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Gendered capital in psychotherapy: A thematic analysis of patients' experiences of the therapists' gender

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Abstract

Background: The impact of therapists' and patients' gender on therapy processes and outcomes remains a subject of intense debate in psychotherapy research.

Aims: This article explores the role of gender in psychotherapy from the patients' perspective.

Method: By conducting semi-structured interviews with 20 patients undergoing individual psychotherapy in private practices in Austria, the influence of the therapist's gender was investigated. The data collected were subjected to qualitative thematic analysis.

Findings: The authors adopted a Bourdieusian feminist perspective to interpret the results, revealing that patients perceived female psychotherapists as possessing unique resources not found in male therapists. These resources encompassed knowledge, skills, traits perceived as 'female', and shared body and life experiences. Referred to as 'female gender capital', these resources influenced the preferences of most female and one male patient, leading them to favour female psychotherapists.

Conclusion: Given the strong perceptions and preferences around gender observed in this study, gender identity and gendered practices should be critically reflected on by individual therapists as well as in psychotherapy training programmes.

KEYWORDS
gender, Pierre Bourdieu, psychotherapy, psychotherapy patients' experience, qualitative analysis

1 | INTRODUCTION

The influence of therapists' and patients' gender on psychotherapy processes and outcomes remains a subject of intense debate in research. Despite decades of investigation, the findings have been largely inconclusive (Schmalbach et al., 2022). Prior studies on this topic have predominantly used quantitative research designs, lacking adequate integration of the social theory (Schigl, 2018). Consequently, there is a lack of research that incorporates the lived subjective experiences of both patients and psychotherapists within their respective societal contexts.

1.1 | Psychotherapy research on gender

Research conclusions regarding the impact of the 'gender variable' in psychotherapy differ based on the specific aspects examined and the sample population. Some studies propose higher patient

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satisfaction when the therapist and patient share the same gender (Johnson & Caldwell, 2011; Schigl, 2014). A British online survey (Furnham & Swami, 2008) showed a preference for same-gender therapist–patient pairings. Female patients seemed to favour female therapists (Ilagan & Heatherington, 2021; Landes et al., 2013; Pikus & Heavey, 1996), while male respondents did not display a distinct gender preference (Pikus & Heavey, 1996; Seidler et al., 2022). Notably, two Australian surveys indicated that female and male patients were more likely to seek therapy (Black & Gringart, 2019) and to be satisfied (Seidler et al., 2022) when their therapist's gender matched their preference. This suggests that meeting patient preferences pertaining to the therapist's gender identity enhances therapy accessibility and patient satisfaction.

However, the majority of psychotherapy research indicates that the therapist's gender identity or patient–therapist gender match does not significantly affect therapeutic outcomes (Blow et al., 2008; Lambert, 2016; Ogrodniczuk & Staats, 2002; Wyl et al., 2021). In contrast, a German cross-sectional study (Schmalbach et al., 2022) suggests that both female and male patients' quality of life improves more when paired with female compared with male therapists. The authors suggest that female therapists' potential for greater empathy and responsiveness could positively influence psychotherapy outcomes, indicating a beneficial role of female identity and gendered practices in therapeutic results.

Some studies from the perspective of patients or external raters found that female and male therapists used different styles of therapy. Female therapists appeared more supportive, caring and emotion-focused, while male therapists seemed more confrontational, direct and problem-focused (Gehart & Lyle, 2001; Wyl et al., 2021). Interestingly, a randomised controlled trial study by Ogrodniczuk and Staats (2002) demonstrates that men improved more with a psychodynamic, confrontational form of therapy, whereas women gained more from supportive approaches. Therefore, a gendered therapy practice seems to shape the therapy outcome. Owen et al. (2009) introduced yet another facet of the effect of gender in therapy. According to the authors, ‘gender competence’ is a central predictor of therapy outcomes. They define gender competence as the psychotherapists' skill to accomplish a positive outcome in treatment with either female or male patients. Empirically, some therapists appeared to be better at treating male patients, and others seemed to be better at treating female patients.

Qualitative studies on gender relations from the perspective of psychotherapists argue that gender identities and gendered practices shape therapy processes. Assumed shared gender experiences between patients and therapists seemed to allow some topics to be more easily discussed, such as sexuality, gender identity, reproduction, corporeality, intimate relationships, and division of care and home work in the family (Schigl, 2019). In particular, in the female patient–female therapist dyad, Schigl (2019) highlights a common background of assumed shared gender experiences that allowed trust and solidarity to be established more easily. Moreover, the female therapists could be perceived as ‘good mothers’, friends and role models. Yet, according to the psychotherapists interviewed by Tolle and Stratkötter (1998), the therapists' gender identity could only be purposefully used as a therapeutic resource if therapists reflected on their gender identity. Gender sensitivity pertaining to oneself turns out to be an aspect of gender-competent psychotherapy practice.

Implications for practice and policy

- The findings of this study suggest that, for many patients, gender identity and the gendered practices of their psychotherapists are important. If given a choice, many female patients will likely prefer a female therapist. At the same time, a few patients, especially males, do not seem to prioritise the gender of their therapist. To determine patients' gender preferences, gender considerations should be explicitly addressed in assessment and therapy.
- To adequately address gender issues in therapy, psychotherapists need to be both gender-sensitive and gender-competent, and to be able to critically evaluate their own interactions with patients through a gender lens.
- Given the strong perceptions and preferences around gender observed in this study, ensuring a match between a patient's gender preference and their therapist may lead to a more effective and tailored psychotherapy experience.
- Therapist training and professional development programmes should include modules on gender dynamics, ensuring therapists are equipped to understand and navigate these issues effectively. Therefore, policymakers should consider making such training modules compulsory in psychotherapy education in countries where such modules are not yet part of the curriculum.

1.2 | A Bourdieusian feminist approach

While previous psychotherapy research on gender has yielded important insights, most psychotherapy studies lack a social theoretical perspective on gender (Schigl, 2018). This absence could contribute to the inconsistency in research findings, as research participants' subjectivity and context sensitivity are often overlooked. To integrate social theory into psychotherapy research, one could adopt a Bourdieusian feminist perspective. Pierre Bourdieu's approach, considered a form of ‘relational phenomenology’ (McNay, 2008), could provide a useful lens. This social theoretical perspective examines how we perceive and experience the world and how this experience is shaped by social structures and practices (Atkinson, 2020). This approach is well suited to integrating subjectivity and context in psychotherapy research.

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Bourdieu (2002) posits that gender relations are perpetuated through social practices within societal institutions, such as families, schools, states and, we propose, psychotherapy practices. These gendered and gendering social relations are internalised and normalised within a person's schemes of sensing, feeling, thinking and acting, forming what is known as a 'gendered habitus'. This gendered habitus, in turn, reinforces gendered distinctions between men and women (Bourdieu, 2002). Doblytė's (2020) study on mental health care in Spain illustrates how both health professionals and patients propagate these gendered distinctions. Male patients experiencing pain were viewed as strong and independent, while female patients were perceived as fatigued, vulnerable and needy.

From a Bourdieusian perspective, capital is one of the central theoretical notions to examine empirical phenomena (Bourdieu & Wacquant, 1992). Capitals are various forms of economic, cultural, social and symbolic resources, such as money, knowledge, social networks or good reputation (Bourdieu, 1986; Bourdieu & Wacquant, 1992). Depending on their possession of capital, social actors are more or less likely to accomplish their goals in a specific social field.

Bourdieusian feminists inaugurated and employed the notion of a gendered or gender capital (Huppatz, 2009; McCall, 1992; Wong, 2021). Gendered capital comprises traits, skills, and dispositions perceived and appraised as 'female', 'male' or, more recently, beyond the gender binary. These traits, skills and dispositions become a resource in a specific field. Huppatz (2009) shows the workings of female gender capital in the social work and nursing field in Australia. From the perspective of her interlocutors, access to the field of paid care work was easier for women. They argued that skills and traits perceived as feminine, such as empathy and being caring, were valued in the field. Moreover, clients and patients preferred working with women. Female managers rather employed women than men. However, Huppatz also highlights the limits of female gender capital in the field of care work. The highest-ranking positions in management, both in social work and nursing, were still occupied by men.

This Bourdieusian perspective can also be applied to psychotherapy. Most psychotherapy research conceptualises therapy as an interpersonal psychological treatment to aid patients with psychological disorders or issues (Wampold & Imel, 2015). However, this limited psychological view of psychotherapy omits its sociocultural context, as both psychotherapy researchers working within the contextual paradigm (Wampold & Imel, 2015) and anthropologists (Davies, 2019) point out. From a Bourdieusian feminist perspective, we may argue that psychotherapy is always a gendered and gendering sociocultural healing practice. In the field of dyadic psychotherapy, this practice is mainly shaped by two social actors, the therapist and the patient. However, therapists and patients bring to this encounter their respective gendered habitus and capital possessions, which were acquired in the broader societal context. The gendered habitus of both the therapist and the patient influences the therapeutical interactions and makes some developments more likely than others. We argue in this study that patients, through their gendered habitus, often appraise their therapists' skills, knowledge and traits as gendered. In this process, these resources might become gendered capital, which, in turn, may shape the psychotherapy process.

This study, therefore, uses the Bourdieusian feminist framework to delve into the role of gender identity and gendered practices in psychotherapy. It strives to shed light on patients' perceptions of their therapists' gender during therapy and how such perceptions could impact the therapy process.[i]

2 | MATERIALS AND METHODS

2.1 | Data collection

This study is a component of the Process and Outcome of Psychotherapy in Private Practice project, utilising a mixed-methods design for a holistic perspective (Schaffler et al., 2022, 2024). The analysis in this article is derived from qualitative data obtained from 20 semi-structured interviews with Austrian psychotherapy patients. A detailed interview guide was used, with questions on psychotherapy access; expectations and goals of therapy; the development of the psychotherapy process; the experience of the therapists' gender; helpful and challenging phases in treatment; teletherapy; and changes through therapy.

Psychotherapists in training, enrolled in psychotherapy study programmes with interviewer training, conducted problem-centred interviews (Witzel, 2000), face to face, in psychotherapy practices, private homes of patients, or public places during the summer and autumn of 2021. Each patient was interviewed once at some point during their psychotherapy. The interviews were recorded and had a duration between 39 and 110 min. Subsequently, the interviewers transcribed the interviews verbatim. Patients provided written informed consent to the study. Research ethics approval for the study was obtained from the Ethics Committee of Danube University Krems, Austria (EK GZ 28/2018–2021). The interviewers did not ask about personal secrets revealed in therapy, but rather focused on the therapy process. Moreover, the interviewers signed a confidentiality agreement prior to the interviews.

2.2 | Participants

The participants were patients receiving individual psychotherapy from licensed psychotherapists in private practice in Austria between the autumn of 2020 and the summer of 2021. They were recruited through their therapists. At the start of the study, therapists asked their next patient of legal age who started therapy to participate. While there was no preselection regarding diagnosis, patients in acute crises were excluded.

The research team implemented a process to inform patients via the REDcap (REDCap, 2024) platform and invited them to register for a face-to-face qualitative interview voluntarily. This invitation

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appeared on the online platform each time after they had submitted their session questionnaires for the quantitative research component of the larger research project. Only after the study participants actively provided their email addresses did the research team contact them to coordinate the interview process, location and date.

Upon agreeing to participate, interviewees were provided with the contact information of a designated interviewer. This measure ensured that the research participants had a contact person should any queries or concerns arise. Additionally, participants were given an extra set of study details, including the Principal Investigator's contact information. At this point, they reiterated their consent specifically for the qualitative component of the study, with a clear understanding that they retained the right to withdraw at any stage without any consequences.

Participants were not interviewed by their current psychotherapists. Instead, trained interviewers who were psychotherapists in training ('PsychotherapeutInnen in Ausbildung unter Supervision' in German)[ii] at this research stage conducted the interviews. If participants were distressed during or after the interview, these mental health professionals could provide immediate support (Smith & Nizza, 2022). Moreover, the interviewers maintained ongoing communication with seasoned psychotherapists and participated in regular discussions to exchange insights and experiences related to conducting the interviews. Due to the professional training of the interviewers and their institutional embeddedness, adverse effects on the mental health or the therapy process could be mitigated.

In the analysed sample, 15 persons identified themselves as women and five as men (Table 1). The patients' ages were between 20 and 59 years. All psychotherapy orientations (psychodynamic, humanistic, systemic and behavioural) were represented. Almost all female patients were seeing female therapists (ff). One female patient was being treated by a male therapist (fm). All besides one male patient (mm) was seeing a female therapist (mf). In Austria, women comprise two-thirds of patients and three-quarters of therapists in private practice (Schigl, 2019). This indicates that, in comparison with the overall demographics in psychotherapy, our sample somewhat underrepresents male patients and therapists. At this research project stage, we did not receive additional responses from male participants.

2.3 | Analysis

The analysis focuses on aspects of the interview transcripts which pertained to questions about gender relations in the interview guide:

- How do you perceive the gender of your therapist?
- How do you experience therapy with therapists of the same or a different gender?
- Are there specific themes or situations where you feel gender plays a significant role?

According to thematic analysis procedures (Braun & Clarke, 2006, 2019; Clarke & Braun, 2018), the interview transcripts were analysed with MaxQDA (VERBI Software, 2021), a qualitative data analysis software. Thematic analysis is a theoretically open yet systematic approach to qualitative data analysis, making it compatible with the Bourdieusian feminist approach outlined above. The 'themes' in this method signify distinctive patterns of meaning within the data (Clarke & Braun, 2018). These themes are not simply discovered in the data but actively constructed by researchers, intersecting data, theory and analytical competence (Braun & Clarke, 2019). The analysis was conducted following the six phases suggested by Braun and Clarke (2006): (1) data familiarisation, including memoing, (2) the development of initial codes, (3) generation of themes, (4) verifying relationship between themes and coded transcript extracts, (5) refining themes and, finally, (6) data presentation. The presentation of

TABLE 1 Sample characteristics of patients.

Variable	Description	Number of patients
Gender	Female	15
	Male	5
Therapy dyad	Female patient–female therapist (ff)	14
	Male patient–female therapist (mf)	4
	Female patient–male therapist (fm)	1
	Male patient–male therapist (mm)	1
Psychotherapy orientation	Psychodynamic	7
	Humanistic	9
	Systemic	3
	Behavioural	1
Age (Years)	20–29	7
	30–39	8
	40–49	3
	50–59	2

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the results follows the 'Scoring Scheme for Qualitative Thematic Analysis' developed by Rodgers and Cooper (2006). The scheme allows a systematic and consistent 'translation' of numbers to verbal descriptions. In doing so, the reader may get an impression of quantity without losing the characteristic complexity and plurality of qualitative data presentation (Table 2).

3 | RESULTS

Most female patients and one male patient preferred female therapists, at least pertaining to particular topics or some phases of their lives. This was a somewhat surprising empirical outcome because the participants were not explicitly asked about the preferred gender of their therapist. Based on the thematic analysis, the authors developed four themes with subthemes (see Table 3). All themes present possible reasons for patients' preference for female therapists. This preference was evident not just in the sheer frequency of its mention but also in the intensity and depth of the discussions surrounding it. Participants often spoke with conviction, drawing from personal experiences or deeply held beliefs, making it a prominent theme in the data. A complementary preference for male therapists was only very rudimentary articulated by the participants and did, therefore, not constitute a separate theme.

3.1 | Female therapists and female patients share body experiences: The physical body, the social body and the body in intimate relationships

Some female patients reported feeling more comfortable with and better understood by their female therapists because of the shared experiences of corporality and embodiment in individual, interpersonal and societal contexts. When participants referred to a shared experience of *the physical body*, they most frequently mentioned menstruation and circumstances around birth. For example, one patient (ff, 20–29) explained, 'Men can't really understand when emotions go haywire because of the period'. Another participant (ff, 30–39) mentioned the experience of postpartum depression: 'A man could never comprehend postpartum depression. I mean, in medical terms, how it is taught in books, of course. However, he will never have it, no matter if he is the father of one or two children'.

TABLE 2 Scoring scheme for qualitative thematic analysis adapted from Rodgers and Cooper (2006).

Verbal description	Number of patients
All	20
Nearly all	18–19
Most	12–17
Around half	10–11
Some	3–9
A couple	2
One	1

The subtheme of *the social body* is exemplified by a patient's (ff, 30–39) group therapy experience with a male and female therapist. She participated in the therapy group prior to her treatment with her current therapist in this study. She explained that women would understand each other better because of shared body and non-verbal communication. Regarding shared understanding among women, another interlocutor (ff, 20–29) referred explicitly to the role of the female body in society: 'I believe that she [her therapist] can perhaps better understand than a man the pressure to adhere to societal images or body images. She can perhaps better understand this because she probably knows that pressure as a woman herself'.

Lastly, in the subtheme of *the body in intimate relationships*, some patients reported that they could better talk about sexuality, intimacy and relationships with female therapists. One patient (ff, 20–29) pointed out, 'If I talked about intimate issues, I would feel more comfortable with a woman'. Another patient (ff, 30–39) explained similarly that she would feel inhibited from talking freely to a male therapist if she had to talk about sexuality.

3.2 | Female therapists and patients share mindsets: Female emotionality, women's communication style, the 'female psyche'

The subsequent theme encapsulates emotionality, communication styles and general psychological aspects that patients perceive as gendered. Some patients highlighted female therapists' enhanced empathy towards the specific experiences of *female emotionality*. One participant (ff, 30–39) articulated this phenomenon as follows:

> I would see it rather on an emotional level. … A woman understands better how to deal with a situation or how one feels and perceives it. I believe that this makes a difference. … The perspective of women is different from the one of a man.

How gender differences pertaining to emotionality and *communication styles* are articulated by patients is demonstrated by the following statement by an interlocutor (ff, 30–39) who shared her experiences with a former group therapy led by a female and male therapist:

> Women always said, 'What does he [the male therapist] wants from us. I don't understand his type of therapy' or 'how painstaking.' And the men said, 'I really liked this [the male therapist's approach],' 'really good,' or 'I really got it.' And with the women, it was the other way around. Then I realized that the emotional approach, of course not of everybody, but of many people, turns out to be different whether one is a man or a woman. Partially, how one perceives

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TABLE 3 Themes and subthemes.

Theme	Subthemes
Female therapists and female patients share body experiences	• Physical body • Social body • Body in intimate relationships
Female therapists and patients share mindsets	• Female emotionality • Women's communication style • The 'female psyche'
Female therapists understand women's social roles	• Women's roles in society • Motherhood
Female therapists contribute to women's identities	• Female perspectives • Women's role models

> and interprets may be a body posture, a gesture, the wording, or whatever. I believe it makes a great difference.

One male patient (mf, 30–39) said he would prefer a female therapist because of communication: 'I have the feeling that I can generally better communicate with women'. In contrast, a female patient (ff, 40–49) shared a negative experience with a former female therapist who might be interpreted as rejecting certain kinds of gender-stereotypical female emotionality: 'No, that doesn't work for me. I had the feeling that she [her former therapist] felt enormous pity for me. That was too much for me. I was thinking, "no! that feels weird."'

Besides communication and emotionality, some female patients introduced more general psychological differences between the genders. A participant (ff, 30–39) connected the '*female psyche*' with hormonal processes: 'The female psyche is different to the one of men. With women, the hormones are more connected with the psyche than with men. … It's easier if you have the same gender'.

3.3 | Female therapists understand women's social roles: Women's roles in society and motherhood

Another theme pertains to the female therapists' understanding of women's social roles. Interlocutors frequently used the term 'roles' to refer to diverse social identities that women are associated with, either by self or by external attribution. An essential aspect of these female roles was the presumed motherhood of the female therapist.

One patient (ff, 30–39) referred to *women's roles in society* and how her female therapist, rather than a man, could empathise with her: 'Generally, I have the feeling that she [her therapist] understands my role as women in society very well and also in work and, men perhaps would not. … However, that is my impression based on the men I know'. Another participant (ff, 20–29) also reported on gender-specific identities and how shared experiences of challenges create commonalities among women:

> Men have different social roles and expectations than women. Well, they can be feminine as well, but one expects socially other things from men than women. Of course, there are problems as well. One expects a man to have a six-pack, that he does sports, and so on, which is folly. However, as a woman, I feel better understood by a woman because we have more or less the same problems.

Similar statements were made by another patient (ff, 30–39), who additionally mentioned the typical socialisation 'in a patriarchal society', which would contribute to a mutual understanding of female therapists and patients. The potential critical stance of her female therapist towards patriarchal social structures was appreciated by another participant (ff, 20–29). She recounted seeing feminist magazines in the waiting room. While she did not discuss this in therapy, she interpreted the existence of the literature as a sign of a shared feminist attitude between the therapist and herself. Moreover, she believed that her therapist would better understand female social roles and the accompanying societal pressures on women.

Another patient (ff, 30–39) talked about female social roles and their adverse effects, which female therapists could better empathise with. She described her excessive demands regarding household chores and her limited career opportunities as a mother. Men could not comprehend these phenomena because they would not experience them first hand.

A particular aspect of women's social roles that patients discussed in the interview was *motherhood*, which patients ascribed to their therapists. An interlocutor (ff, 30–39) highlighted the significance of the motherhood of the therapist for her ability to empathise:

> These are things where a woman, a doctor, or a therapist, would more easily say, 'Yes, I understand you. I am also the mother of two children or one child, I understand, I can relate to this.' I would feel a little mocked if I talked with a man about this.

Another patient (ff, 30–39) did not even know whether her therapist was a mother, but she assumed that she was one because of 'the way she talks'. Therefore, she felt that her female therapist could better understand her than a male therapist.

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However, the mother identity of the therapist was not always seen as unambiguously positive. Replying to whether the fact that her therapist was a woman was somehow troublesome for the therapy, one participant (ff, 30–39) replied whilst smiling, 'Yes, she sometimes reminds me of my mother'.

3.4 | Female therapists contribute to women's identities: Female perspectives and women's role models

The last theme deals with the female therapists' contribution to women's identities by providing a female perspective or being a role model. One patient (ff, 40–49), for example, recounted the *female perspective* of her female therapist in contrast to her family situation, which was very much shaped by masculinity:

> I feel my therapist knows the context in which I live very well. She can empathize well with my situation. And … what I perhaps realized for the first time in therapy is this female gaze. At home, I am surrounded by three men. And yes, that is just different.

Consequently, the same participant (ff, 40–49) explained how therapy strengthened her female identity:

> There exists a male perspective and a female perspective. I oppose thinking only in terms of stereotypes; however, in some areas, it is like that. And I believe being supported … in my female perspective, was good. That this is not my imagination, but my perception is accurate. … It makes sense … my uneasiness with some things. Yes, that this is justified from a female perspective.

Another subtheme concerns the function of the female therapist as a *women's role model*. One patient (ff, 20–29) reported the existence of crucial male attachment figures and the lack of women in that regard in her life. She added that her female therapist could be a female role model. In a similar vein, another participant (ff, 30–39) detailed her preference for a female therapist:

> I believe I intentionally chose a woman [as a therapist], perhaps because I do not have such a great image of my mother. And I also fear that if I have children myself one day, I might become the same [as my mother] because I don't know it differently. I grew up like that. That's the role model of a mother that I know.

Furthermore, she explained that she knew that her female therapist had a daughter, and she could learn a different way of being a mother from her.

3.5 | On the lack of male gender capital

A couple of male patients reported feeling more comfortable discussing sex with therapists of the same gender. One participant (mf, 30–39) in therapy with a female therapist reported feeling more comfortable talking with his former male therapist about sexuality and sexual transgressions. Another male patient (mf, 40–49) shared that he found his former younger female therapist attractive. He, therefore, felt insecure when talking about his sexuality with her. A couple of other male interlocutors (mf, 30–39; mm, 50–59) generally considered the gender of their therapists as secondary. Instead, feeling trust and safety with the therapist was most relevant (mm, 50–59), regardless of gender identity. In sum, among the male patients, there were no pronounced general tendencies regarding a preference for the therapists' gender.

A couple of female patients who generally preferred female therapists would have considered working with male therapists if they possessed specific characteristics. One participant (ff, 20–29) would not have seen an older male therapist but would have accepted a younger one. Another female patient (ff, 20–29) would have sought therapy with a person of an LGBTIQA* background, 'with heterosexual [men] rather not … However, with a gay or a trans man, it would be okay, I believe'.

One female patient (fm, 20–29) mentioned the fatherly role of her male therapist. With her father, she had a problematic relationship. In contrast, she perceived her therapist as a 'good father'. This triggered various feelings in her, from jealousy and envy to longing. Another female participant (ff, 40–49) introduced a different facet opposing stereotypical reductions. She described the motherly nature of her female therapists but added, 'that men can also be … motherly … sometimes more than women'.

While these last statements indicate that male therapists could possess gendered forms of capital, overall, the data did not provide substantial evidence to support the notion of a distinct male gender capital.

4 | DISCUSSION

The present study indicates that patients receiving individual psychotherapy by licensed psychotherapists in Austria perceive female psychotherapists as possessing distinct 'resources' unavailable to male counterparts. They see female therapists' gender identity and gendered practices as assets that positively influence the therapy process. Patients attributed specific knowledge, skills, and traits to their female therapists and assumed shared life and body experiences. From a Bourdieusian feminist viewpoint, we interpret these resources as a form of 'female gender capital'. This gendered capital that female psychotherapists possess appeared to shape the decision of most female patients in this study to prefer female over male psychotherapists, while many male patients did not articulate clear gender preferences.

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Female patients, for example, mentioned the tacit knowledge of female therapists on women's roles in society and how they could, therefore, better empathise with women's burdens pertaining to work and motherhood. Using a Bourdieusian feminist framework, we propose that the combination of these attributes, as perceived by patients, could be conceptualised as female gender capital in the therapeutic context. This finding aligns with previous research indicating a gendered approach of female therapists, which appears to be more supportive, caring and emotion-focused (Gehart & Lyle, 2001; Wyl et al., 2021).

Most female patients in this study perceived shared bodily and life experiences—a gendered habitus—with their female therapists. Female participants pointed to similarities between therapists and themselves when they recounted the common effects of hormonal states on the psyche and mutual suffering under patriarchal societal structures. This increased comfort when discussing personal and societal issues due to a perceived empathetic understanding of female therapists, mirroring findings from other qualitative studies (Schigl, 2019; Tolle & Stratkötter, 1998).

At the same time, patients' statements indicated that they subjectively benefited more from female therapists. For example, a female participant who lived in a masculine-shaped household with a husband and two sons highlighted how her therapist's 'female gaze' strengthened her own female perspective. Another female patient, for instance, explained that her female therapist was a role model for her to become a better mother. Our findings resonate with studies suggesting that female therapists' empathy and responsiveness could enhance their effectiveness overall (Schmalbach et al., 2022) and that a female-gendered psychotherapy style could be more effective for female patients (Ogrodniczuk & Staats, 2002). Our results partially align with studies demonstrating heightened patient satisfaction when the therapist shares the same gender with the patient (Johnson & Caldwell, 2011; Schigl, 2014). In our study, this finding mainly applies to the female patient–female therapist dyad.

In empirically supported theoretical terms, the gendered capital and habitus led most female and one male patient in this study to favour female therapists. This trend aligns with prior studies (Landes et al., 2013; Pikus & Heavey, 1996). Additionally, other studies have demonstrated that if men had a gender preference, they tended to favour female therapists (Pikus & Heavey, 1996; Seidler et al., 2022). In contrast, neither male nor female patients provided evidence of a complementary male gender capital in the same capacity. One female patient perceived her male therapist as a 'good father', and a couple of male patients reported feeling more at ease discussing sexuality with male therapists. Overall, the male participants did not have a pronounced preference for either male or female therapists. This correlates with studies suggesting most male patients do not have a gender preference in therapy (Pikus & Heavey, 1996; Seidler et al., 2022). Prior research has indicated that a male-gendered therapy approach that was more confrontational, direct and problem-focused might lead to better outcomes for male patients (Ogrodniczuk & Staats, 2002; Wyl et al., 2021). Therefore, future research needs to include more male participants to determine whether male therapists also possess gendered male capital.

Adopting a Bourdieusian feminist perspective prompts the question of how therapists are impacted by their gendered capital within the specific field of Austrian psychotherapy where this study was conducted. In Austria, women comprise three-quarters of therapists and two-thirds of patients in private practice (Schigl, 2019), indicating a substantial prevalence of female gender capital in psychotherapy. This dynamic bears structural significance, although individual female therapists may not reap significant benefits due to the oversupply of female gender capital, a conclusion echoed in a parallel study on the paid care work field in Australia (Huppatz, 2009). That is, while female patients may benefit from accessibility to and higher satisfaction with therapy, female therapists will not necessarily be able to transform their female gender capital into economic or symbolic capital by having more patients in their practice or obtaining higher positions in professional bodies, for example. Future studies could explore therapists' perspectives on their gendered capital and the effects of the dynamics of the wider psychotherapy field in Austria on the significance and value of gendered capital.

Some of the workings of female gender capital and habitus cannot be captured by a mere focus on outcome, which most psychotherapy research scrutinises. A subjective and context-sensitive perspective on psychotherapy is essential. Here, the feminist magazines that one female patient observed in her therapist's waiting room might turn out to be an aspect of a female gender capital, making some therapy developments more likely than others. This study is an initial exploration in this direction. In doing so, the authors extend an invitation to psychotherapy research to include more qualitative methods and social theory to gain a more nuanced and complex understanding of the significance of gender in psychotherapy.

5 | LIMITATIONS AND IMPLICATIONS

Several limitations must be kept in mind when interpreting these results. First, there were only a few male therapists in the sample analysed, which limits the generalisability of the findings. Second, each patient was only interviewed once, and the interview timing (beginning, process and near the end of therapy) might influence the results. The effects and value of female gender capital may change across the treatment process. Female patients tend to have a more trusting and supportive relationship with their female therapists, which may promote satisfaction with therapy and idealisation of their therapist in the initial phase of therapy. In later stages of the treatment, patients may devaluate their therapist. A 'good mother' might then be viewed as a 'bad mother'. Towards the end of therapy, the therapist's image should be differentiated and less idealised. Third, patients would have provided more answers about real-life experiences with female and male therapists if they had psychotherapy with both female and male therapists. The naturalistic study design, however, did not allow for assigning patients to female or

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male therapists. Fourth, clients have selected their therapists in private practice. Their choice is presumably shaped by gender and, therefore, influences the results of this study. Future studies could include research participants from outside the private sector who might not be able to choose their therapists to mitigate this effect on the findings.

Finally, we would like to highlight some implications of our findings for the practice of psychotherapy. For many patients, gender identity and the gendered practices of their psychotherapists are essential. Many female patients will likely prefer a female therapist if given a choice. At the same time, a few patients, especially males, do not seem to prioritise the gender of their therapist. To determine patients' gender preferences, gender considerations should be explicitly addressed in assessment and therapy. This necessitates psychotherapists who are both gender-sensitive and gender-competent, and who critically evaluate their own interactions with patients through a gender lens. Given the strong perceptions and preferences around gender observed in this study, therapist training and professional development programmes should include modules on gender dynamics, ensuring therapists are equipped to understand and navigate these issues effectively. Therefore, policymakers should consider making such training modules compulsory in psychotherapy education. Ultimately, ensuring a match between a patient's gender preference and their therapist may lead to a more effective and tailored psychotherapy experience.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data are available upon reasonable request.

PATIENT CONSENT

Patients provided written informed consent. Research ethics approval for the study was obtained from the Ethics Committee of Danube University Krems, Austria (EK GZ 28/2018–2021).

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ENDNOTES

[i] The research presented in this article builds on as well as extends and refines previous work by one of the authors in Schweitzer (2022).

[ii] Psychotherapists in training (‘PsychotherapeutInnen in Ausbildung unter Supervision’ in German) are in the final phase of their professional training in Austria. They are allowed to independently practise psychotherapy under continuous supervision by experienced therapists according to Austrian law.

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