Therapeutic Alliance between Psychologists and Perpetrators of Intimate Partner Violence: A Feminist Ethics of Care Interpretation

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I would like to dedicate this thesis to my mother, father, and brother who inspire me every day to seek knowledge, be true to myself and fight for transformative changes.

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Abstract

This thesis investigates the construction of the therapist-client alliance in the therapeutic setting with perpetrators of intimate partner violence (IPV). Moreover, it explores the ways a Feminist Ethics of Care perspective could enhance the partnership between the actors. To fulfil such aims, the author conducted six in-depth semi-structured interviews with psychologists working at one of the most renowned institutions for perpetrators of IPV in Norway and Sweden. The analysis of the psychologists' discourses demonstrates that several factors are influential in the alliance construction. The most important aspects are: the clients' perspective towards the psychologists; the therapists' views towards the clients; the psychologists' engagement with moral sentiments; the power struggle between the actors; and the use of techniques for the professionals to enhance their connection with the clients. Besides that, the discourses also show that moral superiority seems to guide the psychologists when relating with the perpetrators. Their views are embedded in an individualistic ethics based on the principles of Kohlberg's Ethics of Justice. The thesis suggests that a collective ethics such as Gilligan's Feminist Ethics of Care would enhance the partnership between the actors. This theoretical framework allows the psychologists to change their superior moral views of the clients to a moral responsibility towards them. When such movement in perspective happens, the therapists begin to see the perpetrators as human beings with many different facets. Consequently, they truly deny a judgmental impression towards their identity.

Key words: intimate partner violence, perpetrators, therapeutic alliance, morality, feminist ethics of care.
## Contents

**Introduction** ................................................................................................................................. 1  
Previous Literature .............................................................................................................................. 3  
Aims and Positionality ........................................................................................................................... 4  
Research Questions and Outline .......................................................................................................... 6  
**Section One: Feminist Ethics of Care** .............................................................................................. 7  
Preface .................................................................................................................................................. 7  
Ethics of Justice ................................................................................................................................... 8  
Ethics of Care ....................................................................................................................................... 9  
Political Theory of Care ...................................................................................................................... 11  
Phases of Care ..................................................................................................................................... 11  
Values of Care ..................................................................................................................................... 12  
Empathy ............................................................................................................................................... 12  
Compassion and Sympathy .................................................................................................................. 14  
Trust, Responsibility and Power ......................................................................................................... 15  
Relational Autonomy ........................................................................................................................... 16  
Final Considerations ............................................................................................................................ 17  
**Section Two: Context** ................................................................................................................... 18  
Overview .............................................................................................................................................. 18  
Institution ............................................................................................................................................ 18  
Foundation .......................................................................................................................................... 18  
Enrollment .......................................................................................................................................... 20  
Therapy ............................................................................................................................................... 21  
Institutional Training ........................................................................................................................... 21  
Psychologists ....................................................................................................................................... 22  
Clients .................................................................................................................................................. 24  
**Section Three: Approach** ................................................................................................................ 26  
Methodology ......................................................................................................................................... 26
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Ethics</td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>Section Four: Analysis</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Preface</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Identification</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Attentiveness</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>Nurturance</td>
<td></td>
<td>39</td>
</tr>
<tr>
<td>Issues of Power</td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>Section Five: Conclusion</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>Connecting the Dots</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>Situating Myself</td>
<td></td>
<td>59</td>
</tr>
<tr>
<td>Limitations and Further Knowledge</td>
<td></td>
<td>59</td>
</tr>
<tr>
<td>Contributions to the Field</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>References</td>
<td></td>
<td>61</td>
</tr>
</tbody>
</table>
Introduction

In the late 1980s, the insights of the Norwegian criminologist Kristin Skjørten drastically changed the field of intimate partner violence (IPV), especially concerning the therapeutic scenario in Europe. Until then, women’s shelters, feminist movements and family/child protection governmental agencies in the Nordic countries engaged with treatment centres to assist survivors of IPV. It was through Skjørten’s revolutionary idea that the focus eventually changed from IPV survivors to perpetrators. The proposition to provide therapeutic treatment to male perpetrators generated an indispensable inter/national debate.¹

The World Health Organization (2006) defines IPV as any harmful physical, sexual and psychological action(s) that occurs between intimate partners in a relationship. This relationship can be either heterosexual or homosexual, even though the latter remains in need of research (COAG, 2015). Many scholars consider the violent act between intimate partners as a result of the unequal patriarchal/gender system individuals are embedded. Consequently, they link IPV to dominant notions of masculinity (Pina et al., 2009). When society values rationality over emotions more, men are pressured to deny their vulnerabilities and demonstrate their power over women. The indulgence of violence will continue if individuals do not recognize an embodied notion of self (Enander, 2011).

Men are mostly reported to be the perpetrators of IPV in heterosexual relationships, but there is a clear evidence of female perpetrators in heterosexual relationships, and both genders in homosexual relationships (WHO, 2006). This gender symmetry is a disputed issue among researchers of violence against women and family violence. Even though there are similar figures of women and men performing violent acts, researchers point out to the importance of also considering the nature of the acts, its context and the structure of the relationship between the actors involved. By doing this, it is clear that the type and degree of physical violence differs significantly, with men committing more severe violent acts than women (Graham-Kevan, 2007).

Skjørten and their² colleagues saw in the inclusion of male perpetrators to the therapeutic setting as an opportunity to engage with IPV from a different perspective. Even though the Duluth Model³(Pence and Paymar, 1993) was already widespread in the United

¹ Reference note: the participants of this dissertation provided the information regarding Skjørten and the institution in question.
² Throughout the entire dissertation, I have tried as most as possible to use gender-neutral pronouns since I want to distance myself on making assumptions about the individual’s gender identity. However, I think it is relevant to identify the participants of this research according to the gender identity they provided me.
³ It is uncertain how much influence the US context had on Skjørten, but this doesn’t diminish the revolutionary aspect of her actions in the European framework. I will explore more about interventions
States of America among interventions for male batterers, it appears that the basis for Skjørtens support can be found in Norwegian criminology, particularly, in its strong belief in alternative, rehabilitative solutions to social issues, not only relying on criminal justice. Prison and conviction are also part of the process, but this specific criminology trusts intervention in a complex social issue with therapeutic treatment.

The revolutionary aspect appears in the possibility to redefine the moral norms surrounding criminality and punishment. Skjørtens and their colleagues surprised the society and sparked a discussion on the unclear barriers of morality. Traditionally, individuals pursuing improper moral choices are judged by the society as evil characters who deserve a form of punishment based on retaliation. They become forgotten societal members differentiated from those with a superior morality. Engaging with the morally wrong in the therapeutic level would transformatively change the rigid notions of deviance. It would allow an empathic and holistic understanding of perpetrators, without forgetting the responsibility they have towards the violent act. Moreover, the form of punishment would change, by societal members recognizing their responsibility towards the ones committing violence.

Giving male perpetrators the opportunity for behavioural and mind-set change through therapy was an idea that was hard to swallow. Several politicians, members of the health care system and social services boycotted Skjørtens idea by implying that they – and the other professionals involved in the project – were building a morally degrading partnership with the offenders. The critics were questioning the founders’ will towards eradicating violence against women. They believed in the traditional punishment of male perpetrators by only incarcerating them. In their logic, male perpetrators should by no means receive assistance on regenerating their behaviour. They considered it morally absurd that the perpetrators should be treated on equal terms with the survivors since they were the ones causing harm.

Even though there was a definite resistance established, the Norwegian women’s movement – in constant dialogue with Skjørtens team – understood their intentions and the importance of bringing male perpetrators to the clinical setting. Such a movement, along with the women shelters in the country, had a significant influence on state policy and other social agencies. This allowed Skjørtens project to continue and eventually transform it into a treatment centre. It then became one of the most renowned institutions providing therapeutic treatment for IPV perpetrators in Norway – and later on in Sweden.

The historiography of the institution demonstrates the importance of Skjørtens resistance to the societal models that were provided for individuals involved with IPV. It created the possibility to produce knowledge in the field of IPV and, consequently, the engagement with other bodies of thought. The therapeutic relationship between psychologists working at

for perpetrators as well as the Duluth model on the next subsection regarding previous literature on the field.
the institution and their clients is particularly useful for understanding more about Skjørten’s intentions when proposing their idea.

**Previous Literature**

In 2003, the World Health Organization (WHO) published a report to cover all the existent interventions for male perpetrators around WHO’s acting countries (Rothman et al., 2003). Such document demonstrated the type of interference – therapeutic, social and political – and the central institutions conducting it. It showed that the United States was the pioneer in providing treatment for male batterers after IPV was officially considered a crime in the country – in the 1970s (McLaughlin, 2017). The Duluth model (Pence and Paymar, 1993), which I previously mentioned above, is a programme created among several others. Feminists, women shelters and the criminal justice partnered for the creation of the Duluth Model as a social-therapeutic intervention for male batterers. The program joins aspects of gender and societal norms along with the personal background of the male perpetrator (Barner and Carney, 2011). In Europe, programmes for male perpetrators emerged in the late 1990s, with Skjørten’s institution being the third organisation created, after others in Germany and Austria.

Scholars have been focusing on treatment approaches in order to understand its efficacy, find solutions for improvement and to contribute to the reduction of IPV in society (Stuart, 2005). However, there is a lack of research on the precise therapeutic alliance between therapists and perpetrators. Moreover, literature is scarce regarding the professional’s ethical considerations when providing therapy for this group of clients (Abrar et al., 2000).

Lambert and Barley (2007) reflect on the therapist-client relationship by reaffirming that a positive relation between actors increases the success of therapy and consequently, the chance of client’s behavioural/mindset change. According to the authors, to acquire such relationship a series of factors need to be ensured, such as the reflection towards the particular positions of psychologist and client. Empathy appears as a potential contribution to sustaining a beneficial interaction between the actors.

Recently, McLaughlin (2017) published an article in which they inquired the considerations regarding IPV at the American Psychological Association Ethics Code (APA). Their study does not deeply investigate how psychologists are ethically inclined towards their clients (perpetrators). Rather, it resumes the possible ethical challenges that clinicians might have when working with these clients. Also, it examines how the APA can guide psychologists to have a better ethical relation with perpetrators.

McLaughlin’s (2017) contributions are important for my thesis since it reassures the importance of therapists to acquire knowledge towards IPV and be prepared for a complex ethical relation to their clients. It points out the difficulty for some professionals to balance their own moral considerations with their clients. Besides, the author reflects on the meanings of an
ethical justice when therapists let their personal views of their clients influence on the process. The principle of justice that appears at the APA reminds professionals that all individuals are entitled to seek treatment and benefit from it. The negative image that the therapists might have towards people that conduct harm can be an obstacle for engaging with such principle.

The study mentioned above (McLaughlin, 2017) specifically contributes to my understanding of the ethical considerations that psychologists might have towards perpetrators. Unfortunately, the author does not touch upon the particular contributions of theoretical frameworks based on ethics – such as a Feminist Ethics of Care perspective – can bring to the therapist-client alliance. Tong (1997) comes closest to this issue when analyzing care and empathy on the ethical relation of doctors and patients. The scholar shows the clinicians’ dilemma towards subjectivity and objectivity regarding their involvement with patients. Tong (1997) defends that there should be a balance between becoming non/personal, since both emotions and rationality are part of moral considerations. Their paper reflects on the gender lens attributed to care and empathy as belonging to women. The terrain of oppression and discrimination towards women is illustrated in the traditional discipline of medicine, that considers that care and empathy, as women’s characteristics, are inferior moral attitudes.

Tong’s (1997) considerations were very helpful for my understanding of how ethical considerations of care and justice relate to the particular doctor-patient bond, which is embedded in a context of male dominance. It also encouraged me to redefine the negative image that care has towards masculine-grounded disciplines such as Psychology, by observing the contribution that a caring, ethical perspective can bring to the therapeutic setting. Carol Gilligan’s (1982) Feminist Ethics of Care focuses on the construction of care as an ethics of resistance, in which women’s morality are valued and applied.

**Aims and Positionality**

I find the connection between morality and ethics that Skjørtten’s insight brings fascinating. It revisits the responsibility of treatment centres and psychologists to social issues through a reflection on moral and ethical boundaries. Therefore, I was quite surprised to find a lack of research illustrating the involvement of Feminist Ethics of Care in the therapeutic relation between psychologists and perpetrators of IPV. The work of Carol Gilligan (1982) provides a relational understanding of self and other that is essential for the psychologist-perpetrator dynamic. Not only does it challenge the traditional understanding of justice, but it also allows for a humanistic psychological perception of those considered morally wrong.

In this sense, I had the idea to conduct this research with the aim of calling attention to possible transformative changes in the therapeutic relation between psychologists and perpetrators of IPV, taking into consideration contributions from Feminist Ethics of Care.
perspective. To do this, I needed to investigate the way in which this particular group of therapists perceive their clients and construct their relationship. Therefore, in this dissertation, I examine the discourses of six psychologists – one woman and five men – working at the institution created by Skjørten and their team. These professionals work in offices of the institution both in Norway and Sweden.

It is not my intention to carry a comparative analysis between Norway and Sweden when analysing the discourses of the research participants. I focus on the meanings that they generate collectively. I am not particularly interested in these countries' contexts since I am mostly interested in the institution per se and the environment in which the institution was created. Thus, the choice of the institution – due to its expertise – and the lack of research towards the European context when investigating ethical perspectives and therapy for perpetrators were the reasons that I chose such contexts. Moreover, my choice was also based due to my positionality both in Sweden and Norway.

As mentioned above, I am interested in examining the power relation between the client and the psychologist, from the perception of the latter. The reason for this is not only a scientific curiosity due to a lack of research on the psychologists' opinions towards this group of clients; but also due to my positionality as a trained psychologist, and a woman who has experienced violence. My perceptions towards perpetrators were constructed through my experiences in Brazil – the place I was born and grew up in – and different countries around the world, where I have lived and experienced what it means to be in the position of a white woman.

In Sweden, India, Brazil, and Iceland I was unfortunate to experience acts of violence from both complete strangers and members of the community I was part of. These included variations of small harassments, inappropriate touches, verbal and psychological abuses, daily stares, sexual invitations and so on. My body was perceived as an object. I tried to hide my features or to change my clothes. But my appearance was not the problem. The problem was my status as a woman, particularly a woman from a country where women are seen as sexual deviants. However, similarly, local women experienced daily forms of harassment, even worse depending on their race, sexuality, and class. Even though my experience of violence was not within my family, IPV has knocked on my door during small talks with friends, therapy sessions with clients and public events.

As a trained Jungian psychologist, I was taught to act as a mirror in front of the clients. I had to be a tool for the clients that helped them to see themselves and ponder if change was desired and needed. By allowing my experiences of harassment to interfere with my pre-judgment, I am unable to act as a mirror. Moreover, rather than seeing the client as human, I would only be able to view them as deviant. For me as a psychologist and a gender studies

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4 Due to ethical considerations, the name and specific details of the institution won’t be provided.
scholar, it is necessary that I am aware of this bias. Though I am mindful of the fact that my positionality will always influence the therapeutic setting, I do not want to have the resistance towards the clients’ narratives on account of my personal experience.

Research Questions and Outline

To conduct my inquiry and touch upon all the issues mentioned above, I will explore the following research questions.

- How do psychologists working with perpetrators of IPV in the therapeutic setting construct the client-therapist alliance?
- What could a Feminist Ethics of Care perspective contribute to this client-therapist alliance?

I have structured this dissertation in four different parts. Section one refers to the theoretical framework of Feminist Ethics of Care. In section two I will present the material, together with the institutional context and participants/clients details. Section three consists of the dissertation’s approach, with its methodology, methods, and ethics. Section four is the analysis, where I present the influential factors for the construction of the client-therapist alliance. Also, I explore my second research question. In the conclusion of this work, in section five, I will come back to the dissertation’s aim, summarize its findings, indicate its limitations and suggest future research topics.

I would like to conclude this section by contemplating on the form of writing of this thesis. My two-year Master Programme in Gender Studies taught me invaluable lessons for living a life with more attention to my surroundings. The act of challenging my rigid thoughts and moving away from my comfort zone – that propelled this thesis – were aspects that I have learned during the programme. Here, I am taking the challenge of not only dialoguing between two bodies of thought – Gender Studies and Moral Psychology – but also engaging with a mix of creative and academic writing.

Creativity as a form of writing encourages my mind and body to dialogue, and, together, develop a fluid cohesion that gives me the motivation to produce knowledge differently. It is a way to challenge the academic status quo and to evoke a pluralism of ideas (Lykke, 2014). After all, this pluralism brings the acceptance that is so important in this thesis; it is the first step in creating relational societies where care and justice go hand in hand.
Section One
Feminist Ethics of Care

Preface

One of the perks of living in a society relates to the demand of becoming a moral being. Morality has been questioned and constructed by philosophers, psychologists, and members of the religious communities, among others. It consists of judging material aspects and individuals' actions and thoughts into values of right and wrong. But what constitutes that which is morally good or bad? The systems of values that we allocate to our behaviour/thinking determine an action in/proper. Moral systems might contribute to the construction of an egalitarian social structure. At the same time, it can reinforce judgmental perceptions towards individuals. Then, who makes such decisions? Who structures the values that people nurture when relating to one another? All the answers will depend on the investigation of morality, which means, on the ethics that takes places (Wienpahl, 1948).

Ethics are the practices that regulate and define morality, which implies problematizing moral behaviour and thinking (Yuval-Davis, 2011). Each profession and body of thought conceptualizes ethics differently according to the prevalent type of relation between the actors involved. In the case of this dissertation, it is the ethical relation between the psychologist and the perpetrator of IPV that interests me. This interaction is a unique alliance between two actors with different power positions. Social, political and personal considerations influence their role in relation to one another. The morally questionable attitude of someone that inflicts harm can be too demanding to be accepted depending on the professionals’ moral discourses. The problematization of morality and the construction of an ethical relation can either be a motivation or an obstacle for an empathic understanding.

In this section, I take into account the considerations of Moral Psychology, especially the discussion involving feminist ethics of care and ethics of justice (Gilligan, 1982; Kohlberg, 1969). I believe that the meanings brought by feminist care ethicists contribute to an integrative understanding of what it means to have an ethical relation in the particular therapeutic setting that I investigate. This happens because the meanings of empathy, relationality, trust, power, compassion, responsibility, and justice that emerge from this context are of great significance when analysing the psychologists’ perceptions towards their clients. Feminist ethics of care reminds us that a proper conduct involves much more than an abstract notion of justice. It argues for a moral development where self and other morally constitute one another through their attachment (Gilligan, 1977). To start, I will briefly explain the context in which feminist ethics of care emerged.
Ethics of Justice

Her life was endangered. All the memories we had made together were going to disappear. I could no longer sit there and watch her facing this disease. Suffering and despair became our ghosts. We were winning some battles, but it did not matter anymore. The cancer was going to win the war. Suddenly, I heard about a new medicine that could save us, mainly, save her. Our lack of means was a huge obstacle of acquiring such miraculous drops. But there was this man. I was going to appeal to the humanity of this pharmacist. He could help us; he could give us the medicine. He will be touched when hearing about our love story and her personality. How could he not be? Well, he was not. Telling him about the beauty of the woman that was going to depart this world and leave behind so many loving souls did not matter. Asking for money from a friend or promising the pharmacist to pay the rest later did not matter. Not even questioning his compassion and tenderness towards human life made any difference. I did not have any choice. I took it. I stole it. It was for everyone’s sake. I had to do it (Kohlberg, 1969).

This and other moral dilemmas constituted the study of Lawrence Kohlberg (1969) when analysing the meanings of human morality. Based on Piaget's considerations towards Development Psychology, Kohlberg (1969) became the key figure in discussions of the stages of moral development in connection with cognitive aspects of the individual. They presented moral dilemmas, such as the one described above, to white North American men in the 1960s. Was it right to steal from the pharmacist to save his wife life? Was it wrong to cross the limits of another human being? How to establish values of right and wrong? Through the participants' discourses, Kohlberg elaborated on a theory of moral development based on six main stages. This theory would culminate in Gilligan’s reflection towards a non-individualistic ethics. It would lead to the emergence of the Feminist Ethics of Care.

Kohlberg (1969) perceived morality as a move from an egocentric perspective of self to a universal principle of justice. At first, individuals see their own needs as absolute and more important than those of the society where they are embedded. Then, they move from a personal to a social perspective, which represents a transition to the ultimate performance of universal rights and duties based on fairness. Thus, individualistic notions of social justice define the meanings of right and wrong, which are considered universal to all humans (Medina-Vicent, 2016). However, through universalism, Kohlberg ignores the intersection with social categories such as gender, race and sexuality. As a consequence, the author reinforces the moral philosophical tradition of considering the human through a male perception (Gilligan, 1977; 1982).

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5 This is a personal interpretation of the Heinz Dilemma presented by Kohlberg (1969).
The main result of Kohlberg’s (1969) study demonstrates the differences between men and women as moral beings. Women are unable to reach the most advanced stage of moral development because of their position in the private sphere of intimacy and care. Such position ties women to a relational mode of being with the other.

I found Gilligan’s (1977) observations on the paradoxical nature of Kohlberg’s statement particularly illuminating. The author points out that the basis of what it means to be a woman, regarding conduction of affective relationships where emotions and connection are central, is the one that harms their acquisition of a more appropriate morality. Thus, women’s judgment will always be deficient under the eyes of Kohlberg due to their nature and how they relate to others. This unequal normative perspective not only places women as hierarchically inferior to men but also opens space for the latter to silence women due to their considered lack of judgment (Gilligan, 1982).

**Ethics of Care**

Gilligan’s book *In a Different Voice* was the founding work in the movement toward a Feminist Ethics of Care perspective. The author enters the conversation precisely to question the oppressive male perception that Kohlberg – among other ethicists – have universalised uncritically. Gilligan’s (1982) critique expresses the problematic nature of considering one perspective of moral development as a universal framework for all. The theoretical model created by Kohlberg (1969) not only reinforces the women’s moral conduct as improper but also contributes to positioning them as both secondary and less relevant. Women become beings that one cannot trust in judgment. Their concern with the other through a relational perspective troubles their capacity of making decisions and, consequently, diminishes them to infants who have still a lot to learn in respect to morality (Gilligan, 1977).

Therefore, for Gilligan, the biggest problem of Kohlberg’s theoretical considerations arises from the relationship between autonomy and rational obedience towards justice. To connect the individuals’ agency with principles of justice without taking into account their positionality in relation to the surrounding is to ignore the interdependence between people (Nordhaug and Nortvedt, 2011). Gilligan’s critique opens space for the valorisation of an interactional ethics. This means that the author urges the understanding of humans in relation with one another and with the particularities of each, which are embedded in the social, political and psychological context. Universalism is substituted with people’s positionality and their connection with others when making moral decisions. This symbolizes ethics and morality as dialogical constructs between self and other, where affection, intimacy and attachment cannot be ignored (Gilligan, 1977).

The so-called women’s morality – which is a term that will be discussed further on by Tronto (1993) – became possible through Gilligan’s study on the relation between women and
abortion. Their research data included discourses of women engaging with the complex decision of aborting their pregnancy. Through the analysis of such speeches, Gilligan understood that responsibility is an issue of extreme importance when going through such moral dilemma. The responsibility aspect does not only refer to the possible future newborn (other), but also the potential future mother (self). These women were concerned with solving the moral dilemma without hurting oneself and the other (Gilligan, 1977).

At first, their internal desire not to have a child prevailed, but then, as the moral reflections developed, they could not ignore their own obligations and duties towards the other. This does not necessarily imply that they did not conduct the abortion, rather that the sense of responsibility of self and other is present in the development of their moral thinking and actions. This means that they were taking into consideration such responsibility when deciding the best conduct towards the matter (Gilligan, 1977).

I find it important here to take a moment to reflect on the particular choice of participants in Gilligan’s (1982) study. The interviewees were women dealing with a specific dilemma that involved their own sexuality. Moreover, they were potential mothers. It is through the control over their body that women can move from a space of dependence to a place of self-empowered judgement where judgment occurs towards their own methods. Their sense of responsibility emerges from their perception of a non-isolated self, but in relation to the possible child.

By choosing this particular population, Gilligan is problematizing the meanings of morality, but also the patriarchal principles that allocate women only to the private sphere. The mother-child relation that is symbolized through Gilligan’s choice promotes a dialogue on the meanings of motherhood, womanhood and humanism. It is a feminist perspective that calls for the acceptance of considering more than rights and duties, but the choice of moral decisions through the consideration of both self and other (Gilligan, 1977).

Hence, through Gilligan’s considerations, pluralism is possible. The author argues for the consideration of another view towards moral boundaries and decisions. The scholar’s most important conclusion is that the moral inferiority of women is implausible. Their societal position and role do not make them morally less capable; rather it gives them a different voice. She affirms “the ideal of care is an activity of relationships, of seeing and responding to need, taking care of the world by sustaining the web of connections so that no one is left alone” (Gilligan, 1982:73). By doing this Gilligan ensures that an affective and relational meaning of care is valued as much as an individualistic sense of justice on ethical considerations (Gilligan, 1977).

In summary, Feminist Ethics of Care argues for the attentiveness and empathy to the vulnerable, the sense of responsibility of self/other and the nurturance of a relationship where intimacy and trust are at the core (Gilligan, 1977).
Political Theory of Care

Joan Tronto is another feminist care ethicist who has brought meaningful considerations to the discussion of ethics of care and justice. Following from Gilligan’s work (1982) and the body of thought created by the Scottish ethicists Hume, Smith and Hutcheson, Tronto (1993) deeply merges the considerations about ethics of care and ethics of justice presented above. The scholar emphasises that care is necessary for justice to occur.

Moreover, Tronto brings the meanings of care to the political and social level of power structures. One of the biggest critiques that Tronto (1993) has towards Gilligan’s work is the lack of involvement with the political body. Gilligan (1977) highlights the importance of making moral judgments based on care and responsibility but does not necessarily reflect on how such ethical dialogue might occur within institutions. Tronto (1993) reinforces the values of care in the political context by determining how political and social discourses contribute to the assistance towards human need. Morality in Tronto’s perspective is both seen in the interpersonal perspective of a mother-child relationship and in the political arenas that provide the meanings for motherhood.

Tronto (1993) reminds us to see care as practices that assist individuals to connect with each other and give a helping hand to one another in times of need. Responsibility, attentiveness, empathy, trust, interdependence, intimacy and power are care values that individuals should nourish for the establishment of a “just, pluralistic and democratic society” (Tronto, 1993: 162).

Phases of Care

Caring about, taking care of, care giving and care receiving are critical phases that describe the ethical relationship between self and other (Tronto, 1993). I will explain these meanings taking into consideration the ethical relation explored in this thesis, that is the relation between a psychologist and a perpetrator of IPV.

When the client enters the office, the psychologist asks them to explain the reasons for seeking therapeutic treatment. In the case of IPV, the consequences of a violent act are the main reason for requesting assistance. In listening to the story of the client, attentiveness is the first value of care to appear. It is through the recognition of the vulnerable other and the needs of this other that the psychologist is going to be able to care about their client. This recognition appears when the professional listens to the client’s discourse with empathic ears (Tronto, 1993).

The action of care designates the phase taking care of. After listening to the objectives of the client and developing a perspective on what the aims of the therapy should be, the

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6 This term was coined by Tronto (1993).
psychologist reflects on the necessary steps to be taken during the therapeutic process. The sense of responsibility appears here when the psychologist assumes responsibility as a professional towards that individual who needs care. This feeling of responsibility helps the professional to ensure methods for ending suffering and harm both to the client and to others situated in the client’s surroundings. At the same time, the client needs to trust the competence of the professional, to believe that their behaviour and mind-set will change (Tronto, 1993).

Care giving correlates intrinsically with taking care of because it corresponds to actively carrying out the activities that were planned in the latter. Here, the psychologist needs to reflect on their role as a therapist and consequently, on the ways their advantageous power position will influence the therapeutic relation. Compassionate authority is an important idea to account for so that one is not trapped in a morally superior position of power (Tronto, 1993).

Care receiving corresponds to the alliance between the psychologist and the client. The interaction between them will depend on a series of factors. The success of the therapy will only be achievable if cooperation between the therapist and the client is possible. Issues of power on both sides will influence this interaction that needs to be taken with tolerance, sympathy and compassion between both actors. Trust appears here again since for the cooperation to be conceivable mutual trust needs to exist. The psychologist will demand a series of measures on the part of the care receiver to ensure this mutual trust and the cooperation between both. For example, this includes taking responsibility for the acts of violence committed (Tronto, 1993).

For the treatment to be viable and for social justice to be served – through the end of violence – ethics of care with all its meanings needs to settle. By observing the ways ethics of care takes place in the therapeutic/ethical relation between the psychologist and the perpetrator, I am arguing for the need to create a dialogue between values and practices of care. The next sub-section explores such values. Empathy is vital for this dialogue since it is through an empathic understanding of self and other that connection is indeed feasible (Slote, 2007).

**Values of Care**

**Empathy**

Here, I take the definition of empathy as the ability to move from one’s own position to the position of the other. This movement involves the capacity for understanding the perceptions and emotions of the other, with tolerance and compassion (Mercer and Reynolds, 2002). Reading previous literature on empathy, I could not help noticing that it was regarded as an attitude. I contend that this is a problematic way of understanding it. As Bondi (2007)
explains, if we pursue empathy as a trait, we are rejecting the possibility of developing empathy as a process and, consequently, its volatile nature.

Therefore, empathy should be considered a process of ‘becoming’ (Deleuze and Guattari, 1987) that always evolves through the acquirement of new characteristics and intersections with different emotions (Mercer and Reynolds, 2002). In the therapeutic setting, for example, the relationship between therapist and client will generate a set of positive, neutral and negative emotions that will contribute to – or hinder – an empathic understanding of the other’s point of view (Cuff et al., 2014).

The process of becoming empathic involves a series of factors. Masto (2015) points out that an empathic understanding occurs not only when one individual absorbs sentiments from the other. The presence of cognitive ability for identifying the meaning(s) of such emotions is also necessary. Otherwise, the person would only feel an emotional contagion and would not be able to characterize the perspective of the other. Thus, cognitive and affective empathy need to merge in a constant partnership during the empathic process.

Slote (2007) highlights this aspect by stating that without both the dialogue between mind and body – emotion and cognition – empathy cannot be established. Slote’s (2007) deliberation sees empathy as the ‘glue’ that joins the ethics of care and justice. The author demonstrates that a deeper and truthful understanding of the other will only happen when morality takes into consideration individuals as embodied selves and sustain the connection among them. For Slote (2007), an empathic understanding is a way of acquiring such integrative morality.

Moreover, Slote (2007) defends an empathic, caring ethics, in which empathy is grounded on a care relationship. In their book The Ethics of Care and Empathy, they discuss the role of empathy in the morality of care, by affirming that moral education is possible through the comprehensive account of empathy. Through the engagement with several feminist care ethicists, Slote (2007) concludes that when a relationship involves care, it signifies as morally acceptable. Consequently, an empathic concern develops. Thus, by provoking harm to an intimate partner, the client in question conducts a morally ‘wrong’ attitude. The perpetrator did not care for the well-being of the other and did not exhibit empathy towards the other desires, emotions and thoughts (Slote, 2007).

In the case of the therapeutic alliance between the psychologist and the perpetrator, empathy involves respect towards the client’s point of view and positionality, which means a rational/emotional understanding of the client’s experiences, thoughts, feelings and conflicts (Tronto, 1993). An ethics of empathic care, as Slote (2007) advocates, signifies a relationship

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7 In this thesis, I am trying to escape from the Descartian dualism of emotion and reason. Both categories are seen as constitutive and in need of one another (Pulcini, 2017).
of trust, cooperation, compassion and responsibility. The nurturance of this alliance is necessary for both actors, but mostly the psychologist. The professional will take the first step in demonstrating concern and care for the client’s suffering and at the same time will make an effort to mirror the positionality of the latter. A cooperative alliance between the therapist and the client creates a space where moral development can happen. Thus, this increases the success of the therapeutic process on ending the present violence (Elliot et al., 2011).

**Compassion and Sympathy**

Two feelings that interconnect with empathy and most of the times receive the same definition as the former are compassion and sympathy. Compassion is when the psychologist discerns their client suffering and are considerate about it. At first glance, compassion and empathy do not differ, since the first can also be constitutive of an empathic process. However, by looking attentively, empathy is better defined as the process of sharing feelings with someone, no matter the morality of those feelings. Compassion is directed to the suffering of the other and generates the emotional state of sorrow for the other, due to the experiences that the individual is facing (Beaumont et al., 2016). Compassion does not have an inferior status to empathy, and it is considered an act of care. Consequently, compassion is an important feminist ethics of care value.

As seen above, through Gilligan’s (1977) considerations, the sense of responsibility does not apply only to the other, but also to the self. The need to engage in a relation of care to oneself allows the psychologist to be able to conduct their best as a professional and, consequently, increases the therapeutic bond and the success of therapy. Self-care is intrinsically correlated with compassion and empathy since it signifies a look of tolerance towards the limitations and possibilities of one’s positionality (Slote, 2007).

Now, sympathy must enter the conversation. Hein and Singer see this affective state as the capacity for “feeling for the other”, both negative and positive emotions (2008, 157). Such moral sentiment differentiates from empathy, since the latter means “feeling as the other” (Hein and Singer, 2008, 157). In the therapeutic setting, the client can describe a harmful situation that they suffered as a child, which would make the therapist recognize this emotion and feel it, characterizing an empathic understanding. In being concerned with the client due to their suffering, but not indeed feeling the same pain, the therapist is acting sympathetically towards the client. Again, both are acts of care and values from a feminist ethics of care perspective (Slote, 2007).[^8]

[^8]: Empathy, compassion and sympathy are considered moral sentiments since they are capable to generate moral judgments (Slote, 2007).
Trust, Responsibility and Power

As mentioned before, responsibility towards self and other in feminist ethics of care is seen through the paradigm of relationality. Individuals are embedded in relations with others, and it is through the eyes of the other that moral regulation happens. Thus, responsibility to comprehend such interdependence is essential. In the therapeutic context, the psychologist recognizes the vulnerabilities of the client and establishes an ethical relation by having an empathic understanding. After the recognition, the professional has a moral responsibility of engaging with this suffering if they truly care about the client’s well-being and the ones involved (Tronto, 1993).

At the same time, the client engages in a relation of trust towards the psychologist. This trust is embedded in the certainty that the therapist, as a caregiver, will do their best to take care of the client. The construction of this trust will depend on a number of factors, among them, the institution where the therapist acts and the knowledge of IPV. From the psychologist's perspective, the trust posted on the client refers to the acceptance of the treatment and the recognition of conducting a violent act (Sevenhuijsen, 2003).

Therefore, trust involves cooperation from both actors. The client openly needs to share all the behaviours, thoughts and emotions that are part of the violent act that was committed. This openness can be extremely difficult due to the infliction of harm that is morally unacceptable. At the same time, the psychologist needs to be open to listening empathically to a content that might cause moral disgust. Moreover, it involves a recognition from both parties that therapy is embedded in relationality and interdependence. In this sense, becoming dependent on one another is only possible when both parts can count on each other.

Sevenhuijsen (2003) mentions the danger of labelling specific roles for therapist and client, even though their different positions lead to such classification. Understanding the care relation is problematizing the notion between rescuer and victim. As just seen before, both psychologist and client have a responsibility towards each other, the success of therapy and, in this case, the end of the violence. Indeed, their responsibility has different weights since the client is the one conducting the violent act. By holding more knowledge and being distant from the problem, the psychologist holds the power position over the client. The professional has no right to be considered the ‘rescuer’ because they hold an advantageous position, since the therapeutic process is of cooperation and interdependence, and the psychologist also has vulnerabilities.

Hence, it does not give permission to actually abuse their power over the client. The non-paternalistic process of care allows the therapist to act without control and imposition of their own believes. It implies an understanding of the client’s discourse. Since harm is constituent of this discourse, the moral development will be the priority of the psychologist. Sentiments that positively empower the client to conduct well will accompany such
development. Consequently, the psychologist acts with authority based on growth and care (Jones, 1993).

**Relational Autonomy**

Autonomy has traditionally been linked to an individualist notion of self. Self-governance, self-sufficiency and self-reliance are the main characteristics that an individual must have to be autonomous, according to a liberal morality based on rationality and justice. Feminist care ethicists argue for an autonomy based on care values such as interdependence and relationality. Their argument goes hand in hand with all the concerns of this section – the notion that self and other are in constant dialogue with each other and shape the construction of both identities and moral judgments. Consequently, ‘relational autonomy’ has been created as a term to highlight the respect and recognition for someone’s social-political surroundings (Christman, 2014).

Alongside autonomy, there is the notion of paternalism, which was briefly mentioned above. A paternalistic attitude limits individual’s autonomy since it takes into consideration that the latter is not capable of conducting moral judgments. The psychologist, for example, when imposing on their client a particular method of work or only one possible moral behaviour is going against the client’s will. This imposition shows a lack of understanding of the individual as a master of their own (Christman, 2014).

Paternalistic attitudes in an ethical relation have several levels, varying from the total eradication of autonomy to a soft interference. Often times, the professional can affirm that the client is not able to make decisions of their own, since they are governed through sentiments of harm and violence towards another. In this case, they mildly interfere with the autonomy of the client, since they believe that as soon as the client acquires knowledge, one will make better decisions. A strong paternalism, on the other hand, is characterized by the situation in which the psychologist does not think that the subject lacks knowledge or understanding, but even so continues to impose what one believes is morally right. In this case, the moral opinions of the psychologist are controlling because of the belief that the client will not develop knowledge that is necessary for behavioural change (Christman, 2014).

Relational autonomy calls for an ethics where the professional engages dialogically in the process of developing the client’s moral behaviours, and this leads to better decision-making. Through the reflection on the client’s feeling and attitudes towards others, the psychologist can show the importance of compassion and empathy towards another position. Moreover, the attachment between them will possibly demonstrate a relation of trust and care in which the client might not be used to but can replicate one’s own intimate partner. Relational autonomy allows the cooperation between therapist and client to grow, to eradicate
paternalism – weak or strong – and advance the client's perceptions towards what it means to conduct morally acceptable actions (Christman, 2014).

**Final Considerations**

In this section, I outlined the main concepts in a Feminist Ethics of Care. Gilligan (1982) argues for the problematization of the individualistic and universalizing view of Kolhberg's theory of moral development. Through the relationship between mother and child, Gilligan demonstrates that the self interacts with the other interdependently and responsibly. They remind us that we cannot consider only moral acts as that which is right or wrong for the self since we have responsibility towards the other.

Tronto (1993) enhances the argument by affirming that this other is not only personal but also political. This social-political view means that the relationship between self and other is inserted in a context. The political and social actors at play are also interdependent with the self, at a different level. At the same time, Slote (2007) adds that empathy is the key sentiment for a relation of care to actually take place. It is towards empathic understandings of the other and the community that the self will be able to have moral attitudes of care. Trust, compassion, sympathy, power and relational autonomy appear as care values of the connection between self and other.

In this section, my aim was to advocate for the understanding that an empathic and caring relation is only possible when both actors relate to each other in an interdependent level. Besides, through the work exhibited here, I argue for a plural morality where right and wrong are seen through the concern for the vulnerabilities of the self, the other, and the context in which both are inserted. The theoretical framework presented will serve as a basis for the investigation of the psychologists' perception.

After this theoretical exposition, I am now in a good place to analyse the psychologist-client relation through a feminist ethics of care perspective. In particular, I am interested in the question whether this alliance is based on an ethics where care and justice have similar importance.
Section Two
Context

Overview
As seen in the last section, discourses and perceptions of self and other are always inserted into a particular socio-political context. In this dissertation, the history of the studied institution and the transmission of its ideas contributes to the work conducted by the psychologists. Consequently, the way such work is led, and the fundamental principles behind it, influences the construction of the therapist-client relation.

In this section, I will present the empirical material of this dissertation. I will first return to the history of the institution that was briefly mentioned in the Introduction. Then I will introduce the participants of this thesis: six psychologists working in Sweden and Norway, and coming from different career backgrounds. Finally, I will briefly introduce the characteristics of the clients (perpetrators of IPV) that attend the therapeutic treatment.

The aim of presenting this group of perpetrators is to describe the therapeutic scenario vividly. However, the focus in this section is not the psychologists’ perceptions of their clients, but to outline the characteristics of the latter according to gender, age, nationality, class, education and sexuality.

Institution

Foundation
As previously mentioned, during the 1980s, the Norwegian criminologist Kristin Skjørtten had an idea that would revolutionize the field of IPV in the therapeutic setting. They held all the experience of working with women survivors in Norwegian crisis centres, to suggest that men who commit violence should receive therapeutic treatment. By that time, the Norwegian women's movement was quite influential among the state and society as a whole.

Initially, the project received state funding for three years that could be later renewed. However, even though the team of psychologists and the Norwegian criminologist had strong support from the women’s shelters and Norwegian feminists, in the first year, the project suffered an intense backlash. This reaction happened because of its controversial nature. The healthcare system and social services affirmed that the project served as an alibi for male perpetrators to continue committing violence.

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9 The participants of this research – psychologists working with perpetrators of IPV – provided the information in this subsection.
The stable dialogue between the women’s movement, women shelters and members of the project enhanced the comprehension of the importance and the type of work that was being conducted. It was thanks to their influence that the survival of the project was possible. Over the years, the project grew and turned into one of the most renowned institutions in Europe.

Today, the institution receives funding from the government, though there is a lack of municipal grants in a few of the Norwegian offices. This financial absence remains an obstacle for the institution because it limits its ability to offer treatment to some individuals. Without public funding, the treatment would cost 300 Norwegian Krones per hour. Also, there is no possibility for a refund of this amount from the healthcare system.

In 1997, the psychologists working at this institution studied female perpetrators of IPV. They inquired into the differences between men and women when committing violent acts. From this initial study, an internal project offering therapeutic treatment for female perpetrators started. The Norwegian law that obliged women to have the same opportunities as men made the institution’s internal project a permanent matter.

Hence, today, the eleven offices of the institution, spread across Norway, provide individual/group therapeutic treatment to both male and female perpetrators and violence towards their children. Intimate partner violence intertwines with this type of violence.

In Sweden, the National Strategies indicate the necessity of working with IPV, since this is a significant health problem in the country\textsuperscript{10}. Nevertheless, psychologists faced more difficulties when trying to establish a treatment centre for perpetrators in the country than their colleagues in Norway. The dialogue between the women's movement, women's shelters and the team of professionals willing to offer treatment was challenging because they did not agree on core principles. There is still a particular resistance from the healthcare system and the social services for applying the methodology established in the national strategies.

Even though there were obstacles and a public controversy, the professionals launched a community project in 2010, focusing on therapy for male perpetrators. They started without partnering with the aforementioned Norwegian institution. It was only after two years when they changed their gender focus by accepting female perpetrators as well that the Swedish branch run the treatment centre jointly with its Norwegian partner. By this time, the latter had constructed a solid expertise in the field of IPV. Both members share the same structure of therapy, though there are some differences in their treatment ground model.

\textsuperscript{10} A report conducted in 2016 by Statistics of Sweden shows that 25% of women admitted to "being subjected to intimate partner violence at some point in their lives" (Statistiska Centralbyran, 2016, 85). The report points out a lack of reported crimes which demonstrates that many more cases still exists even if not reported.
Enrollment

As seen above, a series of actors and institutions from distinct societal levels – national and regional authorities, health professionals, scholars and activists – are involved in the treatment process for perpetrators. In the Nordic countries, a perpetrator seeks treatment voluntarily, even if convicted and arrested. Dissemination of information on the offered treatment is essential for the institution to receive more clients and, consequently, reduce IPV in society.

The Swedish branch of the institution does not focus on a particular gender when disseminating their work to future clients. Rather, their target is all people that want to seek help voluntarily for their violent behaviour(s). There is an effort from the professionals to engage with other places that work in/directly with the field of IPV. The healthcare system and social services are their closest allies. During the meetings with these organizations, the staff present their work and give training on the nature of IPV. Every second year, the Swedish team conducts PR campaigns to promote their work. The justification for providing therapeutic treatment to perpetrators for other professionals is something frequently discussed. The psychologists emphasize the need for focusing on violence since it appears as an important social theme.

Similarly, in Norway, the different offices of the institution focus on all genders and ensure that their work is visible. In order to attract people, the Norwegian agencies have different tactics. Conferences about violence are one of the mechanisms used. The staff members of the institution conduct lectures and workshops with staff members of schools and hospitals on the topic of violence within the family, the consequences of violence and key signs for identifying it. Reaching out to nurses to dialogue about IPV is another form of spreading the word. Advertising the institution on the internet, newspapers and cinemas are used to attract people and inform the population about the institution.

The child protection services and family therapy offices refer potential clients to the institution. Their cooperation goes beyond this since the Norwegian staff counts on these organizations’ efficiency when necessary. Another way to book a therapy session is by calling the institution directly or calling the Red Cross help line and/or the Crisis Centres.

There are various reasons for perpetrators to seek treatment. For some of them, it is their partner that demands the search for treatment and threatens to break up with them if they do not take such action. For others, the concern about their actions and identity as a violent person is the biggest motivation. Some clients want reassurance that they will not begin a new relationship with violent mindset. The motivation for improving their identity as fathers is also important for some clients.

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11 The participants of this research also provided the information of this subsection.
In most cases, the clients search for treatment happens immediately after a crisis begins. This period is when they are most emotionally vulnerable and in search of options that before were seen as impossible. For the psychologists, the ideal situation would be to receive a call in the first incidence of violence, rather than when violence has already happened. This preference is because, in most cases, when violence occurs, the relationship is irreconcilably destroyed and it is very difficult to repair it.

Apart from local strategies, the institution ensures an open dialogue at the national level to continue its work. It is important to make the institution reachable also to those that provide funding for treatment. There is an effort from the institution’s director to meet with politicians or governmental agencies. The results of such dialogue are visible since the current opening of new offices indicates the possibility of treatment to different regions.

**Therapy**

The length of treatment varies between clients, but it is approximately 15 to 30 sessions in the Swedish office, and ten to 15 sessions in the Norwegian offices, for individual therapies. Some psychologists ask their clients to attend therapy for a minimum of half a year. This solicitation is because they want their clients to appreciate the process of patience, by highlighting that the act of change takes time and effort. For the group therapies, the typical length is 24 sessions. This longer length is because professionals focus on having an impact on the clients that are not motivated to stay, in an attempt to reduce the number of drop-outs. The sessions are conducted weekly.

The Swedish branch of the institution provides an online treatment for clients, with the aim of reaching a different population that do not want to attend individual/group face-to-face therapy. At the same time, the Norwegian branch of the institution initiated a new project with male refugees to inform them about laws and rights in Norway, different types of violence and the consequences for those exposed to the violence.

**Institutional Training**\(^\text{12}\)

The professionals employed by the institution mentioned above chose to work precisely with perpetrators of IPV in the therapeutic setting. It is rare to see recently graduated psychologists with experience in clinical work with this group of clients. Bachelor and Master degrees tend not to teach their students about violence in general and much less about the therapeutic process involving perpetrators. Therefore, it is necessary for the institution to provide adequate training to the new therapist on the institution model and its theoretical frameworks. The institution acknowledges their psychologists as unique individuals immersed

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\(^{12}\) The participants of this research also provided the information of this subsection.
in different surroundings, consequently, relating to their work differently. However, even with such understanding, the institution believes that its training provides an equal and necessary basis to all staff members.

Reviewing previous literature about violence and the structure of the institution are initial steps taken by the psychologists to familiarize with the contents of their job. The institution provides an initial course at entry level where the professionals learn about the institution’s history and its approach towards IPV.

The institution ground model centres on four pillars: the history of violence; responsibility; consequences for the clients and their intimate partners; and end of violence. In Sweden, because of work preferences, professionals have modified the ground model by adding more guidelines.

The institution perceives IPV as a both structural and individual issue. For the professionals, violence is one of the symptoms of a romantic relationship facing challenges. Also, it represents the power of men over women manifested in the societal scenario. Gender inequality and rigid masculine/feminine norms merge with the individual psychological understanding of self, other and the environment.

What is in the clients' background that allows psychologists to comprehend the violent act? What are clients' notions of masculinity and femininity that contribute to an unequal relation with their intimate partners? What are the social and political forces contributing to the appearance of the violence? These are a few questions that guide the psychologists to observe the gender power approach illustrated in society.

For one year, therapists receive supervision from more experienced psychologists. During this period of training, professionals have the opportunity to design the type of treatment they are going to provide. The institution encourages them to develop a therapeutic model that combines the principles of the institution's ground model with the psychologists' theoretical preferences and the particular client in therapy. This combination ensures that the needs of each client are going to be met since it rejects one fit-all type of treatment.

**Psychologists**

This thesis investigates the discourses of six psychologists working at the studied institution. Two of them, Fabian and Erik, work in the Swedish office. Bianca, Luca, Paul and John work in different Norwegian offices across the country. These professionals started working at the institution in distinct periods. Two of them have been working for one year, one

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13 The participants in this study also provided the information for this subsection.
14 The names of the participants – Erik, Fabian, Luca, Bianca, Paul and John – were randomly chosen. Due to the ethical consideration regarding anonymity, I had to choose names that did not resemble at all the original ones.
of them for about ten years and three of them since the institution respective foundations (Norway – 1987; Sweden – 2010).

Fabian decided to apply for his current position – psychologist conducting therapy with perpetrators at the Swedish branch of the institution – as soon as he saw the job announcement. At the beginning of his professional career, Fabian worked with clients who had psychosomatic complaints, such as headaches and body pain. Many of his clients were experiencing violence in their relationship, which helped Fabian to become familiar with the field. After this job, Fabian worked at a treatment centre for people with addictions, such as alcohol and substance abuse. Violence was also a present theme in this group of clients.

Fabian’s colleague, Erik, took a significant change in his career when accepting his current job as a psychotherapist for perpetrators in the Swedish branch of the institution. After 25 years working with teenagers and adults with drug addiction in a psychiatric hospital, the licensed psychotherapist was motivated to look for something new. The daily commute to a different city to conduct his work became an obstacle. Besides, the former nurse was already interested in treating clients with a particular issue, which lead him to the field of IPV. It was not that he was entirely unfamiliar with the area since some of the children he met at the psychiatric clinic were suffering from violence in the family. However, violence was experienced from a different perspective.

Similarly, John also spent most of his professional career working at drug abuse centres, before accepting his current job as a psychologist conducting therapy to perpetrators in one of the Norwegian offices. He explains that the interest in working with this phenomenon and, consequently, at the institution, was more of a coincidence of life events than a strong desire. Since the start, John has been very pleased with working with the institution and affirms that nothing else can satisfy him. His involvement with IPV not only appears by being a therapist for perpetrators but also to survivors. His speech demonstrates that he is very proud of being able to see all sides of the family in such a complex phenomenon and assist the men, women and small children involved in it. Apart from his work as a therapist, John researches IPV in the family context.

Paul also does research apart from being a therapist for perpetrators in one of the Norwegian offices. Paul started to work at the institution after finishing his education in Psychology. The psychologist shared his fascination for the influential aspect of Norwegian criminology on his work and, broadly, in the field. His research addresses important issues that contribute to the alliance between therapist and client in this precise therapeutic setting. Paul also conducts training groups and lectures for newcomers when entering the organization.

Paul’s colleague, Luca, had six years of experience in a psychiatric intensive care unit before starting to provide therapeutic treatment to perpetrators in one of the Norwegian offices. Luca shared his discontent with working as a regular psychologist at the hospital unit and the
fascination of his current job, which he considers more dynamic and complex. The psychologist explains that when finishing his studies, he had the opportunity to train as a therapist at the studied institution under the supervision of a licensed psychologist. This helped him to get familiar with the phenomenon of IPV.

Bianca showed her surprise with her satisfaction of working with adults in the therapeutic setting. The psychologist works with perpetrators in one of the Norwegian offices. Before, she worked with children and youth at a local Swedish school and with adults outside the country. Bianca also had experience working with drug rehabilitation. Her first contact with the institution was through her university. She participated in a lecture given by one of the founders and considered particularly interesting the way the institution understood IPV. Her engagement with this came from the curiosity of understanding the causes of the violent behaviour. Since her speech always came back to her connection with children, I could not ignore that her concern for the child involved in the violent scenario is one of the biggest reasons for conducting her work.

**Clients**

The clients consist of men and women who commit violence against an intimate partner. Some of them also commit(ed) a violent act against a stranger and/or their children. 10% of the clients attending the Swedish office are women, and 90% are men. In Norway, the clients received are mostly men, but they periodically receive women as well.

In the virtual programme that the Swedish treatment centre provides, there is a gender symmetry among the clients (50% each gender). According to the psychologists, the difference in attracting more female perpetrators to the online programme is related to shame. Since the culturally normative identity of a woman involves care, it is more shameful for female perpetrators to physically attend the institution.

Fabian and Erik receive Swedish citizens – born and raised in Sweden – but there are a few clients of different nationalities who immigrated to the country. The Swedish branch of the institution believes in the need to adapt and change the treatment for people from different cultural backgrounds. The psychologists are still unsure if the current treatment fits all their clients, due to norms of masculinity that differ between societies.

John, Paul, Luca and Bianca receive mostly Norwegians as clients, but depending on the geographical location of their office, there are also many foreigners who seek treatment. Clients from different parts of Europe – especially Eastern Europe – South America, North America, Asia and Africa attend the therapeutic treatment at the institution.

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15 The participants in this research also provided the information for this subsection.
The institution in both Nordic countries receives clients from different age groups. Most of them are between 30 and 40 years old. However, the institution accepts any individual from 18 years onwards. Youth perpetrators are present in society but rarely seek therapeutic treatment. The 40-year-old male perpetrators attending treatment, frequently, are in a particular phase of their life journey. They are starting a family, having children and becoming financially stable. The pressures of acquiring such factors can be influential on the violence committed. Having children is an important motivation for seeking treatment since most of the clients start to reflect on how the violence will affect their kids negatively. The institution very rarely receives a client who is not a parent.

The clients are sometimes individuals with low education, working as carpenters or with a profession using their manual skills, but equally, very well educated individuals, such as bankers, CEOs and members of the military. Most of them have their income, and, thus, do not depend on the government.

The institution rarely receives clients that are engaged in homosexual relationships. Indeed, of 200 clients per year, one of the Norwegian offices receives approximately two clients involved in homosexual relationships. The psychologists believe that the reason for this is the lack of information on the type of treatment that the institution offers, even though, they try to be very clear that any perpetrator included in any intimate relationship is welcome. A few years ago, one of the Norwegian’s offices conducted a large-scale project to motivate members of the LGBTQ community to join the therapeutic treatment, but it was without significant success.

There are many reasons for someone to act violently towards an intimate partner. For some people, violence is a form of control used to win a particular discussion. To others, lack of communication towards an intimate partner is the biggest trigger. Very often, clients do not have proper ways of handling difficult situations and feelings. They feel rejected and reduced by their intimate partner. The use of threats, for example, is a way of coping with this fragile ego.

In the Swedish office, 70% of the clients have witnessed or experienced violence themselves in their home. Consequently, most of the time, the professionals consider that IPV was a consequence of the trauma experienced. Since in their childhood, most of the clients have learned to deal with their emotions by using violence, they reproduce the same behaviour when they become adults. Fear, anger and powerlessness are regulated through violent acts.
Section Three
Approach

Methodology

Presenting the data of this research was something that involved a lot of reflection on my part. I was extremely cautious to not include myself in an objectivist god-trick situation that rejects all the feminist aspects that I have been nurturing. A few analytical tools helped me to conduct such presentation, and to analyse my data. Jacques Derrida’s deconstruction (1988) and Karen Barad’s intra-action (2003) helped me to interact with the dissertation’s data dynamically.

Derrida’s deconstruction was an important complement on this way of thinking. Communication and representation never separate from the psychological-social-political reality surrounding it. Thus, in this dissertation, the emergence of meanings appeared in the engagement between the data within itself, with me and with the field that this thesis is rooted. It is a form of constant dialogue (Derrida, 1988).

To illustrate, I considered the theme of identification, where the psychologists’ perceptions of the clients and the clients’ perceptions of the therapists interact with each other. I asked myself what this theme was saying regarding their alliance. Moreover, I thought about the ways it could be connected with ethics and morality. I moved on to another item where I looked into the vulnerabilities of the clients. But then an aspect of this issue also correlated with the identification theme. So, it was a constant movement of creating a large scenario of what the content was trying to tell me, but also reflecting on what I thought that the data was telling me according to my understandings.

In my view, Barad’s considerations on language fit with the relational aspect of this thesis, one that is embedded in a feminist ethics of care. Barad uses the notion of performativity to transform speeches from fixed grouped words to active constructs that delimit several different meanings. The author reminds me that speeches and texts are always inserted in context, and its meanings should be considered in relation to this context (Barad, 2003).

With this in mind, I observed the psychologists’ statements as discursive practices, in the sense that I am steadily dialoguing with them to be able to understand their different meanings. By transcending their linguistic form, I am actively engaging with my dissertation data. For example, the psychologists spoke about various topics that in some way correlated with each other during the interview. In section four of this thesis, I analyse such speeches by grouping them in different themes. It is only through the constant exercise of merging the issues that I could find its meanings. These meanings are not fixed, but always interacting with each other and constitute different correlations.
Barad’s (2003) conceptualization of intra-action assisted me in understanding more about this dialogical way of relating to the dissertation’s data. The notion of intra-action denies the possibility that factors determine the meanings of language and representation beforehand. On the other hand, it is within relationality that language will gain representation and significance. It is through Barad’s questioning on the materiality of science that intra-action arises. Barad demonstrates that instruments in a laboratory, for example, become something else when in relation to the researcher using it. At the same time, the researcher also has a new becoming because of the material used.

In the case of this dissertation, I am taking into account the performativity of matter to connect with the spoken words that I have acquired from the interviews. Thus, in my case, I am not talking about Barad’s apparatus, but using its symbolic meaning to demonstrate that language is a multiple construct constantly changing and becoming something new. The reality that I am trying to grasp in this dissertation is the one that emerges from the intra-action between me and the material and consequently, me and the participants, the institution and the field (Barad, 2003).

I believe that considering language in the ways just described above is a form of creating a proximity and attachment with the dissertation’s content. Such proximity allows me to critically engage with the data as if I am an active participant in them. My considerations of morality and ethics and consequently, my understanding of the world influence how I am representing the material in this thesis (Barad, 2003).

In sum, by using the analytical tools presented above, I am not relating to my data in the way of finding the ultimate truth. On the contrary, I am considering that truth is relational and will become possible according to different questions. In this thesis, I am intra-acting with the discourses presented by the psychologists in a unique way and with a specific inquiry in my mind. As I produce them, they produce me. If such discourses were analysed for different purposes and by a different person or time in my life, the meanings would differ (Barad, 2003).

Methods

To understand the psychologists’ perspectives towards their clients and to explore my research questions, I decided to conduct in-depth, semi-structured, individual and face-to-face interviews with the participants. The interviews were tape-recorded. On the first day of meetings, one of the participants cancelled at the last minute, and we conducted his interview through Facebook Messenger with the video tool. It was the only non-face-to-face interview. The interview questions involved the therapeutic process at large – participants’ career background, the structure of the therapy and aspects of the therapist-client alliance.

The aim of using the semi-structured interview method was to avoid the restriction of speeches to a particular repertoire. I wanted to allow the participants to conduct free
associations regarding the questions asked. But equally, I needed a structure to organize my thoughts and not lose any relevant questions (Hesse-Biber, 2014).

Taking into consideration that an interview goes beyond asking and answering questions in the search for a unified truth, I wanted an interview method that allowed me to have the dialogical fluidity between the participants and myself. At the same time, a process of inquiry in which the spoken word was not only the one taking into consideration but all the hidden meanings in it (Derrida, 1991).\(^\text{16}\)

I have chosen the institution mentioned earlier due to its excellence in the field of IPV. Moreover, the particular way of seen violence with a mix of social, political, psychological and gender lenses caught my attention. The process of acquiring participants was conducted online. My first contact with the institution was through different emails to all offices in Norway and Sweden. I introduced myself, explained briefly the aim of my research and my desire to do interviews with psychologists working in the field. I emphasized that the interviews would be face-to-face, anonymous and would last approximately one hour and a half. Along with my availability and an invitation to participate in the study, the email was finalized with a request for the institution to spread the word among the staff to assist me in finding participants.

After four days, I had received only one response. I waited approximately five days until sending additional emails, this time individually to each member of the institution. The email addresses were available on the institution's website, where I could see the names of the professionals by their respective office. Out of 39 emails sent, I received eight responses. Five of them were positive (and arrangements were made).

One week before conducting the interviews, a female psychologist working in a different office from where I was planning to go, sent me an email and expressed interest. We decided to conduct her interview through Skype, but she dropped out at the last minute, due to a sickness in the family. The lack of female psychologists in this study happened because no more than one female psychologist showed interest to participating in my study. This aspect is considered a limitation for the in-depth understanding of the differences between the genders when relating to the client, regarding how the psychologists’ positionality interferes in the alliance with the client.

**Ethics**

In the beginning of each interview, I re-introduced myself, explained the purpose of this thesis and the content of the meeting. I asked the participants to sign a letter of consent before

\(^{16}\) Derrida’s work “Signature Event Context” (1991) was a great influence when preparing the interview process, communicating with the participant and analysing the psychologists’ discourses.
I started asking questions. At first, the interviewee read about the topic of this dissertation and my details (university, supervisor, emails, Master’s programme).

Second, all the details of the interview – anonymity, face-to-face, semi structured, conducted in English, length, purpose – were described. I made a note explaining that the interview was going to be tape-recorded, but once this study was finalized the tapes were going to be destroyed.

Third, the participants agreed that their participation was entirely voluntary since none of them received monetary compensation for it. Also, the participants could withdraw from this research at any time and for any reason. The content of the interviews would be available to the psychologists before its publication only if quotations were used.

Fourth, I also explained that I would maybe require a follow-up interview through Skype if further information or clarification were needed from the participants. The details about the presentation of this thesis and publishing were also included in the letter. I informed the participants that the results would be published online at Linköping University Library and maybe, in the future, in academic journals.

The ethical considerations of this dissertation were grounded in the Swedish Research Council Guidelines for qualitative research. It was a concern of mine to clarify that all necessary steps were taken to ensure anonymity, confidentiality and professional secrecy. The data of this research deals with human relations and a particular body of work that is extremely sensitive. Therefore, before conducting the interviews, I reflected on ethical aspects of consent, research information, data sources, my role as researcher and the presentation of data. All this information provided in this paragraph was also explained in the letter of consent. To finalize, I made myself available to the participants during the entire research process and promised to send them the final version of the thesis, if they wished to see it.\textsuperscript{17}

\textsuperscript{17} This was done according to the guidelines of the Swedish Research Council Guidelines for Qualitative Research (Vetenskapsrådet, 2011).
Section Four
Analysis

Preface

“There are many reasons why people use violence and, still, we treat the group of perpetrators as perpetrators. It is (will be) great to see when things change” (John).

John’s quote above appears to symbolize the psychologists’ perception towards their clients, perpetrators of IPV. It demonstrates the stigma that rises on committing violence towards an intimate partner. Also, it illustrates a hope that, one day, the negative label will no longer be part of society. Finally, it acknowledges that people use violence because of many reasons and not out of the fact that they are pure evil or mentally disabled. If I only read John’s quote, I would think that the psychologist-perpetrator alliance is embedded in understanding, lack of prejudice and affection. However, my findings proved that such collaboration is more complex than it is represented in the quote above.

In this section, I am going to present the psychologists’ perceptions towards their clients, the violence committed and the therapeutic process. The therapy involves a constant back and forth dialogue between ethics of care and justice. I can see values of care taking place in the psychologists’ examples and their understandings of the clients. But I can also see a huge commitment to the concept of violence. The success of therapy means the end of violence. I would say that it seems as a kind of traditional form of justice, in which the universal moral principle of not hurting the other is applied. However, is justice so rigid?

Following the theoretical considerations of section one, especially Tronto’s (1993) understanding that ethics of care and justice complement each other, I am advocating for an ethics of relational justice. This notion means that through the psychologists’ discourses I am going to question the fixation of justice and point out that actions rooted in care are not only effective for the therapeutic alliance, but necessary. Through such ethics, punishment is not only seen as individualistic, violence is not only the individual’s fault, and responsibility means more than stopping the violence, but nurturing autonomy and connection.

The subsections were constructed according to my first research question regarding the ways in which the therapist-client alliance is built. It is through identifying with the other, allowing oneself to enter into a relationship, sustaining a connection, balancing issues of power and confronting oneself with moral considerations that the psychologist engages in a bond played by two, but represented here with just the view of one. The examples shared by the therapists are presented as stories, most of the times, since I wanted to exercise creative
writing. Moreover, keeping in mind my methodological considerations, I try to dialogue with the psychologists’ speeches by engaging with the theoretical considerations of section one.

As mentioned in the introduction of this thesis, creative writing induces the appearance of my embodied self and creates fluidity in the text. It is not only a resistance to a singular acceptable form of writing academically but a way of thinking different. I believe it is relevant to use in this section because it will generate a vivid resemblance to the interviews conducted and consequently, approximate the reader to the content that is present. Through creative writing, I am aiming to evoke a different feeling for the reader and myself, a connection in which one was not used before. This imaginative bond with the text might allow the reader and me to make different associations and enhance plural knowledge (Lykke, 2014).

Identification

The clients arrive in therapy with many expectations in mind. Luca explains that some men are relieved when they come across a male psychologist because they can relate better to someone of the same gender. Clearly, this kind of thinking was something very uncomfortable to Luca. At first, I was confused about his feelings, but, then, he tells me that he is a feminist and most of his clients are not. In his logic, the clients believe that a male psychologist will have the same patriarchal perception of women that they have. Thus, when this generalization of men into one homogeneous group occurs, Luca contradicts his clients’ point of view and make sure to denote that he is in a different position.

Similarly, John shares that his physical appearance, traits of his personality and his different nationality are advantages for the clients’ association with him. The fact that he is not Norwegian, and had to adapt to the culture is one important aspect of the connection. Also, for some clients, John is not someone that they expect to encounter. This surprise is because he has a more direct and confrontational way of communicating which is not common among Norwegians.

In a similar situation, Paul affirms that his physical appearance is an identification factor for his clients. Cautious, he starts his explanation by clarifying that this is not something that he planned, but his male clients perceive him as a masculine man because of his body and his voice. It was through Paul’s inquiries about trust that he discovered this fact. Several clients affirmed that upon their first encounter with Paul, they perceived him as a violent man. Astonished, Paul understood that they thought he was a violent man because his physical appearance was similar to theirs.

Here, it is clear that even though Paul has never been a violent man, his clients viewed him as a reformed perpetrator. For Paul, the reason for this has to do with the necessity for connection. The professional explains that his clients were afraid of being misunderstood.
Hence, perceiving the psychologist as someone that could have committed violence in the past, and now has the position of knowledge, gave them hope to be comprehended.

Above, Luca, John and Paul shared with me interesting aspects that influence the client-therapist alliance. It is through matters of identification that the client feels comfortable to share aspects of their life and the violence he has committed. The discourses provided above demonstrate that for the client, having a relationship of trust means seeing oneself in the other (the therapist). This aspect could signify the beginning of a dialogical intimacy between self and other. However, by the moment that the psychologists – in the particular case above, Paul and Luca – position themselves differently from the client, such attachment gets shaken. The client will need to find another identification trigger, to strengthen the unstable bond.

For me, it was interesting to observe that stating a different positionality came from the psychologists’ need – consciously or not – of proving a different moral understanding of the situation. They are demonstrating that engaging in a relationship of oppression or harm is not the ethical consideration that they have with another individual. By affirming the truth – being a feminist and not committing any violent act – the psychologists are inserting themselves in a different level of understanding towards the rights and wrongs of social relations. Such understanding allocates hierarchical power positions between the actors. Hence, the psychologists will have to find a different form of sustaining connection with their clients if their wish is for the alliance to grow.

Psychologists’ perceptions towards their clients also contribute negatively or positively for the construction of the therapeutic alliance. As seen before, because of different opinions towards society and/or moral judgments, the relationship between the client and the therapist can get shaken. Consequently, the psychologists’ negative perceptions can reach the point in which it is impossible to continue therapy. On the other hand, if a real understanding takes place, the psychologists strengthen the affection and observe their clients empathically.

Fabian refuses to think of their clients only as perpetrators of IPV. He believes that viewing the clients in this form pushes them away from the therapeutic setting. Moreover, the professional considers it an unfair stamp since it does not represent the clients’ nature as human beings. Rather, it serves to negatively label individuals due to the wrongness of the moral conduct.

Likewise, Luca, Erik and Bianca affirm that they have never met perpetrators of violence. The psychologists see them as human beings that have used violence in intimate relationships. Bianca advocates for recognising her clients as individuals who made wrong moral choices. Paul agrees with Bianca by saying that, in general, people do not want to be evil. They are just persons found in the situation of violence. Paul’s perspective becomes
clearer by John’s acknowledgement that the acts committed by his clients could be his in other circumstances. He finds himself fortunate to sit in the psychologist’s chair.

Luca shares a situation when clients disconnect from the self and acknowledge the difficulty of Luca’s position. They claim that sitting in front of a perpetrator of violence must not be easy. When this happens, Luca is determined to separate the client from the act, since he believes that the overwhelming feeling of identifying oneself as a perpetrator is not helpful for the therapy and the client to take different actions.

John shares another way to separate the clients’ identity from the acts that they commit. In the therapeutic setting, he starts making links between the actions undertaken and the clients’ positionality as soon as possible. Bianca believes that making this separation helps clients to be perceived differently from the image of monsters that the society might impose. She explains that associating perpetrators with the violence would be the same to correlate them with a disease; in the sense that the psychologist never believes that someone is a diagnosis.

The speeches of Paul and John above illustrate the psychologists’ empathic understanding towards their clients. Revisiting the theoretical considerations of empathy that were presented in section one, this concept is a process of considering oneself in the place of the other. When John points out that he could have the position of a perpetrator if his surroundings were different, for a moment, he becomes the client. Consequently, he absorbs emotionally and cognitively the client’s embodied self.

All the psychologists share their perceptions of perpetrators as any other human beings. Fabian points out that staying in the position of a perpetrator is only one aspect of what it means to be human. They try to distance the client from the violence in an attempt to avoid any form of judgment. However, if I consider Luca’s speech, it appears that this act is a therapy tool for encouraging the client to change. When the psychologist affirms that identifying oneself with the label of being a perpetrator can be overwhelming, it could mean that he, symbolically, moves from the position of self to the other. In other words, that he has an empathic understanding of the client. But with only the scant information above, my analysis remains uncertain.

Bianca affirms the wrongness of her clients’ moral choices. It seems to me that her speech is similar to the discourses mentioned before when Paul and John positioned themselves as morally different. When Bianca identifies the ones committing the violence as morally improper, she is automatically disconnecting herself from the title, since she did not commit any violent act. I am pointing out this aspect again because I think it has a significant impact on the way the psychologist builds the therapeutic relationship. So far, Bianca, Luca and Paul demonstrate that such interaction is constructed through the establishment of clear ethical boundaries: the ones that harm and the ones that do not.
In another part of the interview, Fabian, John and Erik affirm that it is not always that they perceive their clients positively. Fabian, for example, contradicts himself. At first, he claimed to refuse to consider his clients as perpetrators, but later he revealed that sometimes he classifies the clients as bad individuals who only want to hurt other people. For him, as a psychologist, it is important not to trust everything that his clients say since they might not tell the entire truth.

Fabian’s statements slightly confuse me. As it was pointed out earlier, the psychologists advocate for a perception of their clients as more than perpetrators of violence and, hence, evil beings. They defend a view of them as regular individuals with improper moral choices. If that is the right ethical way of considering perpetrators, the only explanation that I can think of regarding Fabian’s statements refers to a matter of empathy, sympathy and compassion.

My hypothesis is that when Fabian faces clients who clearly do not show any shame or regret from the violence that they committed, Fabian is not able to put himself in the position of them. He is not even able to feel sympathy or compassion for the clients. This difficulty of engaging with moral sentiments is because the lack of shame and regret on the clients’ side is completely against Fabian’s mindset of what it is morally correct. In the statements above, Fabian considers not trusting his client when they face lack of regret and shame. Therefore, Fabian gives them a form of punishment or, in a sense, justice, by not trusting the client’s speech.

Another example of contradiction is John and Erik’s statements about female perpetrators. At first, John demonstrated an empathetic understanding towards his clients and affirmed that he separates them from the violence committed, in order not to consider them negatively. However, in another part of the interview, he claims that it is hard to have the same mindset towards his female clients. He justifies through identification. As a man and a father, John relates better to his male clients. Furthermore, he elaborates on his views towards female perpetrators that arrived at the office. The latter are entirely open about their issues, in the sense that they know about the seriousness of their acts and take responsibility for them. In comparison to his male clients, women do not try to minimize their role in the violence and to neglect their fault, which is something that many men do.

Similarly, Erik’s perceptions towards female clients are influenced by a societal standard understanding – could be called a norm – that women cannot conduct harm towards another person. The psychologist did not have an extensive experience working with female perpetrators during his career, but he emphasized his rigid view towards this group of clients. His perception appears as a blind spot for his work with the client and consequently, for his position as the psychologist.

I found it interesting to hear John and Erik’s statements related to this issue. In John’s case, he initiates the session by talking about his positionality and the identification of the
similar. Here, I come back to what I reflected on before on the client’s identification with the therapist. The similarity of positions (man and father) allows the therapist to connect better with the other.

Afterwards, John talks about the openness that his female clients have towards the violence they committed. This aspect seems to scare John. As if there is no actual logic for a woman to be conscious about their violent acts and still be able to conduct it. Here, I can connect with the considerations I made about Fabian’s statements. For John and Fabian, it is impossible to consider that someone would still commit violence even knowing about the moral inadequacy that it entails.

It is with this same argument that John reminds me of the Gilligan and Kohlberg’s discussion on women’s morality. John affirms that contrary to men, he sees women taking responsibility for their actions, instead of minimizing their role in it. Going back to the theoretical framework of section one, it appears that John accepts the findings of Gilligan’s study. The female perpetrators exhibit the relational notion of self and other in moral considerations, akin to Gilligan’s female participants on the abortion issue. Comparably, the male perpetrators emerge with the individualistic thinking that an ethics of justice advocates.

Now, I come back to Erik’s speech. It shows that the positionality of women as mothers and caregivers were implicit in his perspective. For Erik, it seemed difficult to accept that a woman can act morally improperly, due to her nature. I find it clear that a dominant social perspective that violence is not morally acceptable for women influences Erik’s mind-set. Also, I can identify a rigid conception of women’s nature and roles. It appears, through his speech, that if a man commits the violence, the psychologist – and society – can understand the man’s reasons for doing so, due to the community that raised him with oppressive and discriminative norms towards others. But if a woman commits the violence, it is impossible to accept, since society raised her to be kind to others and remain in a position of passivity. Therefore, it seems that harm is valued hierarchically from a moral point of view.

**Attentiveness**

As presented in the theoretical framework of this dissertation, it is through the attention to the vulnerable other that the self can assist on the other’s need. Hence, caring about is the dialogue between attentiveness and assistance. This practice involves empathy and other moral sentiments since the caregiver needs to be concerned with the well-being – desires, emotions and thoughts – of the care receiver. With this in mind, and to be able to understand better how the psychologist-perpetrator alliance is constructed, I turn to the care value of attentiveness.

Luca points out the importance of perceiving the client as an individual with vulnerabilities. Bianca claims that her clients are mostly afraid to be disliked when sharing
information about the morally wrong acts and/or thoughts that they committed. I could imagine the scenario.\textsuperscript{18}

The client starts to talk about the violent act. \textit{It was a little bit before supper.} He speaks calmly. \textit{I was jealous.} He slowly looks at the psychologist. \textit{I mean, she provoked me the entire time.} He articulates faster. \textit{I did not know what happened or how I came to hit her. I spoke about something, and her answer was not right. I just throw her through the stairs and kicked her head into the TV set.} He continues to give Bianca details about the intensity of his acts. As he tells about the description of the wounds, he looks at her with curiosity.

\textit{Is she considering me less? Is she going to be abusive because I hit my wife? Is she going to understand my side?} He continues talking about the despair of his wife and the children walking in on her while she was still on the floor. Bianca makes a slight movement with her eyebrows. \textit{I knew it! You are going to judge me now,} he thought silently. \textit{I wasn’t in control of myself, and I did not know why I reacted like that.} He tries to use all possible arguments to express a scenario where he was not the villain. He wishes to be liked by that professional sitting in the chair in front of him. After all, it was only through understanding that Bianca could help him.

The scene above, based on Bianca’s statements, illustrates the most vulnerable moment that her clients appear to be in when they are talking about moments of shame. Bianca reveals that their fear of not being understood and/or treated with respect is calmed when she gives attention to the clients’ sufferings. Fabian relates to this situation. He affirms that his clients are often scared of being condemned considered as bad persons by the professional. Johns complements that it is imperative for his clients to be not considered as bad men, terrible fathers and consequently, to have the feeling that the therapist despises them.

Until now, the psychologists’ statements demonstrate that their clients fear the most to be disliked, misunderstood, disrespected, and condemned, or to be considered evil individuals by them. Clients are conscious of such issues. Such consciousness appears in the statements above, but also in the subsection ‘Identification’, where I present the client’s expectations towards the psychologists.

Here, as I can see through Bianca’s scene, for example, the client’s fear of being considered secondary refers to the necessity of being cared. Maybe this need arises because of the traumatic environment the client was inserted when young, perhaps not. But what actually matters is that even though the client acted in a way that is considered morally unacceptable by the society, he wants to feel a connection with the person that he sought help from.

\textsuperscript{18} The following scene is my personal interpretation from a story told by Bianca.
For me, it appears that the hint of an effective way of constructing an alliance is in the client’s fear: based on care and responsibility, rather than justice and individualism. The client’s concern demonstrates that he does not want to be traditionally punished or being considered as one isolated subject that incites harms in a society of good individuals. This aspect shows the client’s awareness towards the relation with the other.

Symbolically, it seems to me that the client needs an ethical relation similar to a mother with a child in which the mother has the notion of herself being responsible towards her and the child, of the child’s responsibility towards the self and other and, consequently, of her responsibility towards the community. Thus, the mother thinks about the child in an affective and relational matter even though one did something wrong. This way of thinking is because justice became relational and inserted in a network, affecting not only the child but the mother and their surroundings.

Maybe therapeutic treatment is a form of ethically engaging with the other on matters of a relational justice, which means thinking about the entire context of the violence and not only individualistically condemning the person that committed it. Shortly, I will come back to this thought. But for now, I would like to keep in mind that through relational justice, the empathic understanding of the other does not deny the other’s need to be responsible for one’s moral actions. Rather, it allows the other to relate to such moral actions in a more autonomous and ethically more mature way.

Coming back to the interviews, the psychologists shared the practices they conduct to help the clients with their fears. To avoid clients feeling neglected, John consciously values their improvements. For the psychologist, pointing out the positive actions taken by his clients, even though they are small, is a form of acknowledging their growth. He shares an example with me.19

His physique was breathtaking. He had that long hair and skinny body that many women like. His charm was a plus for his success in the romantic arena. He had several relationships that were intense while they lasted. Most of them did not last long though because of his aggressive behaviour. The beating was never as problematic as the psychological abuse. He was never unfaithful, even though he had plenty of opportunities to be. It was common for him to receive sexual propositions or/to be flirted with. His profession allowed him to go away from home during long periods of time. Every time he came back, fights started. The insecurity of his partner increased every day. She was on the edge of a breakdown. She wanted to end the relationship but was intimidated by his reaction. He was always threatening to leave, but it was only empty words.

19 The following scene is my personal interpretation of a story told by John.
John explains that even though his client was emotionally and physically abusive with one’s intimate partner, he had an aspect that should be recognized by the psychologist: the possibility of cheating, but never doing so. For John, many men would not have the strength of saying no to propositions of sex, as his client did. The psychologist thinks that focusing on this aspect is a form of not only pointing out the negative sides. This helps the client to have a motivation for change and the psychologist to keep a balanced picture of the client entirely – the positive and negative factors.

Bianca also expresses the positive aspects and achievements of her clients, especially at the end of treatment. For her, showing satisfaction towards the improvement of the client’s behaviour and thinking is a form of demonstrating that change was established during the therapeutic process and to show her concern for the client.

In the statements of both Bianca and John, I understand that the psychologists focus on improvements and good moral conducts to enhance the value of their clients. This action demonstrates that they not only understand the client’s vulnerabilities but take measures to help them to overcome such fears. Within these extracts, it is uncertain to affirm that the psychologists are ethically engaging with their clients through the values of an ethics of care, since caring about the other is just one phase of a care relation. However, I believe that it also reveals that they are motivating their clients to continue acting appropriately. Thus, they are constructing a relationship where assistance and connection are based on the appreciation of the other’s ability to change to a better moral judgment.

With this in mind, I should provide the perspective of Erik and Fabian, regarding significantly valuing the clients’ good sides. Erik advocates for the balance between being empathetic and being critical with clients. Criticality on the clients’ appears when Erik dislikes their behaviours. However, he makes an effort to clarify to the client the parts that he empathises with. Erik’s logic is that if he manifests approval, he will tend to forget about the violence, which will not be helpful for the therapy. Accordingly, if he only focuses on the improper attitudes of the client, he will ignore the positive aspects that should be enhanced.

Fabian always tries to keep in mind that there is an outbreak of violence that took place, which means that someone committed it and someone else received it. For him, this reflection is necessary for psychologists not to extensively be on the clients’ side and run the risk of becoming their ally. Continuously agreeing with clients is an obstacle for therapy. Fabian highlights the necessity to challenge his clients during the therapeutic process. Accordingly, for him, there are two possible ethical sides that the psychologist needs to balance: one where he finds himself thinking that the client has not done anything wrong and the other where he needs to maintain a certain distance.

Erik and Fabian’s speeches are alike. Both demonstrate that the psychologist commitment should be both to the violence and the client. For me, it seems as if the
psychologists are unconsciously afraid of acting in a wrong way by perceiving their clients as a regular individuals and consequently, forgetting about the harm committed. As if when they do this, their image as psychologists becomes as wrong as that of someone who committed violence. Again, this reminds me of putting oneself in a different level of morality. Specifically, at this point, it gives me the impression that their fear matches with the clients’ fear, in the sense that they do not want to be judged and disliked by the observing society.

**Nurturance**

This subsection refers to the nurturance of the alliance between client and therapist. In a care ethical relationship, sustaining the therapist-client bond means reflecting on the ways to nurture empathy, compassion, sympathy and trust towards the client. In the following speeches, I am observing whether these care values appear on the ethical relation between psychologist and perpetrator; and the meanings that such values might have to the construction of the alliance between the actors.

For Luca, it is necessary to have respect for his clients’ stories. He believes that curiosity and willingness to understand what happened in the clients’ lives are crucial to feeling empathic towards them. Fabian complements that understanding the reasons for the violence are factors that keep him connected with his clients. Paul agrees with Luca that there is always a meaning behind people’s stories. Therefore, for the psychologist, it is always possible to understand the violence committed. The curiosity to listen to the story and understanding how his clients acquired their human ethical views of the world are crucial aspects for the therapist. Erik agrees with his colleagues by firmly believing that every individual has a reason for acting violently towards another.

Erik and John share the idea that one of the facets of the treatment is to talk about the context in which the clients have grown up in and the lessons learned from such context. Since the first contact, John tries to get closer to his clients. For him, this means making eye contact and an effort to show interest in the content being presented during the therapy – not only in the first meeting. Also, he believes that humour relieves the stress in the room, being a great ally for emotionally dense conversations.

Through the psychologists’ statements, I can understand that there are always reasons for perpetrators to commit violent acts. The professionals show that they are willing to take into consideration such pleading for a better understanding of their clients’ position. However, the participants might encounter many obstacles on the way, when listening to the clients during the therapeutic process. These obstacles appear because some of the actions and thoughts brought from the clients can be opposite to the psychologists’ point of view, which can become disturbing.
Paul reports that there are times where it is challenging to feel empathy for clients. On these occasions, anger appears, and he feels disgusted. During his career, Paul conducted therapy for sexual offenders, which has been particularly painful to him. It was at the same time that his children were growing up and coming of the age of the victims. This association affected Paul considerably. His most demanding clients, including the sexual offenders, transmitted to him a feeling of powerlessness as a therapist.

John experienced an episode where one of his clients threatened him in front of his family. Even though he was emotionally unstable after this intense episode, it helped him to grow as a therapist. He understood better the state of a person who is living with someone that ridicules, threatens and acts verbal, emotionally and physically violent. John feels that in an episode of violence, a sense of weakness is activated in the individual, because of the lack of control of the situation. Most of the times, this feeling generates frustration and anger.

Both John and Paul relate to their position and surroundings when treating a client. Paul talks about listening to the violence that his clients were conducting towards women who were the same age as his daughter. The psychologist’s anger comes from the fact that he imagined that daughters like his were suffering sexual assault. He was not able to connect with someone that would potentially hurt someone innocent and precious like his daughter.

I have the feeling that John felt something similar. In his speech, being threatened in front of his family entered his most vulnerable space. The weakness that the therapist felt was because he could not do much in front of the situation. It seems that the alliance between him and a client is only possible if boundaries are not crossed. The psychologist needs to trust the client and feel that violence will not be committed towards him or the ones nearest him. In this sense, the professional needs to be sure that a different relationship from the one that the client has with the intimate partner is being established. Trust, empathy and respect need to be the core aspects for the alliance to take place.

For Luca, the sentiment of anger also intersects with the capacity to empathize. When he is feeling angry because of something a client said during/outside therapy, he loses his empathetic understanding of this client. Luca is unsure on why this happens. The psychologist shared an example on the matter.20

They were in the second month of therapy. From the start, Luca and his client have been talking about the violence. The perpetrator committed severe violence towards his intimate partner. He was destroying his wife and children physically and consequently, emotionally. In therapy, the client was consistently affirming that he wanted to change his behaviour. Luca was happy, after all, the perpetrator wanted to stop acting violently. Since the

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20 The following scene is my personal interpretation from a story told by Luca.
beginning, they discussed some tools for achieving these goals, but it was difficult for the client to apply them.

It was a rainy day. The client came in completely wet. Before catching his breath, he affirmed his commitment to using the learned tools. Being a better father and husband was consciously set on his head as a goal. Once more, he claimed that change was in his future. Luca was motivated. In his mind, he finally influenced the client’s behaviour for the better. On the two sessions afterwards, the client showed impressive improvements. It was almost as if Luca was calling the other therapists and proudly saying ‘this is how it’s done’.

It was until the day when the sun was heating the office for the first time in two weeks that Luca had a meeting with his client’s wife. Meetings like this one were quite average for Luca to understand if his client was, basically, telling the truth. The woman was desperate. The violence was still very severe, and she could not have been more concerned about herself and the children. The terrible reality that she was living in was quite the opposite from what the client had been telling Luca.

Another week passed until Luca and the client met again. The client was complaining about his wife. He felt she was becoming more annoying every day. Luca realized that he was each day portraying himself more and more as a victim. He felt tricked. He knew violence was still taking place, even though his client was illustrating a reality of happiness. Irritation and anger invaded the room. Luca took it personally, feeling that he was a bad therapist for this client because he lost his ability to empathize with him. The frustration became too much to bear. Luca felt urged to act. He reflected that if he continued judging his client and feeling angry at him, he would lose his ability to relate to him. *We would have to end the therapy*, affirmed Luca emphatically to himself. The matter was resolved when the psychologist sought help from his supervisor.

Both agreed that the situation was pressing and the client was difficult to handle. But at the same time, they did the exercise to go back to the client’s personal history and find out the reasons for his actions. The supervisor reminded Luca of the client’s terrible childhood because of emotional neglect. The therapist tried to take the perspective of this neglected child and accordingly, to think of the client in this way. In the end, it helped him to relate better to the client.

Erik also talks about the challenge of hearing something from the client and realising that the reality was the opposite. For the psychologist, his work is similar to walking in the dark and having to see the way. The uncertainty of not always listening to the side of the client’s intimate partner is something that seems to scare him.

Above, Luca and Erik bring more complements to the aspect of trust to my discussion. As seen in section one, the theoretical considerations of an ethics of care demonstrate that mutual trust is needed in a care relation. From the statements above, I can observe that the
Psychologists expect their clients to be committed to therapy, once they agree to do so. Thus, trust is also when perpetrators share with the psychologists the reality of their romantic relationship and towards the violence.

Luca felt tricked when not having such truth, which makes me think that trust signifies partnership as well. The psychologist is willing to have an alliance where he can relate to the client as a partner, by believing in the client’s stories and intentions and cooperating for the client to change. Luca’s example gives me the impression that he expects not only that the client will share the truth about what is going on at home, but will also engage in changing. The therapist becomes disoriented when he trusts on the client’s improvement, but it turns out to be false.

When I go back to the beginning of this subsection, I understand that the psychologists are willing to understand their clients’ reasons for acting violently, until the clients no longer accept to change. When this happens, the participants feel tricked, angry, weak and powerless. These reactions symbolise that only the psychologists’ moral considerations are acceptable. This aspect gives me the impression that the therapist-client alliance is mainly constructed only through the insights and beliefs of the therapist. A dialogical relation appears to be challenging up to this point.

However, at the same time, I can see a glimpse of such relation when I go back to the part when John talks about approaching his clients. The use of looking them into their eyes is not only a form of showing interest, but of creating a connection of intimacy and affection. Correspondently, Johns acknowledges that therapy can be intimidating and uses humour to make it lighter. Both these actions symbolise that John not only cares about his clients’ fears and need but gives care to them. Thus, a care ethical relation seems to take part at this moment and appears as a contribution to making a stronger alliance.

Until now, this subsection touched upon the psychologists’ views towards the violent acts; the practices conducted to understand the clients’ reasons; and the obstacles that the psychologists face when listening to something that they strongly disagree upon. The connection between the client and the therapist was established through these different aspects. Now, I will present the psychologists’ statements that illustrate the aspects used to sustain these connections.

For the connection with the clients to grow, Erik needs to find aspects that he likes in them. Fabian, on the other hand, tries to picture his clients as young children. He goes back to the following scenario.21

It was in the early days of his life. The client was absorbing all the matters and discourses of his family. The mother was speaking badly about the new neighbour’s family.

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21 The following scene is my personal interpretation from a story told by Fabian.
She could not imagine living next to a black family. The aunt complemented with concerns about letting the young boy play with their kid. Lots of racist statements continued during the client’s childhood. Simultaneously, in the absence of a father, the uncle helped to raise this client. The uncle was extremely conservative and believed that a relationship should only be possible between a man and a woman.

The teenage years arrived, and the client was not as manly as his uncle thought he should be. After all, in his uncle’s mind, it was an absurd that he was 13 years old and never asked a girl out. The fear of his uncle concerned the sexuality of the client. At the same time, the client was concerned towards his own sexuality, since he always heard from the male figure that human beings are heterosexuals. He had no friends; hence, he could not lose the trust of the only person that seemed to care about him, thought the client. He kept convincing himself that he needed to be masculine. To him, this meant not crying or acting weak in front of other people.

The story illustrates the influences of oppressive societal norms in the client’s mind-set since an early age. The therapist perceives the client as a frightened child, who never had support from the others closest to him. It is through encouraging the client to be in contact with his inner child that Fabian can illustrate the link between the violent act and the client’s background. The psychologist believes that teaching ‘the child’ in front of him about non-discriminative attitudes and the rightness of morality is a form of connection between him and the client.

Correspondingly, John also believes that perceiving his male clients as boys who try to organise chaotic lives is something that helps him connect with them and for the clients to trust John. He affirms that he never met a client who has not a pressing trauma. Most of his clients had trust issues and did not have good experiences with reciprocity. The psychologist explains that his clients continue to use the same strategies for confronting a problem as when they were children. Comparably, Bianca reflects on the lack of control that her clients have when experiencing anger and harm.

Autonomy entails interdependence. By considering perpetrators as children, who know nothing, and by putting themselves in the position of teachers, John and Fabian symbolically see themselves as fathers with good moral values that will provide for the helpless offspring. Here, the participants’ attitudes would not be considered paternalistic acts if the distribution of knowledge aims to enhance their clients’ autonomy. If it is considered a process of moral development that leads to a better decision making and the professionals are acting in the way of demonstrating, through the therapist-client relationship, that trust and care when making moral judgments is possible, then relational autonomy is taking place. I will explore this thought further in the next subsection.
Now, I come back to a reflection that I made before. To imagine that the client did not conduct the violent act because he did not know better is a form of keeping moral sentiments (empathy, sympathy and compassion) alive. It appears to be the only way that the participants find to connect with their clients. The psychologists could not consider that the perpetrators have the knowledge, but yet still conduct wrong moral choices. The question that keeps knocking on my mind: is it an accurate understanding of the other? At this point, it gives me the impression that it might be a therapeutic mechanism to sustain an alliance for the sake of achieving forms of justice (violence to stop/the client to change).

A sympathetic understanding can also nurture the connection. Bianca shared an example on the matter. She was talking with a colleague about one client in particular. This co-worker was providing therapy to the companion of Bianca's client. Her colleague shared with her that the intimate partner was going to end the relationship. This information was something that Bianca's client did not know yet, consequently, neither did Bianca. The psychologist claims to feel sorry for the client because she knew his effort on changing his behaviour and mindset. She complements that she cared a lot about her client’s family. Bianca especially thought about the affected child in this situation. She was confident that her work was helping on the construction of a better father.

The following example from Erik also demonstrates his engagement with the client on an emotional level. He was treating a man of a similar age as himself but of different nationality. The client had a difficult childhood and migrated to Sweden when he was still a student. Power and control were daily companions in the client's life when still living with his father. Two relationships marked the story of this client. He was aggressive, mostly verbally, with the two intimate partners at different times. In the first relationship, he had children, whom he lost contact after some time. It was when he was talking to Erik that he expressed his sadness about not relating to his children anymore. His despair touched Erik and he cried along.

When telling me the story, Erik laughed and said: “So, here we were, two old men crying together”. The psychologist affirmed to get emotional and sad with his clients because he allows himself to be private. He made sure to clarify that he does not lose control of his emotions, but he permits himself to encounter them. Correspondingly, Paul also engages emotionally with his clients. However, in Paul’s case, feeling sympathy for his clients is an act that demonstrates that he is not afraid of them.

Keeping in mind the theoretical considerations of section one, sympathy appears when Bianca and Erik are concerned with the client and feel compassionate about the latter. They actually do not feel for the client’s suffering, but understand their pain. With this example, I understand that the recognition of the client’s hurt is an aspect of sustaining the bond between the therapist and the client. Interestingly, I could observe that Bianca felt especially sorry because her client was trying to act as a considerate father. It seems to be easier for the
psychologist to demonstrate values of care such as sympathy and compassion when the client is motivated to act morally correctly. Paul’s comment shows that not showing weakness is a sympathetic act. Perhaps, stating a clear position of someone that acknowledges the intensity of harm, but still is not afraid is a form of clarifying a stronger power. Here, moral sentiments hold hands with power dynamics on the therapist-client alliance.

**Issues of Power**

As a psychologist specifically working with perpetrators, Paul conducts his job always keeping in mind his central goal for the therapeutic process: to stop the intimate violence. For him, this means terminating both the physical and emotional attitudes that cause harm. Bianca, Erik, Fabian and Luca also believe that the primary goal of therapy should be to end violence. John agrees with the others in this matter. He complements that it is not enough for him to see his client stop beating his intimate partner, and, sometimes, the children. They need to demonstrate the understanding of the consequences the violence committed convey to their intimate partner. John is asking his clients to take responsibility for the violent acts that they have committed.

I can see that John is demanding from his clients’ acceptance of their intimate partners as they are. But, is this the case regarding the clients? As seen in the subsections before, it appears not to be the case because, differently of the intimate partners, the clients are considered morally inadequate. So, acceptance seems only to be possible through correct moral judgments. To acquire such moral development, John and Paul demonstrate above that responsibility is the key. Perpetrators need to acknowledge that they were morally improper and feel the harm they committed to others.

For John, the consciousness of the responsibility of the violent acts allows perpetrators to act differently. The psychologist believes that his clients need to do things that they have not been doing before, such as to show concern for the family and to give attention to the child. Therefore, I can see that therapy for John is a process of building a new attitude and mind-set towards the main goal of ending the violence.

Lucas also emphasises the importance of the clients to take responsibility for their actions for the success of the therapeutic process. According to the statements in the subsections above, if the client is not willing to change, the alliance will be shaken. Here, Luca tells me that the therapy can only take place if the severe ongoing violence is controlled and the family is secured. If his clients are not responsible for accomplishing this, the therapist activates the child protective services or the women shelters to take the necessary measures to ensure the family’s safety.

Usually, to evoke responsibility Luca reminds his clients of the power they have towards the violence. He clarifies that it is them who are acting violently, no matter their complaints.
about the romantic relationship, intimate partners, their childhood or their own addictions (alcohol and drug abuse). Luca acknowledges that perpetrators have no responsibility for the negative factors that might have happened on their childhoods and that it is unfortunate that they had to go through it. However, for the psychologist, clients should not be excused from the responsibility for their actions in the current moment.

Paul defends that it is only through the acknowledgement of responsibility that perpetrators will be able to deal with deeper contents that lead them to violence, such as mastering powerlessness and helplessness. Both Paul and Bianca affirm that it is challenging to empathise with clients who avoid responsibility since they can be provoking and easily justify their own violence. Bianca explains that she needs to feel her clients’ shame and regret about conducting the violent act to connect with them.

The psychologist believes that avoidance of responsibility is a defence mechanism. Many of her clients have experienced traumatic episodes during their childhood which contributed to their lack of knowledge of the ways they relate to the other. For Bianca, this explanation is comforting, since it shows that perpetrators are not monsters, but rather individuals who were very unlucky with their parents and the surroundings. However, still, if glimpses of responsibility or regret do not arise, she feels she needs to terminate the therapy. The making of this decision is because, through her perspective, showing responsibility is ensuring that the violence will stop. If she continues the process with people who do not seem to change, she considers it – and also the child protection service – as a form of covering up the violence and being an alibi to her clients.

The statements of Bianca are similar to others presented in the subsections above. The psychologist condemns the client for the acts committed. This action signifies that believing in the clients’ lack of power is relieving oneself from the reality that people can consciously conduct improper moral acts. When I go back to Luca’s statement, I see that the psychologist defends the position that there should be no justifications for evading responsibility, such as considering the traumatic experiences from the past. In this sense, Luca does not take the false comfort in believing that the perpetrators did not know any better, but accepts that their moral judgments differ from his.

Nevertheless, all the participants consider their clients’ willingness to be morally right as a motivation for connection. Again, the alliance seems to be constructed upon the premise that an improper morality is not acceptable. The psychologists’ ethics appear to be embedded in the goal of stopping the violence. Considering the meanings concerning responsibility and therapy goals, I get the impression that the psychologists answer more to the violence and society than to the clients. As if perpetrators are music boxes that do not transform into music and psychologists are the one wanting to listen to the music. The therapists fix the music boxes
in order to achieve their final goal (playing music), but not necessarily because of the relation they have with the music boxes.

The construction of the therapist-client alliance and, consequently, the therapeutic process, is based on the client’s responsibility and the goal to end the violence. In a regular therapy, it is common for both the psychologist and the client to co-construct the process according to the client’s aim. In the therapy that I was trained in\textsuperscript{22}, this means that the psychologist assists the client in the journey that one chooses to follow, and acts as a mirror in the understanding of the self. It is similar to a process of adding one stone per day in a river for the client to be able to cross.

According to Fabian, therapy for perpetrators runs differently from a regular therapy, since it has the clear goal of stopping the violence; even if such aim is not the client’s purpose. John shares that in the beginning of therapy, his clients present their plans to him. He only accepts such intentions if it matches with his goal of ending the intimate violence. Thus, it is not acceptable for perpetrators to arrive at the therapeutic setting and talk about what comes to their minds. On the contrary, they follow a model of treatment that was agreed upon before, specifically designed to reach the therapy’s goal.

For John, this is the main difference in comparison to other therapies where, for example, the clients want help dealing with their phobia for flying, and they decide the time period treatment should take place. In the therapy that he provides, ideally, the therapeutic process would only stop if the client stops acting aggressively. It is up to the psychologist to design the process in order to assist his clients in achieving the goal of terminating the violence installed in their relationships.

Paul says that, ideally, it would be better if there were a dialogue between the therapist and the client on the construction of therapy. He tries to create such dialogue with his clients regarding what they should do, the way they should do it and what aspects they do together and separately. Paul claims that this action is not always successful, but after years of working with perpetrators, he understands that informing and preparing his clients for the course of therapy is very important. However, even though Paul is eager for creating such a partnership with his clients, he admits that there were two times that he had to terminate the therapy and refer the clients to colleagues because of their lack of commitment to change.

John compares the therapeutic process to running a marathon. He knows that he has to go somewhere, but it will take a long time until he gets there. This constant effort rises because every time he has to go backwards in order to move forward again. This back and forth movement appears when the psychologist thinks that his clients understood something new to change their behaviour, but they act morally wrong again. John’s frustration resembles

\textsuperscript{22} Under the theoretical framework of Carl Gustav Jung (Analytical Psychology).
to be a caring act towards sincerely wanting for the clients to change. But also, that such change should happen under John’s terrains.

Fabian acknowledges the unequal power inserted in this therapist-client alliance. He calls it as a form of abuse, as a psychologist power over the client. As mentioned before, these different power positions come from the enforcement of the therapist regarding the treatment model that should be taken. However, Fabian believes that since he works with motivational interviewing among other techniques, he is making sure that his clients feel that they have the same purposes as him regarding therapy. For the participant, the appearance of an uneven power would be more problematic if he did not use this tool.

It reminds me when a young child refuses to eat a particularly healthy food and the father mixes that food with something that the child likes in order to trick them to eat the father’s choice. In this analogy, the client is as if a child who needs to be convinced and not an adult who could reflect on moral questions. Again, it leads me to conclude that ethical considerations are rooted in an image of the client that relates to a child who knows nothing and should not have much of a say.

For John, if individuals stay in therapy it is because they accept the psychologist’s role as someone to help to end the violence. He advocates for the proper establishment of the psychologist and the client’s position by the beginning of therapy. Fabian reinforces that psychologists have the role to guide and assist their clients to achieve the ultimate goal. New strategies and ideas are created for each client following the content and phase of therapy. For Erik, the position of therapists working with perpetrators is to teach their clients to understand their own feelings and mostly, the intersection between these emotions with their actions and thinking. Erik explains me about the counselling that he conducts with his clients through the following story, which is a biblical saying.23

It had been days since the man ate properly. Every day he found a little bit of food to calm down his stomach. It was an attempt to pretend that food was not scarce in his life. The river was in front of him, and he could enviously see the fishermen catching their dinner day after day. He was there, hungry and desperate for compassion. One day, an old and wise fisherman appeared next to him. He was coming back from a day in the sea when he sees the man suffering next to a tree. He briefly asked about the man’s life and when was the last time that he had eaten. The man did not have any more energy to spend, so, speaking was quite a challenge. The fisherman smiled and continued his way home.

The next morning, the fisherman came back with several tools. He asked the man to accompany him on a boat trip. Confused, the man entered the vessel. In the perfect spot, the fisherman started to teach the man how to fish. The man inquired the reason for such guidance.

23 The following scene is my personal interpretation from a story told by Erik.
The fisherman explained that he could either give the hungry man a fish, or he could give him a fishing tool and teach him how to fish. In the first situation, he would eat the fish, but during the next sunrise, he would be hungry again. In the second situation, he could eat the fish for as long as he wanted.

Erik believes that this story represents the work that he has been conducting. For him, to understand his clients is mattering, but at the same time it is important to give them tools, for the clients to take care of themselves. Through Erik’s example, I understand the psychologists intention to create an alliance based on autonomy and compassionate authority. The perspective of before, when the psychologists mainly demonstrated their imposition towards the treatment, transformed my perception a bit.

Erik’s appears to impose a form of therapy based on the premise that he knows best what is right for his clients. But while doing it, he tries to create a guidance that seeks the clients’ growth. He passes his knowledge to them with the intention that they will actively engage with it for times when the psychologist is not there. Compassion comes from the grief towards the clients’ suffering because of being individuals who cause harm. Authority comes from the belief that the therapist’s morality is the one that should be followed.

Correspondingly, John believes that his knowledge about IPV and ways to stop violence put him in a privileged power position compared to his clients. The participant explains that his distance from the situation and his ability to take the scenario broadly, by considering the children and the partners, are something that his clients cannot do and could learn from him. John challenges them to go beyond their personal views and, by doing it, he exposes the perpetrators to painful feelings. In exchange, he offers his knowledge to be used for the embodied change.

Paul believes that the broader picture mentioned above is something that all psychologists must have when relating to their clients. For him, violence is a social-political issue, and even though he only meets the individual, he feels that his actions reflect society as a whole. Bianca considers her job as a way of spreading knowledge to other professionals and the public audience. Here, I see that the participants are concerned about their power position as someone who knows more. They take into consideration the political engagement associated with their role as psychologists for perpetrators. The guidance that they conduct is constituted by their views of morality, but also, social, political issues. Paul, for example, tells me about his firm attitude against violence, something that he was raised upon. His personal beliefs significantly influence the therapy that he conducts and the moral judgments that his clients make.

Paul talks about guidance concerning being a role model to his clients. He motivates his male clients to engage with their vulnerability and to understand that feeling sad and afraid is allowed by using his own positionality. This connection to his own emotions is something
exercised by Fabian as well. He explains that showing his vulnerabilities to his clients is a way of leading the way. For him, it is possible to show weakness and to acknowledge the unknown.

Later on, Erik and John talk about not relating to the client professionally, but person to person. When listening to this, I have the feeling that the clients want to connect with the embodied human being sitting in front of them, rather than some modified professional who conducts himself through the duties of his profession. With this feeling in mind, perpetrators are looking to establish relations of trust, in which they can feel safe.

Through encountering someone who cannot empathize when different moral judgments take place, the client does not enter in a relationship of care, but justice in form of punishment. However, if an ethics of care would be held here, the psychologist would be able to sustain a partnership with the client demonstrating that self and other should be taken into consideration. It seems to me that the participants are asking their clients for a responsibility towards the violent acts, for achieving some justice, much more than encouraging a reflection towards what it means to be in a dialogical care relationship.

To keep talking only about the violence committed during the therapeutic process is not easy. Neither is it easy to accept the goal of stopping the violent acts. Luca affirms that some clients try to stray away from the violence during the process. In these cases, he needs to point out to them that they are only there because they acted violently. John is not afraid to argue with his clients when not agreeing with them, in fact, he believes this to be an assertive tool for therapy. Since perpetrators have mostly experienced people withdrawing from their lives when they become violent, they will not expect John to continue to be involved and show up after the argument. Here, I can see that John is trying to establish an alliance of trust between him and his clients. Moreover, John appears to demonstrate that a relationship of interest for the other, who is morally wrong, is possible.

Erik presents a different situation, in which there was a power struggle between him and a client, and he had to withdraw from it. He shares with me the story of a narcissistic male client that he received once, who wanted to be on top of everything, including the therapy. For this client, he was in command of the therapy. Erik’s voice showed indignation by this assumption. Confused, I asked who was supposed to be in charge of the process. Laughing, the psychologist emphatically affirms that he should be the one in control. He complements that because of the client’s dominance, the therapeutic process could not continue.

In this example, the psychologist and the client have different power positions. As I knew before, the therapist is in a more advantageous power position because he has the control over the therapeutic process. This example confirms my suspicion that when a power struggle is established, the professional uses his/her authority. It seems that the end of therapy happened because of the narcissism of the client, and Erik felt the need to recommend him to
psychiatric treatment. But also the case demonstrates the client’s lack of power in the therapeutic process.

Fabian believes that by holding facts, not opening up to the psychologist and resisting information, clients do not cooperate with the therapist and indirectly, they affirm their power to him. Erik feels this lack of power from his position when he is trying out different strategies, and his clients do not change. Similarly, Bianca affirms that if her clients talk about things that are relevant, she does not need to take control of the situation. Otherwise, she needs to be authoritarian.

Paul feels the power struggle with his male clients. He admits that frequently being in the position of a male therapist is an obstacle because of the natural impulse that his male clients have of fighting over who is the strongest man. For Paul, this is very unfruitful for the therapeutic process. Even though Bianca is very proud of transmitting respect to her clients, she experienced situations where her clients tried to reduce her. The comparison of Bianca to their intimate partners because of her position as a woman is something that occurred. She shares with me one example when she felt diminished.24

It was the session after Bianca contacted the child protection services. It was impossible for her to continue listening to the abuses committed towards the client’s child and be quiet about it. Yes, the client has been promising to stop the violent behaviour, but Bianca did not see this happening. So, she made the call. The session afterwards initiated with the client slightly late. He entered the room abruptly and yelled. You destroyed my life and my family’s life forever he said in a challenging tone. Are you happy now? . Bianca remained quiet and calm. She knew that it was the right thing to do for the child and the family. The client kept his discourse about the trust between them being broken and the wrongness of her attitude. He allocated her negatively to the position of a woman who should not be trusted.

Bianca explains that the episode was one downside of her work, but she believes that as long as she conducts what is best for the children, she will be consciously satisfied. This demonstrates that, for her, the child is the most important. Moreover, her empathy goes to the violence committed, more than to the client. The client could be willing to change and willing to demonstrate improvements, but since the violence was still present against the child, the psychologist needed to ensure the security of the other. It goes back to Luca’s statements about always keeping the family safe.

Discussion

The findings and comments in the subsections above helped me to explore the two research questions of this dissertation. My first research question was about the ways

24 The following scene is my personal interpretation from a story told by Bianca.
psychologists working with perpetrators of IPV in the therapeutic setting construct the client-therapist alliance. Through the data presented above, I could notice that this partnership is not rigid; it changes depending on each client. Moreover, several factors contribute to its construction. However, some common factors shape the nature of such alliance. In this subsection, I will summarise such factors, and relate them to my second research question about the contributions feminist ethics of care can bring to this therapeutic process.

Several dimensions influence the construction of the therapist-client alliance: client’s identification with the psychologist; therapist’s engagement with necessary moral sentiments; mutual trust and respect; the connection between these actors and nurturance of this bond; the establishment of different moral positions between them; the definition of the psychologist’s role in therapy; and the goal of the therapy.

It seems clear to me that the clients appear to feel more comfortable with sharing aspects of their lives, and the details about the violence committed if the psychologists have a similar behaviour and physical appearance than them. Identification with the psychologists seems to be a key factor in the therapeutic process because the clients fear to be judged, misunderstood and disliked. They need to believe that the psychologists will do everything to assist them, without judging their thoughts and actions.

On the psychologists’ side, it also seems to be clear that the participants interviewed demonstrate to understand the importance of identification. In several moments, participants stated that clients should not be judged by the violence committed. They also seem to reveal such way of thinking to their clients, by clarifying that they believe that the clients are not violent by nature, but, rather, act violently. Moreover, they showed me different techniques to connect with their clients, to create some identification. For example, they tried to imagine the client as a scared child who did not receive any support from family or friends. By doing this, the psychologists recognize the client’s traumas and suffering. This recognition helps them to create a bond – through identification – and to sustain it during the therapeutic process. Overall, psychologists are aware that judging their clients goes against the alliance’s strength.

I think it is important to notice here that the concept of “judging someone” is problematic in this context. By “judging”, participants mean “not to morally condemn” the actions of their clients. Although this seems a valid way to deal with what their clients did, this would imply that participants were able to ignore, or to suspend, their ethical values – in essence, their sense of justice – while in therapy. This suspension is not possible, and it is not desirable either. During my interviews, I came across signs of this impossibility. The psychologists affirmed that sometimes they did consider their clients as evil individuals with the unique aim of hurting other people. This state was especially true for situations in which they faced clients that did not show any shame or regret. In these circumstances, participants seem not to be able to feel empathetic, sympathetic or compassionate for these clients.
Also, there are times that they are significantly influenced by dominant societal norms towards gender roles. There is an apparent prejudice towards female perpetrators because of their nature and position of women. It is challenging for the professionals to accept that potential mothers and caregivers can act improperly in a moral relation to another human being. This is also evidence that their system of values cannot be simply suspended during the therapy.

I could also notice that their ethical considerations towards the ways in which the clients should be perceived influence them to act empathically. As I discussed before, empathy is a sentiment that is built both cognitively and emotionally. To be empathic means to understand the position of the other in these two dimensions. However, as it became explicit to me, this is not something that they can fully accomplish. An evidence of this is the participants’ claim that criticizing the clients is something that they need to do because their clients’ point of view needs to be challenged during the therapeutic process. This is a clear obstacle to develop empathy and comes from their fear of being considered the clients’ ally.

With this mind-set, the psychologists establish different moral positions between them and their clients. They create a separation between the individual that does harm (client) and the one that does not (psychologist). This distinction seems to show that the psychologists’ morality appears to be the only one taken as valid. It then becomes superior to the clients’ morality. When constructing the therapist-client alliance, inappropriate moral choices end up being denied.

The goal of therapy consists on the end of violence. To reach such a goal, the psychologists demand that their clients take responsibility for the acts committed. This action means the clients’ acknowledgement over their morally improper actions and the harm they cause towards their intimate partner. For the psychologists, only through such acceptance moral development seems to happen. Here, the psychologists’ moral superiority leads to a hierarchical power position between psychologists and clients.

If clients do not accept this goal and the treatment model, then therapy is not possible. Sometimes, the clients try to engage in the therapeutic process and are willing to change, but obstacles appear which make them detract from these objectives. When this happens, the professionals refuse to continue giving them treatment. Taking control over the therapeutic process and choosing how it will be conducted is not something possible for the clients. The reasons for being so reluctant to accept the clients’ engagement in the construction of therapy appear because of the psychologists’ commitment to violence. They feel crossing ethical boundaries when opening space for other topics than violence in the therapeutic setting.

To assist the clients in ending violence, the psychologists teach them how to understand their feelings. Also, the professionals try to behave as role models to their clients, by engaging with their own vulnerability. Therapy becomes a process for the clients to build a
new attitude and mind-set. The partnership created between psychologists and clients appears to me as an exchange of favours: the psychologists give knowledge on how to make morally correct decisions and the clients receive the assistance to change. Again, I can see an imposition of the psychologists’ values over the clients’ values.

The professionals expect to establish a relationship with their clients that have a different nature from the relationships that the clients have with their intimate partners. This establishment is not always possible. Frequently, there is a power struggle between the actors. This conflict happens when clients do not cooperate with the process, by holding facts, not opening to the psychologists and/or transmitting a different scenario than the reality. The power struggle is also visible when the professionals go against the will of their clients, for example, when they report an ongoing violence during the therapeutic process. In both situations, the alliance becomes shaken, and the professionals feel frustrated and tricked by their clients. Thus, trust is no longer possible.

As presented in section one, Kohlberg’s (1969) theory of moral development identifies a movement from an egocentric to a social perspective of self. The individual creates universal rights and duties from an individualistic perspective. The person pursues a moral dilemma by thinking about what the self would do in the position of the other, without actually considering the other as other and the self-other relation.

The dissertation’s data demonstrated that the psychologists problematize the moral judgments of the other from a self-perspective. As if they were situated in the position of the clients, they question whether the same moral choices would be taken. They feel comfortable to morally compare themselves with the clients because they believe they belong to a similar context and gender. When doing this universalization, they ignore intersectional factors that are crucial for the decision of a particular moral choice. Such factors constitute of the crossing between different categories that form the other’s identity. Thus, the psychologists are ignoring multiple aspects when judging the clients’ morality. Rather, they are considering only the issues that they think it matters.

Besides, they create a moral superiority based on the self's morality as the one that is appropriate. This mismatch happens because professionals differentiate themselves from the clients as non-harmful human beings. As seen above, the alliance is constructed through the understanding that since the clients committed morally wrong acts, they have an inferior level of morality. The professionals see themselves as those who lead the way, by teaching the clients to perform correctly in a moral way. The psychologists cannot understand how someone similar to them could commit profane acts of violence since they would not do it. This moral superiority represents the egocentric movement of an Ethics of Justice when the self becomes more important than the inter-connection between self-other.
In this sense, even though the psychologists claim that an overall perception of their clients is necessary, they seem not to accomplish it fully. Since they have this moral superiority, the professionals end up reducing the clients to the violent acts that they committed. They cannot comprehend the other person entirely, as a human being with different facets and performances.

The egocentric view of morality just found on the psychologists’ discourses ignore such relationality. By using a Feminist Ethics of Care, the moral choices become collective. As Gilligan (1982) demonstrates, individuals are not isolated selves, rather they exist consistently in relation with others. An interactional ethics does not mean to ignore the violence committed by the clients and the responsibility that the clients have towards it. Rather, it means that the psychologists, as members of the same society, should consider their positionalities in relation to the other. When doing this, they notice the responsibility they have towards these clients.

As the mothers in Gilligan's study (1982), if the psychologists do not move from an ethics of justice to a collective ethics of care, the therapist-client alliance will deny the entire existence of the client. Through this ethical movement, paternalism transforms in relational autonomy. The psychologists will focus on a moral education of the other, instead of moral development. The first involves a moral responsibility towards the autonomy of the other that will be reinforced through an interdependent moral education. The second implies the existence of inferiority and that a higher level must be reached. Recalling Slote’s (2007) considerations, this moral education will only be possible if an empathic perspective of the other takes place. Such view will be achievable towards the acknowledgement of the responsibility mentioned above.

Distancing themselves from the rigid positions of rescuers and victims that moral superiority brings allows the psychologists to problematize the notion of punishment and justice. When psychologists do not get involved in a care ethical relation, they do not necessarily perceive the clients’ well-being. On the contrary, they remind of the wrongness facet of the clients and use retaliation as a punishment. For example, when the clients do not cooperate with treatment and do not demonstrate shame and regret, the psychologists identify them through the violent act and use the punishment of ending the treatment as retaliation for their wrong morality.

Through a feminist care ethics perspective, the psychologists will see that they are responsible for their clients and even if they consider them acting morally incorrectly, they have the moral responsibility towards their well-being. They comprehend that their welfare will depend on the care giving since they are in relation to one another. Doing this is a step closer to be concerned for the vulnerabilities of the other and to trust the other.

This care ethical perspective is beneficial for the construction of the client-therapist alliance because it allows the psychologists to enter in an honest partnership with their clients.
without considering themselves as morally better than the clients. This movement implies that the psychologists will empathically look at the other and the client will no longer fear being seen as evil. Moral responsibility will lead the way for a moral education towards the goal of ending the violence.

As Tronto (1993) demonstrates, it is through care that justice will be possible. Moreover, a caring relation implies the importance of the political arena that actors constitute and are constituted by. The ethical care relation that would be established in the therapist-client alliance would be able to influence political structures to act accordingly. Other members of the society would also be able to perform moral responsibility, and the relation that individuals have with justice would change drastically. Justice would be highlighted much more than retaliation. It would signify that the so-considered dangerous beings are part of a societal structure and this structure has the same responsibility towards them than they have towards other members. Thus, a redefinition of justice based on moral care and responsibility for perpetrators and others considered morally inappropriate would be imaginable.
Connecting the Dots

I initiated this dissertation with the aim to call attention for the positive changes that Feminist Ethics of Care could bring to the therapeutic setting involving perpetrators of IPV and psychologists. I knew that Gilligan’s (1982) considerations towards a relational ethics between self and other would allow me to question the moral roots of a therapist-client connection. My precise purpose was to explore two central research questions: how do psychologists working with perpetrators of IPV in the therapeutic setting construct the client-therapist alliance?; what could a feminist ethics of care perspective contribute to this client-therapist alliance?.

To achieve these purposes, I investigated the discourses of six psychologists – one woman and five men – working at one of the most renowned therapeutic institutions for perpetrators both in Norway and Sweden.

As I showed in section two, the studied institution received opposition from actors such as the women shelters in Sweden and politicians in Norway. These characters seemed to believe that since perpetrators acted morally wrong towards another, they should deserve to be forgotten behind bars and judged as evil characters by society. However, the institution’s founders did not agree with such perception. They realized that leaving perpetrators to the justice of the criminal system was a form of reinforcing the prejudice towards this group of people. This insight signifies that they acknowledged their responsibility towards those that acted violently.

The psychologists that participated in this dissertation are important agents for achieving such responsible perspective towards the other. They come from different career backgrounds and theoretical orientations, but when employed by this institution they receive similar training. Such training demonstrates the social-political framework that involves the institution’s creation and the aim towards the clients. The latter seek therapy voluntarily, which shows their willingness to change. This enthusiasm does not necessarily imply that they will stay in treatment or cooperate with the psychologists. Rather, it signifies that they have an intention to conduct morally different.

Through in-depth semi-structured interviews, I examined the participants’ point of view towards their position, their clients and the therapeutic process.

In section four, with the analysis of the psychologists’ discourses, I found out that the psychologists construct the therapist-client alliance based on a series of factors. These aspects are: the client’s identification to the psychologist; the understanding of possible reasons that the client had to act violently; the recognition of the client’s needs and fears;
psychologist’s perceptions of the client’s in order to enhance and sustain connection; power struggle between the actors; and psychologist’s engagement with moral sentiments.

When constructing the therapist-client alliance, the psychologists establish a different moral position between them and their clients. The perpetrators need to position themselves as morally incorrect, by taking responsibility towards the violent act. The psychologists’ morality appears to be the only one valid and, consequently, becomes superior. Through this higher view, the psychologists silence their clients when constructing the therapeutic process. This act is harmful to their alliance, since it creates judgment, even though not intentionally.

This advantageous moral position demonstrates that the participants engage ethically with their clients under the presumptions of the Ethics of Justice. As presented in section one, this ethics entails an individualistic perspective towards moral judgments as universal. This egocentric ethics allows the psychologists to differentiate themselves from their clients, acquire a moral superiority and, consequently, contribute for condemning the clients as the Others. As the data shows, they are not consciously willing to do so, since they know that it is morally wrong and not beneficial for the alliance. However, since they perceive their clients as morally inferior, they tend not to accomplish an entire perspective of the clients. Thus, a total empathic relation becomes impossible.

More than that, by taking such ethics the psychologists seem to go against the purpose of the founders of the institution. This resistance occurs because they neglect the moral responsibility towards the clients’ well-being. They appear to focus such responsibility on those that suffered the violence. When relating to clients that they do not agree, the participants’ advantageous power position becomes stronger, and the therapy is governed by their ethical considerations.

As a result of the analysis, I am advocating for a shift in morality, considering the framework of Feminist Ethics of Care, which will improve the psychologists’ perceptions of the clients and nurture the therapist-client alliance. Care and responsibility will become central aspects of this cooperation. Such ethics demonstrates that self has a moral responsibility towards the other since they are interdependent. When understanding such relationality, the psychologists will be able to have an empathic perception of their clients, and attachment will be consolidated through mutual trust.

Besides, the institution would be able to accomplish the social and political role that it desires. As Feminist Ethics of Care demonstrates, the notion of care is connected to justice. The institution and the psychologists will show to political structures of society that justice and punishment should not be considered through individualistic ethics. Through this action, justice and punishment could be questioned and redefined.
Situating Myself

During the early process of writing this thesis, I still held a feeling of disgust towards perpetrators. I am confident that such sentiment was influenced by my own experience of harmful acts committed by strangers. As I started to understand ethics of care in relation to ethics of justice, I realised that I was applying the same individualistic ethics that the participants of this thesis seemed to use. I was condemning the other because I thought that if I were in their situation, I would not do the same. Basically, I was considering myself morally superior to the perpetrator.

This thesis became a mechanism to allow me to challenge this moral superiority and acquire a morally responsible perspective. It was not something easy to be obtained, and I confess that I am still struggling with the particularities of applying such ethical perspective in my daily life. However, the theoretical framework of this study gave me a new insight. I comprehended that it is through the acquisition of moral responsibility that my relation with the improper Other would change significantly and frank empathic understanding would rise. This way of thinking helps me to engage not only with the perpetrator - as an individual and future client in therapy - but to myself. It allowed me to question my moral choices broadly from a caring and responsible basis, something that increased my awareness towards my own morality.

Limitations and Further Knowledge

The conduction of the interviews in English is considered a weakness for this thesis. Neither the participants nor I have English as the first language, which limited us to use adequate words that would better transmit the meanings that we wanted to convey. Besides that, unfortunately, I could listen to the perspective of only one female psychologist. Expanding the gender and number of participants would be vital for an accurate consideration of how the positionalities of the psychologists change when relating to the clients. Here, I have considered the participants’ discourses collectively and not made a comparison between gender or other social categories, since I wanted to acquire a collective view of how the therapist-client alliance is constructed. Nevertheless, I understand the importance of focusing on the particularities of each professional and inquiry how such factors influence their relation with their clients.

Another limitation that I found is that I never questioned the idea of treatment in this dissertation. I had on the back of my mind when writing about the therapeutic scenario and trying not to find myself in the position of considering therapy for perpetrators as a treatment in which the client should be cured of something. I believe that perceiving therapy as a form of curing goes hand in hand with the moral superiority view that I just mentioned. To problematize the idea of treatment is to acquire a genuinely empathic perspective of the other and to apply
a care ethics view. I believe that I did not find the right space to make such problematization here since it involves much more than a few words on the issue. Thus, a future study on the topic and the ways therapists deal with this notion of cure when providing therapy for perpetrators could be interesting to be conducted.

Also, I have not gone deep into the political-social structure of both Norway and Sweden in this thesis. This is because my focus was not extensively on the countries’ context, rather in the context in which the institution was created. However, it would be interesting to observe the morality of social-political structures that work in/directly with perpetrators in future research. Mainly, to investigate if a feminist ethics of care is applied in the criminal system of both Norway and Sweden, in which the notion of social welfare is so nurtured.

**Contributions to the Field**

I believe that this dissertation contributes to the fields of Moral Psychology, Gender Studies and Intimate Partner Violence since it integrates a feminist theoretical framework with a particular psychological relation in a significant way. The perspective of psychologists towards perpetrators in the therapeutic setting is something that is lacking and necessary to be brought into the existing literature. The position of the therapists as vital actors for the therapist-client alliance and consequently, the success of therapy gives significance to transmitting their voice to the field. I understand that their views, which were presented in this thesis, will contribute to the improvement of interventions for perpetrators.

Furthermore, I consider that the inclusion of a feminist theoretical framework in such perspectives encourages a dialogue between disciplines that is vital for the construction of new knowledge and the reflection towards existing practices. The inquiry of ethics and morality towards their clients allows the therapists to negotiate the complexity of their daily work and to problematize rigid paradigms that might be an obstacle to a relational understanding of self and other. This thesis opens space to the awareness of the importance of such relationality for the construction of the therapist-client alliance, the success of therapy and also to the therapist personally.
References


