendered political nature of abuse (Warner, 2000). I have taken the premise that

the ways in which we construct problems and people who undergo distress, have significant consequences for how we then 'intervene' and 'treat' them. The 'painstaking' task (Chu, 1998) of developing therapeutic relationships with women who have experienced abuse is not 'played out' in secluded rooms that are unbridged by wider societal discourses of the ways in which men and women are constructed. Nor is the emphasis on 'techniques' a 'way around' the consideration of gender dynamics as they may occur in the therapy room. Such dynamics must be acknowledged if we are to further advance our knowledge and practice of therapeutic interventions for those who seek our help following experiences of abuse.

In carrying out this research I am not setting out to prove or disprove hypotheses or to test a particular theory. I am instead aiming to generate useful rich exploratory data from which understandings of the experiences of male clinical psychologists, working with gender difference in the context of trauma work, might be developed. Thus, I aimed to ascertain how a group of male clinical psychologists defined and made sense of their work with such clients. I am interested in whether they are problematized in their work and the different subject positions available to them to counter or to resist such problematizations whilst working with a group of clients who are often constructed as highly vulnerable and in need of 'treatments'. I believe this will offer the opportunity to highlight the possible various different experiences and challenges that are faced doing trauma work in the context of gender difference and to contribute to a further understanding of the experiences of this group. This would inform support for male clinicians and it is hoped that this will also encourage further consideration and research around the experiences of gender difference in clinical psychological work.

This research approaches these questions using a social constructionist thematic analysis (Braun & Clarke, 2006) also informed by the work of Michel Foucault (1972), set within critical realist ontology. In the following chapters, male psychologists' experiences of working with gender difference in trauma work will be explored. The analysis presents themes in regards to questions that were

asked of the data and explored within these themes are their implications including the subsequent subject positions that are enabled for them and their clients. The research also made salient practices of governmentality and how these operated to enable or constrain the participants. The research questions were:

Main research question:

- How do male clinical psychologists construct their work with female clients who have experienced abuse and what are the implications for their experiences and therapeutic work?

Secondary research questions:

- How are male clinical psychologists problematized in their work with female clients who have experienced abuse?
- What subject positions are offered for both the participants and their female clients that are constructed in their talk?

CHAPTER 2: METHODOLOGY

In this chapter I will be clarifying the epistemological position that I have taken in this research, namely critical realist. I will outline the method of analysis I have used and the rationale for this followed by positioning and ethical considerations.

2.1 Epistemology

For this research I have drawn upon a range of writers to inform a critical realist epistemological position to social constructionist analyses (Parker, 1992; Nightingale & Cromby, 1999; Willig; 1999; Sims-Schouten, Riley & Willig, 2007; Harper, 2012). An advantage of adopting a critical realist position offers the opportunity to explore not just the discursive constructions of male clinical psychologists' work with female clients who have experienced abuse, i.e. their constructions of female clients and abuse itself, but also providing a further layer of detail in going beyond the text drawing on a range of evidence and in setting what is said in a broader historical, cultural and social context (Harper, 2012).

Critical realists, as I have drawn upon for this research, highlighted by Harper (2012) are ontological realists whereby it is assumed that the data is able to tell us something about reality although it is not viewed as directly mirroring it. Data here is assumed to not be a complete representation of reality, therefore does not explicitly tell us what maybe underlying or driving the studied phenomena. From this position, relying on accounts alone is not enough and there is a need to go beyond the text to gather further support from other sources, such as other evidence (Harper, 2012).

Post-structuralism or social constructionism, as it is labelled within the discipline of psychology, is an umbrella title for a growing number of alternative approaches to understanding human experience. Social constructionism primarily concerns itself with how knowledge is constructed and mainly takes the position that this occurs in social processes between us (Harper, 2011). Burr (2003) identifies that social constructionism has many forms but uses the term as a kind of 'family resemblance' for a variety of approaches, each varying in their epistemological

and ontological positions. Bringing them together in this 'family resemblance', Burr (2003) highlights Gergen's (1985) assumptions that, to varying degrees, underpin these different variations of social constructionism, which include; a critical stance toward taken for granted knowledge; historical and cultural specificity; knowledge as sustained by social processes; knowledge and social action as going together (Burr, 2003). Within these different variations of social constructionism there are the familiar relativism/realism debates that concern the status afforded to reality and truth (Liebrucks, 2001). Arguments have focused on how we may preference one perception of the world over others, particularly if 'reality' is deemed to be inaccessible in the context of relativism, with the absence of 'reality' as a measure of truth. This largely concerns the implications it has for the possibility of taking up a moral or political position in regards to some accounts of reality over others.

In contrast, in critical realism, constructions are positioned as connected to the material world as reality offers constraints and limitations on the possibilities of what can be said and how (Willig, 1999). The non-discursive here cannot be reduced to the discursive but posited as having an ontological status in relation to discursive practices (Sims-Schouten, Riley & Willig, 2007). From this position, the non-discursive impacts upon the possibilities of discursive meanings. I feel this offers the opportunity to situate what is being said within its context. In taking this position I am proposing that male clinical psychologists' constructions of trauma work will be mediated through the available discourses regarding trauma work, their own experiences and constructions of gender alongside the demands of working within regulated professional services. This offers the opportunity for the researcher to go beyond the level of the text in analysis and to incorporate the broader social, historical and cultural context. For this research, this included the incorporation of 'expert' discourses regarding trauma work, gender and participants' material context such as their service demands.

The grouping of critical realism with social constructionism has been described as a form of 'weak' social constructionism that differs from a 'strong' version, which is often referred to as adopting a relativist position (Burr, 2003). Harper (2012) proposes that holding a critical realist position with social constructionism can be

defined as ontologically realist with an epistemologically relativist position. It has been suggested that this may lead to a potential inconsistency and selective relativism as a result of choosing to focus on the foundations of some knowledge claims but ignoring others, thus leading to a form of ontological gerrymandering (Woolgar & Pawluch, 1985). However, it could be argued that there is a subjective quality in all qualitative work but that it is important to be clear and to justify the decisions one makes in choosing to include some areas for analysis over others.

2.1.1 Reflexivity

In this section I will give an account of myself in the role of researcher and how the data I collected have been co-produced following my own interpretations, and the choices that I have made. In doing so I am acknowledging that my role in this research has not been one of a neutral observer (Silverman, 1997). Through making decisions regarding how to approach the research therefore requires the need to be accountable and responsible for those decisions and actions. Willig (2013) notes that the researcher influences and shapes the research process both personally and as theorist/thinker. These notions of personal reflexivity (the person) and epistemological reflexivity (theorist/thinker) offers the opportunity to acknowledge the identity of the researcher, their biases and epistemological and theoretical positions as implicated in the research process and its findings. This also encompasses both the personal values and interests that I may have held and the elaboration of any held assumptions that impact on the co-production of the data and its analysis (Nightingale & Cromby, 1999). This included my own gender as a man also training to become a clinical psychologist, alongside my own interests in both social constructionist research and making salient the importance of gender issues in trauma work.

Therefore, in carrying out and writing up the research I became aware of a number of factors that influenced my analysis. I was aware that my personal reasons for engaging in this project were borne out of my own experiences in clinical training with female clients who had experienced abuse (see section 1.0) and my interest in wanting to explore other male clinical psychologists' experiences as well as

sharing these within the discipline of psychology. This meant that I needed to be mindful of not 'jumping to conclusions', assuming that as a training male clinical psychologist, I 'implicitly understood' the data. This required being aware of my own beliefs and ideas about gender difference in trauma work, which I felt created many different challenges for a male practitioner given the dominant discourses regarding both gender and abuse. This allowed me, both during interviewing and the analysis, to stop and reflect at each stage of the research process on any ideas that I developed and to think about whether it is truly 'backed up' within the data set. Being close to the participants as a male trainee clinical psychologist meant that I held in mind my own interests and assumptions, acknowledging that they may not be shared by the participants. However, recognising "....it is not always possible for researchers to set aside things about which they are not aware" (Ahern, 1999, p 408), I acknowledged that I too had experiences of doubt about the relevance and importance of the research questions. This included concern that by exploring something that was a problem for me, I might actively be engaging in a process of creating one. In addressing this I was supported by my director of studies, which involved questioning me in regards to my motivations regarding doing the research and inviting me to reflect on what I brought to the research process and to be explicit about these. This was also supported by my use of a research journal (Finlay and Gough, 2003) to further think about these issues and to acknowledge how they informed the analysis process and therefore was highly useful when including reflexivity considerations at that stage of the process.

2.2 Method

Willig (2008) distinguishes between method and methodology, highlighting the former as regarding the specific process of collecting data and the latter as being concerned with epistemology, the philosophical assumptions that form the foundations of the research. In this project a critical realist epistemological position was employed with a social constructionist thematic analysis (Braun & Clarke, 2006). The work was also informed by the oeuvre of Michel Foucault (Foucault, 1985) whilst also drawing from the work of discursive psychology (Willig, 2008).

2.2.1 Social Constructionist Thematic Analysis

For this research, I have chosen to employ a social constructionist thematic analysis (Braun & Clarke, 2006). I have chosen this form of analysis as there are currently no other research in the literature exploring male clinical psychologists' experiences of trauma work with female clients and how they talk about this. Therefore, the research was exploratory and subsequently sought to obtain rich data. Thematic analysis is an ideal method to deal with such rich data as it is exploratory and can be used to structure the data. It is also an ideal method because it is not linked to any epistemological position and can draw on a social constructionist and a set of Foucauldian informed principles (Braun & Clarke, 2006). So by positioning a thematic analysis as independent of theory and epistemology, Braun and Clarke (2006) are not suggesting that it can be applied theory-less or without an acknowledged epistemological stance but that it can be applied across a range of theoretical and epistemological approaches.

I have chosen this form of analysis instead of a Foucauldian Discourse Analysis (FDA; Willig, 2008) as I was not exploring the broader institutional practices that would be necessary for an FDA as proposed by Arribas-Ayllon and Walkerdine (2008). Therefore, I have followed the suggestions of Braun and Clarke (2006) in using a thematic analysis to arrive at a pattern in the data and the analytic work was further enhanced by use of a set of Foucauldian informed principles to look at the extracts and explore how things are talked into being and how they are being positioned.

Braun and Clarke (2006) point out that thematic analysis has in the past been criticized for not having clear guidelines and provide a six phase guide to doing such analysis whilst still retaining the flexibility of this approach. They highlighted that qualitative research should be clear about the assumptions that are made including what was done, why and how (as explained below) and the epistemological stance taken (critical realist social constructionist).

This form of analysis is a method for identifying themes or patterns across a data set. As a social constructionist method I have deployed this to examine the way in

which events, realities, meanings and experiences are made sense of and are produced through the effects of discourses and their social context. As a starting point, in the participants talk I began by closely looking out for the various constructions of particular objects, events and experiences that were being constructed and were informed by Foucauldian principles for my analysis (Arribas-Aylon & Walkerdine, 2008).

The underlying epistemology is not reductionist or essentialist in that there is no attempt for a singular objective and universal truth. There is not an attempt to make sense of participants' complex experiences through an appeal to the inner truth residing within them. Thus, there is no attempt at a meta-theorization, rather a focus on the multiple subjectivities and how these are made possible through participants talk and their socio-cultural contexts (Taylor & Ussher, 2001). Participants' active attempts to make sense of and interpret their own realities are posited as being drawn from the discursive resources they find themselves in and that the extra-discursive raises potentialities in this process such as through the range of readily available 'expert discourses' on how trauma work 'should' be conducted along with the participants' working context including service demands. By using a social constructionist framework in this way gives focus to the use of discourse in constituting various subject positions that make possible or close down various ways of being for male clinical psychologists' working with female clients who have been abused.

2.2.2 Social Constructionism

Focusing on a 'macro' level within social constructionism (Burr, 2003) is commonly associated with a critical realist stance. This type of analysis is concerned with the function of discourse in the constitution of social and psychological life. Discourse here is constructed as enabling, constraining, and limiting what can be said by whom, where, and when (Parker, 1992 in Willig, 2008). This 'macro' level of analysis situates discourse in its institutional context and is aligned to power. This focuses on the availability of discourses (discursive resources) within a culture and how they construct the objects and subjects of which they speak (Parker, 1992)

and therefore have implications for how people see and experience the world through the offering up of subject positions. For example, the construction of 'survivor' as a 'damaged' person positions women who have experienced abuse as in need of 'treatment' in order to recover through psychological therapeutic interventions. Therefore, discourses construct various subject positions that make possible certain actions and experiences over oneself and others.

This places a social constructionist framework, drawing on the work of Foucault (1985), as in a position to analyse power relations through exploring how particular discourses can be drawn upon over others and subsequently legitimated. As discourses are noted as offering particular subject positions, they are seen as implicated in the exercise of power through privileging certain ways of seeing the world over others (Willig, 2008).

In addition to this, for the analysis I have also drawn upon discursive psychology (Potter & Wetherell, 1987), whereby the primary focus is upon social interaction and language and also adopts an anti-essentialist stance thus being critical of positioning language as a reflection or direct route into interior mental states (Burr, 2003). Within this, how discourse is used in social interactions is particularly attended to, as is how people use discourses to build specific accounts of events with potential consequences for themselves and others. This positions talk in interactions as largely to perform certain functions, the result of interpretive repertoires and rhetorical devices, which I drew upon to inform the analysis.

2.2.3 Drawing on Foucault

In developing a social constructionist thematic analysis, I have drawn from Foucault's oeuvre (O'Farrell, 2005), positioning participants' discursive constructions within the material world that is being negotiated. For this study, I wanted to understand how male clinical psychologists are 'problematized' as men in their work with female clients who have experienced abuse. Problematizing here is drawn from the work of Michel Foucault (1985) and is the making strange of something familiar, whereby in doing so it then becomes visible and knowable (Marshall, 2007).

Subjectification also forms part of my analysis primarily in the form of technologies of the self (Foucault, 1988). Arribas-Ayllon and Walkerdine (2008) highlight that power can be located beyond the text, including an assemblage of knowledge, instruments, persons, buildings and spaces that have its influence on persons distally (technologies of power) as opposed to the person exercising power over themselves (technologies of the self). Thus, Foucault (1988) later positioned his work as exploring how people develop knowledge about themselves and others through the use of technologies. These kinds of technologies are observed when individuals work to transform themselves into a particular kind of person. These can be identified as 'self-steering mechanisms' that shape our experience and conduct in the world (Gordon, 2011). It is here that drawing on rhetorical psychology (Edwards and Potter, 1992) can be useful in my analysis through exploring the argumentative and persuasive nature of talk as informing everyday resources (Arribas-Ayllon & Walkerdine, 2008).

2.3 Steps of Analysis

Within this analysis a theme is understood as capturing something important about the data (Braun & Clarke, 2006). This is informed by the research question and is representative of some level of patterned or meaningful response within the data. Therefore, deciding on what counted as a theme, which is a decision as opposed to an objective scientific discovery, was a subjective process dependent upon my own judgement. For this study, the analysis was inductive in that the data produced here was read and re-read for any themes relating to experiences of working with female clients who have experienced abuse, including challenges and constraints. This was chosen as there has not been any specific research carried out on this area and the aim of the project was to develop further understanding of male clinical psychologists' experiences. Analysis operated at the latent level, exploring the fragments of possible discourses informing the semantic level of the data, which involved interpretive work. Below I have outlined the steps taken in this analytic work, which have been informed by Braun and Clarke's (2006) six-phase guide to thematic analysis and a set of Foucauldian and discursive psychology principles;

- Step 1

At the point of data collection, I used my reflexive journal to take notes following each interview, writing down my thoughts and feelings towards the process and outcome of the interviews. For example, this was used in helping to continually construct the interview schedule (see appendix four) in noting which questions had been useful in generating rich responses.

- Step 2

Following transcription of the data I read the interview transcripts at least three times and changed the sequence to ensure my ideas were not 'primed'. This was to familiarize myself with the data and I noted down any thoughts and ideas about the interesting features of the data corpus.

- Step 3

I coded by looking for the interesting features in the data and by asking questions drawn from the work of Foucault (Arribas-Ayllon & Walkerdine, 2008) to help generate meaningful codes. These were;

What were the objects, events and experiences that are being constructed in the participants' talk?

In what ways are the participants' being problematized in their talk?

For example, below is an extract from Phil (46-49) discussing the challenges of developing a therapeutic relationship with female clients who have experienced being abused by a man. This is a brief example showing how some of the initial codes were generated using these questions;

> Phil (46-49): "…they kind of figure all men, they make all these generalisations that are sometimes very unhealthy about men and how they might abuse them and so forth. So that's why I think there's a problem. It's clear that, natural for a woman to er make those conclusions. But they're not healthy".

From this extract I noted that the object of the 'abused woman' is here constructed as one who will make 'generalisations' about 'all men', that they too will be abusive and that this is 'natural' for a woman who has been abused although also being 'not healthy'. This is talked about as being a 'problem' for him in his position as a psychologist but also in his position as a man working with this client group i.e. 'abused women' as making 'generalisations' about 'all men'.

This is just a brief example of generating some initial codes using the analytic questions. I went through the data, giving equal attention to each data item with the above questions in mind and noted down in the margins all codes ensuring they were matched to the extracts and capturing as much relevant information as possible.

- Step 4

Having collated a long list of codes from the data corpus I began sorting the different codes into potential themes (see appendix seven). In this stage of the analysis, I was concerned with paying close attention to the initial codes in order to identify commonalities as well as differences. This stage was difficult as there was a number of different ways that the codes could be grouped together. As a result this stage involved going back to the extracts and checking that the groupings of the codes matched what the participants were saying. During this stage I was also linking in the relevant literature to aid with analysis. For example, holding in mind relevant literature in regards to clinical work with clients who have been abused, I noted how much of these 'expert discourses' were being explicitly drawn upon by the participants in their accounts. In this stage, I also revisited the research literature when psychological theories were drawn upon by participants in their accounts, such as the notion of the corrective emotional experience (Palvarini, 2010), which was referred to in varying ways by many of the participants.

Step 5

This step involved a refinement of the themes generated. At this stage I mapped out how each theme was connected and began trying to bring these together into

a coherent narrative. This process was made difficult as the themes overlapped in a number of ways. In going through this, I grouped together two main themes with six sub themes. This required going through each separate theme and identifying what made them distinct from the other themes and whether they fully capture important aspects of the participants' talk. This involved revisiting the codes and their associated extracts and subsequently resulted in forming a number of sub themes within the main themes.

- Step 6

Arriving at a number of themes that I felt closely captured the significant points of the participants' talk, I began defining and refining them. This involved a process of returning to the extracts and writing down what I felt was represented in the theme and building a narrative of how they were all connected to aid in the analytic write up. I continued to link in relevant literature and asked the following questions, which were informed by a set of Foucauldian principles. These were;

-What fragments of discourses or potential extra-discursive resources are being drawn upon and deployed.

-What processes of governmentality are in operation and what are their implications for subjectivities (including technologies of the self)?

- What *subject positions* are enabled for both the participants and their female clients that are constructed in their talk?

- Step 7

I identified the following themes and sub-themes:

Gender difference in trauma work	Male clinical psychologist as associated with the abuser
	Gender difference as therapeutic
	Female clinical psychologists as problematized by gender
Male clinical psychologists' perspectives in the wider context	Supervision and peer support
	Service constraints
	Maleness as a minority in clinical psychology

2.4 Positioning and Ethical Considerations

Brinkman and Kvale (2008) note that ethical issues in qualitative research arise from the very start of formulating a research question. For this research I have chosen to explore male clinical psychologists' constructions of their work with female clients who have experienced abuse. In doing so, I am subsequently treating this as a problem through raising this as something that would be useful to research. As mentioned above (see section 2.1.1), prior to beginning this research I wondered whether I was 'creating a problem' through formulating my research questions and choosing to problematize this experience. I considered how this research might be received both by the participants and the wider clinical psychological community and whether it would be offering something useful to the profession.

In reflecting on my own experiences of psychological work with clients, I acknowledged that the interviews I would conduct could potentially be highly emotional for participants. In working with my director of studies, I reflected upon

the experiences I had undergone to choose to explore this area for research. I acknowledged that these had been particularly difficult experiences that I myself had struggled to both acknowledge and to express. Through exploring this, I came to a position that choosing to do the research was necessary to 'shine a light' on the experiences of male practitioners that I had felt had not received much attention. However, in this research, I am not just 'shining a light' on male clinical psychologists' constructions of their experiences but I am also taking a critical stance towards these constructions. This then further requires the need to ensure that ethical issues are fully taken into consideration. This primarily began with continuing conversations with my director of studies in regards to 'why' I wanted to do this piece of research and what I wanted to achieve from it. From these discussions, I understood that my own intentions where to take a critical stance towards taken for granted assumptions of both the importance or the lack of in respect to gender and its role within therapeutic work with female clients who have been abused. Therefore, in taking a critical stance, I hoped to not just raise the profile of the varied experiences male clinicians may have but also to encourage more debate and thinking about how gender difference in such work may inform how we conceptualise and approach therapy with this client group.

In the recruitment of participants I sought to ensure that participants were able to choose to opt-in to the study though contacting me via the email or telephone number provided and fully informed of the right to withdraw from the interview. This was followed up at the interview stage itself, whereby I ensured that participants had fully read the information sheet (see appendix two) and the consent form (see appendix three) before signing and agreeing to continue with the interview. Alongside this prior to and after the interview I ensured participants had the information and opportunity to ask questions regarding the research and the interview, alongside making sure that participants were aware of the nature of the questions that would be asked (Kvale, 2007).

At the start of the research I clarified my position as a trainee clinical psychologist at the University of East London and that this research was to form part of my doctorate in clinical psychology. In further clarifying my position, I acknowledged

that I had some experience in doing psychological work with female clients who had experienced abuse but that although this was quite limited I had some awareness of the nature of this work. Alongside this, I aimed to explore and share with participants prior to the interview the following points:

- That I was interested in talking with them regarding their experiences of working with female clients who have experienced abuse and subsequently what this work involves.
- That I was also interested in their motivations for why they chose to engage in the research.
- That I wished to further develop the agenda for the interview by inviting them to introduce any specific questions or areas to explore that they felt was relevant to the interview.

In addition to this, during the course of the interview I also asked participants for their general views of clinical psychology and how it relates to their experiences. At the end of the interviews I also checked on participants and how they felt and offered them feedback on the findings of the study at its conclusion to which all participants agreed they would like to receive.

2.5 Methodological Rationale

Presently there has not been research exploring gender differences in male clinical psychologists' work with female clients in the context of abuse. Therefore, it can be argued that the views and experiences of this group have been overlooked in the current research literature. Exploring the experiences and views of this group is arguably important to capture given the high likelihood of male clinical psychologists working with this client group. However, it can be proposed that it is equally important to explore how the discursive resources available to this group and the material conditions of possibility play a part in shaping these constructions of their work, subsequent subjectivities and actions. in doing so served to position what occurs and is constructed in the therapeutic context as not 'newly' created or 'cut off' from the wider social context (Hare-Mustin, 1994). By doing so, we are acknowledging the role of the wider social context in the

constitution of our experiences alongside the varied positions we may take up in a number of social hierarchies.

Through examining the discursive and extra-discursive practices that shape both the experiences and actions of male clinical psychologists could potentially be beneficial through informing:

- The training and supervising of male clinical psychologists in trauma work.
- The awareness and consideration of working with gender difference in therapy, and more generally.

2.6 Procedure

2.6.1 Participants

For this study I recruited male clinical psychologists who were working in the National Health Service (NHS) in a variety of different settings. This included working in psychosis teams, child services and learning disability services. This was done in order to gain access to participants with a variety of different experiences, backgrounds and material circumstances.

In regards to the size of the sample selected, generally in discourse analysis, sample size is not deemed a significant issue primarily due to the interest this approach has in the function and use of language as opposed to those who are using it (Boles & Bombard, 1998). Therefore, meaningful patterns can be constructed from the data without particularly requiring very large samples.

Wodak and Meyer (2001) suggest that sampling can continue up to a point where there is a variety in circumstances and situations reported, generating enough data for discourses and discursive practices to be understood. In my sample I recruited eight male clinical psychologists to be interviewed by myself, with interview lengths ranging from seventy to ninety minutes. All participants had trained and were registered with the Health Care Professions Council (HCPC) as

clinical psychologists, which is a necessary requirement for practitioners working in this field.

The age range of was 33-58 years old. Participants were from various cultural and ethnic backgrounds such as white British and European. Seven participants spoke English as a first language and two participants spoke other languages including English regularly. All participants lived in the London and Greater London area. All participants were registered with the HCPC as clinical psychologists and were working in a variety of different settings such as children and adolescent services, psychosis teams, assertive outreach teams and community learning disability services.

2.6.2 Inclusion criteria

All recruitment materials were presented in English as this was identified as the first and regular language of the participants. The materials provided offered participants to engage in the interview at the University of East London or at their place of work. Two interviews were conducted at the University of East London and six were carried out at the various work sites of participants and collectively produced approximately fourteen hours of interview material.

The inclusion criteria for the study involved identifying participants who identified as male clinical psychologists and were placed in the information sheet provided for participants (see appendix two). In addition to this, the criteria also involved those who had experience of working with female clients of all age groups who had experienced abuse. This included emotional, physical and sexual abuse. Participants were required to have had some engagement with this client group in carrying out psychological work in regards to abuse.

2.6.3 Recruitment

This study utilised one method in the recruitment of its eight participants, the snowball method (Salganik & Heckathorn, 2004). This involves using existing participants to recruit future participants from those they know. The first three participants of the study were referred by a non-participating contact of the director

of studies. These participants later referred subsequent recruits to the study through sharing information about the research to those they identified as male clinical psychologists with experience of working with female clients who had experienced abuse, which was included in the information sheet (see appendix two). Of the remaining participants that were referred, one more participant was recommended for the study but they were subsequently deemed unsuitable as they had only worked with male clients that had experienced abuse and not female clients.

The information sheet (Appendix 2) provided to participants gave information about the study, detailing the rationale for doing this research and some information of what the interview would entail. This included emphasising the co-construction of the interview questions and how the data would be analysed. Participants were given an email address and the contact details for the University of East London to use if they wished to participate in the study. Those who expressed willingness to engage in the study were followed up by email and a telephone to confirm their engagement and arrange an interview date and time.

Having agreed the details for the interview date, participants were sent an email confirming their interview along with information regarding confidentiality and how the data will be used as part of research project for a doctorate in clinical psychology. Those attending the University of East London for an interview were given details of address and directions.

2.6.4 Data Collection

The data for the study were obtained through conversational style interviews and the questions asked in the interview were influenced by the epistemological position and theoretical framework of the research. I was keen to take up an approach to the interviews that would lead to data suitable for this type of analysis. Conversational style interviews gave the opportunity for participants to talk freely and openly about their experiences and for me to ask questions of these experiences.

The interview schedule (Appendix 4) was developed to help me keep sight of the research questions and aims. The development of the interview schedule was a process that occurred over the course of the interviews. Prior to the first interview I held discussions with my director of studies in regards to what we wanted to know from the interviews. This helped me to put together a list of exploratory questions that would bring forth their experiences of working with this client group and how they made sense of this. In addition to this, at the beginning of each interview I asked the participants what questions or areas for exploration they felt should be included in the interview schedule as part of the co-authoring of the interviews (Kvale & Brinkman, 2009). I used this to help build and refine the interview schedule by including or changing any of the questions, particularly keeping those that I felt were useful in bringing forth participants constructions of their work. I was keen to hear about their experiences and any tensions from their accounts that would be useful for the analysis.

The conversational style of the interview was supportive in helping to develop rapport particularly in giving space and time for participants to reflect and allow their voice to come through in the interview. The interviews ranged from sixty to one hundred and forty minutes with the average time for an interview at approximately one hundred minutes. Before the start of each interview there was a briefing to recap the situation for the participant, discussing the purpose of the interview and how it will be recorded along with the opportunity to co-author the interview as mentioned above. This was done to help set the scene for the participants and to allow for any questions about the interview and to facilitate rapport (Kvale, 2007). In addition to this, participants were also given a consent form to sign before starting the interview and informed that there would be an opportunity at the end of the interview to ask questions and to talk about the interview.

Alongside this, at the end I asked questions regarding how they had found engaging with the interview process and checked on participants with regards to any potentially distressing information that may have been discussed or disclosed. Where this was appropriate I engaged in discussion with participants about their

experience of the interview and sought to acknowledge and validate their experiences. In addition to this, options for further support were available for participants but they all stated that this was not needed.

During the interviews I took notes to keep a record of my own thoughts and experiences during the interview. This was also used to help me be aware of particular constructions, assumptions and aspects of discourses that were being used by participants in their talk and to be aware of my own assumptions during the interview. Alongside this, I took up an active role in the interview ensuring that I remained curious and expressed my own position as a naïve interviewer (Willig, 2008).

2.6.5 Transcription

Transcribing audio material to written form can be identified as a form of initial analysis as this requires the structuring of the recording into something that can subsequently be analysed. For this study I audio recorded each of the interviews, and transcribed them verbatim. Due to this research focusing on broader global constructions as opposed to the micro-situated language use of participants, I adopted a simplified transcription convention as per Malson (1998), which has been adapted from that of Potter and Wetherell (1987). This transcription convention can be seen in the appendices (Appendix 5).

CHAPTER 3: ANALYSIS AND DISCUSSION

In the first chapter I presented literature around how female clients who have experienced abuse are constructed and the role of the therapists working with this client group. In doing so I presented the ways in which trauma work with women who have been abused is interwoven with dominant discourses about abuse and women in the academic literature. I suggested that the therapy room is not 'shielded' off from gender discourses, 'expert' discourses or treatment models. As such, male clinical psychologists may be problematized in their work with female clients who have experienced abuse. They cannot be stripped of their context in the positions they hold within the therapy room. This has implications for clinical psychologists' experiences and subjectivities with this client group, how they construct their work and subsequently their clients.

In this section I will be presenting my findings and discussing them in reference to the research question and sub-questions:

Main research question:

- How do male clinical psychologists construct their work with female clients who have experienced abuse and what are the implications for their experiences and therapeutic work?

Secondary research questions:

- How are male clinical psychologists problematized in their work with female clients who have experienced abuse?
- What subject positions are offered for both the participants and their female clients that are constructed in their talk?

The data corpus for this analysis was the transcripts of the interviews conducted with male clinical psychologists. This data was analysed using a social constructionist thematic analysis (Braun & Clarke, 2006), mainly informed by the work of Michel Foucault (1985). The focus of the interviews aimed at eliciting talk

about their clinical work with this client group. Following the advice of Arribas-Ayllon and Walkerdine (2008), I will be paying particular attention to extracts that throw into 'sharp relief' the practices on the basis of which male clinical psychologists' become problematized in their work with female clients who have experienced abuse. The accounts of the participants will also include an analysis of some of the rhetorical practices that they engaged with in conversation with me as they tried to explain and persuade me to accept their position and actions.

Therefore, I have sought to include within the analysis, some of the interactional features present in the interviews (Arribas-Ayllon & Walkerdine, 2008). These rhetorical practices are thought of as 'truth games' in Foucault's body of work, where he refers to these as 'regimes of truth' in operation when a person is making a specific claim about the 'nature of truth' (Foucault, 1988).

Following the Social constructionist thematic analysis, two main superordinate themes were developed along with six sub-themes. The themes identified have been labelled as;

Gender difference in trauma work	*Male clinical psychologist as associated with the abuser*
	Gender difference as therapeutic
	Female clinical psychologists as problematized by gender
Male clinical psychologists' perspectives in the wider context	*Supervision and peer support*
	Service constraints
	Maleness as a minority in clinical psychology

I will now present these themes revealing their scope and diversity with the use of extracts from the data and analytic narrative. This will involve both a descriptive and interpretive account of each theme and their sub-themes.

3.1 Gender Difference in Trauma Work

In this main theme the participants constructed their experience of trauma work with female clients who had experienced abuse as both a site of challenge but also an area wherein their gender offered particular advantages. Alongside this, in addition to constructing their experience as challenging in regards to being associated with perpetrators of abuse, they also constructed female clinicians as also being problematized as a result of their gender, namely through occupying shared space as women.

3.1.1 Male clinical psychologist as associated with the abuser

In constructing their experiences of therapeutic work with female clients, various accounts were deployed that constructed trauma work as made problematic by virtue of their gender. Participants described their work with this client group as made challenging through being associated with the perpetrators of abuse as a result of being male.

> Extract 1:   Jones: If you've got um matching triggers, it can be quite hard to work with somebody. So say somebody was physically attacked by er someone who looked like me er then it might be quite hard to er work with me because I'd be triggering flashbacks and intrusions. So if somebody was female or male and was sexually assaulted by someone who is male say particularly, I mean anybody whose male, but say somebody who's my height, whose white, whose gotta beard, you know, um er could trigger intrusions. So where it is difficult is just of the fact of being male I could be um triggering their PTSD symptoms rather than allowing them to address it in what feels like a safe way. So that's where it's difficult (**Jones:** 14-21).

In this extract Jones' talk of his role as a clinical psychologist is problematized through sharing the same gender as the perpetrator. He constructs being a male clinical psychologist here as potentially able to trigger distressing symptoms '…it might be quite hard to er work with me because I'd be triggering flashbacks and intrusions'. This is seen as trumping other characteristics (e.g. height and facial hair), though this is constructed as potentially adding to the possibility of triggering 'PTSD' symptoms. Thus, Jones positions himself as presenting a problem by being a man and the female client is simultaneously constructed as one that can be triggered and subsequently distressed by PTSD symptoms (Schachter et al, 2009). This is highlighted elsewhere in the transcripts whereby the development of a therapeutic relationship is understood as central to trauma work but problematized by sharing the same gender as the perpetrator of abuse in the client's experiences (e.g. **Sawyer**: 46-47). Jones had experience of, and specific CBT training in working with trauma and he constructs the term PTSD as a consequence of abuse and one that can be quantified and categorized through the presence of symptoms coming from within the client and that this is a meaningful and valid thing to do (Patel, 2011). It could also be said here that the problem is being located within the female client in associating characteristics of the participant to her abuser.

Jones' talk clearly positions him as needing to join with and develop a relationship of safety, wherein issues and problems can be discussed and worked through (Schachter et al, 1999, Jones 1991). However, he constructs being a man as a potential trigger for distress which constrains him in doing so 'where it is difficult is just of the fact of being male…' as it can serve as a trigger for distressing memories and symptoms. As a result, this positions him in his role as a psychologist as having to be mindful and cautious of how he works with this client group, as demonstrated elsewhere in the transcripts (e.g. **Sawyer**: 268-269) and in the next extract.

> Extract 2:   Hassan: (laughter) I just think, I think er it makes me feel conscious of being male and that's for this person to have a really good therapeutic relationship with me, I've got to be really careful about what I say and I want to build up a really good relationship. So/

Omar: For that being the case because you're a man?

Hassan: Yeah   .

Omar: Right okay. And the client being female, was that gender difference in that/

Hassan: Yeah, I guess because you know I can't even think of people I've worked with where the abuser has been female. So you know both male and females I've worked with have been abused by males. So um and male patients, this sounds really silly saying, but a male patient is a man himself he kind of knows that that men aren't necessarily like the abuser I guess because he is one. So I feel to be, to build up a trusting relationship with a woman whose been abused by a man in anyway in any abuse I'd feel like I'd want to tread so carefully because I'd want to not be/

Omar: Associated with?

Hassan: To an extent or kind of yeah I'd just want to make sure I can as much as possible be different to that person so that I'm, so we can use our relationship as the therapeutic tool (**Hassan:** 269-283).

In this extract, Hassan positions himself, being a man, as difficult in engaging in therapeutic work with the female client and that he is subsequently constrained by this. Hassan is constrained by constructing abusers as mostly being male following his own experiences and the extra-discursive factors of high rates of male perpetrators (Black et al, 2011). This is additionally significant for Hassan in his role working with many adults in the community who are frequently in vulnerable positions and facing a number of social factors such as poverty, homelessness and even sexual exploitation. This is subsequently problematic for him in trying to build up a trusting relationship because he too is a man and notes that this would perhaps be easier if the client was male, presumably as he feels

this would make general assumptions of men as abusers as less likely '…but a male patient is a man himself he kind of knows that men aren't necessarily like the abuser I guess because he is one'.

His experience of men as more likely to be perpetrators of abuse (Walters, Chen & Brieding, 2013) offers the position for him of having to 'tread carefully' in his work with the female client. This appears to be done to ensure he presents himself as different from abusers, as not an abuser himself, therefore subsequently constructing female clients as likely to make such an association. This is demonstrated elsewhere in the transcripts (e.g. **Locke**: 218-225) whereby emphasis on the high frequency of male perpetrators (Walters, Chen & Brieding, 2013) positions the participant as needing to be very aware of his own conduct in session with a female client in order to not recreate the actions of the abuser and particularly informed by being in a position of power. This constructs the female client as one who will be vigilant to the therapist's behaviour because of their experiences with other men who have been abusive.

Hassan talks about himself as being at a disadvantage due to his association to the abusing gender. He positions himself as one that needs to work harder to prove his suitability, ability to make therapy safe (Freidlander, 2006) and to be seen as one who will not also abuse the client. This is an example of having to distance oneself from a type of unwanted masculinity for both the psychologist and the client. This could be identified as a type of hegemonic masculinity that is defined by the seeking of power and dominance over women (Connell, 2005), which is an undesirable position for Hassan in his role as a clinical psychologist working with women who have been abused (Herman, 1998). For the female clients, it can be said here that they are positioned as having a particular type of relationship to their abuse, as one wherein which their perceptions of all men have been affected as a result of such abuse by men. The idea of the damaged survivor is constructed here, one who needs time to develop trust and a position of readiness in the therapeutic relationship before engaging in work on the abuse (Horowitz, 1997). This construction consequently closes down space for alternative relationships that one might have with their experiences of abuse

(Warner, 2003), which may not necessarily be one wherein they see themselves as victims. This may also miss the already 'small acts of resistance' that people engage in when they are oppressed and how building on this can equally be a useful therapeutic tool for clinical psychologists (Wade, 1997).

The next extract captures the participant's construction of his role in addressing power and control in the therapeutic encounter and how this is problematized by gender difference.

Extract 3: Jones: Yeah, yeah, so I'm very careful to, I mean I do this anyway working with children because their often not had the chance to have control and power in situations so I'm very careful to give every choice, every decision over to somebody, to the client, um where would they want to be seen, where would they want to sit, where would they want me to sit, do they want to work with me given, make sure they know they got all that choice. But even with that for some people it's/

Omar: Yeah

Jones: Just the maleness it's too much.

Omar: Well I was going to ask what kind of things do you do to try and overcome that or manage that/

Jones: Yeah

Omar: in some way?

Jones: Um, well I'd label it first of all, I would say, you know, it could be difficult or I could say there's advantages and disadvantages, I'd make sure they realized they got choice. Um, I'd be, I'd try to make sure that I was being very um gentle I guess so um, I mean I'm not a very forceful person anyway (laughter), but to really make sure that I'm not er and it's not always possible to get it right but to make sure that I'm

really not trying to impose my thoughts or my ideas (**Jones**: 32-46).

From this extract, Jones constructs his role as to give control and choice over to the client "…I'm very careful to give every choice, every decision over to somebody, to the client…" It can be said here that he is constructing his position as one of displaying care "…I'd try to make sure that I was being very um gentle I guess…". This is constructing himself as sensitive and able to provide care, which runs counter to popular hegemonic masculinity and complicit masculinity discourses (Connell & Messerschmidt, 2005). Jones justifies this through identifying that he works with children, who are often not given choice in their lives. In Jones' working context, his main client group is with children and young people and therefore this can be argued, raises the importance of being mindful of choice, control and power in the therapeutic setting. This can also be positioned as making space for the client to resist therapy through giving control to them in deciding whether they wish to engage in work with him. This draws upon approaches to working with people who have experienced oppression and abuse in valuing the importance of enabling client resistance and not treating this as pathological or further 'evidence' of disorder or distress but as a valuable tool to make sure clients have access to (Afuape, 2011).

Further to this, he constructs his role as to be 'very careful', ensuring they he is not acting oppressively or in a dominating way, which leads to being cautious with female clients and thus implementing a technology of the self over his own actions and conduct (Foucault, 1988). Therefore, the unwanted position here is a type of masculinity that is being identified as 'too much' for the female client. This offers the need to adopt particular behaviours to demonstrate his own distance from this type of masculinity such as being 'gentle' and avoiding forcefulness and being imposing but still carries the risk of not 'getting it right' as evident elsewhere in the transcripts (e.g. **Hassan**: 48-60). In addition to this, abuse is being constructed here as involving the taking away or lack of choice and control for an individual, where things can be done to them. As such, in emphasising the need to give as much choice and control to the client, the participant is here demonstrating his awareness of the

'tactics of abuse' (Warner, 2000) and seeking to ensure that he does not replicate this.

In the next extract, the participant constructs abuse as associated to what it means to be a man and that this throws up questions for both the psychologist and client regarding this close association.

Extract 4:   Locke: I think that I would probably be a little bit more, yeah I would probably be more um, well actually its more my default setting because most of the abuse does seem to have happened, occurred from men so it's always been I suppose a little bit um, there are sort of questions in the air then aren't there sort of. Implies certain questions like are you also going to be abusive? How much of the abuse can we attribute to um this sort of dysfunctional parts of the abuser? How much can we attribute it to gender? Let's say we do some sort of factor analysis so you can actually single out. Maybe, I mean it's no um coincidence that most abusers are male. There's something about being male that probably lends itself more to er a certain physicality, a certain sexuality or certain sexual er I can't quite find the words to explain it but er.

Omar: In what way?

Locke: Well, um men are more physical, um, you know young boys seem to be more rough and tumble play and stuff then female siblings and stuff and so, clearly we are more inclined to, for whatever reasons actually. I mean, it's not actually the most important thing why, whether its nature or nurture or what have you but we do tend to be more um likely to express ourselves physically I think. Maybe it's when we can't tolerate certain emotions that we might not have been encouraged to um to talk about when younger. So that's one of the reasons why men do abuse I suppose. There's no other way to handle

69

that at the time. Um, and I suppose with sexual abuse um it's sort of another way in which, well I think the idea of sexualisation in the psychodynamic literature, I think is er it's a way of um kind of feeling more powerful and it's a way of dealing with powerlessness essentially. Um some of these things may be more of issues for men generally then for women (**Locke**; 220-235).

In this extract, Locke is constructing abuse as a more masculine act as opposed to a feminine one, as something that is attributed to being male. The abusive act is construed as coming from a hegemonic position whereby it is constructed as a way of feeling powerful. Hegemonic masculinity discourses often contain beliefs about men that function in a way that ensures dominance over women (Connell, 2005). From a feminist perspective, this can be seen as positioning the act of abuse as a way of controlling women, supported by the historical and social norms about how men and women are supposed to act (Dobash & Dobash, 1998). In this extract, Locke appears to be constructing masculinity within a hegemonic position. This is then justified through examples of the high numbers of perpetrators of abuse who are men and even noting the presence of characteristics of young boys associated with aggression and physicality (Keddie, 2003) 'um, you know young boys seem to be more rough and tumble play and stuff then female siblings'. This can be seen as positioning men as innately aggressive and physically stronger, with associated forms of abuse towards women (who are positioned as less aggressive and physical) as almost logically following this or inevitable.

Locke here is subsequently problematizing and constraining himself as a male. Intrinsic characteristics of what it is to be male are closely associated with the act of abuse, which is seen here by Locke as a need to gain power over others drawing on a psychoanalytic discourse. Thus, it can be said that he is positioning himself as problematized by being male not only through the high rates of perpetrators but through maleness itself having a close relationship to the act of physical and sexual abuse. He then constructs this as raising questions for both the practitioner and the

client and thus how he is then able to achieve being different or distanced from the abuser when sharing such an association with abuse itself by being a male.

In the next extract, Locke constructs the role of the psychologist to know oneself in order to offer a therapeutic experience. This can be seen as deploying a technology of the self, in monitoring not just one's conduct but also one's inner thoughts and feelings as a way of managing this close association with the abuser but may also be positioned as a form of resistance on part of the therapist.

Extract 5:   Locke: Yeah. Well some of it is er I guess with therapy generally one of the most important things is to be able to know yourself. So that you cannot go, you know, your own stuff tangled up with that of the client's as far as possible. At least be able to recognise when you know you have certain reactions to things. Um I think there's something yeah there are some various things you have to think about in relation to being within the same sort of bracket as the abuser, in this case by being male. Er, I think one thing about it is it could be something, um I don't know if this is more a men thing or, probably is more so actually cross-gender, but there could be something voyeuristic about hearing somebody talking about um experiences of abuse. Could be something kind of, it's sort of um a bit like when you turn on the TV to watch the news and the sort of excitement factor in hearing something er shocking. But then there's also a sort of disgust or could be anger about it. I mean this is I think some of the things I think people live, go through when they watch the news or read the papers. You know a sort of a vehicle to sort of excite certain feelings and um, so maybe a very common reaction, not by a therapist, but by someone hearing these stories, to get very cross and defensive on part of their patient. Um, which can potentially feed into, a little bit of that can be helpful but it can also be unhelpful in that um sort of saying you're not actually

tolerating what you're hearing in some ways. Um you want to um, they need you to actually not rush off and retaliate on their behalf (**Locke**: 246-260).

The participant places knowing oneself as an important aspect of the role of a clinical psychologist doing therapy "…with therapy generally one of the most important things is to be able to know yourself" (Haas, 1997; Yalom, 1995). Knowing oneself is constructed here as preventative of 'getting tangled up' with the client's responses. Therefore, knowing yourself is positioned as being able to be aware of one's own reactions to the client's story as demonstrated elsewhere in the transcripts (e.g. **Sawyer**: 151-161). The psychologist is constructed as one who is likely to have particular emotional reactions to hearing traumatic and difficult experiences, which are described as at times a form of 'voyeurism' and therefore needs to be monitored and kept in check. This also appears to serve as a way of ensuring one does not take up the abuser position of enjoying or getting something from being a witness to the client's abusive experience. Alongside this, it also simultaneously constructs the psychologist as one who can access the truth of oneself through a form of inner reflection. Here a psychologist is spoken of as being able to be self-aware of the range of emotional reactions that they might have, being able to manage these and as something that one should do (Haas, 1997).

Knowing yourself can be described as a form of self-monitoring. This is ensuring that one's own emotions are under control and surveillance in order to be able to clearly perceive what belongs to the client in the therapy session, which can be identified as a form of technology of the self through monitoring and policing one's own emotions and actions (Foucault, 1988). In addition to this, a similar construction of the role of a psychologist is made, as elsewhere in the transcripts (e.g. **Michael**: 246-263), in regards to tolerating the reactions that are evoked from hearing difficult stories 'Um you want to um, they need you to actually not rush off and retaliate on their behalf'. Alongside this, the participant is also warding off a particular type of reaction that can be found in masculine identities (Connell, 2002), a kind of 'hero' response in which the participant is responding in a

gendered way by trying to take up a familiar male role and thus can be seen as a small act of resistance to an unwanted position.

The role of the psychologist here and the language being used, such as 'knowing oneself', feelings being 'tangled up' with that of clients, could be understood as speaking to psychodynamic and psychoanalytic discourses (Lemma, 2003). This particularly speaks to the concept and skill of counter-transference and being aware of one's own reactions to the difficult stories they hear in therapy (Dalenberg, 2000) as demonstrated elsewhere in the transcripts (e.g. **Phil**: 93-96 and **Sawyer**: 300-306). This may have particular significance for Locke in the context of his work in psychosis and the high likelihood of encountering difficult and often traumatic stories. This identifies knowing yourself as more than the self-growth of the therapist but as one that is necessary for therapeutic treatment of clients who have experienced abuse (Davies & Frawley, 1994) as well as dealing with issues of self-care. The failure of paying attention to and appropriately using counter-transference is noted in the psychodynamic and psychoanalytic literature, particularly in regards to trauma (Modestin, 1987; Dalenberg, 2000). Therefore, it can be said that this may be illustrating the deployment of power on the participant whereby they are required not just to be aware of their own reactions, particularly gendered reactions, but also to manage these and deploy them usefully in the act of therapy.

The next extract illustrates the participant's experience of feeling associated with an unwanted subject position. This experience is one of being associated with abusers and a particular type of masculinity and subsequently not having the opportunity to distance himself from this position when working with a male client.

Extract 6:   Michael: I, I could see the challenge but I was frustrated because it came simply by me having an appearance of man (laughter). Physical appearance of man, nothing except, nothing he could actually figure out what my idea of masculinity is. Before I said anything he made up his mind

that I would think less of him now that I know he's er raped in prison.

Omar: Yeah. (.) In that sense you're being judged quite quickly before/

Michael: Just being, by entering the room really.

Omar: Hmmm.

Michael: And interestingly you would expect that to be more case in female victims of abuse. But in my experience I got more, I got second chance for female victims of abuse. I was allowed to at least say something or to allow them to talk and me to listen. But in this case I was telling you, just by me looking at the man (laughter); I was dismissed as not suitable for pursuing therapy.

Omar: Hmmm. And you described that as quite frustrating in that sense/

Michael: Frustrating in the sense that I wasn't allowed to maybe show to this man that I don't think less of him because of that experience. So before I could say anything he assumed that I do. I'm quite sure that my body language or how, because I hardly said anything I had nothing in my voice could show that so he came with a clear, he made up his mind before I said anything (**Michael**: 169-184).

Michael, who also works often with clients given a diagnosis of psychosis, is talking of an experience of being judged before given a chance to reveal his construction of his own masculinity 'Before I said anything he made up his mind that I would think less of him now that I know he's er raped in prison'. Thus, Michael here is constructing the possibility of multiple masculinities and that he holds one that would be non-threatening, acceptable and non-judgemental of the

client's experiences, which he is not given a chance to 'show'. The client described (who in this extract is a male), is constructed as having made a judgement of the participant's masculinity just by looking at the participant. Michael here could be identified as constructing the client as utilising an essential or biological-reductionist theory of masculinity (Tiger, 1969), whereby the fact of occupying a male body is positioned as engendering a particular type of masculinity, here in this case as potentially a hegemonic or complicit one (Connell, 2005).

From this position again, 'working harder' is denied by not being given a 'chance' and is experienced as frustrating for the participant as this is in tension with the importance of creating a safe environment for trauma work to take place and which is also seen as a necessary aspect of working in the context of psychosis (Jones, 1991; Chadwick, 2006), further problematizing the male clinical psychologist. This is evident elsewhere in the transcripts (e.g. **Jones**: 278-287). This frustration and wish for the opportunity to demonstrate his own construction of masculinity can be considered as an act of resistance through technologies of the self (Foucault, 1988) in deliberate and conscious refusal to behave or take up a particular subject position or an act of de-subjectification (Agamben, 2002). Therefore, constructing himself as different from popular conceptions of masculinity (hegemonic masculinity), the client is positioning himself as coming from a position whereby, if given the opportunity, he could demonstrate and convince the client of his safeness and non-judgmental stance as a therapist.

Following this, in the next extract, Michael subsequently engages in rhetoric of argument (Edwards & Potter, 1992) in constructing his account, from this position of being problematized at the level of being an embodied man, to inevitably lead to a logical conclusion of how he must respond to experiences where clients' refuse to work with him because of his gender.

Extract 7:   Michael: I, I think you have very limited options really. Because, just remember you are encountering this person for first time, they seeing you for that hour and you are facing years of abuse accumulated in this person. This is I feel hard

or even impossible to shift in that hour. And the only thing, going back to what I said before, what works, seems to work, is doing <u>nothing</u> (laughter).

Omar: Doing nothing? In what sense?

Michael: but giving this person enough time to have a good look at you and to decide to give you another chance really. I feel the more you try to persuade this person I'm not like those men who abused you, you might find more resistance really. But by staying with this person, staying with that pain, listening, you might get them to call you when they might start considering that you might be worth actually sharing their story.

Omar: In that way it does sound almost as if you're, in that situation you're in a way kind of powerless to affect that in many ways. That all you can do is, as you said earlier before in hold the pain and demonstrate that you can hold that. And hope in time that they can see something else and feel safe enough to use that space.

Michael: Hmmm. But then that holding the pain, as you just said, I think that's the key. And it is in that sense, in terms of your, your topic, that the gender is, is an issue. Because there is so much abuse by men to female (laughter) er it is something that unfortunately so many female clients come with, you might not even know they come for something else. They would never tell you. But if you start thinking about it, it's quite frightening thought that you are sitting from so many clients that might have history of abuse by man. And you might, you might be perceived as one of them (**Michael**: 246-263).

With the previous extract (e.g. **Michael**: 169-184) demonstrating a feeling of powerlessness over how one is positioned by the actions of the client, in this extract the renunciation of that position is highlighted by constructing the client as the one who holds responsibility. Michael here is positioning himself as one who does not have much choice due to the gravity of the impact of potentially years of abuse that the client has faced. He identifies the limitations inherent in such therapeutic work as "…impossible to shift in an hour" and as such concludes that this leaves him with 'limited options', evident elsewhere in the transcripts (e.g. **Hassan**: 489-506). He sums up his only option as 'doing nothing', which consists of "giving this person enough time to have a good look at you and to decide to give you another chance really". Michael here is constructing the response to being associated with the abuser as resting with the client whereby they need to 'have a good look' at the therapist to decide whether it is worth 'taking a chance'.

However, even here Michael's role as a psychologist is constructed as more than just 'doing nothing' but as one who is 'staying with that pain', which can be connected with ideas of containing emotional transferential experiences in therapy (Lemma, 2003) and being available when the client is ready to 'share their story' as highlighted elsewhere in the transcripts (e.g. **Locke**: 313-325). This is again problematized by how 'men' might be constructed as the participant notes '…it's quite frightening thought that you are sitting from so many clients that might have history of abuse by man. And you might, you might be perceived as one of them'. This acknowledgement limits his ability to control the actions of the client through routine practices of making therapy safe.

The responsibility here belongs to the client. Clients are constructed as ultimately the ones who make the decision and that they must choose to see a male psychologist as one who is safe to work with (and not as associated with abusers). Clients' are constructed as needing and benefiting from 'sharing their story' and engaging in the therapeutic process but importantly as the ones to decide whether or not they wish to do so. Michael is thus further constrained through a construction of 'cure' through therapy and his role as a provider of that, which is made not possible by the client's choice to not take up the therapeutic space.

Governmentality can be drawn on here to further illustrate the deployment of power that can be argued is in operation. This relates to a technology of the self through the confessional (Foucault, 2003). The confessional is positioned as closely connected to Christianity and identified as a technology by Foucault through the confessing of one's sins. Thus, in order to show the truth of the self, they must first renounce themselves. Renouncing oneself has become central to the practice of psychological work through verbalisation. What is being constructed here is a form of pastoral power that aims to produce the truth of a subject that they must achieve through their confessional, verbalization ('sharing their story') of their inner thoughts and experiences in the therapy room in order to realise their goals for happiness and the alleviation of distress. Thus, clinical psychologists are implicated in the construction of a 'harm' story that can draw one away from an alternative position which has space for honouring different responses to experiences of abuse and to invite different ways of intervening or supporting this client group.

In the next extract, what is being constructed is the female client who has experienced abuse and is now positioned, as a consequence of such abuse by men, as one who is likely to be suspicious of men through generalizing the actions of the perpetrator to all men.

> Extract 8: Omar: Okay. So the trusting relationship between you and the client becomes more important if the abuser is a man.
> Phil: Right.
>
> Omar: And can I ask why, just so we can get at the specifics.
>
> Phil: Well I think most women who went through a period of abuse by a man um they're very weary of male figures, especially usually male authority figures, someone who has power over them.
>
> Omar: Hmmm.
>
> Phil: So they become very apprehensive about that. And they kind of figure all men they make all these generalisations that

are sometimes very unhealthy about men and how they might abuse them and so forth. So that's why I think there's a problem. It's clear that, natural for a woman to er make those conclusions but they're not healthy (**Phil**:).

In this extract, Phil constructs the therapeutic relationship (Dalenberg, 2004) with the client as more important if the abuser is a man. This again problematizes the male practitioner due to his shared identity as a man with the perpetrator of abuse, emphasising the importance of the need to develop trust in the working relationship (Herman, 1998). This is positioned as often an objective truth that resides within the female clients as opposed to just his construction. Here the female client is one who as a consequence of her experience now makes generalisations regarding all men. Thus, the client here is one who is responsible for problematizing the therapist and in being able to enter into therapy with Phil due to such a generalisation that associates him, as a male, with the abuser. Furthermore, the construction of the client is both noted as 'natural' and 'not healthy', serving to both normalize and pathologise the client. By identifying decisions to not trust men as 'not healthy', female clients here are constructed as the problem due to generalizing and as a problem that is inherently 'natural'. This locates the problem that needs to be addressed as residing in the woman as opposed to a consideration of the wider context or in constructing the act of 'generalising' as a form of resistance to oppression and abuse from men, which would serve to honour her strengths and capacities they may have shown in the face of abuse and its effects (Wade, 1997).

In Foucault's work on disciplinary power (Foucault, 1980), the subjection of people through surveillance processes such as observation, judgement and examination can result in normalization and subjectification effects (Foucault, 1977). Thus, these characteristics of the female client who has experienced abuse ('generalisations') become unwelcome and subsequently constrained through their construction as unhealthy both for the client and the therapist. They may also serve to make visible the abused woman as one that can be distinguished from non-abused women due to their lack of trust in men (O'Dell, 2003).

In the following extract Phil positions himself as at a disadvantage following an incident with a female client. He constructs female clients generally as having a lot of power in the therapeutic relationship, particularly due to him being a male.

Extract 9:   Phil: I was afraid. And then people would say it's just me and her in the room you know and I'd be at a disadvantage even though I was talking to my supervisor about it. But she didn't do that she complained that I misrepresented her in the files and I talked to other people about her issues and that and "what do you mean" she wasn't interested in me and she was very offensive and that was dropped. I mean fortunately it was found there was no actual claims to follow on and er. I mean yeah it got me very nervous um just because I didn't know how you know other people would take that. So what helped me there was having a supervision for that issue. Soon as I recognised that there was a boundary problem here I made sure that I talked about it in supervision.

Omar: Yeah.

Phil: And that helped me. Yeah so.

Omar: Yeah that was, I was thinking that, I'm thinking about you as a man in that context um and that you know your client potentially sharing or complaining or making a comment about the therapeutic encounter and you sort of said you felt, you felt vulnerable in a way.

Phil: Yeah, I did, I felt very, I felt like almost defenseless. I mean there's nothing stopping a client, especially a woman client for saying "he did this to me" or "he did that to me" and then immediately it goes to investigation. And you know as a man I think we're kind of at a disadvantage (**Phil**: 362-376).

In this extract Phil is constructing male practitioners as being at a disadvantage due to their gender and the power that female clients have. The female client is here constructed as having the power to make a claim about the conduct of the psychologist. He constructs his position as a powerless one wherein the client's claims would 'immediately' lead to an investigation. Thus, he is constructing his role as one wherein, under investigation, he must prove his conduct in therapy as appropriate (British Psychological Society, 2006) and that through being a man this is made harder following assumptions about men as abusers in society generally. Thus, his construction of his experience of fear can be understood as being made salient through the very real negative consequences that arise from breaching boundaries with clients in therapy (Simon, 1993) and the explicit guidelines and policies in regards to such conduct of therapists (Sarkar, 2004). As a result, his conduct is constrained by a 'technology of power' (Foucault, 1982), a fear of professional and personal loss and a technology of the self, namely conducting his own conduct. In addition to this, the 'gaze' of others can also be said to be operating upon Phil's experience which he described as "yeah it got me very nervous um just because I didn't know how you know other people would take that". The impact of how this complaint might be taken by others appeared to also have an impact on Phil, making him 'nervous' in regards to the judgements of others.

3.1.2 Gender difference as therapeutic

For this sub-theme, the accounts served to address the experience of being problematized by their gender by also constructing being a man as having therapeutic utility, namely through the providing of an alternative, positive or corrective experience.

The next extract demonstrates an attempt to both make sense of a female client's request to see a female clinical psychologist and to counter this discursive construction that positions the male as an unsuitable choice for therapeutic work.

> Extract 10: Omar: So the fear of seeing a er man, when they themselves
>   have suffered abuse from a man, working with one, there's

that fear that it may bring up those past feelings of as you sort of said, re-traumatise them? Um, so do you feel that that's the primary reason why um female clients generally request to be seen by a, in your service, in your experience, generally request to see er a female practitioner?

Sawyer: I think it's mainly erm victims of male perpetrators that they mainly wish to be seen by female member of staff.

Omar: For that reason/

Sawyer: For that reason. However, the majority of clients that have suffered abuse in the past they wouldn't mind. They don't mind. Er being seen, you know they don't mind about the gender of the therapist. Like you know they are happy to be seen by either a male or a female.

Omar: Ah okay. And is that; are they a different group in terms of kind of abuse that they have experienced? From those that you found do want to er see a woman.

Sawyer: No er things like you know I think that main factor er was probably maybe clients that would er prefer to be seen by the female therapist. Maybe they are clients that er that have avoided most of their lives reflecting on those experiences. And they are worried that exposing themselves to er to a male might trigger quite intense feelings of anxiety and uncertainty (**Sawyer**: 48-63).

In this extract, female clients are constructed as avoiding what is a difficult but necessary experience through their request for a female psychologist, i.e. working with a male, which involves the 'triggering' of 'intense feelings' and 'uncertainty'. However, these proposed feelings generated by therapy with a man are constructed by Sawyer as the result of the client's abusive experiences and subsequent lack of reflection and exposure to these feelings '…Maybe they are clients that have

avoided most of their lives reflecting on those experiences'. This elaborates a desired position for female clients to take up, being able to confront these 'intense feelings' and do 'reflecting' as noted in popular discourses within trauma regarding the restorative effect of confronting and sharing their story (Herman, 1998). This speaks to a discourse of psychologizing the experience of abuse (Patel, 2011) as one that needs to be spoken about, confronted and worked through in the context of psychological therapy and ultimately a form of pastoral power (Foucault, 2003).

In the next extract, the male gender of the participant is now constructed as offering potential advantages in trauma work with female clients and presents a potential way around an unwanted position (resistance and counter-discourse) of being associated with the abusing perpetrator. This also further emphasises the construction of the client as needing to verbalise her inner experiences in a process of therapy to achieve alleviation from distress.

> Extract 11:   Paul: Well yes. Yep there are, there is that erm however you
>
> know one could also say well actually she's had this
>
> horrendous experience with a man but she's able to come and
>
> see me and I think that is actually a huge erm you know a big
>
> thing for her.
>
> Omar: Does that offer an opportunity in some way?
>
> Paul: Yeah I think so. I do think so. I think that actually maybe
>
> more therapeutic than not you know than seeing a woman
>
> actually.
>
> Omar: Can I ask why? That's quite interesting in that sense/
>
> Paul: I guess if you're thinking about it because I, I guess the
>
> way I work in that particular service in er a sort of more
>
> psychodynamic kind of way and it's you know your, her
>
> relationships with men in the past may well be reenacted in a
>
> sense you know in the therapy situation that is a dynamic of
>
> the therapy. And if she can actually have an experience with a

man that's not abusive then that in itself is therapeutic.
Looking at it from a kind of, from an attachment dynamic
perspective (**Paul**: 225-236).

In this extract, the male clinician is constructed as offering potential advantages for a female client to take up in a process of therapy and constructs this drawing directly from a psychodynamic perspective (Alexander, 1944), which is his main therapeutic approach working with adult clients given a diagnosis of psychosis. Paul positions himself as having an advantage, presumably over a female clinician, in being able to provide an experience of a relationship (a therapeutic one presumably with a male) that in itself is not abusive. The female client here is being constructed as being able to learn something in this therapeutic dyad about the nature of men '…if she can actually have an experience with a man that's not abusive then that in itself is therapeutic'. This is positioning the client as in need of a different experience that is lacking and can be best provided by the participant because he is a man as demonstrated elsewhere in the transcripts (e.g. **Phil**: 8-13). This can be considered as a form of resistance on part of the participant to the unwanted position of being problematized due to sharing the same gender as the abuser and instead now breaking free or de-subjectifying oneself (Agamben, 2002) through reconstructing the utility of 'man' in the therapeutic process. This can be seen as a process of self-making, breaking free from discourses of which the participant is subject to (O'Farrell, 2005) i.e. male psychologists as potentially re-traumatising or a trigger of distress for female clients to one of the advantage and therapeutic value of a male practitioner offering a kind of corrective experience (Lemma, 2003).

In the following extract, the participant constructs the psychologist engaging in this type of work as one that can be subject to counter-transference experiences and the need to be aware of these in therapeutic work.

> Extract 12: Sawyer: So issues like er, what kind of feelings the client
> provokes to you and then reflect on why. Because we talked a
> lot about transference, how clients might feel about seeing a
> male therapist but it's also like you know, sort of important to

acknowledge what kind of feelings er an abused female triggers to a male therapist. Er I think er personally believe that another might be aware to the assumption that it's like, no my therapist might feel empathic towards the person or maybe might feel sorry for them. But I strongly believe that depending on a number of factors like for example their personal life, their experiences with females, a number of other feelings might also/

Omar: Come up as well/

Sawyer: Come up as well. It might be anger, automatic thoughts such as maybe you deserved it or maybe er you should have been more careful. So in a way erm the idea that we can be neutral and non-judgemental and er probably it's a fantasy because no matter how experienced we are, no matter how confident you feel about doing this work, you always need to take into account erm the experiences that you carry with you. And how they shape you as a person (**Sawyer**: 424-436).

Here in this extract, Sawyer discusses counter-transference (Dalenberg, 2010) and constructs this as an important experience of therapy with this client group and further emphasises the need for this to be monitored as demonstrated elsewhere in the transcripts (e.g. **Paul**: 309-314). Alongside this, the participant constructs the emergence of counter-transference feelings as coming from a psychologist's own social and human experiences, which are positioned as unavoidable and needing to be held in mind. Here the impact of such inevitable experiences is constructed as undermining the possibility of taking up a neutral non-judgmental position, which is labelled as a 'fantasy'. This creates the project of the psychologist to always continually 'take into account' the experiences they carry, which are deemed as constructing and shaping the person.

Thus, the role of the psychologist is one of continuing self-surveillance over both their own personal experiences and the consideration of how that is interacting with the client in the therapy room (Pope, et al 1986). This is positioned as leading to being better able to work with this client group who are here constructed as evoking and bringing out strong feelings in the therapist, which can also be seen as a protection of the self in regards to therapeutic discourses of potential vicarious traumatization from hearing accounts of abuse (Adams & Riggs, 2008; McCann & Pearlman, 1990). This can again be considered as a kind of technology of the self (Foucault, 2003), requiring the psychologist to be continually monitoring his own thoughts and exploring his inner world in order to attain the status of a self-aware clinician, one who is actively working against allowing the impact of such factors as having an influence on their therapeutic conduct (Herman, 1998).

In the next extract female clinicians are constructed as also able to serve as a potential trigger for distressing symptoms and memories. The participant constructs the utility of male clinical psychologists as offering the opportunity for clients' to confront a distressing stimulus as therapeutic.

> Extract 13: Jones: …in terms of that response to er triggers for PTSD there is there could still be a female clinician whose very forceful or talks in a certain way or acts in a way that the abuser acts so um historically there's been an idea of female er clients who've been sexually abused um should see female clinicians but I think there is pros and cons to that.
>
> Omar: Can I ask what those are?
>
> Jones: Yeah, so um well I guess that the er difficulties what we talked about already that somebody might say you know being in a room with a man might be scary or er that there would be embarrassment or shame say to say some of the sexual acts that happened in front of a man or that a man wouldn't understand. But the big plus from my point of view er and um er and this came from some work I did pre-clinical

training in an ******** ****, and this is er one of the female clients there was talking to me and it made me realize this, um is that the big plus is in terms of PTSD work where you're, as part of the work you'd be giving somebody experiences that would be different so say er somebody was hit by a car you'd be slowly getting them back in a car and they wouldn't be getting hit by a car and there would be, they would have to loosen that association.

Omar: Yeah.

Jones: So with er, being a male clinician, by working with somebody and helping them through that problem in a, you know containing way, not in a scary way. Means that they get an experience of being with a male who's not going to abuse them and isn't going to er sexualize them, so it gives them that opposite experience (**Jones**: 135-154).

In this extract, female clinical psychologists are also constructed as potentially being a trigger for unwanted and distressing memories of abuse as potentially being able to act in a manner similar to the abuser (e.g. being 'forceful'). A female clinical psychologist is thus problematized through her potential to also behave in a way that is similar to that of the abuser in a client's history. The participant is therefore countering the assumption that only males can serve as a trigger to a client's abuse history as demonstrated elsewhere in the transcript (e.g. **Locke**: 418-423). He subsequently furthers this resistance through constructing the role of a male clinical psychologist as offering an alternative or corrective experience (Hartman & Zimberoff, 2004). In this extract the participant is utilizing a familiar concept that can often be found within a cognitive behavioural discourse, such as confronting that which you are afraid of, 'so say er somebody was hit by a car you'd be slowly getting them back in a car' (Bennett-Levy, 2004). This also positions the client as in need of confronting that which she fears through engaging in therapeutic work with a man.

3.1.3 Female clinical psychologists as problematized by gender

In this sub-theme the accounts constructed that female clinical psychologists can also become problematized in their work with female clients who have experienced abuse.

Extract 14: Phil: Um ah more or less I'd say but I think if a female is working with another female client whose been abused by a man they would, I would hope that they would look into their own background and history of relationships with men and sexual relationships and whether they ever felt pressured or bullied or things like that.

Omar: Can I ask why?

Phil: Because they'd be able to identify with that situation/

Omar: Right.

Phil: You know of a woman going on a date and it going too far. And they'd have that more experience than I would right. So they'd be able to say, hmm I can see where that'd be misinterpreted you know. So I think that that would give them another you know how they would assert themselves, how did they make sure that this wouldn't happen. Those kind of things, they'd be more able to identify with those situations.

Omar: Being able to identify with that experience?

Phil: Yeah, with that experience of yeah allowing intimacy without losing control or being exploited (**Phil**: 113-124).

Here in this extract, female practitioners working with a female client are constructed as potentially problematized by gender due to their own history of relationships with men. Phil constructs female practitioners as needing to be reflective of any such experiences in order to work with this client group 'I would hope that they would look into their own background and history of relationships with men and sexual relationships'. It could be argued that what is constructed here are female clinicians

88

being able to identify with the abusive experiences of female clients because they too are women and that they are likely to have had similar experiences themselves. However as a result, they may be positioned as needing to be able to reflect on this presumably in order to not compromise their role. It can be argued here that a stable and fixed identity of 'woman' is being constructed, one which other women are positioned as sharing and able to identify with (Warner, 2003) whilst simultaneously constructing 'man' as not one who could relate to such an experience. It is through this shared experience that the female practitioner must be cautious, self-aware and reflective in order to ward off from a type of collusion with the client.

Alongside this, abuse is here constructed as a 'misinterpretation', a consequence of 'going too far', and as a result the advantage the female practitioner is presumed to have is one of being able to help the woman in managing a potentially abusive man, 'Yeah, with that experience of yeah allowing intimacy without losing control or being exploited'. This positions the role of the female practitioner as one of helping the client to better protect herself and can be constructed as taking the responsibility away from that of potential abusers in that the client is one who must learn to allow 'intimacy' without losing 'control' or being 'exploited'. This speaks to a discourse of placing responsibility with the client, as having an instrumental role in their experiences of abuse (Henderson, Bartholomew & Dutton, 1997) and that the intervention that a female practitioner can offer, in her advantageous role as a woman, is one of helping the client to prevent further abusive experiences (Iverson et al, 2011).

In the next extract, the participant constructs the advantage of female practitioners as holding shared space and awareness with female clients but that this can also lead to the development of taken for granted assumptions that need to be considered.

> Extract 15: Seth: …having that shared space that shared social space the shared social roles if you like, the shared awareness of what it is to be a woman um I imagine might be helpful in building a therapeutic bond. Um I think it carries with it its risks as well.

Omar: I was gonna ask what might that be?

Seth: (laughter) er well I think having, I think I find that I try to be very careful of, within a therapeutic one to one in that kind of dyad, of being careful about assumptions and getting drawn into an acceptance of a certain way of things. And I think there's a danger that I think possibly the danger is that this is all become tacitly accepted er that we both think the same thing and woman thinks the same things as the female therapist and vice versa and that we don't even have to explore that you know.

Omar: Or challenge it?

Seth: Or challenge it. So I think that that is, I'm not saying that that's a common failing, more that that's the level of complexity I think that they would need to deal with in that female to female dyad. And is it er which ones easier I don't know (laughter) (**Seth**: 232-244).

The advantage of shared space with the client on the basis of being a woman is talked about as potentially helpful in building a therapeutic relationship, which is noted as essential in trauma work (Chu, 1998). However, Seth constructs this shared space as potentially leading to taken for granted assumptions about female clients or 'tacitly' accepting that assumptions are shared "…that we both think the same thing and woman thinks the same things as the female therapist and vice versa and that we don't even have to explore that you know." This can be seen as possibly leading to a simplifying of clients' experiences as identified elsewhere in the transcripts (e.g. **Jones**: 610-617; **Sawyer**: 66-68). By challenging this, Seth is opening up the possibility of multiple femininities and the importance of not making assumptions about what might be shared or not. Thus, through constructing the 'female to female dyad' as having both advantages and potential disadvantages the participant here is challenging the privileging of female practitioners as an automatic choice for trauma work with female clients and whether 'female' is a

fixed identity shared by all women thus able to give a female practitioner unique insight. In this then it could be argued that advantages of a male practitioner may be one where in which the lack of 'shared space' immediately offers a position of curiosity where they can begin therapeutic work with female clients.

3.2 Male Clinical Psychologists' Perspectives in the Wider Context

In the participants' talk, male perspectives within clinical psychology were constructed as constrained by the policies and demands of the service (to see a set number of clients at a given time) and their working context. This included the various systems available to them for support (e.g. supervision) and their experiences of gender difference within the wider clinical psychology field, which were constructed as areas that encompassed various challenges.

3.2.1 Supervision and peer support

In this sub-theme, participants constructed the importance of supervision and support from their peers as important and necessary in their work. From the transcripts, gender difference within the supervisory relationship was also constructed as important in enabling certain perspectives to be heard that could be useful in working with female clients, offering both some advantages and disadvantages. Alongside this, supervision was talked about as a place for making use of shared experiences and receiving advice from those with more experience. This included the reality of service constraints on the availability of time for such support and space for 'thinking'.

For example, in this extract the participant constructs his experience of working with gender difference in his therapeutic work but being restricted in his use of supervision because of the gender of the supervisor.

> Extract 16:   Hassan: Yeah. I mean it sounds like really crazy thing to say that you know that one could do that but I remembered talking to a friend about it, a male friend, because it kind of felt that, I knew it was important to think that through. But I didn't want to think it through with my supervisor. Because I thought what

would she think about me you know. Would she think "he can't work with someone whose really vulnerable because"… But actually you couldn't help but have it. And again I come back to its better to name it and say it and think about it (**Hassan**: 600-605).

Here in this extract, Hassan describes an experience of doing therapeutic work with a female client who was experiencing ongoing abuse and the subsequent challenges that this brought up through the gender difference. Here the participant constructs being problematized as a male in the context of gender difference in supervision in that certain experiences that he is having cannot be shared with his supervisor through fear of negative judgement. Thus, the supervisors' gaze as negative judgement is being constructed here and its impact on the participant's subjective experience as demonstrated elsewhere in the transcripts (**Seth**: 561-567). He is constructing his supervisor as one who would judge him for such inner thoughts "he can't work with someone whose really vulnerable because…", but continues on to establish the validity of such experiences by stating 'But actually you couldn't help but have it' and the importance of naming it as stated elsewhere in the transcripts (**Jones**: 508-521). The acknowledgment of fear regarding how he will be perceived by his supervisor, who he describes also as a female, speaks to an understanding of the role of self-disclosure practices within clinical psychology through 'speaking the truth about oneself'. Thus, supervision can become a kind of technology of surveillance (Foucault, 1988), which is less about the personal growth and validation of the practitioner's experiences but more as a means to guide, regulate and modify the ways in which psychologists conduct themselves (Burchell, 1996).

In this extract, the participant talks about supervision as a place of support, particularly when encountering gender difference. Alongside this, he discusses the advantages of having either a male or female supervisor and is talked about alongside the option to choose a different gender of supervisor.

Extract 17:   Michael: …I do have er regular supervision, which I believe is the place where you take these things. And I have, which I think is actually quite good, I was able to change supervisors so I would have supervision for a period of time from male psychologist and then from female, which does give er er gives you an opportunity to explore things from different angles.

Omar: In more er how, how is it different?

Michael: Well it is different because they, when I had supervision with male psychologist he would, he would recognise some of what I'm talking about in terms of, of say reluctance of female client working with me or how to get round that. He would recognise that from their own practice and share it with me what they've done in similar situations. And for female psychologist in supervision, they, they would provide more perspective of, from my experience, from the female angle of the therapeutic setting if you like. So they would, they would comment on why, why this person might feel reluctant in engaging with you as a male. And I, I think that's really, that has been an advantage of this service because I could change, I was encouraged to change my supervisors, which is good. I also did not find any resistance in asking for female therapist to replace me in the cases I mentioned (**Michael**: 373-389).

Michael constructs supervision as a place where the gender of the supervisor can have significance in being able to explore different things from different 'angles'. He is constructing here the notion of gaining different types of advice and perspectives from a supervisor as influenced by their gender. This again speaks to the notion of 'shared space' in how Michael is making sense of the advantages a male and female supervisor may hold as found elsewhere in the transcripts (e.g.

Jones: 525-527). A male supervisor is positioned as having similar experiences and so can relate to Michael "…when I had supervision with male psychologist he would, he would recognise some of what I'm talking about…" whereby a female supervisor is positioned as holding shared space with a female client "they would provide more perspective of, from my experience, from the female angle of the therapeutic setting if you like." It could be argued here that this is drawing from a 'liberal humanist' discourse in constructing both men and women as having a shared essential nature (Gavey, 1999) and that the advantages are gaining advice from one who shares his similar experiences and gaining the valuable insight into his clients actions that the female supervisor is presumed to have, as evident elsewhere in the transcripts (e.g. **Phil**: 119-122). However, this may serve to homogenise gender and subjugate alternative identity constructions. In addition to this, Michael also notes the importance of having a choice, being able to choose a different gender of supervisor and thus gain access to both potential advantages. In the next extract, the participant constructs the role of peer supervision as a space that can used for reflection and receiving advice.

> Extract 18: Sawyer: I receive regular supervision and er I also receive peer supervision erm meeting with a group number of psychologists once a month.
>
> Omar: is that, is that psychologists within your work sphere?
>
> Sawyer: Yes. Within this field, erm much more experienced clinicians that er can provide supportive feedback. Erm, I used to do group therapy that was another way like you know that was another space that I would serve my experiences and seek advice and support.
>
> Omar: Have you found that helpful.
>
> Sawyer: I've found it very helpful. I've found it extremely helpful. I've found it much more helpful compared to reading textbooks about how to do this work. Erm you know, more

effectively. I feel that yeah, talking to more experienced therapists was the most effective way to number one reflect on my experiences and number two erm becoming aware of factors but with either negatively or positively impact on the therapeutic process now (**Sawyer**: 380-393).

In this extract, Sawyer discusses the importance of 'supportive feedback' from experienced peers. His working context of adult mental health, severe and enduring difficulties, brings contact with vulnerable clients who typically have histories of abuse, trauma and much distress (Johnstone, 2011) and can prove quite emotive for practitioners working in this field. This gives context to Sawyer's construction of having a shared space with practitioners who have more experience in the field as 'effective'. This is constructed as 'effective' in helping him to become more aware of both positive and negative factors impacting on the therapeutic process, as mentioned elsewhere in the transcripts (e.g. **Seth**: 38-42). This also speaks of an idea of support as something you gain from more experienced clinicians, involving shared space in that they too have had similar experiences. In addition to this, gaining awareness alongside a space for reflection, also speaks to 'knowing yourself', as a form of self-monitoring. This potentially serves as a form of self-surveillance in order to achieve a sought after position of being best able to work with a client in therapy. This can be identified as a form of technology of the self through monitoring and policing one's emotions, actions and thoughts (Foucault, 1988). Supervision therefore can be constructed as a place which practitioners are expected to use to further make them able to carry out clinical work. This is done through exploring dilemmas, gaining advice from those presumably with more experience and thus becoming better practitioners themselves. It can also serve as an opportunity for supervisors to 'know' what is going on in the therapy room and ensure that this is appropriately governed.

In thinking about support available to practitioners, in the next extract the participant discusses that this support has become less available due to service pressures and constraints.

Extract 19:   Jones: There's um, there's the usual routes such as supervision, um we we unfortunately because of how the NHS is going, or how it's going here, we have less and less time for thinking really. When I say thinking really, I mean the kind of meetings where you can reflect and er because we've got more and more demands to do clinical work. So, so there used to be a lot more forums, we had like a reflective practice forum. Where I could, I hadn't there needed to, but they were times I could raise in the team and say er you know I've noticed that, this is hypothetical this isn't what happened, "I've noticed that all the female clients are being assigned to female clinicians, we need to think about that" and this could be done in a reflective way where somebody you know could just say "I've always thought that that's the right thing to do", you know/

Omar: And just talk about it/

(**Jones**: 508-517).

In this extract, Jones discusses the impact that service constraints, 'how things are going', have had on the opportunity for support in the form of forums for reflective practice and a space to think about things. He constructs the importance of this kind of space that has been less available due to clinical demands as offering the opportunity to think about issues in his work. Within this, Jones is also constructing that issues in regards to gender difference in therapeutic work is something that requires thinking and the need to reflect upon with colleagues and fellow practitioners. This is particularly important when acknowledging the difficult and emotionally challenging nature of doing trauma work and the adverse effects that this is reported as potentially having on clinicians, often described as forms of vicarious trauma (Adams & Riggs, 2008; McCann & Pearlman, 1990) or traumatic countertransference (Herman, 1998). Time to think and process experiences amongst peers within supervision or a form of reflective practice are constructed

here as important in doing therapeutic work with clients who have experienced abuse. Thus, Jones constructs service constraints as having significant impact on the ability to make suitable connections or appropriate spaces for talk about his own experiences or concerns. It could be said that power is being deployed here in the form of institutional demands serving to subjugate such experiences through constraining opportunities to talk about them by increasing work demands.

3.2.2 Service Constraints

In this sub-theme participants discussed the context of service constraints that has an impact on their work with clients. This included the importance of having time and space to see clients and the role this played in providing a safe context for clients to engage with therapeutic work in regards to abuse. Constraints on service provision was also constructed as limiting flexibility of clinicians in offering choice to their clients in choosing their clinician in regards to gender.

In addition to this, constraints are also talked about as having an impact on the subjectivities of clinicians themselves, potentially subjugating certain experiences through effecting what can be said by constraining space for reflection, thinking and receiving peer support.

In the next extract, the participant is discussing the importance of having time and flexibility in his work with clients who have been abused. He also connects this with the importance of creating a safe context for the client.

> Extract 20:   Michael: Well I, I'm just really would like to emphasise the, there are psychologists fighting for this freedom to allow victims of abuse to get all the time they need to get engaged with a therapy. And I feel that us just ticking boxes of seeing clients for set number of sessions is going to er create (.) er situation where victims of abuse will slip through the net really because they would see the setting of therapy as we are providing as unsafe for them.
> Omar: Because it doesn't have that space and time? Is that/

Michael: Yeah.

Omar: Okay.

Michael: And in therefore they would be denied a service they need and we would not actually treat people who probably need us most. (**Michael**: 432-436)

In this extract, Michael is again emphasising the need for trauma work to be given time by positioning himself and other psychologists as "…fighting for this freedom to allow victims of abuse to get all the time they need to get engaged with a therapy." This constructs trauma work as something that requires time in order to successfully engage clients' therapy. Further to this, the time needed to do this is not specifically stated and is spoken about as possibly something that is dependent on or different with each client. This connects with his previous statements regarding the importance of having time and space in trauma work to build a relationship and trust with a client (for example, **Michael**: 254-261). This constructs the position of a psychologist as one who is also subject to powerful institutional forces over their clinical work. As highlighted in the previous sub-theme (supervision and peer-support), service demands on clinical work such as being required to see a large number of clients quickly over a set period of time can leave practitioners in a position whereby the possibility for discussing and engaging the wide range of complex issues in trauma work are made extremely difficult and effectively silenced. Therefore, services have the power to make available the opportunity and legitimacy for certain discussions. For example, a service that holds a policy either formally or informally on ensuring female clients see female clinicians, it can be argued that by not making this something that is open for discussion or even providing the space for discussion can be experienced as silencing not just the opportunity to talk about it but even possibly subjugating the very feeling that something is wrong. In the context of high clinical demands this is also evident through mobilising clinicians to work high caseloads in limited clinical time, prioritising 'contacts' at the cost of meetings, reflective practice groups or 'thinking space'.

For Michael here in this extract, the consideration of complex issues within trauma work are constructed as providing a sense of safety to clients. He sees this as giving time and freedom to clinicians to see clients and at the same time helping clients to feel that they have time to 'share their story'. Thus, the limitations being experienced are positioned as creating a form of 'tick boxing' service, which is constructed as having a real impact on being able to make therapy safe for female clients and engaging them. Safety here is constructed as something that requires time in order to do and in working to restricted availability of sessions, he highlights that his ability to provide this for his clients is limited.

In the next extract, Michael further explains that the constraints on time offered to clients can have an impact on facilitating safety and engagement with the client alongside being able to provide a sense of containment.

> Extract 21:   Michael: I fully recognise why services are under pressure to do what limitations are on the session. And I also would like to welcome any, any new ways of working with victims of abuse in the sense that if, er how I see it, if we can provide that sense of safety right from the beginning, which would allow them to feel safe and engage with the work, things can happen actually very quickly. But what they need to know, so in sense what I'm asking for is flexibility. So that we are allowed to say to people yes we can see you for I don't know, a year, even if we know that we in fact we are expected to see this person just for six months right. Just by saying this, creating this setting, person can engage quickly and things can get done quicker and might finish actually in six months' time. But we need to be allowed to also stay with people who need longer for the time promised. And I think it can balance it out and we could have average time of engagement as service wants us to (**Michael**: 446-454).

In this extract Michael furthers his concerns regarding the impact of service constraints upon his work, namely in the amount of time that is available to see clients. He identifies that there is the constraint of limited sessions that can be offered to clients but that if this is to be worked to then it would need new ways of working in order to offer safety to clients 'right from the beginning'. Here he is again constructing safety as an important part of therapeutic work with this client group and his role as one that is instrumental in providing it. Michael here has positioned himself as one who has no control over the constraints being placed upon him.

Michael has talked about the importance of safety in this type of work. The literature regarding working with those who potentially have multiple experiences of abuse emphasises the importance of establishing a context of safety in order to work with this client group. This is relevant given that 'survivors' are often constructed as people who can be quite easily re-traumatised in therapeutic work (Lister, 1982; Herman, 1998). For example, in Herman's model (1994) safety is central to the recovery process. Victims of chronic trauma are positioned as experiencing a sense of betrayal from their experiences and their bodies, with associated symptoms potentially resulting in re-traumatization. Thus, to rebuild both internal and external control for the client is deemed essential to trauma work. A move towards reliable safety within the client and their immediate environment is thus achieved according to this model.

This is also similar to that of Horowitz (1997) and Krupnick's (2002) 12 session interventions for those experiencing PTSD following a singular traumatic event. This approach emphasises the importance of establishing a good therapeutic relationship before a 'working through', addressing loss in regards to the trauma and the therapy (Schottenbauer et al, 2008). Michael's concerns relate specifically to the concept of containment and the idea that this can be built by offering clients time and flexibility. Thus, constraints on sessions and time offered to clients' sets up a difficult task for Michael as he is implicitly constructing the development of a therapeutic relationship with clients who have experienced abuse as a challenging task (Chu, 1988).

In the this extract the participant discusses that the very nature of working within the NHS brings forth particular constraints on flexibility in providing choice to clients over who they see and time available for long-term work.

> Extract 22: Hassan: Yeah. I think the thing that comes to my mind is that were always working in the NHS, well that's not true at all but you know within training we are and I have mostly worked in the NHS since qualifying and there's just never that much flexibility so whilst I think about it you know there's sometimes options but rarely/
>
> Omar: The time for it?
>
> Hassan: No for people to see different gender therapists or for/
>
> Omar: Okay.
>
> Hassan: So yeah you think about it. But also you know we don't do ridiculous, we tend not to do ridiculous long term work. Again because of the NHS setting (**Hassan**: 836-843).

Hassan has here highlighted the constraints he faces in his role whilst working in the NHS. He talks of the NHS as a service with limited flexibility in being able to offer clients the choice of therapist in regards to gender. Alongside this, Hassan also identifies the need for space and time when working with female clients who have experienced abuse and constructs the NHS as a service which cannot provide long-term work, here described as 'ridiculous' in the context of a limited public service. In considering the literature in regards to work with this client group, we can draw on Herman's model (1998) that the experience of trauma 'robs the client of power and control'. From this, recovery is defined as a form of restoring power and control back to those who have survived such traumatic incidents. However, in Hassan's experiences this raises questions of how possible it is for clients to regain such power and control when they do not have a choice over the therapist they get to see or how long the support on offer can last.

3.2.3 Maleness as a minority in clinical psychology

In this sub theme, participants discussed clinical psychology as one that is biased towards the perspective of female clinical psychologists. This was reflected in constructing the male perspective within clinical psychology as less prominent and that this was influenced by the association of maleness with historical marginalization and oppression of women and female voices both within the psychology discipline and wider society, along with male clinical psychologists being a minority. Service constraints here were constructed as also playing a part in further subjugating male perspectives as well as subjective experiences in the constraints placed on practitioners and their practice. This offers implications for considering the wider context in clinical psychology for the possible implications it may have on the experiences of male practitioners, namely the perceived lack of space to discuss such experiences and acknowledgment for the potential difficulties that are encountered.

Extract 23: Seth: One thing I've noticed is usually the heavy bias towards female psychologists, which has been interesting to me, I haven't necessarily felt threatened by it but I've just been curious about it and as I've come through I've come to wonder whether or not that there certainly is, in sort of practice of clinical psychology, that there's quite a lot of the female perspective there. And I've wondered whether there's something that isn't as influential, something that isn't as prominent from male perspectives.

Um it's tricky though because things are slightly cyclical so there were lots of men involved in the seventies and eighties and then it shifted towards a more kind of female majority. So it's tricky but I you know, some things in and I've done studies in the past and I've wondered about various how you know referral policies, how people get admitted to services and the role of gender within that. So the automatic assumption made

by services or the way services set themselves up to receive people, um things like the time of day when they can be seen and things and if their working um yeah, er where does it come from? I guess, I would say I um, I think I'm, if I'm getting drawn into looking at one perspective, I then question that and think hmm what else is going on. That's kind of me a bit and I suppose I probably have my own kind of male angst a little bit about it (**Seth**: 151-162).

In this extract, Seth constructs clinical psychology as having a bias towards female psychologists "One thing I've noticed is usually the heavy bias towards female psychologists…" Seth is viewing this from his position as a man and describes feeling that male perspectives are less important within clinical psychology but more specifically as less important than female perspectives. But yet we can ask of this account as to why he does not feel threatened by this as a male practitioner? The answer to this question may rest in his talk of the 'cyclical' nature of dominant perspectives in psychology, which then places the current dynamic as part of a cycle of changing views in the discipline, not necessarily an intentional oppressive act. Alongside this, the female perspective is constructed as a unified thing as opposed to a diverse number of voices which can be seen as homogenising women. This throws up questions regarding the complexities in defining something as particularly gendered but also the implications in doing so. By constructing clinical psychology as having a 'bias' towards female practitioners, Seth simultaneously positions men in the field as not just a minority but also as less supported and in need of challenging such a bias.

He goes on further to describe this bias towards the female perspective as influencing the wider context of clinical psychology practice, reflected in the assumptions of services and how they are set up. He constructs this as being notable in the referral policies of some services and how they potentially see clients. Thus, the female perspective in clinical psychology that is constructed as dominant is positioned as having implications on practice and on the service context itself. This may also then open up which male perspectives are

constructed here as less prominent, not just male clinical psychologists but also that of male service users. Thus power here is constructed as operating at an institutional level having implications on who gets seen for psychological treatment, which individuals are deemed appropriate and on how distress itself is understood.

In the next extract Seth goes on to give some further explanation as to why he felt that clinical psychology has become more dominated by one perspective and how he manages that in his role.

Extract 24:   Seth: How do I mean? I suppose about noticing that yes that there's a lot of um, yes women have been treated unfairly and marginalized. That's very true but it doesn't preclude that you know it doesn't mean that all men are you know are incapable of showing compassion it doesn't mean that um men don't have a perspective which is useful to offer. You know I, I so I kind of sort of resist the temptation to, to resist the idea that I need to follow er the you know one perspective whether it happens to be female, whatever it happens to be (**Seth**: 164-168).

Seth here is constructing the dominance of the female perspective in clinical psychology as a response to culturally and historically unfair treatment and marginalisation of women in the profession. The privileging of female voices in the profession is therefore positioned as the result of negative judgement towards the oppressive history of male perspectives "it doesn't mean that um men don't have a perspective which is useful to offer". It could be said that this minimises the rise of female voices in clinical psychology from its own merit to one wherein it has gained dominance in part due to the unjust oppressive practices towards women historically, which has created a negative judgement towards male perspectives. Seth presents himself as not being drawn into going along with just one view but proposes the need to hold multiple perspectives here through defending the utility

of male voices in clinical psychology without necessarily saying what those voices are. This experience of male perspectives being subjugated due to being associated with something oppressive is also evident elsewhere in the transcripts (**Locke**: 484-487) and also connects to the perceived availability of spaces to talk about such perspectives.

In the following extract the participant constructs his experiences of working with gender difference in trauma work as made problematic through a lack of available opportunities to discuss the male experience and that this subsequently has implications for his subjectivity.

> Extract 25:   Paul: Well in my job, when I was feeling angry and about because I was seeing too many women who had been abused. And actually I think one needs to be um, you were saying whether I minimized it, I did minimize it at the time. I think because the discourse that's kind of given permission to live in a group wasn't about the male experience and if you haven't got that then it's very then you engage in a process of minimizing and you don't think about it actually you know.
>
> Omar: One feels one is being paranoid?
>
> Paul: Oh yes, I feel I'm being paranoid, I can't you know I should be able to take it you know, I should be able to deal with this or you know I'm just being coarse you know it's got to be to do with something else.
>
> Omar: Yeah. It's almost like er I wrote down licence.
>
> Paul: Yes, license is a good word (**Paul**: 452-461).

Here in this extract Paul's position is one that is constrained by the needs and demands of the wider service. He constructs his experience as one wherein he has limited power over who he sees and that this positions him as needing to get on with it. This offers the expectation of one who should be able to cope with the large

numbers of female clients who have experienced abuse and this is offered up through the omission of the male experience in the wider team context as evident elsewhere in the transcripts (**Hassan**: 93-105). Here this position leads to the subjective experience of doubt over whether his feelings, regarding working with many clients' who have been abused, are valid or if he is actually just being 'paranoid'. Thus, his rights to speak out about his experiences are constrained by the position that he should be able to 'take it' or that it must be due to 'something else' rather than his experiences as a male.

It is through the requirement for the production of work (seeing clients) that it could be said the participant here is being regulated and controlled at distance. Surveillance takes the form of being reliant upon the individual to self-manage his workload (Rose, 1996). Through the objective of seeing a high number of clients at a time and not providing space for discussion of gendered experiences, the role of the psychologist is defined along with their subjectification (Banks et al, 2013). This is one wherein which there are expectations of managing high clinical demands, and the subjective experience of the participant from the position as a man is in many ways suppressed or not given 'licence' to be expressed or legitimated by fellow colleagues and the service.

In the next extract the participant is constructing the masculinity of male clinical psychologists along with his experience of being asked to choose his masculine identity.

> Extract 26:   Locke: I think amongst the male psychology fraternity um
> there's a higher proportion of gay men. I would guess, I don't
> know for certain but I think in mental health services generally
> there are um, which you could argue um set from a
> psychological point of view is, how can it be best put, is sort of
> disownment of some aspects of masculinity, I don't know if
> that's true.
>
> Omar: Or type of masculinity?

Locke: Yeah, there's some, I don't know, I'm trying to find words that are politically correct way to say it but the um certainly, well I met with a supervisor when I was an assistant, said to me rather irritatingly that there were two types of men, two types of psychology, male psychologists. There were the ones who were in touch with their female side and there were the macho ones, which I saw, very annoyed me that she made, she was making me having to choose between these um but then again there's some sort of splitting that goes on that actually you have to be one or the other. There isn't sort of a middle ground that's tolerated by the female sorority I think so easily (**Locke**: 461-475).

The participant constructs encountering a form of 'splitting' whereby he is asked to choose between being a 'macho' or an 'in touch with their female side' man. He identifies his experience of being presented with having to choose as frustrating as his supervisor here is constructing a male psychologist as one that cannot be both. His frustration of this unwanted position of having to choose is further understood through his noting of a high proportion of men in psychology as gay. Here gay male psychologists are constructed as disowning aspects of masculinity, and thus evoking a cross-gender construction and although he expresses uncertainty as to whether this is true, he uses a rhetorical device to justify this claim by constructing it as a 'psychological viewpoint', this speaks to a hegemonic masculine discourse, which self-identifies through its rejection of opposing masculinities (Connell, 2005).

However, his dilemma, presented to him by his former supervisor, is not much of a choice as the suitability of a 'macho' identity to the clinical psychological profession can be questioned. Thus, the dilemma presented to the participant can be argued as one of being persuaded to take up a position whereby he is 'in touch with his female side', he must reject his own construction of masculinity, which is simultaneously constructed as doing something that he argues a high proportion of men do in clinical psychology, who identify as gay.

This is the end of the analysis and in the next chapter I will be picking up some of the key points raised in this section in the next chapter (chapter four).

CHAPTER FOUR – SUMMARY, EVALUATION AND IMPLICATIONS

In this section I will be revisiting the aims of the research and the research questions with the inclusion of the analysis presented in the previous chapter. I will also be evaluating the quality of the research and subsequent implications.

4.1 Research Questions and Aims

The primary aim of the project was to explore how male clinical psychologists construct their work with female clients who have experienced abuse and the implications of such constructions for their subjectivities and therapeutic work. This question was warranted by the lack of research carried out to explore the experiences of male clinical psychologists doing trauma work in the context of gender difference, especially given the high prevalence of rates of abuse in those who seek psychological support.

The secondary questions that were raised in the research were aimed at identifying the ways in which participants might have been problematized in their work with female clients. This also included identifying the subject positions that were available and the implications for action along with the processes of governmentality and how participants were constituted by this. This served to explore how male clinical psychologists negotiated their identity and role in trauma work and the responses to experiences of being problematized on account of being a man.

Main research question:

- How do male clinical psychologists construct their work with female clients who have experienced abuse and what are the implications for their experiences and therapeutic work?

Secondary research questions:

- How are male clinical psychologists problematized in their work with female clients who have experienced abuse?
- What subject positions are offered for both the participants and their female clients that are constructed in their talk?

The main research question and secondary questions have been addressed through the presentation of two main themes and six sub-themes; Gender difference in trauma work (male clinical psychologist as associated with the abuser; gender difference as therapeutic; female clinical psychologist as problematized by gender); Male clinical psychologists' perspectives in the wider context (supervision and peer support; service constraints; Maleness as a minority in clinical psychology).

4.2 Gender difference in trauma work

In constructing their experiences of therapeutic work with female clients, various accounts were deployed that constructed work with clients who had experienced abuse as a site of challenge due to gender difference but also as offering therapeutic opportunities. Within this, female clinical psychologists were constructed as having both advantages and disadvantages in their work with female clients, particularly in the context of occupying 'shared space'.

Participants described their work with this client group as made challenging through being associated with the perpetrators of abuse as a result of being male themselves. From the accounts, being male was constructed as potentially a trigger for female clients who had experienced abuse by male perpetrators, particularly in triggering distressing and possibly PTSD associated symptoms (Schachter et al, 2009). The participants drew on accounts of the importance of joining and developing a therapeutic relationship with clients who have undergone abusive and traumatic experiences (Jones, 1991; Friedlander, 2006; Herman, 1998). This

illustrated the complex nature of their experiences in that they positioned themselves as needing to 'work harder' in order to achieve this due to the gender difference in the therapy room. Thus, the embodiment of being a male, having a male physical presence in the room, the high proportion of male perpetrators of abuse (Black et al, 2011) and the subsequent discourses around men and abuse were constructed as rendering the psychologist in a potentially disadvantaged position. This appeared in the accounts as leading to a high likelihood of being associated with the abuser, simply on account of being male and in some of the accounts this was also noted as a potential difficulty with female and male clients. This appeared to set the context of their clinical work with this client group as a very sensitive and careful process, one in which they needed to 'tread carefully' to varying degrees due to the possibility of triggering distress, sensitivity of power relations and generalisations on part of the client. This served to also simultaneously construct female clients as those who are likely to make such generalisations due to their experience of abuse.

Some of the participants' constructions seemed to validate their being associated with perpetrators of abuse through constructing the therapeutic space as 'intimate' in nature and serving as a potential reconstruction of earlier relationships in the clients' histories. This drew on psychodynamic and psychoanalytic ideas regarding transference, countertransference and projection (Dalenberg, 2010) to make sense of the idea of being associated with the abusers. From this, being aware of their own reactions to being associated with the abusers, an understanding or knowing of the self was constructed as important in preventing the mismanaging or inappropriate responding to transferential processes in therapy. This knowing of the self could be considered as a means to regulate their own conduct, thus a technology of the self was being utilised (Foucault, 1988). This reflected a need to be self-aware, placing one's own emotions and responses under both control and surveillance as a means to becoming an effective clinician.

Female clients who had been abused were constructed as 'making generalisations' regarding all men in their perceiving male practitioners as being associated with the abuser. This was both normalised and problematized creating tension in the

accounts in being described as a normal and 'natural' reaction to one's abusive experiences as well as being a problem that both needed to be worked on in therapy, as the 'work' itself, and as a powerful obstacle that can prevent therapeutic work with the male practitioner all together. However, can such 'generalisations' equally be seen as a form of resistance in its own right? I felt that the strengths and protective stance of such clients may potentially be lost in consuming such 'resistance' within a pathological model wherein such actions are deemed as consequences or the damage that results from abuse itself. This can be seen as speaking to the 'harm story' that surrounds abuse and those who experience it (O'Dell, 2003). In addition to this, the characteristics of the female client (generalising) who has experienced abuse can potentially become unwelcome and subsequently constrained through their construction as unhealthy both for the client and the therapist. This may serve to make visible the abused woman as one that can be distinguished from non-abused women due to their lack of trust in men (O'Dell, 2003).

From some of the accounts, the concept of shared space as with perpetrators of abuse on account of gender was also positioned as problematizing female clinical psychologists in their perceived shared space with female clients. Sharing space as women was seen as offering both advantages and disadvantages. Helping to build therapeutic relationships through being women themselves and perceived as less threatening than their male counterparts was balanced against the possible dangers of this shared space, which included taken for granted assumptions and even possible collusion with negative generalised beliefs about men. Thus, female practitioners were positioned as needing to be cautious, on guard and vigilant over their shared identities as women. This also furthered a singular story of 'woman' that all women can connect to.

It can be said that there was a generalised vigilance and cautiousness regarding 'recreating' the nature or specific acts of abuse such as the breaching of boundaries, being forceful or inconsiderate of power dynamics, not giving clients choice or being invasive. Thus, participants' accounts spoke to a conscious attempt to not recreate the various and complex tactics of abuse (Warner, 2000).

The participants' constructed their experience of being problematized in their work as requiring a response through constructing the therapeutic utility of 'man' in the therapeutic process. This can be noted as a form of resistance on part of the participants' to the unwanted position of being problematized due to sharing the same gender as the abuser and instead now breaking free or de-subjectifying oneself (Agamben, 2002) through reconstructing gender difference as a useful aspect of therapy. Further to this, female practitioners were also constructed as problematized in their work with female clients who have experienced abuse.

The participants' talk was understood here as negotiating the dilemma of being associated or perceived as like the perpetrator whilst attempting to engage the client in a therapeutic relationship. This dilemma presented itself as whether to acknowledge this association and difficulties that might arise for the client in the work and to construct female clients as being better off seeing a female clinician versus whether the gender difference between clinician and client could have therapeutic value.

Thus, the participants' drew on accounts of the corrective emotional experience from psychodynamic approaches (Palvarini, 2010) and cognitive behavioural discourses regarding the confronting of aversive stimuli, in constructing the utility of gender difference in the context of therapy. This served to re-position the participants' as highly useful and having some advantages over their female counterparts. This simultaneously constructed the female clients as in need of psychological work with a male through positioning the value of disconfirming and breaking negative beliefs and associations towards men. Here there was evidence of pastoral power (Foucault, 2003) the need for the clients to reveal their inner thoughts, feelings and behaviours, to engage in a verbalization of their difficulties in order to gain the truth and achieve the breaking of dysfunctional beliefs. As a result, in their talk, participants' were constructing themselves as holding a kind of responsibility of representing and displaying a different construction of masculinity whilst simultaneously constructing a type of 'harm story' about the nature of abuse (O'Dell, 2003).

4.3 Male clinical psychologists' perspectives in the wider context

In the participants' talk, male perspectives within clinical psychology were constructed as constrained by the policies and demands of the service (to see a set number of clients at a given time) and working context. In addition to this, the various surveillance systems that are applied to them (e.g. supervision), the expectations and ways of working in their service and their experiences of clinical psychology were constructed as a site of challenge.

Being problematized as a male furthered to the context of supervision whereby gender difference within this context was considered as potentially constraining in some of the accounts in being able to talk about certain experiences. There was a fear of the negative gaze or judgement of the supervisor whereby a female supervisor was positioned as potentially not able to see the perspective of the participant, leading them to continuingly prove or 'demonstrate' their distance from a type of hegemonic masculinity perhaps associated with the abuser. This ran counter to wider expectations within supervision regarding self-disclosure practices and the way in which this can become a kind of technology of surveillance (Foucault, 1988), concerned with guiding, regulating and modifying the ways in which psychologists conduct themselves (Burchell, 1996). In some of the accounts however, gender difference in supervision was experienced as offering advantages in helping to gain different perspectives, a more female perspective, which to a certain extent presumes female supervisors can relate to other women's experiences and thus provide insight.

In their work contexts, service constraints were seen as impacting on the time, space and opportunity to think and reflect both on the overall demands and the nature of the work but also on gender difference, which required thinking about particularly due to the emotionally challenging nature of the work (Adams & Riggs, 2008). It was through the requirement of the production of work (seeing a number of clients at a given time) that participants' here were being regulated and controlled at distance. Surveillance took the form of being reliant upon the individual to self-manage his workload (Rose, 1996). Through the objectives of seeing a number of

clients' at any given time and not offering discussion or 'license' for gendered experiences, the role of the psychologist was defined along with their subjectification (Banks et al, 2013) as one wherein it was not deemed important or necessary to discuss and therefore as something the participants' could not raise in their practice.

This could be said to position practitioners as subject to the powerful institutional forces that govern their clinical work. It could be argued that services have the power to make available the opportunity and legitimacy for certain discussions. By not making the experiences of practitioners something that is open for discussion or even providing the space for discussion can be experienced as subjugating. Some found ways around this through the benefit of finding other male practitioners through which to share their experiences with.

This extended to the nature of clinical work in that some of the accounts reported service constraints on the length of time that could be offered to clients for therapeutic work made their ability to provide a safe space as more difficult. In the accounts, safety was discussed as important for this type of work regarding those who potentially have experienced multiple abuses in their lives. With this comes emphasis upon establishing a context of safety particularly given the construction of this client group within the wider literature as those who can be easily re-traumatised in therapeutic work (Lister, 1982; Herman, 1998; Horowitz, 1997; Krupnick 2002; Schottenbauer et al, 2008).

Thus, constraints on sessions and time offered to clients' were seen as creating a difficult task for participants in developing a therapeutic relationship with clients. This is coupled with the lack of space and time to voice these concerns and similarly in regards to their perspectives generally from their positions as men. By being a minority within psychology, this was constructed as contributing to suppressing 'male perspectives'. In addition to this, as in their clinical work, being associated with abusers or an unwanted type of hegemonic masculinity was experienced as positioning them so as needing to prove or distance themselves at all times in favour of assumed acceptable roles for them as men in psychology. Therefore, there were similarities in the constructions of how they were

problematized in their clinical work and their experiences in the wider discipline of clinical psychology.

4.4 Evaluation and Critical Review

In this section the research presented will be evaluated and reviewed in regards to the epistemology and methodology, quality of the research, the process and ethics, reflexivity, usefulness and implications.

4.4.1 Epistemology and methodology

For this research I drew upon a range of writers that highlighted the need for a critical realist approach within a social constructionist framework (Parker, 1992; Nightingale & Cromby, 1999; Willig; 1999; Sims-Schouten, Riley & Willig, 2007). An advantage of adopting such a critical realist position within a social constructionist thematic analysis offered me the opportunity to situate the discursive constructions of male clinical psychologists in the context of their role, immediate professional expectations and 'expert' discourses.

Harper (2012) proposes that holding a critical realist position with social constructionism can be defined as ontologically realist with an epistemologically relativist position. It is proposed that doing so may lead to a potential inconsistency and selective relativism as a result of choosing to focus on the foundations of some knowledge claims but ignoring others, thus leading to a form of 'ontological gerrymandering' (Woolgar & Pawluch, 1985). As mentioned in section 2.1, it could be argued that there is a subjective quality in all qualitative work but that it is important to be clear and to justify the decisions one makes in choosing to include some areas for analysis over others.

For this research, I employed a social constructionist thematic analysis (Braun & Clarke, 2006). This approach was exploratory and subsequently aimed to provide rich data having identified from the existing literature a lack of research exploring

male clinical psychologists' experiences or perspectives in regards to working with abused clients in the context of gender difference or in other clinical contexts. Given its status as an ideal method to deal with such rich data, due to its exploratory nature and utility in structuring data, a thematic analysis was a useful approach in this research. This also allowed me to draw upon set of both social constructionist and Foucauldian informed principles. However, I do acknowledge that it would have further added to the research to have also approached the data using a full Foucauldian Discourse Analysis (FDA; Willig, 2008) as this would have enabled me in the role of researcher to explore the broader institutional practices and the deployment of power that may have been operative in the context of the participants as aimed for when doing an FDA (Arribas-Ayllon and Walkerdine, 2008). I also acknowledge that using a qualitative approach such as this offers itself to criticism that there are inconsistencies applied and a significant amount of interpretation carried out by the researcher themselves (Willig, 2008). Furthermore criticisms have been raised in regards to whether subjectivity can be theorised from discourse alone and the relationship between discourse and reality.

It is noted that within a social constructionist framework, such as in discourse analysis, credence is given to the idea of discourse as implicated in giving rise to subjectivity but is noted by Willig (2008) that it is less certain as to whether discourse alone is required for the formation of a personal identity. Thus the very presence of subject positions alone cannot easily account for such 'emotional investments' that are made over such subject positions. Other writers have attempted to address this through the introduction of psychological constructs to account for the motivational actions of individuals for taking up particular positions (Hollway, 1989; Urwin, 1984). Here the position of Davies and Harre (1999) can be highlighted to not be drawn into invoking theoretical psychological constructs to account for such 'emotional investments'.

4.4.2 Quality of the research

In regards to validity of the research, Willig (2008) suggests the use of the participants' in reviewing the findings and being given the chance to feedback,

correct or challenge my interpretations. As a result, I will be constructing a report of my interpretations of the data and making this available to the participants' once finalised and take into account the feedback given. Further to this I acknowledge, as with any qualitative piece of work, the interpretations of data as intimately connected to the position and biases of the researcher. To address this I adopted the use of a reflexive journal (Finlay & Gough, 2003) as a means of reviewing my role in the research process and to justify my decisions.

In regards to reliability, the number of participants is small in regards to quantitative studies but for a qualitative piece of research I was not attempting to achieve a sense of representativeness and as such am not making such claims in regards to the findings. As these experiences captured by this study are possible within this group of participants then this may be more widely experienced in the wider group of male clinical psychologists.

The participants were all recruited under the notion of being qualified male clinical psychologists who had in the past or currently had experience of working with female clients who had experienced abuse.

4.4.3 Process of the research and ethics

In the process of carrying out the interviews for this research I identified the importance of considering the dynamic of a trainee clinical psychologist interviewing experienced qualified clinical psychologists on their work with clients who have experienced abuse. I was mindful that it did not present as a judgement or scrutiny of the nature or quality of their work with clients. There was also the added aspect of trying to minimise and be mindful of the impact of such a trainee to qualified dynamic on influencing the process of the interviews. In addition to this, some of the participants described the interviews as emotionally evocative through discussing their experiences. Following identifying this, I sought to allow time at the end of each interview for debriefing and, as per the information sheet provided during the recruitment process, was available to offer signposting to further support if necessary, although none of the participants felt they needed this.

4.4.4 Reflexivity

In taking up a critically reflexive position in this research using a social constructionist thematic analysis I will summarise my own historical, professional and cultural context to highlight the practices by which I have constructed knowledge in this research. I will be doing this through the importance of making myself accountable to the analysis I have presented here in this study by reason of acknowledging that such contexts have significance in the interpretation of the data. In addition to this, I will be bringing attention to the issues of any power dynamics that have influenced this study and addressing them (Harper, 2003).

As mentioned above (see 4.2.3) I myself am a trainee clinical psychologist seeking qualification through the completion of a doctoral thesis engaging in the interviewing of qualified practitioners about their work. Alongside this, I was also adopting the role of a researcher with my own agenda and sought to make this clear to the participants as to my own interests in finding out about out about how they construct their work with female clients in the context of trauma work and attempted to invite them in the co-construction of the interviews by opening up the agenda for any ideas or questions that they felt were relevant. I felt that this was mostly achievable given their position as male clinical psychologists and their own expressed interests in contributing to research they felt was important to be done. As discussed above this did however require being mindful of the impact of my status as researcher and a trainee on the interviewees and myself. During the process of interviewing I wondered about my suitability to fully gauge the intricacies of what the participants' were sharing due to my own limited experience of working with female clients who had experienced abuse. I wondered if this would show an in some way, limit and constrain the interviews themselves. This was a technical question regarding knowledge of trauma models and therapeutic techniques. One way in which I addressed that was to ensure I adopted as curious a stance as possible as an interviewer and being transparent about what my own knowledge was and the experience I had gained to the participants.

In addition to this, having a reflexive journal was particularly useful during the process of interviewing in bringing to my attention such experiences and concerns. The reflexive journal was also useful in helping me to think about my intentions in doing this research. Gender is considered an aspect of difference along with others including race, religion, class, ethnicity, sexuality and more, often referred to as the social 'GGRRRAAACCEEESSS' (Burnham, 2012). It could equally be argued that all these other aspects of difference are just as important to consider (as I believe they are) but yet in this project I have intentionally focused on gender. In doing so, I initially felt this may be construed as intentionally making gender an issue just by choosing to focus on it more so than others, problematizing it in the process. However, I also acknowledge that issues in regards to gender difference in the context of therapeutic work and in regards to the wider experience within the profession was something that all the participants, in their own way, could relate and connect with, including myself. Thus, my own subjective experience and that of the participants, in many ways was experienced as gender being a significant factor in the context of clinical work and the wider discipline.

The position of being a minority can make salient the discourses of such difference that may be drawn on to understand and construct our experiences. As a black male trainee clinical psychologist I am approaching this research already situated and couched heavily within various discourses of being a minority and thus potentially may be more sensitive to its mere presence. The interwoven nature of these differences can be complex and perhaps it offers something interesting to think about that in the context of abuse and trauma work, gender here might be seen as more easily drawn upon in regards to the wide range of differences. We can therefore ask why we privilege certain aspects of difference over others and how our thinking and practice as practitioners are influenced and informed by these aspects of difference.

From a critical realist position we can consider the relationship between our constructions and the material world as one wherein the latter offers up potentialities for how we discursively construct experiences. Although there are always alternative ways of making sense of anything, it must be noted that within

this idea, some discourses will be made more available and easier to draw upon than others. For example, we cannot ignore the overwhelming number of male perpetrators of abuse, the public knowledge surrounding this and the impact this may have on both clients and practitioners. Burnham (2012) uses the term 'kaleidoscope' to describe this interwoven nature of social differences. These different aspects of difference, depending on the time and context, can be visible or less visible, foregrounded or backgrounded and as things that can be spoken about and named or not (Totsuka, 2014). In addition to this, it is also important to note that these aspects of difference are themselves discourses, in that they are not always operative, or obvious in their operation. Discourses can be understood as offering subject positions for people to take up and in which offers up certain possibilities whilst closing down others.

On personal reflection, to me gender was generally never experienced as the most influential aspect of difference on my life. I grew up here in the UK however my family originated from Jamaica. As a black ethnic minority individual, here in the UK, I grew up in a context which intrinsically foregrounded race as the lens through which to make sense of experiences. Further to this, the privileging of other social differences was often negatively received, seen instead as distraction, diversion or just minimizing the importance of race and culture. This undoubtedly is also influenced by the very visible nature of such difference, which may serve to further foreground it. Thus, embarking on this project created a number of mixed emotions for me as I found it unusual to be privileging gender in the context of clinical psychology, when personally for me race had always taken centre stage and to which I had a number of emotions connected to it as well as important stories from my life that concerned it. In many ways, engaging with my own experience of my gender being foregrounded in my clinical work and interviewing other practitioners, who had a variety of stories, beliefs and emotions connected to this aspect of difference, was both challenging and liberating. I was inspired by the thoughtfulness of the participants but mainly found myself becoming more aware to the active role that gender plays in my own experiences, simultaneously challenging the very dominant story that race has played for me in my life.

4.4.5 Recruitment

For the research I utilised only one method of recruitment for the eight participants that participated. This was the snowball method (Salganik & Heckathorn, 2004) which involved using existing participants to recruit future participants from those they know with the first three of the study referred by a non-participating contact of the director of studies. A possible limitation of the study may have been in regards to not specifically accounting for the areas of work of the participants and whether there experience of trauma work was in the context of a specific trauma service as this may have led to more variation in the type of experiences reported.

4.2.6 Implications

It was my initial hope when I undertook this research that it would serve to highlight the experiences of male clinical psychologists in their work and the significance of this. I felt when I undertook this research that there was a need to consider their voice and experiences and that this study would offer that alongside the value of also giving a space for the participants to share their experiences with myself. I also sought to contribute to the research literature on trauma work and raise the potential importance of the experience of male practitioners working in the context of gender difference. In addition to this I also hoped the impact of this study would in some way contribute to the development of further support for clinical psychologists in their work with clients and in their training and have included recommendations (see below) in regards to this.

The findings highlighted that the participants in this study had a number of experiences when engaging in trauma work or work with clients who have experienced abuse in the context of gender difference. The experience of being associated with the abuser can present further challenges to the practitioner in being able to develop a therapeutic relationship and potential subsequent trauma-specific interventions. In the literature, the consideration of being a male practitioner is raised as focused on the importance of avoiding boundary violations and re-traumatisation (Herman, 1998; Jones, 1991), problematizing men as needing to be mindful of the development of a therapeutic relationship with this

client group. Therefore, 'working harder' here requires having to navigate the potential various and different effects that their gender can have on the work. With greater emphasis that some approaches place on the importance of establishing working therapeutic relationships with this group of clients, the findings here suggest the added importance of consideration of gender difference.

Further to this, the implications of particular service guidelines, policies and informal rules of female clients seeing female practitioners in the context of abuse, can also be considered as contested here by the experiences of the participants in this study. Firstly these sometimes formal or informal practices can be argued as serving to reproduce discourses that construct masculinity in largely hegemonic ways (Connell, 2005) as a potential threat, one that needs to be guarded. This also further subjugates, as was identified in the findings, the potential utility of male practitioners to trauma work in providing a different emotional experience with a man. In addition to this, such assumptions are heavily bound up in discourses surrounding gender and the actions of men in wider society. This potentially has the converse effect of homogenising both male practitioners as well as clients themselves. This can be done through assumptions that female clients would not want or be able to work with a man and that male psychologists would not be able to undertake such work with female clients.

In terms of services and the role of clinical psychology, I believe it would be highly useful for services to further conceptualise gender difference in trauma work and to not do so in ways that automatically assume and position female clients who have experienced abuse as needing to see female clinicians but rather to be curious about clients' wishes and to ensure that they have the choice to decide what would be best in regards to the practitioner they work with. In regards to clinical psychology I believe there are some areas that would be useful to consider. That male clinical psychologists can be problematized in their work in the context of gender difference holds implications for the need for this to be considered in supporting and supervising male clinicians. Offering opportunities and space for such discussions which bring into light male perspectives in the profession will serve to address the impact of dominant implicit gender discourses

and assumptions that may be in operation. Within clinical psychology there are currently a smaller minority of men in the profession further added by the few male trainee psychologists enrolling on courses each year. Training courses here can play a crucial role in critically evaluating and bringing to attention the experiences of men in the profession and adding to the diversity of perspectives both on training programmes and in the wider discipline of clinical psychology.

-Recommendations

* For psychology services to make available and offer to clients who are seeking support choice in regards to the gender of their practitioner. Services here should be supportive of helping clients to make such decisions as opposed to making assumptions about what would be most appropriate.

* For psychology services to make available time and space for clinicians to use for reflection on aspects of difference, including gender, and how this impacts on the self and practice. This could include supervision, but would also need consideration of the impact gender difference can have between practitioners and supervisors.

* For clinical training providers to include opportunities for trainees to think about both gender difference in the context of their work and in their experiences in the wider context of clinical psychology.

* For more use of alternative constructions of the impact of abuse. Thus, allowing for other positions to be heard and engaged with, which may also include utilising discourses of resistance as opposed to just those regarding a 'harm' story or the damaged survivor.

4.4.7 Final Thoughts

In the course of this research I have come to appreciate the complexity surrounding the gendered experiences of men within clinical psychology. From carrying out research on this area, I have come to appreciate the various difficulties that can be faced and the implications of not having available time and

space to discuss such experiences. In my own clinical work, I too have come across the complexities regarding gender difference and the various issues this brings up. However, I have also benefited greatly from doing this research and speaking with more experienced practitioners. This has helped to put into words experiences that I have found difficult to explain and also served to support me in feeling legitimated in raising these issues and undoubtedly will transform many aspects of my work in the future.

References

Afuape, T. (2011). *Power, Resistance and Liberation in Therapy with Survivors of Trauma: To have our hearts broken.* Hoboken Taylor and Francis.

Ahern, K. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research*, 9(3), 407–411.

Alexander, F.G. (1944). The indications for psychoanalytic therapy. *Bulletin of the New York Academy of Medicine*, *20*, 320–332.

American Psychiatric Association. (2012). *Diagnostic and Statistical Manual of Mental Disorders: DSM V*. Washington DC: American Psychiatric Association.

American Psychiatric Association Work Group on ASD and PTSD. (2004). *Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder*. Washington, DC: Author.

American Psychiatric Association. (2004). Practice guidelines for the treatment of patients with acute stress disorder and posttraumatic stress disorder. *American Journal of Psychiatry, 161*(suppl.), 3–31.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders: DSM IV-TR* (4th eds). Washington DC: American Psychiatric Association.

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders: DSM III*. Washington DC: American Psychiatric Association.

Arribas-Ayllon, M., & Walkerdine, V. (2008). Foucauldian Discourse Analysis. In C. Willig, & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology (pp 91-108).* London: Sage.

Banner, L, W. (1983). *American Beauty.* Chicago: University of Chicago Press.

Beck, J. (1995). *Cognitive Therapy Basics and Beyond.* New York: Guildford Publications.

Beck, A. T., Emery, G., & Greenberg, R. L. (1985). Anxiety disorders and phobias: A cognitive perspective. New York: Basic Books.

Bem, S, L. (1974). 'The measurement of psychological androgyny'. *Journal of Consulting and Clinical Psychology* 42: 155-62.

Bennett-Levy, J., Butler, G., Fennel, M., Hackman, A., Mueller, M. and Westbrook, D. (2004). *The Oxford guide to behavioural experiments in cognitive therapy.* Oxford: Oxford University Press.

Bisson, J., Ehlers, A., Matthews, R., Pilling, S., Richards, D, & Turner, S. (2007). Systematic review and meta-analysis of psychological treatments for posttraumatic stress disorder. *British Journal of Psychiatry,* 190, 97-104.

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T. & Stevens, M. R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Boles, L., & Bombard, T. (1998). Conversational discourse analysis: appropriate and useful sample sizes. *Aphasiology*, 12(7/8), 547.

Boonzaier, F., & De La Rey, C. (2004). Woman abuse: The construction of gender in women's and men's narratives of violence. *South African Journal of Psychology, 34*(3), 443-463.

Bradshaw, J., Finch, N., Kemp, P., Mayhew, E. & Williams, J. (2003). *Gender and Poverty in Britain,* Working paper series 6. Manchester, UK: Equal Opportunities Commission.

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162,* 214–227.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3: 77-101.

Bremner J, Vermeeten E. (2001). Stress and development: behavioral and biological consequences. *Developmental Psychopathology*, 4:233–237.

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effect*s. London: Sage.

Brinkman, S. & Kvale, S. (2008). Ethics in qualitative psychological research, in C, Willig & W, Stainton-Rogers (eds), *The Sage handbook of qualitative research in psychology.* Sage Publications, London, pp.263-279.

Brom, D., Kleber, R. J.,& Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology, 57,* 607–612.

Burnham, J. (2012) Developments in Social GRRRAAACCEEESSS: visible – invisible and voiced – unvoiced. In I.-B. Krause, (ed.) *Culture and Reflexivity in Systemic Psychotherapy: Mutual Perspectives* (pp. 139–160). London: Karnac.

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

Burton, A. (1994). *Burdens of History: British Feminists, Indian Women and imperial Culture 1865–1915*. Chapel Hill: University of North Carolina Press.

Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity.* New York: Routledge.

Cawson, P., Wattam, C., Brooker, S., & Kelly, G. (2000). *Child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect.* London. England: National Society for the Prevention of Cruelty to Children (NSPCC).

Calhoun, P.S., Hertzberg, J.S., Kirby, A.C., Dennis, M.F., Hair, L.P., Dedert, E.A & Beckham, J.C. (2012). The Effect of Draft DSM V Criteria on Posttraumatic Stress Disorder Prevalence. *Depression and Anxiety, 29, 1032-1042.*

Chahal, P, K. (2013). A trainee counselling psychologist's considerations in CBT-informed practice with adult survivors of childhood sexual abuse. *Counselling Psychology Review, 28* (3), 30-42.

Chard, K. M. (1997). Cognitive processing therapy for sexual abuse: Therapist adherence and competence protocol. Unpublished manuscript, University of Kentucky.

Chouliara, Z., Karatzias, T., Scptt-Brien, G., Macdonald, A., MacArthur, J & Frazer, N. (2011). Talking therapy services for adult survivors of Childhood Sexual Abuse (CSA) in Scotland: Perspectives of service users and professionals. *Journal of Child Sexual Abuse,* 20, 128-156

Chu, JA (1988). Some aspects of resistance in the treatment of multiple personality disorder. Dissociation, 1 (2), 34-38.

Coid, J., Petruckevitch, A., Feder, G., Chung, W., Richardson, J & Moorey, S. (2001). Relation between childhood sexual and physical abuse and risk of revictimisation in women: a cross-sectional survey. *Lancet,* 8, 11, 450-455.

Connell, R.W., & Messerschmidt, J.W. (2005). Hegemonic Masculinity: Rethinking the Concept. *Gender and Society 19(6),* 829-859.

Connell, R.W. (2005). *Masculinities* (2nd ed.). Cambridge: Polity Press.

Cromby, J., & Nightingale, D.J. (1999). What's wrong with social constructionism? In D.J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: A critical analysis of theory and practice* (pp. 1-19). Buckingham: Open University Press.

Cross, S. & Baglihole, B. (2002). Girls' jobs for the boys? Masculinity and non-traditional occupations. *Gender, Work & Organisations, (9), 2, 204-226.*

Dalenberg, C. (2010). *Countertransference and the treatment of trauma.* American Psychological Association.

Dalenberg, C. (2004). Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma. *Psychotherapy: Theory, Research, Practice, Training, (41), 4, 438-447.*

Davies, B., & Harré, R. (1999). Positioning and personhood, in R. Hare and L. Van Lagenhove (eds) *Positioning Theory.* Oxford: Blackwell

Dobash, R.E., & Dobash, R.P. (1998). *Rethinking violence against women.* London: Sage.

Dunleavy, K. & Slowik, K.A. (2012). Emergence of Delayed Posttraumatic Stress Disorder Symptoms Related to Sexual Trauma: Patient-Centered and Trauma-Cognizant Management by Physical Therapists. *Physical therapy, 92, 339-351.*

Dunmore, E., Clark, D. M., & Ehlers, A. (2001). A prospective investigation of the role of cognitive factors in persistent posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy, 39,* 1063–1084.

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

Ehlers, A., Bisson, J., Clark, D, M., Creamer, M., Pilling, S., Richards, D., Schnurr, P, P., Turner, S, & Yule, W. (2010). Do all psychological treatments really work the same in posttraumatic stress disorder? *Clinical Psychology Review,* 30, 269-276.

Ehlers, A., & Clark, D, M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour, Research and Therapy,* 38, 319-345.

Ehlers, A., Clark, D, M., Hackmann, A., McManus, F, & Fennell, M. (2005). Cognitive therapy for posttraumatic stress disorder: development and evaluation. *Behaviour, Research and Therapy,* 43, 413-431.

Finlay, L., & Gough, B. (2003). *Reflexivity: A practical guide for researchers in health and social sciences.* Oxford: Blackwell.

Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67,* 194–200.

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment, 11,* 303–314.

Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A. M., Riggs, D. S., Feeny, N. C. & Yadin, E. (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology, 73,* 953–964.

Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2005). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (2nd ed.). New York, NY: Guilford Press.

Foa, E. B., & Rothbaum B. O. (1998). *Treating the trauma of rape: Cognitive-behavior therapy for PTSD*. New York, NY: Guilford Press.

Foucault, M. (1972). *The archaeology of knowledge.* London: Tavistock.

Foucault, M. (1977). *Discipline and Punish. The Birth of the Prison.* Cornwall: Penguin.

Foucault, M. (1980), *Power/knowledge: Selected interviews and other writings 1971-1977.* New York, NY: Harvester Wheatsheaf.

Foucault, M. (1982). The Subject and Power. In H.L. Dreyfus & P. Rabinow (Eds.), Michel Foucault beyond structuralism and hermeneutics (pp. 208-26). New York: Harvester Wheatsheaf.

Foucault, M. (1985). Discourse and Truth. The Problematization of Parrhesia. Retrieved from http://www.naturalthinker.net/trl/texts/Foucault,Michel/Foucault%20-%20Discourse%20and%20truth.pdf

Foucault, M. (1988) 'Technologies of the Self'. In Luther H. Martin, Huck Gutman and Patrick H.

Freud, S. (1957). The future prospects of psycho-analytic therapy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 11, pp. 141–151). London: Hogarth Press. (Original work published 1910).

Finkelhor, D. & Dzuiba-Leatherman, J. (1994). Victimization of children. *American Psychologist* 49 (3), 173-13.

Gavey, N. (1999). "I wasn't raped but…": Revisiting definitional problems in sexual victimization, in Lamb, S (ed), *New Versions of Victims: Feminists struggle with the concept,* New York and London: New York University Press, pp57-81.

Gergen, K, J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40, 266-275.*

Gordon, M. (2011). Primary school teachers and traveler children: A foucauldian-informed analysis into the conditions of possibility for traveler education in Ireland. (Unpublished PHD thesis).

Guilfoyle, M. (2005). From therapeutic power to resistance? Therapy and cultural hegemony. *Theory & Psychology, 15 (1), 101-124.*

Hare-Mustin, R, T. (1994). Discourses in the mirrored room: A post-modern analysis of therapy. *Family Process, 33 (1), 19-35.*

Harper, D.J. (2003). Developing a critically reflexive position using discourse analysis. In Finlay, L., & Gough, B. (eds.). *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences* (pp. 78-91). Oxford: Blackwell Science.

Harper, D.J. (2011). Choosing a Qualitative Research Method. In Harper, D., & Thompson, A.R. (eds.). *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (pp. 83-97). Chichester: Wiley-Blackwell.

Harvey, M. R., & Harney, P. A. (1997). Addressing the aftermath of interpersonal violence: The case for long–term care. *Psychoanalytic Inquiry, Suppl.,* 29–44.

Hegadoren, M.K., Lasiuk. G.C & Coupland. N. J. (2006). Posttraumatic Stress Disorder Part III: Health Effects of Interpersonal Violence Among Women. *Perspectives in Psychiatric Care, vol.42 , 163-173.*

Herman, J. (1994). *Trauma and recovery: From Domestic Abuse to Political Terror.* New York, NY: Basic Books.

Herman, J. (1998). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences, 52, 154-150.*

Hollway, W. (1989). Subjectivity and method in psychology: Gender, meaning and science. Gender and psychology. Thousand Oaks, CA, US: Sage.

Horowitz, M. J. (1997). *Stress Response Syndromes* (3rd ed.). Northvale, NJ: Aronson.

Hruby, G, G. (2001). Sociological, postmodern and new realism perspectives in social constructionism: implications for literacy research. *Reading Research Quarterly,* 36 (1), 48-62.

Improving Access to Psychological Therapies (IAPT). (2007). *The competencies required to deliver effective cognitive and behavioural therapy for people with depression and anxiety disorders.* London: Department of Health.

Jehu, D. (1989). 'Sexual dysfunction among women clients who were sexually abused in childhood', *Behavioural Psychotherapy* 17: 53-70.

Johnson, D., Pike, J., & Chard, K. (2001). Factors predicting PTSD, depression, and dissociative severity in female treatment-seeking childhood sexual abuse survivors. *Child Abuse & Neglect,* 25, 179-198.

Johnstone, L. (2011). Can traumatic events traumatize people? Trauma, madness and psychosis. In M. Rapley., J, Moncrieff & J, Dillon, *De-Medicalizing Misery* (pp. 27-44). Palgrave Macmillan.

Jones, E. (1991). Working with adult survivors of child sexual abuse. London: Karnac Books.

Kessler, R. C. (2000). Posttraumatic stress disorder: The burden to the individual

and to society. *Journal of Clinical Psychiatry*, 61 (Supplemental, 5), 4–12.

Kitzinger, J. (1992). 'Sexual violence and compulsory heterosexuality', *Feminism and Psychology,* 2, 3: 399-418.

Kleim, B., Grey, N., Wild, J., Nussbeck, F, W., Stott, R., Hackman, A., Clark, D, M., & Ehlers, A. (2013). Cognitive change predicts symptom reduction with cognitive therapy for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology,* 81 (3), 383-393.

Kramer, U. (2009). Individualizing Exposure Therapy For PTSD: The Case Of Caroline. *Pragmatic Case Studies in Psychotherapy,* Vol. *5*(2), Article 1, 1-24.

Krupnick, J. L. (2002). Brief psychodynamic treatment of PTSD. *Journal of Clinical Psychology, 58,* 919–932.

Krupnick, J. L. (1980). Brief psychotherapy with victims of violent crime. *Victimology, 5,* 347–354.

Kvale, S. (2007). *Doing Interviews.* London: Sage Publications.

Kvale, S., & Brinkmann, S. (2009). Interviews. London: Sage.

Lamb, S. (1999). 'Constructing the victim: popular images and lasting labels', in S. Lamb (ed) *New versions of victims: feminist struggle with the concept,* New York and London: New York University Press, pp. 108-138.

LeDoux, J. E. (2002). The synaptic self. New York: Viking

Lemma, A. (2003). *Introduction to the practice of psychoanalytic psychotherapy.* John Wiley & Sons Ltd.

Levett, A. (1994). 'Discourses of child sexual abuse: regimes of power' in G. Lopez and J. L. Linaza (eds) *Psicologia, Discuro y Poder: Metodologias cualitavas perspectives critical,* Mardid: Visor.

Liebrucks, A. (2001). The concept of social construction. *Theory & Psychology, 11 (3), 363-391.*

Lindy, J. D. (1993). Focal psychoanalytic psychotherapy of posttraumatic stress disorder. In J. P. Wilson & B. Raphael (Eds.), *International Handbook of Traumatic Stress Syndromes* (pp. 803–809). New York: Plenum.
Lister, E. (1982). Forced silence: A neglected dimension of trauma. *American Journal of Psychiatry. 139, 872-876.*

MacKinnon, C. (1983). 'Feminism, Marxism, method and the state: toward feminist jurisprudence', *Signs,* 8: 635-58.

MacLeod, M & Saraga, E. (1988). 'Challenging the orthodoxy: towards feminist theory and practice', *Feminist Review* 28: 16-55.

Malson, H. (1998). The Thin Woman. Feminism, post-structuralism and the social psychology of anorexia nervosa. Great Britain: Routledge.

Marshall, J.D. (2007). Educational research as problematisation. In M.A. Peters & A.C. Besley (Eds.), *Why Foucault? New directions in educational research* (pp. 15–28). New York: Peter Lang.

McGuire, W. (1974). *The Freud/Jung letters: The correspondence between Sigmund Freud and C. G. Jung.* Princeton, NJ: Princeton University Press. PEABODY.

Morss, J. E. (1990). *The biologising of childhood: developmental psychology and the Darwinian myth,* Hove, Sussex: Lawrence Erlbaum.

National Institute for Health and Clinical Excellence. (2005). *Posttraumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care* (NICE Clinical Guideline 26).

Nylund, D. & Nylund, D, A. (2003). Narrative therapy as a counter-hegemonic practice, *Men and Masculinities, 5 (4), 386-394.*

O'Dell, L. (2003). The 'harm' story in childhood sexual abuse: Contested understandings, disputed knowledges, in Reavey, P & Warner, S. *New feminist Stories of Child Sexual Abuse, Sexual Scripts and Dangerous Dialogues.* London: Routledge.

O'Farrell, C. (2005). *Michel Foucault.* Sage Publications.

Palvarini, P. (2010). Is the concept of corrective emotional experience still topical? *American Journal of Psychotherapy, 64, 171-194.*

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. Psychological Bulletin, 136(2), 257_301.

Parker, I. (1992). Discourse dynamics: critical analysis for social and individual psychology. London: Routledge.

Patel, N. (2011). The Psychologisation of Torture, in Rapley, M., Moncrieff, J., & Dillon, J. *De-Medicalising Misery: Psychiatry, Psychology and The Human Condition.* Palgrave MacMillan.

Potter, J., & Wetherell, M. (1987). Discourse and Social Psychology. Beyond Attitudes and Behaviour. Bristol: SAGE.

Plummer, K. (1995). *Telling Sexual Stories: power, change and social worlds,* London: Routledge.

Pringle, R. (1992). 'Absolute sex? Unpacking the sexuality/gender relationship'. Pp76-101 in *Rethinking Sex: Social Theory and Sexuality Research,* ed. Connell, R, W and Dowsett, G. W. Melbourne: Melbourne University Press.

Read, J., Rudegair, T. & Farrelly, S. (2006). 'Relationship between Child Abuse and Psychosis', in W. Larkin and A. P. Morrison (eds) *Trauma and Psychosis: New Directions for Theory and Therapy,* London: Routledge.

Reavey, P & Warner, S. (2001) 'Curing women: child sexual abuse, therapy and the construction of femininity', *International Journal of Critical Psychology, Special Issue on Sex and Sexualities* 3: 49-71.

Resick, P., Bovin, J, M., Calloway, A, L., Dick, A, M., King, M, W., Mitchell, K, S., Suvak, M, K., Wells, S, Y., Wiltsey Stirman, S & Wolf, E, J. (2012). *Journal of Traumatic Stress,* 25, 241-251.

Resick, P. A., & Schnicke, M. K. (1993). Cognitive processing therapy for sexual assault: A treatment manual. American Psychological Association Press.

Rose, N. (1996). *Inventing our-selves: Psychology, Power and Personhood.* Cambridge: Cambridge University Press.

Rothbaum BO, Atsin M, Marsteller F. (2005). Prolonged exposure versus eye movement desensitization and reprocessing (EMDR) for PTSD rape victims. *Journal of Trauma & Stress,* 18:607–616.

Roth, A. & Fonagy, P. (2005). *What works for whom? (2eds).* The Guilford Press.

Salganik, M.J., & Heckathorn, D.D. (2004). Sampling and Estimation in Hidden Populations Using Respondent-Driven Sampling. Sociological Methodology, 34, 193-239. Retrieved from http://www.stat.cmu.edu/~fienberg/Stat36-835/SalganikHeckathorn-SocMeth-2004.pdf

Saunders, B. E., Villeponteaux, L. A., Lipovsky, J. A., Kilpatrick, E. G., & Veronen, L. J. (1992). Child sexual assault as a risk factor for mental disorders among women: A community survey. *Journal of Interpersonal Violence, 7,* 189–204.

Seidler, G, H., & Wagner, F, E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive behavioural therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine,* 36 (11), 1515-1522.

Schachter C, Stalker C, Teram E. Toward sensitive practice: issues for physical therapists working with survivors of childhood sexual abuse. *Physical Therapy*. 1999;79:

248–262.

Schachter C, Stalker C, Teram E, et al. *Handbook on Sensitive Practice for Health Professionals: Lessons from Adult Survivors of Childhood Sexual Abuse.* 2nd ed. Ottawa, Ontario, Canada: Public Health Agency of Canada; 2009.

Schottenbauer, M, A., Glass, C, R., Arnkoff, D, B. & Gray, S, H. (2008). Contributions of psychodynamic approaches to treatment of PTSD and trauma: A review of the empirical treatment and psychopathology literature. *Psychiatry, (1), 13-34.*

Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles, protocols and procedures (2nd ed.). New York; Guilford.

Silverman, D. (1997). Validity and credibility in qualitative research. In G. Miller & R. Dingwall (Eds.) *Context and method in qualitative research. The alternative paradigm* (pp. 12-25). London: Sage.

Sims-Schouten, W., Riley, S.C.E., & Willig, C. (2007). Critical Realism in Discourse Analysis: A Presentation of a Systematic Method of Analysis Using

Women's Talk of Motherhood, Childcare and Female Employment as an Example. Theory & Psychology, 17, 101-124.

Stewart, R. E., & Chambless, D. L. (2009). Cognitive-behavioral therapy for adult anxiety disorders in clinical practice: A meta-analysis of effectiveness studies. *Journal of Consulting and Clinical Psychology,77,* 595–606.

Taylor, G.W. and Ussher, J.M. 2001: Making sense of S&M: a discourse analytic account. Sexualities 4, 293-314.

Totsuka, Y. 'Which Aspects of social GGRRAAACCEEESSS grab you most?' The social GGRRAAACCEEESSS exercise for a supervision group to promote therapists' self-reflexivity. *Journal of Family Therapy.* 2014, 36, 86-106.

Trickett, P. K., & Putnam, F. W. (1998). Developmental consequences of child sexual abuse. In P. K. Trickett & C. J. Schellenbach (Eds.), *Violence against children in the family and the community.* Washington, DC: American Psychological Association.

Wade, A. (1997). *Honouring Resistance: A response based approach to counselling.* Vancouver, Canada: Viewers Guide Stepping Stone Productions.

Walters, M. L., Chen, J., & Breiding, M. J. (2013). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 findings on victimization by sexual orientation. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Warner, S. (2003). Disrupting identity through Visible Therapy: A feminist post-structuralist approach to working with women who have experienced child sexual abuse, in Reavey, P & Warner,S. *New feminist Stories of Child Sexual Abuse, Sexual Scripts and Dangerous Dialogues.* London: Routledge.

Warner, S. (2000). *Understanding Child Sexual Abuse: Making the Tactics Visible.* Handsell Publishing.

Weedon,C. (1987). *Feminist Practice and Post-Structuralist Theory.* Oxford: Blackwell.

Westbrook, D., Kennerley, H. & kirk, J. (2007). *An introduction to cognitive behavioural therapy: Skills and applications.* London: Sage Publications.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionist work. In Nightingale, D.J., & Cromby, J. (Eds.) (1999). *Social Constructionist Psychology: A Critical Analysis of Theory and Practice* (pp. 37-51). Guildford: OU Press.

Willig, C. (2008). *Introducing qualitative research in psychology (2nd edn.).* Maidenhead: Open University Press.

Willig, C. (2013). *Introducing qualitative research in psychology (3rd edn.).* Maidenhead: Open University Press.

Wilson, J., & Lindy, J., (1994). Empathetic strain and countertransference. In J. Wilson & J. Lindy (Eds.), *Countertransference in the treatment of PTSD* (pp. 5–30). New York, NY: Guilford Press.

Wodak, R. & Meyer, M. (2001). *Methods of Critical Discourse Analysis.* Sage Publications.

Woolgar, S. & Pawluch, D. (1985). Ontological Gerrymandering: The anatomy of social problems explanations. *Social Problems, (32), 3, 214-227.*

Worrell, M. (2003). Working at being survivors: Identity, gender and participation in self-help groups, in Reavey, P & Warner, S. *New feminist Stories of Child Sexual Abuse, Sexual Scripts and Dangerous Dialogues.* London: Routledge.

Yalom, I, D. (1995). *The Theory and Practice of Group Psychotherapy.* New York: Basic Books.

Yehuda, R., & McFarlane, A.C. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *American Journal of Psychiatry*, *152*(12), 1705–1713.

Yuen, A. (2009). Less pain, more gain: Explorations of responses versus effects when working with the consequences of trauma. *Explorations: An E-Journal of Narrative Practice www.dulwichcentre.com.au/explorations-2009-1-angel-yuen.pdf,* (1), 6-16.

APPENDIX ONE – UEL Ethics Letter

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Pippa Dell   **ASSESSOR:** Gordon Jinks

STUDENT: Omar Timberlake   **DATE (sent to assessor):** 07/03/2014

Proposed research topic: A Foucauldian discourse analysis of how male clinical psychologists construct their work with female clients who have experienced abuse.

Course: Professional Doctorate in Clinical Psychology

1. Will free and informed consent of participants be obtained?   YES

2. If there is any deception is it justified?   N/A

3. Will information obtained remain confidential?   YES

4. Will participants be made aware of their right to withdraw at any time? YES

5. Will participants be adequately debriefed?   YES

6. If this study involves observation does it respect participants' privacy? NA

7. If the proposal involves participants whose free and informed

   consent may be in question (e.g. for reasons of age, mental or

   emotional incapacity), are they treated ethically?   NA

8. Is procedure that might cause distress to participants ethical?   YES

9. If there are inducements to take part in the project is this ethical?   NA

10. If there are any other ethical issues involved, are they a problem?   NA

APPROVED

YES

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: GHJ   Date: 9/4/14

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Pippa Dell   **ASSESSOR:** Gordon Jinks

STUDENT: Omar Timberlake   **DATE (sent to assessor):** 07/03/2014

Proposed research topic: A Foucauldian discourse analysis of how male clinical psychologists construct their work with female clients who have experienced abuse.

Course: Professional Doctorate in Clinical Psychology

Would the proposed project expose the <u>researcher</u> to any of the following kinds of hazard?

1   Emotional   YES

2.   Physical   NO

3.   Other   NO

(e.g. health & safety issues)

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: LOW

APPROVED

YES

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: GHJ   Date: 9/4/14

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London

www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966   fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk   web: www.uel.ac.uk/psychology

INVESTOR IN PEOPLE

CUSTOMER SERVICE EXCELLENCE
The Government Standard
UK

The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853

APPENDIX TWO – Information Sheet

Information Sheet

Aim of the study

The aim of this study is to explore how male clinical psychologists experience their clinical work with female clients who have experienced various types of abuse. This will involve exploring themes such as gender difference within the therapeutic relationship and its impact on clinicians along with access to resources and supervision support.

Invitation to the study

I would like to invite you to take part in this research study. Before deciding whether to take part, it is important that you understand why the research is being carried out and what it will involve.

Background to the study

Much research has highlighted the prevalence of various forms of physical and sexual abuse within society and its association with psychological distress (Boonziaser and Rey, 2004). Research has highlighted psychological, physical and sexual difficulties experienced by survivors (Cawson et al, 2000), tendencies towards re-victimisation, substance abuse and post-traumatic symptoms (Johnson, Pike and Chard, 2001) and its association with psychosis (Read, Rudegeair and Farrelly, 2006, and Johnstone, 2011).

Clinical psychologists in various fields of work are routinely encountering clients' who have experienced forms of physical and sexual abuse, with many being predominantly female.

There is currently a lack of research exploring the impact of gender difference between practitioners and clients and its relevance to interventions.

Who can take part?

This study is recruiting male clinical psychologists who have experience of working with female survivors of physical or sexual abuse in any clinical context.

How do I take part in the study?

If you wish to take part please contact the research on the telephone number or email address provided below. You are free to withdraw from the study at any time without reason and may request further information from the researcher.

What will happen if I take part?

If you agree to take part you will be given a consent form to read and sign and offered an interview. Interviews will last approximately 60 minutes and will take place at a time and date that is convenient for you. The researcher will also reimburse you for any reasonable travel expenses incurred. Interviews will initially be recorded digitally and subsequently transcribed to be used in the analysis. All digital recordings will be kept on an encrypted hard drive disk for confidentiality and destroyed at the end of the study. Any identifiable information, such as names and other material, will be omitted to maintain confidentiality.

What are the possible disadvantages and advantages of taking part?

It is acknowledged that this topic may be quite sensitive as working with trauma can have profound effects upon practitioners. As a result, advice and sign posting to services that can offer support will be provided.

The advantages of taking part in this study are that you will be providing important information to help raise awareness and understanding of male clinicians' experience of working with this client group, which can benefit the wider literature and clinical practice in the community.

Will it be confidential?

Participation in the study will be confidential. Interviews will initially be recorded digitally and subsequently transcribed to be used in the analysis. All digital recordings will be kept on an encrypted hard drive disk for confidentiality and destroyed at the end of the study. Transcribed interviews will be anonymised and any identifying information will be omitted.

This will be kept in a locked storage space and held by the researcher for up to 5 years before being destroyed. Consent forms and any other information that may potentially identify you will be stored separately and securely.

Any information regarding your identity will be held by the researcher and supervisor of the project. Examiners will also have access to both digital recordings of the interviews and transcripts.

What will happen to the results of the research study?

The results of the study will be written up and submitted as a research project as part of a Doctorate in Clinical Psychology.

Has the research obtained ethical approval?

The research has obtained ethical approval from the University of East London's Ethics Committee.

Contact information:

If you would like to take part or have any questions or please contact the interviewer, Omar Timberlake at:

If you would like to contact by phone please feel free to call *********** and leave a brief message.

Thank you for reading this information sheet and please feel free to contact me if you have further questions. Please also see below for useful organisations if you require further support.

APPENDIX THREE – Consent form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

A Foucauldian Discourse Analysis of how male clinical psychologists construct their work with female clients who have experienced abuse.

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

…………………………………………………………………………………..

Participant's Signature

………………………………………………………………………………….

APPENDIX FOUR – Interview Schedule

To begin with the researcher will introduce himself. Before beginning the interview a conversation will be held with the participant to give some information of what to expect when the interview starts such as how long the interview will roughly take, the use of the recorder, what to do if they would like to stop at any point and some information regarding the interview questions. Participants will then be invited to 'co-author' the interview through adopting a sense of transparency and emphasising the co-authored nature of the interview and inviting the participant to add and shape the interview agenda. Participants will then be asked to read and sign the consent form.

Questions:

- Can I ask what motivated you to taking part in the research at this time?
-
- Is being a man working with women who have been abused difficult?
-
- Does this affect your role as a therapist?
-
- Does this change how you see the goal of therapy compared to if the client was male?
-
- Have you experienced clients refusing to work with you because you are a man?
-
- Does your service or team have ideas, policies or guidelines as to who female clients who have been abused should work with?
-
- Does it change your approach to a piece of therapeutic work if the perpetrator is male or female?
-
- Are there any advantages or disadvantages to the gender difference in therapeutic work?

-

- Do you feel clients are influenced by the gender difference?

- Have you experienced clients' not wanting to work with you because you are a man?

Following this, at the end of the interview there will be a short de-brief about the interview and an opportunity to discuss how they found the interview and ask any further questions. In addition to this participants' will be asked if there are any feedback points that they would like to share in regards to further helping future interviews with other participants. In addition to this, participants' will be asked if they would like to be kept informed regarding the outcomes of the study.

APPENDIX FIVE – Transcription Convention

For this study a full transcription convention (for example, Jeffersonian) were not used in this study. This was done as it was not considered that it would improve the analysis, due to this research focusing on broader global constructions as opposed to the micro-situated language use of participants, I adopted a simplified transcription convention (as per Malson, 1998), which has been adapted from that of Potter and Wetherell's (1987). Here the focus is on readability of content rather than detailed reproduction of speech features.

Noticeable pauses were identified by a full stop in brackets (.) but not timed.

Full stops …. indicated unfinished utterances.

Brief interruptions were identified by the use of forward slashes e.g. /*SIMON:* mm/;

Chevrons were used <inaud.> to highlight parts of the audio recording that was omitted due to inaudibility or other significant doubts about its accuracy.

An asterix was used to provide descriptive information when names or identifying information had been removed for reasons of confidentiality.

For use in the analysis, all extracts were numbered as present in the analysis and discussion section.

Where words were noticeably stressed they were indicated with an underline ___.

Punctuation was added to facilitate reading.