
An Exploration of Transference Issues in
Working Psychotherapeutically with Couples
Presenting with Intimate Partner Violence.

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Abstract

This research utilised psychoanalytical and psychodynamic perspectives to explore transference issues when working psychotherapeutically with couples presenting with intimate partner violence (IPV). Five separate semi-structured interviews were conducted with three male and two female participants who are practising and accredited therapists from diverse psychotherapeutic orientations. Interview transcripts were analysed using qualitative thematic analysis. Three superordinate themes emerged, the findings of which highlight the importance of the therapist maintaining an awareness of how their relationship experiences, and personal belief regarding gender and IPV may influence the treatment process through the processes of transference and countertransference. The results revealed conflicting views regarding screening, assessment and safety procedures. The findings may pose important implications for training and supervision, as well as the treatment of IPV in individual or couple work.

Chapter I Introduction

Strauss (1999) highlighted the uncertainty and confusion associated with choosing the appropriate terminology to discuss violence between partners, and referred to terms including wife beating, domestic abuse, intimate partner violence and partner abuse. It should be noted, that while the initial intention was to include the phraseology “Domestic Violence”, current international research now utilises the terminology “Intimate Partner Violence”. This current research employs the latter term to reflect such recent developments.

Intimate Partner Violence (IPV) has been an issue in Ireland for a considerable amount of time. In 2011, it was recognised with the establishment of Cosc, the national agency for domestic, sexual and gender-based violence in Ireland, which reflects a governmental response to tackle problems of domestic and sexual violence. This agency is governed by the Department of Justice, Equality and Law Reform, representing a major step towards addressing the problem of domestic violence in Ireland. IPV can be inflicted on men by women, or in same-sex relationships. However, the most common occurrence is abuse of women by men. According to Amen, which is a support service for males, 15% of women (approximately one in seven) have experienced severe abuse, of a physical, emotional and/or sexual nature at some point during their lives. From a male’s perspective, the rate decreases to 6% (one in 16). According to the report on the National Study of Domestic Abuse conducted by the National Crime Council and ERSI in 2005, the data suggested that an average of 213,000 women and 88,000 men in Ireland have experienced abuse at some stage in their lives (Watson, 2005). This data suggested that while women are at a higher risk, IPV also affects a significant amount of men. Women’s Aid National Freephone reported 17,855 cases disclosing incidents of IPV in 2013, citing 11,756 incidents of emotional abuse, 1,813 of financial abuse, 3,711 of physical abuse,

and 575 incidents of sexual abuse which included 201 cases of rape. Thus, between 2012 and 2013, there was a 52.3% reported increase in incidents of IPV. (Domestic Abuse of Men and Women in Ireland: Report on the National Study of Domestic Abuse, National Crime Council and ERSI, 2005).

The Marriage and Relationship Counselling Service Report (2004), based on a survey of 160 couples, found that mutual violence accounted for 33% of cases, female perpetrated violence accounted for 37%, and male perpetrated violence accounted for 26%, where there was domestic violence (McKeown, Haase, & Pratschke, 2004). Trinity College, Dublin conducted a study for the European Journal of General Practice (2006), of patients attending their family doctors. The findings revealed that 52 % of men and 43% of women in this setting experienced domestic violence. (Domestic Abuse of Men and Women in Ireland, 2005). Organisations such as Women's Aid, Safe Ireland, Amen, Rape Crisis Ireland, and Move are a response to the problem of IPV in Ireland, offering support, awareness and protection to those experiencing abuse. When addressing IPV in today's context, it is important to be open and aware of discriminatory factors, such as gender.

Description of intimate partner violence

Intimate partner violence is a pattern of behaviour used by one person to control another, and involves physical and/or psychological violence/abuse. The term IPV is used to describe many types of abuse, including physical, sexual, psychological harm, threat or force against a current or former person or spouse and does not necessarily include sexual contact. IPV affects all nationalities, genders, ages and educational levels, and can occur in all types of relationships,

even after the relationship has terminated. IPV exists along a continuum and can vary from an isolated episode to ongoing abuse, and can involve, emotional, economic, verbal aggression, bullying, control, power, stalking, grooming, and harming of property. Gottman, et al., 1995; Holtzworth-Munroe and Stuart (1994), and Tweed and Dutton (1998) suggested that IPV is more complex than originally assumed and distinguished two types of abuse, namely, situational abuse, which is defined as mutual low-level violence such as pushing and shoving, and characterological abuse, which describes severe violence undertaken as a means of inducing fear and control. The primary goal of such research was to evaluate an effective screening process when working with situationally violent couples, non-violent couples and characterologically violent couples in order to assess the suitability of conjoint treatment (Friend, Cleary Bradley, Thatcher, and Gottman, 2011). However, additional research is required to further explore situationally and characterologically violent couples, and particularly to examine safe modes of working with couples who present with cases of IPV.

Implications for therapists

In clinical practice, therapists are presented with an array of different circumstances and may themselves be particularly vulnerable when faced with challenging issues such as IPV. Importantly, Brosi and Carolan, (2006) highlighted the need for therapists to be attuned to their own reactions and how such issues may influence whether the therapist either successfully recognises or neglects recognition of IPV. In discussing the diverse sets of issues presented to therapists in the clinical setting, Brosi and Carolan (2006), explicated how therapists may be vulnerable to their own reactions when presented with controversial cases such as IPV. According to (Goldner, Penn, and Sheinberg, 1990) and Register (1993), partner abuse evokes strong emotional feelings in the therapist but little is known about how family of origin, or

more critically, how the therapist's family of origin, may impact upon therapy, the therapeutic relationship, or the therapeutic treatment outcome. Such research furthermore highlighted the risk that countertransferential reactions in cases of IPV may be largely neglected and not adequately addressed, as suggested by Brosi and Carolan (2006).

Lawson, Kellam, Quinn and Malnar (2012) explained how IPV has a substantial and negative impact on victims, children who witness IPV, and perpetrators. Exploring modes of screening and assessment may highlight any trends or gaps in current clinical practice. Further examination may highlight factors that may be inadvertently overlooked should the psychotherapist lack a thorough understanding of IPV, and illuminate the impact of transferential issues that may operate at the level of the therapist's family of origin, pre-existing beliefs, values and judgements. These issues pose critical implications not only for screening and assessment, but for training, supervision, and treatment outcomes.

Current treatment has proved only marginally effective in preventing or minimising IPV by men (Lawson et al., 2012). Recent research (Lawson et al., 2012) has largely focused on the evaluation of different treatment approaches including the feminist sociocultural and cognitive behavioural therapy (CBT) approaches. While the former has been criticised for failing to acknowledge the therapeutic alliance, personality factors, and the tendency to focus on patriarchy as the cause of IPV, CBT has been viewed as failing to attend to motivational issues in the treatment of IPV. Furthermore, previous research has primarily examined IPV within the context of male perpetrators (Lawson et al., 2012), whereas recent studies have begun to acknowledge how IPV may be perpetrated by both genders. Specific exploration of more

complex transference issues that arise in difficult cases of IPV in couple therapy may offer valuable insight and awareness in terms of this tendency towards gender bias.

Additionally, Brosi and Carolan (2006) explained how partner abuse is rarely disclosed by couples in the beginning of therapy as the presenting problem. Given the rate of IPV and the manner in which this issue is presented in therapy, many therapists may tend to focus on the couple's presenting issues, and thus fail to recognise partner abuse. Thus, while research has examined IPV through examination of which psychotherapeutic and psychological frameworks and therapies may effectively treat IPV, additional research is required to explore how the therapists' "ecosystemic influences", such as the therapist's clinical experiences, family of origin experiences and the therapist's personal belief systems, may influence how the therapist approaches partner abuse in the therapeutic setting, as suggested by Brosi and Carolan (2006).

While such considerations present important implications for clinical training and practice, exploration of transference issues is necessary to further examine how psychotherapists manage their internal process and personal issues, as well as how these issues may influence whether the therapist either successfully recognises or neglects recognition of IPV. Importantly, Brosi and Carolan (2006) highlighted the importance of considering the influence of the therapist's personal values and belief systems, not just within specific instances of IPV, but within general psychotherapeutic treatment.

Aims of current research

This current research will examine IPV from the standpoint of psychoanalytical and psychodynamic approaches, and will provide a forum within which to examine how transference and countertransference may operate within the therapist-couple relationship in cases of IPV, and furthermore influence treatment outcomes. This research aims to highlight important considerations to support methods, enhance standards, and identify important thought-provoking themes and questions that will broaden the understanding of how IPV is managed in couple therapy. This research aims to place specific emphasis on the role of the therapist and how the therapist's personal process presents particular transference issues that require management in cases of IPV in couple therapy. In particular, this research will examine how transference factors, family of origin, and the therapist's pre-existing belief systems regarding IPV may inadvertently cause the therapist to neglect recognition of IPV, or impact upon their management of IPV throughout couple therapy. This research will examine how transference and IPV operates in couple therapy and how the therapist manages transference in the work. This study aims to identify and examine challenges and assumptions arising from this research, and to consider the history of transference in relation to IPV and its emergence into the field of psychotherapy. This research will explore current frameworks that are adopted to address IPV and transference, identify areas of neglect, and critically consider the impact of the therapist's personal process and values system regarding IPV. This study will explore the transference role that such factors play in the screening and treatment process.

The research question is "an exploration of transference issues in working psychotherapeutically with couples presenting with intimate partner violence".

Chapter II Literature review

This chapter critically reviews empirical research from the perspective of transference and countertransference, focusing on theoretical material that examines the therapist's history from the point of view of their family of origin and how these early experiences may impact the therapeutic process when working with IPV in couple therapy. Emphasis is placed on patterns that have arisen with transference and countertransference when working with intimate partner abuse. This research will specifically address the ways in which transference issues are recognised from an emotional and psychological perspective, and how therapists work with these experiences in the therapeutic process when presented with IPV.

The role of transference and countertransference

Falchi and Nawal (2009) stated that transference and countertransference has been important to many psychotherapists in various modalities, has different meanings and interpretations depending on orientation, and has been a controversial debate amongst different schools of thought. Research (Hill, Nutt-Williams, Heaton, Thompson and Rhodes, 1996; Gelso, Kivlighan, Wine, Jones and Friedman, 1997; Gelso and Hayes, 1998) has explored the concepts of transference and countertransference in psychotherapy, advocating that the therapeutic relationship is the most important factor to elicit change and influence outcomes in all treatment modalities. Therefore, exploring the issue of transference and countertransference is fundamental in developing a good working alliance (Marmarosh et al., 2009). According to Gelso and Hayes (1998), research data supports the theory that both psychoanalytic and non-psychoanalytic therapists use transference as a tool to achieve positive therapeutic outcomes (Schaeffer, 2007, p. 3).

Originally derived from Sigmund Freud (1907), the term transference has been used inconsistently and is difficult to define. Freud defined transference as an unconscious displacement of feelings, sensations and thoughts about, or towards, a person in the client's life which belongs to their earlier life, and becomes projected onto the therapist. The client's unconscious displacement of phenomena that has been repressed in the unconscious may be resolved through the therapeutic relationship (Schaeffer, 2007 p.4). Comparable to transference, countertransference was introduced by Freud (1910) and has diverse meanings and understandings. Countertransference (Freud, 1912) was viewed as a hindrance to analysis, an interference to the freedom of the analyst's mind. Schaeffer (2007) defined countertransference as a construct, representing the therapist's unconscious response to a client's material that surfaces and relates to their early unresolved relationships, and is transferred to the client. Schaeffer (2007) likened countertransference to a process, whereby classical countertransference constitutes a client's transference material that is communicated through the unconscious mind of the therapist, and includes feelings and attitudes that are connected to their earlier life. As cited in Schaeffer (2007), Olnick, (1969) posited that the implicit neuroscientific processes of the therapist's right brain communication receptors would hopefully attune with the client's right brain communications, and communication represented processes that are being worked through. As Schaeffer noted, the ideas of transference and countertransference have been developed since Freud's early concept.

Psychoanalysis may be likened to psychodynamics and object relations theory, and contemporary theorists such as Winnicott (1949) and Heimann (1950). Indeed, the Kleinian (1946) concept of "projective identification" may be equated with transference. Furthermore, Bateman and Holmes (1995) described projective identification as the patient's unconscious projection of denied aspects of the self onto the analyst who may unconsciously begin to behave

or identify with the patient. As outlined by Falchi and Nawal (2009), the former is viewed as transference, and the latter as countertransference. Rusczyński (1992) elaborated on marital countertransference, and witnessed an acting out of this process with colleagues and co-workers. Rusczyński (1992) drew particular attention to co-therapists working together and holding the countertransference unconsciously through projective identification, and suggested it is “put there” and needs to be made sense of. The fundamental rationale suggests that some of the stirred up feelings in the psychotherapist have been projected onto her/him as a way of communicating the client’s internal world (Clulow, 2001). The task of the psychotherapist is to unconsciously connect this communication and offer it back to the couple, where appropriate. In the absence of this, there is a possibility that material may become acted out, and that ultimately, the psychotherapist is not doing the task of therapy (Rusczyński, 1993, p. 12).

In utilising in-depth semi-structured interviews that focused on relationship therapy, Brosi and Carolan (2006) conducted a qualitative research study of seven trainee couple therapists and explored “ecosystemic” product reactions of the therapist’s environment, including both social and family interactions. Brosi and Carolan (2006) stated that the National Institute of Justice (2000) reported that 25% of all intimate couples engage in partner violence at some stage in their relationship. Of couples who seek therapy, research (Cascardi, Langhinrichsen and Vivian, 1992; Vivian and Malone 1992) suggested that between 54% and 62% of couples reported incidents of IPV within their relationship and that IPV is rarely disclosed as the presenting problem, and is actually uncovered as the work progresses (Brosi and Carolan, 2006; Holtzworth-Munroe, Meehan, Rehman and Marshall, 2002). Given these facts, IPV may not be identified and the therapist is at risk of focusing on the presenting issue.

Therapists are presented with various challenges in therapy and a wide range of issues. When working with IPV in therapy, it is likely that therapists are vulnerable to their own reactions and responses when dealing with controversial topics such as IPV. Therapists come from all walks of life and bring with them their assumptions, beliefs and values regarding life events.

Brosi and Carolan (2006) investigated the idea that countertransference reactions are “ecosystemic” products of the therapist’s environment, and such influences include both social and family interactions. It is within these environments that the values and belief systems of the therapist are continually challenged, and prove critical in considering the origin of clinical reactivity. Brosi and Carolan (2006) identified family of origin experiences, clinical experiences, and the therapist’s personal processes as factors affecting beliefs, values and clinical reactivity. Such factors were considered fundamental when working with couples in cases of IPV and may affect the treatment outcome. According to Brosi and Carolan (2006), IPV will likely evoke strong emotional feelings in the therapist, such as anger, frustration and fear. Kernberg (1965) explained that the therapist’s personal conscious or unconscious responses, as well as their immediate or delayed reactions, are equally important to the treatment process and to the work with clients. Countertransference can interfere with working with clients around abuse and can affect the clinician’s ability to be the objective person in the therapeutic process (Brosi and Carolan, 2006).

Challenges in the therapeutic process

There is a great deal of information available detailing the complexity of partner abuse. However, exploration of the therapist’s values and belief systems, and its origin, is essential

when dealing with partner abuse. Making sense of one's personal responses that may impact the treatment process is not as easily acknowledged. Siegel (1997) cited that countertransference reactions may arise for a number of reasons, including family dynamics and emotionally charged issues that relate to one's family of origin. Reactions may arise due to the relational interaction between the therapist and client that satisfies unconsciously driven needs, and particular experiences may be evoked in the therapist as a result of this dynamic. Countertransference can be increasingly complex when dealing with issues of partner abuse and it is important to consider how these responses are different for each therapist, as each therapist has unique developmental backgrounds, particularly when dealing with IPV. Therapists may be activated by their personal, value-based theoretical orientation, and may be unaware how these values shape their decisions, as suggested by Brosi and Carolan (2006). Walrond-Skinner and Watson (1997) cited that therapists operate from their own personality make-up, which includes his/her personal emotional needs, knowledge, therapeutic experience and skills, or lack of, and that these variables contribute to the therapeutic process. In general, these factors are formed within socialising agencies, such as the family of origin (Brosi and Carolan, 2006). McGoldrick (1982) suggested that issues therapists experience with clients are due to negative emotional reactions that are rooted in the family of origin. In concurring with this suggestion, Franco (1965) suggested that therapists may be unconsciously attempting to work through their personal family struggles when working in the therapeutic process with clients. Indeed, Titleman (1987) elaborated this idea further by proposing that the position the therapist plays when working with clients may be similar to the role they played in their family of origin, as cited in Brosi and Carolan (2006). According to Bowen (1976, 1978) and Kerr and Bowen (1988), it is crucial that therapists address their individual position within their family of origin in order to contain anxiety and reactivity. Titleman, (1987) posited that by managing this process, therapists are less likely to become fused, triangulated or induced into

the emotion system of the client's material (Brosi and Carolan, 2006). Research (Goldner et al., 1990; Register, 1993) has outlined how intense clinical issues such as partner abuse may elicit strong emotional feelings in therapists, and little is known about the extent to which certain factors regarding family of origin or specific life experiences may impact emotional responses (Brosi and Carolan, 2006). The objective of this current research is to further illuminate information that may prove important when working with clients in cases of IPV, and to critically consider implications for future training and supervision.

Brosi and Carolan's (2006) study further examined the therapist's personal and professional development from the perspective of clinical supervision and implications for training. Supervision is an important component of psychotherapy when working with clients, particularly when working with IPV. Brosi and Carolan (2006) explained how both supervisee and supervisor may be influenced by their different belief systems, and highlighted the issues that may arise from the power position that the supervisor holds. The supervisee may find him/herself in the position of agreeing with the supervisor, challenging, conforming or resisting their personal belief systems. The consequences of the latter scenarios may result in therapists neglecting to address their personal process or values systems, and hence, the process of partner abuse may become lost, or overlooked. Importantly, Brosi and Carolan (2006) suggested that the therapist's awareness and capacity to self-reflect is critical to effectively addressing and working clinical with partner abuse. Additionally, the therapist's task is to understand and make sense of how their personal values and belief systems influence their way of working, thinking and feeling. Working from an insight-based framework is important when dealing with partner abuse.

The results of Brosi and Carolan's (2006) study highlighted how the therapist's reactivity in the therapeutic relationship is related to various factors in their personal lives. The primary themes that emerged from Brosi and Carolan's (2006) study included ecological components, or narrative related to reactivity, family of origin issues, developmental processes and the interpretation of client interaction. An additional theme that arose was that the trainees believed that their training environment and clinical experiences played a significant role in how they viewed partner abuse.

Supervision and training has been somewhat neglected, and it is hoped that this current research will offer a template to educate and inform trainers and supervisors. Transference and countertransference is an essential part of supervision, particularly when working with couples. Searles (1955) suggested that the emotional experience of the supervisor may provide additional information and shed light on the supervisee's work with a couple. The "reflection process" (Searles, 1955) or "parallel process" (Shohet, 1989)ⁱ that functions in the supervision process between supervisor and supervisee is key to the therapist-client relationship. Unconsciously, the supervisee may begin to act out something that has been projected onto him/her by the client, and the supervisor may pick this up in the session and begin to make sense of what may be at work (Ruszczynski, 1993).

Theoretical approaches

Various theoretical frameworks have been explored to understand couple relationships, such as social exchange theory, systemic theory, object relations and psychodynamic theory. In

ⁱ Shohet (1989) cited seven levels of reflection that can take place between the supervisor and supervisee.

researching transference and intimate partner violence, it is important to acknowledge how insecure attachments and early psychopathology impacts couples in forming a healthy, intimate relationship. Emotional contact in relationships is one of our primary needs and is important for healthy development. Intimate relationships provide an opportunity for the reciprocal expression of emotions and connections.

John Bowlby's (1969-1973) attachment theory offers a framework within which to examine the use of transference in the psychotherapeutic relationship and promotes the importance of attachment for good health. Bowlby (1969-1973) advocated that an individual's attachment is a fundamental determinant of their relationships, constituting a reflection of how we see ourselves and others. Relationships offer a unique opportunity for dealing with our unfinished business of early, primary relationships. Attachment in early life serves as a blueprint for patterns of relating in later, adult life. Couple relationships offer a mode of being both adult and child to the other. Individuals with secure attachment styles can enjoy and grow through this development and regulate their own emotions. Indeed, secure individuals are unlikely to tolerate IPV because of their integrated sense of self, and such individuals generally feel deserving of a healthy relationship.

In outlining how attachment theory proved beneficial to understanding partner abuse in couple relationships, research (Hazan and Shaver, 1987; Fraley and Davis, 1997; Sonkin and Dutton, 2008), highlighted how empirical research findings revealed high levels of insecure and disorganised attachment styles within such relationships. Indeed, Murphy and Mess (2008) noted that research has found that the insecure and disorganised attachment styles were prevalent particularly with regard to intimate partner violent men. Murphy and Mess (2008)

explained how male partners who have insecure and fearful attachment styles often express rage responses towards their intimate partner. Dutton (2007) drew a parallel between this mode of relating and childhood histories of shame and/or abuse, and outlined how such individuals may exhibit traits of borderline personality disorder in adult life. According to Siegel (2006), “one construct that is particularly potent in diagnosing and treating pathology in both individuals and relationships is the defence mechanism, splitting. Patients whose defence constellation revolves around splitting live in emotionally turbulent worlds” (Siegel, 2006, p. 418). The impact of splitting in an intimate relationship elicits damaging effects. Individuals may exhibit an inability to experience ambivalence, fluctuations in self-esteem, and a lack of observing ego and impulsiveness. With couples, splitting creates impaired communication, volatility and poor sense of self.

Comparable to the psychodynamic model, attachment theory considers how the therapist serves as a secure base for the client, and acknowledges the importance of transference issues within the therapist-client relationship. In treating couples presenting with IPV, it is imperative to consider defence mechanisms operating within the couple relationship, as well as how the past led to the creation of this unhealthy system. While the origin of the defence system is often well-hidden and possibly unconscious, object relations theory postulates that “early childhood trauma such as abuse or profound emotional neglect can cause splitting to be retained as a shield that protects against an excessively hostile intrapsychic world” (Siegel, 2006, p. 418).

Indeed, protecting the self often emerges in cases of IPV, causing conflict in the discovery of one’s real self, or in responding to a partner in an empathetic manner.

A central concept of Kleinian theory (Klein, 1946) is that of projective identification which constitutes the onset of the paranoid-schizoid position. To manage the overwhelming experience of the world around them, the infant splits such experiences into two opposing extremities. Experience is polarised, and constituted as either good or bad. During this period, the primary caregiver, if available, acts as a container for feelings that the child is unable to hold. However, invariably the bad rebounds back into the child, causing what Klein described as “persecutory anxiety” which results in terror for the infant (Gomez, *An Introduction to Object Relations*, p. 1997). The child may split off parts, which may result in fragmentation of the self. In the second half of the first year, the natural progression is to the depressive position. It is during this developmental stage that the child realises that the part objects they have split off are belonging to those that they love. The child then fears their anger, which may elicit diverse feelings, including shame and guilt. Both stages continue to fluctuate in the individual throughout life. Intense levels of either stage can result in splitting and fragmentation of the self; deficits associated with failures to navigate these stages successfully include failure to reach personality potential and poor affect regulation. (Gomez, 1997). Issues to consider are the extent to which the attachment relationship mirrors other close relationships in the therapeutic space, and what happens in couple therapy if the therapist identifies with the victim or perpetrator.

Intimate partner violence may be examined in terms of the clinical issues that arise when working with couples of this nature. In particular, couples seldom present for therapy specifically naming the issue of IPV. Friend et al. (2011) conducted an investigation to evaluate the effectiveness of a screening instrument designed to distinguish between characterologically violent, situationally violent, and distressed, non-violent couples. The focus was concentrated on recognising situationally violent couples in order to evaluate the efficacy of participation in

conjoint therapy. When working with couples with partner abuse, it is critical to consider issues surrounding assessment, safety and the appropriateness of how to work with couples who present for therapy. Dytch (2015) discussed the failure of couple therapists to have an adequate assessment process when working with partner abuse. Dytch (2015) suggested that therapists have a responsibility and a professional obligation to carefully assess factors that may undermine treatment. An individual in couple therapy may feel unsafe bringing up the issue of IPV in the presence of the other due to the threat of retaliation. Dytch (2015) further suggested that therapists may have a tendency to dive into therapy without adequately considering assessment and treatment process.

This current research explores how therapists engage in assessment when working in couple therapy, and will provide information and data for training institutions and clinical supervision. Assessment is important when working with partner abuse and disagreement exists amongst clinicians in terms of how to work with couples with IPV. Therapists may fail to attend to signs of partner abuse or neglect to ask the right questions to illicit information. This current study may offer interesting and novel insight, as earlier investigators have largely concentrated on the perpetration of IPV by men, and have generally utilised self-report measures and semi-structured interviews with perpetrators and victims of IPV. While the research outlined above has proved beneficial in broadening the understanding of IPV, research has neglected to explore IPV from the perspective of the therapist.

Chapter III Methodology

Chapter three describes the methodology that was employed to conduct this current research. While this chapter outlines the aims and objectives of this present study, a detailed description of the research methods are presented, clearly identifying the sample, recruitment of participants, research design, method of data collection and analysis, and ethical considerations.

This current research utilised semi-structured interviews and qualitative thematic analysis to identify emerging patterns and themes that will inform the data and research findings. This mode of data collection and qualitative method of data analysis provides an opportunity for diverse issues and themes to emerge, thus offering a rich foundation to explore and embed the theory. Thematic analysis further permits consideration of any drawbacks or limitations, and recognises the emergence of themes from the early descriptive and categorical stages of analysis through to the identification of superordinate constructs (Langdrige, 2004).

Objective and Aims

The objective of this current research was to gain a more thorough understanding of transference issues that emerge in the clinical setting when psychotherapists work with couples who present with intimate partner violence (IPV). This present study aimed to examine how transference and IPV is addressed in couple therapy, as well as how the therapist manages transference in the work. This study aimed to reflect upon and make sense of the challenges and assumptions arising from this research, and to consider the history of transference in relation to IPV, and its emergence into the field of psychotherapy. This present research seeks

to create an opportunity for new material to emerge and to develop new hypotheses. In so doing, this study aimed to explore existing frameworks that attempt to address issues of IPV and transference, as well as to identify any areas which may have been neglected in relation to transference and countertransference in the clinical setting of couples presenting with IPV. In addition, this current research sought to identify any limitations and stumbling blocks that may hinder the process and development of transference and IPV. In light of recent research, this present study deemed it necessary to explore and acknowledge how the therapist's personal issues may operate within and influence the treatment process through the dynamics of transference. This study considers particular transference issues that may arise when couples present with difficult and emotionally challenging cases of IPV.

Research Design

The researcher adopted a qualitative research orientation to conduct this study. Qualitative research aims to discover and establish what things mean to people (McLeod, 2001). The small sample size permits an in-depth analysis of participants' responses. Utilising the mode of semi-structured interviews facilitated an open-ended investigation of the viewpoints of professional psychotherapists who are currently working with clients. Qualitative research has proven to be an effective, engaging and flexible method as it provides an in-depth exploration of an area of human experience (McLeod, 2001). Qualitative thematic analysis provides a means of identifying patterns and themes that inform the researcher's data. This method of data analysis permits consideration of any drawbacks and the identification of categories for analysis. Thematic analysis is appropriate for this study as it allows focus to be placed on the therapist's personal and professional experience of transference and countertransference in the therapeutic relationship. It creates an opportunity for various issues and themes to emerge and offers a

rich foundation to explore and embed theory. Originating from within the phenomenological perspective which focuses on subjective experience, thematic analysis places particular emphasis on participants' feelings, experiences and perceptions, which meets the objectives of this research. It lends itself to exploring the internal world of the couple and therapist, and affords participants the freedom to feel free to use their own language, and not be limited by the constraints that quantitative methods can impose. Thematic analysis is a reflective process that includes reading and listening to transcripts, reflecting on emerging themes, and considering theoretical modalities (Banister and Cooper, 2007).

Limitations of this current research include the small sample size. Thus, findings cannot be generalised (Bannister and Cooper, 2007). In addition, the researcher acknowledges the subjectivity inherent to the themes identified. However, this is not to say that the issue of subjectivity invalidates the experiences described.

Sample

In order to obtain data specifically relevant to the research question, the researcher sought the participation of professional, accredited psychotherapists from different modalities that reflected their particular orientation. The researcher sought participants who were both trained and untrained in partner violence, who had previous experience of working with IPV, and who currently work in this area with couples in the clinical setting. All participants satisfied the inclusion criteria of engaging professionally with couples who presented for psychotherapy with IPV. Psychotherapists that did not work with couples were excluded from this study.

In obtaining participants who were both trained and untrained in this area, the researcher posited that this may highlight any existing limitations in current clinical treatment, and assist in identifying areas which require consideration and may be improved upon.

The researcher interviewed five professionals who currently work with couples in the area of IPV, who were both trained and untrained in the area. The researcher approached potential interviewees through colleagues and associates who work within the psychotherapeutic domain. Initial contact was made with participants through email and telephone conversations inviting these professionals to take part in this study. From the outset, participants were informed of the research question, that a semi-structured interview would be conducted face-to-face, and that the interview would be recorded, for later transcription. All interviews took place at a location convenient to participants and each interview was no longer than one hour in duration.

Procedure

The researcher interviewed five therapists, comprising three males and two females, from different therapeutic orientations to ensure that the research captured the experiences of a variety of therapeutic approaches and created an opportunity for different themes to arise as different modalities utilise different theoretical frameworks, and place varying emphases on various models of treatment (Table 1). Participants were informed that their anonymity would be protected as much as possible and that they could withdraw from the interview at any time. Participants were provided with an information sheet and consent form (Appendix B and C) which was discussed and explained prior to the interview taking place. The information sheet

and consent form was signed by both the participant and interviewer, and a copy of each given to participants.

Method of Data Collection/Materials

Five separate semi-structured interviews were conducted with three male and two female participants. All interviews were recorded using an audio-recording device and were subsequently transcribed. Previous research has primarily utilised self-report measures and interviews with perpetrators and victims. Thus, by interviewing therapists, this research provides a novel and interesting approach whereby participants may provide a rich source of data that elaborates upon the therapist's process in emotionally challenging cases of IPV in couple therapy. Through placing focus on the therapist's experience and perspective, this research may offer interesting insight into how the therapist's personal process, beliefs and values system may influence the operation of transference when treating couples who present with IPV in the clinical setting.

Data collection through semi-structured interviews allows the researcher to gain an in-depth description of each participant's unique experience. Semi-structured interviews permit a flexible approach, whereby the researcher may pose open-ended questions so as to elicit spontaneous, unrehearsed responses. Kvale (1996) advocated the view that interview questions should capture an order of themes, while remaining open to all possibilities (Kvale, 1996). Open communication should be encouraged, allowing participants to express their underlying perspectives. Kvale (1996) encouraged an atmosphere of safety so as to allow the interviewee to feel free to express themselves and their experiences. This can be achieved through the

balance of being real and of maintaining an awareness of knowledge, ethics and connection. The list of open-ended questions utilised in this current research (Appendix D) were discussed, amended and approved with the research supervisor prior to the commencement of the interviews (McLeod, 2001).

Unlike quantitative research, qualitative research methods offer an opportunity for going off at tangents, to follow what the interviewee sees as relevant and significant. The difference between qualitative and quantitative methods are that qualitative methods reflect a narrative research study that is person-centred (Smith, 2008). Qualitative interviewing is, by its nature, explorative research, thus allowing the views and beliefs of participants to be shared with the researcher. It explores the processes of meaning-making, and is both collaborative and subjective. It caters to the dynamic between the researcher and the participant.

Method of Data Analysis

The researcher listened to each audio recording, transcribed each interview, and utilised qualitative thematic analysis to analyse the data. The researcher began this process by firstly listening to each interview soon after it had taken place in order to attain her first impressions and reflect on the content. The researcher then listened to the interviews several times before transcribing them. This gave the researcher the opportunity to increase her familiarity with the interview content, and to reflect on what might be omitted by participants. This is important in the overall analysis of data.

Qualitative thematic analysis was employed as it places emphasis on the process of meaning-making. This method allows the researcher to gather rich data as participants were afforded space to develop and elaborate upon meanings during the interview. This method allows the researcher to frame questions based on the participant's responses and to ask follow-up questions to elicit further meanings. Braun and Clarke (2006) noted that thematic analysis is a method for identifying and analysing patterns and themes within data, and organises data into rich detail. In creating the opportunity for diverse issues to emerge, thematic analysis permits elaboration of hitherto neglected aspects of the therapist's personal process that may exert influence on the assessment, screening and treatment of IPV, thus posing important implications for future training and supervision.

Thematic analysis (Appendix E) began with first-order coding. At this stage, the researcher identified descriptions that recurred in the transcribed interview. Second-order coding was then conducted. The researcher moved from a descriptive level of analysis to a more categorical level of analysis, identifying categories that suggested the repeated emerging themes. Finally, third-order coding was conducted whereby the researcher moved from a categorical level of analysis to identifying superordinate constructs that reflect the main, recurring themes in the transcribed interview data.

Ethical Considerations

This current research received ethical approval from the ethics committee at the Dublin Business School (DBS). Each participant was approached and asked if they would be prepared to take part in a psychotherapeutic research project that would entail an interview of no longer

than one hour in duration. Participants were informed that this would require discussing personal experiences, as well as partner abuse, and that should this prove problematic, they could choose to decline participation. Participants were briefed as to the purposes of the research and were informed that the information provided would be treated confidentially and anonymously, and stored safely. Participants were informed as to when this data would be destroyed, and who would have access to the data and research. Participation was voluntary, and participants were informed of their right of withdrawal from the study at any time, including their right of retrospective withdrawal. Participants were then requested to provide their written, informed consent (Appendix A).

McLeod (2001) outlined consent, confidentiality and avoidance of harm which are three key principles that need to be maintained in ethical research. Gillespie (1994) advocated that ethical researchers must try to reduce any risks to participants, colleagues and others while endeavouring to get the best information possible (Gillespie, 1994). It was important for the researcher to examine her biases and pre-existing judgements. With this in mind, the researcher kept a reflective diary and used supervision to explore any issues that arose. It was essential for the researcher to bracket her personal meaning-making and assumptions in an attempt to prevent any skewing of the data.

Chapter IV Results

Introduction

The research question was “an exploration of transference issues in working psychotherapeutically with couples presenting with intimate partner violence”.

This chapter presents the findings from data obtained through semi-structured interviews with five accredited and practising therapists, who are both trained and untrained in the area of intimate partner violence (IPV). Interviews were transcribed and analysed by the researcher using qualitative thematic analysis (Appendix E). All five participants came from a background of clinical private practice. Three participants (P3, P4 and P5) also work in organisations, two participants (P3 and P5) work in the public sector, one in the area of addiction, and the other in an organisation providing general mental health services. P4 works in a charitable organisation that provides relationship counselling.

Family of Origin issues

A theme that was common across all participants’ accounts, was how their family of origin, namely, their childhood and family experiences, as well as their intimate adult relationship experiences, influenced their professional perceptions and personal beliefs and values in relation to IPV. All participants discussed how these experiences shaped how they view anger more generally, as well as how they view abuse in couple relationships. Additionally, all participants discussed the importance of maintaining and developing personal and professional awareness in the treatment of IPV in couple therapy. By its nature, IPV elicits issues that are emotionally challenging, which may influence the operation of transference in the therapeutic relationship. As such, participants commented on the importance of reflecting on and

addressing any issues pertaining to their personal process, particularly when working with couples who present with IPV. An additional theme that was common throughout all participants' narratives was the importance of supervision and training, particularly when working with very complex issues, in order that therapists be well-equipped and have the necessary resources to manage challenging cases like IPV.

Overview of participants.

Participants are referred to as P1, P2, P3, P4, and P5. Relevant participant details are outlined in Table 1 below.

Table 1 *Participant Details*

Participants (P)	Age range and gender (M/F)	Years as a therapist	Accreditation ⁱⁱ	Orientation	Percentage of work with couples
P1	60+, M	25	IACP and PSI	Psychoanalytic	10%
P2	50-59, F	19	IACP	Humanistic	20%
P3	40-49, F	21	FTAI and IACP	Family therapist	20%
P4	60+, M	18	NAPCP	Humanistic and person-centred	55%
P5	50-59, M	18	FTAI	Family therapist, addiction therapist	30%

ⁱⁱ IACP: Irish Association for Counselling and Psychotherapy; PSI: Psychology Society of Ireland; FTAI: Family Therapy Association of Ireland; NAPCP: National Association for Pastoral Counselling and Psychotherapy.

Themes identified using qualitative thematic analysis

The researcher devised the interview questions (Appendix D) so as to develop upon previous research, and elicit data relevant to the research question. The researcher aimed to explore which factors contribute to the operation and management of transference in the therapeutic relationship with couples who present with cases of IPV. The researcher conducted qualitative thematic analysis on all five transcribed, semi-structured interviews (Appendix E). Levels of analysis including first-, second- and third-order coding were carried out, and three main themes were identified (Table 2).

Table 2 *Themes identified*

Theme (a)	Influence of the therapist's family of origin on transference in cases of IPV in couple therapy
Theme (b)	Therapist's experience of gender differences in relation to IPV
Theme (c)	Therapist's management of IPV in couple therapy

Theme (a): Influence of the therapist's family of origin on transference in cases of IPV in couple therapy.

Analysis of the data revealed that all five therapists recognised the importance of being aware of their family of origin issues when working with couples with IPV. While participants discussed issues in relation to the couple's childhood family experiences, participants also spoke about their personal childhood family experiences. Participants elaborated upon their personal family history, and how this inevitably shaped them as individuals and influenced their beliefs, values and judgements, particularly when working with IPV in the therapeutic setting. Participants further discussed how such family of origin experiences impact their engagement in the room with couples, eliciting both positive and adverse effects on therapeutic outcomes.

P2 explained:

"Family of origin stuff is definitely activated ... So when you grow up in conflict, and certainly the second part of my life was, that has an influence on how you see conflict..."

P2 added,

"It activates stuff at the core of me – at the edges, and I think that would be said for anyone".

P5 further highlighted,

"I think a lot of it goes back to learned behaviour, maybe, eh, passed on from generation to generation. Look, if you come from a family that's shouting or rowing, pushing and shoving, that's your benchmark".

P1 agreed stating,

"All the time trying to understand the templates that get laid down, that dictate how we experience things in the present, and how we manage them".

Similarly P4 reported,

It can evoke two things in the transference and countertransference – this is the baddy, and I need to save this person, and part of it is being aware of it, and the other bit is supervision. Like, she’s bringing him in for me to fix, and I get caught into fixing him, and I need to look at what’s going on in all of the bits.

P4 also spoke about his experience of conflict in his family in childhood, and how important it is for him to maintain an awareness of the ways in which these experiences shaped how he views anger. This participant noted how he had an awareness of this. Critically, this participant elaborated upon how his early experiences of conflict may influence the operation of transference and countertransference when working therapeutically with couples who present with cases of IPV.

Interestingly, another male participant (P5) spoke about his family of origin experiences, and being comfortable with anger:

“I come from a conflictual environment, I’m used to anger and I’m comfortable with it”.

All participants spoke about their family of origin issues and how personal issues relating to these early experiences may get triggered when working with IPV.

P3 stated,

“I experienced abuse as a child – I minimise the effect on myself. I would have experienced a few clatters when I was young. I don’t think I told anyone”.

P1 remarked,

“Being aware of myself. My own experience, I mean, like childhood experiences that influence me (pause) in every way, not just as a therapist and in relation to violence, but in relation to everything”.

These narratives seem to highlight the importance of therapists managing their own emotionality and reactivity when working therapeutically with couples, and how failure to do so may negatively impact their ability to work with couples and build a good working alliance.

In focusing on the importance of maintaining an awareness of their personal process and childhood family experiences, participants acknowledged how they may be influenced by their conscious and unconscious responses. Participants highlighted how their personal values and belief systems, as partially shaped by their family of origin experiences, may influence their therapeutic approach in cases of IPV, and emphasised the importance of maintaining an awareness of how these systems may inform their decisions and influence their management of the therapeutic treatment process.

Transference is fundamental to the examination and exploration of how psychotherapists manage their internal processes and personal issues, as well as the ways in which these experiences may influence whether the therapist either successfully recognises or neglects recognition of IPV. All participants discussed their childhood experiences from the perspective of attachment, and recognised how insecure attachments may be played out in the room. For example, participants discussed how the therapist may come to identify with the victim or perpetrator, and again emphasised the importance of maintaining an awareness of this dynamic. Participants noted the importance of the therapist maintaining and developing an ability to contain and manage themselves, in addition to managing other parties in the treatment process. Participants noted that this management operates through the processes of transference and countertransference, which also enables them to engage with and manage the therapeutic process effectively.

P5 stated,

“My father was an alcoholic and I didn’t see my mother provoke him so much, but she would have been in a passive role, he was violent with us but not with my mother”.

All participants discussed transference and working with couples from the perspective of victim or perpetrator. For instance, male participants tended to refer to the male as perpetrator, and all male participants spoke about their own anger. Female participants commonly referred to the female as the victim, and discussed their own anger in less detail than male participants. A recurring theme across all participants’ narratives was that of reflection and self-awareness, and two participants spoke about transference from the point of view of “rescuer” and “protector”.

In discussing this issue, P4 stated,

“So you have to be careful when you’re working not to get caught into the rescuer or the condemning the other person and a lot of it is your own, and I’m not sure about you but I get pissed off in the session with people”.

Similarly P5 remarked,

“And I need to save this person, and that is the process that I need to be aware of... Getting into the rescuer or condemning the other person, and a lot of it is your own”.

P4 added,

“So having the awareness is really, what anger is yours’, and what anger is the clients’, and not falling into the role of rescuer or condemning and not protecting yourself”.

P5 continued,

“I’m used to anger and I’m comfortable with it. I can identify with the provoker”.

Interestingly, female participants were less comfortable with anger, and identified with the female as victim.

P2 remarked,

My parents died when I was young, and so I ended up with a relative who was aggressive, and I would have rejected anger for years. I had to work on identifying my anger and owning my anger.

P2 also identified with the female as victim, particularly identifying with her female client's pregnancy.

P3 discussed the importance of the therapist's awareness, as the therapist may find themselves at risk of minimising IPV, perhaps due to their own personal, conflictual, childhood family experiences, and the self-protection mechanisms they can employ to manage their own experience.

P3 described her experience as follows:

"I notice when I'm making sense of things privately, maybe I minimise ... because I experienced abuse as a child – the effect on myself, but I'm getting better in myself".

Indeed, this participant questioned if her sense- and meaning-making was a way of protecting herself.

In addition to the influence of the therapist's childhood family experiences on transference, participants elaborated upon how their personal attachments, and understandings of intimate adult relationships and experiences, influenced how they view adult couple relationships in their capacity as a therapist. Participants noted that, at times, their personal experiences were played out transferentially. For example, the therapist's mother/father's views on sex (P4). Participants discussed issues regarding intimacy in their family of origin, and how they struggled with later adult relationships.

In discussing such issues, P1 explained,

I didn't see a good match, a good fit, and when they split up, they broke up, that was the issue with them, they made out sex to be a dangerous thing in a relationship, a threatening thing in a relationship, rather than a precious thing, and I would say I struggled in early relationships managing my sexual desires and beliefs or values and I didn't have a good template ... I've struggled with intimacy all my life and I choose a wife who probably shared similar intimacy issues, we never knew how to manage difficult things... Maybe we men have learned to hide our feelings, maybe we have learned you have to take control in certain situations ... It's different for men than women.

In discussing a male client, participant five (P5) commented,

... an earlier attachment piece between him and his mother for whatever reason, so he doesn't have trust in relationships...I can identify with him (pause), having a conflictual relationship with my mother and then not trusting in relationships, I will see negativity from my partner, I will see criticism and negative constructivism, they may not be coming from her but with my projection of them, so I can identify with that.

Theme (b): Therapist's experience of gender differences in relation to IPV.

All participants discussed couples from the point of view of gender. Participants commented on family of origin issues in relation to caregivers and how these experiences formed their ideas and belief systems of gender roles. However, data analysis revealed a marked gender difference between female and male participants. For example, this difference can be seen in the narratives of two male participants (P1 and P5) who frequently identified perpetrators as being male. One male therapist (P4) did not identify the perpetrator or victim in terms of gender. Both female participants (P2 and P3) identified the victim as female. The emergence of this theme may be considered within the context of learned socialisation and cultural processes, such as learned societal beliefs about male identity, masculinity, and male aggression, as well as societal and cultural ideas regarding females, who are commonly viewed as being in a weaker or more vulnerable position.

P4 commented on a clinical case with a heterosexual couple, whereby the male stayed in an intimate partner violent relationship for reasons similar to those reported by females in heterosexual relationships.

P4 stated,

I have had very few males come in, and those that did always felt embarrassed and ashamed of staying in the situation... you're a man, and you think we all have tempers and we all have anger, you more than likely won't do it at work and you could be a hothead.

P4 continued,

"Men are very reluctant to expose themselves with IPV, there's a lot of shame and they see themselves as weak, you should put up with it".

This participant added,

"Another couple did have children and they stayed for the very same reason the women stayed, they stayed for the children and not to break up the family".

P3 remarked,

"I can feel quite threatened as a female working with perpetrators, especially where there is an attraction towards you ..."

P3 commented,

"...some people say it is about grooming - the men grooming the woman – I find it hard to believe as a woman. Some of the organisations say it is a defect in a man – that's hard to swallow".

P3 discussed her experience stating,

"I think I work hard to engage the man and get him on side, it's hard to balance it and not alienate the woman".

P3 proceeded to discuss training, and stated that training needs to be more balanced:

"My experience of training is that often the language that is used is judgemental and pathologising, I would like to see it looked at from the point of view of meaning, the hurt and getting underneath it".

P3 continued,

“At the moment, I feel we come down more on the man and more on the violence, but women can be violent in a different way, in a tone of voice, sexually withholding ...”

P5 stated,

“He jumps into a very intellectual mode and you can see his defences”.

P5 captures the theme of gender and transference/countertransference in the following statement:

The danger would be that I would be manipulated by the woman, and in the vast amount of cases, it would be the woman rather than the man, and I could be recruited into that position, and at the moment, a couple I am seeing ... she would get into the habit of almost giving out about him and almost getting me to collude with her and I keep on saying to her that I don't want to support you in a really negative picture of your partner because I almost become part of the problem and that is not a healthy role.

P2 discussed personal clinical experiences as follows:

I remember the first time I had a male who was violent and I subsequently referred him on to a male therapist because he had no respect for females, and I was quite scared of him”.

This participant expands on her experience a few years later, when she asserts herself with a male perpetrator who she reported physically shook his fist at her. This participant also speaks about a female client she is concerned about.

P2 stated,

“... what the victim is living with, I am concerned for her, she is very much in the early stages of pregnancy and it is very difficult ... but I think I'm managing it”.

P1 discussed identifying with the violent male, his need to be in control, and how he can shout and raise his voice:

Just mm (pause) being aware of it is half the battle, (coughs) I'm not going to take his side 'cause I think he's right ... I would hope it makes me work harder to understand

the couple, I might find myself saying things like maybe it's different for men than women.

The interviewer inquired further by asking, "So you'd normalise these ways of being?"

P1 answered,

"Yeah that maybe I'd identify, yeah, that's not to say it's right, it's what we've learned and this is common between men and women".

The interviewer inquired about how this participant manages countertransference when working with couples who present with cases of IPV.

P1 elaborated,

... Through awareness and supervision ... I think it's [supervision] very important, especially with couples, (pause, coughs) yeah, because the emotional temperature - storminess can be much greater than an individual, (pause) because things get acted out physically and strongly and (coughs, pause) things are going to get projected into you intensely and stronger too.

This comment highlights the importance of how the therapist needs to be mindful of transference and countertransference, and being able to distinguish between what to contain and what to offer back in terms of the client's work.

The theme of the therapist's experience of gender differences in relation to IPV may be viewed to arise, at least partially, from socialised understandings of males and females, particularly with regard to aggression and violent behaviour. Analysis of the participants' narratives suggests that therapists' understandings, views, beliefs and perceptions of gender in relation to IPV may exert a potent influence on how therapists view couples in the clinical setting. Findings suggest that male therapists may identify with aggression in the male, while female therapists may be more likely to identify with a female victim of IPV. The researcher tentatively suggests that such gender-related factors necessarily operate within and influence the dynamics of transference and countertransference throughout the treatment process. The findings suggest

that the therapist's awareness of their potential identification with a perpetrator or victim is crucial to work effectively within the therapeutic relationship.

Theme (c) Therapist's management of IPV in couple therapy.

The findings illustrate how IPV presents practitioners with some highly challenging situations in the clinical setting. Participants' narratives reveal that couple therapists are likely to encounter different forms of IPV in clinical practice, whether they have been trained in this area or not. The results also suggest that many therapists have not been exposed to training in IPV, and furthermore, that therapists from diverse orientations hold different views and beliefs about how to treat couples presenting with IPV. The analysis evidenced different and conflicting views concerning screening and safety agreements. These conflicting views were evident amongst participants who were both trained and untrained in IPV.

P2 described,

Couple work is more complex where there is IPV, not even physically, it can be emotional abuse ... I suppose its abuse of power and control – really, you know, whether it's emotional or physical.

Two of the five participants that engaged in this research received formal training in the area of IPV, and had a clear assessment process in dealing with IPV, which involved asking a direct question at the first assessment session. These participants used safety orders, where appropriate, and had a framework for working with couples who presented with IPV. However, these participants were the only participants who had a tangible way of working with IPV, and these participants seemed to illuminate a difference between psychotherapists that are trained and untrained in the area of IPV.

P2 discussed the assessment process as follows:

Yes I would ask particular questions and sometimes more organically, in that I mightn't take the particular forms out because I am identifying different things. Generally, I would see them individually if something emerges and then I have the assessment forms ... and you have them tailored, sometimes you sense more subtle emotional not physical and you see the power and control.

In relation to screening processes, P4 remarked,

"... talking about the screening process, we ask this of everyone, is there any domestic violence or pushing or shoving, anything like that."

P2 and P4 discussed having received training in IPV, which appeared less formal and structured. P3 stated that her under-graduate degree dealt with it more on the area of IPV than her family therapy training, and remarked,

"Training briefly looked at IPV, but a bit neglectful of it – probably my undergraduate degree dealt with it more and I came across it on placement there too".

P1 and P5 stated that they did not ask direct questions about IPV in the beginning of the work, but intuitively or somatically remained attentive to any sign of IPV in terms of cues, body or verbal language, and interactions between the couple or triad.

P3 commented,

"I think I make every attempt to put measures in place to protect all parties... A lot of times a lot of fear about keeping people safe and no guarantee – very frightening a lot to hold – very hard".

P1 could not understand why a therapist would ask a question about IPV in the beginning of the work. P1 stated that it could "close down good work" and that "IPV would emerge in the work as it proceeded". He referred to a form of symptomatology or behaviour, and likened it to self-harm, or possibly, to other defensive symptoms such as eating disorders. These dilemmas offer some insight into the issues that arise when working with couples who struggle with IPV, and the results suggest that there is no singular or particular mode of working, and

that the process is, and is often, ambiguous, uncertain, and anything but black or white for both clinicians and couples.

P5 stated,

“I’ve had couples when actually it gets more grey in a way with the intimidation. Where there is violence it gets black and white and you can see that. But with the process of intimidation, aggression is more difficult to deal with”.

P2, a female participant, proceeded to discuss a clinical case, issues of power and control, and a male in a heterosexual relationship who has not come to the session, but is communicating by email, instructing her about how to approach therapy with his partner.

P2 discussed this issue by stating,

“I’m bombarded with his emails which I’m not responding to and just sending him one-liners, the transference - it’s very intimidating and threatening ... I can’t wait to get to supervision...”

In discussing the early assessment of IPV, P4 stated,

“Em, I think where there is high conflict, that’s the first cue ... But in the high conflict, that’s the first flag, and then it can be more subtle and it comes bit by bit”.

In describing her early years as a therapist, P2 stated,

When I look back and see how I reacted to my early experience of aggression as a therapist and some years later, it shows how my own material gets activated and how important our own work is in clinical practice. When working with couples, you get drawn in, and you get caught up in triangles, and you can find it harder to hold onto yourself.

Issues pertaining to power and control were found throughout all participants’ narratives. P2 discussed a particular challenge of working in private practice as opposed to an organisation, as follows:

“He is sending me emails... So there is the power and control and very different in private practice than when I worked in organisation. He has my work email, he has access to my emails”.

In describing IPV, participants stated:

P4: It comes at many levels. At its most extreme in a physical sense, control and power, intimidation, stopping people seeing friends, controlling behaviour, threatening, using money to control, all that type of thing is as bad psychologically.

P.3: Each type of abuse brings its own violence, emotional, verbal, a lot of power and control, subtle isolation, difficulty if the perpetrator doesn't take responsibility. I experienced a male that didn't take ownership. Left as a couple and she came back as an individual – they ended up separating. Don't know if that was successful or not. He blamed me and left of his own accord. Couple work is so complex.

Participants discussed how they can struggle with the level of empathy they felt for perpetrators in the course of their work as a therapist.

P3 stated,

“Sometimes I feel empathy for the perpetrator, which I question in myself. You feel sometimes you should feel some level of repulsion against someone who's been violent and it's not always there”.

P3 continued,

Sometimes the weakness, character and behaviour of the perpetrator, I find unattractive and challenging, more in the public sector, but I have had my fair share of it. I have had good relationships also with perpetrators and acknowledge what they have done and are remorseful and regretful.

P3 added,

“The only way to stay in this work is to think change is possible”.

P2 discussed his experience by stating,

There's a lot to carry and address when working with IPV. We need to know our limits. We need to be able to address our own stuff. You have to be quite robust to work with domestic violence and have your feet on the ground.

P4 explained,

So you're naming when abuse is inappropriate behaviour, so it gives a reference point...Often you see a look, a behaviour, a gesture that you can't miss, and I'd name what I saw and say look, manage it by naming it, work through it in supervision.

Summary

The verbatim extracts demonstrate various challenges in therapy when working with couples with IPV. Participants' levels of self-awareness and self-reflection are fundamental in the therapeutic process, as are their conscious and unconscious processes that may become reactivated when presented with complex issues such as IPV. The issue of gender presented additional challenges for male and female participants, and data analysis revealed a marked difference between male and female experiences. The management of IPV is a controversial issue when working with couples. The results demonstrate how participants from diverse orientations hold conflicting beliefs and views in terms of how best to treat couples who present with IPV. The findings will be discussed further in the following chapter.

Chapter V Discussion

This chapter presents a discussion of the findings of this current research. The research examined the concept of transference in the psychotherapeutic relationship with couples presenting with intimate partner violence (IPV). The researcher conducted semi-structured interviews which were transcribed and analysed using qualitative thematic analysis (Appendix E). Five accredited psychotherapists from various professional orientations were interviewed. At the time of the research, all participants worked with couples. Participants were asked questions (Appendix D) regarding their experiences of issues relating to transference and countertransference when working with couples who present with IPV.

This study explored IPV from psychoanalytical and psychodynamic perspectives which provide a framework within which to examine how transference and countertransference can be experienced within the couple-therapist relationship in cases of IPV. This study sought to examine how the findings of this research may present an opportunity to improve treatment outcomes. This research aimed to place specific focus on the personal and professional role of the therapist, and particularly sought to examine how the therapist's personal process may operate transferentially in cases of IPV. For example, the findings suggest that certain factors, including the therapist's family of origin, and the therapist's personal beliefs and values systems may operate within the dynamic of transference. An important function of therapy is the therapist's ability to be used as the target of projective identification through the process of transference. Clulow (2001) cited that within the therapeutic process, the therapist allows themselves be used as the client's object, facilitating enactments and re-enactments that provide for the exploration of unconscious material in the client's inner world, as well as offering an opportunity for development through the therapist, whereby the therapist becomes the

container for the uncontained. This is a reciprocal process that often creates a struggle to distinguish between feelings that are being prompted from the client from those that are unrelated, and may in fact be connected with the therapist's personal family history. Bowen (1976, 1978) and Kerr and Bowen (1988) suggested the importance of therapists addressing personal issues relating to their family of origin, and proposed that this is a necessary step in order to maintain emotional reactivity and contain anxiety. By exploring these issues, the therapist is better equipped to avoid triangulation or being seduced into the emotional system of the couple (Titleman, 1987) In supporting the findings of previous research, for example, Brosi and Carolan, (2006) such factors may contribute to whether the therapist successfully recognises or neglects recognition of IPV, as well as influence how the therapist manages IPV in treatment. This current research considers the implications for standards, training and clinical practice, and seeks to broaden the understanding of IPV through examination of transference regarding IPV in couple therapy, from the therapist's perspective.

Previous research has largely collected data through self-report measures and semi-structured interviews, studying male perpetrators in cases of IPV in heterosexual relationships (Lawson, Kellam, Quinn and Malnar, 2012). In contrast, this current study utilised participants who are practising and accredited male and female therapists to illuminate the study of IPV and transference from the therapist's perspective, as opposed to examining IPV from the viewpoint of victims or perpetrators. The findings of this current research elaborate upon the therapist's experience of the transference process, particularly in emotionally challenging cases of IPV in couple therapy. Additionally, transference in the therapeutic relationship has been examined more generally (Marmarosh et al., 2009), that is, without specific or extensive examination of transference within the context of IPV. Recent research (Brosi and Carolan, 2006; Lawson et

al., 2006) highlighted a need to further examine how the therapist's family of origin, personal process, and experience of adult intimate relationships may play out transferentially.

The first primary theme that emerged across all participants' narratives was the influence of the therapist's family of origin on transference in cases of IPV in couple therapy. The majority of participants revealed how their early childhood family experiences and their experiences of adult relationships shaped their views of anger and partner abuse in couple relationships. Furthermore, the findings suggest the importance of therapists maintaining an awareness of their personal issues, as such issues may influence the treatment of IPV in couple therapy. The results suggest that participants' views of anger and their personal experience of conflict may impact their emotional reactivity when presented with challenging cases of IPV.

In examining the therapists' response to the client's partner abuse, the findings of Brosi and Carolan (2006) suggested implications for the training and development of couple therapists. Brosi and Carolan's (2006) qualitative study utilised in-depth interviews with trainee therapists and placed emphasis on particular aspects of the therapist's attitudes in relation to partner abuse. Brosi and Carolan (2006) highlighted how family of origin experiences influence the therapist's beliefs and values systems, as well as their emotional reactivity towards clients who present with partner abuse. In supporting Brosi and Carolan's (2006) findings, the results of this current research similarly draws attention to how the therapist's childhood family experiences, as well as their experiences of adult intimate relationships, may shape the therapist's beliefs and judgements about IPV, and how such value systems may play out transferentially in the therapeutic relationship. Brosi and Carolan (2006) examined the notion that countertransference reactions are "ecosystemic products" of the therapist's environment,

such as the therapist's personal family history and social environment. Consistent with Brosi and Carolan (2006) in terms of how the therapist's family of origin experiences may impact the therapeutic relationship, this current study further emphasises the role of adult relationship experiences in influencing the therapist's professional and personal beliefs, values and judgements, particularly when working with couples in cases of IPV.

All participants in this present study discussed how childhood and adult relationship experiences shaped how they view anger more generally, as well as how they view abuse in couple relationships. Participants discussed the importance of maintaining and developing personal and professional awareness in the treatment of IPV in couple therapy. IPV entails issues that are emotionally challenging for the therapist, the nature of which may influence the operation of transference in the therapeutic relationship. Participants commented on the importance of reflecting on and addressing any issues relating to their personal process, particularly in cases of IPV. Furthermore, while studies such as Brosi and Carolan, (2006) have examined IPV through evaluation of which psychotherapeutic and psychological frameworks and therapies may effectively treat IPV, additional research may be required to explore areas such as the therapist's clinical experience of couple work.

The findings of this present study illuminate the therapist's experience of transference in relation to gender differences in IPV couple therapy. Data analysis highlighted marked differences between male and female participants, whereby male participants frequently referred to perpetrators as being male, and female participants tended to discuss the victim as being female. The researcher tentatively suggests that the emergence of this theme may be partially understood within the context of socialisation processes, as well as the participant's

personal experience, regarding ideas about male identity, masculinity, aggression, and often socially formed ideas about females being in a weaker or more vulnerable position. The findings suggest that the therapist's personal beliefs and values system, as well as their understandings of gender in relation to IPV, influences how the therapist may come to identify with the perpetrator or victim. These factors may operate transferentially, and impact the efficacy of the therapist's treatment approach and outcome.

Lawson, et al. (2012) examined previous research regarding IPV and gender perpetration, and explored the effectiveness of different approaches including integrated cognitive-behavioural therapy (CBT), psychodynamic psychotherapy, and the feminist sociocultural approach. Lawson et al. (2012) evaluated the efficacy of current psychological treatments for IPV, and attended to relationship and personality factors exhibited by male perpetrators of IPV. While Lawson et al.'s (2012) study was beneficial in highlighting how psychodynamic and relational perspectives provide a more integrative approach, such research has mainly examined IPV within regard to male perpetration. Additionally, research (Sonkin and Dutton, 2003; Dutton, 2007; Lawson et al., 2012) noted the importance of considering attachment when working with IPV. Indeed, Fraley and Davis (1997), and Hazan and Shaver (1987) acknowledged the importance of attachment in the treatment of IPV due to the dynamics and regulation of closeness and distancing in intimate relationships. This dynamic may serve as a form of regulation to create emotional distancing and protection in the presenting couple and in the psychotherapeutic process when working with couples with IPV. Such dynamics may operate transferentially in the therapeutic relationship. For example, the therapist may find him/herself identifying with a victim, or alienating a perpetrator.

In contrast to Lawson, et al. (2012) this current research examined IPV from the perspective of practising therapists who work with couples presenting with cases of IPV. The findings of this present research found that male participants tended to be more comfortable and willing to acknowledge their anger and aggression. This finding may be partially considered from the perspective of socialisation processes. Female participants appeared less comfortable discussing their anger, which may arise from certain social understandings of how anger may be viewed as less acceptable for females. The results of this current study found that participants, when working therapeutically with couples who present with IPV, identified with clients who were the same gender as themselves. For example, a female participant discussed her concerns for a client who was pregnant. The researcher considered how this female participant may have identified with her female client who was a victim of IPV. The narrative of another female participant (P3) suggests that female therapists may adopt a firmer approach towards male perpetrators of IPV, and view females as less threatening in cases of IPV. This finding perhaps highlights hitherto neglected aspects regarding the influence of gender in the treatment of IPV. Lawson et al. (2012) largely overlooked examination of females in cases of IPV, and instead focused on male perpetration.

Participants' experiences of gender differences in relation to IPV may be viewed to arise, at least partially, from socially formed understandings of male and female identity, femininity and masculinity, particularly regarding aggression and violence. This finding highlights how therapists from different backgrounds may hold different beliefs and perceptions about IPV, due to unique and personal understandings of gender, and gender roles. The results suggest that therapists' understandings, views, beliefs and perceptions of gender in relation to IPV may influence how therapists work and connect with couples, thus impacting their therapeutic approach. Future research may consider examining how gender-related factors operate within

and influence the dynamics of transference and countertransference throughout the treatment process. Additionally, the findings of this current research suggest that the therapist's awareness of their potential identification with a perpetrator or victim is crucial to work effectively within the therapeutic relationship.

Comparable to findings of previous research (Lawson et al., 2012), the results of this current study suggest the importance of attachment when working with couples in cases of IPV. Participants described the impact of their personal attachments, family of origin experiences, and how they struggled in their personal understanding of adult intimate relationships. A male participant (P4) discussed a previous adult relationship and being unavailable to connect intimately. This participant attributed this issue to intimacy, which may be acted out transferentially in a struggle to connect with a couple. Interestingly, Sonkin and Dutton (2008) outlined the importance of attachment theory in understanding partner abuse, and drew on empirical research findings that revealed high levels of insecure and disorganised attachments within IPV relationships. Murphy and Mess (2008) proposed that insecure and disorganised attachments were prominent particularly with intimate partner violent men. Dutton (2007) suggested that partners who have insecure and fearful attachment styles may exhibit rage responses towards their intimate partner, and compared this way of relating to childhood issues, such as, shame and abuse, and how such individuals may exhibit traits of borderline personality in adult life. As previously noted, however, Lawson et al. (2012) neglected to explore IPV from the perspective of how IPV may be bi-directional, and perpetrated by both genders. Such research may adopt a narrow and gender-biased approach, limiting the study of gender and IPV, not only in relation to clients, but from the perspective of therapists. This current research found that gender-related issues may operate transferentially and countertransferentially in the

therapeutic treatment of IPV. Indeed, participants recognised how their insecure attachments may influence how they may come to identify with a victim or perpetrator of IPV.

While the study of IPV has largely focused on perpetration by males, Langhinrichsen-Rohling (2009) examined the different typologies of IPV, as well as gender symmetry in relation to IPV perpetration. Langhinrichsen-Rohling (2009) proposed that IPV is relationship-based and bi-directional, and suggested that women perpetrate at a comparative rate to men. Langhinrichsen-Rohling's (2009) suggested implications for improving treatment, and highlighted that IPV is not solely perpetrated by men. Similarly, the findings of this current research suggest that interventions must acknowledge the role of gender, as well as the operation of cultural norms in regard to IPV. Prevention efforts and treatment approaches must be developmentally appropriate, and up-to-date with current research findings regarding IPV. Indeed, research (Holtzworth-Munroe and Stuart, 1994; Tweed and Dutton, 1998) has emphasised the complexity of IPV, and succeeded in identifying the nature of situational as well as characterological abuse. However, while such research has contributed to broadening the understanding of IPV, issues relating to gender may be experienced not only in relation to the client as male/female or as victim/perpetrator, but gender-related issues may be experienced by the therapist. The therapist's experience of gender-related issues may influence how the therapist may identify with a male or female victim or perpetrator of IPV. Such issues are closely intertwined with the therapist's personal experience of adult intimate relationships, their family of origin and attachment styles, as well as their personal beliefs and perceptions about gender and IPV. The findings of this present study further emphasise the importance of the therapist maintaining an awareness of these issues in order to treat IPV effectively.

The findings of this current research highlight particular issues regarding the therapist's management of IPV in couple therapy. IPV is complex, intricate, evocative and emotionally challenging, and may present unique issues in terms of screening, assessment, training and supervision, as well as in relation to transference and countertransference reactions. The results suggest that differences arise in terms of whether the therapist is trained or untrained in the area of IPV. The findings suggest that therapists from different orientations may hold conflicting views about the treatment of IPV in couple therapy, and differ in their approach to screening and safety agreements. Additionally, the results suggest that female therapists may experience particular challenges in terms of issues of power and control when presented with male perpetrators of IPV. A female participant (P2) in this present research discussed having felt more exposed when a male, who was a partner of a female client who presented with IPV, began to send her emails. This participant commented that this circumstance would not have arisen if she had been working in an organisation, as opposed to private clinical practice. Such challenges may be exacerbated when the therapist is working in private practice, as opposed to an organisation, where boundaries are more clearly defined.

All participants in this present study distinguished between different types of abuse, from subtle forms of abuse to extreme physical abuse. However, this present study found that less than half of participants felt clear about the IPV screening and assessment process. In distinguishing between the different typologies of IPV, Langhinrichsen-Rohling (2009), suggested that it is critical that clinicians and researchers be able to distinguish between different types of IPV in order to improve their knowledge about IPV and the treatment process. All participants in this current research emphasised the importance of managing their awareness throughout the treatment of IPV, as early personal experiences of conflict in childhood or in adult intimate relationships may surface, and get played out transferentially and countertransferentially

throughout the treatment process. In terms of the management of IPV in couple therapy, these factors may pose important implications for training and supervision, as such issues impact upon the effectiveness of the therapeutic process.

Moreover, in discussing their experience of training, most participants believed that their training would have proved more comprehensive if it specifically addressed IPV, and suggested that most relationships, at some stage, may be viewed as exhibiting some traits of IPV. The findings of this present study support Brosi and Carolan's (2006) research which explained that partner abuse is rarely disclosed by couples at the outset of therapy as the presenting problem. All participants in this current research agreed that IPV is seldom experienced by the therapist as the presenting problem, which can make IPV difficult to recognise in the initial stages of therapy. Rather, the results suggest that therapists may focus on the couple's presenting issues, and thus fail to recognise partner abuse. In fact, Holtzworth-Munroe, Meehan, Rehman and Marshall (2002) explained that therapists may fail to neglect the presence of IPV, as couples may often not disclose IPV as a presenting issue.

The findings of this present study offer support for Brosi and Carolan's (2006) research, and highlight the importance of the therapist maintaining an awareness of how their personal experience of relationships and views of gender and IPV may influence treatment through the processes of transference. However, in addition, the results of this present research suggest that therapists trained in IPV may have a more tangible screening process than those with less formal training, or no training with regard to managing IPV. The results highlight ambiguous and conflicting views in relation to the IPV screening process and the use of safety agreements. Friend, Renay, Cleary Bradley, Thatcher and Gottman (2011) evaluated the efficacy of the IPV

screening process, examined the appropriateness of working with couples, and sought to identify which types of couples may be suitable for conjoint treatment. Friend et al. (2011) emphasised the importance of therapists being able to distinguish between different IPV typologies in order to tailor a more effective treatment approach. Given the high prevalence of IPV, which Friend et al. (2011) found to be as high as 74% among couples seeking therapy, it is likely that all couple therapists will at some point, encounter IPV, regardless of whether they have received training in this area or not. In this present research, the participants' conflicting views regarding screening and assessment, as well as issues relating to identifying IPV, perhaps highlights a need to further examine the area of screening and assessment of IPV, as this may pose implications for training and supervision.

The results of this current research centre on more tangible issues regarding the therapist's management of IPV in terms of screening and assessment. However, the findings furthermore suggest that consideration of transference and countertransference reactions is important in terms of the management of IPV in therapeutic work. Therapists must consider and acknowledge how their personal and clinical experiences may influence the therapeutic process at large, and evaluate how such experiences may best be managed in treatment. In discussing the diverse sets of issues presented to therapists in the clinical setting, Brosi and Carolan (2006), explicated how therapists themselves may be particularly vulnerable to their own reactions when presented with controversial and emotionally charged cases such as IPV. All participants agreed that their family of origin experiences strongly affected who they were in the therapeutic relationship. Each participant stated that their personal work, self-awareness, experience, ability to reflect, make sense of themselves, and contain themselves, were crucial factors in working with couples with who present with IPV. The findings of this current research suggest that these issues may either limit or enhance the possibility of change. The

results suggest that a therapist's understanding and experience of self is fundamental to successfully addressing and working clinically with partner abuse.

This current research highlights the importance of the therapist managing their awareness. Issues relating to the therapist's family of origin may be "*activated at the core of you*" and "*the templates that get laid down dictate how we experience things in the present and how we manage them*", as participants described. All participants believed awareness to be crucial in order to manage challenging cases like IPV effectively. Indeed, Brosi and Carolan (2006) emphasised the importance of therapists acknowledging how their personal and clinical experiences influence the therapeutic process, and suggested that it is critical that therapists evaluate and address how these experiences may be played out through the processes of transference and countertransference. The results of this current study similarly suggest the importance of the therapist maintaining and developing an awareness of how their personal experiences, beliefs, values, judgements and understandings, may influence the therapeutic process and treatment of IPV. The therapist's personal experience can result from a number of factors, and according to Kernberg (1965), the therapist's personal conscious or unconscious responses, as well as their immediate or delayed reactions, are equally important to the treatment process and to the work with clients. Indeed, McGoldrick (1982) suggested that difficulties that arise between the therapist and clients are often connected.

IPV has largely been examined through the utilisation of data collection methods including self-report measures and semi-structured interviews with individual male perpetrators, largely neglecting to examine IPV from the therapist's perspective. Additionally, while research has examined transference in relation to individual psychotherapy, research has been limited in

terms of exploring the dynamics and operation of transference in IPV and couple therapy. In contrast, this present study utilised semi-structured interviews with participants who are practising and accredited therapists from diverse orientations, and research is also limited in this regard. Conflicting views regarding the area of screening and assessment may perhaps be further explored in terms of the approaches adopted by therapists from different orientations and modalities. As this research utilised participants who are both trained and untrained in the area of IPV, this factor may have contributed to the finding that participants held different views concerning screening and assessment measures, as well as the management of IPV. In utilising participants who are practising and accredited therapists, results may be influenced by hesitation on behalf of participants to freely discuss their approach to the treatment of IPV, perhaps due, in part, to the fact that the interviewer was also a practising therapist, and participants were aware of this. The researcher was also aware of her personal, potential biases, family history and professional experiences of working with couples in the therapeutic process. The researcher managed these issues through the process of a reflective diary, personal therapy and supervision. The researcher struggled at times to convey and articulate some of the research data in a cohesive manner, and reflected on the ambiguity and complexities that emerge when dealing with difficult issues such as IPV, as well as the dilemmas that arise in assessing and disclosing IPV.

An additional consideration relates to the utilisation of a small sample size, and as such, findings cannot be generalised. Furthermore, participants comprised of three males and two females. Thus, results may be affected by a gender imbalance. Future research may benefit from ensuring a gender balance in terms of male and female participants. It should also be noted that the results, obtained through qualitative thematic analysis of data, may be influenced

by the subjective experience and meaning-making of participants, as well as the subjectivity of the researcher when carrying out the analysis.

Conclusion

Previous research (Friend et al., 2011) has largely examined IPV through semi-structured interviews and self-report measures with participants who were generally either perpetrators or victims of IPV. While such studies have contributed to furthering the understanding of IPV, research has, however, mainly focused on exploring the perpetration of IPV by males. Furthermore, research has tended to neglect exploration of IPV from the perspective of the therapist, and how the dynamics of transference and countertransference may influence the treatment approach and outcome. This current research collected data from five accredited psychotherapists from various professional orientations, and the findings highlight the necessity of considering transference and countertransference from the perspective of the clinician. In supporting previous research (Brosi and Carolan, 2006), this current study suggests that the therapist's family of origin and experience of adult intimate relationships may prove essential when working with couples, particularly in cases of IPV.

Additionally, the findings suggest that the therapist's personal perceptions, beliefs and values regarding gender and IPV may influence how the therapist may come to identify with a perpetrator or victim in IPV couple therapy. Such gender-related issues, as experienced by the therapist, may operate transferentially in the treatment of IPV and future research may benefit from further examination of this issue. The findings suggest that it is crucial that the therapist maintains and develops an awareness of how these issues may influence the treatment approach, and play out transferentially in the clinical setting. Interestingly, the results also

suggest that therapists may experience conflicting views regarding the treatment of IPV, particularly in relation to the areas of screening, assessment and safety procedures. This latter finding may highlight implications for training and supervision. Participants discussed the importance of trainers being equipped to address issues such as IPV in all therapeutic relationships, and not just in the area of couple work. Participants viewed supervision as a resourceful space, and agreed that the skills and training of the supervisor are fundamental in order that the therapist be able to recognise the most subtle signs of IPV.

Future research may benefit from utilising participants who are practising and accredited therapists, in order to further explore how the therapist's experience in terms of family of origin, adult intimate relationships, and perceptions of gender and IPV, may influence the treatment process. This may be examined with particular emphasis on how such issues may operate through transference and countertransference reactions. These issues may pose important implications for training and supervision, and additional studies may illuminate how screening, safety and assessment may be improved upon, in both private clinical practice, and within an organisational clinical setting.

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Appendices

Appendix A: Consent form

Appendix B: Information form

Appendix C: Demographic details

Appendix D: Interview questions

Appendix E: Qualitative thematic analysis and coding notes

Appendix B

INFORMATION FORM

My name is Gail McGuinness and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is concerned with an exploration of transference issues in working psychotherapeutically with couples presenting with intimate partner violence. I will be exploring the views of people like yourself who work with couples.

What is involved?

You are invited to participate in this research along with a number of other people because of your experience of being a couple therapist. You will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Anonymity

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be made unidentifiable. All data that has been collected will be stored confidentially. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature _____

Date / /

Signature of Interviewer _____

Appendix C

Demographic Details

An exploration of transference issues when working psychotherapeutically with couples presenting Intimate Partner Violence

1. Are you male or female?

- Female
- Male

2. What is your age?

- 17 or younger
- 18 - 20
- 21 - 29
- 30 - 39
- 40 - 49
- 50 - 59
- 60 or older

3. How long (in years) are you working in this area?

4. How much of your work (in percentage terms) involves working with couples?

5. Which body are you accredited with?

Appendix D

Interview Questions for Participants

1. What for you indicates abuse in a relationship?
2. Can you tell me if you have an assessment process in place when working with couples?
3. Do you ask particular questions?
4. Are there any particular cues/clues that you might pick up on?
5. How do you manage the assessment process when dealing with couples who present for IPV?
6. Did your training look at how to manage abuse in intimate couple relationships?
7. If there is continues abuse how do you manage it?
8. What is your experience of working with perpetrators of abuse?
9. How do you manage yourself when issues of IPV arise?
10. How do you feel about working with clients with IPV?
11. How do you manage your own countertransference when working with couples of IPV?
12. How do you think your own personal experiences or experiences of intimate relationships has influenced how you view IPV?
13. How do you feel your own family/childhood experiences have influenced your perceptions of IPV?
14. Do you think that abuse in same-sex relationships is understood or treated as well as abuse in heterosexual relationships?
15. Have you been aware of any biases you experienced when working with IPV?
16. If so, how have you managed these?
17. Do you think that there are any aspects of a couple's culture or socio-economic background could influence your perceptions of partner abuse in their couple relationship?
18. Do you think any improvements can be made in treating couples who present with cases of partner abuse?
19. Have you anything you would like to add or talk about in relation to this topic?

Thank you for taking the time to do the interview

<p>IPV is challenging. Supervision is important.</p> <p>Couple work can be more intense and harder.</p> <p>Conflict between safety agreements and effectively treating a couple.</p> <p>Childhood family experiences of the therapist... influences the participant's beliefs and judgements re cases of IPV, their views of the perpetrator/victim.</p> <p>How does the therapist manage this?</p> <p>The importance of self-awareness.</p> <p>Managing awareness. Training, supervision, treatment process.</p> <p>Can play out transferentially- e.g. mother/father views on sex.</p> <p>the therapist's own personal view of this, the importance of the therapist's</p> <p>awareness of their own personal views, and the importance of their views being properly managed in the room with a couple with IPV... transference.</p> <p>Therapist's adult relationships shapes their views of IPV.</p> <p>Must maintain awareness- how do such issues affect treatment approach?</p>	<p>Family of origin influences in cases of IPV...transference</p> <p>Importance of maintaining awareness of how participant's family of origin experiences may influence treatment of IPV via transference</p> <p>Influence of participant's adult relationship experiences on therapeutic process, operating through process of transference</p>	<p>Family of origin experiences and transference in IPV</p>
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<p>“Men have learned to hide their feelings, and see themselves as having to take control”.</p> <p>-“it’s different for men than it is for women”</p> <p>-“she has to feel more emotionally connected before she feels sexual”</p> <p>-a socialised understanding of how men and women view sex as a way of reconnecting.</p> <p>Most of the references to IPV in this interview discuss the male as perpetrator, and female as victim</p> <p>-the issue of control</p> <p>Social factors: IPV in terms of socio-economic background- working class couples may treat IPV differently to a middle class couple who may have more experiences of sense of shame ...perhaps couple from different socio-economic backgrounds bring different concerns to the treatment process...with different emphases placed on “shame”</p>	<p>IPV and Gender</p> <p>Ideas of males and females in relationships and IPV</p> <p>Gender and IPV ideas of male as perpetrator and female as victim</p>	<p>Gender-based ideas of IPV</p>
<p>Interview 2</p>		
<p>- Training- important that IPV is specifically addressed in training, the benefits and support offered by group supervision, and supervision support overall. IPV difficult to deal with as a therapist, due to its disturbing nature.</p>	<p>Training</p> <p>Supervision, training, support</p>	<p>Management of IPV (screening, assessment, safety, awareness, transference)</p>

<p>Power and control, IPV may be emotional, and not just physical.</p> <p>And the need to acknowledge that, especially when the signs are more subtle when couple presents.</p> <p>IPV can be a little hard to detect in cases where IPV entails emotional abuse, as opposed to physical.</p> <p>Implications for training.</p> <p>“Power and control”, which itself is often viewed as being perpetrated by the male). Acknowledgement of IPV in lesbian relationships, and females as perpetrators...much discussion on males perpetrating in heterosexual relationships.</p> <p>Male as perpetrator</p> <p>Referral to male therapist.</p> <p>Participant discusses experience of emails from the male “perpetrator”.</p> <p>How such a situation can influence her identification with the victim.</p> <p>Transference & awareness of this is important.</p> <p>Transference-</p> <p>Female participant identifying with the woman as victim, and particularly the mention of pregnancy</p> <p>IPV brings up therapist’s own issues and if therapist has had any personal experience of abuse/IPV.</p>	<p>What is IPV</p> <p>Extreme physical, and subtle</p> <p>pre-existing ideas about male as perpetrator</p> <p>Transference, female participant identifying with female as victim, influence of therapist’s personal relationship experiences in how IPV is approached in treatment</p>	<p>Therapist’s experience of gender differences in IPV, Transference and gender.</p>
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<p>Childhood family experiences influence therapist's views.</p> <p>Influence of therapist's personal experience on views of IPV.</p> <p>It brings up personal issues for the therapist, family, childhood experiences.</p> <p>Adult relationship experiences.</p> <p>Maintaining awareness is crucial</p> <p>These issues can play out in transference.</p>	<p>Family of Origin/Adult Relationships</p>	<p>Influence of therapist's family of origin & adult intimate relationship on IPV treatment</p>
<p>Interview 3</p>		
<p>Inadequate training re IPV, inadequate assessment process for IPV, different approaches to assessment of IPV</p> <p>Believes that training is neglectful of IPV,</p> <p>Family therapy doesn't really address IPV adequately</p> <p>Importance of picking up subtle cues...mannerisms.</p> <p>Doesn't like the aggression...finds the conflict in IPV work hard.</p> <p>More uncomfortable in the public sector when working with IPV</p> <p>Importance of working through own issues in supervision in terms of dealing with challenges of IPV work</p>	<p>Inadequate Training, conflicting approaches in assessment, screening etc</p> <p>Challenging working in IPV, necessary to work through own issues, has personal experience of physical abuse...influences IPV approach</p>	<p>Managing IPV (training, assessment, screening, awareness of personal experiences influencing treatment)</p>

<p>Again states she can feel quite threatened as a female working in the public sector with IPV"...with male perpetrators.</p> <p>Importance of managing this in supervision</p> <p>Personal experience re physical abuse</p> <p>Training needs to be improved, she states.</p> <p>Therapists can "come down more on the men" who are violent.</p> <p>Again refers to men as perpetrators</p>		
Interview 4		
<p>The type of treatment approach.</p> <p>Type of training</p> <p>Paying particular attention to subtle behaviours and interactions.</p> <p>The importance of training- in being able to attend to the more subtle gestures, looks, expressions, silences, hesitations, fear of speaking openly in the presence of the perpetrator-</p> <p>The importance of training and policies in determining what is tolerable, how to manage, what protocols to implement,</p> <p>Form of initial assessment, safety parameters...</p> <p>Importance of training in determining what is safe.</p>	<p>Theory, Approach, Initial Assessment, Training & Supervision</p>	<p>Management of IPV</p>

<p>The difference between individual and couple settings- the latter may prove more challenging-</p> <p>Considering arguments, conflict in the room, aggression etc. “It’s not black and white”....the importance of procedures, training etc.</p> <p>Supervision and groups- important support resource for the therapist... perhaps to get another’s feedback too, in the case of manipulation.</p> <p>Importance of training & awareness. ...to manage transference.</p> <p>Often perceived as only entailing physical violence, and “extreme”, but is often- emotional, psychological... “subtle”- the “silences”, “the odd shove of a shoulder as we walk past each other”. DV can be progressive. “Learned behaviour may be passed on from generation to generation”...”that’s your benchmark”</p> <p>Nature-nurture issue? Learned behaviour from abusive family environment in childhood...anger as an environmentally learned response to not getting one’s own way?</p> <p>Constantly monitoring their own emotional reactions if they have their own particular issues with anger/anger management due to their childhood family experience</p>	<p>What is IPV? Subtle to extreme forms.</p> <p>The role of Family of Origin in IPV- shapes participant’s views of anger.</p>	<p>Influence of therapist’s family of origin on treatment of IPV</p>
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<p>The importance of not falling into the black and white perpetrator/victim perceptions.</p> <p>Being mindful not to fall into the role of rescuer.</p> <p>Maintaining awareness.</p> <p>What each socio-economic/social group considers “normal” behaviour/conduct...varies from social group to social group, and across socio-economic backgrounds. Example, “if you come from a family that shouting and rowing pushing and shoving. That’s your benchmark it’s the people that don’t do it and it’s what’s wrong with them. It’s like they don’t care about each other.”</p> <p>How participant perceives IPV, and who perpetrates IPV? i.e. male/female?</p> <p>The therapist’s own personal experience, how this shaped how they view anger,</p> <p>how they manage their own anger, their in-room interaction with a couple.</p>	<p>The role of Socialisation & Cultural Processes in IPV</p> <p>Gender & IPV, Transference</p> <p>Male/female perpetrators/victims.</p> <p>Ideas of gender perpetration.</p> <p>Not falling into the “rescuer”.</p>	<p>Gender-based ideas of IPV and how these beliefs and experiences influence transference.</p>
<p>Interview 5</p>		
<p>Conflicting views on assessment, screening, safety agreements.</p> <p>Importance of attending to subtle cues indicating IPV in the work.</p>	<p>Conflicting views re assessment, screening, safety agreements.</p> <p>Needs for improvement in training and supervision.</p>	<p>Managing IPV (training, supervision, safety)</p>

<p>Somatically experience in the work.</p> <p>Attending to felt sense of communication in the room, and picking up on intimidation...transference.</p> <p>Observing what he feels in the room, attending carefully to it.</p> <p>Importance of training and utilising correct approaches in IPV.</p> <p>Different types of IPV, understanding it is often not black and white, challenging to deal with aggression.</p> <p>Importance of not falling into the role of rescuer/protector, white knight, hero role.</p> <p>Aware of danger of being allowed to be manipulated “by the woman”... importance of attending to transference issues and maintain awareness.</p> <p>Gender and Transference.</p> <p>“he jumps into a very intellectual mode”... pre-existing ideas, perhaps socially formed, of males in IPV...”she provokes him”, “he likes going into a space where he rationalises things”...importance of attending to somatic experience.</p> <p>“she was the appeaser ... he needs a boundary”</p> <p>Family is a map.</p> <p>Identifying with male, as interviewee has had a “conflictual relationship with [my] mother”</p>	<p>Importance of being able to distinguish different types of IPV, attending to subtle cues.</p> <p>Gender and Transference. Pre-existing ideas re males and females, and in IPV, identifying with aspects of IPV in the work, participant identifying with male/female perpetrator/victim, importance of maintaining awareness of this and how this may operate transference.</p>	<p>Gender-based ideas and beliefs re IPV...operates via transference</p>
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<p>Can find himself identifying with IPV couple due to adult relationship experiences</p> <p>“I can identify with intimidators”</p> <p>He has to attend to not projecting this...importance of awareness and attending to transference reactions.</p> <p>Identifying with the provoker- came from a conflictual environment.</p> <p>Importance of family of origin experiences in influencing transference reactions of how he may come to identify with provoker etc</p> <p>Deficits in supervision</p> <p>Gender based ideas of females and males. Sees cultural and social differences in how IPV is viewed.</p> <p>How own experiences can affect therapeutic relationship... “because of my own experiences, I can go into fight/flight mode ...”</p> <p>Importance of working “on the self-regulation”...emotional regulation.</p> <p>Improvements in training, supervision in IPV necessary</p>	<p>How family of origin experiences influences identification with aspects of IPV in the room...with perpetrator/victim... implications for transference/importance of awareness.</p> <p>Importance of emotional regulation, awareness, awareness of transference...IPV challenging.</p> <p>Need for improvements in training & supervision</p>	<p>Family of Origin & adult relationship experiences influence treatment via transference</p> <p>Management of IPV (Training, supervision, maintaining awareness of personal issues, and awareness of transference.</p>
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