

THERAPEUTIC RESPONSES TO VIOLENCE: A DETAILED ANALYSIS OF
THERAPY TRANSCRIPTS

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Dedication

To my husband, Chris, for his unfailing support and encouragement.

Abstract

The Interactive and Discursive View of Violence and Resistance proposes the existence of four-discursive-operations that “(i) conceal violence, (ii) mitigate perpetrators’ responsibility, (iii) conceal victims’ resistance, and (iv) blame or pathologize victims” (Coates & Wade, 2004, p.500). These linguistic operations produce incorrect representations of violence that ignore the unilateral nature of acts of violence and, instead focus on pathologizing victims (Coates & Wade, 2004). Examining how violence, victims, perpetrators, and responsibility for the violence are represented in therapy transcripts in which the presenting issue is violence, will allow us to see if linguistic strategies that are used to discredit victims in everyday talk are also used in therapy by therapists. Analysis of 19 therapy transcripts found that the four-discursive-operations were used in each of the transcripts and that therapists often initiated the use of these inaccurate representations or encouraged the perpetrator’s use of four-discursive-operations.

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Chapter One – Violence against Women

Introduction

This thesis is an analysis of language used to talk about violence, victims and perpetrators in therapy transcripts. The language we use to talk about violence has important implications for how we perceive the seriousness of the violence, who is to blame and how we respond to victims. As such, how violence is linguistically represented in therapy can have important implications for the outcome of therapeutic interventions. While this study focuses on therapy transcripts that dealt with the issue of violence against women and children, this study contains important implications that are applicable to the broader context of discussions about violence.

Violence against women by men is a very serious problem (Alberta Roundtable on Family Violence and Bullying, 2004; Berger, Searles, & Neuman, 1995; Boyle, 1985; Bonnycastle & Rigakos, 1998; Burt, 1980; Conway, 1997; Ehrlich, 2001; Family Violence in Canada: A Statistical Profile, 2005; Gartner & Macmillian, 1995; Gavey, 1999; Gunn & Minch, 1988; Hilberman, 1980; Hodgson & Kelley, 2002; Keane, 1995; Roberts, 1994; Rodgers, 1994a, 1994b; Scott & Lyman, 1970; Scully, 1990; Scully & Marolla, 1999; Tjaden & Thoennes, 2000; World Health Organization, 2002, 2005). The Canadian Violence Against Women survey (VAW Survey), in 1993 found that 39% of women have suffered sexualized violence, and 30 % (2.7 million) of married women have suffered physical and/or sexualized violence at the hands of their partner (Rogers, 1994a). The same survey also discovered that 23% of women have suffered physical and/or sexualized violence by strangers, 24% by a known man, 16% by a date or boyfriend, and 49% by a previous spouse (Keane, 1995). The VAW survey measured not

only the occurrence of violence but also womens' fear of victimization; they found that "64% of women express some worry about walking alone after dark, and 39% worry about being alone at home in the evening" (Keane, 1995, p.439).

The self-report data of women, reported above, is also supported by the self-report of men. For example, the 1986 Statistics Canada Survey of Canadian Men, found of men 18 years of age and older that "almost 1.1 million men used forms of physical violence against their romantic partners in 1980, including up to 80 to 90,000 who threatened to use, or actually used, a knife or gun" (Conway, 1997, p.182).

Actual rates of violence against women may even be higher because many instances of violence go unreported. In 2004, it was found that only 47% of women who suffered physical or sexualized violence reported that they had ever requested help to deal with the violence from a formal aid agency (Family Violence in Canada: A Statistical Profile, 2005). While all types of violent crimes against women are under-reported, women are even less likely to report when the perpetrator is known to them (e.g., family member, date, friend, acquaintance) independent of the type of violence that is perpetrated. Women may not be reporting violence perpetrated against them by a known man because they fear it would be viewed as minor (Gartner & Macmillian, 1995). This finding may be related to cultural discourses that construct violence by a known man as less serious than violence perpetrated by a stranger (Gartner & Macmillian, 1995).

While violence against women occurs across all classes, and in all ethnic groups, certain groups of women suffer more violence. For example, the 2004 General Social Survey revealed that Aboriginal women were three times more likely to be victims of

spousal violence than those who are non-Aboriginal, 21% vs. 7% (Family Violence in Canada: A Statistical Profile, 2005). More aboriginal women (41%) reported suffering severe and life threatening violence than non-aboriginal women (27%) (Family Violence in Canada: A Statistical Profile, 2005). When considering only victims of spousal violence, Aboriginal women (54%) were more likely to report experiencing severe life threatening violence (e.g., being beaten, choked, threatened with or having a gun or knife used against them) and (37%) were more likely to be sexually assaulted than non-Aboriginal women (Family Violence in Canada: A Statistical Profile, 2005).

Rates of violence against women may also vary somewhat from province to province. The Canadian Institute for Health Information Report, released in September 2003, found that Alberta had the highest percentage of cases that involved domestic violence against women; 5,921 incidences of spousal assault were reported to police in Alberta in 2002 (Alberta Roundtable on Family Violence and Bullying, 2004).

While these statistics provide us with insight into the degree to which violence against women is a significant problem, some have suggested that these surveys are inherently flawed (Verburg, 1995). While overall incident rates may not be affected, these studies may have underestimated the incidence of violence by men known to women (Verburg, 1995). Both the Statistics Canada Violence Against Women Survey, and the “Women Assaulted by Strangers” study have defined violence perpetrated by a stranger as any violence perpetrated by a man other than their spouse; this overestimates the occurrence of violence perpetrated by a stranger while severely neglecting violence perpetrated by an acquaintance (e.g., date, boyfriend) (Verburg, 1995). This is problematic because it effectively conceals the fact that women are more likely to be

assaulted physically or sexually by a known man than by a stranger (Tjaden & Thoennes, 2000)

On an international level, violence against women is a problem of epic proportions. In the United States, a national survey found that intimate partners perpetrated 76% of the physical assaults and rapes on women (Tjaden & Thoennes, 2000). The World Health Organization's World Report on Violence and Health found that in some countries, up to 69% of women reported having been physically assaulted and up to 47% of women reported that their first sexual intercourse had been forced (World Health Organization, 2002). The report also found that 7% of all deaths of women, between the ages of 15-44 worldwide, are related to acts of violence and that virtually half of the women who are killed are killed by their current or former husbands or boyfriends (World Health Organization, 2002).

Violence against children is also a very common problem on an international level. The World Health Organization (WHO), has also found that in the European Region, four children aged 0 to 14 years-of-age are killed every day, and 1300 die every year, due to homicides or assaults (2005). In industrialized countries it is estimated that between 40% and 70% of men, who physically assault their partners, also commit acts of violence against their children (World Health Organization, 2005). The World Report on Violence and Health (2002) found that 8% of male and 25% of female children had experienced some form of sexual abuse. Finally, a UNICEF youth poll in 2001 found that 60% of children in Europe and central Asia reported facing violence and aggressive behaviour at home (World Health Organization, 2005).

These statistics demonstrate that there still is a high rate of violence against women and children worldwide despite women's and children's rights movements and the resulting socio-legal changes. Findings like these have prompted many to conclude that we are living in a world that seems to encourage violence against women (Berger et al., 1995; Ehrlich, 2001; Gunn & Minch, 1988). Some researchers have argued that the socialization of men and women promotes violence against women by socializing men to be sexually aggressive, and women to be passive and coy (Berger et al., 1995). For example, patriarchal societal messages (e.g., that men should be sexually aggressive and women passive, or that men should be able to control their wives) provide men with ways to justify and excuse their violent behaviour against women (Conway, 1997; Scully, 1990; Scully & Marolla, 1999). Studies have shown that these patriarchal societal messages allow men to excuse and justify supposedly unacceptable behaviours, such as rape, by appealing to messages that present their actions as reasonable; examples would be, "women mean yes when they say no", that "women eventually "relax and enjoy it"", and that "nice girls don't get raped" (Scully, 1990; Scully & Marolla, 1999). These types of expressions provide "mechanisms by which everyday violations of expectations may be excused or justified; it provides a ready-made process by which the label of deviant may be avoided or removed" (Scott & Lyman, 1970, p.90). Male violence against women is so common that many suggest that it has become "normalized" and thus viewed as normal and legitimate (Bonnycastle & Rigakos, 1998; Hilberman, 1980), so much so, that many women who have experienced what would be legally defined as rape, do not acknowledge that they have been raped (Gavey, 1999).

Family violence has become particularly “normalized”, and is often perceived as more acceptable than violence perpetrated outside the family (Hilberman, 1980). “Real” violence, is constructed as that which occurs between strangers, denying the fact that the majority of female victims are victimized by men they know (Burt, 1980; Ehrlich, 2001; Hilberman, 1980).

An examining of how violence is linguistically represented in legal or therapeutic interventions with victims is of the utmost importance given that: a) violence against women and children is still a serious problem; b) that linguistic strategies like rape myths, exist to discredit victims; and, c) representations of violence, victims, and perpetrators, impact how we interpret the seriousness of the violence, and issues of responsibility.

The Interactive and Discursive View of Violence and Resistance is a research and intervention strategy that takes into account the role of language in the construction of social meaning. This framework proposes the existence of four-discursive-operations that “(i) conceal violence, (ii) mitigate perpetrators’ responsibility, (iii) conceal victims’ resistance, and (iv) blame or pathologize victims” (Coates & Wade, 2004, p.500. People who use these linguistic operations produce incorrect representations of violence that ignore the unilateral nature of acts of violence and, instead focus on pathologizing victims (Coates & Wade, 2004). Examining how violence, victims, perpetrators, and responsibility for the violence are represented in therapy transcripts in which the presenting issue is violence, will allow us to see if linguistic strategies that are used to discredit victims in everyday talk are also used in therapy by therapists. The critical realist view of language postulates that the process of formulating a person or event is never neutral (Fairclough, 1992, 1995; Parker, 1991). As such, even talk within the

context of therapy is not free of biases and, should be critically examined to see if accurate representations of violence and victims' experiences are used. In this study, 19 therapy transcripts, from various theoretical backgrounds, were analyzed to see if the four-discursive-operations were used. Next, five transcripts were randomly selected for a detailed analysis which involved an examination of how the four-discursive-operations impacted formulations of violence, the victim, the perpetrator, and ultimately the movement of the therapeutic interview. Analyzing these transcripts, moment to moment, allowed me to clarify how these linguistic strategies are accomplished in therapy, that is of how these representations are initiated; whether the violence is represented as mutual or unilateral; and, who/what is constructed as the problem. It is important to note, that there are many diverse approaches to therapy and, that not all therapists or legal professionals misrepresent acts of violence. This study serves as a critique of bio-medical and cognitive approaches, as well as specific processes that are used by legal and helping professions, that act to re-victimize victims of violence. Such critical examinations will help us work toward facilitating more successful therapeutic and legal interventions with victims of violence in which the violence is exposed, perpetrators' responsibility is clarified, victims' resistance is elucidated and clarified, and victim blaming and pathologizing is contested (Coates & Wade, 2004).

Throughout the rest of this chapter, I will discuss the connection between violence and health and mental health problems. I will examine how violence against women connects to broader social inequalities by examining individual narratives, legal implications and feminist theories. Finally, I will propose that how we respond to victims of violence is of the utmost importance.

Definitions

Before beginning, I will clarify some of the terms that will be used throughout this study. Assault is defined by Canadian law as the application of “force intentionally to another person, directly or indirectly, without their consent; attempting or threatening, by an act or gesture, to apply force to another person” (The Dictionary of Canadian Law, 1995, p. 77). Rape is defined as “non-consensual sexual intercourse” (The Dictionary of Canadian Law, 1995, p.1020). In 1983, Canadian courts shifted the focus of sexual assault law away from traditional definitions of rape as a sexual and moral issue to treating it as an inherently violent act, thus using the term sexual assault (Boyle, 1985; Gunn and Minch, 1988; Smart, 1989). Sexual assault is defined by Canadian law, as an assault “which is committed in circumstances of a sexual nature, such that the sexual integrity of the victim is violated” (The Dictionary of Canadian Law, 1995, p.1147). This term has been viewed by some as problematic because it combines a word used to refer to consensual sex (sexual) and a word used to refer to violent acts (assault). Boyle (1985, p.104) commented that:

If sex is stolen rather than willingly shared, then in a world in which sex was understood to be a truly consensual activity, [stolen sex] would not be sex. Yet the law obliges us to label what has been stolen as sexual.

It has been argued sexual activity and sexualized violence are different acts and thus the term sexual should never be used to refer to violent acts (Coates, Bavelas, & Gibson, 1994; West & Coates, 2003). A more appropriate term would be sexualized violence.

The battered woman syndrome label is often used to explain battered women's behaviour. It has been defined “as a symptom complex of violence in which a woman

has, at any time, received deliberate, severe, and repeated (more than three times) demonstrable injury from her husband, with minimal injury of severe bruising” (Parker & Schumacher, 1977, p.760). Two of the major theories behind the battered woman syndrome include learned helplessness and the cycle of violence (Terrance & Matheson, 2003). The battered woman syndrome postulates that repeated physical abuse leaves women feeling powerless to end the violence (Terrance & Matheson, 2003). The notion of learned helplessness is used to explain why battered women often stay with their abusive partners, and, suggests that they may not always clearly see all their possible options (Terrance & Matheson, 2003). The battered woman syndrome also suggests that over time women become sensitized to the cycle of violence, in that they become sensitive to cues that signal that their partner may become abusive towards them (Terrance & Matheson, 2003). The cycle of violence is used to explain why womens’ attacks on their abusive husbands usually occur during a break in the violence (Terrance & Matheson, 2003). This theory allows these womens’ acts of self-defense to be viewed as reasonable by the legal system given the physical difference in strength between men and women (Terrance & Matheson, 2003).

Connection to Health and Mental Health Problems

Violence is a serious issue because violence is also a health and wellness issue. There is a direct link between interpersonal violence and a person’s physical and mental health. The World Health Organization’s World Report on Violence and Health (2002) reported that violence against women is linked to both short and long term conditions including, but not limited to, physical injury, chronic pain syndromes, depression and suicidal behaviour. There is no question that violence causes extreme trauma; however,

the problem is often formulated as an individual one, which allows the violence to be effectively ignored.

Biological Pathology

The majority of research on victims has been done within the medical model which constructs the etiology of problems as located within an individual's physiology; that is, if biological pathology exists, it means that person has an underlying weakness that is the ultimate cause of their problem. This is problematic because it constructs victims as pathological and deficient, without taking into consideration their social context (Breggin & Breggin, 1991, 1994; Conrad & Schneider, 1992; Lalumiere, Harris, Quinsey, & Rice, 2005; Pam, 1990; Tavis, 1992; Wade, 2000). For example, an investigation of diagnoses assigned to sexually abused children revealed that 30% of them were diagnosed with anxiety disorder, 20% were diagnosed with oppositional defiant disorder, 17% were diagnosed with post-traumatic stress disorder, 14% were diagnosed with attention-deficit hyperactivity disorder and 12% were diagnosed with depressive disorders (Merry & Andrews, 1994). The diagnosis of ADHD, for example, is problematic because it is viewed as a biological deficit and, as such, these children's acting out behaviours were not interpreted as a negative effect of the abuse but instead, as predisposing quality that may have made them more susceptible to being abused in the first place (Wade, 2000). Instead of viewing the child as being understandably traumatized and confused by the act of violence perpetrated against them, these diagnoses focused on the problem as residing strictly within the child (Wade, 2000). This practice attributes personal deficiencies to victims of interpersonal violence by constructing victims' internal weaknesses as precipitating their victimization (Pam, 1990; Tavis,

1992; Wade, 2000). Characterizing problems as the result of the internal, negative characteristics (deviance), constructs problems as individualistic in nature (Breggin & Breggin, 1991, 1994; Conrad & Schneider, 1992; Pam, 1990; Tavis, 1992; Wade, 2000). It shifts the focus from blame and punishment to that of treatment and prevention (Conrad & Schneider, 1992). This shift has important implications because it means a shift from looking at the perpetrator to looking at the victim. This formulates the victim's problems as individual, thus ignoring the role of the perpetrator and the violence (Conrad & Schneider, 1992).

Dealing with violence through the medical model requires that perpetrators and victims submit to the sick role (c.f. Conrad & Schneider, 1992). It is particularly problematic in the area of violence for perpetrators to take on the sick role because this would suggest that they should not be held responsible for their actions or for their illness; this allows them to avoid taking responsibility for their violence (Conrad & Schneider, 1992; Wade, 2000). For victims of violence, many frequently problematic assumptions co-occur with taking on the sick role. For example, many psychotherapists assume:

- individuals who seek therapy have a personal deficit or disorder;
- that only an expert can diagnose and treat the problem;
- that this deficiency is located within the individual and that these mental deficiencies objectively exist ;
- that the best way to help individuals is to search out abstract concepts (a diagnosis);
- that the process of diagnosis is neutral;

- and finally, that individuals have been negatively effected by the events that have brought them to therapy (Wade, 2000).

Moreover, virtually all models of psychotherapy contain theories about the effects of violence on victims; most construct victims as sick by suggesting lasting impacts thus implying personal pathology (Breggin & Breggin, 1991, 1994; Wade, 2000). For example, cognitive models assume that individuals internalize deficient beliefs about themselves, psychoanalytic models assume that victims develop a maladaptive defense mechanism, narrative approaches suggest that victims develop feelings of self-hate or self-blame, and feminist models assume that victims internalize negative stereotypes associated with being a victim and thus employ denial strategies (Wade, 2000). In all of these approaches, practitioners and researchers use words like “impacts”, “symptoms”, or “consequences” to discuss the harmful “effects” of interpersonal violence (Wade, 2000). These theories construct a victim’s sickness as a direct result of the violence (Wade, 2000). This language of effects presents a mechanistic interpretation of events that suggests that if A occurs then B must occur and implies that the action of B is simply a passive response to A (Wade, 2000). Applying this mechanistic approach to victims of violence denies victims’ agency by formulating their responses as something that is reflexively shaped by the perpetrators’ violence and thus is beyond their control (Wade, 2000).

Medicalization is problematic for victims of violence because it constructs them as deficient and assumes that these deficiencies are represented as either precipitating the victimization, or as occurring as a direct result of their victimization (Coates & Wade, 2004; Coates & Wade, in press; Wade, 2000). The medical model may also be used to

remove blame from perpetrators, by presenting their actions as non-deliberate, and proof of their “sickness” (Coates & Wade, 2004; Coates & Wade, in press; Conrad & Schneider, 1992; Morgan & O’Neill, 2001a, 2001b). Thus, it is clear that using the medical model is not a politically neutral act. Instead, the medical model acts as a powerful form of social control by individualizing behaviours that should be addressed socially to better understand why they occur to begin with (Breggin & Breggin, 1991, 1994; Coates & Wade, 2004; Conrad & Schneider, 1992; Pam, 1990; Ridley & Coates, 2003; Wade, 2000).

A study on the language used to describe victims of sexualized violence in therapy articles, found that many of victims’ responses to violence were recast, as the “negative” effects of interpersonal violence (Ridley & Coates, 2003). They found that therapists represented victims as passive, damaged, deficient and in need of professional help. This is not just an objective but a discursive process (as will be discussed in later chapters) in which “symptoms” are recast as deficiencies. Within the context of therapy, resistance to the therapist’s formulations of the victim (as deficient or pathological) will often be interpreted as proof of their deficiency (Wade, 2000). As such, these diagnoses can easily be interpreted as a form of social control (Conrad & Schneider, 1992; Lerner, Rober, & Strong, 2004; Strong, 1995; Wade, 2000). According to Wade (2000, p.321),

The process of identifying and representing certain specific behaviours or subjective experiences as effects of interpersonal violence is itself an interpretative and inherently political process, in the sense that it occurs in a context of power relations, shapes the nature of the practices used in

psychotherapy and other social services, and profoundly influences the lives of individual victims.

While it is true that interpersonal violence causes harm, focusing solely on the pathology and deficiency of the victims ignores the broader social issues that allow violence against women to occur in the first place (Coates & Wade, 2004; Conrad & Schneider, 1992; Ridley & Coates, 2003; Wade, 2000). By ignoring the role of societal influences in the perpetuation of violence against women, the medical model offers, at best, a “band-aid” solution because it does not address the societal influences that allow violence against women to occur in the first place and, at worst, further victimizes victims of interpersonal violence and obfuscates perpetrator responsibility by forcing both victims and perpetrators to take on the sick role (Conrad & Schneider, 1992; Wade, 2000). As described above, it is clear that the very process of defining something as a disease or a sickness is not a neutral process and can have very serious negative effects (Conrad & Schneider, 1992). Under the guise of healthcare, certain social behaviours are constructed as problematic, and attempts are made to modify and eliminate them (Conrad & Schneider, 1992).

Power Inequalities and Violence

In Canada, we have a tendency to assume that women have achieved equality, but such an assumption is not supported by research (for example, women are overall still paid less than their male counterparts). These power inequalities also underlie violent patterns. The majority of victims of spousal and sexualized violence are women and the majority of perpetrators are men; children are abused by adults; and, members of visible minority groups, such as Aboriginal women, are more likely to be victims (Conrad &

Schneider, 1992; Family Violence in Canada: A Statistical Profile, 2005; Gunn & Minch, 1988; Sangster, 2001). All of these instances demonstrate the power imbalances involved in interpersonal violence, namely, that victimized individuals are generally members of marginalized groups. Perpetrators anticipate resistance from their victims, and, as such, take steps to conceal or suppress it before, during, and after the assaults (Coates & Wade, 2004; Coates & Wade, in press; Wade, 2000). Perpetrators do not knowingly pick on the strong; instead, they focus their efforts on those weaker than themselves (Coates & Wade, in press; Wade, 2000). Those in positions of power (for example, men and adults) are able to impose their definitions of reality on others (Coates & Wade, 2004; Coates & Wade, in press; Conrad & Schneider, 1992; Wade, 2000). Perpetrators often utilize strategies that misrepresent their violence in such a way that their responsibility for the violence is diminished and victims are portrayed as passive or submissive participants in the violence (Coates & Wade, 2004; Coates & Wade, in press; Conrad & Schneider, 1992; Scully, 1990; Scully & Marolla, 1999; O'Neil & Morgan, 2001a, 2001b; Wade, 2000).

These power inequalities can be seen by the fact that child and wife abuse have not always been conceptualized as social problems. Moreover, once these issues were recognized as problematic, those in positions of power (the male dominated medical community) were quick to pathologize victims. For example, the creation of “the label ‘battered child syndrome’, gave physicians both a measure and legitimacy for medical intervention” (Conrad & Schneider, 1992, p.164). Conrad and Schneider suggest that these definitions of children, as weaker and not responsible for their actions, have encouraged those in positions of power (the medical community) to medicalize children’s

“behaviors that would not be defined as medical maladies in adults”(1992, p.170). The definition of child abuse as a medical problem has also labeled the abusive parent as sick, but by simply focusing on the pathology of the individual, they ignored the social context in which child abuse was ignored for so long (Conrad & Schneider, 1992).

These concepts can also be applied to women who, like children, are in a disadvantaged position relative to men, thus making them susceptible to the medicalization of behaviours that the male world does not view as acceptable or, would rather ignore (Lamb, 1999). When women suffer abuse at the hands of their husbands and fight back, they are diagnosed as having “battered wife syndrome” (Renzetti, 1999; Walker, 1984). When women are raped, they are often diagnosed as having posttraumatic stress disorder to explain the trauma and difficulties they experience (Lamb, 1999; Wade, 2000).

The creation of syndromes or and disorders to account for the behaviour of victims is controversial. Some people view the creation of battered wife or child syndromes and post traumatic stress disorder as beneficial because they help alleviate blame from the individual by suggesting that individuals are experiencing a normal response to trauma (Conrad & Schneider, 1992; Lamb, 1999). Others wonder why there must exist a syndrome or disorder to explain a victim’s fear, heightened anxiety, emotional numbing or nightmares which should be interpreted as understandable reactions to trauma (Lamb, 1999). While child abusers, rapists, and wife batterers are all viewed as being “sick”, it is the women and children who are labeled and become the focus of the medical community (Conrad & Schneider, 1992; Lamb, 1999).

Social Responses to Violence Against Women

While some say that violence against women was not recognized as a problem until the 1970s (Bonnycastle & Rigakos, 1998), it is more accurate to say that violence against women, in general, was not responded to as a social problem. Prior to the 1970s, women who sought justice through legal recourse were often faced with an ideological context that was strongly located in patriarchal notions of gender roles and a husband's right to control his family (Sangster, 2001). While these stereotypes are still common today, female rape victims were even more likely to fall prey to rape myths that implied that victims in some way precipitated their own victimization (e.g., "she asked for it" or "nice girls don't get raped"). Feminists wanted social services to be put in place to help victims of violence, and to draw attention to societal ideals that perpetuated the notions of violence against women as acceptable (Tierney, 1982). In order to do this, feminists appealed to the justice system to construct wife abuse and rape as assaults, which made the issue of violence one to be controlled through the legal system. "For the women's movement, controlling violence meant changing power relations between women and men by punishing men for enforcing dominance by violent acts" (Walker, 1990, p. 211). Proponents of this movement sought broad social changes to patriarchal ideologies that suggest that violence against women is acceptable (Scully, 1990; Tierney, 1982; Walker, 1990).

While the criminalization of violence against women is a step in the right direction, for the women's movement, simply punishing men who batter, or who rape, is not enough (Scully, 1990; Tierney, 1982; Walker, 1990). Many have argued that simply getting the courts to treat violence against women as serious, would not ameliorate the

problem (Tierney, 1982; Walker, 1990). Simply punishing men who are violent towards women does not address the societal messages that precipitate violence against women. An example of this is the man who killed 14 female engineering students at the University of Montreal (Walker, 1990). Analysts suggest that this man sought out female students in the same department that had refused to admit him, not because they were women, but, because they had moved away from their stereotypical roles as women by gaining access to the predominantly male field of engineering (Walker, 1990). Isolating this act as simply one of violence does not take into account the political context in which it occurred, thereby ignoring the patriarchal ideologies that motivated this man's rage that women would be admitted into the male profession of engineering while he was not (Walker, 1990). Along the same lines, ignoring the political and social context in which wife battering and sexual assault occurs, we are essentially ignoring the societal values that motivate men to act violently towards women (Coates & Wade, 2004; Walker, 1990).

Victim Blaming

Patriarchy

In a patriarchal society, in which the interests of men are the primary focus, there is a significant fear that women will take advantage of the victim label by making false accusations (Burt & Estep, 1981). For example, rape victims are often accused of lying or crying rape out of revenge, and must legitimize their claims before they are allowed to claim the role of victim (Burt & Estep, 1981; Frohmann, 1991).

Investigators have found many biases against female victims of violence in courts (Burt & Estep, 1981; Coates, Bavelas, & Gibson, 1994; Coates & Wade, 2004; Denike,

2002; Ehrlich, 2001; Frohmann, 1991; Hodson & Kelley, 2002; Reiff, 1979; West & Coates, 2003). The criminal justice system represents the dominant views of our culture and, therefore, it should come as no surprise that the majority of rape policy reforms in Canada generally “amount to little more than ‘impression management,’ masking the public face of the institution while the internal operations, for the most part, go unchallenged and unchanged” (Hodson & Kelley, 2002, p. 5). Our justice system still strongly focuses on the rights of the male perpetrators not to be wrongly accused by “irrational women”, instead of on the rights of victims’ not to be victimized (Ehrlich, 2001; Reiff, 1979). Women, in the legal system, are “constructed both as victims (when the perpetrator is heinous) and agents (when the perpetrator is respectable)” (Ehrlich, 2001, p.28). Mistrust of sexual assault victims has resulted in legal processes that make it difficult for victims to seem credible (Denike, 2002). Therefore, women learn they will be aided by the system only if their experience matches stereotypical notions of rape, in which innocent victims are attacked by heinous strangers (men) (Ehrlich, 2001). In his study of a rape trial, Matoesian (2001, p.40) argued that the “patriarchal logic of sexual rationality” was utilized to create a notion of sameness and difference. For example, men and women were cast as having the same definitions of sexual access and desire but it was acceptable only for men to have “casual sex”, not women (Matoesian, 2001). This notion can be extended to the issue of self-defense, in that women and men are expected to engage in similar self-defense, thereby ignoring the power inequalities that exist between men and women both physically and socially (Matoesian, 2001). As such, female victims are placed in a no-win situation, “if they fight back and defend themselves, the crime is minimized; if they are passive and are raped [or otherwise

victimized], they are condemned by the jury for not fighting back” (Gamble, 1991, p.17). It is no wonder that the vast majority of victims fail to report incidences of violence (Gamble, 1991).

By examining the talk used to promote these patriarchal ideologies, biases against victims, we can better understand how these biases and ideologies occur and how they can be identified. As Ehrlich (2001, p.4) says, “language is the primary vehicle through which cultural and institutional ideologies are transmitted” in professional, academic and legal settings. Therefore, it is likely that victim blaming practices also occur in speech within personal, academic, legal and therapeutic settings (Alcoff & Gray, 1993; Anderson, 1999; Bachman & Paternoster, 1995; Bavelas & Coates, 2001; Caplan, 1995; Coates, 1997; Coates, Bavelas & Gibson, 1994; Coates & Wade, 2004; Davis, 1986; Del Bove & Stermac, 2002; Denike, 2002; Ehrlich, 2001; Estrich, 1995; Frohmann, 1991; Gamble, 1991; Gunn & Minch, 1988; Hodgson & Kelley, 2002; Karuza & Carey, 1984; Kurz, 1987; Jenkins, 1990; Los & Chamard, 1997; Loseke & Cahill, 1983; Matoesian, 2001; McCaul, Veltum, Boyechko, Crawford, 1990; Pam, 1990; Reiff, 1979; Renner, 2002; Scully, 1990; Scully & Marolla, 1999; Wade, 1997, 2000; West & Coates, 2003).

“Victim” as a Totalizing Identity

Research has shown that victims are often blamed for their own victimization (Berger, et al., 1995; Burt, 1980; Burt & Estep, 1981; Marecek, 1999; Renzetti, 1999). Victim blaming is done by creating the label “victim” as a totalizing identity rather than a term that represents the person in a specific social interaction (Coates, 2005; Coates & Wade, 2005; Wade, 2000). For example, constructing victims as “once victimized, forever a victim” represents a woman’s past, present, and future as being affected by the

violence instead of representing the person as a victim of violence in that particular interaction (Coates, 2005; Coates & Wade, 2005; Wade, 2000). Doing so allows the woman's character and actions to be interpreted as damaged and deficient as a direct result of the violence (Ridley & Coates, 2003; Coates, 2005; Wade, 2000). For example, one therapist stated that "B. learned the victim role well. . . B did not know any alternative but to live as a victim" (Ridley, & Coates, 2003, p.12). The use of the word, "role", implies that the victim participated in the violence that was perpetrated against her (Ridley & Coates, 2003, p.12). By saying that "B did not know any alternative" the therapist is implying that the victim is deficient or damaged as a result of the violence and, therefore, she is incapable of living a "healthy" life (Ridley & Coates, 2003, p.12).

Using the label, "victim", as a totalizing identity also portrays victims as passive agents who submit to the violence that is perpetrated against them; this overlooks the victims' resistance (Renzetti, 1999; Wade, 1997, 2000). The label does not take into consideration the inner strength of victims and ignores their resistance efforts, particularly if their efforts were "unsuccessful" (Renzetti, 1999). These notions exist despite research that has proven that "whenever persons are badly treated, they resist" and that this resistance is a sign of health (Wade, 1997, p.23, 2000). "The labels "victim" and "battered women" are stigmatized identities" used to rob women of their agency (Renzetti, 1999, p.52).

Victims' Resistance

Many researchers and theorists have criticized common notions of victim resistance for discrediting the types of resistance used by victims (Burstow, 1992; Burt & Estep, 1981; Caplan, 1995; Coates et al., 1994; Coates & Wade, in press; Kelly, 1988;

Wade, 2000). Most research on sexualized and physical violence has portrayed victims as passive recipients of violence, has viewed victims as suffering from long term effects of violence and, has characterized womens' responses to violence as merely coping or as a survival mechanism, with little to no mention of victims' resistance (Kelly, 1988). This lack of attention to victims' resistance has helped reinforce commonplace stereotypes of victims as passive, powerless and deficient (Kelly, 1988). It has also made possible misconceptions about womens' means of coping and resisting that allow women to be blamed for or viewed as precipitating the violence (Kelly, 1988). Cultural stereotypes about what constitutes rape and what are deemed "appropriate" responses to rape, are also problematic (Burt & Estep, 1981). For example, the notion that "rape is a fate worse than death" suggests that a victim's resistance should be prolonged and persistent regardless of the risk (Burt & Estep, 1981, p.18). Victims whose narratives do not meet this definition of resistance will not be viewed as having been raped, nor as having responded as a 'real victim' would have (Burt & Estep, 1981). Judges, for example, criticize victims who eventually stopped "struggling" against the perpetrator (Coates et al., 1994). Victims stopping or not physically resisting was cast by judges as "acquiescing" or "unauthentic" (Coates et al., 1994, p. 195). For example,

She testified that after the first bout of intercourse she **stopped struggling** and that she **acquiesced** in the second bout, although the intercourse was still without her consent. (Coates et al., 1994, p.195)

This ignores the fact that victim have good reasons to stop "struggling" for example, trying to avoid further retaliation by the perpetrator which could increase their likelihood of staying alive.

Criticisms of victims' chosen forms of resistance allow the blame to be shifted back onto the victims for not having resisted "enough" or "appropriately" (Coates et al., 1994). For example, one judge described a victim's verbal resistance as unauthentic:

[that] she went to the door and opened it to invite him out **does not have the ring of authenticity about it.** (Coates et al., 1994, p.195)

The language used by judges to discuss victims' resistance also reflects traditional notions of resistance as purely physical and as occurring between two equal combatants (Coates et al., 1994). These notions of resistance do not take into consideration asymmetrical situations (e.g. a woman being attacked by a man who is much stronger than her or a child being abused by an adult), where physical, or overt forms of resistance, are likely to precipitate further violence and harm (Coates et al., 1994). In fact, none of the judgments analyzed in Coates et al (1994), represented verbal refusals as adequate, or suitable, forms of resistance. It seems that despite the 1992 amendment to Canadian sexual assault law which requires that consent be established before sexual contact, judges are resistant to notions of verbal resistance being sufficient in cases of sexualized assault. In short, judges continue to "operate on the basis of traditional assumptions and they do not always comply with the statutes. Decisions regarding sexual assault cases are still subject to a great deal of discretion, and the reforms do not necessarily affect the information operations of the criminal justice system" (Berger et al., 1995, p.229). In other words, the making of reforms is one thing but putting them into application is quite another.

Researchers using the Interactive and Discursive View of Violence and Resistance have argued that victims' resistance has also been used to blame victims in therapy. In therapy, a victim's resistance is often characterized as a sign of pathology (Wade, 2000). For example, women who were battered by their husbands are often diagnosed as clinically depressed and children who were abused are often diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) (Wade, 2000). These diagnoses are problematic because they conceal the seriousness of the violence that has been perpetrated against the victim, by shifting the focus away from the act of violence, and, onto the victim by characterizing their responses to violence (e.g., feeling sad, being active rather than calm) as signs of deficiency (Wade, 1997, 2000). Wade provided an example of a woman who had become depressed over the course of several years after her adulterous husband raped her (Wade, 2000). According to her husband, she had become "less patient, less affectionate, not willing to do what she used to do around the house", and she seemed to be "unhappy with being a mother" (Wade, 2000, p.42). The husband complained that it was very difficult for him and the children to deal with her depression and took her to a physician who diagnosed her with clinical depression (Wade, 2000). This diagnosis constructed the anger and depressed woman as pathological and deficient instead of rational and reasonable given the situation. Her unhappiness and her refusal to do housework became characterized as symptoms of depression and signs of internal deficiency. The social context of violence in which these actions occurred was left unexamined (Wade, 2000). This example demonstrates how professionals often "enable violence and inequality through asocial diagnosis" (Wade, 2000, p.45). By

suggesting that the woman's problems were the result of something in her mind, her husband's violence and mistreatment were effectively ignored.

Responsibility

Representations of violence against women generally do not present accurate depictions of the violence that occurred (Coates & Wade, 2004). For example, rape is often described as "having sex" or "intercourse" which conceals the violent nature of rape because the terms, "having sex", or "intercourse", are generally used to describe a consensual and mutual act between two people (Bavelas & Coates, 2001; Coates et al., 1994; Coates & Wade, 2004; Coates & Wade, in press). Presenting rape as mutual and consensual also denies victim resistance (Bavelas & Coates, 2001; Coates et al., 1994; Coates & Wade, 2004; Coates & Wade, in press; Todd, Wade, & Renoux, 2004). Another example includes acquaintance rape which, in contrast to stranger rape, is stereotypically perceived as less serious and less common; as such, it is often described as a consensual sexual act instead of sexualized violence (Coates et al., 1994). These inaccurate depictions of violent acts create space in which victims can be blamed for their own victimization (Bavelas & Coates, 2001; Coates et al., 1994; Coates & Wade, 2004; Coates & Wade, in press).

West & Coates (2003), examined 28 New Brunswick sexual assault judicial judgments. They found that 32% of cases misrepresented sexualized violence by representing these acts as mutual (West & Coates, 2003). Sixty-seven percent of the representations obscured perpetrators' responsibility for the sexualized violence by minimizing the degree of violence involved and, 62% removed any representations of sexualized assaults as being violent acts (West & Coates, 2003). West & Coates (2003)

found that judges often made no reference to the perpetrators' use of force and depicted the offenders' actions as non-violent (West & Coates, 2003). Seventy-eight percent of the representations of sexualized assault minimized the severity of sexualized assaults which had the effect of minimizing perpetrators' responsibility and denying the disagreeable nature of these acts (West & Coates, 2003). Sexualized assaults were represented as pleasurable 34% of the time, both pleasurable and unpleasant 5% of the time and neutral (neither pleasurable nor unpleasant) in 39% of the representations (West & Coates, 2003). They also found that the more judges used language that misrepresented acts of violence as mutual or pleasant, the more likely they were to give perpetrators lenient sentences (West & Coates, 2003). Overall, West & Coates found that not one judgment represented sexualized assault "as unequivocally and systematically unilateral, violent, and unpleasant" (West & Coates, 2003, p.23).

The language used to describe sexualized violence in sexual assault trial judgments is problematic because often they do not present these as acts as unequivocally unilateral and violent acts (Bavelas & Coates, 2001; Coates et al., 1994; Coates, 1997; Coates & Wade, 2004; West & Coates, 2003). For example (Coates et al., 1994, p.194):

when sentencing a man convicted of sexually assaulting a girl, a judge noted that

"there was no violence and no physical force, no coercion or intimidation."

While sexual assault is defined by Canadian law as a violent act, judges are frequently cited as using the word intercourse to describe rape (The Dictionary of Canadian Law, 1995). This is problematic because intercourse conveys mutuality and, therefore, does not adequately describe the violence and fear associated with acts of rape (Bavelas & Coates, 2001; Coates et al., 1994; Coates, 1997; West & Coates, 2003). Linguistic processes are

critical to issues of perpetrator responsibility, whether in a legal or a therapeutic context. Coates and Wade (2004), in their study of British Columbia and Yukon sexual assault trial judgments, found that judges were often likely to minimize perpetrator responsibility. They found judges excused perpetrators' actions by suggesting that they were affected by forces beyond their control (Coates & Wade, 2004). Thirty-five percent were likely to blame the use of alcohol or drugs, 31% blamed men's biological sex drive, 10% implied that the perpetrator had a psychological disorder, 8% blamed a poor family environment, and 5% implied that the perpetrators were, at the time of their assaults, experiencing stressful situations (Coates & Wade, 2004). These reformulations "mitigated offenders' responsibility by holding them accountable for non-violent rather than violent acts (e.g., consuming alcohol, pathology, or having sex)" (Coates & Wade, 2004, p. 514). Importantly, "judges gave sentences that were congruent with the reformulated versions of events" put forth by the defense (Coates & Wade, 2004, p. 523). These actions reinforce the notion that the way we speak about sexual assault plays a strong role in determining to whom we attribute blame and how these individuals are punished.

Legal & Therapeutic Settings

Experts in legal proceedings and therapeutic interviews exert a great deal of control over talk by directing and interpreting talk about violence and victims' experiences (Davis, 1986; Coates & Wade, 2004; Wade, 2000). For example, in court lawyers have a great deal of linguistic power, because they are the ones in control of what questions can be asked (Ehrlich, 2001). Lawyers often limit questions to those which require a "yes" or "no" answer in attempts to limit the victim's ability to speak about

their experiences. Cross-examiners may also negate victim resistance, and bring attention to the countless forms of resistance that the victim could have employed but did not employ. Ehrlich found that lawyers also rely on myths such as the one that suggests that rape occurs due to “male/female miscommunications” (Ehrlich, 2001, p.121). These linguistic practices attempt to paint a picture of victims as “ineffectual agents”, “whose passivity and lack of resistance is considered tantamount to consent” (Ehrlich, 2001, p.95).

In therapy, it is the therapist who directs the flow of the therapeutic interview by asking the questions and deciding which points should be further explored and which should be ignored. Davis (1986), examined the process through which a client’s talk was reformulated in therapy. She examined the talk in a therapy transcript, moment to moment, to see how a young woman’s complaint of having trouble adjusting to being a full time housewife and mother was reformulated into a personal deficit, namely, the inability to express her feelings openly and honestly (Davis, 1986). For example, after the client presents her version of why she has come to therapy, the therapist begins to present his version of the problem by criticizing the client’s use of the word “upset” to describe her situation (Davis, 1986, p.53). The therapist went on to suggest that the client has a problem expressing her “true” feelings. Instead of listening to what the client is saying, the therapist chose to focus on and criticize how the client expressed her feelings about her problems (Davis, 1986). The therapist then defined how the client talked about her feelings as a symptom of the problem to be addressed in therapy, namely, that the client was not honestly expressing her feelings (Davis, 1986). The therapist continues to formulate what the client has said about her feelings as problematic. Instead of

recognizing the client as someone who is strong and capable who is experiencing a “problem with living”, the therapist presents a deficient, pathological version of the client (Davis, 1986). Instead of commenting on the client’s strength, in not only trying to solve her own problems but also being strong enough to seek help when it is necessary, the therapist represents this as part of the problem (Davis, 1986). The therapist criticizes the client for trying to solve her problems on her own first before seeking the help of a therapist. The therapist suggests that the client’s trying to be strong and capable when she is not is just another example of how her actions do not coincide with how she’s really feeling.

Battered Woman Syndrome & Self-defense

Intimate partner violence is another area where legal and therapeutic responses are problematic, particularly in the use of the self-defense defense and the “battered woman syndrome”. As discussed earlier, the criminal justice system represents the dominant views of our culture and as such its definition of self-defense is ripe with male bias, particularly, that “fights” occur amongst equals (Coates et al., 1994). The law stipulates that acts of self-defense must occur during the assault, and that a reasonable person would feel that there were no other options but physical self-defense (Coates et al., 1994). But this does not fit the experiences of women (Coates et al., 1994; Shaffer, 1997). Women have less social and physical power and, therefore, overt physical resistance sometimes occurs when they may have an increased likelihood of success, such as in moments of apparent calm (Coates et al., 1994; Shaffer, 1997; Wade, 2000). It was not until 1991 that battered women were afforded the same rights as men to the “self-defense” defense (Shaffer, 1997). Feminists initially introduced the notion of the

“battered woman syndrome” in hopes that it would help construct victims’ actions as reasonable but it has had the latent consequence of portraying victims as helpless and psychologically deficient (Shaffer, 1997).

In the landmark case *R v. Lavallee*, the court accepted evidence of the “battered woman syndrome” to explain why Lavallee had shot her husband as he walked away rather than during an assault (Shaffer, 1997). This decision legitimized the “battered woman syndrome” and expanded the range of self-defense to include actions by women (Shaffer, 1997). While this case was a triumph in that the patriarchal court system seemed to take into account a woman’s perspective in self-defense, it can also be conceptualized as a failure (Shaffer, 1997). In this case, women were cast as exhibiting “learned helplessness” rather than engaging in a reasonable course of action given the macro (e.g., social power) and micro (e.g., interactional) social circumstances. Therefore, the use of the “battered woman syndrome” perpetuated the myth of the passive woman (Wade, 2000) and created another “type” of female victim (Shaffer, 1997). As such, womens’ real life actions, exhibiting some strength and abilities, are found to be unacceptable or unreasonable compared to this “type” (Shaffer, 1997; Wade, 2000).

The assumption that women are helpless and fail to respond when victimized is increasingly coming under criticism (Kelly, 1988; Ridley & Coates, 2003; Shaffer, 1997; Wade, 2000). The creation of a “type” of battered women also made this defense accessible only to certain “types” of women (Shaffer, 1997). Many feminists, victim advocates and legal professionals worry that having ‘helplessness’ as one of the characteristics of the “battered woman syndrome” may allow the fact that not all battered women are helpless to be ignored (Shaffer, 1997). In fact, it may falsely construct women

as helpless or passive. Wade argues, “whenever persons are badly treated they resist” (Wade, 1997, p.23, 2000). According to Wade, “any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any type of disrespect) or the conditions that make such acts possible, may be understood as a form of resistance” (Wade, 1997, p. 25, 2000). According to Wade, all battered women in one way or another resist their batterer, and, whether or not this resistance is overt or not is inconsequential (Wade, 1997, 2000). What is important is that battered women are not helpless, and in fact, “many battered women engage in resourceful attempts to stop, or at least control their partner’s violence” (Shaffer, 1997, p.13). In keeping with this position, the “battered woman syndrome” defense does not appear to be very successful.

Despite the problems with this defense, many still hoped that it would be helpful in allowing more women access to the plea of self-defense (Shaffer, 1997). However, Shaffer, in her search of newspaper coverage of trials, found that since the groundbreaking Lavallee case in which the battered woman syndrome was first accepted as a legitimate defense in 1991, there does not seem to be an increase in the number of successful self-defense defenses for women. This was evidenced in that, “of the 16 women charged with murder or manslaughter of an abusive partner, only three were ultimately acquitted” (Shaffer, 1997, p.17). A study conducted by Terrance & Matheson (2003), attempted to evaluate the effectiveness of expert testimony in manipulating the opinion of jurors. They found that in the case of “battered woman syndrome”, “the expert witness did not persuade jurors to view the actions of the victims as justifiable from the

perspective of a “reasonable person”” (Terrance & Matheson, 2003, p.43; White-Mair, 2000). They went on to find that the addition of a diagnosis of post-traumatic stress disorder only served to construct battered women as even more pathological.

Summary

Violence against women is a pervasive and serious problem that is intrinsically linked to notions of health. Unfortunately, much of the literature on victims suggests that the professionals and institutions that are set up to help victims often end up blaming them. For example, in therapy, victims’ responses to violence are often recast as the “negative” effects of interpersonal violence and therapists often represent victims as passive, damaged, deficient and in need of professional help (Ridley & Coates, 2003; Wade, 2000). Discourses of violence that “(i) conceal violence, (ii) obscure and mitigate perpetrators’ responsibility, (iii) conceal victims’ resistance, and (iv) blame or pathologize victims”, allow victims to be represented as, at least, partially to blame for the violence perpetrated against them (Coates & Wade, 2004, p.500).

Violence against women is not just a womens’ issue; it is a Human Rights and Charter of Rights issue. Violence against women will not be solved until men take responsibility for these acts and recognize them as fundamentally wrong (Scully, 1990).

While violence against women is not a problem that will disappear overnight, positive social change can be accomplished by encouraging the use of more accurate interpretations of violent acts (Coates, Todd & Wade, 2003; Coates & Wade, 2004). Prevention and intervention strategies must carefully consider the language used to represent the actions of both the perpetrators and the victims (Coates, Todd, & Wade,

2003; Coates & Wade, 2004). In the next chapter I will discuss the role of language in therapy.

Chapter Two – Therapy as Discourse

Introduction

Chapter One highlighted the prevalence of violence against women and how it is responded to so problematically. This raises the question, how is such violence handled in therapy? Do therapists, whose goal is to aid women who have been assaulted, also fail women? To answer this question, we must move beyond examinations of theoretical perspectives and policies to examining actual practice. Principles, policies and theories tell us little about what actually occurs because they must be interpreted and implemented in practice (Coates & Wade, in press). Therapists must translate theoretical practices, policies, and best practice guidelines into practice. In therapy, that practice is mostly performed through language or discourse.

Language is central to therapy. In the majority of cases, talk in therapeutic interviews is the raw material for diagnosis. When dealing with medical problems we can measure blood pressure, heart rate, do specimen tests (e.g. blood, urine, stool), but in therapy we must rely on linguistic descriptions of events. In therapy, we need a description of the problem, “problem talk”, and this talk is the raw material for the diagnosis (Davis, 1986; DeJong & Berg, 1998a). The diagnosis is formulated within talk and given in talk. Therefore, it is important that a critical analysis of therapy should analyze actual talk in therapy. Moreover, it is critical to understand language processes and identify erroneous assumptions about language as they relate to therapeutic discourse. Models of language may be divided into two: the individual and the social (Bavelas, Coates, & Johnson, 2000; Clark, 1996). Following is a brief description of each model.

The Individual View versus The Social View of Language

Individual View of Language

The individual model (which has also been called the product tradition), is the traditional view of language (Bavelas, Coates, & Johnson, 2000; Clark, 1992; Clark, 1996). In this model the speaker is conceptualized as independently forming a message; that is, he or she is uninfluenced by the listener when encoding thoughts and ideas into words and other symbols. The listener is conceptualized as passively receiving the message from the speaker and then decoding the message. The decoding process is described as uninfluenced by the speaker (Bavelas et al., 2000; Clark, 1992; Clark, 1996).

When the individual model of language, is applied to therapeutic interviews it has important implications for the therapist and client interaction, and the process of diagnosis. According to this model, the therapist objectively, and independently, collects information and arrives at a diagnosis without influencing the client's talk (Bavelas et al., 2000; Clark, 1992; Clark, 1996). The diagnosis is seen as objective, that is, as about the object of the study (the client). The therapist is viewed as mute or invisible and simply mirrors what the client is saying. According to this, the therapist does not direct the therapeutic interview (e.g., assertions, questions, interpretations, and formulations) and, as such, has little to no influence on the nature of the client's talk. The individual model, views the client as providing information but not influencing the flow of the therapeutic interview, the therapist, or the diagnosis. But, is the diagnosis of problems such an individual, independent objective process?

Research over the last 30 years does not support this model. Research has shown that the use of language, especially in face-to-face dialogue, cannot be accurately

conceptualized as an individual process (Bavelas et al., 2000; Clark, 1992, 1996; Clark & Schober, 1992a, 1992b; Linell, 1982, 1988). This research has culminated in the articulation of the social (which is also called the collaborative, the constructionist view, or the action tradition) model of language.

Social View of Language

Language as a Collaborative Process

In the social view of language, language is conceptualized as a joint activity among participants (Clark, 1992, 1996; Clark & Schober, 1992a, 1992b). That is, language is described as a two-way reciprocal process in which speaker and listener work together to negotiate meaning (Clark, 1992, 1996; Clark & Schober, 1992a, 1992b). The acts of forming and receiving messages are viewed as involving some degree of reciprocity. Clark, for example, stated that “speaking and listening aren’t autonomous activities, but parts of collective activities” (xvi, 1996). In these collective activities, speakers are influenced by listeners and listeners are influenced by speakers (Clark, 1992, 1996; Clark & Schober, 1992a, 1992b).

Unlike the individual model of language, the social model is well supported by an ever increasing number of studies (Bavelas et al., 2000; Clark, 1992, 1996; Clark & Schober, 1992a, 1992b; Linell, 1982, 1988). These studies have found that message formation is not an individual process, and that listeners are active not passive participants, thus supporting the description of language as a joint and collective process. For example, Bavelas et al. (2000) demonstrated how the telling of a story is affected by the actions of the listener. When listeners did not listen closely to the narratives to identify features of talk, narrators’ stories were significantly less well told (Bavelas et al.,

2000). Listeners who were distracted, were not able to keep up with the narratives, and, were not collaborating with their narrator through the use of specific responses that communicate full understanding of the narrator (Bavelas et al., 2000). Significantly, when listeners were not helping narrators by communicating that they understood the full implications of the story, it affected the narrators' telling of the story (Bavelas et al., 2000). This study demonstrates that "the social process of interacting in conversation plays a role in the cognitive process of understanding" (Clark & Schober, 1992a, p.195).

Language as action

Given that language is a social or joint, rather than an individual process, (Bavelas et al., 2000; Clark, 1992, 1996; Linell, 1982, 1988), one cannot simply conceptualize language as the transmission of mental states (Austin, 1962; Clark, 1996; Holzman, Newman, Strong & Pare, 2004; Potter & Wetherall, 1987). Instead, a focus must be on what function the language is performing within the interaction. One function that is of interest is the way in which language influences the interaction. While the social model argues and has found that conversational participants influence each other, this influence is not necessarily equal (McGee, 1999). Unequal influence is exerted in social interactions through power differences. Those in more powerful positions occupy more public discursive space and, thus their utterances have a stronger impact (Austin, 1962). For example, a judge saying, "I sentence you. . .", has a much stronger impact than your friend saying, "I sentence you. . .", because a judge has the social power necessary to back up an utterance like that.

One way in which influence is exerted in conversation is through the use of questions (Clark, 1996; Matoesian, 2001; McGee, 1999). Most simply, asking a question

places pressure on the other person to answer (McGee, 1999). But other influences and constraints exist (McGee, 1999). Questions involve a three part sequence: 1) The speaker asks a question or states something, 2) the listener responds, and then 3) the turn returns to the speaker (McGee, 1999). This three part sequence can be used to control and direct the talk (Matoesian, 2001). For example (Matoesian, 2001, p.214),

1. DA: Your friend says that she was raped is that right?
2. AM: Yes.
3. DA: But what she tells you is that she wants her shoes is that correct?
4. AM: Yes.
5. DA: Several times she was worried about her shoes.

In court, where the listener is required to respond exclusively to the question asked, information can be taken out of context to present the victim in a particular light. In the above example, the victim's claim that she was raped is being contrasted with her concern over her shoes. By presenting the victim as a woman who is more concerned about her shoes than her safety, the District Attorney attempts to cast doubt in the minds of the jury about the victim's credibility (Matoesian, 2001).

The form of the question also exerts an influence. For example, a "yes" or "no" question can greatly constrain how the listener responds (McGee, 1999). Researchers have argued that presuppositions perform the function of communicating the perspective of the questioner (Clark & Schober, 1992; McGee, 1999). For example, the question, "Don't these bananas taste great?", allows the questioner to not only communicate his or her opinion on the taste of the bananas but also to bias the answerer's response to be in agreement with the questioner's opinion (Austin, 1962; Clark, & Schober. 1992, Clark 1996; McGee, 1999).

Other presuppositions function to bridge inferences in which being able to contextualize words is necessary in order to understand their meaning (Clark & Schober, 1992; McGee, 1999). For example (Clark & Schober, 1992, p.20):

A: The guy next door just bought a motorcycle. . . .

Q: **How bad is the noise?**

The above question implies that bad noise exists and that this bad noise comes from the “guy next door’s motorcycle” (Clark & Schober, 1992; McGee, 1999). In order for the listener to be able to answer that question he/she has to understand that the questioner is referring to the motorcycle as being the reason for the bad noise (Clark & Schober, 1992; McGee, 1999). Such shared knowledge is referred to as common ground (Clark & Schober, 1992; McGee, 1999)

Embedded assumptions also influence discourse (Matoesian, 2001; McGee, 1999). Knowledge states, that categorize questions, involve understanding the presuppositions that the question implies (McGee, 1999). For example, questions like, “Where are my keys?”, imply that the speaker lacks information (a lacking of a knowledge state) that the listener may possess (a possessing of a knowledge state) (McGee, 1999). Conversely, a testing question assumes that the speaker has this knowledge while the listener/answerer may or may not possess this information (McGee, 1999). Polite requests (pre-request), such as, “Can you pass the salt?”, and polite orders, such as, “Why don’t you bring the wine?”, assume that the speaker has information and is requesting action and that the listeners also have this information and have an ability to perform the action (McGee, 1999, p.144). Socratic-questions or Zen Koans, such as

“What is the sound of one hand clapping?”, assume that the questioner possesses this knowledge and that the listener is seeking this knowledge (McGee, 1999, p.144).

Common ground is important in the interpretation of presuppositions (Clark & Schober, 1992; McGee, 1999). Throughout conversations, interactants rely on previously established common ground and create new common ground (a process called accumulation) (Clark & Schober, 1992; McGee, 1999). When new points of view are presented as embedded presuppositions, they are introduced into talk as if they were part of the interactants’ common ground (Clark & Schober, 1992). According to Clark & Schober (1992), there are four reasons why this is easily accomplished (McGee, 1999). First, presuppositions place responsibility on the listener to disagree; if they do not, this implies their acceptance of the embedded presupposition (Clark & Schober, 1992; McGee, 1999). Disagreement can be difficult because it may be interpreted as being argumentative (Clark & Schober, 1992; McGee, 1999). Second, addressing each perspective would dramatically slow the flow of conversations because the majority of utterances contain embedded perspectives which are often relatively unimportant (Clark & Schober, 1992; McGee, 1999). Third, contesting embedded presuppositions involves questioning the speaker’s judgment, which is often interpreted as impolite and requires significant effort on the part of the listener (Clark & Schober, 1992; McGee, 1999). Finally, as conversations progress those involved will increasingly assume that their perspectives are shared if their presuppositions are not directly disproved (Clark & Schober, 1992; McGee, 1999). Thus, for all of these reasons conversational participants typically just go along with them because to address each one would dramatically slow the flow of conversations (Clark & Schober, 1992; McGee, 1999).

Based on the notion that all questions contain presuppositions and that it is easier for an answerer to accept this presupposition than to question it, what happens when individuals have no common ground or when it does matter what perspective is taken (Clark & Schober, 1992; McGee, 1999)? What happens when the questioner does not assume that the answerer shares his or her perspective, but “the perspective is smuggled in as an embedded presupposition” (McGee, 1999, p. 154)? Treating certain information as given or restricting the realm of inquiry constrains the possible response of the answerer (Clark & Schober, 1992; McGee, 1999). Take, for example, the utterance “Should we have pizza or Chinese food?” (McGee, 1999, p. 154). This utterance not only presumes that takeout is the plan for supper, but, the questioner constrains the answerer’s possible options as to what kind of food they should order by offering pizza or Chinese food as the only possible options (McGee, 1999). Researchers have argued that listeners’ options are limited by the presuppositions because they are expected to respond to questions with split-second timing and because it is considered rude for a listener to object to the questioner’s perspectives (Clark & Schober, 1992; McGee, 1999). In short, even though language is social and involves mutual influence, the influence is not necessarily equal (Clark & Schober, 1992; McGee, 1999). When someone asks a question, the answerer’s response is constrained by the question; specifically, the questioner is exerting a lot of influence on the answerer (Clark & Schober, 1992; McGee, 1999).

As can be seen from the above descriptions, “language is for doing things” (Clark, 1996, p. 3), and is “the vehicle through which we render our world intelligible and negotiate our needs with others” (Strong, 1995, p. 56-57). We perform activities through

language; our talk and writing are not simply conceptual but, are in themselves, forms of social action in which we exert social influence (Potter & Wetherell, 1987).

Therapy as Discursive

These views of language have important implications for therapy. As already mentioned, diagnosis is typically accomplished through talk in therapeutic interviews. Psychology places responsibility for diagnosis and treatment with the experts, whose views are supposedly neutral and based in science (Strong, 1995). The experts' views, or more accurately their interpretations of behaviours, are often taken for granted as truths and are treated as if they were independent and objective; these assumptions rely on the traditional view of language. (Conrad & Schneider, 1992; Strong, 1995).

The individual or traditional view of language, has little empirical support whereas, the social view is well supported (Bavelas, Chovil, Coates & Roe, 1995; Bavelas, McGee, Phillips, & Routledge, 2000; Bavelas et al., 2000; Clark, 1992, 1996; Clark & Schober, 1992; Clark & Willies Gribbs, 1986; Linell, 1982, 1988). Thus, the assumption that psychotherapeutic diagnoses are independently, and objectively, accomplished by the therapist is unlikely to be accurate.

Diagnosis is a unilateral act in the midst of a mutual (but not equal) process. Diagnosis should be treated as a conversational process in which diagnoses are not constructed independently or objectively (Davis, 1986). Instead, diagnoses are a product of the discursive process and, as such, can be traced through talk. In fact, Davis (1986) did exactly this by tracing the process of diagnoses through therapeutic interviews.

Reformulation & Constructing the Problem

Formulations allow us to demonstrate understanding by “explaining, characterizing, explicating, translating, summarizing or furnishing the gists of talk-so-far” (Davis, 1986, p.47). However, formulations are not simply a reflection of what was originally said, but instead, they help progress narratives by adding new ideas, particularizing meaning and characterizing the meaning of talk (Davis, 1986). Formulations generally have three distinct characteristics: i) they preserve some aspects of what is said; ii) they delete some aspects of what is said; and iii) they transform some aspects of what is said. Reformulations can be defined as a special case of formulation in which the therapist, when formulating the client’s (patient’s) description of the problem, substantially transforms this description into a different problem (Davis, 1986).

In Davis’s (1986) analysis of a therapy transcript she found that the problem that initially brought the client to therapy was significantly changed, or reformulated, through the therapeutic interview. Davis (1986), documented that the therapist was responsible for this transformation. From her analysis, she concluded that the reformulation of the client’s problem was “by no means a spontaneous artifact of the therapeutic interview, but the result of considerable interactional ‘work’ on the part of the therapist” (Davis, 1986, p.44). The therapist used reformulation in a three stage process of constructing the problem (Davis, 1986). In this three stage process, the therapist defined the problem, documented the problem and organized the client’s consent (Davis, 1986). In the definition stage, the therapist repeatedly introduced alternative formulations of the problem as described by the client, namely, that the client is not honestly expressing her feelings (Davis, 1986). For example (Davis, 1986, p.53):

T: You're kind of piling things up, I think – to
to – go back to the beginning when – you started out with upset, a kind of word
which I'm starting to see as not really fitting your situation.

It's a – too flat word. I think,

C: Mmhmm

T: – to – describe your experience

(pause)

Is that right? Huh?

C: Yeah.

Here the therapist questioned the way the client described her situation by suggesting that she was not describing it accurately because the word, “upset”, was apparently “too flat” (Davis, 1986, p.53). This allowed the therapist to introduce how the client talked about her feelings as the problem to be addressed in therapy (Davis, 1986). The therapist went on to suggest that the client was not honestly expressing her feelings and that this could be problematic (Davis, 1986). In this transcript, the therapist's reformulations were always in the direction of defining the client as deficient or pathological (Davis, 1986).

In the documentation stage, the therapist used reformulations to construct behaviours, emotions, and events as consistent with the problem he had defined (Davis, 1986). For example (Davis, 1986, p.60):

T: So he too had a way of doing things on the outside that didn't match what was happening inside. Yes.

(pause)

And that – changing that is really kind of nice for you –

C: Oh, yes

T: - because then –

C: Yeah

T: You're getting a little closer to one another as two people

(pause)

who – have their weaknesses –

C: who are both weak

T: Yeah

C: Yeah.

Here the client discussed the changes in her relationship with her husband (Davis, 1986). The therapist reformulated what the client was saying when he used the word, “too”, to imply that the client was behaving like her husband in that what was happening on the inside was not always demonstrated by what was happening on the outside (Davis, 1986). The use of the word, “too”, casts this as an instance when the client was not completely honest about her feelings, despite the fact that she was talking about her husband's behaviour (Davis, 1986). Thus, the therapist rendered aspects of the client's talk as evidence of the problem (Davis, 1986). Importantly, in this stage of constructing the problem, the therapist also cast the reformulated problem as having detrimental effects on all aspects of the client's life, including her behaviour in therapy (Davis, 1986).

In the final stage, the therapist organized the client's consent (Davis, 1986). In this stage, Davis argued that a large proportion of time was spent convincing the client that the defined problem was “real” (Davis, 1986, p.54). Much of this work is tied to documenting the problem (Davis, 1986). For example (Davis, 1986, p.61-62):

T: Yeah. Apparently you want to see yourself as someone
who's

strong and capable

C: Yeah

T: and you're finding it difficult to accept that it sometimes
just isn't that way.

C: Yeah.

T: Mmm.

Yeah. Anyway, probably – that –

if, as long as you go on acting like I'm getting along just

fine, or I'm coping pretty well, that people are going to

react –

C: Mmhmm

T: to that too with – oh well, O.K., huh? That – that

(unclear) leaning on someone –

C: Yeah

T: Huh? Or – or she probably has her problems once in

awhile,

but A. is really a person who – who manages

C: Mmhmm

T: So you actually – stay locked up in your own system.

C: Yeah

By constructing the client's talk as evidence of the reformulated problem, the therapist bolsters his presupposition that the diagnosis was "real" (Davis, 1986). Thus, "although the therapist himself has introduced it as a topic, it appears to be firmly embedded in what the client has been saying, part and parcel of the ongoing talk" (Davis, 1986, p.58).

Davis's analysis demonstrates that the process of diagnosis is a discursive process: it is marked not by the therapist engaging in objective and independent assessment but by the therapist directing and influencing the client (Davis, 1986). Through this social process, the therapist creates a problem suitable for therapeutic intervention (Davis, 1986). Davis (1986) notes, the process of constructing a problem through reformulation is particularly important when therapy deals with problems such as violence against women because cultural and psychiatric discourses often blame and pathologize victims and their responses to violence. Moreover, it is not just diagnoses that are constructed through therapeutic discourse (Davis, 1986); people, events, and actions are also formulated.

Processes in Therapy

Questions

As already documented, questions are a key aspect of conversations. However, most traditional therapeutic models view questions as simply information gathering tools at best, or, at worst, as evoking "distorted or defensive reflections" from clients or, as distracting from the flow of therapy in nondirective therapy (McGee, 1999, p.11). In contrast many newer therapies, particularly interactional therapies, recognize that questions are a powerful tool to gain information, and frame the information and the direction of the interview (McGee, 1999; Strong & Pare, 2004; Wade, 2000). Therapists

use constructive questions with embedded presuppositions to orient the answerer to “a particular aspect of his or her experience” (McGee, 1999, p. ii-iii). The information or viewpoint in the embedded presupposition is indirectly treated as common ground and, as such, is never marked as new information by the therapist and, is rarely marked as new information by the client (McGee, 1999). As predicted by the three-part structure of questions, the client answers the question and then the talking turn returns to the therapist for further comment. This research found that asking a question is never a neutral process. The questions were always urging the client to talk about particular subjects or to view particular subjects as important or relevant (McGee, 1999). In short, the client was directed to be connected to the therapist’s theoretical orientation (McGee, 1999). McGee (1999) found that therapists using traditional models (e.g. client-centered therapies, behavioural therapies, Goldberg’s Question-centered therapy, and psycho-educational therapy), tended to construct questions that assumed that the client was pathological, deficient, or unable (McGee, 1999). In contrast, questions by therapists using interactional therapy models (e.g., brief solution-focused therapy, Milan systemic therapy, and narrative therapy), tended to contain the assumption that the client was agentic, capable, and, possessed positive qualities (McGee, 1999).

Diagnoses and Individual Pathology

Like other discursive processes, arriving at a therapeutic diagnosis involves influence, particularly by the therapist. If therapists, psychiatrists, or other mental health professionals do not recognize this influence and assume that the process of diagnosis is neutral and objective, they will not acknowledge their own role in constructing and defining the problem. Some argue that diagnosis, particularly in traditional therapies is an

abusive – even violent process (Larner, Rober, & Strong, 2004; Wade, 2000). Typically, individuals in therapy are formulated as personally deficient, or pathological. These deficiencies are located within the mind of the client and are assumed to objectively exist (Wade, 2000). Associated with this belief in personal deficiency is the notion that an individual's behaviour can be explained by abstract concepts like temperaments, attitudes, and drives that focus on understanding mental states (Wade, 2000). These assumptions deny the importance of social factors, and view conversations as important only when they tell us something about the internal workings of the mind (Wade, 2000). In fact, the diagnostic bible, the DSM, purposely ignores or minimizes the role of social context in understanding human behaviour because it is assumed that doing so will allow them to develop an apolitical system that could objectively diagnose disorders (Wade, 2000). Indeed, DSM diagnoses are often treated as if they were objective rather than subjective, that is, “the DSM fixes meaning in psychotherapy that could otherwise be regarded as arbitrary and negotiable”(Strong, 1995, p.60).

Nevertheless, time after time, there is little reliability to be found amongst psychiatric diagnoses, which seems to point to the fact that asocial and neutral psychiatric diagnoses are impossible (Boyle, 1990; Breggin & Breggin, 1991, 1994; Kirk & Kutchins, 1992; Pam, 1990; Wade, 2000). The very act of ignoring social contexts helps to minimize the role of violence in the development of individual problems (Wade, 2000). For example, women who have suffered violence often talk of low energy, changes in mood, and thoughts of suicide, which are consistent with symptoms of depression (Wade, 2000). Importantly, because psychiatry believes that depression has a partially biological etiology, they will focus on the client's behaviours as symptoms of

depression and the context in which these behaviours occur (the violence) is often ignored (Wade, 2000). Even if the violence is partially acknowledged, models that focus on the biological model, shift the focus back onto the biological deficit within the women by reformulating the violence as the stressor that triggered her predisposition to depression (Wade, 2000). Once the victim has been labeled as being clinically depressed, the violence is ignored and the perpetrator becomes absolved of responsibility (Wade, 2000).

For all of these reasons, many therapies have been criticized as formulating problems as something only an expert can diagnose and treat (Wade, 2000). Doing so denies victims' capability by implying that they are "sick" and, as such, are not capable of knowing what is best for them. An increasing number of therapists are recognizing that by developing a better understanding of what therapists actually "do" in therapeutic discourse, therapists will be able to understand their role in the therapeutic process, including directing the client and diagnosing the problem, and adopting helpful practices (Davis, 1986; McGee, 1999; Routledge, 2003; Wade, 2000) .

Summary

Language use in ordinary conversations can be best described as a social and reciprocal event, and the influence is often equally distributed between the two participants (Bavelas, et al., 2000; Clark, 1992, 1996). Principles that individuals would normally have used when engaged in a conversation are not forgotten when people enter different situations such as therapy. Indeed, research has found that therapeutic conversations are similar to regular conversations, even though they have clear power imbalances. A notable difference is that the power imbalance inherent in therapist-client

interactions, in which therapists are constructed as the “experts”, will typically result in therapists exerting more influence on the talk (Coates & Wade, 2004; Potter & Wetherall, 1987; Strong & Pare, 2004; Wade, 1997, 2000). Rather than a neutral and objective act, diagnosis is subjective and political (Coates & Wade, 2004; Potter & Wetherall, 1987; Strong & Pare, 2004; Wade, 1997, 2000). Through reformulation, through questions and through other social processes, therapists actually direct the talk to particular issues, formulate the meaning of the talk, diagnose the problem, document the problem, and organize the client’s consent (Davis, 1986). Many researchers have criticized the mental health professionals as diagnosing problems as individual, mental deficiencies or problems (Breggin & Breggin, 1991,1994; Burstow, 1992; Coates & Wade, 2004; Davis, 1986; Tavris, 1992; Wade, 1997, 2000). Wade has argued that this practice may be particularly prevalent and problematic when clients have suffered violence (Wade, 1997, 2000).

Therapists influence the information they use to form diagnoses. Indeed, it has been argued that therapists too often construct clients as damaged, deficient or pathological (Burstow, 1992; Conrad & Schneider, 1992; Ridley & Coates, 2003; Strong & Pare, 2004; Wade, 2000). However, few studies have examined how violence against women is formulated in therapy from a discursive and social perspective. There is a need for researchers to examine therapeutic interviews to see how victims of violence, perpetrators of violence, and violence itself are formulated.

Chapter Three – Representations of Violence

Introduction

While many positive social changes have occurred as a result of the Charter of Rights (e.g., women and ethnic minorities now have the right to vote and own property; wife battering and child abuse are treated as social problems), violence and other forms of oppression still occur in both private and public domains. As such, it is crucial that our techniques of prevention and intervention take into account the strategies and social conditions that enable personalized violence to occur in the first place. The Interactional and Discursive View of Violence and Resistance addresses these factors.

The Interactional and Discursive View of Violence and Resistance is focused on the actions of perpetrators and the victims (interaction) and stresses the importance of accurately conceptualizing violent interaction. Its proponents also emphasize the importance of discursively representing these interactions (social discourse) and, stresses that many current representations are inaccurate (Coates et al., 2003; Coates & Wade, 2004; Coates & Wade, in press). The Interactional and Discursive View of Violence and Resistance recognizes the importance of correct representations of violence that place full responsibility on the offender - “fitting words to deeds” (Coates & Wade, 2004; Danet, 1980, p.189)). The Interactional and Discursive view has six tenets that are relevant to this study, namely, violence as social and unilateral, violence as a deliberate action, the ubiquity of resistance, misrepresentation, fitting words to deeds and the four-discursive-operations. Below I will now explain the six tenets of this framework.

Interaction

Violence as Social and Unilateral

The proponents (Linda Coates, Nick Todd, & Alan Wade) of this framework have drawn from research on the social model of language. From this research they have argued that, like other social behaviours, violent behaviour can best be understood when examined in context, where we can examine the perpetrators' violent actions and the victims' responses to this violence (Coates & Wade, 2004). When victims' responses to violence are taken into account, it becomes clear that rape, for example, is not just one violent act but a series of violent acts in which the perpetrator is violent towards the victim and the victim defends herself as best she can (Coates & Wade, 2004). Through contextual analysis it becomes obvious that perpetrators understand violence and so expect their victims to resist, and thus take steps to conceal or suppress it. For example, perpetrators often only abuse their victims in private or isolation so that there is little chance victims' protests will be heard and the perpetrator caught (Coates & Wade, 2004). It is also only through contextual analysis that victims' responses to violence can be conceptualized as forms of resistance (Coates & Wade, 2004). For example, a child's taking hours to walk two blocks home from school can be conceptualized as a form of resistance only when we examine this behaviour within the context it occurred (Coates & Wade, 2004). We might then discover that this child's father would have raped him after school before his mother got home from work (Coates & Wade, 2004).

The proponents of this framework have also argued that when the actions of perpetrators and victims are viewed in isolation, we are more likely to look to psychological processes to explain specific behaviours and, that these decontextualized

interpretations can be very misleading and inaccurate (Coates & Wade, 2004). For example, if the behaviour of the boy who took hours to walk home from school is examined out of context, his father's complaints that he takes too long to get home would be viewed as legitimate (Coates & Wade, 2004). The boy would then be open to formulations of his psychology that, for example, he is disobedient or has ODD (Oppositional Defiant Disorder). The psychological interpretations of the boy and his behaviour appear valid unless the boy's actions are closely examined within the context in which they took place (Coates & Wade, 2004).

Contextual analysis also exposes the unilateral nature of violent acts (Coates & Wade, 2004). That is, while violent social interaction is comprised of at least two people, the violent act is committed by the perpetrator. He or she is the sole agent of the violence (West & Coates, 2003). In violence, victims are merely objects or receivers of actions (Coates & Wade, 2004). They do not participate in accomplishing the violence (Coates & Wade, 2004). Thus, victims should not be conceptualized as "participating in" or sharing responsibility for violent behaviour (Coates & Wade, 2004). Nor should they be conceptualized as "putting up with" or "letting the violence happen" (Coates & Wade, 2004). By contextualizing acts of violence, we can see that victims are not to blame for the violence perpetrated against them but, that they do, in fact resist and, as such, cannot be viewed as participants or passive recipients of violent acts (Coates & Wade, 2004).

While the notion of violence as a unilateral act may seem obvious, previous research on legal judgments in sexual assault trials found that judges did not treat sexualized violence as a violent act despite the fact that sexual assault is defined by Canadian law as a unilateral and violent act (the act of one person against the will of

another) (Coates & Wade, 2004, *The Dictionary of Canadian Law*, 1995). Instead, the courts explicitly or implicitly formulated victims as co-agents or participants in the assaults perpetrated against them (Bavelas & Coates, 2001; Coates et al., 1994; Coates, 1997; Coates et al., 2003; Coates & Wade, 2004; West & Coates, 2003). For example, victims were formulated as having “sex with”, “playing with”, or “kissing”, the perpetrators (Bavelas & Coates, 2001; Coates, 1997, Coates et al., 1994; Coates et al., 2003; Coates & Wade, 2004; West & Coates, 2003). Such mutualizing language has also been found in descriptions of spousal assault and, to a lesser extent, assault (Coates, 2005). This occurred despite the fact that all of these crimes are defined by Canadian law as violent acts - that is as unilateral acts where force has been used against another person (Coates, 2005; *The Dictionary of Canadian Law*, 1995).

Mutualizing violence denies the violent nature of assault. Using the same terms to describe violence as you would sexual acts within a loving, consensual relationship, formulates sexualized violence as a mutual act. Such representations even imply that the victim derived or could have derived pleasure from these acts (Bavelas & Coates, 2001; Coates, 1997; Coates et al., 1994; Coates et al., 2003; Coates & Wade, 2004; West & Coates, 2003).

Violence as Deliberate Action

Proponents of the Interactional and Discursive View of Violence and Resistance take the position that violence is deliberate. They argue that the deliberate nature of violence is demonstrated by the fact that offenders employ many strategies before, during and after the abuse to conceal and suppress victims’ resistance (Coates & Wade, 2004; Todd, Wade & Renoux, 2004; Wade, 1997, 2000). For example, perpetrators who abuse

children will use a combination of bribes, threats and misinformation to ensure secrecy and to gain access to the child (Coates & Wade, 2004). Husbands who batter their wives often isolate their wives from friends or family, control money, and behave aggressively and unpredictably (for example, coming home at different times to check up on their wives) (Coates & Wade, 2004; Hilberman, 1980). Even violent acts that are conceptualized as “explosive” or “out of control” are often, when examined in context, deliberate and carefully planned (Coates & Wade, 2004). Perpetrators isolate their victims before the abuse begins; they threaten and humiliate victims during the abuse in order to instill fear and ensure secrecy; after the assault, they conceal violence and attempt to reduce the likelihood that victims will leave them through the use of fake apologies and victim blaming (Coates & Wade, 2004).

The Ubiquity of Resistance

The Interactive and Discursive view of Violence and Resistance also asserts that when the actions of the perpetrators and victims are examined in context, it becomes evident that “whenever persons are badly treated, they resist” (Wade, 1997, p.23) (Burstow, 1988, 1992; Coates & Wade, 2004; Gilligan, Rogers, & Tolman, 1991; Kelly 1988; Wade, 2000, 1997, 1995).

Current research is providing more and more evidence about the accuracy of this tenet (Burstow, 1988, 1992; Coates & Wade, 2004; Gilligan et al., 1991; Kelly, 1988). Kelly (1988) conducted 60 interviews with women from various women’s groups, in order to obtain first-person narratives of women’s experiences with violence and oppression and their varied acts of resistance. Kelly defined resistance as attempts to

oppose actively, to fight, to refuse to co-operate with or submit. . . Resistance is a particular form of coping strategy. It has obvious relevance to instances of sexual violence in which overt force is used and women physically resist. It is not, however, limited to these actions and covers a range of other responses.

(Kelly, 1988, p.162)

Kelly (1988) suggested that womens' resistance could take on forms other than the traditional notion of physical resistance. She noted:

Women resist in situations by refusing to be frightened or to let the fear they do feel be apparent to the abusive man. When men are violent to women they are close to, they are invariably attempting to control their behaviour in specific ways.

Women resist by refusing to be controlled, although they may not physically resist during the actual assault. (Kelly, 1988, p.161)

She went on to discuss the importance of contextual factors when considering womens' resistance when she said:

The extent and form of womens' resistance to particular assault(s) is dependent on the circumstances of the events(s) and on the resources that they feel that they can draw on at the time. To resist requires feeling strong enough to take the risk that the incident might escalate; in some situations resistance may prevent or limit violence, whilst in others it may result in greater levels of violence. (Kelly, 1988, p.162)

Consistent with Kelly's research, the proponents of this framework argue that because these abusive situations can be extremely dangerous for the victim, they often resist in covert ways. As such, their acts of resistance are often not readily recognized by

other people, including the perpetrator. According to this framework, victims' forms of resistance need not be overt or successful in ending the violence in order to be viewed as important (Coates & Wade, 2004).

In Kelly's study, none of the women who had been raped had responded passively to the assault. Instead, 60% resisted physically and 40% resisted verbally (Kelly, 1988).

For example, one woman stated:

I went on fighting and there was this really terrifying bit where he'd got me pinned against the wall, and I'd banged my head slightly so I was feeling kind of woozy and I thought for a minute that I was going to faint. I was absolutely terrified: but I managed to get a hand free and I started scratching his face. I think at that point he started giving up and realized that it was going to be difficult to overpower me. Maybe I had made too much noise to risk it. He – I think in total anger – punched me in the mouth and, in doing that, he had to let go of me and I managed to get away. (Kelly, 1988, p.165)

Another woman said:

He tried to put it in my mouth and that was the wrongest thing he ever did, because I bit. That stopped him, I bit him that hard that he poured blood. (Kelly, 1988, p.170)

Other women used less overt forms of resistance. For example, one woman said:

I was quite rational through the whole thing. Very much feeling that I wanted to get away from this without being raped and without being hurt, but primarily without being hurt – it seemed to be the most important thing He just about managed to penetrate me, but I started pretending I was going to be sick and

looking it was again fairly rational but not entirely I managed to make him think I was going out of my mind, acting quite hysterical. He clearly got quite frightened and ran off. (Kelly, 1988, p.170)

And others recounted how they were able to distance themselves from the actual violence:

I used to struggle before, but then I just stopped, I became totally passive. I kind of didn't see it as sex somehow, I cut off, completely cut off. (Kelly, 1988, p.171)

For example, another woman recalled:

I was just really aware that it wasn't my body, it was me and my brain was somewhere else, just staring down at what was happening – it just wasn't real, like it isn't me, it isn't me! (Kelly, 1988, p.171)

These women strategically used different forms of resistance by taking into consideration their situation, what they wanted to achieve and their risk of increased violence. Kelly (1988) found that women were more likely to retaliate physically near the end of their relationship; however, most women resisted by refusing to be controlled. For example, one woman stated:

I think because I was sticking up for myself the hidings got harder. I think that's what it was, he wanted to show that he was still my governor (Kelly, 1988, p.178)

Another woman said:

He was always threatening me. Me being me, I wouldn't do whatever it was because I wouldn't let him do that to me. I used to fight against it all the time. As far as I was concerned, I'm a person, I could do what I wanted, I didn't want anyone telling me what to do.(Kelly, 1988, p.179)

Burstow (1992), a Canadian radical feminist therapist anti-psychiatry activist, also recognizes the importance of women's resistance to violence and oppression, no matter how small or seemingly insignificant the act, and clearly differentiates between active resistance and the passiveness implied by the psychiatric community. Burstow demonstrated how a woman who refuses to do housework or who always has a headache can be conceptualized as resisting bad treatment:

Some women's acts are limited, individual, and border on resignation, but even here is a core of resistance that is poignant and meaningful. In this category we find the housewife who stops cleaning up and just sits there unhappy and "unable" to do anything. In the past psychiatry would have said that she is having a nervous breakdown. Today it would say that she is "chronically depressed". These diagnoses are not so much wrong as horrendously limited. She is clearly "sick to death" of the endless repetitive chores that befall her as woman. She is fundamentally exhausted, worn out, bored; she "cannot take it anymore", and her being is rebelling. Her exhaustion is not phony but absolutely genuine. At the same time, as the contradiction inherent in linking *cannot* with *rebellious* implies, "cannot take it anymore" to some degree means "*is not* and *will not* take it anymore". Although the refusal may not be happening on a reflective plan and refusal is only one dimension of what is occurring, this woman in her own way is going on strike. The wife who always has a headache is similarly on strike.

(Burstow, 1992, p.18)

Victims' resistance becomes clearer when we examine the many strategies used by perpetrators to obscure and conceal victims' resistance (Coates & Wade, 2004; Scott,

1990). Perpetrators employ many strategies that conceal their violence and reformulate their victims' resistance as a deficit or disorder (Ridley & Coates, 2003; Wade, 1997, 2000). If offenders are successful in concealing their victims' resistance, the focus shifts from the perpetrators violent acts, to questioning why the victims did not resist (Ridley & Coates, 2003; Wade, 1997, 2000). For example, the social construction of the battered women syndrome has had the latent consequence of shifting the focus onto the battered woman by asking the questions, "why does she stay?", "what is wrong with her?", instead of focusing on the husband's violent acts by asking, "why do men beat their wives?" and, "what social processes make it acceptable for these events to occur?" (Bonnycastle & Rigakos, 1998). These linguistic devices that conceal victims' resistance also conceal the deliberate nature of violent acts (Coates & Wade, 2004).

Social Discourse

Misrepresentation

Perpetrators often misrepresent their actions in order to avoid responsibility, to conceal the violent nature of their acts and to blame the victim (Coates & Wade, 2004). Proponents of the Interactional and Discursive View build on the notions of language as inherently powerful and apply these concepts to interpersonal violence (Coates & Wade, 2004; Foucault, 1972; Potter & Wetherall, 1987). They examine how misrepresentations of violent acts are an important part of recounting acts of violence and oppression and, as such, accounts of violence should not be taken at face value (Coates & Wade, 2004; Scott, 1990). The misleading nature of accounts can be seen in some representations of violence, such as: violence is unilateral but is represented as mutual; violence is deliberate but is represented as non-deliberate, and; victims resist violence but are

represented as passive (Coates & Wade, 2004). Because perpetrators actively conceal their violence and suppress victims' resistance, chances of people siding with the perpetrator are high (Coates & Wade, 2004).

Mutualizing representations of violence is, unfortunately, widespread even within professional and academic discourses (Coates & Wade, 2004). For example, Jane Stewart, the Minister of Indian and Northern Affairs is quoted as referring to the European imperialism of First Nations people as a "relationship problem" (Coates & Wade, in press). Referring to the aggression of one nation against another as a "relationship problem" mutualizes responsibility and conceals the violent nature of these acts instead of calling it what it really was "war" (Coates & Wade, in press). This is also the case with domestic violence, which is often represented as an "argument" or "fight" (Coates & Wade, in press). In both of these examples, unilateral violent acts were depicted as mutual and non violent (Coates & Wade, 2004). According to the Interactional and Discursive view language that is used to mutualize acts of violence suggests that victims play a role in precipitating violence (Coates & Wade, 2004). This conceals victims' resistance; it also dismisses the fact that the violence is unilateral and, as such, is exclusively the responsibility of the perpetrator (Coates & Wade, 2004).

Perpetrators try to conceal the deliberate nature of their violent actions by using culturally appropriate linguistic techniques that allow them to either justify or excuse their behaviour, thus neutralizing the blame associated with their actions (Scully, 1990; Coates & Wade, 2004). Scully (1990), in her study of convicted sex offenders, found that rapists represented their actions by admitting or denying. Their "explanations are drawn

from knowledge acquired through contact with one's culture, and they reflect what individuals have learned to expect that others will find acceptable" (Scully, 1990, p.98).

Deniers reformulated rape as sexual contact and admitted that some sexual activity occurred (Scully, 1990). They denied that their actions were unilateral acts of violence even when they had used a weapon and/or excessive force. Scully noted, that deniers "drew on stereotypes of women in our rape-supportive culture to present their victims as both precipitating and to blame for the rapes" (Scully, 1990, p.101). They invoked themes such as "women as seductresses", that "women mean yes when they say no", that "women eventually "relax and enjoy it"", that "nice girls don't get raped", that they are only "guilty of a minor wrong doing" and the notion that they are a "macho man" (Scully, 1990, p.102). These justifications used by rapists to account for their actions demonstrate the dangerousness of the existence of rape myths. These myths make it possible for rapists not only to justify their actions, but also, for society to disregard rape as fundamentally wrong.

Admitters, on the other hand, acknowledged that their actions were morally wrong but at the same time excused their behaviour by suggesting that it was precipitated by factors beyond their control (Scully, 1990). This allows them to portray their behaviour (raping), as an anomaly - not a true representation of their character (Scully, 1990). In this way, the men discursively avoided characterizing themselves as rapists (Scully, 1990). Admitters were often likely to suggest that alcohol/drugs (69%), emotional problems (40%), or an unhappy childhood (33%), were the root cause of their behaviour (Scully & Marolla, 1999). They were also likely to suggest that because they were such "nice" guys, their victims had actually enjoyed the rape, implying that had they

not been such good guys, the rape would have been a lot more traumatic for their victims (Scully, 1990).

Scully's findings can also be applied to excuses and justifications used by perpetrators of other violent offences (Coates & Wade, 2004; Scully, 1990). For example, use of linguistic devices such as "I just lost it", "I couldn't take it anymore", or "She pushed my buttons", are used by perpetrators to represent their actions as either reasonable given the situation or completely out of their control (Coates & Wade, 2004; Scully, 1990). Morgan and O'Neill (2001a, 2001b), in their evaluation of a stopping-violence program, analyzed perpetrators' talk prior to their participation in the program to see what kind of explanatory resources (discourses) they utilized. In concordance with the aforementioned studies, Morgan and O'Neill (2001b) found that perpetrators were most likely to describe their violence toward their partners in terms of "inner tension" that overwhelmed them to the point that they lost control of their behaviour. For example,

I just looped out, snapped out, just you know went blank just for I don't know, however long it was . . . I *wasn't really conscious* of what I was doing, it *just happened*, and then when I sort of did come clear I sort of stopped straight away in horror, and went oh no. . . I *just looped out, snapped out*. (Morgan & O'Neill, 2001b, p.280)

Another attempted to excuse his violence by saying:

I just get wild you know, inside me, really wild. . . Well it's sort of in the head too really, you know it feels like pressure to get out. (Morgan & O'Neill, 2001b, p.280)

These discourses allow perpetrators to excuse and justify their violent actions as being precipitated by external stressors that caused them to temporarily lose “control” over their actions (Morgan & O’Neil, 2001b). By presenting themselves as temporarily “abnormal”, due to externalized factors, they mitigate responsibility for their actions by presenting themselves as victims of factors beyond their control (Morgan & O’Neil, 2001b). Embedded in this discourse is the notion of pathology in which they present themselves as having a “personal impairment”, namely having a “problem” with violence (Morgan & O’Neil, 2001b). In doing so, they mitigate responsibility for their actions by presenting themselves as “sick”, which implies that they were not “aware” enough to be truly responsible and, as such, “they need ‘help’, not ‘punishment’” (Morgan & O’Neil, 2001b, p.281).

They also found that some perpetrators tried to shift blame onto their victims by presenting themselves as “victims” (Morgan & O’Neil, 2001b). They did this by implying that the problem was not their violence but instead, their partner’s “irrational” behaviour (Morgan & O’Neil, 2001b). For example:

I didn’t know what she was on about . . . a lot of irrational things came up . . . I was feeling very confused. . . I was getting very angry. . . I was just feeling everything is so unjustified and unfair. . . I just got so frustrated and I sort of felt like hurting her. (Morgan & O’Neil, 2001b, p.281)

Some perpetrators attempted to “justify” their violence by suggesting that the woman initiated the violence (Morgan & O’Neil, 2001b). For example one perpetrator stated:

When it comes to violence she's got it in her and I aint gonna stand there for anyone to hit me that's for sure, male or female, well I'll take it to a limit.

(Morgan & O'Neil, 2001b, p.281)

Perpetrators were also found to excuse their violent actions as the effects of "pathological agents", namely, drugs and alcohol (Morgan & O'Neil, 2001b). For example:

Beer's the main problem. . . Drinking too much beer. . .Something's gotta set me off eh. It's stink eh, if you're running around like a lunatic. (Morgan & O'Neil, 2001b, p.281)

Deliberateness and misrepresentations of violence are also evidenced in a study by Bohner, Reinhard, Rutz, Sturm, Kerschbaum, & Effler (1998). They examined the impact of rape myth acceptance on "normal" men's self-reported likelihood of raping to see if there was a connection. In order to do this, they performed two experiments. In the first, male participants were asked to report their rape proclivity by answering a questionnaire that measured their attraction to sexual aggression. In the second, participants reported their rape proclivity in the context of date scenarios (Bohner et al., 1998). The study found that in both experiments there is a strong correlation between rape myth acceptance and rape proclivity when the men first responded to the rape myth acceptance scale (Bohner et al., 1998). The majority of males (63%) "indicated at least some likelihood of using sexual violence against women" (Bohner et al., 1998, p.264). This study suggests that once men are made aware of these rape myths, their likelihood of considering raping or using some form of sexual violence against women goes up considerably (Bohner et al, 1998). Such findings evince the deliberate nature of sexualized violence (Bohner et al., 1998). Once men were made aware of rape myths that

justified rape and excused perpetrators, they were more likely to say they would consider committing sexualized violence (Bohner et al., 1998). Therefore, it could be suggested that in contexts where rape is justified and excused, men may be more likely to rape (Bohner et al., 1998). These studies suggest that “the rapist [perpetrator of violence] does not invent techniques of neutralization, but derives them from generally accepted cultural norms” (Jackson, 1995, p.18).

Researchers who examined the impact of language on attributions of responsibility have identified the use of problematic linguistic representations of violence in legal discourse (Coates & Wade, 2004). As mentioned earlier, Coates and Wade (2004) found that judges were often likely to excuse perpetrators’ actions as though they were beyond their control (for example “He was influenced by alcohol”) and to reformulate violent acts by using terms like “having sex” to describe rape or sexual assault.

Fitting Words to Deeds

As discussed previously, there is no such thing as an impartial account; as such, the words used to describe acts of both offenders and victims have significant impacts on how we conceptualize violent acts (Coates & Wade, 2004; Danet, 1980).

Accounts are not objective or impartial reflections of events; rather, they must be treated as representations of events that vary in accuracy. Such fundamental constructs as the nature of the events (e.g. violent versus sexual), the cause of the events (e.g. deliberate versus accidental), the character of the offender (e.g. good versus bad), and the character of the victim (passive versus active) are constructed

within the account of the crime. Different accounts call for different kinds of social action (Coates & Wade, 2004, p.503)

As such, descriptions of acts of violence in public, professional, legal or academic settings will directly influence how they will be interpreted and responded to (Coates & Wade, 2004). For example, although the words “having sex” and “rape” can be used to refer to the same physical act, they have very different meanings in that one is a violent and criminal act that requires legal intervention, while the other is a consensual act that requires no intervention (Coates & Wade, 2004).

Four-Discursive-Operations

The linguistic strategies discussed have shown how representations of violence can significantly impact our understanding of violent acts (Coates & Wade, 2004). Misrepresentations of violence are accomplished through linguistic strategies that are used to “(i) conceal violence, (ii) mitigate perpetrators’ responsibility, (iii) conceal victims’ resistance, and (iv) blame or pathologize victims” (Coates & Wade, 2004, p.500).

Linguistic strategies such as, passive voice, embedded presuppositions and reformulations are used to accomplish the four-discursive-operations (Coates & Wade, 2004; McGee, 1999; Routledge, 2003, Trew, 1979). For example, the use of passive voice allows individuals to speak of the victims as though they are the focus of the discourse, while ignoring the acts of the perpetrator (Bohner, 2001; Coates et al, 1994; Lamb, 1991; Lamb & Keon, 1995; Trew, 1979). “The sentence ‘the woman got raped’, for example, may invoke the conclusion ‘got herself raped’ and may thus indicate the women’s active participation” (Bohner, 2001, p.517). The use of passive voice also

diminishes the responsibility placed on perpetrators and instead focuses on victims' participation in their own victimization (Bohner, 2001). A study by Bohner (2001), found that while their participants used passive voice significantly less often than active voice *overall*, that passive voice was used significantly more often when perpetrators' actions were being described. They also found that those participants who had a high use of passive voice also scored higher in rape myth acceptance, were more likely to view victims as responsible for their victimization and, to perceive the rape as not severe (Bohner, 2001). "These correlational findings support the idea that use of the passive voice and other distancing text features reflect anti-victim attitudes and judgments" (Bohner, 2001, p.527).

Lamb & Keon (1995) also found that newspaper articles about wife battering often avoided assigning responsibility to men as perpetrators. This is accomplished through: a) the use of linguistic strategies such as passive voice; b) portraying the couple as the agent, thus implying that both parties are equally responsible for the violence; c) nominalization, for example, the over-use of words like "batterer", which prevents the perpetrators from being named; and d) gender obfuscation, through the use of gender neutral terms like "victim" and "perpetrator" (Lamb & Keon, 1995). They also found that readers tended to be more lenient in assigning punishments to the male perpetrators after reading articles that represented domestic violence as a shared responsibility between both the man and the woman (Lamb & Keon, 1995).

Embedded presuppositions are another linguistic practice used to accomplish the four operations. Embedded presuppositions are often introduced as common ground in questions (Matoesian, 2001; McGee, 1999). In the context of questions, the very act of

responding to a question involves a degree of acceptance of the embedded presupposition and thus embedded presuppositions are often not addressed (McGee, 1999). For example, in a transcript, where the therapist asked a man who beat his wife the question, “Why this marriage?” (Lansky, 1987, p.343), the embedded presupposition is that there is something about this marriage that is precipitating the husband’s violence. Because a marriage is a joint relationship between husband and wife this question also implies that there is something about the wife that precipitates her husband’s violence (Lansky, 1987). The embedded presupposition in this question misrepresents the violence by presenting it as a mutual action (Lansky, 1987). This could be seen to blame the victim and mitigate perpetrator responsibility by presenting the husband and wife as equally responsible for the violence (Lansky, 1987).

Another linguistic practice that can be used to accomplish the four operations is reformulations. Reformulations can be defined as a special case of formulation in which the therapist, when formulating the client’s (patient’s) description of the problem, substantially transforms this description into a different problem (Davis, 1986). Davis (1986) and Routledge (2003) suggest that therapists use reformulations to selectively focus on specific aspects of the client’s talk while ignoring or transforming other aspects. For example, Wade (2000) gives the example of a therapist reformulating a client’s lack of affect, trouble sleeping, and the complaint of mistreatment at the hands of her husband as symptoms of clinical depression.

The importance of using correct representations of violence is particularly important in the context of therapy with victims of violence (Coates & Wade, 2004; Wade, 1997, 2000). Representing victims of violence is a political act in that the

representations we use involve formulating a person and their actions (Ridley & Coates, 2003). Two interpretative frameworks used to represent victims of violence are a) Effects Based Representations and b) Response Based Representations (Wade, 1997, 2000). These two frameworks formulate victims in conflicting ways; while Effects-Based representations formulate victims as passive and deficient, Response-Based representations formulate victims as proficient, resourceful and active agents (Wade, 1997, 2000). Next I will describe in further detail the characteristics of these two frameworks.

Language of Effects

Effects-Based representations adhere to a determinist cause effect model of causation in which violence is viewed as having three stages of effects: impact, transfer, and actuation (Ridley & Coates, 2003; Wade, 1997, 2000). The perpetrators' violent act is conceptualized as a force that has an impact on the victim (Ridley & Coates, 2003; Wade, 1997, 2000). By having an impact on the victim, the negative force (the violent act) of the perpetrator is seen as being transferred to the victim (Ridley & Coates, 2003; Wade, 1997, 2000). This negative force is viewed as causing a change within the victim, and thus the perpetrator, by committing an act of interpersonal violence against the victim, is viewed as activating the behaviour of the victim (Ridley & Coates, 2003; Wade, 1997, 2000). For example, the act of the perpetrator hitting the victim causes the victim to jump up and say "ouch", and thus the force of the act can be said to have precipitated this response from the victim (Wade, 1997, 2000). This actuation of the victim can be conceptualized as occurring in much the same way as a stationary marble moving after it has been hit by a moving marble (Ridley & Coates, 2003).

This interpretation of victims' behaviour as being actuated (that is, to be given energy) by the negative force of the perpetrators' violence constructs victims as passive (Ridley & Coates, 2003; Wade, 1997, 2000). Rather than active, proficient individuals who respond to their oppression, they are constructed as passive individuals who, as a causal result of their oppression, are now damaged (Ridley & Coates, 2003; Wade, 1997, 2000). During the assault, victims are represented as passive objects of the violence, and after the assault, victims' actions are represented as being directly related to the negative force that they passively accepted (Ridley & Coates, 2003; Wade, 1997, 2000). Victims are represented as passive both during and after the assault despite the fact that victims often engage in overt actions of resistance (Ridley & Coates, 2003; Wade, 1997, 2000). Effects-Based representations of victims reformulate their actions as symptoms of the perpetrators' violence (Davis, 1986; Ridley & Coates, 2003).

By representing perpetrators' violence as the acting force behind victims' actions, they are also representing the violence as establishing the nature of the victims' behaviour (Ridley & Coates, 2003). Because the perpetrators' acts are used to harm the victims they are conceptualized as a negative force (Ridley & Coates, 2003). If this negative force directly produces the behaviour of the victim, then it would make sense that these behaviours would also be negative (Ridley & Coates, 2003). Sometimes, however, violence is conceptualized, not as damaging the victim but as revealing predispositions to mental illness (Wade, 2000). For example, women who are treated badly by their husbands, are likely to report symptoms that are associated with clinical depression such as, lack of energy, change in mood, thoughts of suicide (Wade, 2000). Because some psychiatric models contain the position that that depression has a

biological etiology (Firestone & Marshall, 2003), they will focus on the client's behaviours as symptoms, and the context in which these behaviours occur will effectively be ignored, thus obscuring the husband's violence (Wade, 2000). Even if the violence is partially acknowledged, models that focus on the biological model will shift the focus back onto the biological deficit within the woman by formulating the violence as the stressor that awoke her predisposition to depression (Wade, 2000). Once the victim has been labeled as being clinically depressed, the violence is ignored and the perpetrator becomes absolved of responsibility (Wade, 2000).

Language of Responses

Wade developed the Response-Based approach through his work with victims of violence (1997, 2000). Wade observed victims were not only upset by the acts of violence that they had suffered but were also upset by representations that presented them as passive, damaged and deficient (1997, 2000). His work represents an important movement away from traditional forms of psychotherapy that represent victims as passive, to one that recognizes that victims actively resist acts of violence and constructs victims as proficient and capable (Wade, 1997, 2000). Feminists and victim advocates have objected to the use of psychological labels and negative characteristics to describe victims and have recognized that victims actively resist violence and oppression (Caplan, 1995; Burstow, 1992; Gilligan et al., 1991; Kelly, 1988; Scott, 1990). However, even some researchers who have recognized victims as actively resisting acts of violence and oppression have interpreted victims' acts of resistance as crude and "maladaptive" coping skills (e.g. Burstow, 1992; Robinson & Ward, 1991). Wade's work is the first to

conceptualize victims' acts of resistance to violence and oppression as prudent and creative responses (1997, 2000).

The Responded-Based framework rejects the deterministic model of causation (Wade, 1997, 2000). Instead, it focuses on the victims' ability to choose how they will respond to violence (Ridley & Coates, 2003; Wade, 1997, 2000). The central tenet of the Response-Based framework is that "whenever persons are badly treated, they resist. That is, along each history of violence and oppression, there runs a parallel history of prudent, creative and determined resistance" (Wade, 1997, p.23). According to this model, resistance is conceptualized as any action (mental or physical), that opposes the violence or its impact (Wade, 1997, 2000). Therapists using the Response-Based framework represent victims as resourceful, active agents who resist violence in a variety of different ways (Wade, 1997, 2000). For example, crying, pulling up pants, feeling shame, and going somewhere in their minds are a just a few of the strategies that victims have used to resist, and sometimes, end acts of violence perpetrated against them (Wade, 1997, 2000). Whether or not these acts of resistance are successful in ending the violence or oppression is not the focus of the Response-Based framework (Wade, 1997, 2000) (Ridley & Coates, 2003). What is important is that victims' behaviours are not conceptualized as being a direct result of violent acts perpetrated against them; instead, victims' actions are represented as a result of their choice of how to respond to acts of violence based on their evaluation of dangers and opportunities available to them (Ridley & Coates, 2003; Wade, 1997, 2000). In this framework, victims are viewed as experts about violence and resistance (Wade, 1997, 2000). Because victims are the only ones who can truly understand the intricate nature of the interpersonal violence, they are the

only persons who can evaluate the dangers and opportunities available to them (Kelly, 1988; Ridley & Coates, 2003; Wade, 1997, 2000). For example, just as perpetrators recognize that victims will resist and take steps to prevent it, victims also recognize that their resistance will often not be successful in ending the abuse and, conversely, that it will often result in further retaliation on the part of the perpetrator (Coates & Wade, 2004; Kelly, 1988; Ridley & Coates, 2003; Wade, 2000).

This framework places a great deal of importance on examining acts of violence and resistance in context (Coates et al., 2003; Coates & Wade, 2004; Wade, 2000). Taking into consideration the context of these women's everyday lived experiences provides us with a different interpretation of their actions (Wade, 2000). When viewed in the context of violence, an abused woman's depressive symptoms may be interpreted as a form of resistance. Burstow (1992, p. 63) says, "oppression is depressing, and depression paradoxically is often the strongest protest that people can muster in a dehumanizing situation". Therapists who use the Response-Based framework allow victims to talk about and recognize their acts of resistance thus constructing them as competent and proficient (Coates et al., 2003; Ridley & Coates, 2003; Wade, 1997, 1999).

Critical Realist View of Language

The underlying theoretical framework of this study is based on the critical realist view of language (Fairclough, 1992, 1995; Parker, 1991). Central premises of this framework include: a) the material world exists but that our reality is socially constituted through talk, b) discourse performs social actions, and c) social responses influence talk and social interaction (Fairclough, 1992, 1995). This framework postulates that discourse is not neutral and, that we are always in the process of formulating and interpreting. As

such, this framework also rejects the idea that as researchers, we can be completely neutral and objective. Therefore, how acts of violence and issues of responsibility for violence are represented linguistically is important since these representations directly influence beliefs and interpretations. Discourse analysis allows us to examine “the tensions within discourses and the way they reproduce and transform the world” (Parker, 1991, p.5).

Summary

Much research has been done on victim blaming and how the culturally available linguistic discourses, for example, rape myths and psychiatric labels such as battered women syndrome, allow victims to be discredited and effectively revictimized by society at large (Berger et al., 1995; Burt, 1980; Scully, 1990). While some people use these linguistic strategies strategically to conceal their acts of violence, others unintentionally pick up linguistic strategies that misrepresent violent acts because they are so common (Coates et al., 2003; Coates & Wade, 2004; Scully, 1990; Wade, 1997, 2000). Even if these individuals do not intend to misrepresent acts of violence, the use of these linguistic strategies encourages the further perpetration of violent acts and disregards the experiences of victims (Coates et al., 2003; Coates & Wade, 2004; Wade, 1997, 2000). Because these misrepresentations are so common, they are ultimately picked up by individuals and become interpreted as accurate accounts of violent acts even by professionals in the justice and helping professions who are supposed to be assisting and advocating for victims (Coates et al., 2003; Coates & Wade, 2004; Wade, 1997, 2000).

Given that violence is a major problem, that social responses often fail, and that diagnoses and intervention are not neutral and objective but instead, actively constructed

through discursive processes such as reformulations, questions, and embedded presuppositions, it is important that we examine therapy transcripts closely to see how violence is handled. This is particularly important in cases of violence against women where social and physical power imbalances exist. There exists a need for a research and intervention strategy that takes into account the role of language in the construction of social meaning. The Interactional and Discursive View of Violence and Resistance is such a framework.

Most traditional clinical and research work ignores the difference between effects (victims' pathology as a direct result of the violence) and responses (how victims resisted the violence) (Wade, 2000). As such therapists in therapy articles most often represent victims of sexualized assault as passive, deficient and damaged (Ridley & Coates, 2003; Wade, 1997, 2000). Based on these findings, I propose that examining therapy interviews for the presence of the language of effects through the four operations, which are manifested using various linguistic strategies such as passive voice, embedded presuppositions, and reformulations, is crucial to ensuring effective and respectful therapy. This thesis is innovative because while feminists have criticized courts and therapy for blaming victims and excusing perpetrators, very few studies have ever examined how this occurs (Matoesian, 2001). By examining therapy interviews, I will examine whether or not these linguistic strategies are used in the context of therapy. If so, I will demonstrate the process through which blame is constructed by examining the use of the four operations (Coates & Wade, 2004).

CHAPTER FOUR - METHODS

Purpose

This study is an inquiry into the talk that occurs in therapy with victims of violence. An important step in any social intervention must be to gather an accurate account of what is going on and who is doing what to whom. Such information must be gathered through talk in therapeutic interviews. Because therapeutic interviews are social interactions, it is likely that in therapeutic interviews the social and social-interactive processes identified in previous research will occur (Coates & Wade, 2004; DeJong & Berg, 1998a). This study investigated the use of the four-discursive-operations in therapeutic interviews and how they were accomplished locally.

Sample

This study involved analyzing a sample of published transcripts. Transcripts were chosen by identifying as many transcripts as possible that were published in counseling books and that focused on the issue of violence against women and children. In total, 19 were identified. All of these were analyzed to see if the four-discursive-operations were present. Next, six transcripts were used for an in-depth analysis of the four operations of discourse. The first time a random selection was drawn, there were two transcripts from the same author; so the second transcript from that author was excluded from the detailed analysis and a seventh transcript was selected. Five were randomly selected and the sixth was selected for use in a pilot-test of the system of analysis.

Justification of Sample

Focus on Process

This study serves as a test of the Interactional and Discursive View of Violence and Resistance, which predicts that the four-discursive-operations are likely to occur in talk about violence where there are asymmetrical power relations such as in wife-assault (Coates & Wade, 2004). Thus, this study focuses on examining the processes by which (i) violence is concealed, (ii) perpetrators' responsibility is mitigated, (iii) victims' resistance is concealed, and (iv) victims are blamed and pathologized (Coates & Wade, 2004, p. 500). These findings are not meant to be generalizations about the styles of therapy examined, but, an investigation of the processes through which the four-discursive-operations are accomplished.

Sample Selection

A representative sample was not gathered for this study because the goal was to document and investigate discursive processes in therapeutic interviews rather than to differentiate in-between different types of therapies. Therapeutic interviews were randomly selected from a limited population of available published therapy transcripts about violence against women or children (May, Mason, & Hunter, 1989). When working with therapy transcripts, only a limited random sample may be obtainable because one cannot freely access these transcripts. Instead, researchers must obtain permission to analyze transcripts from clients, and therapists. It may be that a selection bias exists in samples such as this one, as it seems likely that clients and therapists would be more likely to allow transcripts to be used for research when they felt the session had gone well. A similar selection bias may exist in published transcripts. The therapists must get

the client's permission before publishing the interviews and therapists are likely to choose interviews that they believe are good examples of how to "do" their style of therapy. Therefore, even though published transcripts were used in this study, the sample selection process is likely very similar to one that would be used if we were examining non-published transcripts. Moreover, the selection bias that may exist in published transcripts will not have a negative impact on this study. If the discursive operations investigated occur in therapy interviews that are "good" examples of the style of therapy, then their occurrence was not considered by the therapists to be detrimental to the interview in any important way.

Multiple Transcripts by the Same Author

In three instances, more than one transcript from one author were utilized. This was done to see if the occurrence of the four-discursive-operations was specific to one particular therapist/patient interaction or if the therapist always appealed to these discursive operations.

Published Transcripts

The use of published transcripts is particularly important because these transcripts are used to teach students and others how to use therapeutic models, improve techniques, clarify styles, and approach particular problems. As such, there is an increased likelihood that these transcripts are seen to best demonstrate the approach and technique of the various therapists. Thus published transcripts, regardless of their publication date, exert a stronger impact on the field than non-published interviews.

Ethical Issues

Therapy transcripts must be approved by ethics boards before their publication. The fact that the transcripts selected for this study have been published suggests that they have already gone through the appropriate channels and have been deemed to pose minimal ethical problems.

Date of Publication

The sampling framework consisted of any published transcripts in which the presenting issue was violence. Published transcripts are an important data source because they reflect current practices and shape future practices. Generalizations are not the goal of this study; therefore, the actual date of publication is unimportant. The assumption that the treatment of victims and perpetrators would change over time is an empirical question that will not be addressed in this thesis. Transcripts, both old and new, serve as resources that are readily available as training tools to counseling, psychology, and social work students in university libraries. As such, old and new transcripts continue to exert an influence on the field which makes them equally appropriate sources of data for the investigation of the discursive processes examined in this study. Previous research by Wade (2000), Routledge (2003), McGee (1999), and Ridley & Coates (2003), have also examined published therapy transcripts for similar reasons.

Therapeutic Models

While the specific therapeutic model used in each transcript was recorded when a specific model was identified (see Table #1) the background and training of the therapist, in each of the selected transcripts was not the focus of this study. Instead, the linguistic strategies used across different therapeutic models were examined (Routledge, 2003).

Table #1: Year of publication and Therapeutic model used in each Therapy Transcript

Transcript #	Year	Therapeutic Model Used
1	1997	Solution-Focused Brief Therapy
2	1986	Systemic Family Therapy
3	1989	A form of Clinical Interviewing (no specific model was specified)
4	1989	A form of Clinical Interviewing (no specific model was specified)
5	1987	A form of Clinical Psychiatry (no specific model was specified)
6	1990	Family & Brief Therapy
7	2004	Narrative Therapy
8	2004	Narrative Therapy
9	1990	A form of Psychotherapy (no specific model was specified)
10	1989	Family Systems Approach
11	1988	Family Therapy
12	1988	Family Therapy
13	1988	Family Therapy
14	1996	Solution-Focused Brief Therapy
15	1995	Therapy of Social Action (a form of Family Therapy)
16	1996	Solution-Focused Therapy
17	1998	Solution-Focused Therapy
18	1990	Brief Narrative Therapy
19	1995	A form of Psychotherapy that focused on self esteem

Table #2: Basic Tenets of the Therapeutic Models Used

Therapeutic Model	Basic Tenets
Family Therapy	<ul style="list-style-type: none"> ▪ Views problems as precipitated by the family structure (patterns of interaction). ▪ Assumes that the family system must be restructured in order to solve the problem. ▪ Assumes that each family member plays a role in the interactional patterns that facilitate the problematic family structure even though the perpetrator is ultimately responsible for the violence. (Trepper, 1986).
Narrative Therapy	<ul style="list-style-type: none"> ▪ Views individuals as experts about their lives.

	<ul style="list-style-type: none"> ▪ Views problems as external to the individual. ▪ Assumes that individuals have the necessary skills to solve their own problems. ▪ Focuses on the telling and re-telling of individuals' personal stories. (White & Epston, 1990; Monk, Winslade, Crocket, & Epston, 1997; Lieblich, McAdams, & Josselson, 2004)
Solution-Focused Therapy	<ul style="list-style-type: none"> ▪ Views problems as external to the individual. ▪ Assumes that individuals know what they want to be different in their lives. ▪ Focuses on solutions instead of eliciting detailed descriptions of the problem. (DeJong & Berg, 1998a; Miller, Hubble, & Duncan, 1996)
Therapies that were classified as "Brief"	<ul style="list-style-type: none"> ▪ Focuses on taking direct action towards the resolution of a specific problem. This allows change to occur faster. (Cade & O'Hanlon, 1993)

Content Analysis /Discourse Analysis

This study involves two parts and utilizes a combination of both content analysis and discourse analysis. Content analysis is "an approach to the analysis of texts (which may be printed or visual) that seeks to quantify content in terms of predetermined categories and in a systematic and replicable manner" (Bryman, 2004, p.181). Content analysis involves identifying or counting specific features of discourse (Bryman, 2004). For example, who is mentioned, what is mentioned, where it is mentioned, location of coverage within the analyzed item, how much it is mentioned, and why it is mentioned

(Bryman, 2004). For the content analysis portion of this study, published therapy transcripts were examined to identify if the four-discursive-operations were occurring (Bryman, 2004). An advantage of using content analysis is the transparency of the method which allows for replication and follow-up studies to be conducted easily (Bryman, 2004). Another advantage of using content analysis is that it is viewed as an unobtrusive method because participants (in this case the therapists and clients) are not affected by the researcher since the data was already collected for the purpose of publication (Bryman, 2004). Disadvantages of using content analysis are a) the analysis is reliant on the reliability and validity of the source, and b) coding and analysis involves some interference and interpretation (Bryman, 2004).

For the second part of this study, discourse analysis was used to conduct a detailed analysis of five transcripts. Discourse analysis involves more than identifying specific features of talk; it involves examining how language is used to perform social actions (Wood & Kroger, 2000). Discourse analysts examine three features of language: “(a) their locutionary or referential meaning (what they are about), (b) their illocutionary force (what the speaker does with them), and (c) their perlocutionary force (their effects on the hearer)” (Wood & Kroger, 2000, p.5). Once it was established that the four-discursive-operations were indeed occurring in these published transcripts, discourse analysis allowed an examination of how the four-discursive-operations impacted formulations of violence, the victim and the perpetrator, and ultimately the movement of the therapeutic interview.

Validity determines whether we are measuring what we say that we are measuring and how accurate the results are. Traditionally, social research focused on unearthing

findings that most accurately reflected the real state of the world (Wood & Kroger, 2000). Conversely, discourse analysts focus on how the world is socially constructed and how this impacts discursive constructions. Because they view discourses as socially constructed, they also view discourses as having “shifting and multiple meanings” (Wood & Kroger, 2000, p.166). However, this does not mean that discourse analysts reject the notion of validity. Instead, validity is established by ensuring that interpretations are well grounded in evidence, in this case, the talk in therapy transcripts. Talk is action, and thus, the goal of this study was to identify talk that accomplished the four-discursive-operations and examine how this talk impacted notions of violence and responsibility for the violence in therapeutic interviews as evidenced by the actual talk.

Objectivity is established in methods through construct validity. When using case studies (transcripts in this case), objectivity is accomplished by articulating clearly the research procedures which allows us to demonstrate that decisions were made systematically (Berg, 2004). This is done by operationalizing the variables examined and creating a set of rules and procedures for the system of analysis. Operationalizing a variable means making variables measurable, quantifiable concepts. This involves clearly defining and setting out guidelines for what constitutes each of the four-discursive-operations. Having rules and procedures for the system of analysis helps guide decisions and keep them systematic and also makes it possible for studies to be easily reproduced (Berg, 2004). Transparency of method in discourse analysis is established by grounding findings in text. In the results section, presentation of the analysis will allow the reader to see how judgments were made. Therefore, the reader is in the position to judge if the judgments were made systematically that is, the same way every time.

System of Analysis

The system of analysis that was used in this study was adapted from studies and published articles by Coates and Wade (in press) (*see Appendix 1 for a full description of the System of Analysis*). As such, this system of analysis has met the social-scientific criterion of being peer reviewed. The analysis involved a five step procedure: 1) identification of sections of transcripts that described violence against women (e.g., spousal assault or sexualized assault); 2) analysis of the identified sections for each of the four-discursive-operations (it is likely that almost every utterance in the transcripts will be relevant to the analysis); 3) analysis of reformulations and embedded presuppositions that either clarify or conceal acts of violence; 4) recording who is representing the violence and wherever relevant, if the violence was reformulated; and 5) recording the impact of these discursive operations (conceal violence, mitigate perpetrators' responsibility, conceal victims' resistance, and blame or pathologize victims) in the movement and final outcome of therapy (Coates & Wade, 2004, p. 500). The four-discursive-operations are not mutually exclusive categories; often all occur together in the same utterance. Thus, it would be extremely difficult to count the number of times each of the four-operations occurred. Instead, the percentage of speech turns that contain the usage of any or all of the four-discursive-operations will be calculated. A speech turn or talking turn was defined as each time the speaker changed. For example, if the therapist spoke, the victim responded, and then the therapist again, this would be counted as three separate talking turns.

The exact function of the representations analyzed was determined by analyzing its meaning in context. Below are descriptions of how certain forms of representations

typically functioned. Most of the examples in this section are taken from a therapy transcript where the presenting issue was wife assault (Lansky, 1987). The therapist indicates that the husband (Mario) had hit his wife (Anna) three times in the last week. Anna spoke of being “frightened” and of Mario as “being out of control” (Lansky, 1987, p. 341).

Operational Definitions

Four-Discursive-Operations

Violence

How violent acts are described in these transcripts was of the utmost importance. Whether the representations functioned to conceal or expose violence was examined.

1. Concealing violence. Concealing representations can be done directly or indirectly through for example, the use of embedded presuppositions. Representations that obfuscated, denied, minimized, or mutualized the violent nature of acts or the extent of the violence were classified as concealing representations (Coates & Wade, 2004). Representations that *obfuscated* violence were those that attempted to conceal the violence as the problem to be addressed. For example, the word, “marital problems”, conceals the violence by playing up the mutual nature of marriage and normalizing the violence by suggesting that violence (wife battering) is a “normal” part of marriage problems, instead of what it really is, a criminal act (Coates & Wade, 2004).

Representations that concealed violence through *denial* were those that discounted the violence. For example, in commenting on the sexual assault of a girl, a judge said that “there was no violence and no physical force” (Coates et al., 1994, p.

194). This utterance conceals violence by framing sexual assault as essentially a non-violent act.

Representations that concealed violence through *minimizing* were those that discredited the seriousness of the violence. For example, “I’m much more emotional with her” (Lansky, 1987, p. 343). Here the perpetrator denies the violence by calling it something else (emotions). Embedded in this utterance is the notion that violence is caused by emotions. By equating spousal violence to emotions, he conceals the seriousness of spousal violence.

Representations that concealed violence by representing the violence as *mutual* were those that concealed the unilateral nature of an act of violence. For example, the word, “fight”, represents both parties as equally involved (Coates & Wade, 2004). Instead of saying, “I hit her”, the perpetrator uses the word, “fight”, to conceal the unilateral nature of violence by implying that both spouses were equally involved and thus should both be held responsible (Coates & Wade, 2004; Lansky, 1987, p.342). A more appropriate word to describe the event would have been “attack” which would denote the unequal distribution of power and the unilateral nature of wife battering violence (Coates & Wade, 2004).

Broad or global descriptions of violence typically tend to conceal violence and do not create the discursive space necessary to discuss how victims responded to or resisted these violent actions (Coates & Wade, 2004; Wade, 2000). For example, in the article entitled the “Apology Session”, the therapist expected both parents to apologize for the sexual abuse perpetrated by the father against one of their daughters; this was counted as concealing the violence (Trepper, 1986). It would seem logical for the mother to

apologize only when descriptions of the violence are kept at a global, abstract level (Trepper, 1986). If the violence and the experience of the victim had been discussed in detail, it would become clear that the violence was perpetrated by the husband alone while the mother was in the hospital, and so she could not be logically construed as responsible (Trepper, 1986). It may be the case in some of these transcripts that global terms are used to refer to the acts of violence because contextualized, detailed accounts were given in earlier therapeutic interviews; if so, then details could be referred to in short-hand fashion because they form common ground (Clark, 1992, 1996).

Cases where the description of the violence represented it as a combination of joint and individual actions (e.g., “he had sex with her against her will”) were recorded as *combination*. These representations formulated the acts as non-violent (e.g., “had sex”) and violent (e.g., “against her will”), and so were typically counted as concealing violence to some degree.

Exposing violence. Discursive operations that exposed the unilateral and deliberate nature of the violence and included accounts of victims’ responses were classified as exposing the violence (Coates & Wade, 2004; Coates & Wade, 2005). Representations that exposed violence as *unilateral* were those that exposed the violence as the act of an individual against the will of another. For example, using the utterance “rape” to formulate sexual assault exposes the fact that the sexual assault was the unilateral act of the perpetrator against the will of the victim.

Contextualized, detailed accounts (who did what to whom) were counted as exposing violence and creating the discursive space necessary to discuss how victims responded/resisted these violent actions (Coates & Wade, 2004; Wade, 2000). In the

context of therapy and discussions of violence, it is important to keep clear who did what to whom in order to clarify the unilateral nature of the violence.

Perpetrators' Responsibility

Whether representations functioned to mitigate or clarify perpetrator responsibility was also analyzed.

2. Mitigating perpetrator responsibility. Any representation of the violence that mutualized responsibility, presented the violence as precipitated by externalized factors, or inaccurately described the violence was classified as mitigating perpetrator responsibility (Coates & Wade, 2004). These representations can be done directly or indirectly, for example, through the use of embedded presuppositions. Representations that present the violence as *mutual* were those that attempted to mitigate perpetrator responsibility by presenting the victim and the perpetrator as equally to blame (Coates & Wade, 2004). For example, "We've had three physical confrontations" (Lansky, 1987, p. 342). The use of "we" formulates the perpetrator as being a co-actor of a joint action rather than the sole actor of a violent action (Coates & Wade, 2004).

Representations that present violence as occurring due to *externalized* factors were those that connected to the notion that the perpetrator's violent behaviours were precipitated by factors beyond his/her control, suggesting that he/she should not be held responsible. For example, Lansky (1987, p. 339), formulates domestic violence as an "impulsive action". Embedded in this utterance is the presupposition that violence occurs on impulse. Representations that presented the violence as caused by externalized factors beyond his control (e.g. alcohol and drugs, buttons pushed, lost control) typically worked to mitigate responsibility. For example, researchers have found that judges were more

likely to give more lenient sentences when external factors were used to explain violence (Bavelas & Coates, 2001; Coates et al., 1994; Coates, 1997; Coates & Wade, 2004; West & Coates, 2003). These representations equate perpetrators with automatons that have no control over their behaviours; they simply react to pressures. These representations also deny the extent to which the violent actions of perpetrators are planned, premeditated and deliberate (Coates & Wade, 2004).

Representations that present *inaccurate descriptions* were those that represented the perpetrator in glowing terms despite his/her acts of violence. An example would be a representation that represents the perpetrator, a man who had been convicted of raping a woman two times, as being a man “of impeccable character” (Coates et al., 1994; Coates & Wade, 2004). This utterance denies the seriousness of the perpetrator’s violent acts by presenting himself as a “good guy”, thereby distancing him from his heinous actions.

Clarifying responsibility. Any representations that functioned to make clear perpetrator responsibility were counted as clarifying responsibility. Representations that represented the violence as the *unilateral* responsibility of the perpetrator were those that attempted to clarify perpetrator responsibility, for example, “he hit her”. Questions can be used to clarify responsibility. For example, if violence is formulated as a “fight”, responsibility can be clarified, by asking “what do you mean by fight?” or “what do you do when you fight?” (Coates & Wade, 2004). These questions sometimes lead to the perpetrator making statements with clear responsibility, for example, “I broke her jaw”.

Victims’ Resistance

The transcripts were also analyzed for whether they concealed or revealed victim resistance.

3. *Concealing victims' resistance.* Representations that denied victim agency and presented them as passive in the face of violence (e.g., “she did not resist, or “we need to work on assertiveness and passivity”), or reformulated the victim’s resistance as negative, for example, causing the violence perpetrated against them, functioned to conceal resistance. In the following example, the therapist casts the victim’s acts of resistance as causing her husband to be irresponsible:

he’s so hurt that no matter how much truth there is in what you’re saying, nothing’s going to get done right here unless we understand how you both feel, and work with that for a while. Because I think you’re so hurt, Mario, by what she’s saying, that the content’s going to get lost. (*To Anna*) Do you follow what I’m saying? He’s going to hear it like his father telling him he’s not good enough. (Lansky, 1987, p.348)

Here the therapist is lecturing the wife (Anna) on how “hurt” her husband (the perpetrator) is by her complaints that he does not take responsibility financially or otherwise (Coates & Wade, 2004). He is suggesting that Anna (the victim) should not say anything to Mario “no matter how much truth there is” in what she’s saying (Coates & Wade, 2004). By doing this, the therapist is concealing Anna’s resistance by disregarding her side of the story. Instead of focusing on what the husband (the perpetrator) needs to work on, the therapist focuses on what the victim is doing wrong and reformulates her complaints as unreasonable and problematic.

Representations also *concealed* victims’ resistance through broad or global descriptions that did not create the discursive space necessary for descriptions of victims’ actions. For example, stating “they argued” implies that the victim was not resisting the

assault so much as participating in it. This description fails to give a detailed account of who did what to whom.

Elucidating and honouring victims' resistance. Representations of victims' resistance that clarified the victims' agency in opposing perpetrators' violence or abuse functioned to reveal victim resistance (Coates & Wade, 2004). Descriptions of resistance did not have to cast the actions as successful in ending the violence to be counted as elucidating victim resistance.

Victim Blaming

Whether accounts blamed victims or contested accounts that blamed victims was also analyzed.

4. Blaming or Pathologizing Victims. Representations that mutualized responsibility for the violence by representing the victim as deficient and passive, or as precipitating, provoking, or deserving the violence perpetrated against them were classified as blaming or pathologizing victims.

Representations that *blamed* the victim were those that represented the victim as responsible for the violence. For example, when the therapist said, "Well, if you can tell me, then she'll have a chance to listen. Perhaps we'll have something to work on" (Lansky, 1987, p. 343), he placed responsibility for the violence on Anna. She needed to listen and then if she did, there would be something to work on.

Representations that *pathologized* victims were those that suggested that there was something about the victim that caused the perpetrator to become violent (e.g., "she seeks it out"); typically the violence was formulated as a problem within the victim's mind. Such formulations may occur with such psychiatric labels as self defeating

personality disorder, battered women syndrome and post traumatic stress disorder. These psychiatric labels tend to remove the focus from the perpetrators' violent acts and place it on the victims. For example, women who are battered by their husbands are pathologized and blamed for remaining in abusive situations. Victims of sexualized violence are often pathologized for how they dealt with violence; these representations were analyzed as victim-blaming. For example, when the therapist stated that the victim had a "pathological propensity to disorganize and inflict shame. . ." (Lansky, 1987, p. 361) and that her "role in the destructive relationship is evident" (Lansky, 1987, p. 357). Embedded in these utterances is the assumption that although Mario may have been the one who actually behaved violently, that Anna was the true perpetrator and Mario was the victim because she "drove" him to it (see Coates & Wade, 2004).

Contesting the Blaming and Pathologizing of Victims. Any representation that challenged the blaming and pathologizing of victims was analyzed as contesting blaming and pathologizing victims. For example, formulating the victim as mentally healthy, as prudently responding, or as an object of violence are representations that contest blaming and pathologizing.

Outcome

Finally, the outcome of the therapy transcript will be examined. For example, was the victim's safety adequately addressed in therapy (particularly when the therapy transcript dealt with physical or sexual violence against a child)? Diagnoses, or the problems to be fixed, worked on or managed, are often conceptualized as the outcome of the therapeutic interview process; as such, how these diagnoses were made was also examined. Diagnoses include formal disorders from the Diagnostic and Statistical

Manual (DSM) such as post-traumatic stress disorder (PTSD), and less formal diagnoses, such as an “assertiveness problem”. The implications of the diagnosis for the victim was also recorded, particularly when the diagnosis served to accomplish one or more of the four-discursive-operations. For example, in the Lansky transcript, Anna (the wife and victim) was diagnosed as having a “pathologic propensity to disorganize and inflict shame” (Lansky, 1987, p. 361). This diagnosis cast Anna as being verbally abusive and as precipitating or contributing to her husbands’ violence (Coates & Wade, 2004). Mario was then cast as merely being triggered or reacting to Anna’s unreasonable complaints, which allowed him to avoid taking full responsibility for his actions. Thus, the therapist obfuscated Mario’s responsibility by casting Anna as primarily responsible for or precipitating, his violence (Coates & Wade, 2004).

Reformulation

One way movement or change occurs is through reformulation. Reformulations occur when a person substantially transforms an earlier representation into a different problem (Davis, 1986). Reformulations were analyzed for whether they changed the representations in either a negative or positive way (Routledge, 2003). Negative reformulations involved changing a representation to a less accurate one which included those that concealed violence, diffused responsibility, concealed victim resistance, and blamed and pathologized victims (Coates & Wade, 2004). In contrast, positive reformulations involved a more accurate description of violence which included those that clarified responsibility, exposed violence, contested victim blaming and pathologizing, and recognized victim resistance (Coates & Wade, 2004).

Summary of Method

Examining the interview process will allow us to see if violence is being concealed, responsibility is obfuscated, victim resistance is ignored and if victims are being blamed in therapy with victims of violence or if the opposite is occurring (Coates & Wade, 2004). As is always the case in human rights issues, if the four-discursive-operations are found even in one interview, it would be an important and socially problematic finding. If the four-discursive-operations do occur, examining the interview process will clarify how these processes are accomplished. For example, are these functions equally performed by therapists, victims and perpetrators. By tracking the course of the transcripts we will be able to examine how representations get picked up or dropped by therapists and clients. We will be able to examine the process through which diagnoses are made and, whether these diagnoses clearly represent violence as a unilateral act of one person against another and thus the problem to be worked on in therapy, or, if the violence is mutualized. Finally, we'll be able to examine whether violence is interpreted as an individual problem of the victim or as a social problem of the perpetrator. As others have noted:

“For therapists, the question of how the actions and subjective experiences of perpetrators and victims of violence are constructed in discourse is always at issue” (Todd, Wade, & Renoux, 2004, p. 159).

Thus, therapy with victims of violence must present accurate interpretations of violence that “(i) expose violence, (ii) clarify responsibility, (iii) elucidate and honour victims’ responses and resistance, and (iv) contest the blaming and pathologizing of victims” (Coates & Wade, 2004, p. 522). If none of these transcripts utilized the four-discursive-

operations, this would also be an important finding. It would allow us to feature the absence of the four-discursive-operations in therapy, in contrast to judges' decisions in sexual assault trials (Coates & Wade, 2004).

Chapter Five – Results and Discussion: Part I

Introduction

This study investigated the use of the four-discursive-operations in therapeutic interviews and how they were locally accomplished. The study was comprised of two parts: first, an analysis of 19 transcripts to identify the use of the four-discursive-operations; second, a detailed analysis of five randomly selected transcripts to discuss how these discursive-operations were accomplished and how they directed the flow of the therapeutic interview. This chapter will deal with the results of the first part of the analysis and includes the percentages of talking turns taken by therapists and perpetrators that contained one or more of the four-discursive-operations. Examples of how each of the four-discursive-operations were accomplished will also be examined. Chapter 6 will deal with the results of the second part of the analysis. While five transcripts were analyzed in detail, for pragmatic reasons, only two of the five transcripts randomly selected for a detailed analysis will be the focus of this thesis, along with a discussion of how within the four-discursive-operations, embedded presuppositions and reformulations influenced formulations of violence, responsibility for the violence, the perpetrator, and the victim.

Part I

The four-discursive-operations were found to occur in all of the nineteen transcripts analyzed (See Table #3). 27.5% of talking turns taken by either the therapist or perpetrator contained one or more of the four-discursive-operations (See Table #4). Thirty-nine percent of the therapists' talking turns contained one or more of the four-discursive-operations. In the ten transcripts where the perpetrator was present, one or

more of the four-discursive-operations was used in 59% of the perpetrators' talking turns. While the four-discursive-operations were found in all of the transcripts analyzed, it is important to note that just because they occurred does not mean that every utterance in these transcripts contained one of the four-discursive-operations. Some of the transcripts, despite the presence of the four-discursive-operations, also included representations of the violence, the perpetrator, and the victim that were clarifying, and according to the Interactive and Discursive View of Violence and Resistance, represented more accurate descriptions of the violence. Examples of these clarifying representations will be given later on. Below are examples of how therapists and perpetrators used each of the four-discursive-operations (See Tables #5-8 for Examples of the Four-Discursive-Operations).

Table #3: Percentages of Talking Turns that Contained One or More of the Four-Discursive-Operations

Transcript #	Year Published	Therapeutic Model Used	% of Therapist's utterances that contained one or more of the four-discursive-operations	% of Perpetrator's utterances that contained one or more of the four-discursive-operations
1	1993	Solution-Focused Brief Therapy	2%	n/a
2	1986	Systemic Family Therapy	61.5%	75%
3	1989	Clinical Interviewing	3.8%	53.8%
4	1989	A form of Clinical Interviewing (no specific model was specified)	56.8%	n/a
5	1987	A form of Clinical Psychiatry (no specific model was specified)	91.3%	67.4%
6	1990	Family & Brief Therapy	64.2%	69.4%
7	2004	Narrative Therapy	41.7%	n/a
8	2004	Narrative Therapy	47.4	n/a
9	1990	A form of Psychotherapy (no specific model was specified)	36%	n/a
10	1989	Family Systems Approach	66.6%	59.7%
11	1988	Family Therapy	9%	n/a
12	1988	Family Therapy	44.8%	n/a
13	1988	Family Therapy	14.3%	n/a
14	1996	Solution-Focused Brief Therapy	64.7%	64.7%
15	1995	Therapy of Social Action	46.3%	35.7%
16	1996	Solution-Focused Therapy	75%	90.9%
17	1998	Solution-Focused Therapy	11.8%	n/a
18	1990	Brief Narrative Therapy	62.5%	34.5%
19	1995	A form of psychotherapy that focused on self esteem	24%	63.2%

n/a not applicable - perpetrators were not present during the therapeutic interview

Table #4: Total Percentage of Talking Turns that Contained One or More of the Four-Discursive-Operations

Total % of utterances that contained one or more of the four-discursive-operations	Total % of Therapist's turns that contained one or more of the four-discursive-operations	Total % of Perpetrator's turns that contained one or more of the four-discursive-operations (perpetrators were only present in 10 of the 19 transcripts)
27.2%	38.6%	59%

Four-Discursive-Operations

Violence

Concealing the Violence

How violent acts were described in these transcripts was examined. Whether the representations functioned to conceal or expose violence was examined. Concealing representations were done directly or indirectly, for example, through the use of embedded presuppositions. Representations that obfuscated, denied, minimized, or mutualized the violent nature of acts or the extent of the violence were classified as concealing representations (Coates & Wade, 2004).

Minimizing the violence.

Representations that concealed violence through minimizing were those that discredited the seriousness of the violence. Two therapists concealed the seriousness of the violence by assuming that a simple apology, a forced apology in one case, was enough to negate the victim's fear and make up for the trauma of the abuse. Demanding that perpetrators apologize in a therapy session is particularly difficult, not only because these apologizes are often not heartfelt, but, also because once the perpetrator apologizes, the onus shifts onto the victim to accept their apology (Coates & Wade, in press). If the victim does not accept the perpetrator's apology they are often viewed as impeding the

healing process (Coates & Wade, in press). Both of the therapists noted that victims almost always forgive their offenders; this minimizes the trauma associated with sexualized violence and does not recognize that it is reasonable for victims to be angry and not to forgive their abuser. The issue of victim safety when returning home with the offender was not addressed in either of these transcripts. Once the apology was given and the victim accepted, it was considered safe for the victim to return home.

In a transcript where the presenting issue was sexualized violence perpetrated by a sixteen-year-old boy against his younger sister over a period of a year, the therapist concealed the seriousness of the violence through the utterance:

There's another thought, another plan. Something else needs to happen, which is that, when Harold is able to, I think it would be a very **good idea for him to get a job and for the money from that job to go in a fund for Sarah's use in her future as a sort of reparation, damages so to speak.** (Transcript #6, 1990, p. 72)

This utterance conceals the seriousness of the violence through the negative embedded presupposition that money can "make up" for the violence. While reparation is a good idea, this utterance conceals the degree to which sexualized violence is an extremely traumatic event that cannot be undone by the giving of money.

Perpetrators also often attempted to conceal the seriousness of the violence. For example, in a transcript where the presenting issue was wife assault, the perpetrator used the following utterance to conceal the violence:

...basically we have a **good marriage** (Transcript #10, 1989, p. 147)

This utterance conceals the seriousness of the violence by either equating wife battering as a normal part of a “good marriage”.

In another transcript, where the presenting problem was also wife assault, the husband concealed the seriousness of the violence by saying:

She said **she was scared of me. That’s crap.** (Transcript #14, 1996, p. 155)

The utterance, “That’s crap”, conceals the violence through the negative embedded presupposition that his wife has no reason to be afraid of him.

Mutualizing responsibility for the violence.

Representations that concealed violence by representing the violence as mutual were those that concealed the unilateral nature of violence. This was evident in two transcripts involving sexualized violence in which innocent family members were asked to take responsibility for the perpetrators’ violence. For example, in a transcript involving a sixteen-year-old boy (Harold) who molested his younger sister (Sarah) over the period of a year, the therapist said the following:

I’d like for **everyone in this family** except for Harold to get on their knees in front of Sarah. And I’d like for **you all** to tell Sarah how sorry you are **that you were not able to protect her.** (Transcript #6, 1990, p. 78)

Here the therapist mutualizes responsibility for the violence by constructing the entire family (including the other children) as responsible for the violence because they were not “able to protect her”. This utterance conceals the violence by presenting it as a failure of the family to “protect” Sarah, instead of focusing on Harold’s violence. If the violence and the experience of the victim had been discussed in detail, it would have become clear that the violence was perpetrated by the perpetrator alone and would have created the

discursive space necessary to discuss how the victim resisted these violent actions (Coates & Wade, 2004; Wade, 2000).

Therapists were also found to misrepresent the violence as a fight. For example, in a transcript where the presenting issue was wife battering, the therapist said:

What I'd like you to do, Sheri, is **describe in precise detail** the last time you and Kevin **fought**. (Transcript #19, 1995, p.388)

The use of the utterance "you and Kevin fought" mutualized the violence by implying that both the perpetrator and the victim were equally involved and thus should both be held responsible. This also implies that the victim was not resisting the assault as much as participating in it. More appropriate words to describe the perpetrator's violent acts would have been "attack" or "abuse" which would denote the unequal distribution of power and the unilateral nature of the violence.

Perpetrators often mutualized responsibility for violent acts by using terms that are typically used to describe consensual sexual relationships to describe acts of sexualized violence. For example, in a transcript where the presenting issue was sexualized violence, the father (the perpetrator), referred to the abuse as a "sexual affair". Use of the term "sexual affair" conceals the violence by misrepresenting the abuse as a consensual sexual relationship. Formulating sexualized violence as a consensual sexual relationship does not create the discursive space for victims' to discuss how they experienced the violence and how they resisted. More appropriate words to describe perpetrator's violent acts would have been "rape" or "molestation" as these words would have denoted that the violence was perpetrated unilaterally by the father against the will of his daughter.

Misrepresenting the violence as something else.

In a transcript involving a man who battered his wife, the therapist reformulated the problem to be addressed to something other than the issue of violence:

Well you wanted to get close to her and you worked hard at it. **I respect your intentions. However, your recipe for getting close is not only out of date but totally misguided.** (Transcript #18, 1990, p.81)

Here the therapist conceals the violence by presenting the motivation for the assault as something positive, that the husband “wanted to get close” to his wife and that he “worked hard at it”. These representations immediately connect us to affectionate acts as the background for interpreting his acts and making attributions about his character. For example, he “wanted to get close to his wife” versus he intended to hurt her. The therapist presents these motivations as not only believable, but also admirable, by saying, “I respect your intentions”. Formulating the perpetrator as trying to “get close” to his wife displaces descriptions of what the perpetrator did to the victim, how he beat her up, and how he overcame her resistance. Without detailed descriptions of what actually took place, we are not able to understand the full extent of the violence. The therapist presents the perpetrator’s “recipe” on how to get close to his wife as “out of date”. This allows the violence to be seen as out of time, as a misguided act and, therefore, not so bad. The therapist’s choice of words, are consistent with an affectionate context, not the context of violence. This does not reflect the victim’s experience of having been beaten up by her husband and denies the degree to which the perpetrator consciously chose to hit his wife. Throughout the entire transcript, this affectionate context influenced all formulations of the perpetrator and the violence.

Table #5: Examples of Utterances that Concealed the Violence.

1. Conceal the Violence.	
	Explanation
<p>1. In a transcript, where the presenting issue was sexualized violence perpetrated by a teenage boy against his younger sister, the therapist said:</p> <p>“There’s another thought, another plan. Something else needs to happen, which is that, when Harold is able to, I think it would be a very good idea for him to get a job and for the money from that job to go in a fund for Sarah’s use in her future as a sort of reparation, damages so to speak.” (Transcript #6, 1990, p. 72)</p>	<p>This utterance conceals the seriousness of the violence through the negative embedded presupposition that money can “make up” for the violence. While reparation is a good idea this utterance conceals the degree to which sexualized violence is an extremely traumatic event that cannot be undone by the giving of money.</p>
<p>2. In a transcript, where the presenting issue was wife assault, the husband (the perpetrator) said:</p> <p>“. . . basically we have a good marriage” (Transcript #10, 1989, p.147)</p>	<p>This utterance conceals the seriousness of the violence by either equating wife battering as a normal part of a “<u>good marriage</u>” or by implying that violence is not occurring.</p>
<p>3. In a transcript, where the presenting issue was wife assault, the husband (the perpetrator) said:</p> <p>“She said she was scared of me. That’s crap.” (Transcript #14, 1996, p.155)</p>	<p>The utterance “<u>That’s crap</u>” conceals the violence through the negative embedded presupposition that his wife has no reason to be afraid of him.</p>
<p>4. In a transcript where the presenting issue was a father who had sexually abused his daughter, the father referred to the sexual abuse as a “<u>sexual affair</u>”. (Transcript #2, 1986, p.97)</p>	<p>Use of the term “<u>sexual affair</u>” conceals the violence by misrepresenting the abuse as a consensual sexual relationship.</p>
<p>5. Father who sexually abused his daughter said:</p> <p>“And I know you’re embarrassed but there’s no sense in being embarrassed. You shouldn’t be embarrassed in front of us, there’s no sense being embarrassed in front of Dr. Trepper.” (Transcript #2, 1986, p. 97)</p>	<p>The father conceals the seriousness of the violence he committed against his daughter by referring to the trauma and anguish of abuse as being “<u>embarrassed</u>”.</p>
<p>6. An abusive husband whose wife left him said:</p> <p>“We have a kind of old-fashioned marriage.” (Transcript #3, 1989, p.420)</p>	<p>The utterance “<u>we have a kind of old-fashion marriage</u>” conceals the violence by referring to it as an “<u>old-fashion marriage</u>”.</p>

7. In a transcript, where the presenting issue was wife assault, the therapist said:

“Well you wanted to get close to her and you worked hard at it. I respect your intentions. However, your recipe for getting close is not only out of date but totally misguided.” (Transcript #18,1990, 81)

Here the therapist conceals the violence by presenting the motivation for the assault as something positive, that the husband “wanted to get close” to his wife and that he “worked hard at it”. These representations immediately connect us to affectionate acts as the background for interpreting his acts and making attributions about his character, for example he “wanted to get close to his wife” versus he intended to hurt her. The therapist presents these motivations as not only believable but also admirable by saying “I respect your intentions”. Formulating the perpetrator as trying to “get close” to his wife displaces descriptions of what the perpetrator did to the victim, how he beat her up, and how he overcame her resistance. Without detailed descriptions of what actually took place we are not able to understand the full extent of the violence. The therapist presents the perpetrator’s “recipe” on how to get close to his wife as “out of date”. This allows the violence to be seen as out of time, as a misguided act and, therefore, not so bad, which are interpretations consistent with the affectionate interpretative context, not the context of violence. This does not reflect the victim’s experience of having been beat up by her husband and denies the degree to which the perpetrator consciously chose to hit his wife. Throughout this transcript this affectionate interpretative context influenced all formulations of the perpetrator and the violence.

<p>8. In a transcript, where the presenting issue was sexualized violence perpetrated by a teenage boy against his younger sister, the therapist said:</p> <p>“Mr. Adams, I have a task for you this week. I would like you this week to think about what could be absolutely the most severe punishment that you can have in store for your son Harold if anything like this – if you were even to have a suspicion of anything like this – were to occur again. And I mean a punishment that would be so severe that this young man won’t even want to contemplate something like that again.” (Transcript #6, 1990, p.70)</p>	<p>The therapist conceals the seriousness of the violence perpetrated by the son by suggesting that any punishment the father could think up (e.g., grounding, taking away phone privileges etc.) could ever make-up for the trauma caused by the violence.</p>
<p>9. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>“Is this before or after you lose your temper?” (Transcript #10, 1989, p.149)</p>	<p>Equating violence with losing his “<u>temper</u>” conceals the seriousness of the violence.</p>
<p>10. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>“I want to discuss in front of Louise and Howard, is the difference in styles in the families of origin: how they handle temper, how they handle anger.” (Transcript #10, 1989, p. 155)</p>	<p>It conceals the violence by constructing it as a “<u>difference in styles in the family of origin</u>” instead of Howard’s problem with violence. Reformulates the problem of violence to a problem of “<u>styles in family</u>”.</p>
<p>11. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>“No way, no offense. I don’t think I need this. I don’t beat my wife. She took out a restraining order” (Transcript #14, 1996, p.155)</p>	<p>The perpetrator attempts to conceal the violence by denying that he ever hit his wife.</p>
<p>12. In a transcript, where the presenting issue was a father who beat his daughter, the therapist said:</p> <p>“So one of the issues, not only for you, Ken, but also for Kristen, is not knowing whether you’re going to leave or stay, live or die. Kristen’s problem about not knowing whether she wants to live or die seems similar to your problem not knowing whether you want to stay in the home or not. (Transcript #15, 1995, p.26)</p>	<p>The therapist reformulates the problem to be addressed in therapy. He constructs Kristen’s problem as being “<u>not knowing whether she wants to live or die</u>” instead of viewing her problem being her father’s violence. The therapist reformulates the father’s problem as being “<u>not knowing whether you want to stay in the</u></p>

	<p><u>home or not</u>” instead of viewing his violence as the problem. These utterances effectively conceals the fact that the father’s violence was the problem that initially brought the family to therapy.</p>
<p>13. In a transcript, where the presenting issue was a father who beat his daughter, the father (the perpetrator) said:</p> <p>“I haven’t been able to show affection.” (Transcript #15, 1995, p.30)</p>	<p>The father conceals the violence by attempting to excuse his violence and his being referred to as a “<u>caged animal</u>” because he hasn’t “<u>been able to show affection.</u>” He thereby creates a link between not being “<u>able to show affection</u>” and behaving violently. While he has agreed that the violence is his responsibility he also keeps introducing excuses. He here reformulates the problem as his inability to show affection to not be his violence.</p>
<p>14. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>“You are two different people and always will be – both of you have the right to your opinions, this is not a matter of right or wrong. We also cannot undo the past. Let’s imagine for a moment that a similar situation comes up in the future when both of you feel very strongly that you are right and don’t want to yield to the other, and those situations will come again.” (Transcript #16, 1996, p.83)</p>	<p>The therapist conceals the violence by effectively ignoring the fact that the husband has essentially been threatening his wife. Instead, the therapist reformulates the problem as a situation where both partners felt like they were right and neither wanted “<u>to yield to the other</u>” instead of an issue of violence.</p>
<p>15. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>“It sounds to me like both of you are saying you feel a lack of respect from the other. Millie doesn’t feel respect for her need to express herself and Tom doesn’t feel respect for his need to have some time out first. You both deserve that respect. How can you learn to communicate at those times so you can respect the other without feeling put down?”</p>	<p>The therapist conceals the violence by reformulating the problem to be a “<u>lack of respect from the other</u>” and a need to learn to communicate respectfully instead of focusing on the husband’s violence.</p>

(Transcript #16, 1996, p. 84)	
<p>17. In a transcript, where the presenting issue was sexualized violence perpetrated by a teenage boy against his younger sister, the therapist said:</p> <p>“I’d like for everyone in this family except for Harold to get on their knees in front of Sarah. And I’d like for you all to tell Sarah how sorry you are that you were not able to protect her. (Transcript #6, p. 1990, p.78)</p>	<p>Here the therapist mutualizes responsibility for the violence by constructing the entire family (including the other children) as responsible for the violence because they were not “<u>able to protect her</u>”. This utterance conceals the violence by presenting it as a failure of the family to “<u>protect</u>” Sarah instead of focusing on Harold’s violence. If the violence and the experience of the victim had been discussed in detail it would become clear that the violence was perpetrated by the perpetrator alone and would have created the discursive space necessary to discuss how the victim resisted these violent actions.</p>

Perpetrator Responsibility

Mitigating perpetrator responsibility

Whether representations functioned to mitigate or to clarify perpetrator responsibility was also analyzed. Representations of the violence that mutualized responsibility, presented the violence as precipitated by externalized factors, or inaccurately described the violence, were classified as mitigating perpetrator responsibility (Coates & Wade, 2004).

Mutualizing responsibility for the violence.

Representations that presented the violence as mutual were those that attempted to mitigate perpetrator responsibility by presenting the victim and the perpetrator as equally to blame. Therapists often failed to construct perpetrators as unilaterally responsible for the violence. For example, in a transcript involving a complaint of wife battering the therapist mutualized responsibility for the violence through the question:

What's going on between the two of you when you feel the escalation, when things start to really heat up? (Transcript #10, 1989, p. 147)

The utterance, “what's going on between the two of you”, contains the negative embedded presupposition that it is something that occurs between the husband and the wife that precipitates the violence. This utterance mutualizes responsibility by constructing both partners as co-agents who are equally responsible for the violence; it also denies the degree to which the husband behaved violently toward his wife. This does not create the discursive space necessary for the victim to discuss how she resisted. The use of the word, “escalation”, in the utterance, “when you feel the escalation”, seems to imply that the violence is mutual, something that two interlocutors do, versus formulating

the violence as the deliberate action of the perpetrator. In the same transcript the therapist said to the victim that she:

. . . must have several different ideas that you play around with about **what triggers this in the relationship**. (Transcript #10, 1989, p. 148)

In this utterance, the therapist mutualizes responsibility for the violence by formulating the “relationship” between the victim and the perpetrator as the “trigger” for the violence, which again constructs the victim as knowing what “trigger[s]” her husband’s violence and as purposely precipitating the violence. These utterances deny the extent to which violence is the unilateral responsibility of the violent actor (in this case, the husband) and ignores the fact that the wife is the victim.

Perpetrators also tried to mutualize responsibility for the violence by representing their victims as equally responsible for the violence. For example, in a transcript that involved sexualized violence the father used the following utterance to refer to the violence he perpetrated against his daughter:

. . . **we** had a bad situation happen while mom was in the hospital (Transcript #2, 1986, p.97)

The use of “we” (referring to the entire family) in the above utterance implicates the entire family, including the mother, in the offence by suggesting that the abuse occurred because she was not there. The father goes on to refer to the violence as:

. . . when **dad and Barb got involved in a sexual affair**. (Transcript #2, 1986, p.97)

While the above utterance also conceals the violence by equating sexualized violence with a “sexual affair”, this utterance also obscures perpetrator responsibility. The father’s

use of the third person in the above utterance allows him to avoid representing himself as the perpetrator, by talking as if it was someone else who perpetrated the violence. Also, the utterance, “dad and Barb got involved”, mutualizes responsibility by implicating Barb (the victim) in the sexualized violence perpetrated against her.

Concealing the violent actor.

The therapists’ use of passive voice also worked to obscure perpetrator responsibility by concealing who was responsible for the violence and what type of violence took place. For example, in a transcript, where the presenting issue was sexualized violence, the therapist said:

This really was **a horrible thing** to do. (Transcript #6, 1990, p. 68)

Passive voice is a linguistic practice that allows individuals to conceal the violence by concealing the actor and the violent act (Bohner, 2001; Coates et al, 1994; Lamb, 1991; Lamb & Keon, 1995; Trew, 1979). The therapist’s use of passive voice in the utterance, “This really was a horrible thing to do”, conceals the agent (the perpetrator) and the action (violence). It would have been more accurate to say, “Harold, sexually molesting your sister was a horrible thing to do”. This would have identified Harold as the perpetrator and clarified the violence by verbalizing what he did and to whom.

Externalized Factors.

In order to avoid taking responsibility for the violence, some perpetrators attempted to externalize responsibility for the violence. Representations that present violence as occurring due to externalized factors were those connected to the notion that perpetrators’ violent behaviours were precipitated by factors beyond his/her control, suggesting that he/she should not be held responsible. In a transcript, where the

presenting issue was physical violence against a child, the father (the perpetrator) obscured his responsibility for the violence by saying:

It's not something that I'm proud of myself for, the things that I've done. Yet, I've done them, and **I would like that not to happen again.** (Transcript #15, 1995, p.21)

The father's use of the utterance, "I would like that not to happen again", implies that he "would like" the violence to not occur again but that he cannot control whether or not the violence "happen[s] again". This utterance presents the violence as caused by externalized factors beyond his control. This allows the perpetrator to avoid taking full responsibility for the violence that he already perpetrated and allows him to present himself as not able to control whether or not he behaves violently in the future.

Inaccurate Descriptions.

Perpetrators also often tried to present inaccurate descriptions of events that allowed them to present their actions as non-violent. For example, in a transcript where the presenting issue was wife assault, the perpetrator obscured perpetrator responsibility by saying:

My wife said I have to come. **She says I have a problem with my anger.**

(Transcript #14, 1996, p.155)

The use of "She says" in the above utterance works as a qualifier, which presents his wife's statement that he has "a problem with [his] anger" as an opinion rather than a fact. While it may appear as though the perpetrator is taking ownership for his actions in this utterance, he qualifies it by presenting it as simply his wife's opinion and only presents it as a problem with emotions (anger), not violence.

Table #6: Examples of Utterances that Mitigated Perpetrator Responsibility

2. Mitigate Perpetrator Responsibility.	
	Explanation
<p>1. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>“What’s going on between the two of you when you feel the escalation, when things start to really heat up?” (Transcript #10, 1989, p. 147)</p>	<p>The utterance “<u>what’s going on between the two of you</u>” contains the negative embedded presupposition that it is something that occurs between the husband and the wife that precipitates the violence. This utterance mutualizes responsibility by constructing both partners as co-agents who are equally responsible for the violence and denies the degree to which it is the husband who behaved violently toward his wife and does not create the discursive space necessary for the victim to discuss how she resisted. The use of the word “<u>escalation</u>” in the utterance “<u>when you feel the escalation</u>” implies that the violence is mutual, something that two interlocutors do versus formulating the violence as the deliberate action of the perpetrator.</p>
<p>2. A therapist says to a victim of wife battering that she “must have several different ideas that you play around with about what triggers this in the relationship.” (Transcript #10, 1989, p. 148)</p>	<p>In this utterance, the therapist mutualizes responsibility for the violence by formulating the “<u>relationship</u>” between the victim and the perpetrator as the “<u>trigger</u>” for the violence, which again constructs the victim knowing what “<u>trigger[s]</u>” her husband’s violence and as purposely precipitating the violence. These utterances deny the extent to which violence is the unilateral responsibility of the violent actor (in this case the husband) and ignores the fact that the wife is the victim.</p>
<p>3. In a transcript, where the presenting issue was sexualized violence perpetrated by a teenage boy against his younger sister, the therapist said:</p> <p>“This really was a horrible thing to do.” (Transcript #6, 1990, p. 68)</p>	<p>The therapist’s use of passive voice in the utterance “<u>This really was a horrible thing to do</u>” conceals the agent (the perpetrator) and the action (violence). It would have been more accurate to say ‘Harold, sexually molesting your sister was a horrible thing to do’. This would have identified Harold as the perpetrator and clarified the violence by verbalizing what he did and to whom.</p>

<p>4. In a transcript, where the presenting issue was sexualized violence perpetrated by a father against his daughter, the father said:</p> <p>“ . . . we had a bad situation happen while mom was in the hospital” (Transcript #2,1986, p.97)</p>	<p>The use of “<u>we</u>” (referring to the entire family) in the above utterance implicates the entire family, including the mother in the offence by suggesting that the abuse occurred because she was not there.</p>
<p>5. In a transcript, where the presenting issue was sexualized violence perpetrated by a father against his daughter, the father said:</p> <p>“ . . . when dad and Barb got involved in a sexual affair.”(Transcript #2,1986, p.97)</p>	<p>While the above utterance also conceals the violence by equating sexualized violence with a “<u>sexual affair</u>” this utterance also obscures perpetrator responsibility. The father’s use of the third person in the above utterance allows him to avoid representing himself as the perpetrator, by talking as if it was someone else who perpetrated the violence. Also, the utterance, “<u>dad and Barb got involved</u>”, mutualizes responsibility by implicating Barb (the victim) in the sexualized violence perpetrated against her.</p>
<p>6. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>“My wife said I have to come. She says I have a problem with my anger.” (Transcript #14, 1996, p.155)</p>	<p>The use of “<u>She says</u>” in the above utterance works as a qualifier, which presents his wife’s statement that he has “<u>a problem with [his] anger</u>” as an opinion rather than a fact. While it may appear as though the perpetrator is taking ownership for his actions, in this utterance he qualifies it by presenting it as simply his wife’s opinion and only presents it as a problem with emotions (anger), not violence.</p>
<p>7. In a transcript, where the presenting issue was a father who beat his daughter, the father said:</p> <p>“It’s not something that I’m proud of myself for, the things that I’ve done. Yet, I’ve done them, and I would like that not to happen again.” (Transcript #15, 1995, p.21)</p>	<p>The father’s use of the utterance “<u>I would like that not to happen again</u>” implies that he “<u>would like</u>” the violence to not occur again but that he cannot control whether or not the violence “<u>happen[s] again</u>”. This utterance presents the violence as caused by externalized factors beyond his control. This allows the perpetrator to avoid taking full responsibility for the violence that he already perpetrated and allows him to present himself as not able to control whether or not he behaves violently in the future.</p>

<p>8. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>“We’ve had three physical confrontations, break-down, knock-down, drag-out fights. (Transcript #5, 1987, p.342)</p>	<p>The use of ‘<u>we</u>’, mutualizes the violence and obscures his responsibility as the sole violent actor through the embedded presupposition that both Mario and Anna were responsible for the violence.</p>
<p>9. In a transcript, where the presenting issue was sexualized violence perpetrated by a teenage boy against his younger sister, the therapist said:</p> <p>“. . . what has happened in the family” (Transcript #6, 1990, p.68)</p>	<p>Presenting the violence as occurring “<u>in the family</u>” obscures perpetrator responsibility and mutualizes responsibility by casting the violence as something that occurred in the entire “<u>family</u>” instead of being perpetrated by one family member, namely Harold. Also the use of the word “<u>happened</u>” obscures the fact that the perpetrator consciously chose to behave violently.</p>
<p>10. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>“At that point I had totally lost my cool” (Transcript #10, 1989, p. 151)</p>	<p>Equating the violence with losing his “<u>cool</u>” obscures perpetrator responsibility because it contains the negative embedded presupposition that he was not in his right mind and as such should not be viewed as totally responsible for the violence.</p>
<p>11. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>“Huh, well, I didn’t hit her. We were having a fight. She lies all the time. I caught her in this lie, and I got really mad and grabbed her shirt, but I never hit her.” (Transcript #14, 1996, p.156)</p>	<p>The perpetrator presents the victim of questionable moral character (“<u>she lies all the time</u>”) and thus as deserving the violence. This allows him to excuse his violence by presenting it as reasonable given the situation – because she drove him to it by her lying.</p>
<p>12. In a transcript, where the presenting issue was a father who beat his daughter, the therapist said:</p> <p>“So she doesn’t know how much is her responsibility and how much is her father’s responsibility,” (Transcript #15, 1995, p.25)</p>	<p>The therapist’s utterance contains the negative embedded presupposition that the victim is partially to blame for the violence, which mutualizes responsibility for the violence. This allows the perpetrator to avoid taking full responsibility for his actions and to present his violence as somewhat reasonable because he was provoked.</p>
<p>13. In a transcript, where the presenting issue was a father who beat his daughter,</p>	<p>Because the therapist has formulated both the victim and the father as both being</p>

<p>the father (the perpetrator) said:</p> <p>“I agree that the issue of responsibility is something that’s very muddy,” (Transcript #15, 1995, p.25)</p>	<p>partially to blame for the violence, this opens up the way for the father to avoid taking full responsibility for his violence by saying that the “<u>issue of responsibility is something that’s very muddy</u>”.</p>
<p>14. In a transcript, where the presenting issue was a father who beat his daughter, the therapist said:</p> <p>“Now to what extent when you hit Kristen are you really wanting to hit Laura?”(Transcript #15, 1995, p.34)</p>	<p>The therapist conceals the degree to which violence is deliberate and planned by suggesting that the husband really wants to hit his wife but instead hits his daughter. This conceals the degree to which the father hits his daughter in attempts to manipulate the mother. If the violence was truly out of his control, as he has presented it, he would not be able to limit himself, by only hitting his daughter when he really wanted to hit his wife. This utterance reformulates the problem to be that the mother precipitates her husband’s abuse of their daughter.</p>
<p>15. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>“I’ve got some problems in my marriage – we had a fight and my wife walked out. I tried to get her to come and talk to you . . . we’ve got to face this together. .perhaps you could talk to her. . . I can’t seem to get through to her” (Transcript #18, 1990, p.69)</p>	<p>The perpetrator conceals the seriousness of the violence by referring to it as a “<u>fight</u>”. The word fight is typically used to describe two equal combatants and ignores the power imbalances involved in violence. Thus using the word “<u>fight</u>” presents both partners as equally responsible. The use of “<u>we</u>” and the utterance “<u>we’ve got to face this together</u>” implies that both partners are responsible for the violence.</p>

Victims' Resistance

Conceal victims' resistance

The transcripts were also analyzed for whether they concealed or revealed victim resistance. Representations that denied victim agency and presented them as passive in the face of violence (e.g., “she did not resist, or “we need to work on assertiveness and passivity”), or reformulated the victim’s resistance as negative, for example, causing the violence perpetrated against them, were interpreted as concealing the resistance.

Reformulated Resistance as Negative.

Representations that concealed victims’ covert forms of resistance were those that reformulated victims’ resistance as negative. Therapists in these transcripts frequently failed to recognize the covert forms of resistance often utilized by victims of violence. In a transcript that involved a father who beat his daughter, the therapist characterized the daughter as “harden[ed]” and “harsh” when she did not believe that her father’s apology was sincere (Transcript #15, 1995, p.22). This comment concealed the victim’s resistance by ignoring the fact that the victim had said that her father had apologized before and that the violence had continued. Not accepting her father’s apology can be viewed as a form of resistance because it exposes the falseness of the father’s previous apologizes and is a way that the victim can stand up to her father. Calling the victim “harden[ed]” and “harsh” characterizes the victim’s resistance (not accepting his apology) as an unreasonable response to her father’s apology by formulating the victim as having a problem. Apologies in therapy are often problematic because once an apology is given by the perpetrator, the onus is on the victim to accept that apology, and if they do not, they are viewed as impeding the healing process.

In a transcript, involving a woman who, as a child had been raped by her father for many years, the client came to therapy complaining that she has been treating people in her life badly, and that she has a problem with anger. Throughout the course of the interview, the therapist reformulates the client's problem to be not a problem with anger, in general, or a problem with treating people badly, but a problem with her being angry toward her father. For example:

DR.G – Don't you sometimes **get mad at yourself for feeling so mad at your dad** and at others? (Transcript #12, 1988, p.77).

Here the therapist suggests that the victim should get "mad" at herself for "feeling so mad at [her] dad". This utterance constructs the victim's resistance, being "mad" at her father, as problematic. This denies the degree to which the victim has every right to be angry with her father as the sole violent actor and constructs the victim's resistance, her anger towards her father, as problematic, even pathological.

In some instances, perpetrators reformulated their wives' resistance as the problem. For example, in a transcript where the presenting issue was wife assault, the perpetrator concealed his wife's resistance by saying:

CLIENT – I've rung her . . . sent letters . . . I've **told her what she's doing** to the kids . . . I've gone to her parents and told them what she's doing to me and the kids . . . I just can't get through to her. (Transcripts #18, 1990, p.70)

The victim's resistance is concealed through the utterance, "I've told her what she's doing to the kids. . . what she's doing to me and the kids", which formulates the wife as abandoning her family. This utterance focuses on the wife and what she is doing by reformulating her actions and presenting her leaving out of context. Concealing the

violence allows the perpetrator to deny that his wife's leaving is an appropriate response to his violence which in turn, allows him to construct his wife's leaving as the problem, not his violence.

Denial of victims' resistance.

Perpetrators also tried to conceal victims' resistance by discrediting victims' accounts. For example, in a transcript where the presenting issue was wife assault, the perpetrator disagreed with his wife when she explained how she reacts when her husband becomes violent.

LOUISE – And when I see it coming I hide, I run. I try to get anywhere away.

HOWARD- **I don't totally agree with that** (Transcript #10, 1989, p.150)

By denying that the victim resists the violence by hiding and running away, the perpetrator denies the full extent of the violence.

Broad or Global Descriptions.

Representations also concealed victims' resistance through broad or global descriptions that did not create the space for descriptions of victims' actions. For example, therapists and perpetrators were often found to misrepresent the violence as a fight. For example, in a transcript where the presenting issue was wife battering, the therapist said:

What I'd like you to do, Sheri, is describe in precise detail the last time **you and**

Kevin fought. (Transcript #19, 1995, p.388)

The use of the utterance, "you and Kevin fought", mutualized the violence by implying that both the perpetrator and the victim were equally involved, and thus both should be held responsible. This also implies that the victim was not resisting the assault as much as

participating in it. This description fails to give a detailed account of who did what to whom. A more detailed description of the violence would have clarified perpetrator responsibility and victim resistance.

Table #7: Examples of Utterances that Concealed Victims' Resistance

3. Conceal Victims' Resistance	
	Explanation
<p>1. In a transcript that involved a father who beat his daughter the therapist characterized the daughter as "<u>harden[ed]</u>", and "<u>harsh</u>" when she did not believe that her father's apology was sincere (Transcript #15, 1995, p.22).</p>	<p>This comment concealed the victims' resistance by ignoring the fact that the victim had said that her father had apologized before and that the violence had continued. Not accepting her father's apology can be viewed as a form of resistance because it exposes the falseness of the father's previous apologies and is a way that the victim can stand up to her father. Calling the victim "<u>harden[ed]</u>" and "<u>harsh</u>" characterizes the victims' resistance (not accepting his apology) as an unreasonable response to her father's apology by formulating the victim as having a problem.</p>
<p>2. In a transcript involving a woman who as a child had been raped for many years by her father, the client came to therapy complaining that she has been treating people in her life badly and that she has a problem with anger. In this transcript, the therapist said:</p> <p>"Don't you sometimes get mad at yourself for feeling so mad at your dad and at others?" (Transcript #12, 1988, p.77).</p>	<p>Here the therapist suggests that the victim should get "<u>mad</u>" at herself for "<u>feeling so mad at [her] dad</u>". This utterance constructs the victim's resistance, being "<u>mad</u>" at her father as problematic. This denies the degree to which the victim has every right to be angry with her father as the sole violent actor and constructs the victim's resistance, her anger towards her father, as problematic, even pathological.</p>
<p>3. In a transcript where the presenting issue was wife assault, the perpetrator disagreed with his wife when she explained how she reacts when her husband becomes violent.</p> <p>"LOUISE – And when I see it coming I hide, I run. I try to get anywhere away.</p> <p>HOWARD- I don't totally agree with that" (Transcript #10, 1989, p.150)</p>	<p>By denying that the victim resists the violence by hiding and running away the perpetrator denies the full extent of the violence.</p>
<p>4. In a transcript, where the presenting issue was wife assault, the perpetrator concealed his wife's resistance by saying:</p>	<p>The victim's resistance is concealed through the utterance, "<u>I've told her what she's doing to the kids. . . what she's doing</u></p>

<p>“I’ve rung her . . . sent letters . . . I’ve told her what she’s doing to the kids . . . I’ve gone to her parents and told them what she’s doing to me and the kids . . . I just can’t get through to her.” (Transcript #18,1990, p.70)</p>	<p><u>to me and the kids</u>”, which formulates the wife as abandoning her family. It focuses on the wife and what she is doing, reformulating it and presenting her leaving out of context. Concealing the violence allows the perpetrator to deny that his wife’s leaving as an appropriate response to his violence which in turn, allows him to construct his wife’s leaving as the problem, not his violence.</p>
<p>5. In a transcript, where the presenting issue was wife assault, conceals the victims’ resistance by shifting the focus onto the victim.</p> <p>“THERAPIST – Do you ever get angry with him? Do you get back?</p> <p>LOUISE – Yeah, but not like this.</p> <p>THERAPIST – [To Howard] How does she do it? How does she get angry back at you? What does she do?” (Transcript #10, 1989, p. 149)</p>	<p>The therapist directs the question “<u>how does she do it? How does she get angry back at you?</u>” to the perpetrator after the victim has already said that she gets upset when he becomes angry and violent towards her but that it isn’t the same as the violence he perpetrates against her. This utterance conceals the victim’s resistance through the negative embedded presupposition that the therapist does not believe what the victim said about her getting angry with him as not being the same thing as the violence.</p>
<p>6. In a transcript involving a woman who as a child had been raped for many years by her father, the client came to therapy complaining that she has been treating people in her life badly and that she has a problem with anger. In this transcript, the therapist said:</p> <p>“You feel helpless because your dad is gone; and you think there’s nothing you can do about the abuse now” (Transcript #12, 1988, p.78)</p>	<p>The therapist in line 40 characterizes the victim as “<u>helpless</u>”. This utterance contains the negative embedded presupposition that the victim did not resist the violence as a child and that her anger towards him is not an acceptable form of resistance to him now – after the fact.</p>
<p>7. In a transcript, the presenting issue was sexualized violence perpetrated against the client when he was a child, the therapist said:</p> <p>“DAVID – I hate that word victim.</p>	<p>The therapist’s utterance, “<u>No one likes to think of themselves as helpless in any situation</u>”, conceals the victim’s resistance by referring to him as having been “<u>helpless</u>”. This contains the negative embedded presupposition that the victim was helpless and thus conceals the fact</p>

<p>THERAPIST – I know. No one likes to think of themselves as helpless in any situation.” (Transcript #13, 1988, p.91)</p>	<p>that the victim resisted the abuse.</p>
<p>8. In a transcript where the presenting issue was a father who beat his daughter, the therapist shifted the focus onto the mother:</p> <p>“Perhaps he wouldn’t have been able to hit her if others had known, right.?” I asked her. (Transcript #15, 1995, p.32)</p>	<p>When the mother says that she felt responsible for the violence her father perpetrated against her mother when she was a child, the therapist blames the victim through the utterance, “<u>Perhaps he wouldn’t have been able to hit her if others had known, right?</u>”. This utterance contains the negative embedded presupposition that if she and her siblings had told someone, this would not have happened. This blames the children for their father’s violence by concealing the degree to which the children in that family were afraid of their father, and denies the fact that she ever told anyone about the abuse or that she resisted it in any way.</p>
<p>9. After the therapist had said that the mother should be the one to take care of all the household duties and everything to do with the kids, the mother resisted by saying:</p> <p>MOTHER - “But then all the responsibility is on my shoulders,” said Laura, crying again.</p> <p>THERAPIST – “Why?”</p> <p>FATHER – “She’d like to know that if she needs help, that I’m there and willing to come help and support her.”</p> <p>THERAPIST - “That’s exactly what I don’t want to happen,” I said. “That does not work” (Transcript #15, 1995, p.36)</p>	<p>The therapist conceals the victim’s resistance by saying that the wife should not call on her husband when she needs help with things around the house or with the girls because, according to the therapist, “<u>that does not work.</u>” This allows the father to shirk his fatherly and husbandly responsibilities. The therapist does not really address the mother’s concerns before moving on to another topic. This utterance contains the negative embedded presupposition that the mother should do everything around the house in order to avoid violent outbursts from her husband.</p>
<p>10. In a transcript, where the presenting issue was wife assault, the perpetrator (Tom) said:</p> <p>MILLIE – I just wanted to tell him how I</p>	<p>The husband’s utterance contains the negative embedded presupposition that he has the full power to say when she can talk to him about the things that hurt/bother her.</p>

<p>feel.</p> <p>TOM – And I think I should have the opportunity to tell you that I don't want to talk about it at that point in time, but you stick to the point regardless of what I say.” (Transcript #16, 1996, p.82)</p>	
<p>11. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>“Well, that's her opinion that it isn't a scolding. I think in light of why we are here [the violence], she should be more yielding, and when I ask her not to talk about it she should do that; it's not forever. She should respect that and bring it up at a different time” (Transcript #16, 1996, p.83)</p>	<p>He conceals his wife's resistance by threatening her - saying that if she wants things to get better that “<u>she should be more yielding</u>” which contains the negative embedded presupposition that she should do whatever he says in order to avoid his violence.</p>
<p>12. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>“I've got some problems in my marriage – we had a fight and my wife walked out. I tried to get her to come and talk to you . . . we've got to face this together. .perhaps you could talk to her. . . I can't seem to get through to her” (Transcript #18, 1990, p.69)</p>	<p>By the utterance, “<u>my wife walked out</u>”, the perpetrator presents the victim as the problem for walking out. This conceals the fact that her leaving was a form of resistance to her husband's violence. The perpetrator presents himself as ready and willing to get help but his wife as not cooperating. He conceals her resistance by saying, “<u>I can't seem to get through to her</u>”.</p>
<p>13. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>THERAPIST – Is this the first time you've told Kevin that that's how you feel when he abuses you? Like a child that has been unjustly chastised?</p> <p>SHERI – Well, not like I just did. Not as clear. I'm afraid I usually freak out or just break down and cry.</p> <p>THERAPIST – Sounds to me then, that this is the first time you've risked telling Kevin just exactly how you feel. It must have been very difficult to say such an important</p>	<p>While this utterance is positive because it exposes the violence by connecting Kevin to the “<u>abuse</u>”, it also contains the negative embedded presupposition that this is the first time that Sheri has really told Kevin how she feels – the first time she has resisted the violence. It suggests that the violence could go on and that Sheri wouldn't resist. This can be viewed as a movement towards making the problem one of communication instead of violence.</p>

<p>thing; something that we need to address. (Transcript #19, 1995, p.390)</p>	
<p>14. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>“... he’s so hurt that no matter how much truth there is in what you’re saying, nothing’s going to get done right here unless we understand how you both feel, and work with that for a while. Because I think you’re so hurt, Mario, by what she’s saying, that the content’s going to get lost. <i>(To Anna)</i> Do you follow what I’m saying? He’s going to hear it like his father telling him he’s not good enough (Transcript #5, 1987, p.348).</p>	<p>Here the therapist is lecturing the wife (Anna) on how “hurt” her husband (the perpetrator) is by her complaints that he does not take responsibility financially or otherwise (Coates & Wade, 2004). He is suggesting that Anna (the victim) should not say anything to Mario “<u>no matter how much truth there is</u>” in what she is saying (Coates & Wade, 2004). By doing this, the therapist is concealing Anna’s resistance by disregarding her side of the story. Instead of focusing on what the husband (the perpetrator) needs to work on, the therapist focuses on what the victim is doing wrong, and reformulates her complaints as unreasonable and problematic.</p>
<p>15. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>“What I’d like you to do, Sheri, is describe in precise detail the last time you and Kevin fought. (Transcript #19, 1995, p.387)</p>	<p>This also implies that the victim was not resisting the assault as much as participating in it. More appropriate words to describe perpetrators’ violent acts would have been “attack” or “abuse” which would denote the unequal distribution of power and the unilateral nature of violence.</p>

Victim Blaming

Blame and pathologize the victim

Discursive operations that blamed victims, or contested accounts that blamed victims were also analyzed. Representations that mutualized responsibility for the violence were those that represented the victim as deficient, passive, as precipitating, provoking, or, as deserving the violence perpetrated against them.

Victim blaming.

Representations that blamed the victim were those that represented the victim as responsible for the violence. It was found that the therapists were often the ones to initiate formulations of victim provocation. For example, in a transcript in which the father had beaten up his daughter, the therapist said:

I understand that **she provokes you**. I'm sure of that. Yet your responses should never be violence because you're the adult in the situation. Would you do this?

(Transcript #15, 1995, p. 21)

Here the therapist constructs the victim as "provok[ing]" the violence which contains the negative embedded presupposition that the victim incited the violence perpetrated against her. Despite the fact that the therapist goes on to say that his responses "should never be violence because you're the adult in the situation", the former comment about the victim "provok[ing]" the violence, implicates the victim in precipitating the violence by formulating the victim as "getting what she deserved" or "asking for it".

Perpetrators also tried to blame victims for provoking or precipitating the violence. For example, in a transcript where the presenting issue as wife assault, the perpetrator blamed the victim (his wife) for the violence by saying:

I'll get to the point where I'll feel that **she is provoking me** (Transcript #10, 1989, p.147)

In this utterance, the perpetrator shifts the blame onto the victim by constructing her as precipitating the violence.

Victim as Deficient.

Other perpetrators tried to shift the focus away from the violence by constructing the victim as the problem. For example, in a transcript where the presenting issue was wife assault, the husband tried several times to shift the focus away from his violence and construct his wife as the one with the problem. When the therapist asked the husband what reason his wife gave for leaving, the husband admitted that she said that it was because he hit her, but, quickly shifted the focus onto his wife by saying:

. . . but it's more than that . . . everyone has fights . . . I dunno, **maybe she's on with someone else.** (Transcript #18, 1990, p. 70)

When the therapist tries to bring the attention back to the violence, the husband again shifts the focus onto his wife by saying:

She's been listening to her bloody girlfriends too much. (Transcript #18, 1990, p.70)

Constructing his wife as possibly having an affair, constructs the victim as of questionable moral character and, saying that she listens to her girlfriends too much constructs her as a passive person who is easily influenced by her friends. This allows the perpetrator to shift the focus away from his violent actions by presenting the victim as the one who is behaving negatively.

Pathologizing the victim.

Representations that pathologized victims suggested that the victim had caused the perpetrator to become violent (e.g., “she seeks it out”); typically the violence was formulated as a problem within the victim’s mind. In one transcript, a therapist diagnosed a woman who had been beaten by her ex-husband and was left to raise their 11 children on her own, as having a self-defeating personality disorder. The therapist constructed the woman as having a self-defeating personality disorder because she felt overwhelmed and depressed, and did not want to seek out her ex-husband for child support.

The following is a brief excerpt from this transcript:

PATIENT – Yeah, he got pretty mad. I got him so angry one time that he hit me in the face and broke my nose.

INTERVIEWER – Hmmm.

PATIENT – Another time he hit me in the eye and my retina came off. That’s when I lost my job, because I couldn’t see well enough any more to put the chips in the holes and do the soldering.

INTERVIEWER – Mary, it sounds like **you took a lot of abuse**. (Transcript #4, 1989, p. 426)

The patient tells the therapist that her husband used to beat her up and the therapist responds by saying that the patient “took a lot of abuse”. The use of the word, “took”, presents the victim as passively accepting the violence. This allows the victim to be conceptualized as pathologically and self-destructively allowing the abuse to continue, without doing anything about it, which also denies the possibility that the victim resisted the violence. Suggesting that the victim passively “took” the “abuse” constructs her as the

problem, which allows the therapist to formulate the victim as a having self-defeating personality disorder. In the context of the patient's situation, considering her fear of her husband, and how difficult it would be both emotionally and financially for a woman to leave the father of their eleven children, allows the patient's actions to be constructed as reasonable instead of pathological.

Table #8: Examples of Utterances that Blamed & Pathologized Victims

4. Blame & Pathologize Victims.	
	Explanation
<p>1. In a transcript, in which the father had beat up his daughter, the therapist said:</p> <p>“I understand that she provokes you. I’m sure of that. Yet your responses should never be violence because you’re the adult in the situation. Would you do this?” (Transcript #15, 1995, p. 21)</p>	<p>Here the therapist constructs the victim as “<u>provok[ing]</u>” the violence which contains the negative embedded presupposition that the victim incited the violence perpetrated against her. Despite the fact that the therapist goes on to say that his responses “<u>should never be violence because you’re the adult in the situation</u>” the former comment about the victim “<u>provok[ing]</u>” formulates the victim as “getting what she deserved” or “asking for it”.</p>
<p>2. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>“PATIENT – Yeah, he got pretty mad. I got him so angry one time that he hit me in the face and broke my nose.</p> <p>INTERVIEWER – Hmmm.</p> <p>PATIENT – Another time he hit me in the eye and my retina came off. That’s when I lost my job, because I couldn’t see well enough any more to put the chips in the holes and do the soldering.</p> <p>INTERVIEWER – Mary, it sounds like you took a lot of abuse.” (Transcript #4, 1989, p. 426)</p>	<p>The patient tells the therapist that her husband used to beat her up and the therapist responds by saying that the patient “<u>took a lot of abuse</u>”. The use of the word “<u>took</u>” presents the victim as passively accepting the violence. This allows the victim to be conceptualized as pathologically and self-destructively allowing the abuse to continue without doing anything about it which also denies the possibility that the victim resisted the violence. Suggesting that the victim passively “<u>took</u>” the “<u>abuse</u>” constructs her as the problem, which allows the therapist to formulate the victim as having a self-defeating personality disorder. If the patient’s actions were considered in context, the patient’s fear of her husband and the fact that it would be difficult, both emotionally and financially for a woman to leave the father of her eleven children, would be recognized as understandably impacting the victim’s response to the violence perpetrator against her.</p>
<p>3. In a transcript where the presenting issue as wife assault, the perpetrator blamed the victim (his wife) for the violence by saying:</p> <p>“I’ll get to the point where I’ll feel that she</p>	<p>In this utterance, the perpetrator shifts the blame onto the victim by constructing her as precipitating the violence.</p>

<p>is provoking me“ (Transcript #10, 1989, p.147)</p>	
<p>4. In a transcript involving a teenage boy who sexually molested his younger sister over the period of a year, the perpetrator was told that he could not return home until his sister felt safe and was no longer afraid of him. The perpetrator refused to recognize that what he did was wrong and apologize:</p> <p>“What’s the difference? What’s the difference? She doesn’t want me home anyways!” (Transcript #6, p.1990, p.75)</p>	<p>Here the perpetrator shifts the blame onto the victim (his sister) for him having been taken out of the family home. This allows him to avoid admitting that it was his violent actions that got him removed from the family home.</p>
<p>5. In a transcript where the presenting issue was wife assault the husband tried several times to shift the focus away from his violence and construct his wife as the one with the problem. When the therapist asked the husband what reason his wife gave for leaving, the husband admitted that she said that it was because he hit her, but quickly shifted the focus onto his wife by saying:</p> <p>“but it’s more than that . . . everyone has fights . . . I dunno, maybe she’s on with someone else.” (Transcript #18, 1990, p. 70)</p> <p>When the therapist tries to bring the attention back to the violence, the husband again shifts the focus onto his wife by saying:</p> <p>“She’s been listening to her bloody girlfriends too much.” (Transcript #18, 1990, p.70)</p>	<p>Constructed his wife as possibly having an affair, constructs the victim as of questionable moral character, and saying that she listens to her girlfriends too much constructs her as a passive person who is easily influenced by her friends. This allows the perpetrator to shift the focus away from his violent actions by presenting the victim as the one who is behaving negatively.</p>
<p>6. In a transcript, where the presenting issue was sexualized violence perpetrated by a father against his daughter, the father (the perpetrator) said:</p> <p>“It was pointed out to me that, I guess if they didn’t have this program I would have gone to jail for this. And Lord knows that</p>	<p>The utterance, “<u>you guys might have been returned to mom and might not have. I don’t really know that</u>”, contains the negative embedded presupposition that even without him there the mother may not have the children returned to her. It presupposes that there is something wrong with the mother as well.</p>

<p>you guys might have been returned to mom and might not have. I don't really know that." (Transcript #2, 1986, p. 97)</p>	
<p>7. An abusive husband whose wife has recently left him.</p> <p>"When we got married my wife was quite immature. Whenever we had an argument she was on the phone to tell her mother." (Transcript #3, 1989, p.420)</p>	<p>The husband constructs the wife as "<u>immature</u>" when they first got married because she wanted to talk to her mother when she was upset. In doing so, he shifts the blame onto her for being "<u>immature</u>" and thus forcing him to do something about it.</p>
<p>8. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>"Because Anna seems to have a talent for pushing buttons that make me go. . . ." (Transcript #5, 1987, p.343)</p>	<p>Mario gives agency to Anna for being able to "<u>push his buttons</u>", making her the focus of therapy instead of his violence (Coates & Wade, 2004). Anna is constructed as the problem.</p>
<p>9. In a transcript, where the presenting issue was sexualized violence perpetrated by a teenage boy against his younger sister, the therapist said:</p> <p>". . . help Harold and to help Sarah to make sure that nothing like this happens again?" (Transcript #6, 1990, p.69)</p>	<p>The therapist's utterance, "<u>help Sarah</u>", presents the victim as somehow responsible for the violence perpetrated against her so that the other family members need to help her so she does not get involved in something like this again.</p>
<p>10. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>". . . she beats me up verbally" (Transcript #10, 1989, p.149)</p>	<p>The perpetrator also constructs Louise as the perpetrator by saying that "<u>she beats me [him] up verbally</u>". The perpetrator also presents himself as a victim and Louise as the perpetrator. This reformulates the problem to be addressed in therapy from the husband's violence to the fact that the victim beats up her husband verbally.</p>
<p>11. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>"There is one other thing we want you to begin to think about, Howard. That is how can you help Louise learn when you are beginning to lose your temper, beginning to get to the point where you're going to hit</p>	<p>This utterance contains the negative embedded presupposition that the victim precipitates the violence and is deficient because she does not have a "<u>radar</u>" to know when the perpetrator is going to hit her. By suggesting that the perpetrator needs to teach the victim to be able to read when he will hit her, they are</p>

<p>her. She doesn't have the experience to really know when this is beginning to happen." (Transcript #10, 1989, p. 157)</p>	<p>constructing the victim responsible for ending or avoiding the violence instead of making the perpetrator responsible for his own behavior. Neither does this show any regard for the victim's safety.</p>
<p>12. In a transcript, where the presenting issue was sexualized violence perpetrated against a man when he was a child, the therapist said:</p> <p>"Well, abuse does happen between siblings, and the effects on the victim are just the same." (Transcript #13, 1988, p.91)</p>	<p>The therapist uses the Language of Effects by saying that abuse between siblings has the same "<u>effects on the victim</u>". This contains the negative embedded presupposition that victims are directly affected by the perpetrators' violence. Instead the therapist could have said that it is just as 'painful', 'traumatic', or 'serious'.</p>
<p>13. In a transcript, where the presenting issue was wife assault, the therapist said:</p> <p>"So, when she stops lying, what will be different?" (Transcript #14, 1996, p.156)</p>	<p>The therapist goes along with the perpetrator's notion of shifting the responsibility onto the victim to stop the violence. The solution-focused model focuses on solutions such that, the therapist does not call into question or challenge the perpetrator's comments; instead, the therapist focuses on what the perpetrator thinks would be different if the victim was to stop lying which constructs the victim as the problem.</p>
<p>14. In a transcript, where the presenting issue was wife assault, the perpetrator said:</p> <p>"You understand how tough it is to bust your head all day at work, try to buy nice things for the family, all the stress and garbage you have to put up with just to try and get ahead a little bit. (Therapist looks intently at Kevin, but gives no response, only an indication that he is listening.) Anyway, when you come home and see that nothing has been done to keep the house nice, you just start wondering if it is worth it all." (Transcript #19, 1995, p.388-389)</p>	<p>Here Kevin reformulates the problem to be Sheri because she is a lazy wife. This utterance contains the negative embedded presupposition that his violence was justified.</p>
<p>15. In a transcript, where the presenting issue was wife assault, the therapist said:</p>	<p>Here the therapist placed responsibility for the violence on Anna. She needed to listen, and then, if she did, there would be</p>

<p>“Well, if you can tell me, then she’ll have a chance to listen. Perhaps we’ll have something to work on” (Transcript #5, 1987, p.343)</p>	<p>something to work on.</p>
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All Four-Discursive-Operations

It is important to note that the four-discursive-operations are not mutually exclusive categories. In most cases, they overlap and often all occur within the same utterance. For example, in a transcript where the presenting issue was sexualized violence perpetrated by a teenage boy (Harold) against his younger sister (Sarah), the therapist addressed the following utterance to their father:

Mr. Adams, are you willing to do the best you can to **help Harold and to help Sarah** and to make sure that nothing like this ever **happens again**? (Transcript #6, 1990, p.70)

Here the therapist mitigates perpetrator responsibility, and conceals the deliberate and unilateral nature of violence, through the negative embedded presupposition that the father should be responsible for ending the violence. The utterance, “ever happens again”, conceals the violence and obscures perpetrator responsibility by not directly naming the violence and by denying the deliberate and unilateral nature of violence. The negative presupposition embedded in this utterance is that the violence was something external that “happened” to the perpetrator instead of something that he deliberately and unilaterally did. This utterance is particularly problematic since the therapist never directs comments to Harold about making sure that he does not behave violently towards his sister again. The utterance, “help Harold and to help Sarah”, accomplishes all four of the discursive-operations. It obscures perpetrator responsibility through the negative embedded presupposition that Sarah also needs to be helped to not allow the violence to occur again. This mutualizes responsibility for the violence by presenting the victim as a

co-agent in the violence which conceals the unilateral nature of the violence and denies any victim resistance.

The Ripple Effect

The social view of language views language as a collaborative process in which both the speaker and the listener negotiate meaning (Bavelas et al., 2000; Clark, 1992, 1996; Clark & Schober, 1992a, 1992b; Linell, 1982, 1988). When the four-discursive-operations are used in therapists' or perpetrators' talking turns, both the speaker and the listener must negotiate their meaning. As such, the use of the four-discursive-operations in therapists' or perpetrators' talking turns directly influences not only the initial moment in which they are used, but also influences the movement of the therapeutic interview as the involved parties negotiate the problem to be addressed in therapy. For example, in a transcript involving a complaint of wife battering, the therapist shifted the focus onto the victim by formulating her as the problem, through the following utterances:

THERAPIST – And **how do you respond** when he's angry at you but not really angry at you?

LOUISE – It's hard!

THERAPIST - **Do you ever get angry with him? Do you get back?**

LOUISE – Yeah, but not like this.

THERAPIST – [To Howard] **How does she do it? How does she get angry back at you? What does she do?**

LOUISE – I talk.

HOWARD – She **criticizes and complains**. I mean, there are times when one can go on indefinitely over some trivial thing. I feel that what she says about me also

goes for her, but her means are verbal. She will, if she's anxious or if she's uptight, **she will lash out at me verbally** and sometimes will continue for a long period of time. (Transcript #10, 1989, p.148-149)

Here, the therapist shifts the focus onto the victim by reformulating the problem to be how the victim responds to her husband's violence instead of the fact that her husband becomes violent in the first place. This mutualizes responsibility by suggesting that the wife may precipitate the violence by responding negatively toward her husband's violence, even though she supposedly knows that he is "not really angry at" her. The shift to a focus on the victim's behaviour in this utterance also creates the discursive space for the husband to mutualize responsibility for the violence by formulating the victim as the perpetrator who "verbally" abuses him. The therapist implies agreement with the husband's formulation of his wife as the perpetrator and him as the victim through the utterance:

THERAPIST – When Louise is going at you, how do you deal with it?

(Transcript #10, 1989, p.149)

Mutualizing the responsibility for the violence and constructing how the victim responds to her husband's violence, allows the problem to remain on the victim instead of addressing the issue of the husband's violence. The utterance, "when Louise is going at you, how do you deal with it?", formulates the wife as the perpetrator and the husband as the victim; this conceals the fact that he is the one who hit her. Finally, at the end of this transcript, the problem was reformulated again with a focus on the fact that the couple came from very different families; Louise (the wife) came from a family that could fight

or argue without violence, whereas Harold (the husband) came from a family that did not fight or argue very often.

CONSULTANT – The **radar is not there** with Louise right now.

THERAPIST – We’d like you to begin to think about how **you can begin to help her develop her radar**. Because you have more experience in your family with this. (Transcript #10, 1989, p. 157)

Here the therapist and the consultant construct the victim as the problem because she does not possess the “radar” to know when she’s pushed her husband too far. The therapist focuses on the victim’s need to develop this “radar” and the perpetrator’s need to help her to “develop her radar” instead of focusing on the perpetrator’s need to learn to control his violence. The therapist’s initial shift toward focusing on how the victim responded to her husband’s violence, instead of focusing on his violence as the problem, influenced the rest of the interview by constructing the victim as the problem to be discussed in therapy, which essentially ignores the fact that she is the victim. This transcript is a good example of how the occurrence of the four-discursive-operations can directly impact formulations of the violence, the perpetrator and the victim. This concept was further explored in the detailed analysis of the five randomly selected transcripts.

The Four-Clarifying-Discursive-Operations

While the four-discursive-operations were found in all of the transcripts, there were several transcripts in which more positive representations were also found (See Table #9). While many of the following examples are still problematic, they also worked to expose the violence, clarify perpetrators’ responsibility, elucidate and honour victims’ resistance and contest the blaming and pathologizing of victims. Only therapists, not

perpetrators, were found to utilize the more clarifying representations of violence. It is also important to note that transcripts that contained the four-discursive-operations were not always all bad. Therapists often began therapy transcripts by utilizing more clarifying representations and then deviated from that throughout the transcript. Below are examples of how therapists avoided using the four-discursive-operations.

Exposing Violence

Discursive operations that exposed the unilateral and deliberate nature of the violence and included accounts of victims' responses, were classified as exposing the violence (Coates & Wade, 2004; Coates & Wade, 2005). For example, in a transcript where the presenting issue was wife battering, the therapist exposed the violence through the following utterance:

3. PAULA – What did he. . . you said that he apologized?

4. ANNA – He only said “please forgive me, I didn’t mean to, it was a complete misunderstanding.”

5. PAULA – **A misunderstanding that he hit and kicked you?** (Transcript #8, 2004, p. 79)

The therapist exposes the violence by contesting the perpetrator’s attempt to construct the violence as a “misunderstanding”. The question, “a misunderstanding that he hit and kicked you?”, contains the positive embedded presupposition that the perpetrator’s attempt to conceal his violence, by constructing it as a “misunderstanding”, is ridiculous since he consciously chose to “hit and kicked” her.

In another transcript, where the presenting issue was wife assault, the therapist tries to get the husband (the perpetrator) to admit to the violence through the question:

4. THERAPIST – What **reason did she give** for leaving? (Transcript #18, 1990, p. 70)

Here the therapist attempts to get the perpetrator to admit to the real reason why his wife left him.

Clarifying Perpetrator Responsibility

Any representations that functioned to make clear perpetrator responsibility were counted as clarifying responsibility. For example, in a transcript where the presenting issue was the sexual abuse of a young girl by her aunt's fiancé, the therapist helped clarify perpetrator responsibility through the utterance:

56. THERAPIST – You've done real good. I guess I'm wondering. Did **he do other yukky things** to you? (Transcript #9, 1990, p. 152)

Here the therapist's use of the question, "did he do other yukky things to you?", contains the positive embedded presupposition that it is the perpetrator who did the "yukky things" which helps clarify perpetrator responsibility. While the word, "yukky", clearly communicates the unpleasantness of the perpetrator's acts, it does not communicate the violence, and, as such, could be viewed as one of the four-discursive-operations.

However, this phrasing came from the child who referred to the things the perpetrator did to her as "yuk!". Because this phrasing initiated with the client, the use of the word "yukky" is not considered one of the four-discursive-operations, although the therapist could have utilized an equally simplistic term to denote both the unpleasantness and the violence associated with the perpetrator's actions.

In another transcript, where the presenting issue was wife assault, the therapist helped clarify perpetrator responsibility by discrediting the perpetrator's excuses and justifications for the violence.

16. THERAPIST – When you felt that the house wasn't clean, did you call Sheri an “ungrateful bitch”? (p. 389)

17. KEVIN – (Pauses.) Don't you get angry sometimes? I mean, just every once in a while you get just a little inappropriate? (p. 389)

18. THERAPIST – **I don't call my wife a bitch, if that's what you're asking.**
(Transcript #19, 1995, p. 389)

The therapist's question, “when you felt that the house wasn't clean, did you call Sheri an “ungrateful bitch”?”, exposes the violence by clarifying the fact that the Kevin has been verbally abusive to his wife by asking Kevin to admit whether or not he called his wife an “ungrateful bitch”. Kevin does not answer the question. Instead in line 17, he tries to cover his abusive actions by shifting the focus onto the therapist by asking, “Don't you get angry sometimes?”. Shifting the focus to the therapist and answering a question with a question allows Kevin to avoid admitting that he called his wife an “ungrateful bitch”. It also allows Kevin to attempt to excuse his actions and minimize their seriousness by suggesting that everybody behaves inappropriately sometimes. In line 18, the therapist shifts the focus back onto Kevin by saying, “I don't call my wife a bitch, if that's what you're asking”. This clarifies perpetrator responsibility and establishes calling his wife “a bitch” and being abusive towards her as both deliberate and unacceptable.

Elucidating and Honouring Victims' Resistance

Representations of victims' resistance that clarified the victim's agency in opposing the perpetrator's violence or abuse functioned to reveal victim resistance (Coates & Wade, 2004). For example, in a transcript involving a client who had suffered physical, emotional and sexual abuse:

3. THERAPIST – **What does it say about you that you've held on for nearly three years in pursuit of justice**, what does that say about you?

4. CLIENT – That I'm tenacious, that I did not buckle under pressure

5. THERAPIST – **What kind of person doesn't buckle under pressure?**

6. CLIENT – Someone that is strong, has a good sense of their values. Somebody that wants to make things better for herself, even if it gets worse first. Someone who just wasn't going to take it lying down. (Transcript #1, 1993, p.278)

Here the therapist, instead of focusing on her depression, chose to focus on the fact that the client had maintained her determination to prosecute her perpetrator despite the fact that it has taken three years. The fact that the client held on so long, even though it was difficult, can be interpreted as a form of resistance in that she would not "let" the perpetrator continue to get away with hurting her without seeking justice. This line of questioning created the discursive space for the client to define herself as strong and capable in the face of adversity. It is much more meaningful for these descriptions to be arrived at by the client than for the therapist to tell the client that she is strong. However, there exists the embedded presupposition in this transcript that if the victim had not continued to pursue justice that she would have been passively letting him victimize her.

While this is problematic, this approach is obviously better than many others encountered in this study.

In another transcript, where the presenting issue was wife assault, the therapist constructed the client as knowing what was best for her.

13. THERAPIST – So, he didn't want to break up? (*trusting client expertise and affirming it*) But **you knew this was best for you?** (Transcript #17, 1998, p.163)

The therapist's question implies capability and strength by suggesting that even though the perpetrator did not want to separate, the client knew that leaving her abusive husband was the best course of action.

Contesting the Blaming and Pathologizing of Victims

Representations that challenged the blaming and pathologizing of victims were analyzed. In a transcript, where the presenting issue was sexualized violence perpetrated against a young girl by her uncle:

86. THERAPIST – Should we work together to change that? To help you believe you aren't bad?

87. LYNN – Okay.

88. THERAPIST - Maybe one way to do this would be to talk about how brave you actually were. Have you ever thought about the big part of you that did something brave?

89. LYNN – No. I did?

90. THERAPIST - Well, this is how I think about it. Bob was sneaky. He started out tickling you. Then he tickled you in your private places. Then he made you kiss his pee. No one was home to help you. **You were protecting Joshie. And**

you still told, even though he told you not to and you were scared. That sounds brave to me. (Transcript #9, 1990, p.153-154)

Here the therapist clarifies perpetrator responsibility by referring to how the perpetrator began slowly, first by introducing the “tickling game”, then touching her inappropriately in private places, and then forcing her to put her lips on his “pee”. This demonstrated the deliberateness of the perpetrator’s actions and presents him as the sole violent actor. The therapist calls attention to the fact that there was no one home to protect them and that the perpetrator had threatened to hurt Joshie if Lynn didn’t cooperate. This creates the discursive space for the therapist to characterize the victim as brave – in that she was able to tell even though she was afraid. This allows the victim to view herself as capable and strong for having resisted the perpetrator, despite the fact that he threatened to hurt them, as opposed to viewing herself as guilty for not telling someone earlier. While the words, “tickling”, and “kiss”, conceal the violent nature of the perpetrator’s actions, the therapist’s use of these words is not viewed as an example of the four-discursive-operations. Because the victim utilized these words to describe the abuse, and because of the victim’s age, it is understandable that the therapist would continue to utilize the terms used by the victim to describe the violence. However, it is important to note that the therapist could have represented these acts in a simplified way that would have clarified the violence.

In a transcript in which the client, who as a child had been sexually abused by his older sister, was concerned that his daughter would abuse his son, the therapist said:

37. DR.G – Well, **I can see why** you’d be worried about Scott being safe.

(Transcript #13, 1988, p.90)

This utterance contests blaming and pathologizing the victim by presenting the client's concern about keeping his son safe as reasonable given the abuse he had suffered as a child.

Table #9: Transcripts Where Therapists Used More Positive Representations

Transcript #	Year Published	Therapeutic Model Used	% of Therapist's utterances that contained one or more of the four-discursive-operations	% of Perpetrator's utterances that contained one or more of the four-discursive-operations
1	1993	Solution-Focused Therapy	2%	n/a
3	1989	A form of Clinical Interviewing (specific model was not specified)	3.8%	53.8%
11	1988	Family Therapy	9%	n/a
13	1988	Family Therapy	14.3%	n/a
17	1998	Solution-Focused Therapy	11.8%	n/a

Multiple Transcripts by the Same Author

In three instances, more than one transcript from one author was utilized (See Table #7). This was done to see if the occurrence of the four-discursive-operations were specific to one particular therapist/patient interaction, or, if the therapist always appealed to these discursive operations. While this study was not meant as a critique of a specific therapist, the use of multiple transcripts from the same author would demonstrate whether the four-discursive-operations were used consistently. The results were quite varied. While some transcripts by the same author were similar in the therapist's use of the four-discursive-operations, others were very different even to the point that one transcript would have many instances of the four-discursive-operations and another would have almost none. These findings suggest that the four-discursive-operations are not always used consistently and, as such, we cannot in this study, simply assume that a particular therapist or therapeutic model is negative because the four-discursive-operations were used.

Table #10: Multiple Transcripts by the Same Author

Transcript #	Therapeutic Model Used	% of Therapist's utterances that contained one or more of the four-discursive-operations	% of Perpetrator's utterances that contained one or more of the four-discursive-operations
3	Clinical Interviewing	3.8%	53.8%
4	Clinical Interviewing	56.8%	n/a
7	Discursive Practices	41.7%	n/a
8	Discursive Practices	47.4	n/a
11	Family Therapy	9%	n/a
12	Family Therapy	44.8%	n/a
13	Family Therapy	14.3%	n/a

Summary of Results from Part I

The results from Part I of the analysis demonstrated that the four-discursive-operations (conceal violence, mitigate perpetrators' responsibility, conceal victims' resistance, and blame or pathologize victims) occurred to varying degrees in all of the therapeutic interviews examined. While these findings are not meant to be generalized to the larger population of all therapy transcripts and are not meant to be generalizations about the styles of therapy examined, the fact that they were used by both perpetrators and therapists in this small sample is problematic from a social justice perspective.

Once it was established that the four-discursive-operations occurred in the 19 transcripts analyzed, the next step (Part II) was to examine how these four-discursive-operations affected formulations of the victim, the perpetrator, violence, and how they affected the flow of the therapeutic interview. The results of the second part of the analysis will be discussed in the next chapter.

Chapter Six – Results and Discussion: Part II

Part II

The second part of this study involved the detailed analysis of five transcripts randomly selected from the sample. The detailed analysis involved an examination of how therapists' use of the four-discursive-operations affected the progression of the therapy sessions. This involved an examination of how these utterances were accomplished, namely, who initiated their use, how they were responded to, who picked up on them, and who contested them, and how the therapist gave agency through his or her utterances. The study also examined opportunities that the therapist missed and what the therapist could have, according to *The Interactional and Discursive View of Violence and Resistance*, done to clarify the act of violence and represent the abuse in a manner that would "(i) expose violence, (ii) clarify responsibility, (iii) elucidate and honour victims' responses and resistance, and (iv) contest the blaming and pathologizing of victims" (Coates & Wade, 2004, p.522). The five transcripts randomly selected for the detailed analysis all used different therapeutic models. Three of the transcripts clearly specified the therapeutic models they used including, family brief therapy, narrative therapy, and solution-focused brief therapy. The other two transcripts did not specify which therapeutic models they utilized however, one used a form of psychotherapy that focused on self esteem and the other a form of clinical interviewing. For pragmatic reasons, only two of the five transcripts analyzed will be presented.

Transcript #14

The therapeutic model used in this therapeutic interview was Solution-Focused Brief Therapy (1996). The presenting issue in this transcript was wife assault. The

perpetrator was a thirty-nine-year-old man who has been married for three years and has one son. The perpetrator came to therapy as a mandated client (ordered to come to therapy by the courts), although he refused to admit that he ever hit his wife. In accordance with the tenets of Solution-Focused Therapy, the therapist in this transcript focuses solely on solutions. Because of this, getting the perpetrator to accept full responsibility for the violence or eliciting detailed descriptions of the violence did not occur.

1. THERAPIST – So, what brings you here today?
2. CLIENT – My wife said I have to come. She says I have a problem with my anger. (p. 155)
3. THERAPIST – So, it was not your idea to come? [This helps validate the client's view of the situation. Asking about his anger would not validate his mandated status.]
4. CLIENT – No way, no offense. I don't think I need this. I don't beat my wife. She took out a restraining order this weekend after we had a fight. (p. 155)
5. THERAPIST – Okay.
6. CLIENT – She said she was scared of me. That's crap. (p. 155)
7. THERAPIST – So, what do you think your wife hopes will happen in therapy [cooperating with the view that the wife wants him in therapy]?
8. CLIENT – She wants me to control my anger, not yell so much, I guess. (p. 155)
9. THERAPIST – What do you want? [Directly asking about the client's goals, juxtaposes them with the wife's desire.]

10. CLIENT – I want to get back into my house. I work really hard to support her, and this is what I get. (p. 156)

11. THERAPIST – What will need to happen for you to be able to go back to your house [co-operating with his worldview and accepting his goal – to get back into the house]?

12. CLIENT – I guess my wife will have to drop the restraining order. I'm sorry, I have to ask a question.

13. THERAPIST – Please [allows the client to put his agenda first, which usually enhances co-operation].

14. CLIENT – You have not asked me if I hit my wife. How come?

15. THERAPIST – Good question. I assume if it is important for me to know, you will tell me. [This gives the client control and respect.]

16. CLIENT – You mean I don't have to tell you my whole life story, like the couples therapist?

17. THERAPIST – Not unless you think it will be helpful in solving the current problem. (p. 156)

18. CLIENT – Huh, well, I didn't hit her. We were having a fight. She lies all the time. I caught her in this lie, and I got really mad and grabbed her shirt, but I never hit her. (p. 156)

19. THERAPIST – Okay. [To maintain and enhance cooperation it is helpful to resist the temptation to elicit more details here. Doing so may be perceived by the client as the therapist judging him.] So, you mentioned you wanted to get back

into your house. What do you think your wife would say would need to be different for her to drop the restraining order so you could go home? (p. 156)

20. CLIENT – I have to learn to control my anger and just take a walk when I get that angry. [The client has shifted here. Through the therapist's cooperating with the client, he is now agreeing with the wife's goals and trying to find ways to accomplish them.] (p. 156)

21. THERAPIST – What would it take for you to be able to do that? (p. 156)

22. CLIENT – She would have to stop lying to me. (p. 156)

23. THERAPIST – So, when she stops lying, what will be different? (p. 156)

24. CLIENT – I won't have any reason to get so mad. (p. 156)

25. THERAPIST – Does she lie all the time [looking for exceptions]?

26. CLIENT – Yes . . .no, not really. Just when I'm asking her where she's going with her friends. (p. 156)

27. THERAPIST – So, when you are not asking her about where is she going, she is not lying?

28. CLIENT – No. (p. 157)

29. THERAPIST – How do you know when she is not lying?

30. CLIENT – She doesn't hesitate to tell me things, we just have a normal conversation.

31. THERAPIST – So, when she does that, what do you think she notices you doing differently?

32. CLIENT – I'm not yelling. (p. 157)

33. THERAPIST – Is that a sign that you are controlling your anger?

34. CLIENT – Yeah. (p.157)

Transcript # 14 – Detailed Analysis

1. THERAPIST – So, what brings you here today?

2. CLIENT – My wife said I have to come. **She says I have a problem with my anger.** (p. 155)

The therapist begins by asking the client what brings him to therapy. The client responds by saying that his wife told him that he had to come and, that she says that he has a problem with his anger. This is the first usage of the four-discursive-operations in this transcript. This is to be expected because perpetrators usually attempt to excuse or deny their violent actions (Davis, 1986; Morgan & O’Neil, 2001a, 2001b). The use of the utterance, “She says”, in the above utterance works as a qualifier, which presents his wife saying he has “a problem with [his] anger” as an opinion rather than fact. While it may appear as though the perpetrator is taking ownership for his actions in this utterance, he qualifies it by presenting it as simply his wife’s opinion, and only presents it as a problem with emotions (anger), not violence.

3. THERAPIST – So, it was not your idea to come?

4. CLIENT – No way, no offense. I don’t think I need this. I don’t beat my wife.

She took out a restraining order this weekend after **we had a fight.** (p. 155)

The therapist clarifies that it was not the perpetrator’s “idea to come” to therapy. The perpetrator continues to avoid taking responsibility for why he is in therapy (as a mandated client, which means that he was required to attend therapy by the courts) by diminishing the seriousness of the violence by equating violence with a “fight”. The words, “we” and “fight”, mutualized responsibility for the violence because the word,

“we”, implicates both parties and the word, “fight”, is typically used to describe two combatants of equal strength. Conversely, violence is the unilateral act of one person against the will of another and there is often a large power difference. Concealing the violence by representing it as a “fight”, allows the perpetrator to blame & pathologize his wife (the victim) by characterizing her as irrational for going to the police because the violence never occurred, it was just a “fight”.

5. THERAPIST – **Okay.**

6. CLIENT – **She said she was scared of me. That’s crap.** (p. 155)

Line five contains the therapist’s first usage of the four-discursive-operations. The therapist, by saying, “Okay”, after the client has characterized his wife as unreasonable for getting a restraining order because of a little “fight”, contains the embedded presupposition that the therapist is in agreement with the client. The utterance, “Okay”, is a discourse marker; these are words and phrases, (for example: oh, but, because, oh, and okay), that help us to develop and relate ideas to one another within conversations (Schiffrin, 2001). The therapist’s use of the utterance, “Okay” (in line 5), denotes agreement or understanding with the client’s characterizations of the victim as unreasonable and, indicates that this position about the victim will be treated as common ground in the therapeutic interview. We then see a continuation and escalation of discrediting the victim. According to the Interactive and Discursive View of Violence and Resistance, it would have been more clarifying if the therapist had asked, “why have you been required by the courts to attend therapy if there was nothing for your wife to be afraid of?”. This would have denoted that the therapist did not accept the perpetrator’s characterization of the victim as behaving unreasonable and would have returned the

focus to the perpetrator's violent behaviour. The perpetrator's previous utterance (line 4), where he minimizes the violence by presenting it as a little "fight", and the therapist's agreement with that characterization allows the perpetrator to deny that his wife has any reason to be afraid of him (line 6) by saying, "she said she was scared of me. That's crap". This casts the victim's response (seeking help from the authorities), as problematic and unreasonable and thus conceals the violence, obscures perpetrator responsibility and blames and pathologizes the victim.

7. THERAPIST – So, what do you think your wife hopes will happen in therapy [cooperating with the view that the wife wants him in therapy]?

8. CLIENT – She wants me to control **my anger, not yell so much, I guess.** (p. 155)

The therapist's question, "So, what do you think your wife hopes will happen in therapy", implies that the client knows what his wife wants him to work on in therapy even if he does not believe that he has this problem. By asking this question the therapist exposes the things that the perpetrator needs to work on without directly confronting the client about the violence. The perpetrator continues concealing the violence by saying that his wife wants him to control his "anger" and "not yell so much". This constructs the violence as merely an issue of unpleasant emotions ("anger"); however, this does not accurately capture the victim's experience of the violence perpetrated against her. Because the problem had been mutualized previously by the perpetrator and the therapist, through the use of the word, "fight", the violence can be seen here as part of a mutual act in which the focus has been shifted away from the perpetrator's violence and onto the victim's behaviour. The utterance, "I guess", conceals the violence through the embedded

presupposition that he does not know for certain what his wife believes could be done because he does not have this problem; he denies hitting his wife.

9. THERAPIST – **What do you want?** [Directly asking about the client’s goals, juxtaposes them with the wife’s desire.]

10. CLIENT – I want to get back into my house. I work really hard to support her, and this is what I get. (p. 156)

Instead of redirecting the focus onto the perpetrator’s violent actions, the therapist asks the perpetrator, “what do you want?”, which allows the therapeutic interview to move away from the issue of violence and, instead, focuses on what the perpetrator wants. This was interpreted as negative because it allowed the client to focus on what he wants instead of shifting the focus onto the violence. It would have been more clarifying if the therapist had maintained a focus on the violence as the problem to be discussed in therapy instead of creating the discursive space for the perpetrator to continue to excuse or deny that he ever behaved violently towards his wife. The perpetrator, in his response, conceals the violence by representing himself as a man who works hard to support his family and whose wife is not appreciative. This not only allows him to conceal and avoid taking responsibility for the violence but it also creates the space for the client to present himself as the victim and his wife as the perpetrator.

11. THERAPIST – **What will need to happen for you to be able to go back to your house** [co-operating with his worldview and accepting his goal – to get back into the house]?

12. CLIENT – I **guess my wife will have to drop the restraining order**. I’m sorry, I have to ask a question.

13. THERAPIST – Please [allows the client to put his agenda first, which usually enhances co-operation].
14. CLIENT – You have not asked me if I hit my wife. How come?
15. THERAPIST – Good question. I assume if it is important for me to know, you will tell me. [This gives the client control and respect.]
16. CLIENT – You mean I don't have to tell you my whole life story, like the couples therapist?
17. THERAPIST – Not unless you think it will be helpful in solving the current problem. (p. 156)

The therapist does not call attention to the perpetrator's problematic characterization of the victim or try to return the focus of the interview to the perpetrator's violence. Instead, the therapist's question, "what will need to happen for you to be able to go back to your house?", continues to focus on a client based definition of the problem. This question contains the embedded presupposition that the client knows what he needs to do to achieve his goal of being able to "get back into" the house. A tenet of Solution-Focused therapy is that clients know how things would be different if their problems were solved; thus, Solution-Focused therapists focus on how things would be different if clients' problems were solved. This involves discussing how the client can accomplish these differences instead of focusing on the problem. For example, in this case, the therapist focuses on the client's goal of getting back into the house instead of focusing on the violence. However, not directly talking about the violence in a clear and explicit manner also allows the perpetrator to avoid admitting that his violence is a

problem, and allows him to cast the victim as the one to blame. This utterance also allowed the problem to be reformulated to how the client can “get back into” his house.

The perpetrator conceals the violence and avoids taking responsibility for the violence by saying that in order for him to return to the house his “wife will have to drop the restraining order”. This utterance supports victim blaming through the embedded presupposition that the victim needs to change, and not the perpetrator. This obscures perpetrator responsibility and conceals the victim’s resistance by shifting all responsibility onto the victim and denying the fact that the perpetrator has anything to work on because he is the victim in the situation. The therapist continues to focus on what the perpetrator wants, instead of addressing the client’s violent behaviour. This allows a discursive space to be created in which the client can formulate his wife as the problem. The client even asks why the therapist has not asked whether or not he hits his wife. The therapist responds that if it is important for him/her to know that, the client will tell him/her. This places no pressure on the client to tell the therapist whether or not he hit his wife.

18. CLIENT – Huh, well, **I didn’t hit her. We were having a fight. She lies all the time.** I caught her in this lie, and **I got really mad and grabbed her shirt, but I never hit her.** (p. 156)

In the next turn, the perpetrator does admit some of the violence, that he “grabbed her shirt”, and takes some responsibility for his emotions by saying he was “really mad”. However, he qualifies those statements by mutualizing responsibility, minimizing the seriousness of the violence and, denying that he hit his wife. He conceals the unilateral nature of the violence by using the words, “we” and “fight”, which negatively

presupposes the equal participation of both parties. The word, “fight”, is also problematic because the perpetrator equates violence and abuse with fighting or arguing, which minimizes the seriousness of the violence. The perpetrator goes on to present the victim as of questionable moral character (“she lies all the time”) and thus, as deserving of the violence perpetrated against her. This allows him to excuse his violence by presenting it as reasonable given the situation – that she drove him to it by her lying. The perpetrator conceals the violence, obscures perpetrator responsibility and blames and pathologizes the victim by saying that he “got really mad and grabbed her shirt, but. . .never hit her”. He conceals the violence by equating his violence with getting “really mad”. While he admits to grabbing her shirt, he presents this as a reasonable response given how angry she made him; this allows him to avoid taking responsibility for hitting her. By minimizing the seriousness of the violence the perpetrator conceals the degree to which his wife is afraid of him.

19. THERAPIST – **Okay**. [To maintain and enhance cooperation it is helpful to resist the temptation to elicit more details here. Doing so may be perceived by the client as the therapist judging him.] So, you mentioned you wanted to get back into your house. **What do you think your wife would say would need to be different for her to drop the restraining order so you could go home?** (p. 156)

Again we see the therapist use the discourse marker, “Okay”. The therapist’s utterance, “Okay”, denotes agreement with the client’s characterizations of the victim as having precipitated the violence. This allows the client to construct his violent behaviour (grabbing her shirt), as a reasonable response. The author of the chapter, in which this transcript was published, notes that the therapist conveys understanding or even

agreement with the perpetrator's account including the characterization of the victim, as he does not want the perpetrator to feel as though he is judging him. However, the therapist, by accepting the perpetrator's characterizations of the victim as the problem, places the onus on the victim to change; this conceals the perpetrator's violence.

According to the Interactive and Discursive View of Violence and Resistance, the therapist's next utterance, "What do you think your wife would say would need to be different for her to drop the restraining order so you could go home", was viewed as more clarifying. This utterance, helped shift the focus onto what the perpetrator needs to do in order for him to return home, namely, not behaving violently.

20. CLIENT – I have to learn to **control my anger** and just take a walk when I get that angry. [The client has shifted here. Through the therapist's cooperating with the client, he is now agreeing with the wife's goals and trying to find ways to accomplish them.] (p. 156)

Here we see the husband conceals the seriousness of the violence by saying that what he needs to work on is to "control his anger". This presents the violence as a non-deliberate action caused by something beyond his control (his anger) which maintains the focus on his emotions instead of his violence. The therapist constructs it as a positive sign that the perpetrator has agreed that the only way to get home is for him to control his anger which is the wife's goal. While this is a step in the right direction, there is still no mention of the violence and the perpetrator has not admitted to hitting his wife.

21. THERAPIST – What would it take for you **to be able** to do that? (p. 156)

The therapist's question, "What would it take for you to be able to do that?", accomplishes all four of the discursive-operations and contains a negative embedded

presupposition. The therapist attempts to clarify perpetrator responsibility by implying that the perpetrator knows what he needs to do to be able to control his “anger”. The utterance, “for you to be able to do that?”, focuses on the non-deliberateness of the perpetrator’s actions and expands on this by constructing the perpetrator as willing to control his emotions but that there is something that is making it difficult for him to do so. Because the therapist has already agreed with the perpetrator’s earlier characterizations of the victim as inciting the client’s anger, this question contains the negative embedded presupposition that the wife would have to be doing something different for the client to be able to “control his anger”. This question opens up the way for the client to further blame his wife and, does not help shift the focus back onto the perpetrator or his violence.

22. CLIENT – **She would have to stop lying** to me. (p. 156)

As predicted, the perpetrator continues to avoid taking responsibility for his violence, and blames and pathologizes the victim by focusing on what the victim would have to do in order for him to be able to control his “anger” instead of focusing on what he needs to do. He reformulates the problem to be that his wife needs to “stop lying” to him.

23. THERAPIST – So, **when she stops lying**, what will be different? (p. 156)

The embedded presupposition in the therapist’s question implies agreement with the perpetrator’s notion of shifting the responsibility onto the victim to stop the violence and thus is counted as negative. The solution-focused model focuses on solutions and, as such, the therapist does not call into question or challenge the perpetrator’s comments; instead, the therapist focuses on what the perpetrator thinks would be different if the

victim was to stop lying (Miller, Hubble & Duncan, 1996; DeJong & Berg, 1998a). This allows the perpetrator to feel as though the therapist agrees with his characterization of his wife as in the wrong. Shifting the blame onto the victim conceals the violence and, allows the perpetrator to avoid taking responsibility for his violent behaviour.

24. CLIENT – **I won't have any reason to get so mad.** (p. 156)

The therapist's previous responses have made it possible for the perpetrator to continue to shift responsibility onto the victim for making him "mad". He excuses his actions by saying that if she did not lie that he would have no "reason to get so mad". At this point, the perpetrator continues to formulate the violence he perpetrated against his wife as an emotional event (being mad), not a violent event. Casting the victim as precipitating the violence by her "lying" allows the perpetrator to avoid taking responsibility for his actions, and presents his response, "grabbing" her and getting "mad", as reasonable. Referring to the violence as getting "mad", also allows the perpetrator to conceal the seriousness of the violence by equating getting mad with becoming violent.

25. THERAPIST – **Does she lie all the time** [looking for exceptions]?

26. CLIENT – Yes . . .no, not really. **Just when I'm asking her where she's going with her friends.** (p. 156)

27. THERAPIST – So, when you are not asking her about where is she going, she is not lying?

28. CLIENT – No. (p. 157)

The therapist's question, "does she lie all the time?", moves from a generalization to something more precise in order to find out if the victim does, in fact, lie "all" the time.

Looking for exceptions is key to solution-focused therapy as it helps clients realize that their problems are not there all the time and helps them to think about how things are different when their problems are not there (Miller, Hubble & Duncan, 1996; Pichot & Dolan, 2003; DeJong & Berg, 1998a). In this situation, the therapist is suggesting that there may be times when the victim does not lie. This encourages the perpetrator to admit that his wife does not lie all the time, only when he asks “her where she’s going with her friends.” According to the Interactive and Discursive View of Violence and Resistance, this question was considered positive because it problematizes the perpetrator’s initial characterization of the victim as precipitating the violence by always lying and helps reduce victim blaming.

29. THERAPIST – **How do you know when she is not lying?**

30. CLIENT – She doesn’t hesitate to tell me things, we just have a normal conversation.

31. THERAPIST – So, when she does that, what do you think she notices you doing differently?

32. CLIENT – I’m not yelling. (p. 157)

The therapist’s question, “How do you know when she is not lying?”, accomplishes all four of the discursive operations by concealing the violence and the husband’s responsibility for the violence by maintaining a focus on his wife’s “lying” as the problem to be addressed in therapy. The perpetrator conceals the violence and his responsibility for it by saying that he knows that she is not lying when “She doesn’t hesitate to tell me things, we just have a normal conversation”. This statement continues to formulate the victim’s “lying” as the problem. The therapist’s question contains the embedded presupposition that when the victim is not lying, and when they are having

“normal conversation[s]”, the victim notices the client doing something differently; this implies capability and agency, namely, that the client is able to control his anger. While this does not clarify the violence, it does give agency to the perpetrator by presenting him as capable of controlling his anger and thus, as capable of achieving his goal of returning home. However, focusing on how things are better when the victim is not lying accomplishes all four of the discursive-operations by shifting responsibility for ending the violence onto the victim and continuing to present the victim’s lying as the problem while concealing the violence perpetrated by the client; as such, the embedded presupposition was counted as negative.

33. THERAPIST – **Is that a sign that you are controlling your anger?**

34. CLIENT – Yeah. (p.157)

The therapist’s question, “is that a sign that you are controlling your anger?”, contains the positive embedded presupposition that having a “normal conversation” and “not yelling” are signs that the perpetrator is able to control his “anger”. While this utterance continues to focus on externalized factors, namely his emotions, it also gives agency to the perpetrator by presenting him as capable of controlling his anger and being able to recognize when he is in control of his anger. While this is positive in the sense that it presents the perpetrator as capable of controlling his “anger”, it is also negative because focusing on how things are better when the victim does not lie, shifts responsibility for ending the violence onto the victim and effectively conceals the fact that the violence was unilaterally and deliberately perpetrated by the client.

Outcome

Diagnosis.

No formal diagnosis was made in this therapeutic interview. The client's problem controlling his anger was formulated as the informal diagnosis. This informal diagnosis allowed the issue of violence to be effectively ignored and created the discursive space necessary for the victim to be cast as precipitating the violence.

Victim Safety.

Victim safety was not addressed in this therapeutic interview. The client commented that his wife had got a restraining order out against him but formulated this as unreasonable because they only had a small "fight". Because the issue of violence was not made the key issue in this therapeutic interview and because the therapist appeared to be in agreement with the client's formulations of the victim as the problem, there was no discursive space to talk about the victim's safety.

Four-discursive-operations.

The therapist and the perpetrator used the four-discursive-operations throughout the transcript. Sixty-five percent of the therapist's and the perpetrator's utterances contained one or more of the four-discursive-operations (See Table #11 & 12). Conversely, only 17% of the therapist's utterances worked to clarify the violence and responsibility for the violence. As expected, the perpetrator was the first to utilize the four-discursive-operations in his first utterance (line 2), in which he denies that he has a problem with anger. The therapist supported the formulation of the therapeutic goal as the client getting back into the house without addressing the violence. The therapist's use of the four-discursive-operations occurred for the first time in line five when, he denoted

agreement with the perpetrator's negative characterization of the victim as precipitating the violence. Throughout the majority of the transcript when the perpetrator utilized the four-discursive-operations to deny and excuse his violent behaviour, the therapist responded by agreeing with the perpetrator's negative characterizations of the victim rather than redirecting the focus back onto perpetrator's violent behaviour. Because the therapist did not disagree with the perpetrator's formulations of the victim as precipitating the violence perpetrated against her, the perpetrator was able to continue discrediting the victim and downplaying the violence. The therapist finally contests the perpetrator's negative characterization of the victim once in line 25 when he asks, "Does she lie all the time?". This utterance attempts to discredit the perpetrator's earlier suggestion that the victim always lies and also serves to discredit the perpetrator's justification for his violent behaviour. This line of questioning encourages the perpetrator to admit that his wife does not lie all the time and allows the therapist to give agency to the perpetrator by suggesting that there are times when the client is able to control his temper. While this is a positive step, many of the therapist's utterances in this section were counted as negative because they continued to rely on the perpetrator's definition of the problem, namely, that his wife lies too much which implies that she needs to change her behaviour instead of addressing the perpetrator's violent behaviour as the problem.

The four-discursive operations were often accomplished through negative reformulations and embedded presuppositions. In this transcript, the problem to be addressed was reformulated negatively twice, once by the therapist and once by the perpetrator. First, the therapist allowed the issue of violence to be excluded from therapy; the therapist formulated the problem to be addressed as the client getting back into the

house without ever discussing the violence. The lack of discussion about the violence created the discursive space for the client to shift blame onto the victim, by reformulating the victim's lying as the problem. The therapist does not address this reformulation as problematic but, instead, appears in agreement with it by focusing on how things are different when the victim is not lying.

Negative embedded presuppositions were used by the therapist many times in this transcript. Embedded presuppositions that were coded as negative were those that were used to conceal the violence, obscure perpetrator responsibility, conceal the victim's resistance, and blame and pathologize the victim. An example is the therapist's question, "What would it take for you to be able to do that?" This utterance contains a negative embedded presupposition and all four of the discursive-operations. In this question the therapist attempts to clarify perpetrator responsibility by implying that the perpetrator knows what he needs to do to be able to control his "anger". However, due to the fact that the perpetrator had presented his wife's lying as the problem, and, that the therapist had agreed with this formulation, this question was coded as a negative embedded presupposition because it opened up the way for the client to further blame his wife and thus, did not help shift the focus back on to the perpetrator and his violence.

The author of this chapter argues that:

. . . by cooperating with the client's view of the world, these issues are addressed more rapidly than in the traditional approach of confronting the client's assumed denial. (Transcript #14, 1996, p. 157)

Conversely, the Interactional and Discursive View of Violence and Resistance, argues that by not eliciting a detailed account of the violence or encouraging the perpetrator to admit to

the violence, there exists no discursive space to talk about the deliberateness of the violence, how the victim resisted the violence, how the perpetrator overpowered or suppressed the resistance, or, how violence is unacceptable. This allowed the victim's hesitation when she talked to her husband, to be interpreted as lying rather than a form of resistance in which fear of her husband lead her to keep herself safe by controlling what information was revealed. While it is important to search for solutions in therapy, it is also important that issues of violence and responsibility for violence are clearly addressed. By not addressing the violence, the perpetrator is able to avoid admitting that he did anything wrong which creates the discursive space for the perpetrator to characterize his wife's lying as the problem.

Table #11: Transcript #14 – Use of the Four-Discursive-Operations

	# of Therapist's utterances that contained one or more of the four-discursive-operations	# of Perpetrator's utterances that contained one or more of the four-discursive-operations
	11/17	11/17
Percentage:	64.7%	64.7%

Table #12: Transcript #14 – Use of Clarifying Representations

	# of Therapist's utterances that were viewed as clarifying
	3/17
Percentage:	17%

Transcript #19

The therapeutic model used in this transcript is a form of psychotherapy that focuses on “making self-esteem the central issue of concern” (1995, p.xi). This transcript involved a complaint of wife battering and both partners were present during the interview. In this transcript, the perpetrator admits to the violence but attempts to excuse his actions by presenting them as reasonable because his wife drives him to it.

1. THERAPIST – What I’d like you to do, Sheri, is describe in precise detail the last time you and Kevin fought. Try to describe the incident like you were watching a video of you two. It’s very important not to leave anything important out. (p. 387)
2. SHERI – OK. But it’s going to be hard to do. (p. 387)
3. THERAPIST – How come? (p. 388)
4. SHERI – Because Kevin is going to get angry with me. He’ll interrupt and tell me I’m not seeing it the way it really happened. (p. 388)
5. THERAPIST – That’s OK with me. But we should know if that’s what you’re going to do Kevin. It sounds like Sheri is feeling pretty threatened. (p. 388)
6. KEVIN – (With good-natured concern.) No, I am not going to interrupt. Go ahead, Sheri. Tell it like you see it. There’s no reason to be threatened. (To the therapist.) But I have to ask. Can I let you know if I disagree or would like to add something? (p, 388)
7. THERAPIST – Why don’t we let Sheri describe what she remembers and when she’s finished I think it’s important that you tell us how you saw things happening. Kind of take turns. Does that sound all right with you two? (p. 388)

8. KEVIN – Fine. (p. 388)

9. SHERI – Yeah. That’s fine. (p. 388)

(Sheri recounts how Kevin came home and thought that the house was not as clean as he wanted it. Kevin reprimands Sheri as if she were a little girl. When Sheri protests, Kevin calls her ungrateful for all the things he provides the family. He then becomes verbally abusive. He walks over to the stereo cabinet, looks at it and commands Sheri to dust it again. When she becomes angry, he grabs her by the arm and starts pushing her toward their bedroom. He pushes her into the bedroom and tells her to stay there until she can be reasonable. Sheri describes how powerless she feels at this point and winds up lying on the bed crying.) (p. 388)

10. THERAPIST – What do you think, Kevin? (p. 388)

11. KEVIN – (Patronizingly.) I’m not surprised that she perceived what happened like that. But you have to understand some things. (p. 388)

12. THERAPIST – OK. (p. 388)

13. KEVIN – (Leaning toward the therapist.) You understand how tough it is to bust your head all day at work, try to buy nice things for the family, all the stress and garbage you have to put up with just to try and get ahead a little bit.

(Therapist looks intently at Kevin, but gives no response, only an indication that he is listening.) Anyway, when you come home and see that nothing has been done to keep the house nice, you just start wondering if it is worth it all. (p. 388-389)

14. THERAPIST – Could I ask you a question? (p. 389)

15. KEVIN – Sure. (p. 389)

16. THERAPIST – When you felt that the house wasn't clean, did you call Sheri an “ungrateful bitch”? (p. 389)

17. KEVIN – (Pauses.) Don't you get angry sometimes? I mean, just every once in a while you get just a little inappropriate? (p. 389)

18. THERAPIST – I don't call my wife a bitch, if that's what you're asking. (p. 389)

19. KEVIN – OK. OK. That was out of line. But I'd been working since seven that morning. I was tired, and fact of the matter is the place looked like a dump. (p. 389)

20. THERAPIST – So when you've been working hard you're tired, you are more inclined to call your wife names, become physically abusive, and treat her as if she were a little child. How would you describe yourself when you behave like that? (p. 389)

21. KEVIN – I don't buy that at all. (p. 389)

22. THERAPIST – Tell me how you see it. (p. 389)

23. KEVIN – There are times when someone has to take charge especially when Sheri falls short of what I would expect any responsible wife to do. And I wasn't abusive. I hardly touched her at all when I suggested she go into the bedroom and cool off so we could talk about things in a rational manner. I was simply being direct and trying to short circuit a problem that could get much bigger than it did. (p. 389)

24. SHERI – (Angry and frustrated.) That’s not it at all. You degrade me and treat me like I was a two-year old. You always do this – make me look like I’m an idiot and you’re in the right! (p. 389)

25. THERAPIST – Is this the first time you’ve told Kevin that that’s how you feel when he abuses you? Like a child that has been unjustly chastised? (p. 390)

26. SHERI – Well, not like I just did. Not as clear. I’m afraid I usually freak out or just break down and cry. (p. 390)

27. THERAPIST – Sounds to me then, that this is the first time you’ve risked telling Kevin just exactly how you feel. It must have been very difficult to say such an important thing; something that we need to address. But can I ask you a favor? I don’t want you to think that we are ignoring you, but could we keep on taking a look at Kevin for just a few more minutes and then get back to what you just said? (p. 390)

28. SHERI – You bet. (p. 390)

29. THERAPIST – Kevin. Look back at what you just said a moment ago. There seems to be a great big discrepancy between Sheri’s description of how you treated her and how you perceived it. Let me try to summarize what could be the most damaging things that Sheri remembers you doing and you tell me how you would describe someone who does those sorts of things. (p. 391)

30. KEVIN – (Impatiently and curtly.) Fine. (p. 391)

31. THERAPIST – OK. You come home tired. The house isn’t clean. You become angry and call your wife a bitch. You order her to dust the stereo cabinet for a second time. When she protests you physically force her into the bedroom,

slam the door and tell her not to come out until she can be reasonable. How would you describe yourself for doing that? (p. 391)

32. KEVIN – You're taking things out of context. (p. 391)

33. THERAPIST – (Apologetically.) I know. And it really makes things sound bad saying it that way, but I'm wondering if there is a context in which it's appropriate to call your wife names and use physical force on her? (p. 391)

34. KEVIN – My hell, it's . . . it wasn't that bad, and I resent you for making me look like a real SOB. (p. 391)

35. THERAPIST – I don't mean to, Kevin. And this might be a good place to stop for a minute and take a look at what's going on between us. How would you describe yourself in the last couple of seconds. How would you describe how you've been talking to me? (p. 391-392)

36. KEVIN – I've disagreed with what you've said but I've kept my cool. I've been honest. (p. 392)

37. THERAPIST – How have you seen it, Sheri? (p. 392)

38. SHERI – He's trying to make how he treats me look better than it is. And he's doing the same thing to you that he does to me. (p. 392)

39. KEVIN – Don't give me that . . . (p. 392)

40. THERAPIST – I know this is hard, Kevin, but what Sheri has to say could be really important for us to hear. Would you be willing to let her finish? (p. 392)

41. KEVIN – (Visibly angry.) Yeah, yeah. (p. 392)

42. THERAPIST – Say more, Sheri. (p. 392)

43. SHERI – He started getting huffy with you just like he does with me. Then, when you try to call him on it, he either gets this patronizing attitude and starts twisting things around or he gets mad and starts to throw things. Then, he turns around and tries to blame it on you. (p. 392)

44. THERAPIST – So what has just happened here between Kevin and me is what happens to you and Kevin at home. (p. 392)

45. SHERI – That’s right. (p. 392)

46. KEVIN – (To therapist.) Wait a minute. What has “just happened here” between you and me? (p. 392)

47. THERAPIST – Do you really want to know? (p. 392)

48. KEVIN – (Somewhat sarcastically.) Yeah, I really want to know. (p. 392)

49. THERAPIST – OK. But I need to ask you a question. How would you describe the tone of your voice you’ve been using talking to me for the past few minutes? (p. 392)

50. KEVIN – What? What has that got to do with anything? (p. 392)

51. THERAPIST – What are you doing right now? (p. 392)

52. KEVIN – What am I doing? (p. 392)

53. SHERI – (Interrupting.) You’re answering his questions with a question. So you’re not answering his questions. (p. 392)

54. THERAPIST – That’s what it looks like to me. It’s almost like we’re playing a game of tennis – I ask you a question and you hit it right back at me. I wonder what you’re thinking and feeling that stops you from having a meaningful discussion with me? (p. 392)

Transcript # 19 – Detailed Analysis

1. THERAPIST – What I’d like you to do, Sheri, is describe in precise detail the last time you and Kevin fought. Try to describe the incident like you were watching a video of you two. It’s very important not to leave anything important out. (p. 387)
2. SHERI – OK. But it’s going to be hard to do. (p. 387)
3. THERAPIST – How come? (p. 388)
4. SHERI – Because Kevin is going to get angry with me. He’ll interrupt and tell me I’m not seeing it the way it really happened. (p. 388)
5. THERAPIST – **That’s OK with me.** But we should know if that’s what you’re going to do Kevin. It sounds like Sheri is feeling **pretty threatened.** (p. 388)
6. KEVIN – (With good-natured concern.) No, I am not going to interrupt. Go ahead, Sheri. Tell it like you see it. **There’s no reason to be threatened.** (To the therapist.) But I have to ask. Can I let you know if I disagree or would like to add something? (p, 388)

The therapist begins by asking Sheri to describe “in precise detail the last time” they “fought”. Using the word, “fought”, to refer to the violence conceals the unilateral and deliberate nature of the violence perpetrated by Kevin and mutualizes responsibility equally to both partners. The use of the word, “incident”, is also problematic as it does not mention the violence or the fact that husband (Kevin) is the violent actor. According to the Interactive and Discursive View of Violence and Resistance, this was viewed as a missed opportunity. It would have been more clarifying to ask Sheri to describe “in precise detail the last time Kevin was abusive”. Asking the victim (Sheri) to describe the

violence “in precise detail”, is important since it created the discursive space necessary for Sheri to describe the violence in detail. However, suggesting that she describe the violence as if she “were watching a video”, limits the victim’s description of the violence to visual and audible representations versus how she experienced the violence emotionally or mentally. According to the Interactional and Discursive View of Violence and Resistance, it is extremely important to obtain a detailed account of the violence. Without contextualizing the events and obtaining detailed accounts of who did what to whom, it is impossible to discuss what the perpetrator did and how the victim resisted. Sheri says that it will be hard for her to do this because Kevin will become upset and “he’ll interrupt” and say that she is “not seeing it the way it really happened”. The therapist’s utterance, “that’s OK with me”, conceals the victim’s resistance and ignores the fact that the victim has just said that she is afraid to describe what happened because Kevin would “get angry” with her. The therapist goes on to say that they need to know if Kevin is going to interrupt and draws attention to the fact that “Sheri is feeling pretty threatened” by Kevin. This utterance accomplishes the four-discursive-operations, and contains a negative reformulation. Here the therapist reformulates the problem to be that Sheri feels threatened, not her husband’s behaviour, namely, that he will get upset and interrupt. This utterance also omits who the victim is threatened by; the therapist indicates that the victim feels threatened but does not address this. According to the Interactive and Discursive View of Violence and Resistance, this was considered a missed opportunity. It would have been more clarifying if the therapist had said, “Kevin what are you planning to do?”, which would have kept the focus on Kevin’s behaviour.

Kevin denies that he will interrupt, and says that “there’s no reason to be threatened”. Denying the fact that the victim has any reason to be afraid or threatened by him conceals the fact that he has abused her verbally and physically in the past. Next, Kevin asks if he will be given room to “disagree” with what Sheri says or to “add something”. Kevin while seeming to want to give Sheri room to talk is already setting up room to disagree with what Sheri has to say.

7. THERAPIST – Why don’t we let Sheri describe what she remembers and when she’s finished I think it’s important that you tell us how you saw things happening. Kind of take turns. Does that sound all right with you two? (p. 388)

8. KEVIN – Fine. (p. 388)

9. SHERI – Yeah. That’s fine. (p. 388)

(Sheri recounts how Kevin came home and thought that the house was not as clean as he wanted it. Kevin reprimands Sheri as if she were a little girl. When Sheri protests, Kevin calls her ungrateful for all the things he provides the family. He then becomes verbally abusive. He walks over to the stereo cabinet, looks at it and commands Sheri to dust it again. When she becomes angry, he grabs her by the arm and starts pushing her toward their bedroom. He pushes her into the bedroom and tells her to stay there until she can be reasonable. Sheri describes how powerless she feels at this point and winds up lying on the bed crying.) (p. 388)

10. THERAPIST – What do you think, Kevin? (1995, p. 388)

11. KEVIN – (Patronizingly.) **I’m not surprised that she perceived what happened like that.** But you have to understand some things. (p. 388)

Here, Sheri describes the violence that occurred. Next, the therapist gave Kevin room to talk about how Sheri described him. Kevin conceals the violence, obscures perpetrator responsibility and conceals the victim's resistance by saying that he's "not surprised that she perceived what happened like that". This utterance contains the negative embedded presupposition that Sheri is not correctly interpreting the situation and presents Kevin as needing to set the record straight.

12. THERAPIST – **OK**. (p. 388)

13. KEVIN – (Leaning toward the therapist.) You understand how tough it is to bust your head all day at work, try to buy nice things for the family, all the stress and garbage you have to put up with just to try and get ahead a little bit.

(Therapist looks intently at Kevin, but gives no response, only an indication that he is listening.) Anyway, when you come home and see that nothing has been done to keep the house nice, you just start wondering if it is worth it all. (p. 388-389)

The therapist's utterance, "Okay", in line 12 is a shift marker that implies the therapist understands that Kevin is going to tell him important information and may be indicative of agreement that Shari did not correctly interpreting the situation. According to the Interactive and Discursive View of Violence and Resistance, this was considered a missed opportunity. It would have been more clarifying for the therapist to have said, "How would you describe what you did to her?", which would not have implied agreement with the perpetrator's formulation that Sheri had incorrectly interpreted the situation. Kevin explains that he works hard all day, that he puts up with a lot and characterizes Sheri as lazy and not doing anything to help the family. Representing Sheri

as a lazy wife who does nothing to help the family allows Kevin to conceal Sheri's resistance and allows him to blame her for his frustration. This reformulates the problem to be Sheri because she is a lazy wife. By characterizing himself as a hard working husband who "tries to buy nice things for his family" and get ahead, Kevin conceals the fact that he abused her physically, or verbally. This allows him to avoid taking responsibility for the violence and to present his frustration with Sheri as reasonable. This utterance also contains the negative embedded presupposition that his violence against his wife was justified.

14. THERAPIST – Could I ask you a question? (p. 389)

15. KEVIN – Sure. (p. 389)

16. THERAPIST – When you felt that the house wasn't clean, did you call Sheri an "ungrateful bitch"? (p. 389)

The therapist's question, "when you felt that the house wasn't clean, did you call Sheri an "ungrateful bitch"?", exposes the violence by clarifying the fact that the Kevin has been verbally abusive to his wife by asking Kevin to admit whether or not he called his wife an "ungrateful bitch".

17. KEVIN – (Pauses.) **Don't you get angry sometimes?** I mean, just every once in a while you get just a little inappropriate? (p. 389)

18. THERAPIST – I don't call my wife a bitch, if that's what you're asking. (p. 389)

Kevin does not answer the question. Instead in line 17, he tries to cover his abusive actions by shifting the focus onto the therapist by asking, "Don't you get angry sometimes?". Shifting the focus to the therapist and answering a question with a question

allows Kevin to avoid admitting that he called his wife an “ungrateful bitch”. It also allows Kevin to attempt to excuse his actions and minimize their seriousness by suggesting that everybody behaves inappropriately sometimes. In line 18, the therapist shifts the focus back onto Kevin by saying, “I don’t call my wife a bitch, if that’s what you’re asking”. This clarifies perpetrator responsibility and establishes calling his wife “a bitch” and being violent towards her as both deliberate and unacceptable.

19. KEVIN – OK. OK. That was out of line. But I’d been working since seven that morning. **I was tired, and fact of the matter is the place looked like a dump.** (p. 389)

20. THERAPIST – So when you’ve been working hard you’re tired, you are more inclined to call your wife names, become physically abusive, and treat her as if she were a little child. **How would you describe yourself when you behave like that?** (p. 389)

While Kevin does admit that he was out of line calling Sheri an “ungrateful bitch”, he never directly admits to the violence. Kevin obscures responsibility for the violence by attempting to excuse his actions by saying that he had “been working since seven that morning” and that he was “tired” and that the “place looked like a dump”. He tries to present the violence as occurring because he was “tired” which conceals the deliberate nature of violence and the fact that he has behaved this way on more than one occasion. The utterance, “the place looked like a dump”, conceals Sheri’s resistance and blames her for precipitating the violence. In line 20, the therapist sums up what Kevin has said, namely, that when he is tired he becomes verbally and physically abusive to his wife. This exposes the violence and represents Kevin as the violent actor. The therapist’s

question, “how would you describe yourself when you behave like that?”, exposes the violence and gives agency to Kevin by presenting him as the violent actor. This utterance contests the perpetrator’s earlier formulations of the victim and the violence. It implies that this kind of behaviour is inappropriate and attempts to get the husband to admit to the violence.

21. KEVIN – I **don’t buy that at all**. (p. 389)

22. THERAPIST – Tell me how you see it. (p. 389)

Kevin again does not answer the therapist’s question. Instead, when he says that he does not “buy that at all”, he conceals the violence and obscures perpetrator responsibility by rejecting and denying the therapist’s suggestion that he has been verbally and physically abusive toward his wife. The therapist gives Kevin room to explain to him how he “sees it”.

23. KEVIN – There are times when someone has to **take charge** especially when Sheri falls short of what I would expect any responsible wife to do. And **I wasn’t abusive**. I **hardly touched her** at all when I suggested **she go into the bedroom and cool off** so we could talk about things in a rational manner. I was simply being direct and trying to short circuit a problem that could get much bigger than it did. (p. 389)

In line 23, Kevin conceals the violence and the deliberateness of his actions by blaming the victim. He obscures responsibility by representing himself as taking “charge” while blaming Sheri for not being a “responsible wife”. He conceals the violence by saying that he “wasn’t abusive”, that he “hardly touched her”. He conceals the violence by saying that he simply “suggested she go into the bedroom”. He presents himself as

“suggesting she go into the bedroom and cool off” so that they could “talk about things in a rational manner”. This utterance contains the negative embedded presupposition that the victim was the one who needed to calm down and presents her as the one with the problem. He also conceals the seriousness of the violence through the utterance, “I was simply being direct and trying to short circuit a problem that could get much bigger than it did”, which downplays the violence he perpetrated against his wife by implying that it could have been much worse.

24. SHERI – (Angry and frustrated.) That’s not it at all. You degrade me and treat me like I was a two-year old. You always do this – make me look like I’m an idiot and you’re in the right! (p. 389)

Sheri becomes angry and frustrated. She resists how Kevin has described the situation. She tells Kevin that he “degrades” her, treats her like “a two-year old”, makes her look like “an idiot” and presents himself as always “in the right”.

25. THERAPIST – **Is this the first time you’ve told Kevin** that that’s how you feel when he abuses you? Like a child that has been unjustly chastised? (p. 390)

26. SHERI – Well, not like I just did. Not as clear. I’m afraid I usually freak out or just break down and cry. (p. 390)

The therapist asks Sheri if this is the first time that she has told Kevin exactly how she feels when he “abuses” her and treats her like a child. This question contains the embedded presupposition that the therapist does not agree with Kevin’s formulations by characterizing his actions as abusive. This exposes the violence, presents Kevin as the violent actor. While this utterance is positive because it exposes the violence by connecting Kevin to the “abuse”, it also contains the negative embedded presupposition

that this is the first time that Sheri has really told Kevin that she does not like the way he treats her. This utterance suggests that, previously, Sheri has not resisted the abuse. This can be viewed as a movement towards making the problem one of communication instead of violence. Sheri resists this negative embedded presupposition by saying that in the past, she had told Kevin how she felt but, because she was “afraid”, she would usually would “freak out or just break down and cry”.

27. THERAPIST – Sounds to me then, that **this is the first time** you’ve risked telling Kevin just exactly how you feel. It must have been very difficult to say such an important thing; **something that we need to address**. But can I ask you a favor? I don’t want you to think that we are ignoring you, but could we keep on taking a look at Kevin for just a few more minutes and then get back to what you just said? (p. 390)

28. SHERI – You bet. (p. 390)

The therapist elucidates Sheri’s resistance by commending her for being able to tell Kevin how she feels even though it must have been difficult. The therapist’s utterance, “the first time you’ve risked telling Kevin”, exposes the violence by the use of the word, “risked”, which denotes that Sheri was reasonably afraid to tell Kevin how she felt. This utterance is also extremely problematic because despite the fact that Sheri has resisted the therapist’s notion that this is the first time that she has told Kevin to stop treating her like that, the therapist conceals the victim’s resistance by hanging onto the idea that this is the first time that she has resisted the abuse. The therapist’s utterance, “It must have been very difficult to say such an important thing; something that we need to address”, contains the negative embedded presupposition that the victim has not clearly

communicated to the perpetrator that she does not like the way he treats her. This reformulates the problem to be one of communication, namely, that Sheri has a problem communicating clearly to Kevin how she feels. This utterance conceals the violence and obscures perpetrator responsibility by suggesting that there is a problem with the way that Sheri tells him to stop hurting her. This pathologizes Sheri by suggesting that being “afraid”, “freak[ing] out”, or “break[ing] down and cry[ing]”, do not adequately convey to the perpetrator that the victim wants him to stop. The therapist ignores the fact that overt resistant is not always possible or safe. The therapist then goes on to say that they are going to focus on Kevin for a little while and then they will get back to what Sheri just said.

29. THERAPIST – Kevin. Look back at what you just said a moment ago. There seems to be a great big discrepancy between Sheri’s description of how you treated her and how you perceived it. Let me try to summarize what could be the most damaging things that Sheri remembers you doing and you tell me how you would describe someone who does those sorts of things. (p. 391)

30. KEVIN – (Impatiently and curtly.) Fine. (p. 391)

The therapist draws attention to the big discrepancy between Kevin’s version and Sheri’s version of events; he elucidates and honours Sheri’s resistance and contests blaming her for the violence by not going along with Kevin’s version. The therapist says that he will “summarize what could be the most damaging things that Sheri remembers you [him] doing” and then, asks Kevin to “describe someone who does those sorts of things”. Here, the therapist is trying to get Kevin to admit the seriousness of his actions and to accept responsibility for the violence. Making Kevin describe a person who does

those sorts of things helps expose the violence and clarifies Kevin's responsibility despite the fact that Kevin, throughout the interview thus far, has minimized the problem and avoided taking responsibility. Kevin is obviously annoyed by this task, but agrees.

31. THERAPIST – OK. You come home tired. The house isn't clean. You become angry and call your wife a bitch. You order her to dust the stereo cabinet for a second time. When she protests you physically force her into the bedroom, slam the door and tell her not to come out until she can be reasonable. How would you describe yourself for doing that? (p. 391)

32. KEVIN – **You're taking things out of context.** (p. 391)

The therapist describes the scenario previously described by Kevin, in which Kevin comes home from work, he's tired, and the house is a mess. He becomes angry, calls his wife names, orders her to clean up, and physically forces her into the bedroom, telling "her not to come out until she can be reasonable". This whole scenario forces Kevin to face his behaviour by exposing the violence and clarifying Kevin's responsibility for the violence; it also demonstrates agreement with Sheri's version of events. The therapist then asks Kevin, "How would you describe yourself for doing that?". Kevin again avoids answering the question. Instead, he argues that the therapist is "taking things out of context", as if examining these events in context would allow his violence against his wife to be constructed as reasonable.

33. THERAPIST – (Apologetically.) I know. And it really makes things sound bad saying it that way, but I'm wondering if there is a context in which it's appropriate to call your wife names and use physical force on her? (p. 391)

34. KEVIN – My hell, it’s . . . **it wasn’t that bad**, and **I resent you for making me look like a real SOB**. (p. 391)

The therapist agrees that maybe he is taking those particular events out of context but he challenges Kevin by asking, “if there is a context in which it’s appropriate to call your wife names and use physical force on her?”. This utterance implies that being violent towards one’s partner is never appropriate. This undermines Kevin’s previous excuses for why he behaved the way he did. Kevin becomes upset and continues to minimize the seriousness of the violence by saying, “it wasn’t that bad”. He says that he “resent[s]” the therapist for making him “look like a real SOB” which obscures perpetrator responsibility by ignoring the fact that it is his actions that made him look bad, not the therapist.

35. THERAPIST – I don’t mean to, Kevin. And this might be a good place to stop for a minute and take a look at what’s going on between us. How would you describe yourself in the last couple of seconds. How would you describe how you’ve been talking to me? (p. 391-392)

36. KEVIN – I’ve **disagreed** with what you’ve said but I’ve kept my cool. **I’ve been honest**. (p. 392)

The therapist denies that he is trying to make Kevin look like a “SOB”. He instead shifts the focus onto how Kevin is interacting with him and how Kevin has been talking to him. This question attempts to expose the fact that Kevin has been minimizing the seriousness of the violence and has avoided taking responsibility for his actions. Kevin presents himself as only having “disagreed” with the therapist but that he has “been honest”.

37. THERAPIST – How have you seen it, Sheri? (p. 392)

38. SHERI – He’s trying to make how he treats me look better than it is. And he’s doing the same thing to you that he does to me. (p. 392)

Here the therapist gives Sheri a chance to express how she feels Kevin has been behaving towards the therapist in the interview. Sheri says that Kevin is trying to minimize the seriousness of what happened by presenting his actions as reasonable.

39. KEVIN – **Don’t give me that . . .** (p. 392)

40. THERAPIST – I know this is hard, Kevin, but what Sheri has to say could be really important for us to hear. Would you be willing to let her finish? (p. 392)

Kevin conceals Sheri’s resistance by saying, “don’t give me that”. The therapist acknowledges that this is difficult for Kevin to hear but elucidates Sheri’s resistance by saying that “what Sheri has to say could be really important” for them to hear and asks that Kevin let her finish.

41. KEVIN – (Visibly angry.) Yeah, yeah. (p. 392)

42. THERAPIST – Say more, Sheri. (p. 392)

43. SHERI – He started getting huffy with you just like he does with me. Then, when you try to call him on it, he either gets this patronizing attitude and starts twisting things around or he gets mad and starts to throw things. Then, he turns around and tries to blame it on you. (p. 392)

Kevin is visibly angry now but agrees that he will let Sheri finish. The therapist asks Sheri to continue. Sheri says that Kevin gets “huffy”, and when “you try to call him on it, he either gets this patronizing attitude and starts twisting things around or he gets mad and starts to throw things”. Then he tries to blame his behaviour on someone else.

44. THERAPIST – So what has just happened here between Kevin and me is what happens to you and Kevin at home. (p. 392)

45. SHERI – That’s right. (p. 392)

46. KEVIN – (To therapist.) Wait a minute. What has “just happened here” between you and me? (p. 392)

47. THERAPIST – Do you really want to know? (p. 392)

The therapist sums up Sheri’s utterance by saying, “so what has just happened between Kevin and me is what happens to you and Kevin at home.” Sheri agrees. While this utterance is positive in the sense that it exposes the fact that Kevin tries to minimize the seriousness of the violence and avoids taking responsibility for his actions, it is also problematic because it conceals the seriousness of the violence by equating the violence Kevin perpetrates against Sheri with the way Kevin avoids answering the therapist’s questions. Kevin tries to play dumb by pretending that he does not know what “just happened here” between him and the therapist; this obscures perpetrator responsibility.

48. KEVIN – (Somewhat sarcastically.) Yeah, I really want to know. (p. 392)

49. THERAPIST – OK. But I need to ask you a question. How would you describe the tone of your voice you’ve been using talking to me for the past few minutes? (p. 392)

Kevin sarcastically says that he really wants to know. The therapist agrees but first asks how Kevin would describe the tone of voice he has used to talk to him for the past few minutes. This question implies that the Kevin is using a tone of voice that implies that he is getting upset because the therapist has said some things that Kevin does not like.

50. KEVIN – What? What has that got to do with anything? (p. 392)

51. THERAPIST – What are you doing right now? (p. 392)

52. KEVIN – What am I doing? (p. 392)

53. SHERI – (Interrupting.) You’re answering his questions with a question. So you’re not answering his questions. (p. 392)

54. THERAPIST – That’s what it looks like to me. It’s almost like we’re playing a game of tennis – I ask you a question and you hit it right back at me. I wonder what you’re thinking and feeling that stops you from having a meaningful discussion with me? (p. 392)

Kevin denies that his tone of voice has anything to do with the problem at hand.

The therapist calls Kevin on his obvious frustration by saying, “What are you doing right now?”. This implies that every time the therapist asks Kevin something he avoids answering the question but instead gets upset. Kevin continues to deny that he is doing anything. Sheri jumps in and says that he’s answering questions with questions in order to avoid answering the questions. The therapist compares their conversation to a game of tennis in which the therapist asks a question and Kevin “hit[s] it right back at” him, which really does not allow them to move forward. The therapist says that he wonders what Kevin is “thinking and feeling that stops you [him] from having a meaningful discussion”. This question contains an embedded presupposition that was coded as positive because it implies that Kevin is hiding something – namely concealing the violence and avoiding taking responsibility for the violence.

*Outcome**Diagnosis.*

No formal or informal diagnoses were made in this therapeutic interview.

Victim Safety.

The focus of this excerpt was on getting Kevin to take responsibility for the violence and as such victim safety was not discussed. This is not a full transcript; therefore, we can only hope that victim safety was addressed at some point in the transcript because the perpetrator was probably extremely agitated after this session and it would have been unwise to send the victim home with the perpetrator without addressing safety.

Four-Discursive-Operations.

Both the therapist and the perpetrator used the four-discursive-operations in this transcript, each in their first utterances of the therapeutic interview. However, the therapist was the first to use them. Twenty-four percent of the therapist's utterances and 63.2% of the perpetrator's utterances contained one or more of the four-discursive-operations (See Table #13 & 14). While the perpetrator utilized the four-discursive-operations throughout the transcript, the therapist, throughout most of the transcript, attempted to contest the perpetrator's excuses and justifications for his violent behaviour. For example, when the perpetrator attempted to present his wife (the victim) as precipitating the violence, presented his actions as reasonable given the situation, and shifted the focus away from his actions, the therapist shifted the focus back onto the perpetrator as the violent actor and formulated his actions as deliberate and inappropriate. While the therapist in this transcript attempted to use more clarifying representations of

the violence, according to the Interactive and Discursive View of Violence and Resistance, there were still some missed opportunities. For example, when the therapist referred to the abuse as a “fight”, when the therapist said that it was “OK with me [the therapist]” that the perpetrator would interrupt the victim’s description of the violence and become angry or, when the therapist reformulated the problem to be Sheri’s inability to clearly communicate to Kevin that she does not like it when he hurts her.

The four-discursive-operations were accomplished through negative reformulations and embedded presuppositions. Reformulations were used three times, twice by the therapist and once by the perpetrator. First, the therapist reformulated the problem to be that Sheri felt threatened by Kevin, not Kevin’s violent behaviour. This constructed the victim as the problem and concealed the degree to which the perpetrator’s violence was the problem to be addressed in therapy. Next, the perpetrator reformulated the problem to be that Sheri is lazy and ungrateful. This allowed him to represent his violent actions as provoked because he works hard all day and Sheri does nothing to help the family. Finally, the therapist reformulated Sheri as the problem when he reformulates the problem to be Sheri’s inability to clearly communicate to Kevin that she does not like it when he hurts her. This conceals the fact Sheri that had said she would “freak out or just break down and cry”, in response to the abuse. This allowed the therapist to construct Sheri as not having adequately resisted the abuse.

Negative embedded presuppositions were also used by the therapist. For example, the therapist’s question, “Is this the first time you’ve told Kevin that that’s how you feel when he abuses you?”, contains the negative embedded presupposition that this is the first time that Sheri has resisted the abuse. Despite the fact that Sheri resisted this

characterization, the therapist continued to suggest, in line 27, that she has a problem expressing herself and that is something that they “need to address”. This utterance contains the negative embedded presupposition that Sheri does not clearly communicate to Kevin to stop hurting her. These negative embedded presuppositions created the discursive space for the therapist to reformulate the problem to be one of communication. This pathologized Sheri for not telling Kevin “clearly” enough that she does not like it when he hurts her and ignores the fact the violence was perpetrated by Kevin.

Despite the therapist’s use of the four-discursive-operations in this transcript, 40% of the therapist’s utterances clarified the violence and responsibility for the violence. The therapist tried to allow both partners to express themselves without allowing the perpetrator’s characterization of himself as a hard working husband, or formulations of his wife as lazy, to distract from Kevin and what he has done as the focus of therapy. For example, when Kevin tried to redirect the focus of the interview by answering a question with a question, the therapist got right back on track by challenging Kevin on his excuses in a respectful manner. This is important, since going along with Kevin’s formulations of his wife as the problem or his excuse of being tired would have concealed the seriousness of the violence and would not have impressed upon the perpetrator the extent to which his actions were distasteful to the therapist. However, towards the end of the transcript, the therapist suggested that this was the first time that Sheri had told Kevin that she did not like it when he abused her, and then went on to construct the problem to be Sheri’s inability to clearly communicate with Kevin. This transcript is a good example of the fact that transcripts that contained the four-discursive-operations were not always entirely negative.

Table #13: Transcript #19 – Use of the Four-Discursive-Operations

	# of Therapist's utterances that contained one or more of the four-discursive-operations	# of Perpetrator's utterances that contained one or more of the four-discursive-operations
	6/25	12/19
Percentage:	24%	63.2%

Table #14: Transcript #19 – Use of Clarifying Representations

	# of Therapist's utterances that were viewed as clarifying
	10/25
Percentage:	40%

Results of All Five Transcripts that were Analyzed in Detailed

The four-discursive-operations were found to varying degrees in all five of the transcripts randomly selected for a detailed analysis. Overall, the four operations were used in 49.3% of the therapists' and perpetrators' talking turns. The therapists used the four-discursive-operations in 53.6% of their talking turns while perpetrators who were only present in three of the transcripts used the four-discursive-operations in 67.1% of their talking turns (See Tables #15 & 16). In the three transcripts in which perpetrators were present, therapists were found to initiate the use of the four-discursive-operations in two of the three transcripts. When therapists utilized the four-discursive-operations, this set the tone for the entire therapeutic interview and allowed perpetrators' excuses, justifications, and negative characterizations of their victims to be viewed as reasonable.

In the transcripts in which only the victim was present, victims often resisted therapists' use of the four-discursive-operations, although their resistance was usually ignored by the therapist. Despite therapists' use of the four-discursive-operations it is important to note that not all of the therapists' utterances were viewed as problematic according to the Interactive and Discursive View of Violence and Resistance.

The four-discursive-operations were often accomplished through negative reformulations and negative embedded presuppositions. Negative reformulations and negative embedded presuppositions are those that functioned to change a representation to a less accurate representation or to convey perspective that concealed the violence, diffused perpetrator responsibility, concealed victims' resistance or blamed and pathologized victims. McGee (1999) in his study found that reformulations and embedded presuppositions were common features of all therapeutic models. They can either function positively or negatively by implying capability and strength or by implying pathology and deficit. The detailed analysis of the five randomly selected transcripts found that the majority of reformulations and embedded presuppositions were those that functioned to conceal the violence, diffuse perpetrator responsibility, conceal victims' resistance and blame or pathologize victims.

Perpetrators' use of the four-discursive-operations in the transcripts, as expected, was consistent with other previous studies that have examined how perpetrators talk about their violence (O'Neill & Morgan, 2001a, 2001b; Scully & Marolla, 1999; Scully, 1990). Perpetrators typically used the four-discursive-operations in attempts to either excuse or justify their actions. They did this by shifting the responsibility onto the victim or external factors. On the other hand, the use of the four-discursive-operations by the

therapists in these transcripts, as evidenced above, allowed the perpetrators' excuses and justifications for the violence to be accepted as reasonable. This created the discursive space for the victims to become characterized as the problem and the issue of violence to be effectively ignored. It was also found that therapists were often the ones who initiated this kind of thinking by pathologizing and blaming the victim. For example, transcripts where the therapist categorized the wife as having the problem because she did not possess the "radar" to know when her husband was going to become violent, or when the therapist introduced the idea that the husband did not mean to be violent but that he had a faulty understanding of what would bring him and his wife closer.

The next chapter will further discuss the results of this study and the implications as they relate to future research and clinical practice.

Table #15: Transcripts Selected for Detailed Analysis

Transcript #	Year Published	Therapeutic Model Used	# of Therapist's utterances that contained one or more of the four-discursive-operations	% of Therapist's utterances that contained one or more of the four-discursive-operations	# of Perpetrator's utterances that contained one or more of the four-discursive-operations	% of Perpetrator's utterances that contained one or more of the four-discursive-operations
4	1989	A form of Clinical Interviewing	25/44	56.8%	N/A	N/A
6	1990	Family & Brief Therapy	34/53	64.2%	34/49	69.4%
7	2004	Discursive Practices	5/12	41.7%	N/A	N/A
14	1996	Solution-Focused Brief Therapy	11/17	64.7%	11/17	64.7%
19	1995	A form of psychotherapy that focused on self esteem	6/25	24%	12/19	63.16%

Table #16: Detailed Analysis Results

Total % of utterances that contained one or more of the four-discursive-operations	Total % of Therapists' talking turns that contained one or more of the four-discursive-operations	Total % of Perpetrators' talking turns that contained one or more of the four-discursive-operations (perpetrators were only present in 3 of the 5 transcripts selected for detailed analysis)
49.3%	53.6%	67.05%

Chapter Seven - Discussion

Discussion

This study built on previous studies that have demonstrated the importance of how we speak about violent acts (Bavelas & Coates, 2001; Bohner et al., 1998; Coates et al., 1994; Coates, 1997; Coates & Wade, 2004; O'Neill & Morgan, 2001a, 2001b; Scully, 1990; Scully & Marolla, 1999; West & Coates, 2003). For example, whether sexualized violence is portrayed as violent or sexual influences how individuals perceive the seriousness of the violence and to what degree they view the victim as responsible (McCaul et al., 1990). Judges who concealed the seriousness of violent crimes or who shifted the blame onto the victim in their court decisions were more likely to assign more lenient sentences (Bavelas & Coates, 2001; Coates et al., 1994; Coates, 1997; Coates & Wade, 2004; West & Coates, 2003). Men who were more aware of rape myths were more likely to admit that they would rape (Bohner et al., 1998). Perpetrators often appeal to societal myths to either justify or excuse their actions (Bohner et al., 1998; O'Neill & Morgan, 2001a, 2001b; Scully & Marolla, 1999; Scully, 1990). As well, the use of passive voice, as in "the woman got raped", diminishes the responsibility placed on the perpetrators and, instead, focuses on the victim's participation in their own victimization (Bohner, 2001). All of these studies demonstrated the importance of societal responses to violence, namely, that how we talk about violence and victims has a direct impact on how we perceive the seriousness of the violence, who is to blame and how we respond to victims. As such, an examination of talk about violence in therapy is an important extension of this field of research.

According to the Interactive and Discursive View of Violence and Resistance, the four-discursive-operations are so prevalent in everyday speech, that it cannot be said that they are the result of or solely utilized by one professional group. It also suggests that these discursive practices are common in our everyday talk, so much so, that they are not viewed as problematic until examined in detail (Coates & Wade, in press). As such, this study is not meant to be an attack on therapists or specific theoretical models. Instead, this is meant as an examination of problematic discursive practices in therapy, that are so commonly used in everyday speech that they are most often viewed as acceptable ways of talking about violence, victims and perpetrators. Because the therapeutic environment should be geared toward helping victims to deal with the violence perpetrated against them, how we talk about violence in therapy is extremely important. The Funk and Wagnalls Canadian College Dictionary (1989, 1493), defines a victim as “one who is killed, injured, or subjected to suffering”; and, as such, they are worthy of our sympathy. The goal of this study is to create awareness about discursive practices that can be used to further victimize victims by concealing the violence, obscuring perpetrator’s responsibility, concealing victims’ resistance, and blaming and pathologizing victims.

Part I of the analysis revealed that the four-discursive-operations were present in all 19 transcripts analyzed. While the four-discursive-operations were present in all of the transcripts analyzed, that does not all of the therapists’ utterances contained negative representations of the violence, the victim or the perpetrator. These results are consistent with the proponents of the Interactive and Discursive View of Violence and Resistance who suggest that the four-discursive-operations are so common that some may unconsciously misrepresent acts of violence and, as such, even therapists may also utilize

these inaccurate representations in their work with victims. Consistent with previous research on how perpetrators talk about their violence (O'Neil & Morgan, 2001a, 2001b; Scully & Marolla, 1999; Scully, 1990), perpetrators used the four-discursive-operations to excuse or justify their actions. Unlike therapists, perpetrators never utilized fully clarifying representations.

Analyses of multiple transcripts done by the same therapists revealed large inconsistencies in therapists' use of the four-discursive-operations in different transcripts. These findings are not surprising when therapy is viewed within the social view of language, which conceptualizes therapy as an interactive process between the therapist and the client. While clients should not be viewed as precipitating these negative representations, how a person responds or talks with different people in different situations varies. As such, it was viewed as reasonable that therapists' use of the four-discursive-operations would vary given the specific client-therapist interactions.

A detailed analysis of the randomly selected transcripts found that perpetrators were represented as not fully responsible for their negative actions, while victims were pathologized and blamed for precipitating the violence or for their acts of resistance. For example, in a transcript where the presenting issue was wife battering, a detailed examination revealed that the therapist shifted the focus onto how the victim reacted to her husband's violence; this reformulated the problem to be how she reacts to the violence instead of the violence itself. Next, she was pathologized for not possessing the "radar" to be able to tell when her husband was going to become violent. This is but one example of how the use of the four-discursive-operations allowed a perpetrator to avoid taking responsibility for the violence and a victim to become constructed as the problem.

Violent acts were also found to be represented as less serious or as mutual – even consensual acts. For example, both perpetrators and therapists often referred to wife battering as a “fight”. This misrepresents the violence as something that both parties are equally involved in, and denies the extent to which wife battering is abuse. Sexualized violence was also represented as consensual acts, such as, referring to rape as “sex” or “a sexual affair”. These terms (used by both the therapist and the perpetrator) in effect, served to misrepresent the true nature of the violence.

This study also found that therapists were often the ones who initiated these problematic lines of thinking. For example, in a transcript where the presenting issue was a 16 year-old boy who had molested his nine year-old sister for a year, the therapist began the therapy transcript by suggesting that if the perpetrator apologized to his sister, that all would be forgiven and that he could return to the family home. Later in the same transcript, the therapist suggested that the perpetrator get a job so that he could pay the victim. This utterance is extremely problematic as it conceals the seriousness of the trauma associated with sexualized violence by suggesting that money could make up for the violence perpetrated against the victim. Next, the therapist suggested that the entire family apologize to the victim for not being able to protect her. This utterance conceals the fact that the violence was the deliberate and unilateral act of the perpetrator; this conceals the violence and mutualizes perpetrator responsibility by constructing the entire family as responsible for the perpetrator’s violent actions. These ideas were clearly introduced by the therapist and set the tone for the entire therapeutic interview. From a social justice perspective, it is extremely problematic that therapists were found to initiate use of the four-discursive-operations so often. Perpetrators are often sent to therapists as

mandated clients to address their violent behaviour and, victims are sent to therapists to help them work through the trauma associated with violence. Therapy, in which therapists initiate blaming and pathologizing victims, allow perpetrators to avoid taking responsibility for their violent behaviour and serves to counteract the purpose of therapy.

This study has demonstrated the occurrence of the four-discursive-operations in some published therapy transcripts across different theoretical backgrounds and has shown that their usage significantly affected the movement of the therapeutic interviews. While these findings can not be generalized to the larger population of all therapy transcripts (due to the small sample size), they have some important implications for further research and clinical practice. The fact that the four-discursive-operations were used in some published therapy transcripts is, from a social justice perspective, extremely problematic because published transcripts are most often used as training tools and, as such, the occurrence of the four-discursive-operations may further perpetuate these discursive practices as acceptable ways to talk about acts of violence, perpetrators, and victims. The Interactional and Discursive View of Violence and Resistance embraces a human rights ethic that suggests that even if problematic treatment of a person only occurs once in a therapeutic interview, it is still a significant problem and must be addressed. This framework also contends that the use of the four-discursive-operations hinders effective interventions, whether therapeutic, legal, or otherwise, by employing inaccurate formulations of violent acts, perpetrators, and victims. According to this view, accounts of violence must take into consideration violence as unilateral, violence as a deliberate action, the ubiquity of resistance, misrepresentation, fitting words to deeds, and the four-discursive-operations.

Limitations and Implications for Further Research

This study revealed that the four-discursive-operations occurred in some published transcripts and demonstrated how their occurrence impacted the movement of the therapeutic interview. However, the small sample size made it impossible to argue that this study is representative of all therapy transcripts. Therefore, more research on a larger number of published transcripts is necessary to determine to what extent the four-discursive-operations occur in published therapy transcripts. Further research on unpublished transcripts is also needed to determine if the four-discursive-operations occur in unpublished transcripts, to what extent, in which therapeutic models they are most prevalent, and their overall impact on therapeutic interventions.

The Interactional and Discursive View of Violence and Resistance, is the framework from which Response-based therapies were created. Response-based therapies, as a means of intervention with both victims and perpetrators, are a relatively new development in the area of clinical practice (Wade, 2000; Coates & Wade, 2004; Riddley & Coates, 2003; Todd, 2002; Coates, Todd, Wade, 2003; Todd, Wade & Renoux, 2004). Currently, this framework for the prevention of and intervention in violence is being used by therapists, victim service workers, and police officers. However, as with many models of intervention with perpetrators and/or victims of violence, the effectiveness of this approach has not been assessed. As such, a comparison of therapy sessions that were done using the Response-Based model with those done using other models would be useful in allowing us to discover if the therapists using the Response-based model formulate the victim, the perpetrator, issues of responsibility, and accounts of causality, differently than therapists using different models.

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Appendix

System of Analysis**Identification**

- Identify transcripts that deal with the issue of violence.
- Line by line analysis: it is likely that almost every utterance will be relevant to analysis. However, if a specific section is irrelevant it will be omitted from the analysis.

Responses

1. Unilateral: sole agent (perpetrator)?
 - a. Yes → Go to next section (likely exposes violence)
 - b. No → Co-agent/action
 - i. With other perpetrators
 - ii. With Victim
 1. Yes → mutualizing: conceals violence, obscures perpetrator responsibility and conceals victim resistance
 2. No → omitted agent?
 - a. Yes → passive voice/nominally, obscures perpetrator responsibility, obscures victim resistance by using a structure that does not create space to talk about victim's resistance.
 - b. No → Cast as a non-action (eg. Internal state/mental state, his troubles, emotions)?
 - i. Yes → Conceal violence, obscures perpetrator responsibility and conceals victim resistance.
2. Is this description representing the action as a combination of joint and individual actions?
 - a. Yes → E.g. "he had sex with her against her will" Presents the perpetrator as engaging in a mutual action ("sex"), while also engaging in a unilateral violence actions ("against her will").
 - Victim is cast as causing the perpetrator to be violent when his violence is not self defense. This mutualizes the violence, conceals the degree of violence and obscures perpetrator responsibility.
 - Perpetrator sole agent and did this of his own volition?
 - a. Yes → Clarifying
 - b. No → Concealing violence, obscuring perpetrator responsibility and concealing victim resistance.

Description of Violence

1. Unilateral nature of violence described?
 - a. Yes → expose/clarify. . . Go to next section
 - b. No → violence cast as a non-violent action?
 - i. Yes → conceals violence
 - ii. No → violence cast as a minor act of violence
 1. Yes → minimizes – conceals violence
 2. No → magnitude and severity of violence clearly conveyed.
 - Violence cast as mutual → conceals violence.
 - Broad/global accounts typically help conceal violence. Whereas, contextualized detailed accounts expose violence and make room to discuss victim resistance.

Victim Blaming

- Use of pejorative terms
- Describing victim as a co-agent in the violence
- Describing victim as an initiator of mutual action
- Focus on the victim as the only agent of mutual action. Eg. “she had sex”
- Pathologize – victim cast as deficient and passive.
- Talk about victim as precipitating, provoking or deserving the violence perpetrated against them.
- Mental illness, deficiency and weakness of the victim that caused/contributed to the violence. Eg. “she sought out abusive relationships”

Responsibility

1. Own volition?
 - a. Yes → Clarifies violent acts
 - b. No → Externalizes – compelled to commit violent acts, overwhelmed by forces beyond their control. Lost control (Eg. Triggered, buttons pushed, lost control of temper)
2. Perpetrator described in positive glowing terms? Eg. “impeccable character”
 - a. Yes → Conceals violence and obscures perpetrator responsibility.
 - b. No → Clarifies violence and responsibility
3. Global/broad descriptions?
 - a. Yes → Can obscure perpetrator responsibility and conceal victim resistance
 - b. No → Previously established? (Eg. Apology paper (Trepper, 1986))
 1. Yes → previously discussed

2. No → If contextualized detail can help expose and clarify violence and responsibility.
 - Important to contextualize violence acts (who did what to whom and then what was done) in order to clarify responsibility for violence actions and to create space to talk about victim resistance.

Victim Resistance

1. Would structure create space for talk about resistance?
 - a. No → if talked about as mutual, or if there is no agent of violence (eg. “shot fired”) where we can not easily say how the victim resisted the actor.
2. Victim reformulated as maladaptive, deficient or inadequate.
3. Contextualized, micro-account?
 - a. No → Structure does not easily allow for description of victim resistance. If the event is decontextualized it makes it easy to pathologize victims’ responses to violence.
4. Time Frame of Resistance: If just discusses after the violent act it makes it easier to conceal victim resistance and blame the victim.
5. Restrictive Definition – Is this a reformulation of previous information?
 - a. If Yes → is it a positive or negative reformulation?
6. Are there any important embedded presuppositions?
 - a. If Yes → is it a positive or negative embedded presupposition?
 - i. Positive = Imply notions of capability, strength, choice and resistance
 - ii. Negative = Imply notions of passivity, deficiency and pathology.

Outcomes

1. Is safety of victim adequately addressed?
2. Are any diagnoses made?
 - a. How does the diagnosis represent the victim?
 - i. Passive, deficient
 1. Yes → mitigates perpetrator responsibility, conceals victims’ resistance and blames the victim.
 2. No → Represents the victim as capable
 - a. Yes → clarifies victims’ resistance and perpetrator’s responsibility.