AN EXPLORATION OF TRANSFERENCE AND COUNTERTRANSFERENCE IN WORKING THERAPEUTICALLY WITH CLIENTS EXPERIENCING INTIMATE PARTNER VIOLENCE WITHIN PRIVATE PRACTICE

LISA JOHNSTON

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SUPERVISOR: AIVEEN FARRELLY

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ABSTRACT

This paper will examine the transference and countertransference that can occur while working therapeutically with clients experiencing Intimate Partner Violence (IPV). The psychodynamics of Intimate Partner Violence will be explored, highlighting the complexity of the dynamics that occur in violent relationships such as projection and splitting. The findings from existing literature stresses the importance of the psychotherapist's continuous work on self-awareness, training, risk assessment and supervision when working therapeutically with perpetrators of IPV. Some findings of this theoretical work would suggest that more collaborative psychotherapy research and training for psychotherapists is required to focus on creating best practices around violence prevention measures and interventions.

"We need to have the courage to look this problem in the face, say that it is real and then act to bring visibility and voice like never before"

- Safe Ireland (2016)

CHAPTER 1: INTRODUCTION

This paper will investigate how to work psychotherapeutically with the complex issue of Intimate Partner Abuse within psychotherapy. This paper will explore the current literature that exists surrounding transference and countertransference in the therapeutic relationship when working with Intimate Partner Violence. Current research on the topics of psychotherapist supervision and risk assessment when working with individual perpetrators and couples experiencing Intimate Partner Violence will be examined. The definition of Intimate Partner Violence (IPV) for this paper will be:

> "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship"
>
> (*WHO | Intimate Partner Violence*, n.d.)".

IPV is used throughout but could be referred elsewhere as spouse abuse or domestic violence, it will be referred to as IPV throughout this paper (Misso, Schweitzer & Dimaggio, 2019, p248).

There is extensive research in working with clients as survivors of IPV using behavioral techniques (Krahe, 2013). However there appears to be a lack of research that considers working with perpetrators from a psychodynamic psychotherapy standpoint. There is also a lack of literature investigating the impact of working with IPV on psychotherapists (Hogan, Hegarty, Ward, & Dodd, 2012, p44).

OBJECTIVES

A key objective of this paper will be examining transference and countertransference as it occurs in the therapeutic alliance when working with clients as perpetrators of IPV. A second key objective is working through transference and countertransference issues in therapeutic practice including supervision, risk management and the therapist's self-awareness.

During the writing of this paper, there is a worldwide pandemic of Covid-19 virus. According to Safe Ireland, victims of coercive control and IPV are more vulnerable and isolated during the Covid-19 government lockdown (Policy & Publications, n.d.) When someone is in lockdown with their abuser, they do not have the usual escapes such as work or school for children (Policy & Publications, n.d.). Safe Ireland states that "the epidemic that is domestic abuse and coercive control persists and for many, home is the least safe place to be, at all times" (Policy & Publications, n.d.). Safe Ireland believes that more investment is needed in preventing new cases of IPV, by "identifying and addressing the root causes" (Policy & Publications, n.d.).

RESEARCH METHODS AND SCOPE

The research will be performed through detailed searching of the DBS library and online library resources on the topic. To limit the scope of this dissertation, it will be assumed that the perpetrators may be court referred, as the investigation will not focus on the therapist's responsibility around reporting domestic violence or abuse. As this is a broad topic, the aetiology of aggression and gender related issues may be touched upon but not explored.

The following chapter called “Transference and Countertransference” will investigate ways in which the therapist’s own beliefs and background can affect how they work with clients who experience IPV (Hamel, 2017). This chapter will also touch upon psychodynamic theories of projective identification, projection, and attachment issues in exploring dynamics of couples experiencing IPV (Motz, 2014). The chapter “Supervision and Risk Management” addresses the psychotherapists need for continued self-awareness and supervision and risk assessment when working with couples experiencing IPV.

Chapter 1: Transference and Countertransference

Anna Motz's (2014) book *Toxic Couples* explores the dynamics of what happens within a relationship experiencing Intimate Partner Violence. Motz investigates the link between psychoanalytic and attachment theories, highlighting possible reasons why "toxic" couples keep going despite the disruption they cause (Motz, 2014). Motz explores the theme of intergenerational transmission of IPV (Motz, 2014, p48). In order to process their experiences, some children who were exposed to domestic violence, can take on aggressive traits of their caregivers and "disown vulnerability, helplessness and humiliations" (Motz, 2014, p4). The author also believes that more research into intergenerational patterns of repeated violence in families would be helpful. Motz believes that Freud's (1914) theory of "Compulsion to Repeat", and Melanie Klein's Projective Identification (1946) can become manifested within the dynamic of couples experiencing IPV (Motz, 2014, p4). "Unacceptable and unwanted" parts of the perpetrator are projected into their partner, who is then abused, in an attempt to rid themselves of these unconscious feelings (Motz, 2014, p4). Motz theorizes that projection and projective identification are used as defenses, which become addictive, which is why these relationships continue (Motz, 2014, p1). Peter Levine also places considerable weight on the "Compulsion to Repeat", individuals can be drawn into situations that reenact the original trauma, unconsciously (Levine, 2008, p19). The author believes that more research is required into the link between trauma re-enactment by perpetrators of IPV any childhood trauma or experience of witnessing and experiencing IPV as children. Could trauma therapy help to bring cycles of repeating Intimate Partner Violence into consciousness ?

Motz suggests that in order to work with perpetrators of IPV, a psychotherapist would have to attempt to understand how their client's early experiences have impacted them (Motz, 2014, p10). Change can happen when there is an understanding of the connection between the past and present and the pain they have suffered and caused others (Motz, 2014, p10). It is through examining the transference and countertransference within the therapeutic relationship, that this link can be explored and hopefully healed (Motz, 2014, p46). Transference should be examined within the therapeutic relationship to bring into consciousness the repeated patterns and unconscious fantasies of the client (Kahn, 1997, p83). Transference is alive in the here and now as the therapist "finds themselves colluding with unreasonable demands, or placating criticisms", and this can be explored, safely in the therapeutic relationship (Cordess & Cox, 1998, p27). Psychotherapists can unknowingly cooperate with the transferences of the client, if the client manages to influence the therapist to satisfy their unconscious needs or wishes (Kahn, 1997, p83). If the transference can be worked through by a genuine and respectful therapist the client can learn a new way of relating nondefensively (Kahn, 1997, p83).

Motz warns of some countertransferential effects that can occur are feelings such as wishing for a happy ending, feelings of helplessness which mirrors their clients, or experiencing anger towards the survivor for their passivity at staying in the relationship (Motz, 2014, p46). This appears to mirror society at large that asks questions of the survivor who stays, rather than of the perpetrator (Hennessy, 2012). It may prove difficult for a psychotherapist to retain respect for a violent perpetrator of IPV. Countertransference can become overwhelming for the therapist, as the client projects their potentially "disturbed internal world" which can be hard for the therapist to contain (Cordess & Cox, 1998, p27).

Jessica Yakeley (2010) explores transference and countertransference in her book *Working With Violence*. While this book is not specific to IPV, the author believes that the work contributes to the discussion in the context of IPV. Yakeley supports the notion that violence is not a "senseless act" , but one which has "unconscious meaning" (Yakeley, 2010, p101). Yakeley supports her claim by looking at Freud's paper "Remembering, repeating and working through" (Freud, 1914). Freud believed that "acting out" was related to transference and resistance (Freud, 1914). Yakeley believes that acts of violence have an unconscious meaning to the perpetrator (Yakeley, 2010, p102). This appears to be an important point that would need further exploration within the therapeutic relationship to uncover the unconscious defenses of the violence act. The author wonders if shining a light onto the unconscious of the perpetrator by working therapeutically through the transference could help them understand where their anger is coming from and potentially stop the abuse (Yakeley, 2010).

A number of researchers believe a possible root cause of violent behavior and IPV is "emotional dysregulation" (Lee, Rodriguez, Edwards, Neal, 2019). It is believed by the researchers that therapeutic strategies, helping a perpetrator to manage the couples didactic emotions could help in cases of "situational violence", and treating couples may benefit examining the didactic processes being played out (Lee *et al*., 2019).

The psychotherapist may be affected by their client as a perpetrator and can have thoughts and feelings that surprise themselves (Yakeley, 2010, p102). Analysing the countertransference can be useful to gain information about the clients inner world and their relationships which cause

them to act out (Yakeley, 2010, p102). Yakeley states that analysis of countertransference is just as important when working with violent clients (Yakeley, 2010, p102). However, she warns against the "complex concept" becoming oversimplified as a therapeutic technique (Yakeley, 2010, p102). Some feelings may be those projected by the client through transference; however, others may be the defenses of the therapist who finds the thoughts of violence unbearable (Yakeley, 2010, p142). Yakeley proposes that psychotherapists working with violent clients need to gain awareness into their own aggressive and sexual impulses to ensure the countertransference does not interfere when assessing risk (Yakeley, 2010, p143). Common countertransference feelings when working with clients who commit violence are dread, terror, and disgust (Yakeley, 2010, p143).

Gail McGuiness pays particular attention to how psychotherapists' processes of transference and countertransference may influence the treatment (McGuinness, 2015). A theme that emerged from her study was the influence of the therapists family of origin and interpersonal relationships over their personal beliefs and values in regard to IPV (McGuinness, 2015, p30). The participants reflected upon their own anger and how they view violence within interpersonal relationships (McGuinness, 2015, p30). One participant spoke about a couple experiencing IPV. "This is the baddy and I need to save this person, and part of it is being aware of it, and the other part is supervision" and "I get caught up in fixing him" (McGuinness, 2015, p35).
A common theme running through the literature is of the importance of self-reflection and supervision as a therapist while working with IPV (McGuinness, 2015, p30). The study's findings also suggested that it is common that therapists may identify with the survivor or perpetrator, so awareness of these dynamics is vitally important in working therapeutically

(McGuinness, 2015, p36). Another theme coming across in the literature is the therapist working with their own anger when working in the field of IPV couples therapy. A therapist participant of the study states

"So, having the awareness is really, what anger is yours, and what anger is the clients" (McGuinness, 2015, p36).

McGuiness states that another potential pitfall when working with couples experiencing IPV is that therapists can minimise IPV, due to personal childhood or interpersonal experiences (McGuinness, 2015, p38). For therapists their personal experiences can be played out in the transference, especially with family of origin views on sex and intimacy (McGuinness, 2015, p38).

In couples therapy IPV is rarely mentioned as the presenting problem, but one that is gradually uncovered (Brosi & Carolan, 2006, p111). Therapists can be more vulnerable to being triggered when working with survivors of domestic violence (Brosi & Carolan, 2006, p112). The therapist's personal experience with partner abuse, through family of origin or personal relationships, can affect the way they react to the client's experiencing IPV (Brosi & Carolan, 2006, p113). Brosi and Carolan stress the importance of the therapists awareness of their own personal bias, family of origin history, and unresolved conflict, and role within their family of origin, in order to be aware of countertransference (Brosi & Carolan, 2006, p120). One of the participants believed that witnessing violence as a child directly influenced how she sees it in clients, she states, "I have a fear of violence - I get anxious" and reminds herself "remain calm" "you are a therapist - you are not 13" (Brosi & Carolan, 2006, p120).

This reminds us that therapists are humans and they can get triggered by their own family history.

Framo (1965) believed that therapists working with domestic violence might be trying to reenact their own family dynamics, so they can be processed. Psychotherapists must be aware and work through any unresolved family conflict (Brosi & Carolan, 2006, p120). Self-reflection can help a therapist know when their boundaries are being crossed, such as a client becoming violent within a session, "I have learned in my program that I need to end the session when that happens" (Brosi & Carolan, 2006, p124). After time therapists who gain more experience working with IPV can learn what to expect, and tolerate and sit with uncomfortable feelings ,

> "I was definitely very anxious at the beginning and I think it drove me to focus heavily on content and probably not be as helpful as I needed to be"
>
> (Brosi & Carolan, 2006, p121).

Being consciously aware of when the therapist looks away, or triggered by their own experience, and being willing to take their insecurities to supervision is very important (Brosi & Carolan, 2006). With IPV, the perpetrator may disgust you, draw you in, blind side you, frighten you (Brosi & Carolan, 2006). Being aware of the dynamics at play to be somewhat objective, when dealing with a potentially dangerous client is very important (Brosi & Carolan, 2006).

Arlene Vetere and her team work to investigate violence triggers in clients such as abandonment or shaming by attachment figures and unconscious childhood trauma (Scerri, Vetere, Abela, Cooper, 2017, p51). The author can see a theme emerging of the possibility of childhood trauma being replayed through violence in later life. Tracking tools used in trauma therapy are

encouraged to teach clients to recognise their internal responses, so they can learn that they do have a choice in how they react when triggered (Scerri *et al*., 2017, p51). The author finds this important to highlight that the clients can also choose not to use violence. Examining the patterns of interaction that led to the violence, without victim blaming, may make some of the "emotional dynamics" more understood (Scerri *et al*., 2017, p51). It is especially noteworthy for a psychotherapist to examine and be curious about trauma responses, from the survivor and perpetrators' childhood past (Scerri *et al*., 2017, p51). A lot of survivors believe they do not deserve safety from their own insecure attachment styles and do not know what safety feels like (Scerri *et al*., 2017, p51). Again, the author would warn against victim blaming, but would advise some future research in the areas of how to help a survivor of IPV to feel more secure and trusting of themselves and their own worth.

This following chapter explores working therapeutically with individual perpetrators and couples experiencing IPV, focusing on supervision, risk assessment, and therapist self-awareness in working with transference and countertransference issues.

Chapter 2: Supervision and Risk Management

Arlene Vetere and her team work with perpetrators of "situational abuse", where they believe violence happens due to "unregulated physiological and emotional arousal" (Scerri *et al.*, 2017, p68). As clinicians, working with IPV is complex and there are "ethical dilemmas around safety and agency" working alongside people who choose to stay with abusive partners and want to be helped to do so (Scerri *et al.*, 2017, p2). It is recommended best practice to suggest a zero-tolerance contract to violence, without shaming and humiliating the perpetrator (Scerri *et al.*, 2017, p6). When looking to work with perpetrators of IPV, it is important that the perpetrator can take responsibility (Scerri *et al.*, 2017). Vetere and her team refuse to work with perpetrators who "remain angry, entitled and very frightening to others", in these cases it would not be safe to work with the family (Scerri *et al.*, 2017, p68). More research targeting working therapeutically with perpetrators coercive control is required.

When working with family psychotherapy around IPV and domestic violence safety is the main concern and safety planning is of utmost importance (Scerri *et al.*, 2017, p53). Vetere and her team insist on working with "stable third", possibly a social worker to come up with a safety plan to ensure everyone can work together transparently (Scerri *et al.*, 2017, p53). The safety plan uses the families resources to soothe each other, through reassurance, or a smile, to encourage calming down emotional arousals and prevent outbursts (Scerri *et al.*, 2017, p53). As some people were not comforted as children, they may have learned unhealthy ways of escaping unbearable negative feelings such as shame and sadness (Scerri *et al.*, 2017, p53). Helping the family to learn how to comfort each other, can in theory help to change some intergenerational learnings with the hope of lessening violent outbursts (Scerri *et al.*, 2017, p53). It would appear

to the author that Vetere and her team aim to modeling healthy patterns that the couple in IPV can integrate, as they may have not had secure attachments or role models growing up (Scerri *et al*., 2017).

Eric McCollum and Sandra Stith's paper suggests there are cases where couples therapy can be "safe and effective", again potentially highlighting in some cases it would not be appropriate (McCollum & Stith, 2007). Critics of couples therapy for clients experiencing IPV believe that it can cause further victimisation and partially suggest blame on the victim (McCollum & Stith, 2007). As such, joint therapy for couples remains controversial, as many survivors reported violent incidents after family therapy (McCollum & Stith, 2007). The critics believe that the perpetrator may retaliate if it was a particularly confronting session (McCollum & Stith, 2007). Again, this highlights the importance of risk management before considering seeing clients conjointly. McCollum and Stith highlight that not all violence is experienced the same (2007). They distinguish between "situational violence" and "intimate terrorism" which would be more in line with coercive control (McCollum & Stith, 2007). While their paper is in no way attempting to minimise the experience of the survivor of situational violence, with careful screening it may be possible to see both clients together in this instance (McCollum & Stith, 2007). However, it would not be recommended to meet a perpetrator and target of coercive control as a couple (McCollum & Stith, 2007). According to McCollum and Stith screening should be done separately with each client, so each client can speak openly without the presence of the other (McCollum & Stith, 2007). Once therapy begins, it is also recommended for an extra separate check-ins with the psychotherapist(s) (McCollum & Stith, 2007). Therapists should be aware of potential escalations, place responsibility on the perpetrator and be aware of

legal issues around when they should break confidentiality (McCollum & Stith, 2007). Again, the continued theme of the importance of continual risk assessments and working within the community seems essential.

When working with clients, psychotherapists have access to the present moment and also their own history and anticipated futures (Scerri *et al*., 2017, p117). Secondary traumatization and compassion fatigue are risks while working in the realm of IPV (Scerri *et al*., 2017, p117). Supervision plays an important part, in becoming aware of the transference and countertransference, when the therapist is triggered by something that occurs within a session (Scerri *et al*., 2017, p119). Supervision should provide a safe space to discuss mistakes and prejudices, however some therapists may be fearful of the "critical gaze" - and scrutiny (Scerri *et al*., 2017, p119). In a safe supervisor relationship, supervisees can explore their anxieties and experiences of "somatic countertransference" (Scerri *et al*., 2017, p120). The author believes that in order for supervision to work, the therapist has to be able to discuss when things went wrong. The therapist can explore any "defensive processes" that they are using and examine their own relationships with attachment figures (Scerri *et al*., 2017, p120). Supervision is a place where transference can be explored, such as how the clients defenses are influencing the therapeutic relationship (Scerri *et al*., 2017, p120). Scerri believes that it is important that this work of making conscious "what we do not know" when exploring the therapists responses to their experiences in the therapeutic alliance working with IPV (Scerri *et al*., 2017, p120). Some countertransferential themes might be finding it difficult to listen to cruel accounts of abuse and neglect, and also disappointment if violence reoccurs (Scerri *et al*., 2017, p121).

The support of supervision is important to build or develop the trainees self-confidence, and also to normalize their anxiety and help with their reactions to the abuse (Brosi & Carolan, 2006, p125). Supervision creates an open and accepting environment, where blocks in the therapeutic and supervision process can be explored (Brosi & Carolan, 2006, p125). Supervisors can also help to highlight when the therapist has become normalised to abusive situations within the therapeutic relationship and between the presenting couple (Brosi & Carolan, 2006, p125). Brosi and Carolan caution against simply looking at the interaction as a system to stress the importance of recognising abuse, in order to be able to intervene and prevent violence (2006). A major finding from their study is stressing the importance of self-awareness when working in a therapeutic setting with IPV (Brosi & Carolan, 2006, p125). The supervisor can help their supervisees to look for "blind-spots", whether they simply lack the expertise, or whether they are avoiding for more "subdued reasons" (Brosi & Carolan, 2006, p121). The reasons for blind spots may be anxiety around working with such difficult clients, or conflict with their belief systems (Brosi & Carolan, 2006, p121). Brosi and Carolan stress the importance of being able to address fears and anxieties openly and creating a psychologically safe environment within the supervisory relationship (Brosi & Carolan, 2006, p121). Anxieties around countertransference can arise from feelings of incompetence (Brosi & Carolan, 2006, p124). Supervisors should work to "normalise" their supervisee's anxiety, and lack of confidence at the beginning, and be wary of overconfidence, which could be a sign of arrogance (Brosi & Carolan, 2006, p124). While researching, the author feels that training cannot psychologically prepare yourself for the horror and projected feelings in the room, which can come home with you. This is something that needs to be felt, and worked through in supervision, journaling and personal therapy. Brosi &

Carolan and McGuiness's studies highlight the importance of self-awareness and supervision (2006).

Understanding the dynamics of coercive control is very important for risk assessment when working with couples therapy (Scerri *et al*., 2017). Supervision can be a safe place to untangle the couples dynamics from an unbiased perspective. Perpetrators using coercive control use grooming tactics to lull their kind partners into thinking their needs are paramount (Hennessy, 2012). Male sexual entitlement and ownership of their partners' bodily integrity is used to feel a God-like control over their partner (Hennessy, 2012, p23). Society tends to look for blame within the victim. Abusers are very manipulative and can "groom" the law enforcement, courts, and even therapists, that their abuse was justified, as their needs including sexual were not met (Hennessy, 2012). Societies and religious view of male sexual entitlement feeds into considering marital rape a lesser crime than stranger rape (Hennessy, 2012). When working with abusers of this kind - they will try to elicit sympathy, and the only way to avoid this, is to work closely with trained supervisors (Hennessy, 2012, p237). One of their rules of work is never to work with a perpetrator alone, and a supervisory structure must be in place to ensure that the staff is not "groomed" or manipulated (Hennessy, 2012, p237).

Another theme that has emerged from the research is the importance of risk management. A qualitative study by Desreen Dudley, Kathy McCloskey and Debora Kustrol (2008) provides valuable insight into the therapist's perception of the risk of violence and what interventions they would make. When presented with a vignette where it was subsequently revealed there was a lethal outcome, most therapists did not identify the presence of IPV, and none predicted the

victims death (Dudley *et al*., 2008). Dudley's (2008) paper outlines some of the risks of lethal outcomes and believes that therapists should be trained in recognising. These lethal outcomes include: the perpetrators belief that the relationship is in danger or ending; past threats of suicide or to kill their partner; unemployment; the severity of the violence in the past; whether the IPV includes stalking behavior and drug and alcohol use (Dudley *et al*., 2008). The results of the study of examining the vignette found that that blame was attributed to both partners, and only 12% of the sample has assigned blame to the perpetrator, despite his violence and abuse being highlighted centrally in the vignette (Dudley *et al*., 2008). Half of the family therapists stated they did not have enough information to determine responsibility (Dudley *et al*., 2008). In a chilling reminder of the dangers of IPV

"sometimes victims only get one chance to either directly or indirectly ask for help and therapists only have one opportunity to recognise when help is warranted and to intervene effectively". (Dudley *et al*., 2008)

In examining interventions recommended, half of the respondents recommended separation, in spite of widely known research that separation can be the most dangerous time for lethality (Dudley *et al.,* 2008). Some of the therapists focused their interventions on the victim alone, or would work with the couple together, when again this can be very dangerous working with a perpetrator who will not take responsibility for their actions (Dudley *et al.,* 2008). The researchers were surprised with one outcome that a third of the therapists who were sampled, decided against changing their suggested interventions after being informed of the victim's rape and murder by her partner (Dudley *et al*., 2008). It appears the therapists reactions may be due to their apparent lack of power in influencing or predicting the outcome when working with

clients of IPV. However, Dudley warns that the therapists failure to modify their responses, might point to their confidence in their interventions and "unwillingness to make changes" (Dudley *et al.,* 2008). This unwillingness to change and potential ego driven response can pose a threat when working with IPV (Dudley *et al.,* 2008). The main findings from the paper are the need for greater training and awareness of potential signs of IPV when working with couples experiencing conflict (Dudley *et al.,* 2008). The author believes that a limitation of this paper is that in examining a vignette the therapists did not get a chance to meet the couple directly, and they cannot know for sure how they would react in the moment countertransferentially. The author believes that these kinds of studies examining interventions and the outcome for couples experiencing IPV are helpful in further enhancing knowledge on risk assessment and coming closer to finding ways of determining whether therapist interventions are helpful or not in the long term at reducing violence. This paper highlights therapists inability to access the risks in couples presenting with IPV. When a therapist accurately assesses the risk of lethality in IPV they can lessen the risk of choosing "dangerous interventions that may inadvertently increase client risk" (Dudley *et al.,* 2008).

It is also important to consider risk management from the therapist's own personal safety. There is an interesting research called "Psychotherapists in Danger" which investigates working therapeutically with threatening clients (Cornish *et al*., 2019). There seems to be a lack of discussion about the effects of working therapeutically with abusive perpetrators of IPV who threaten the therapist directly. The author has included this research in order to highlight the issue of therapist safety when working with IPV. If a therapist feels under threat and has to call the police the client may lose trust in the therapist and never trust mental health professionals

again. (Cornish *et al.*, 2019). Countertransference reactions may leave the therapist in fear of their safety and may consider whether they can continue to work together or whether the client should be referred (Cornish *et al.*, 2019). These are difficult themes, as the therapist may genuinely be in danger, and they have to balance between their client's confidentiality, duty of care to their client and their own personal welfare and safety. Again, it would appear that supervision with a supervisor trained in IPV would be vital for the therapist who may doubt their actions when placed in a very difficult situation. Self-care of the therapist is vital when presented by a stressful situation such as working with an abusive client (Cornish *et al.*, 2019). It is also advised to take a community approach working with peers to provide a support network where they can provide support and direct feedback (Cornish *et al.*, 2019). It is important for therapists to know their limits and know when to contact the authorities (Cornish *et al.*, 2019).

LIMITATIONS

Due to lack of literature on the psychodynamic psychotherapy process of working with IPV in particular, some references to material covering general violent perpetrators will be referred to. It will be assumed that this violence unconscious processes will be similar; however, some nuances may be lost as to the specifics to IPV. IPV is a complex issue, and appears to be a taboo subject, reflected in the lack of literature of working with preparators. As perpetrators of IPV often fail to take responsibility to change and attend psychotherapy, there is less research available into successful outcomes with perpetrators of IPV (Scerri *et al,*. 2017).

CONCLUSION

The existing literature places an importance on examining transference within the therapeutic relationship to help to discover unconscious patterns of behavior with the hope they can be changed (Yakeley, 2010). Jessica Yakeley (2010) and Anna Motz (2014) highlight the need to understand the unconscious dynamics at play in violence and IPV. A theme that emerged from the current research is the importance of examining the therapist's family of origin and personal history to become aware of countertransference issues in the therapy room (Brosi & Carolan, 2006). As a psychotherapist it is important to be aware of countertransference feelings such as trying to fix things, or hoping things will work out (McGuinness, 2015, p35). The author believes that psychotherapists should challenge a perpetrator's sense of entitlement when examining the transference within the therapeutic relationship, so they can start to take responsibility for their actions (Scerri *et al*., 2017).

There appears to be a lack of research on how to work psychodynamically with Intimate Partner Violence. Current research focuses on gender issues, power and control, and entitlement, without addressing the underline aetiology. A fundamental question the author finds is why the preparator appears to want to hurt their partner they claim to love. Is there any correlation into witnessing this behavior or experiencing trauma in childhood (Motz, 2014)? Is there any correlation as suggested in the literature that IPV is affected by emotional dysregulation (Lee *et al*., 2019)?

Working with a trained supervisor can help the therapist work through transference and countertransference as they occur in the therapeutic relationship between the therapist and perpetrator or couple experiencing IPV (Scerri, *et al*., 2017). The safety of the survivor of the IPV and the therapist's safety are of utmost importance, so risk assessment with a team is vital and understanding how to handle potential threats of violence played out in the therapeutic relationship (McCollum & Stith, 2007, Cornish *et al*., 2019). When considering risk management when working therapeutically with IPV and domestic violence within a family system, a "stable third" such as a social worker is important to come up with a shared safety plan (Scerri *et al*., 2017, p53).

There appears to be a lot of debate on which modalities of psychotherapy are effective for working with IPV and a lot of focus on working with survivors. There does not seem to be a comprehensive approach working with the perpetrator on preventing further violence from occurring. Could researchers of different modalities and ideologies work together on a shared research initiative to investigate outcomes of successful interventions when working with perpetrators of IPV?

The psychotherapist has to do a lot of work in the therapeutic alliance when working with clients as perpetrators without a lot of clear guidance, on the risks and safety involved for the survivor (Dudley *et al.*, 2008). Perpetrators of domestic violence can be dangerous and manipulative, so it seems important not to get caught up in excessive sympathy for them or minimize their abuses (Scerri *et al*., 2017, p53). In working therapeutically with IPV, a clear and objective head is required, a lot of self-awareness and supervision from a person trained in IPV (Brosi & Carolan,

2006) . Having empathy with the perpetrator of coercive control may prove difficult for the therapist, when their client is capable of hurting and humiliating their partner. Being able to walk in the perpetrators shoes who fails to take responsibility might be a step too far for some psychotherapists (Cordess & Cox, 1998). It would appear to the author that more training would be useful in order to address avoidance strategies by therapists who may find it difficult to sit with projected uncomfortable feelings of anger or terror (Brosi & Carolan, 2006).

Perpetrators of coercive control can "groom" their partners, agencies and law enforcements and therapists to redirect attention back to the survivor of IPV (Hennessy, 2012). It would appear important to the author that psychotherapists are specifically trained in coercive control, to recognise it and to ensure that they do not collude with the perpetrators causing more victimisation (McCollum & Stith, 2007). This would be especially the case if the psychotherapist grew up in a controlling household or experienced a controlling relationship and may minimise the effect on the partner who is the target of IPV (McGuinness, 2015).

The author agrees with Hennessy (2012) that society needs to wake up and stop ignoring the horror of IPV and force those perpetrators to be accountable for their actions. Will the law and society take IPV as seriously as an assault or sexual attack by a stranger on the street ? (Hennessy, 2012). The author believes further research and increased training in using psychodynamic psychotherapy with perpetrators and couples experiencing IPV may help in solving the perverse emergence of Intimate Partner Violence.

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