Portfolio for Professional Doctorate in Counselling Psychology (Dpsych)

‘The work chips away parts of yourself’- Exploring therapists’ experiences of working with survivors of domestic violence

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This portfolio is dedicated to all of you.

In Romanian: Acest portofoliu este dedicat intregii mele familii (Doinita (mami), Iulian (tati), Aurelia (tusi), Alin si Mona). Va multumesc din tot sufletul pentru sprijinul continuu acordat pe parcursul acestor ani. Dragostea, intelegerea, rabdarea si sprijinul vostru neconditionat au fost nepretuite. Va multumesc ca ati fost alaturi de mine. Acest protofoliu va este dedicat in primul rand voua.

City University Declaration

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Preface

This portfolio represents the culmination of my training both as a Counselling Psychologist and as a researcher. In many ways, it represents a journey that I have travelled throughout this process. My journey of writing this thesis has taken place over the past two years. However, my journey within the field of domestic violence, the topic of this thesis, has taken place over nearly four years. I have had the privilege of supporting survivors of domestic violence and advocating on their behalf in a variety of settings (e.g hospital, courts, safeguarding strategies meetings and homelessness departments within local authorities). I have also had the opportunity to provide training on domestic violence awareness to a range of professionals within law enforcement, Social Services and specialists within drug and alcohol agencies. During my three-year placement as a Trainee Counselling Psychologist, I have also offered therapy to survivors of domestic abuse. On a personal level, I must confess that I am a survivor of domestic abuse. Therefore, the subject of intimate partner violence has been a huge part of my life. Throughout this journey, I gained a lot of knowledge, skills and understanding of the phenomenon of domestic violence, allowing me to empathise, understand and find ways to support those who are still experiencing or have experienced domestic abuse. Very often, however, throughout this journey, my thoughts went not only to my clients, but also to the professionals involved in this arena. How does this work affect them? What are the experiences of the therapists who work with this client group? Are therapists' experiences different from other professionals working in this field (e.g. advocates, solicitors, nurses, social workers)? In addition, following a thorough literature research that aimed to explore the therapists' and other mental health workers' experience of working with survivors of domestic abuse, I was surprised to find no study written from a Counselling Psychologist perspective. Kasket (2012) highlights the fact that Counselling Psychology is a pluralistic-orientated branch of psychology that aims to embrace a plurality of viewpoints and possibilities. Following Kasket's (2012) idea, I hope this thesis will contribute to the field of Counselling Psychology by offering a Counselling Psychologist perspective of the therapists' experience, being sensitive and open to previous research in this field.

This is what inspired me to carry out this research in the first place.

A note on the terms used in the portfolio

The terms "Counselling Psychologist", "therapist", "psychologist" and "clinician" will be used interchangeably throughout this portfolio.

The terms "victim" and "survivor" of domestic abuse are both used interchangeably to describe women who have experienced domestic abuse. It is argued (Nicolson, 2010) that the term "survivor" is inspired by the feminist-perspective discourses about domestic abuse, as it emphasises "an active, resourceful and creative response to abuse" (p. 30). I endeavoured to use more often the word "survivor", as I believe anyone who has experienced domestic abuse is a survivor.

The terms "domestic violence", "domestic abuse", "spousal abuse", "battering", "family violence" and "intimate partner violence (IPV)" have all been used to describe violence within interpersonal relationships. Nicolson (2010) notes that, recently, the terms domestic violence and domestic abuse have replaced "battering" (previously associated with wife battering and therefore violence perpetrated within martial relationship by a man towards a woman). The phrases "domestic violence" and "domestic abuse" are more frequently used in the UK and Europe, whilst "family violence" and "intimate partner violence (IPV)" are more common in the United States of America (Nicolson, 2010). For the purposes of this study, all the above terms have been used interchangeably. Nicolson (2010) argues that the change from the term "battered woman/wife" , an outdated term when referring to violence within relationships, points out the changes in the social, political, ideological and legal climates over the past thirty years. The new terms allow references not only to the "wives", but also to the partners within unmarried heterosexual and gay couples and violence perpetrated by family members (so-called "honour-based violence").

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This preface introduces the various components of the Doctoral Thesis Portfolio. This doctoral portfolio is divided into three areas related to the topic of working with clients who experience or have experienced domestic violence and to the practice of Counselling Psychology.

Firstly, there is an exploratory piece of research focusing on the experience of the therapists who work with survivors of domestic violence. Secondly, a case study presents a reflexive exploration of the clinical journey undertaken with a client with depression and substance misuse following an abusive relationship. Finally, there is a critical review of the literature exploring the effectiveness of couple therapy in domestic violence cases.

An overview of each piece of work explaining in more detail the area that it covers and its aims and objectives will now be presented. The preface will then be concluded with a summary of how the pieces are connected by a more personal theme.

Part A: The doctoral research

This section consists of an original piece of research that aims to explore in-depth the lived experience of the therapists who work with domestic violence clients and the impact this work might have on the therapists' intimate relationships. The research study is the chief component comprising this portfolio. The study uses semi-structured interview data gathered from a homogenous sample of eight therapists who have worked in the domestic violence arena for over 5 years.

Following Smith, Flowers and Larkin' s (2009) suggestions, the interviews aimed for rich and expressive information about the therapists' experience to emerge. The data analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA) permitted exploration of each participant's unique and individual experience of the meanings and particulars of the phenomenon (Smith & Osborn, 2003). Once analysis was completed on each individual transcript, prevalent themes emerging from the narratives are explored. The analysis is discussed in the light of theoretical insights gained as well as the extent of the empirical literature. Implications for the clinical practice of Counselling Psychology are identified and discussed.

My motivation in carrying out this research developed from my own experience of working with survivors of domestic violence and the impact this work has on my personal and

professional life. I hoped this research would allow me to gain an insight into therapists' experiences, to explore whether their voices could be utilised to identify implications for professional training and supervision. I also hoped that being given the opportunity to reflect upon their feelings about the impact of their work on the personal and professional life may allow them to clarify or process these feelings somewhat. A more in-depth rationale for writing this thesis will follow later in the portfolio.

Part B: Professional practice

This section consists of a clinical case study of a client who presented with substance misuse and depression. The work aims to be a critical reflection on clinical practice as a Trainee Counselling Psychologist, as well as an account of my clinical skills, including the ability to integrate theoretical concepts with practice as well as personal and professional self-awareness. This case study demonstrates some of the effects of domestic violence on women. Previous research in the domestic violence field (Walker, 1979) indicates that victims of domestic violence may develop a number of emotional and behavioural problems, including depression, anxiety, posttraumatic stress disorder and alcohol abuse, to name a few. This client study is an illustration of how substance misuse and depression is partly the consequence of an abusive relationship. There is a focus on the therapeutic alliance between therapist and client across twelve sessions of Cognitive Behavioural Therapy (CBT). The client's presenting difficulties are collaboratively formulated within a CBT model. Based on the formulation, a treatment plan of clinical interventions is developed to address the client's goals. The therapeutic work is critically evaluated within a Counselling Psychology reflective practice, providing an opportunity to learn about psychotherapeutic practice and theory, as well as being a therapist.

Some could argue that choosing to present a client study within a CBT approach might be at odds with the phenomenological approach of IPA. For some authors (Grant et al., 2010), CBT is based on assumptions of positivism and realism exemplified by a quantitative-experimental research. Dobson and Dozois (2009), on the other hand, argue that most philosophical foundations of CBT can be seen in "constructivism", which claims that the reality is socially constructed and it exists as a function of the observers who see it and it

represents dynamic and subjective knowledge. Interpretative Phenomenological Analysis (IPA) has an idiographic focus, which means that it aims to offer insights into *how* a given person, in a given context, makes sense of a given phenomenon. Similarly, a CBT approach looks at how certain life events have generated cognitive schemas, core beliefs through which a person makes sense of their experience. Harré (1995) has commented on the compatibility between constructivism and cognitive psychology, stating that cognitive theories' recent developments are nothing more than "the advent of discursive psychology" (Harré, 1995, p.144).

As Counselling Psychologists, we use cognitive behavioural therapies within a wider framework, integrative, incorporating both cognitive and constructivist principles, focusing upon individual meaning and formulation of problems within a social context. Contextual constructivism here, can be seen as increasing the depth of therapeutic practice, with a focus upon meaning and social context as opposed to "distorted" cognitive processes.

Mahoney and Gabriel (2002) note that this approach has began to influence cognitive therapeutic practice, resulting in what has been named the "third wave" of CBT (such as acceptance and commitment therapy, narrative approaches and mindfulness based cognitive therapy). In this way, cognitive oriented therapies are reaching towards models more adequate to the complexity of human meaning moving away from its realist epistemological roots. Neimeyer and Raskin (2001) acknowledge that this approach moves away from pathologizing, from the dominant use of diagnostic categorical labels turning instead its focus on an individual's meaning of experience creating a bridge between epistemological position that can house phenomenology and IPA and the cognitive therapies used within a wider framework.

Part C: Critical literature review

The aim of this section is to present a systematic and critical appraisal of the literature on a topic relevant to the practice of Counselling Psychology: couple therapy where intimate partner violence is present. Department of Health (2002) estimates that 50% of women presenting for talking therapy have some experience of domestic violence. Relate, the UK organization that delivers relationship support services to adults and children, individually and as couples and families, in 600 locations across England Wales and Northern Ireland state that 45,000 of the 150,000 clients that visit Relate each year reveal that domestic

violence and abuse is an issue in their lives (Owen et al., 2008). Over the years spent working in the field of domestic violence, I have noticed many clients (survivors who were still living with their perpetrators) and professionals (unaccustomed with the knowledge surrounding the cycle of violence and having little domestic violence awareness) seeking to get therapeutic support for the perpetrators of the domestic violence but in the context of couple therapy. This made me wonder how effective couple therapy can be when intimate partner violence still occurs and what the recommendations of the professionals in this arena are.

Thematic connection of the portfolio

The separate components of the portfolio are linked primarily by the overriding theme of the therapeutic work with survivors of domestic violence and how this type of work challenges the therapist both on a personal and professional level. This is explored in the research, looking at the experience of therapists working with survivors. Results will show how the therapeutic work with survivors of domestic violence transforms the therapist both personally and professionally. As a Counselling Psychologist, the data was analysed and discussed through an integrative lens. The client study component allows reflection on the possible impact that domestic violence might have on the clients who come into therapy and the coping strategies they use to cope with this experience. The clinical work was approached from a CBT perspective as required by the therapeutic service. The literature review takes a step further and examines the effectiveness of couple therapy in cases of domestic violence. It was intended that all the components would reflect the scientific-reflective practitioner stance of a Trainee Counselling Psychologist, which, according to Strawbridge and Wolfe (2003), represent the values of Counselling Psychology practice.

Part A: Doctoral Research

‘The work chips away part of yourself’- Exploring therapists’ experiences of working with survivors of domestic violence

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Supervised by Dr. Jacqui Farrants

Abstract

Domestic violence is a widespread concern in our society worldwide. Therapists and other mental health workers often come across clients who have experienced or are experiencing domestic violence. There is significant research, predominantly quantitative, on the phenomenon of vicarious traumatisation/secondary trauma on social workers, domestic violence advocates and sexual abuse therapists. In contrast, research into the impact of domestic violence work on domestic violence therapists is sparse and fails to address how working with this client group might affect therapists' intimate relationships. This study addresses this gap by exploring the lived experience of therapists who are or have been working with survivors of domestic abuse. Semi-structured interviews were conducted and the data was analysed using Interpretative Phenomenological Analysis (IPA). Participants were eight female domestic violence therapists, aged between 31 and 55 years of age, working in the field of domestic violence for over 5 years. Three superordinate themes emerged from the interview data: ***The journey of listening to the clients' story; When work hits home;*** and ***The dawn of a new self*.** This study's findings have been discussed in relation to existing literature in order to understand the mechanisms and processes involved in the experiences reported by participants. Therefore, suggestions can be made for training and clinical supervision for therapists who are working or who contemplate working with this client group. The therapist as "wounded healer" and the potential for vicarious traumatisation in therapists who work with survivors of domestic abuse are also explored. Limitations of the study and recommendations for future research are discussed.

Rationale for the thesis

When I first started to think about conducting this research, my aim was to explore the experiences of the therapists working with the domestic violence clients and, in particular, looking at the impact that the work has had on their intimate relationships. However, there were also more personal reasons for my wish to know more about these experiences. The initial idea for this study was drawn from my own experience of working with domestic violence clients and from my observations regarding the shifts I have experienced in viewing intimate relationships as a result of my work. Moreover, my personal experience of domestic violence within my own intimate relationships generated, I would say, the birth of a "new me", whose views on the world and intimate relationships allowed profound transformations. This generated many questions within me, and I found myself more and more curious about how working in the field of intimate partner violence affects the workers. Discussions with my fellow colleagues (helpline and outreach workers, domestic violence advocates) regarding the personal impact of this work made me realise the extent to which transformations take place within the workers, partly because of a greater awareness of the domestic violence issues and partly because of hearing traumatic accounts. At this point, my thoughts turned to the therapists working in this field. Unlike domestic violence advocates whose work is largely focused on the practicalities surrounding the support offered to the survivors (e.g. housing advice and support, support in courts), the therapists engage with their clients at a deeper level: they aim to reach the core of trauma in order to start the healing process. How do the traumatic stories affect them and their views on intimate relationships? I realised this research would be challenging, mostly because of my positions: a survivor of domestic abuse, a therapist having had clients who experienced domestic abuse in their relationship, and a domestic violence advocate. I wondered if therapists working with this population and who have more experience than I do experience similar feelings. If so, what made them feel this way? What was it that made their experience as it was? Essentially, I felt it was important that participants were provided with an opportunity to discuss and reflect on their experiences. The impact of domestic violence work on therapists and the effect this work has had on their intimate relationships is something that has not been widely researched, especially within the United Kingdom. It seemed important to provide the therapists with a voice regarding their experience. I also hoped that listening to their accounts would answer some of my personal questions about the changes I have experienced within myself in

working with this client group. I have tried to be as open-minded as possible when analysing the data; however, the reader should remind himself/herself that the analysis that emerged is one way of interpreting data, and, undoubtedly, my personal experiences within the field of domestic abuse has impacted the analysis. Nevertheless, I hope that I can give voice to the lived experience of the therapists working with domestic violence trauma and make sense of how this type of work might enmesh with therapists' family life.

The aim of this research, as a Trainee Counselling Psychologist, is to increase understanding and knowledge amongst clinicians and professionals of the potential transformations that can occur as a result of working with survivors of domestic abuse. Having personally experienced changes within myself following work with survivors of domestic abuse, I want to contribute my passion and experiences to further inform this research study.

1. Introduction

In conducting this research, I hope to shed some light on what it means to be working with the survivors of domestic violence and the impact this work might have on the therapists' intimate relationships. Although the literature has focused largely on vicarious trauma, as a result of working with traumatised clients, I wish to provide an insight into the unspoken emotions behind the work with survivors of this specific trauma.

Although each therapist's experience is personal and unique, it is my view that their accounts can be crucial in revealing ways to support the therapists in this field through adequate training and supervision. Ultimately, I hope this thesis will provide a sense of understanding and clarification about the therapists' experience and the changes they face as a result of the work; not only for themselves, but for their intimate partners, friends, family and interested others.

I will introduce this study by initially providing a contextual overview of domestic violence and related concepts of vicarious trauma. Following this, I will present a review of current literature about the vicarious trauma in professionals working with interpersonal violence. I will observe both qualitative and quantitative studies investigating the experience and comment upon the concept of post-traumatic growth. I shall subsequently explain my rationale for conducting this thesis, in light of everything discussed and why it is necessary for a study such as this to take place.

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> *"It is inevitable that the doctor should be influenced to a certain extent and even his nervous health should suffer. He quite literally "takes over" the sufferings of his patient and shares them with him. For this reason he runs a risk and must run it in the nature of things"(Jung, 1966, p. 171-172).*

1.1 Setting the scene – domestic violence as a public health concern

Watts and Zimmerman (2002) researched violence against women worldwide and concluded that domestic violence in our society is widespread worldwide, between people from various cultural backgrounds, across society, regardless of economic status. It is paramount to

recognise that violence against women is an international reality, only recently recognised as a major public health concern. Domestic violence, also known as domestic abuse, spousal abuse, battering, family violence, and intimate partner violence (IPV) is defined as a pattern of abusive behaviours by one partner against another in an intimate relationship such as marriage, dating, family or cohabitation (Shipway, 2004). The UK government gives a more extensive definition of domestic violence: *"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality"* (Home Office, 2000). This definition includes issues of concern to black and minority ethnic (BME) communities, such as so-called 'honour'-based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

In September 2012, the UK government announced that the definition of domestic violence would be widened to include those aged 16-17 and wording should reflect coercive control. The new definition, implemented in March 2013, states: *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality* (Home Office, 2013). This incorporates, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, and emotional.

The decision follows a Government consultation that called overwhelmingly for this change. Extending the definition will increase awareness that young people in this age group experience domestic violence and abuse, encouraging more of them to come forward and access the support they need – advocacy, outreach services, helplines or counselling. The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) have recognised the domestic violence as a concern that the professionals in the mental health field should be aware of. NICE is currently developing a public health guidance on "Domestic violence: how social care, health services and those they work with can identify, prevent and reduce domestic violence" and is expected to be released in February 2014.

1.2 Prevalence of domestic violence in the United Kingdom and its implications for therapists

The British Crime Survey found that there were an estimated 12.9 million incidents of domestic violence acts (that constituted non-sexual threats or force) against women and 2.5 million against men in England and Wales in the year preceding interview (Walby & Allen, 2004). An analysis of 10 separate domestic violence prevalence studies found consistent findings: 1 in 4 women experience domestic violence over their lifetimes and between 6-10% of women suffer domestic violence in a given year (Council of Europe, 2002). In the UK, domestic violence accounts for nearly a quarter of all recorded violent crime (Flood-Page & Taylor, 2003) and have the highest rate of repeated victimisation of any crime (Kershaw et al., 2000; Stanko, 2003). Though only a minority of incidents of domestic violence are reported to the police, the police still receive one call about domestic violence every minute in the UK, an estimated 1,300 calls each day, or over 570,000 each year (Stanko, 2000). However, according to the British Crime Survey, less than 40% of domestic violence crime is reported to the police (Dodd et al., 2004; Walby & Allen, 2004; Home Office, 2002). The very nature of domestic violence (a crime behind closed doors) makes it difficult to quantify.

McGibbon et al.(1989), who conducted a survey on 281 women attending GP surgeries in West London, found that 1 in 3 (33%) reported suffering abuse from a male partner. This included 27% who reported experiencing repeated verbal or physical threats from a male partner, 18% who reported their partners had beaten them, and 13% who reported being forced to have sex. A similar survey conducted by Stanko et al. (1998) found that 1 in 9 women attending GP surgeries in North London reported experiences of domestic violence serious enough to require medical attention in the last year and 60% had experienced some sort of abuse at some time in their life. A related study established that nearly 1 in 5 counselling sessions held in Relate Centres in England mentioned domestic violence as an issue in the marriage (Stanko, 2000).

The staggering figures in the above studies highlight the prevalence of domestic violence and its vast implications for the mental health field. Counselling Psychologists have the opportunity to practice in a variety of settings, and given the high prevalence of domestic violence, it is very likely that they might encounter in their practice clients experiencing it.

Therefore, it is essential the therapists are aware of the possible presentations in therapy when working with this client group and the possible effects of domestic violence on survivors.

1.3 Understanding domestic violence: origins, maintenance and possible interventions

This section aims to offer a brief overview of the main theories that attempt to address possible origins of domestic violence, how the abusive//violent behaviours within relationships are maintained and how these theories address the issue of possibility of change. It hopes to provide the reader with different perspectives on the phenomenon of family violence found in the literature. Several psychological theories address the cause of domestic violence; however, they do not have a common agreement about the fundamental causes that contribute towards the development and maintenance of violent behaviours. Cunningham et al. (1998) describe four main theoretical categories discussed in the literature: psychodynamic theories on domestic violence, social theories of domestic violence, cognitive behavioural theories of domestic violence and family and systems theories of domestic violence. Each theory will be addressed below.

- **Psychodynamic theories**

Psychodynamic theories highlight the individual internal psychological processes that create a need to be abusive or to accept abusive behaviour. According to Howard (2011), psychodynamic models are based on the idea that we have an "inner world" that has a powerful influence on how we feel, think and behave. Engle and Arkowitz (2006) outline the main ideas of the attachment theory based on the work of Bowlby (2005). Attachment theory gives emphasis reciprocity between individuals within a relationship. According to Bowlby (2005), a child develops a "working model" of what can be expected from his or her primary caregiver. If the caregiver continues to respond in expected ways, a secure attachment develops and this will offer a safe haven and a secure base. However, if the caregiver's responses become consistently unpredictable, the infant is forced to revise his or her model, and the security of the attachment changes, fear and insecurity activating the behavioural system (Standish, 2012). Bartholomew et al. (2005) asserts that insecure models tend to lead individuals to recreate, to "repeat" or maintain insecure patterns in their adult relationships. These ideas follow somewhat from Freud's (1914) thoughts about memory and the inter-

related concepts of remembering, repeating, and working through. Freud (1914) believes that the present mind contains the past, though often in unrecognizable form. Remembering — unlike its avoidance, repetition — allows for working through: clarifying, and integrating into consciousness, something previously suppressed. Research (Bartholomew et al, 2005; Standish, 2012; Lawson, 2003) suggests that perpetrators of domestic violence present with a history of attachment disorders caused by abuse, neglect and domestic violence in childhood. Walker (1979) found that 81% of men who were perpetrators of domestic abuse have witnessed domestic abuse between their parents, or were receivers of abuse themselves.

Within the psychodynamic theories, Zosky (1999) examines the object relations theory as applied to domestic violence. Object relations theory suggests that humans are motivated from early childhood by the need for significant relationships and encounters with others (Hyde-Nolan & Juliao, 2012). These early relationships become models for all future relationships, being fundamental for the development of an adequate emotional health later on in life. Zosky (1999) asserts that if an individual did not receive enough nurturing during early stages of life, may find it challenging to maintain their self-esteem and regulate their emotions, leading to a search to complete his or her needs and enter in this way in relationships in which one is either an abuser or a victim. Zosky (1999) acknowledges that the theory of object relations theory makes a unique contribution in explaining some of the causes of domestic violence, offering an "understanding of the processes that influence adult interpersonal behaviours" (p. 55).

Attachment and object relations theories (Engle & Arkovitz, 2006) suggest that internal mental representations of the individual's caregivers and the individual's interactions with their caregivers are stable and resistant to change. These representations influence individual's perceptions and expectations regarding new relationships, being consistent with their early mental representations. These representations are resistant to change and maintained because even if they are maladaptive they offer a degree of security in fulfilling one's attachment needs. Given up these attachment patterns will cause anxiety and the individual's identity is threatened (Engle & Arkovitz, 2006). In conclusion, repeating old patterns generates a degree of security whilst "change" will create insecurity and anxiety.

According to Bowlby (1988), who addresses the issue of domestic violence in terms of attachment, relationships tend to become abusive when one of the partners is "deeply but

anxiously attached to the other and develop a strategy designed to control the other and keep him/her from departing" (p.106). Intimate emotional bonds are threatened; anxiety and fear of one's ability to survive, which come from childhood are triggered and occur in adulthood (Standish, 2012). Attachment preoccupation in either partner increases the likelihood of abuse (Henderson et al., 2005).

Lawson (2003) addresses the issue of possibility of change by approaching domestic violence in intimate relationships through the attachment theory perspective. He proposes modifying attachment styles and internal working models as necessary to bring change (Lawson, 2003). This can be obtained through creating a secure base and assessing client's attachment style, focusing on attachment needs, fears, vulnerabilities, create a collaborative alliance, redefining the self within the attachment style, and therefore redefining the relationship. Herman (1992) describes the primary need to establish safety before work with domestic abuse can begin. Levy & Lemma (2004) advise that in order to provide a secure therapeutic base, feelings of anxiety, fear and anger commonly experienced by survivors of domestic abuse are freely explored within the therapeutic alliance. This creates the base for new relational patterns to develop and eventually to extend outside the therapy room. Bartholomew et al. (2005) and Lawson (2003) suggest that the development of internal working models and attachment styles is an ongoing process with each relationship helping to maintain, enhance or change established patterns. Nicholson (2010) recognizes that in this way survivors will have greater internal resources that reduce the risk of developing future violent relationships

- **Social Theories**

The social theories of domestic violence include control theory, which feminists have adopted since 1970's. In abusive relationships, violence is speculated to arise out of a need for power and control of one partner over the other (Hyde-Nolan & Juliao, 2012). The perpetrators of violence will use various tactics of abuse (e.g., physical, verbal, emotional, sexual or financial) in order to establish and maintain control over the partner. Feminist theory in domestic violence highlights gender and power inequality in opposite-sex relationships (Pence & Paymar, 1993). According to the feminist theories, (Zosky, 1999) men resort to domestic violence in order to keep their "power, control and privilege in a patriarchal society" (p.56).

The feminist movement recognised domestic violence not only a personal problem, but also a social issue, and, while providing shelter for individual women and children escaping violence, also took political action to raise what was seen as the underlying social cause of domestic violence – gender inequity.

Standish (2012) rightly highlights that feminist theories reject the theories that focus on various psychopathologies within the perpetrator, placing the blame for violence squarely on the male perpetrator and the socioeconomic power imbalances of control that keep women trapped in the abusive relationships. The feminist position fails to explain why some women do not terminate abusive relationships when they are able to. The dynamics of the couple relationship are not taken into account regarding the development and perpetuation of domestic abuse and domestic violence tends to be seen as a problem belonging to an individual rather than the couple (Standish, 2012).

Another limitation of the feminist theory is that despite their acknowledgment that women can also be violent in their relationships with men they do not see the issue of women abusing men as a serious social problem. Zosky (1999) considers the feminists' theory limited in their assumption that men are socialised into the roles of power and control and violence is used to maintain patriarchy. The theories choose to ignore the psychotherapeutic theory that proffers that possible early traumatic life experience can predispose some people to use control and conflict in family relationships.

The feminist position has been extremely influential in the development of the treatment programmes for domestic abuse, despite the fact that has been criticised as an oversimplification of a complex problem (Lawson, 2003). These programmes are mainly cognitive behavioural therapies with a social-political nuance regarding the position of the woman in society. Feminist interventions for change (Standish 2012) have a wide range of targets including political, legislative and cultural change to support equality, validate and empower women who have experienced domestic abuse, as well as provision of services.

- **Cognitive behavioural theories- Social Learning Theory**

The Social Learning Theory assumes that the type of behaviour most frequently reinforced by others is the one most often exhibited by the individual and the learning process is achieved

through modelling and reinforcement (Akers, 1973). The Social Learning Theory asserts that family violence occurs due to many contextual and situational factors such as individual/couple characteristics, stress, an aggressive personality, substance abuse, financial difficulties (Hyde-Nolan & Juliao, 2012). Cunningham et al., (1998) describe how from the social learning perspective, children observe the consequences of the behaviour of significant others, receive feedback regarding their own behaviours and start to develop standards and look for models that meet these standards. Therefore, Hyde-Nolan and Juliao (2012) acknowledge that children who are victims of child abuse or who witness violent aggression by one partner against the other will grow up and react to their children or partners in the same manner. The childhood survivor of a violent family thus develops a predisposition toward violence in his or her own family. Therefore, so this theory holds, we have a never-ending chain of violence that is passed from one generation to the next, maintain abusive relationships. Modelling is an important tool in learning behaviour and children learn by watching and imitating others, adopting the behaviour they observe in adults, including aggressive acts.

Interventions based upon the social learning aim to prevent the exposure of children to negative role models and the promote the skill development in those who have been so exposed (Cunningham et al., 1998).

- **Family and systems theories**

Family systems theory sees the family as dynamic organisation made up of interdependent components and violence is seen as reciprocal dynamic that aims to maintain the equilibrium of the system (Zosky, 1999). According to this theory, the behaviour of one member (e.g. violent man) is affected by responses and feedback of other members. The individuals are seen in terms of interactions and relationships with other family members, offering in this way a relational view on domestic violence (Hyde-Nolan & Juliao, 2012); the intervention usually shifts from the individual to the pattern of the relationships within the family as a group. The focus is on patterns of interactions between the couples and within the families and the site of change is the couple/family, as both partners play a role in the "family violence". The change remains primarily on an individual level rather than a social one. This theory offers a new angle when looking at family violence as it provides a framework that

allows observing how emotional difficulties and behavioural patterns are transmitted over generations. Zosky (1999) acknowledges the utility of family systems theory in offering new understandings of domestic violence; however, the author draws attention into its limitations as well. By being largely descriptive, family systems theory fails to explain why some relationships are characterised by violence and others not.

The appropriateness of couple therapy where domestic violence occurs has been widely discussed and researched (see Part C of the portfolio for a critical literature review). A consistent view had emerged -in order to address domestic violence appropriately, a thorough assessment was necessary and that the conventional couples work as an intervention had to be reviewed (Bueno, 2009). The organization RELATE in the United Kingdom has made steps in this direction and developed the "Responsive Model". RELATE is a national federated charity with over 70 years' experience of supporting relationships through advice, relationship counselling, sex therapy, education and learning services, mediation, consultations and support. Its services are delivered all over the UK at over 600 locations to couples, individuals and families. The "Responsive Model" (Bueno, 2009) aims to create a context within which individuals can disclose domestic violence in more detail and with greater clarity, and from which RELATE can "offer a response to each partner appropriately, while prioritising the safety of the vulnerable adult and children" (p. 12). The model changed perpetrator/victim language to "person using violence or abuse and person experiencing violence or abuse" allowing an empathic and non-judgmental interaction with both. The "Responsive Model" is a unique approach to family violence as the focus is not only on the complex relationship dynamic alone, but also offers each partner's opportunity to think more about each individual's personal responsibility for their behaviour within a complex relationship dynamic. The "Responsive Model" developed by Relate (Owen et al., 2008) combines individual sessions for men and women with on-going couple work. Using a double parallel approach, women are encouraged to develop a stronger sense of personal assertiveness and they supported in their own personal growth. Men are encouraged to develop ways to manage angry feelings. The model, which pays close attention to safety, has been welcomed and endorsed by the British Association for Counselling and Psychotherapy (BACP) and is thought to be an effective way of working with domestic violence.

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Many theories have existed and evolved over time to attempt to understand the reasons for violence within intimate relationships. There are still a number of significant controversies in the study of family violence and this gave birth to a number of theories that attempt to explain how or why one person would act aggressively toward another within a relationship. As seen above in the brief summary of the theories that attempt to explain domestic abuse, each one of them offers a valid explanation of the possible roots and maintenance of domestic abuse. However, the multitudes of views and theories surrounding the causes of domestic abuse remind us of the complexity of the phenomenon of domestic violence and the challenges that we face in explaining and addressing the phenomenon. There has not been one theory that identifies causes of family violence that has yet gained total acceptance by all the professionals in this area. The amount of the different perspectives on domestic abuse highlights the need to address the phenomenon holistically, to address family violence on many levels: not only with individuals at risk, with perpetrators, but also on a macro level, raising awareness on the issues of domestic violence at a society level.
What has became apparent was that all professionals must have an understanding of various types of family violence and be able to respond to this form of aggression in a manner that protects the survivors, addresses accordingly violent behaviours.

The experiences of domestic violence described by the survivors are cruel and unforgivable. When I first started this piece of research, my view on domestic violence was from a perspective of a strong pro-feminist, influenced over last 4 years by the feminist theories of power and control and gender inequality in a patriarch society. However, as a Counselling Psychologist in training, I started to address the issue of domestic violence from the position of psychology, becoming more aware of the complexities of the phenomenon, its roots, how it develops and of course, how we can address the change. The different theories on domestic violence brought into my awareness different layers of what is a very complex problem. Of course, as a feminist a natural reaction was to be revolted by partners who abuse, but as a psychologist I can see the complex dynamic within an abusive relationship and I can understand the stance of the therapist who is there to support survivors and their partners if there is a desire for reconciliation.

As a feminist psychologist, I strongly believe that the issue of domestic abuse needs to be addressed both on the individual level and on the society level. As part of the society, we need to examine our attitudes towards women/men, towards abuse, to what is acceptable and what is not in a relationship and to strive to allow equality between partners and not to accept controlling and abusive behaviours in any relationship.
Nicolson (2010) states that violence is a tragedy for everyone involved whether perpetrators, victims, family members or witnesses. As professionals who might encounter this phenomenon in their practice we need to take into account the phenomenon holistically, being aware of the history, culture, gender-power interactions, the material context, the psychology of the phenomenon and last but not least the emotions of all the parties involved.

1.4 Domestic violence and trauma

The concept of trauma is useful in helping clarify and recognise the reactions of the survivors of domestic violence.

Trauma has been defined as "an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience which shatters the survivors' sense of invulnerability to harm" (Figley, 1985, p. xviii).

The concept of trauma has been largely addressed from a broadly medical perspective. The medical model of trauma asserts that those exposed to extreme stressors may develop Post Traumatic Stress Disorder (PTSD). The Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) (APA, 2000) indicates that individuals with PTSD usually experience difficulties in three areas:
a) persistent re-experiencing of the traumatic event via flashbacks, dreams and unwanted recollections, together with persistent psychological or physiological distress with exposure to cues related to the trauma;

b) avoidance of stimuli related to the traumatic event;

c) persistent symptoms of increased arousal, such as hyper-vigilance and exaggerated startle response.

Formal diagnostic criteria (APA, 2000) require that the symptoms last more than one month and cause significant impairment in social, occupational or other important areas of functioning. Ray (2008) criticized the models and philosophies based on medical individualistic assumptions about trauma. Lykes, (2000) and Ray (2008) assert that positivistic philosophy is problematic because it remains rooted in medical individualistic conceptions of illness, where selective symptoms offer evidence of PTSD.

Phenomenology, on the other hand, moves beyond the individualistic Western medical model of diagnostic labelling, toward a global perspective in understanding victims of violence (Ray, 2008). Phenomenology highlights the unique, the personal, the individual within a certain context and with certain background, aiming to understand the individual as a whole (Smith et al., 2009).

As a Counselling Psychologist researcher, conducting a research study from phenomenological approach, I felt it was essential to look at the concept of violence and trauma from the viewpoint of the individual within a context. Looking at the impact of trauma through phenomenological lenses, I hoped to add knowledge to the existing medical model and to bring participants' voices into the forefront of knowledge about the effects of working with survivors of domestic violence.

The concept of PTSD has been a powerful tool for understanding the impact of trauma; however, the concept has its limitations. Ray (2008) asserts that the responses of the survivors are not homogeneous, and therefore PTSD cannot be viewed as a global response to trauma. Moreover, the focus on the symptom of the individuals rather than the impact of trauma can lead to a misinterpretation of the experience of the victims. That is why, Ray (2008) calls for alternative approaches to make sense of the lived experiences of those who have experienced a traumatic event.

Sommer (2008) rightly draws the reader's attention to the fact that PTSD not only affects those directly experiencing the trauma, but may also affect those who witness or learn about that particular event. This confirms Figley's research (1995, 2002) that traumatic events

create a ripple effect so that those who experience trauma-related symptoms are not only the primarily survivors, but also close acquaintances like family members and therapists.

The literature (Aguilar & Nightingale, 1994; Bergman & Brismar, 1991; Cascardi & O'Leary, 1992; Corob, 1987; Walker, 1979, 1984) indicates that victims who experience chronic and intense domestic violence victimisation may develop a number of emotional and behavioural problems, including depression, anxiety, Post Traumatic Stress Disorder (PTSD), battered woman syndrome, alcohol abuse and suicidal ideation. Astin et al. (1993) identified battered women as trauma survivors who are significantly at risk for PTSD.

Several studies (Astin et al., 1993; Cascardi & O'Leary, 1992; Dutton-Douglas, 1992) have investigated the prevalence of PTSD in battered women, and despite results not being consistent in the overall percentages of battered women having PTSD, in all cases, the rates of PTSD were high. In their samples of survivors of domestic violence, Astin et al. (1993) describe a set of psychological symptoms resembling PTSD, including anxiety, depression, memory loss, cognitive dissociation, re-experiencing of the traumatic events when exposed to similar stimuli, feelings of helplessness, sleep and appetite disturbances, fatigue, listlessness, self-imposed isolation and disrupted interpersonal relationships.

Being a victim of domestic violence certainly involves the "fear, helplessness, and over stimulation that are the centre of trauma" (Silvern & Kaersvang, 1989, p. 423).

Working with survivors of domestic violence can be a rewarding experience but, at the same time, can be emotionally draining and enormously challenging (Sanderson, 2008; Farber & Heifetz, 1981). Lindy and Wilson (1994) have acknowledged the intensity of the interaction between a client who experiences trauma and his/her therapist, as well as the collaborative relationships between the two. They metaphorically described this relationship as an exploration of "the darkest corners of the mind" (Lindy & Wilson, 1994, p. vii), having an overwhelming impact on the therapist who faces repeated exposure to the entire range of human glory and degradation.

1.5 The therapist's responses to traumatised clients

Traditionally, the professionals in the mental health field or any other helping professions are expected to create and sustain clear-cut boundaries between professional and private domains

and are not to allow experiences from work to penetrate their private lives (Goldblatt et al., 2009). Nonetheless, there is a lot of evidence in the literature (Carbonell & Figley, 1996; Coppenhall, 1995; Perlman & MacIan, 1995; Valent, 1998; Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995) to suggest that mutual influences are inevitable, particularly for those who practice in sensitive domains, such as that of intimate partner violence. Professionals working with trauma survivors have been identified as being at risk for being negatively affected by their work (Figley, 1995; Herman, 1992).

Considering that domestic violence therapy entails work with victims of ongoing trauma, researchers in the field have adopted concepts used in the general field of trauma. A range of terms has been used to describe the harmful effects experienced by some professionals who provide services to those affected by traumatic events. McCann and Perlman (1990) suggested the term *vicarious trauma*. Figley (1995) used the terms *compassion fatigue* and *secondary traumatic stress*. Maslach (1982) introduced the term *worker burnout*. McCann and Pearlman (1995) and Wilson and Lindy (1994) spoke about countertransference. All these notions offer ways to understand how professionals provide counselling.

The following sections will provide an overview of each of the above terms with reference to some studies that have looked to observe the prevalence of burnout, secondary trauma, compassion fatigue, countertransference and vicarious traumatisation in professionals working with trauma and interpersonal violence. A more comprehensive literature review follows, highlighting the presence of vicarious trauma in mental health workers and professionals in the area of interpersonal violence, sexual abuse and domestic violence.

1.5.1 Burnout

The concept of burnout was first used by psychologists in the occupational stress literature and was used to describe emotional consequences specific to "people at work". Burnout was defined by Maslach and Jackson (1981) as a defensive response to a long-lasting occupational exposure to demanding interpersonal situations that produce psychological strain and provide inadequate support. This can result either in an individual ceasing their employment or remaining in employment and functioning at the minimum of their potential output and creativeness.

Maslach and Jackson (1981), authors of the most commonly used burnout instrument, the Maslach Burnout Inventory (MBI), provided the most widely used construct definition of "burnout" as the combination of three interacting phenomena: emotional exhaustion, depersonalisation and reduced personal accomplishment. They illustrate how over-involvement and emotional exhaustion can lead to a depersonalisation through which the worker develops a cynical and detached attitude towards work and clients in treatment. At first, the depersonalisation is a self-protective mechanism. Workers feel a developing sense of "detached concern". This component of burnout involves the interpersonal and can eventually lead the worker to feeling dehumanised (Maslach & Leiter, 1997). High levels of personal accomplishment sustained by adequate structural support may allow the workers to endure moderate levels of emotional exhaustion without needing to distance themselves from clients. Personal accomplishment, defined by Masclach and Jackson (1998) as a feeling of competence and successful achievement in one's work with people, can be worsened by lack of social support, a feeling of reduced self-efficacy and fewer continual professional development opportunities. Eventually, workers feel a strong sense of failure professionally; they can resort to an apathetic detachment, cynicism or rigidity (Maslach & Leiter, 1997).

McCann and Perlman (1990) depict in their research few reasons for burnout symptoms in mental health professionals. Firstly, they acknowledge the fact that victims can present with chronic, ingrained symptoms that are difficult to treat and require long-term therapy. Secondly, trauma victims may have difficulties in focusing on the traumatic event, which can be a source frustration within the therapists. Finally, they might experience feelings of hopelessness due to the fact that they see victimisation as a reflection of social and political problems and individual psychotherapy might not have the desired impact at that level.

The concept of burnout is significant when exploring the effect therapeutic work with survivors of domestic violence has on the therapists. When discussing burnout amongst therapists, McCann and Perlman (1990) rightly recognise its special meanings: burnout can be analogous to the numbness and avoidance in the survivor, reflecting an inability to process the traumatic material. Kadambi and Truscott (2004) investigated burnout in therapists working with interpersonal violence, and a more in-depth discussion of their study is explored in the literature review section of this research study.

Grosch and Olsen (1995) advise the professionals to conduct an ongoing self-assessment process to prevent burnout by distinguishing between normal tiredness and early symptoms of burnout. This self-assessment involves being sensitive and aware of the feelings of dread about going to work, boredom, feelings of flatness and tiredness, and pessimism about the future. Grosch and Olsen (1995) add that if these symptoms persist after some time off work or a change in work-related routine, burnout should be diagnosed.

1.5.2 Secondary traumatic stress/Compassion fatigue

Unlike burnout, which can result from working with any client group, secondary traumatic stress is the direct result of hearing traumatic material from clients (Canfield, 2005). Figley (1985) defined secondary traumatic stress, which he later named compassion fatigue (Figley, 1995), as the emotional duress experienced by persons having close contact with the trauma survivor, which may include family members as well as therapists. The terms secondary traumatic stress and compassion fatigue are used interchangeably. Secondary traumatic stress (STS)'s symptoms are nearly identical to those of PTSD, including re-experiencing the survivor's traumatic event, avoidance and/or numbing and persistent arousal. As Jenkins and Baird (2003) notice, whilst the survivor can develop PTSD, the person who hears about the traumatic event may develop STS disorder. Figley (1995) depicts a situation in which the therapist is "contaminated" by the survivor and experiences symptoms similar to the post-traumatic stress experienced by the client. Figley considers secondary traumatic stress to be a natural, treatable and preventable effect of working with traumatised clients. However, although STS is a natural response, if left untreated it can lead to secondary traumatic stress disorder (Jenkins et al., 2010). Figley (1995) recommends that therapists develop good boundaries, have anticipated plans for coping, address commitment to work, and involve themselves in replenishing job activities in order to prevent and cope with symptoms of secondary traumatic stress. Implications for professionals working in the field of family violence in terms of secondary trauma will be explored later on through discussions of relevant studies of Ben-Porat and Itzhaky (2009) and Kadambi and Truscott (2004), to name a few, in the literature review that follows.

Working with clients who are survivors of domestic abuse involves the therapists hearing traumatic material from the clients. Arguably, this can lead to secondary traumatic stress

amongst therapists. Therefore, it is essential the symptoms relevant to secondary traumatic stress are highlighted to the therapists who are starting to work with, or are already working with, survivors of domestic abuse in order to address them, if present in their clinical supervision.

1.5.3 Vicarious trauma

McCann and Perlman (1990), using the constructivist self-development theory, defined vicarious trauma (VT) as the permanent "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client's trauma material" (McCann & Saakvitne, 1995, p. 31). Vicarious traumatisation (Pearlman & Saakvitne, 1995) is the transformation in the self of a trauma worker, and the signs and symptoms are parallel to those of direct trauma, although they tend to be less intense.

The constructivist self-development theory takes into account the different responses in people who have experienced trauma and they suggest that each person's reaction is a result of a complex relationship between the person, the traumatic event and the context of work (McCann & Perlman, 1990; McCann & Saakvitne, 1995). The theory describes how people construct their reality through the development of cognitive structures that are then used to interpret events (McCann & Perlman, 1990). The authors identify that the trauma that the counsellor is exposed to through their clients disturbs their cognitive schemata in five areas: safety, trust/dependency, esteem (feeling valued by others and oneself and to value others), control (of one's feelings and behaviours and to manage others) and intimacy (feeling connected to others and oneself).

Ben-Porat and Itzhaky (2009) accurately notice that, in contrast to Figley's concept of secondary traumatic stress, which focuses on external symptoms, vicarious traumatisation focuses on the internal experiences and the gradual change in the therapist's worldview. New connotations are given to the therapists' perceptions of themselves and the world surrounding them (Ben-Porat & Itzhaky, 2009). McCann and Perlman (1990) recommend that the helper must be able to acknowledge and process their reactions to trauma in a supportive setting. It is critical that helpers understand how their own cognitive schemas are altered as a result of trauma work (McCann & Pearlman, 1990). The constructivist self-development theory becomes an essential tool in identifying the areas within the helper's cognitive schemas where disturbances might exist, then helps process, and address them adequately.

Research in the field of interpersonal violence and family violence (Pearlman & MacIan, 1995; Ilife & Steed, 2000; Bell, 2003; Clemans, 2004; Killian, 2008) focused on the prevalence of vicarious trauma amongst the therapists and other mental health professionals. In the literature review on vicarious trauma, a comprehensive examination of most significant studies on vicarious trauma on therapists and other mental health professionals in the field of interpersonal violence will allow the reader to gain more knowledge about the effects of this type of work on professionals.

1.5.4 Countertransference

The concept of transference and countertransference as clinical construct originates in Freud's essays on the techniques of psychoanalysis and they traditionally refer to the impact that the patient and the therapist have on each other during therapy (Freud, 1910). Wilson and Lindy (1994) acknowledge that in the treatment of PTSD, the transference process can be specific, with the client unconsciously relating to the therapist by casting him/her into one or more trauma-specific roles through the transference process. Countertransference has been defined as a process that "denotes all those reactions of the analyst to the patient that may help or hinder the treatment" (Slatker, 1987, p. 3). Countertransference arises as a result of the therapist interacting with their client and identifying with their client's feelings and experiences, and when professionals work with survivors of severe trauma, the countertransference reactions may be particularly intense. Countertransference positions can be positive when the therapist becomes a helpful supporter, a comforter for the client, or negative when the therapist can become a "hostile judge" (Wilson & Lindy, 1994). Wilson and Lindy (1994) explain the negative countertransference by giving an example of a therapist in a trauma case who can feel at times like the perpetrator victimising the client instead of empathising. Slatker (1987) studies the complex phenomenon of countertransference and concludes that is a multidimensional phenomenon that incorporates feelings of guilt, shame, anxiety, tension, and cognitive reactions like fantasies, mental associations and rescuer reactions.

Danieli (1994) introduces the concept of *event countertransference* to clarify that the therapists' reactions in the treatment of trauma originate in the trauma stories of the client, rather than the unresolved neurotic conflicts of the therapist. Just like McCann and Pearlman (1995), Danilei (1994) highlights the fact that the therapists' emotional and cognitive

reactions to trauma are connected to the contents and emotional impact of clients' traumatic material.

Whilst the terms "vicarious trauma", "burnout", "secondary traumatic stress", "compassion fatigue", "countertransference" have all been used to describe the impact that trauma work has on workers in the trauma field, there are important differences that need to be taken into consideration. Vicarious trauma is a theory-based construct (McCann &Pearlman, 1990) that specifies psychological domains that can be affected rather than symptoms that may arise like in burnout (Maslach & Jackson, 1981). Vicarious trauma is specific to trauma workers and the worker will experience trauma-specific challenges such as intrusive imagery which are not present in burnout or countertransference (Pearlman & Saakvitne, 1995). Emotional exhaustion is the common thread in burnout and vicarious traumatisation (Gamble et al., 1994) and a worker might experience both vicarious trauma and burnout. Whilst countertransference is the therapist's response to a particular client, it is an extremely useful tool for psychotherapists, offering vital information about their clients. Classical countertransference (Harrison & Westwood, 2009) is considered to be an intrusion of the clinician's own unresolved material, including previous own trauma. Unlike countertransference, vicarious trauma refers to responses across clients, through time, outside the therapy hour and permeates the clinician's life and worldview (Perlman & Saakvithe, 1995). According to Pearlman and Saakvithe (1995), vicarious trauma increases the therapist's susceptibility to some countertransference responses and this can be less recognisable and therefore more problematic in therapy. Hayes (2004) acknowledges, however, that there seems to be an overlap between the construct of vicarious trauma and countertransference, since the latter has been defined as "all therapist reactions to a client, whatever conscious or unconscious, conflict based or reality based, in response to transference or some other material" (Hayes, 2004, p. 6).

McCann and Perlman (1990) encapsulate a common thread among these different descriptors, stating that vicarious trauma is not a result of the therapist or the client being inadequate, being best conceptualised as an occupational hazard. Knowing about these hazards (Skovholt, 2001) and being prepared to deal with them is crucial for the therapist's well-being.

1.5.5 The concept of posttraumatic growth

The concept of posttraumatic growth (Tedeschi & Calhoun, 1996) was introduced in the 1990s to describe the individual's experience of growth following a traumatic experience. As this is a relatively new area of research, very few studies investigating the positive effects of trauma work on therapists have been conducted. Tedeschi and Calhoun (1996) highlight the areas in which survivors of trauma can experience growth: change in one's self-image, transformation of interpersonal relationships and change in one's values and beliefs.

According to Tedeschi and Calhoun (1996), posttraumatic work can coexist with distress. There are a few studies (Herman, 1995; Arnold et al., 2005; Bell, 2003; Satkunanayagam et al., 2009) that have discussed growth amongst therapists and mental health professionals who work in the field of trauma. These studies identified similar changes in the therapists' lives as the ones in survivors of trauma who experienced posttraumatic growth.

Herman (1995) discovered that as the work increases the therapist's appreciation of life, they become more considerate towards themselves and others and it allows them to form new relationships and expand their current ones. Arnold et al. (2005), who discovered that the therapists working with victims of trauma reported changes in self, in their perspectives of life, their evaluations of life and the strengths underlying human nature, describe similar findings. Arnold et al.'s (2005) study was the first to intentionally explore the positive consequences for therapists of working with trauma survivors. The authors conducted interviews with twenty-one psychotherapists by asking about both the positive and the negative effects of working with trauma clients. Participants reported various symptoms of vicarious trauma, including: distressing emotions, intrusive thoughts, and images related to clients' traumatic content, and doubts about their effectiveness as therapists, providing support for the construct of vicarious trauma. The majority of participants reported at least one positive outcome of their work with trauma clients, with witnessing and encouraging clients' posttraumatic growth most commonly identified as a positive impact. Similarly, participants described how the experience of witnessing clients' growth helped them become aware of their own personal growth and development.

Bell (2003) studied therapists who work in the field of violence against women and found that 40% became more grateful for their lives, appreciate their relationships more and are less judgmental. Satkunanayagam et al. (2009) spoke about growth through adversity and the "rewards" of trauma work, their participants describing a sense of hope and goodness in humanity. Brockhouse et al. (2011) conducted a study that aimed to examine the psychological growth of therapists, following the vicarious exposure to trauma. 118 therapists have completed measures of vicarious exposure to trauma, growth, empathy, sense of coherence and perceived organisational support. The results revealed that empathy is a positive predictor for growth. Empathy also moderated the exposure to a growth relationship when growth involved relating to others. These are vital findings in the field of trauma and for those working with clients who have experienced trauma, offering new perspectives on recruitment, training and supervision of the therapists working in this field.

1.6 Empirical studies on vicarious trauma: Literature review and problem statement

During the past decade, the phenomenon of secondary trauma or vicarious traumatisation has been acknowledged more and more in the psychological literature. Significant research in this area has focused on the incidence and symptoms of vicarious trauma, the validation of the instruments measuring vicarious trauma, correlations between vicarious trauma and other therapist variables as well as examination of the professionals' coping skills and self-care. Research studies on therapists (Pearlman & MacIan, 1995; Ilife & Steed, 2000; Bell, 2003; Clemans, 2004; Killian, 2008; Harrison & Westwood, 2009; Pack, 2010; Jenkins et al., 2010); crisis workers (Ben-Ari & Dayan, 2008; Baird & Jenkins, 2003); social workers (Bride, 2007; Goldblatt et al., 2009; Ben-Porat & Itzahaky, 2009) and domestic violence advocates (Slattery & Goodman, 2009) highlighted the impact of working in the trauma field. The focus of these studies has been the changes that take place in the workers themselves, in their lives and the lives of their families as a result of working with traumatised clients.

Due to the broadness of the topic of vicarious trauma, there is a large amount of literature referring to the phenomenon. I selected to review the literature included here, as it has specifically observed the area of interpersonal violence, sexual abuse, rape and domestic

violence, unlike other studies that focus on vicarious trauma amongst therapists who work with war veterans and survivors of natural disasters or terrorist attacks.

The literature reviewed for this research study was obtained via psychological search engines, such as PsycINFO and PsyArticles. Key words used to attain journals and articles about the topic were “vicarious trauma”, “domestic abuse”, “secondary trauma”, “domestic violence” “Interpretative Phenomenological Analysis”, “qualitative research” and “quantitative research”. Journals reviewed were predominantly from the last thirty years, although the search engines contained journals from the last hundred years, which were also reviewed if relevant to the study. The principal journals reviewed in this study were the *Journal of Interpersonal Violence, Qualitative Inquiry, Violence Against Women, Probation Journal, Traumatology* and *Qualitative Social Work.*

Most of the prior research in the field of vicarious trauma is based on quantitative methods, and it is only in the past decade that qualitative studies have started to emerge. Qualitative research seeks to understand the meaning and complexity of an individual's world through the analysis of their personal account of events and experiences. In contrast, quantitative research seeks to classify the features of a phenomenon and conduct statistical tests upon them in an attempt to explain what has been observed. This study aims to explore participants' perceptions of working with survivors of domestic violence, hoping to enhance and enrich the researcher and readers' overall understanding of this experience.

Many of the studies carried out on vicarious trauma have been from the perspective of a range of mental health professionals, including sexual abuse/rape therapists, domestic violence advocates, crisis workers and social workers. However, little research can be located on therapists who work specifically with domestic violence survivors (Iliffe & Steed, 2000).

Here, I will outline just a few of these studies, and comment on their limitations. The reason for selecting these studies is to highlight the broad variety of professionals who might experience vicarious trauma, as well as to emphasise the need to conduct more qualitative research on therapists who work with survivors of domestic violence and the impact of this work on therapists’ own intimate relationships.

1.6.1 Quantitative studies

A number of studies on vicarious trauma have used quantitative methods of research, predominantly via the use of questionnaires. I found the following studies to be particularly pertinent in highlighting the shortcomings of using this type of quantitative research when assessing participants' views and ideas regarding the vicarious trauma. Additionally, the studies mentioned here demonstrate how some quantitative research has a tendency to observe the overall phenomenon of vicarious trauma, neglecting to focus on perhaps more in-depth experience of the participants working in the field of trauma.

Pearlman and MacIan (1995) were amongst the first researchers to study the effects of trauma work on trauma therapists. Their participants, 188 self-identified trauma therapists, completed questionnaires about their exposure to clients' trauma material as well as their own psychological well-being. The results revealed that the therapists newest to the work were experiencing the most psychological difficulties and the trauma therapists with a personal trauma history showed more negative effects from the work than those without a personal trauma history. Perlman and MacIan (1995) demonstrated how the trauma work appeared to affect those without a personal trauma history in the area of "other-esteem", making reference to the level of positive regard for another person. Although these findings are extremely valuable for the field of vicarious trauma, the results must be interpreted with caution due to this study's limitations. Because the sample is a self-selected group of self-identified trauma therapists, the findings should be generalised with great care (Perlman & MacIan, 1995). It is unclear if the therapists who responded to the questionnaires treat survivors as a major portion of their work or whether they have a different professional identity. Additionally, it is uncertain what kind of trauma their client group has been experiencing. Nevertheless, this study (Pearlman & MacIan, 1995) suggested the need for more training in trauma therapy, more clinical supervision, more emotional support and an awareness-raising for the therapists' self-care.

Similarly, Brady et al. (1999) studied the consequences of conducting psychotherapy with survivors of sexual abuse on vicarious traumatisation and spiritual well-being. A national survey on 1000 women psychotherapists revealed that the therapists with a higher level of

exposure to sexual abuse material reported significantly more trauma symptoms but no significant disruption in cognitive schemas. Spiritual well-being, an area thought to be affected by vicarious trauma, was found to be higher for those clinicians who saw more sexual abuse survivors (Brady et al., 1999). Yet again, this study focuses on general aspects of vicarious trauma, focusing on spirituality and not looking into the depths of the experience of working with sexual abuse survivors.

Few comparative studies (Baird & Jenkins, 2003; Kadambi & Truscott, 2004; Way et al., 2004) looked at the prevalence of vicarious trauma amongst professionals who work with different client groups: sexual assault counsellors, domestic violence counsellors and clinicians who treat sexual offenders. Baird and Jenkins (2003) used questionnaires and scales to asses 101 trauma counsellors, of which 35% were sexual assault counsellors, 17% were domestic violence counsellors and 48% identified themselves as working with both sexual abuse survivors and domestic violence survivors. This study revealed that client exposure workload was related to burnout subscales, but not as expected to overall burnout or vicarious trauma, secondary traumatic stress or general distress. Counsellors that were more educated and those seeing more clients reported less vicarious trauma, whilst younger counsellors and those with less trauma counselling experience reported more emotional exhaustion (Baird & Jenkins, 2003). This study's strength lies in the sample because of the inclusion of domestic violence counsellors. So far, the research has focused on the sexual assault counsellors (Kassam-Adams, 1995; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). Despite this, it appears that the researchers have not made specific differentiations between the results for the sexual abuse therapists and domestic violence ones. They do note and briefly mention that the agencies where they have conducted their study do recognise the frequent joint occurrence of sexual assault and domestic violence. The quantitative nature of the study did not allow tracing of the personal and social processes involved in the development of symptoms in relation to the work with traumatised clients as well as the differences, if any, between the vicarious trauma in sexual abuse counsellors and domestic violence counsellors.

Kadambi and Truscott (2004) investigated vicarious trauma, traumatic stress and burnout amongst three client populations: therapists working with sexual violence, therapists working in psycho-oncology and therapists working in general practice. 221 therapists across the three groups have been asked to complete Traumatic Stress Institute Belief Scale Revision, The

Maslach Burnout Inventory and The Impact of Events Scale. Kadambi and Truscott (2004) concluded that within this sample there was little evidence to support vicarious trauma as an occupational hazard unique to therapists working with trauma survivors. This study raises the debate on whether quantitative gathering of data in the field of vicarious trauma might not be ideal, perhaps revealing the limitations of this method. Kadambi and Truscott (2004) openly identified that the response bias might have affected the results, in the sense that the therapists doing well emotionally might have been more likely to respond to the survey. The absence of differences in the degree of measured distress between therapists who do and do not work with trauma directly suggests that the clinician can experience something specific that is produced by the trauma therapy (Kadambi & Truscott, 2004). The quantitative nature of the study does not allow for exploration, whether the symptoms experienced by the therapists are in response to clinical work or other external life events.

Similar results are revealed by a study conducted by Ben-Porat and Itzhaky in 2009. Their mixed quantitative and qualitative study looked at the positive and negative implications of working with victims of family violence on social workers in terms of secondary traumatisation, vicarious traumatisation and growth. They compared results at the Secondary Traumatic Stress Scale (Bride et al., 2004) and Post Traumatic Growth Inventory (Tedeschi & Calhoun, 1996) of 143 social workers employed in the field of family violence and 71 social workers who were not employed in that field. The study has also had a qualitative component, participants being asked two open questions about negative and positive aspects that occurred in themselves, their lives and their family as a result of working in their field of practice. Ben-Porat and Itzhaky (2009) reported no significant differences in the levels of secondary traumatisation. Despite this, the qualitative part of the study seems to reveal differences in the levels of growth, in positive and negative changes that participants experienced in themselves and their lives. The family violence social workers reported negative changes in spousal relations, viewing these relations through the lens of power and control. In addition, they viewed the world as less safe, less just and humanity more aggressive (Ben-Porat & Itzhaky, 2009). These results are consistent with the findings of Iliffe and Steed (2000)'s research. Ben-Porat and Itzhaky (2009)'s study is significant as it reflects through its qualitative part a unique experience of the professionals in the field of family violence: the confrontation of the aggressor and the victim within themselves. This finding emphasises the distinctive implications of the work in this field. Nevertheless, the

results in the quantitative part of the study highlight the limitations of this study: one possible explanation can be the research methodology and the bias caused by participants' reports. Ben-Porat and Itzhaky (2009) argued that the participants might have been hesitant in reporting negative feelings as this might be seen a sign of incompetence. In addition to that, it is unclear whether the instruments used to measure vicarious trauma were valid and reliable, since Sabin-Farell and Turpin (2003) argued before that these instruments might not cover all the areas of the phenomenon of vicarious trauma.

Another study which uses both quantitative and qualitative methods was conducted by Schauben and Farizer (1995), who explored the vicarious trauma amongst counsellors who work with sexual violence. Schauben and Frazier (1995) published results supporting the hypothesis that trauma work disrupts trauma therapists' cognitive schemas. 148 female psychologists and female rape crisis counsellors working with sexual violence survivors were assessed using different scales and inventories as well as symptom checklists for PTSD and VT developed by the authors. Qualitative data was also gathered through two open-ended written-response questions about aspects of their work with sexual violence survivors that participants found difficult and enjoyable. Schauben and Frazier found that counsellors with higher percentages of survivors on their caseloads reported more schema disruptions, especially with respect to beliefs about the goodness or trustworthiness of others. Counsellors with more survivors on their caseloads also reported more PTSD symptoms. The qualitative data related to the difficulties experienced by counsellors as a result of their work with survivors corroborated the quantitative data. For example, counsellors identified experiencing emotional distress and a change in their beliefs as a direct result of their work with traumatised clients (Schauben & Fraizer, 1995).

The studies conducted by Ben-Porat and Itzaky (2009) and Schauben and Fraizer (1995) highlighted how the qualitative part of the research helped reveal areas of the participants' experience that otherwise would have not been revealed because of the nature of the quantitative instruments.

Sabin-Farell and Tupin (2003) argued that the existing instruments constructed for measurement of secondary traumatisation might still not tap all of the content areas related to the phenomenon. Sabin-Farell and Tupin (2003) noted the inconsistencies between

quantitative and qualitative research regarding the prevalence, scope and severity of vicarious trauma amongst the professionals. Steed and Downing (1998) hypothesised that this might be the result of a combination of the quantitative measures not being sensitive enough to detect true distress with the lack of reliability and accuracy of self-report in identifying work-related trauma. Despite this, Kadambi and Truscott (2004) cautiously advise that it is important to include both quantitative and qualitative assessment tools in order to assess more accurately the experience amongst professionals. The authors questioned the assumption that exposure to traumatic material and the reality of human cruelty were really the "active ingredients" (p. 272) in the development of vicarious trauma in therapists. They further hypothesised that the manner in which therapists empathically connect with their clients' material and subsequently process their own emotions about that material may play a larger role in the development of vicarious trauma than the content of therapy (Kadambi & Truscott, 2004).

The literature review on quantitative studies in the field of vicarious trauma can only highlight their limitations. Whilst their results bring valuable information in terms of the prevalence of vicarious trauma in the professionals working with trauma, it is questionable how much information concerning feelings and emotions can be extracted from a questionnaire – fundamental elements when assessing issues such therapists' experience.

Indeed, it appears that more research is needed which will explore the meanings behind therapists' experiences, using qualitative analytic strategies. Sabin-Farrell and Turpin (2003) concluded that the quantitative evidence for vicarious trauma and secondary traumatic stress was "meager and inconsistent" (p. 467), but the results of the few qualitative studies conducted in the field provide more support for the construct.

1.6.2 Qualitative studies

Upon researching this area, I was only able to identify three significant qualitative studies evaluating the vicarious trauma exclusively on domestic violence therapists. Moreover, these studies were conducted in Australia, the United States of America and Israel. These were conducted by Iliffe and Steed (2000); Bell (2003) and Ben-Ari and Dayan (2008). Other significant qualitative studies (Clemens, 2004; Killian, 2008; Goldblatt, 2009; Harrison & Westwood, 2009) have focused on the experience of sexual abuse/rape therapists or social workers in the field of family violence.

In a qualitative study by Steed and Downing (1998), twelve Australian female therapists were interviewed about how their work with sexual abuse and sexual assault survivors had resulted in cognitive schema disruptions. Data from the semi-structured interviews was then analysed for thematic content. All of the therapists reported experiencing negative effects as a result of their work with traumatised clients. These negative effects included distressing emotions (i.e. anger, frustration, shock, and sadness), experiencing intrusive thoughts and dreams about clients' traumatic material. Some therapists have noticed an increased wariness of men and a decrease of trust with their partner, describing losing faith in human beings; doubting their ability to work effectively with clients, and losing friendships as a result of being unable to maintain intimacy with others (Steed & Downing, 1998). This phenomenological study (Steed & Downing, 1998) has identified negative effects that therapists have experienced in various domains of functioning: physiological, emotional, professional and interpersonal. The participants reported a negative impact on their relationships both within the family and beyond.

Similarly, Iliffe and Steed (2000) explored the experience of therapists who work with perpetrators and survivors of domestic violence. The study utilised a semi-structured interview, which offered the opportunity for open dialogue and provided rich, descriptive data of the lived experience of 18 counsellors (13 women and 5 men).The qualitative method used to analyse data was Interpretative Phenomenological Analysis (Smith, 1993). The researchers concluded that the participants described classical symptoms of vicarious trauma. Almost all participants expressed feeling a loss of confidence when they first encountered domestic abuse issues (Iliffe & Steed, 2000). The participants reported changes in cognitive schema, particularly concerning safety, worldview and gender power issues. The therapists described their challenges of domestic violence work and the need to adapt their counselling practice to the unique needs of their clients. Iliffe and Steed (2000) noted that their participants described fears for clients' safety, feelings of isolation and powerlessness. Iliffe and Steed (2000) also reported that participants in their study noted that they had learned to respect women's choices to stay in an abusive relationship. An aspect of growth noted in Iliffe and Steed's (2000) study was the change of counselling practice. Participants in the study indicated that they were more attuned to the signs of domestic violence and reported feeling more competent in working with this population. According to Iliffe and Steed (2000) therapists need to provide domestic violence clients with "more than just therapy". In

conjunction with counselling, they provide “education on domestic violence, information on community resources, emergency contact numbers, and at times practical support” (Iliffe and Steed, 2000, p. 405).This research was considered an initial exploration of the experience of domestic violence counsellors. The results of this study can only stress the need for further research targeting the impact of domestic violence counselling.

Bell (2003) interviewed 30 American counsellors working with female victims of domestic violence. The participants were asked through semi-structured interviews to discuss the positive and stressful aspects of their work and to describe a situation at work in which they did not respond in a typical manner. Following a thematic analysis using a qualitative data analysis programme, Bell (2003) found that 40 per cent of therapists working with victims of violence became more grateful for their lives, more appreciative of their relationships with significant others, and less judgmental. 10 per cent described feeling more negative than others did and 43 per cent could name both positive and negative aspects of their work or were unsure of its effects. This study is unique in its use of strength perspective as a conceptual framework for qualitative research on vicarious trauma. Using the strength perspective, Bell (2003) allowed exploration of the counsellors’ processes in maintaining good health and using their strengths as powerful allies in the therapeutic relationship as part of the healing process. Whilst informative about the therapist experience, this study does have some limitations. Firstly, the study tends to focus too specifically on particular topics, thus, in some sense, directing the flow of conversation onto what the authors want to know, without allowing participants to simply discuss whatever comes into their minds. For instance, by bringing up the topic of strength, the authors alert the participants' attention to this. Thus, even if this had not been a key part of the individual's experience, it is brought to their attention and focused upon, risking that significant part of their experience to be overlooked. Secondly, participants are interviewed twice, nearly one year apart. Although the authors argue that this was a means of triangulating data, it is important to consider how time and possible life events that the therapists have experienced during this time have impacted their perception. Moreover, it is unclear if the therapists interviewed were still working in the field, information that might have been significant for their perception of their experience.

Ben-Ari and Dayan (2008) carried out an exceptionally interesting qualitative study that focused on the life stories of counsellors who treated battered women in their practice and experienced domestic violence in their own lives. In this unique study, the authors

interviewed nine mental health workers and they have analysed the transformation of the participants' self as reflected between their professional and personal identities. Through the narrative interviews conducted, Ben-Ari and Dayan (2008) found that the participants' identities moved from intentional splitting to integration along a temporal dimension: life with the violence and life after the violence. The authors deduced that the participants were unable to integrate the two selves that transpired from their life stories: the professional who lived with violence and the empowered professional woman. Splitting between these two was apparently the only way to integrate their life experiences and make sense of their lives (Ben-Ari & Dayan, 2008). This study's strength lay in raising awareness of the fact that those who work within the family violence arena are not immune to such experiences; additionally, it drew attention to the needs (in terms of training and supervision) of the workers who are often overlooked.

Goldblatt et al. (2009) conducted another relevant qualitative study, which aimed to shed light on the intersection between the private and the professional. I found this study particularly interesting, as the researchers focused more in depth on the impact of working with intimate partner violence on social workers' marital relationships and gender identity. The study was conducted in domestic violence treatment centres in Israel. Fourteen female social workers who were working with intimate partner violence victims and perpetrators underwent in-depth semi-structured interviews. The interviews aimed to cover five themes: perception of intimate partner relationships, violence in intimate relationships, the worker's view of intervention into violence in intimate relationships, the meaning of the work in the social worker's life and family life and the relationship between intervention with violence in intimate relationships and the social worker's relationship. Findings following a thematic analysis indicate that the boundaries between the worker's private and professional lives are blurred, the work providing a challenge to the participants' intimate relationships, forcing them to re-examine their relationships (Goldblatt et al., 2009). Additionally, the work with the clients who experienced intimate violence was seen as an opportunity for personal development, as it offered the opportunity to clarify their gender identity and relate within their own intimate relationships. Goldblatt et al. (2009)'s study highlighted the social workers' internal conflicts that have an impact on both professional and personal-intimate lives, giving them the opportunity to reshape and enhance the meanings of intimate relationships.

The trauma intrinsic in domestic abuse is often replayed in the therapeutic setting, which can trigger in the therapist unprocessed emotional baggage (Sanderson, 2008). For that reason, therapists need to understand and be aware of the personal and professional impact that work with this particular group of clients might have. The reactions of the secondary traumatic stress are not much different from the responses of the survivors. However, it has to be noted that the therapist is not only the "storage" of the client's material, but also needs to work with the emotional response of that particular material.

The stress generated from conducting trauma therapy can accumulate over time, penetrating every aspect of the therapist's life (Carbonell & Figley, 1996; Coppenhall, 1995; Perlman & MacIan, 1995; Valent, 1998). Vicarious traumatisation can impact on therapists' beliefs regarding their world and interpersonal relationships, such as perception of safety and ability to trust others. This can lead to loss of caring (Figley, 1995). A risk factor identified by Evans and Villavisanis (1997) is that therapists working with trauma tend to socialise less, thus reducing their circle of friends.

The above literature review can only strengthen Pearlman and Saakvitne (1995)'s findings that acknowledge multiple aspects of the therapist's life being affected following trauma work, these being: basic psychological needs, core beliefs about self and others, interpersonal relationships, as well as their experience of their presence in the world. Similarly, Dutton (1992) acknowledges that therapists may develop some of the following perspectives: safety (there is no safe place in the world); power (I am not able to take care of myself or others); independence (freedom is limited); and intimacy (working with victims sets one apart from others).

1.7 Summary

In light of the literature review, looking at the at the possible implications of working with survivors of domestic violence, it can be concluded that a majority of the studies focus on the phenomenon of vicarious traumatisation/secondary trauma with a brief consideration of the impact on therapists' intimate relationships (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Considerable attention has been given to the phenomenon of secondary trauma amongst the therapists in the field of sexual abuse/rape-crisis work (Iliffe & Steed, 2000; Clemans, 2004; Steed & Downing, 1998; Schauben & Fraizer, 1995). The studies that look at the impact of working with domestic violence clients on the workers' intimate relationships are mostly conducted in the field of social work or domestic violence advocates (Goldblatt et al., 2009; Slattery & Goodman, 2009). Very little research looking at the experience of domestic violence therapists has been conducted in the United Kingdom, most of the studies being carried out in domestic violence centres in the United States of America, Australia or Israel.

It would appear that more research is needed on the domestic violence therapists and the impact of the work on their intimate relationships in order to add weight to the above studies and to extend this topic of research in the United Kingdom as well. Additionally, due to the fact that extensive research has been done on the overall experience of the therapists who work with trauma which resulted from intimate partner violence, it would be beneficial to carry out qualitative studies which allow participants to explore in more depth specific topics within their experience.

The present research study proposes to take a step further in filling these "gaps" in the existing literature. The purpose of this study is to expand the current understanding of therapists' responses to trauma work by intentionally exploring the changes within the therapists' intimate relationships. It became clear from the literature review that the constant shift between working with domestic violence and the practitioner's private life is inevitable. This study will provide an opportunity to gain deeper insight into the impact that therapeutic work with this type of client might have on therapists' intimate relationships. By seeking to understand the personal world and how it is experienced, the perspectives gained may provide significant implications for training therapists in the field of domestic violence.

The research study also aims to contribute to a comprehensive and balanced understanding of the impact of trauma work that takes into account the possibilities for both suffering and growth, highlighting the need for a balanced view that takes into account the professional and personal development of therapists working in this field. Increasing the awareness of the impact of domestic violence counselling will eventually lead to a new way to address possible vicarious trauma through adequate training and supervision for the professionals involved in this type of work.

1.8 Contribution to Counselling Psychology

As Counselling Psychologists, we aim to explore different perspectives, to be receptive to phenomena, and to have a curious stance about how individuals make sense of their experiences. As the literature review has shown, there has been a lot of research into the effects of working with interpersonal violence and domestic violence on mental health workers.

Whilst research has helped identified vicarious trauma in sexual abuse therapists, domestic violence advocates and social workers in the field of family violence, it is apparent that research is still required for shedding light into the therapists' lived experience of working within the domestic violence field and how this type of work impacts their personal life. In addition, there is a gap in research conducted from a Counselling Psychology perspective. Therefore, this research study will aim to contribute to the knowledge of the impact of working with survivors of domestic abuse on the therapists' personal and professional lives.

It is also hoped that there will be contribution from this piece of research on the development policies regarding self-care strategies of the therapists and other mental health professionals within the organisations that provide services to survivors of domestic abuse.

2. Methodology and Procedures

I wrote this chapter in the first person in order to address the reader directly and to demonstrate the unfolding nature of the research process as well as reflexivity.

In this chapter, I will discuss the methodology and the procedures implemented in this study. I will examine qualitative research in more depth, specifically, Interpretative Phenomenological Analysis (IPA) and its epistemological underpinnings. I will then explore both my epistemological and personal positions within the research. I will subsequently comment on the validity of Interpretative Phenomenological Analysis, and explain my reasons for using semi-structured interviews in this study.

Following this, I will relay the practical details of this study, describing the sample of participants used, the procedure of constructing the interview schedule, and the recruitment and debriefing phrases. I will then explain my methodological and procedural reflexivity within the research.

2.1 Methodology

2.1.1 Research aim

The purpose of this study is to investigate the experience of therapists who are working with survivors of domestic violence and what these experiences reveal about the challenges and the impact of domestic violence work, with emphasis on secondary trauma and the impact on the therapists' intimate relationships. I anticipated that the participants would be mindful about their experiences and that they would be open to describe these experiences.

2.1.2 Research questions

This study will provide an opportunity to gain deeper insight into the experiences of therapists who work with survivors of domestic violence, how they make sense of this experience and how it has affected them beyond the therapy room within their intimate relationships.

The research questions are:

"What is the personal impact of hearing traumatic material from clients experiencing domestic abuse and what influence has it had on the therapists' intimate relationships?"

2.1.3 IPA methodology and philosophical underpinnings: an overview

The emphasis in this study is on the personal experiences of therapists and it employs a qualitative methodology using Interpretative Phenomenological Analysis, commonly referred to as IPA (Smith, 1996).

IPA was developed by Jonathan Smith, who argued in the mid-1990s for the need for "a qualitative approach to psychology which was grounded in psychology" (Eatough & Smith, 2008, p. 180). Smith et al. (2009) argue that IPA has been used extensively in health psychology, clinical and counselling psychology, as well as in social and educational psychology.

Smith et al. (2009) explain IPA as being an approach to qualitative, experiential and psychological research that has three epistemological underpinnings: Husserlian phenomenology, hermeneutic phenomenology and ideography.

- **Phenomenology**

Phenomenology is a philosophical approach to the study of experience (Smith et al., 2009). IPA is influenced by the phenomenological and existential perspectives of Heidegger, Merleau-Ponty and Sartre, which consider the person as embodied and embedded in the world, in a particular historical, social and cultural context. Shinebourne (2011) describes how IPA draws itself from these intellectual currents of phenomenology in the context of psychology, as it is concerned with exploring human lived experience and the meanings that people attribute to their experiences.

Husserl (Smith et al., 2009) was interested in the phenomenological understanding of the world, and was concerned with finding the way in which the individual becomes familiar

with their own experience and identifies essential qualities of that experience. On a quest to discover the "ultimate truth", Husserl argues that it is necessary to examine the core of everyday experience (McLeod, 2003). Therefore, phenomenology promotes the discovery and depicts everyday experience. Husserl says that, in order to be part of this process, the emphasis should be on the researcher. In doing so, the researcher adopts a phenomenological attitude. That is, the interviewer is able to leave behind her existing theories and/or beliefs, and at the same time, returns to examine those theories and/or beliefs in a different light. Husserl further suggests that it is possible to go beyond the human instinct of seeing the world based on the assumptions that we make on everyday experiences by "bracketing-off" those assumptions. He refers to this as "eidetic seeing" (McLeod, 2003). Husserl believes that understanding real meaning is achievable through an enhanced process of generalisation and this results in a better understanding of the "eidos" itself. Husserl's work has helped the IPA researchers to focus on the process of reflection (Shinebourne, 2011). "Bracketing" has become an important part of the research process in qualitative methods, especially in IPA. However, Husserl's focus was to discover the essence of the experience, whilst IPA attempts to capture particular experience for particular people (Smith et al., 2009).

Heidegger studied Husserl's early writings and had his own ideas about phenomenology, which he described in his major work *Being and Time* (1962). Smith et al. (2009) describe how Heidegger considered that we are always "in the world", so we do not study our activities by bracketing the world; rather, we interpret our activities and the meaning things have for us by looking to our contextual relations to things in the world. Heidegger stipulated that his task is to formulate questions to help him achieve clarification about the meaning of Being (or Dasein, as he refers to it) (Smith et al., 2009). It is not known what "Being" means. Heidegger, therefore, focuses on what it means to be human and make sense of one's existence. This focus essentially distinguishes his thoughts from that of Husserl.

Heidegger's suggestion of individuals "being in the world" is central to IPA's take on phenomenology (Smith et al., 2009). It is the starting point for IPA, which acknowledges the unique inter-subjective experiences of the individual that are inevitably embodied and emphasises the existence of social, historical and contextual influences on the life world (Eatough & Smith, 2008).

Merleau-Ponty connects to Heidegger's thoughts in terms of his emphasis on the "situated and interpretative quality of our knowledge of the world" (Smith et al., 2009, p. 18). Merleau-Ponty (1964) emphasised the body as the primary site of knowing the world, a corrective to the long philosophical tradition of placing consciousness as the source of knowledge, and his insight that the body and that which is perceived could not be disentangled from each other. He declares that knowledge is acquired through the body's exposure to the world. Therefore, the experience of our bodies through the world alludes to our phenomenological experience of the world. This is a critical idea for IPA researchers. This suggests that the individual is a combination of relationships in the world. IPA understands and incorporates this idea and takes into account the individual's experience in the world, given their cultural, social, economic and historic status.

- **Hermeneutics**

The second major theoretical underpinning of IPA comes from hermeneutics, the theory of interpretation. IPA (Smith et al., 2009) contends that people understand events based on previous knowledge and experience. In IPA, the researcher plays an active role, unable to leave behind his/her roots as a member of a social world. Everything that the researcher does is embedded in the existence as a human being. Therefore, it is impossible to access another individual's personal world directly or completely, as this depends on and is complicated by the researcher's own viewpoint.

Therefore, IPA represents a double hermeneutic, with the researcher trying to make sense of the participant trying to make sense of their experience (Smith & Osborn, 2008). This process of interpretation is dynamic and concerned with the relationship between the part and the whole, at various levels (Smith et al., 2009). This complex and dynamic relationship between the researcher and the data calls for "a more enlivened form of bracketing as both a cyclical process and as something which can only be partially achieved" (Smith et al., 2009, p. 25). The hermeneutic circle is the basis of IPA analysis. Analysis is checked and rechecked against emerging patterns and connections that the researcher makes. IPA discovers new meanings which emerge from prior interpretations and moves towards a higher level of abstraction. The researcher attempts to understand what it is like for the participant whilst asking critical questions of the textual account. Thus, interpretation can be descriptive and

empathic, aiming to produce “rich experiential descriptions”, and critical and questioning “in ways which participants might be unwilling or unable to do themselves” (Eatough & Smith, 2008, p. 189). The particular combination used will depend on the study and a richer analysis is likely to involve both (Smith & Osborn, 2008). Phenomenology and hermeneutics represent alternative ways of understanding how the world is constructed.

- **Idiography**

Idiography constitutes the third theoretical underpinning of IPA (Shinebourne, 2011). An idiographic approach aims for an in-depth focus on the particular and commitment to a detailed finely-textured analysis, not possible in nomothetic research studies which focus on aggregated data (Smith, 2004; Smith, Harré & Van Langenhove, 1995). The methodology argues that, through this attention to the particular and the detail of the individual’s life world, we can connect with significant themes that are central to the lives of us all, thus taking us nearer to the universal (Eatough & Smith, 2008; Smith, 2004).

- **Symbolic interactionism**

Symbolic interactionism is another important hallmark in the theoretical underpinnings of IPA (Smith, 1996). Fundamental to symbolic interactionism is the view that the meanings individuals credit to their life events arise within their social interaction. IPA endorses symbolic interactionism's concern for how subjective meanings are constructed by individuals and its emphasis on an individual’s self-reflection (Eatough & Smith, 2008).

To summarise, Interpretative Phenomenological Analysis allows researchers to explore the different meanings behind a person's experiences, and place the meanings of these experiences "within their personal, social and cultural context" (Dean, Smith, Payne & Weinman, 2005, p. 626). A more in-depth rationale for choosing IPA as methodology for this study will follow in the next section.

2.1.4 Rationale for using IPA

The selection of Interpretative Phenomenological Analysis (IPA) as the investigative strategy for this study is based on the aim to reveal something about the experience of therapists working with survivors of domestic violence and the impact that this work might have on their intimate relationships. The participants' accounts provide a rich source of data that can provide valuable insight into a participant's private world of thoughts and feelings. This methodology is informed by phenomenology, a branch of philosophy that has also developed into an approach to research in the social sciences and psychology. Phenomenology is concerned with the knowledge derived from the study of consciousness and individual experience (Willig, 2001), the very essence of the self.

IPA is interested in understanding the lived experience of the individual, how the individual makes sense of that experience and what meanings those experiences hold (Smith, 2004). IPA considers that, whilst it tries to get close to the participant's personal world, the researcher's own conceptions are required to make sense of the other's world through an interpretative activity. Therefore, there are two levels of analysis: the meaning of what is said by the participants and an understanding of what is said by the researcher. In IPA, there are two levels of interpretation: on one level, the participants are trying to make sense of their experiences; on another level, the researcher is examining the participants who are in the process of making sense of their lived experiences (Smith & Osbourn, 2008).

- **Criticism of IPA**

As with most qualitative methods, IPA enables the researcher to explore the perspectives and meaning-making world of the participant. The focus of IPA is to disclose the particulars of individual experiences to understand their meaning and implication from the perspective of the person experiencing. IPA guides the researcher through the process of identifying and integrating themes. However, as a methodology it has its limitations.

These limitations could be divided in two parts: criticisms common to qualitative methods and criticism specific to IPA. Unlike quantitative research, it does not offer a hypothesis

which is then either supported or not; it does not provide evidence that can be either validated or argued against by later research. Rawson (1999) observes that qualitative research can be criticised for not being generalisable beyond the participants studied. Also, as Rawson explains, a qualitative researcher's epistemological stance and personal style will lead them to focus on certain information in order to explain their view of the meaning of the participant, and this will differ for each researcher. Thus, qualitative research is not replicable, which its opponents might say challenges its validity. Silverman (2006) also criticises such work as not being representative of the data available and therefore calls the validity of such studies into question. Silverman (2006) notes that the reliability of qualitative research could be questioned; one researcher might categorise the same data differently from another, plus space constraints lead to only brief extracts from transcripts being included in the published research, thus the reader has insufficient information to form their own view of the data available.

There are also specific criticisms of IPA as a methodology. Willig (2008) argues that IPA suffers from conceptual and practical limitations. Willig (2008) postulates that IPA's limitations fall into the four categories: role of language, suitability of accounts, explanation versus description, and the genuineness of IPA as a phenomenological method.

IPA relies on language to communicate experience from participant to researcher and the method is based on the belief that an individual can describe their experience in all of its richness. Several ideas about the role of language are critically explored by Willig (2008). Firstly, Willig (2008) argues the idea that the language chosen to describe an experience constructs it. The language, through the words used, tells the researcher how an individual being interviewed describes an experience, rather than informing the researcher about the actual experience. Secondly, Willig (2008) advocates the view that language precedes the experience and therefore affects it, the idea being that our thoughts and emotions are constrained by what we are able to express.

Willig (2008) also notes that IPA is subject to participants' ability to give full expression to their experience in all its richness and complexity. She suggests that this is a difficult task, especially for participants unused to articulating their cognitions and emotions or describing their behaviours in detail. The third criticism which Willig (2008) suggests could be levelled

at IPA is that it attempts merely to describe how participants experience the world, rather than to explain the reason why such experiences take place and why they might describe it differently from one participant to another. The authenticity of IPA as a phenomenological method is the fourth limitation that Willig (2008) notes.

According to Smith (1996), cognition is important for IPA because it explores what a participant believes about the phenomenon being investigated. Understanding the participants' cognitions may allow the researcher to make sense of the participants' experience. However, this seems to disagree with the phenomenological stance on which IPA is built because of the distinction between the individual and the world (i.e., "the knower" and "the known"). Thus, IPA is criticised as a study of cognitions, instead of an account of the way in which the world presents itself to a participant in a raw, pre-cognitive way.

- **Summary**

Despite the criticism of IPA, it is an appropriate approach when the aim of the research is to discover how individuals comprehend certain situations they are facing and how they understand their personal and social world. I found IPA fitting for this study as it aims to provide a rich interpretation of the data regarding the experience and impact of working with survivors of domestic violence on the personal and professional life of the therapist.

Another reason for choosing to use IPA, a relatively new method, is that it is not prescriptive and, as Smith and Osborn (2003) mention, has the flexibility to be adapted to the individual's way of working. This freedom, within boundaries, to approach my research data in the manner that seemed to fit it best, made IPA an appealing research methodology.

When considering the methodological approach most suitable to address the research aims, other methods were explored along with IPA. Qualitative research predominantly consists of four main schools: phenomenology (specifically in the context of this study, IPA), Grounded Theory, narratology and discourse analysis (McLeod, 2003).

Grounded Theory methods were considered as an alternative. As Willig (2001) describes, IPA and Grounded Theory share many characteristics: both aim to make sense of a person's or a group's view of the world; and both focus on the building of inductive theories that are directly grounded in the data and are suited to studying individual or interpersonal processes and experiences (Charmaz, 2006).

IPA, however, was considered to have the best fit with the aims of the research as it is concerned with the detailed and flexible examination of individual lived experience, how individuals make sense of that experience and the meaning it may hold for the individual (Eatough & Smith, 2008). Grounded Theory was developed, as Willig (2001) describes, to let researchers study basic social processes, whereas IPA aimed to gain insight into the participants' psychological world, being therefore a specifically psychological method. It can be argued that Grounded Theory is better suited to address sociological research questions. As a new and developing approach, IPA appears to be more open to creativity and allows the researcher a freedom in its exploration.

To summarise, IPA was chosen as it provided an analytic strategy that would seek to answer the main research question of understanding the lived experience of therapists working with survivors of domestic abuse. Grounded Theory, although similar to IPA, does not provide the aim of understanding a phenomenon from an individual's world; rather, it conceptualises social processes. IPA appealed as a research methodology because of its focus on lived experience and sense-making as well as its unique contribution to psychology.

2.1.5 IPA and Counselling Psychology

Counselling Psychology is defined in the Guidelines for Professional Practice (Division of Counselling Psychology, 2005) as a branch of Psychology which "draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology" (p. 1). For that reason, one can argue that the method of IPA with its phenomenological concern is consistent with the underlying principles of Counselling Psychology.

Kasket (2012) argues that Counselling Psychology is "willing to expand its horizons to accommodate a plurality of viewpoints, a multitude of possibilities and infinite varieties of potential truths"(p. 65). Therefore, Counselling Psychology adopts a more holistic view of a topic in order to better understand it. The present study planned to offer the participants the opportunity to explore their overall experience of working with the survivors of domestic violence, taking into account their experience of personal growth as well as their challenges in doing this type of work.

Counselling Psychology is based on the Humanistic principals of empathy congruence and unconditional positive regard (Rogers, 1961): prioritising the client's subjective and inter-subjective experience, focusing on growth, enhancing the potential and recognising the uniqueness of the client. IPA reflects this philosophy, attaching great importance to an individual's subjective experiences and exploring the meanings of these experiences.

In Counselling Psychology as well as in qualitative research, the aim is to comprehend an individual's experience as closely and accurately as possible, interpreting, contextualising and making sense of the individual's story, accounting for perspective both in and outside awareness. When undertaking IPA, the researcher explores the meaning of the lived experience of an individual regarding their position in their world, and the social and cultural co-constructed networks within that world (Spinelli, 2005). IPA focuses on the participant's story, rather than any form of objective truth, fact or cause, which the positivist would seek (Bogdan & Taylor, 1975).

The research/participant relationship plays an important part in qualitative research and this is mirrored in the client/therapist relationship in Counselling Psychology. Kasket (2012) illustrates how Counselling Psychologies values described by Cooper (2009) translate to research. She argues that the commitment to a democratic, non-hierarchical relationship that plays a central part in Counselling Psychology can be noticed in informed consent, transparency about research and continued participation involvement through validation of the conclusions or sharing the findings afterwards. Facilitating growth and actualisation of potential, empowering the clients in Counselling Psychology is related to application to practice of the research conducted and its positive change in people's lives.

2.1.6 Personal and epistemological reflexivity

Reflexivity is an important paradigm in qualitative research and, according to Nightingale and Cromby (1999), it requires an "awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside' of one' s subject matter while conducting research" (p. 228). It is therefore paramount that the researcher reflects upon their position within the research, the relation with the phenomenon in question and how they may have shaped and influenced both the process of the research and the findings (Willig, 2001).

- **Personal reflexivity**

Personal reflexivity involves reflecting on how "our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research" (Willig, 2001, p. 10).

In terms of personal reflexivity, when I started to identify my research area, I must admit many questions arose when thinking about my position within this research because of my previous experience in the domestic violence field, not only professionally but also on a personal level. What feelings would the participants' accounts of their experience evoke in me? How would I respond to their experience? Would they have a similar experience to mine? If so, how would I manage to balance my positions as a researcher, as a therapist that has worked with clients that have survived domestic violence, and as a woman that has experienced domestic abuse? As a Counselling Psychologist, it is difficult to simply be an objective observer in the research process. I have worked in the field of domestic violence for over three years when I decided to start this research and I believe this has enhanced my understanding of the impact that this type of work might have on the professional who works with this type of client. My current role as an Independent Gender Violence Advocate involves offering emotional and practical support to women that are or have been at high risk of gender violence (domestic violence, trafficking, stalking, prostitution, female genital mutilation). I felt I would be able to cope with potentially painful accounts of experiences and I believe this increased my sensitivity towards the participants and the data. However, many questions arose particularly because of this. Would my own experience of working in this

field influence my interpretations? How would the participants find me upon knowing that I have work experience in the field? Would that facilitate their openness in describing their experiences, or would this be an obstacle? Would they think "She must know that since she has been working in the field, I will not mention it" and would I be missing important reflections? Undoubtedly, my personal experience of working with survivors of domestic violence will have affected the way in which this study was conducted, including interpretation and presentation of the data. It is essential to reflect on these types of questions before, during and after the research process.

I was aware from the outset that I may have been inclined to hear material that was relevant to my own experience and ignore possible themes that did not relate to me. As a result, this may have affected interpretation and also my prompts and responses whilst conducting the interviews. However, perhaps because of the experience I had in the field of domestic violence, I felt I was able to offer an empathic response to participants, which may have facilitated the development of the relationship and allowed participants to be more open.

My role as a practitioner in Counselling Psychology will have influenced data collection and interpretation as well. I work primarily within a cognitive behavioural framework with clients in therapy. This has undoubtedly had an effect on the way in which I have interpreted participants' data. It is expected that a researcher whose clinical work is underpinned by another therapeutic approach may have interpreted certain concepts in a different way.

The interpretation of the data may also have been influenced by my feelings during this long process. I found the process of research extremely demanding, tiring, having to balance it with full-time work and other family commitments. The interviews generated a vast amount of data which was experienced as overwhelming on several occasions. All this is likely to have affected the findings. My intention was to be open about it in my reflexive diary from the beginning, to record and discuss consistently my thoughts, feelings, impressions, values and beliefs and to discuss them with my supervisor.

This research has provided me the opportunity to expand my knowledge in the area of secondary trauma and how working therapeutically with clients affected by domestic violence might impact on the therapist. I gained a great deal of understanding on the

associated issues, for example, impact on the therapists' relationships and how they manage that. The process of analysis using IPA has further improved my interpretative skills, particularly with respect to exploring the meaning of words used to describe a phenomenon. The study has also furthered my personal reflection with respect to the work I am doing in the field of domestic violence and increased self-awareness.

- **Epistemological reflexivity**

Epistemological reflexivity aims to indicate our assumptions about knowledge, about what we can know (epistemology), as well as our assumptions about the world (ontology) and how these might have influenced the research and our findings.

In terms of defining my epistemological stance, this was a rather challenging process. IPA does not claim a distinctive epistemological position, but describes itself as "part of a stable of closely connected approaches which share a commitment to the exploration of personal lived experience" (Smith, 2004, p. 41).

In an attempt to clarify my position, I explored three epistemological stances, as described thoroughly by King and Horrocks (2010): realist, contextual and constructionist. King and Horrocks (2010) acknowledge that these epistemological positions are distinctly different and are used frequently by researchers who use qualitative interviewing, drawing on both realist and relativist thinking. Accepting there is a certain amount of overlap with these positions, King and Horrocks (2010), influenced by Willig (2001), examine these epistemological positions looking at their assumptions about the world, knowledge produced and the role of the researcher.

The realist position (King & Horrocks, 2010) assumes there is a direct access to the "real" world where processes and relationships can be unfolded easily. This produces an objective data that is reliable and representative of the wider populations from which the interview sample is drawn. The researcher remains objective and detached, aiming to avoid any biases.

The contextual position claims (King & Horrocks, 2010) that the context is integral to understanding how people experience their lives; data generated is inclusive of context,

aiming to add “wholeness” to the analysis, taking into consideration the cultural and historical context of the participants. The subjectivity of the researcher is an integral part of the process and the researcher plays an active role in data generation and analysis.

The constructionist positions (King & Horrocks ,2010) state that social reality is constructed through the language which produces specific versions of the event; knowledge is produced through verbal exchange. The researcher is a “co-producer” of knowledge, is reflexive and critically aware of the language used.

My research aim was to better understand the experience of therapists working with survivors of domestic violence. As Smith and Osborn (2003) assert, understanding captures two aspects of interpretation, these being "understanding in the sense of identifying or empathising with, and understanding as trying to make sense of" (p. 54). I was essentially trying to make sense of therapists' experiences, yet I was aware that my own identifications and sense of empathy might have an impact in some way, as described earlier in my personal reflexivity. IPA recognises that the knowledge it produces is necessarily dependent upon the researcher's own assumptions and conceptions, since these are required for the process of interpretation (Smith, 1996). Larkin et al. (2006) maintain that both researcher and participant always construct a participant’s account of their experience.

Considering all the above, I distinguished contextual constructionism as the most fitting epistemological foundation for my research. The theory proposes that all knowledge is situation- and context-dependent (Jaeger & Rosnow, 1988), and "that different perspectives generate different insights into the same phenomenon" (Willig, 2001, p. 145). This approach recognises the unavoidability of the impact that one’s personal and cultural perspectives has on research projects. Madill, Jordan and Shirley (2000) believe that contextual constructionism research is based upon the assumption that all knowledge is necessarily contextual and standpoint-dependent.

Contextualism engages in the production of a meaningful account which takes into consideration all the multiplicities, variations and complexities of both the participants' and the researcher's worlds (Henwood & Pidgeon, 1996). I found that as an appropriate stance,

having my position within my research, as described above. A contextual constructionist approach accepts the researcher's pre-conceptions, maintaining that the researcher's avoidance of any assumptions is an impossible demand (Best, 1995). I was mindful from the initial stages of conducting my research that it will be likely that my perception of participants' experiences will be affected by my own feelings, perceptions and previous experiences. The context has so many elements, including ideographic, historic, linguistic, socio-economic, cultural influences; therefore, the researcher "invariably has to make assumptions about some of these elements" (Best, 1995, p. 346). Willig (2008) argues that contextual constructionism provides a sound underpinning for Interpretative Phenomenological Analysis and the research results are justified as long as they are grounded in the interview data (Madill et al., 2000).

2.1.7 Validity and quality

The guidelines for assessing validity and quality in qualitative research produced by Yardley (2000) and Elliott, Fischer and Rennie (1999) describe the criteria that can be applied irrespective of the specific theoretical orientation of the qualitative study. Yardley (2000) suggests four key dimensions by which studies using qualitative methods can be assessed: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. These have been used as a guide in considering the validity of the current research study, and a more extended evaluation of how these dimensions have been met are extended in the methodological and procedural reflexivity section later on.

- **Sensitivity to context**

Yardley (2000) argues that a good qualitative research will demonstrate sensitivity to context. This can be established in different ways: sensitivity to relevant literature on the subject, to the socio-cultural background of the study and to the participants involved in the study.
A comprehensive literature review ensured that the current study is relevant to Counselling Psychology without distancing itself from the subjective experience of the therapists taking part in the research and whose experiences were the focus of the study. Showing empathy

during the interview process, allowing the participant to feel at ease, and giving them as much control as possible over the interview process allowed sensitivity to each participant's own context. The power disparity that exists within the research process was also taken into consideration. Participants were allowed to choose the location of the interview, facilitating in this way a more open dialogue between participant and researcher. The use of a semi-structured interview using open-ended questions, as well as a disclosure from the researcher about their own experience of working with survivors of domestic abuse in a supportive role, was considered to encourage disclosure.

Sensitivity to context continued through the analysis process. Attention to detail and sensitivity to raw material is demonstrated as Smith et al. (2009) suggest by having a "considerable number of verbatim extracts from the participants' material to support the argument being made, thus giving participants a voice in the project and allowing the reader to check the interpretations being made" (p. 180-181). Sensitivity is conveyed in how the data is analysed in this study, remaining close to what is described and using quotes from the transcripts to support findings.

- **Commitment and rigour**

The second dimension is commitment and rigour. These refer to the degree of thoroughness in the process of data collection and analysis (Yardley, 2000). Shinebourne (2011) argues that in IPA commitment is demonstrated throughout all stages of the research process. In this present study, this dimension is present from selecting the sample, which might require persistence in accessing participants; through commitment to engaging with participants with sensitivity and respect; and commitment to attending to thorough analysis. This process is described in depth in the next section, as well as the process of recruiting participants and the procedures used to conduct interviews and collect data. Rigour in IPA "refers to the thoroughness of the study, for example in terms of the appropriateness of the sample to the question in hand, the quality of the interview and the completeness of the analysis" (Smith et al., 2009, p.181). In this study, in-depth interviewing demonstrated rigour, which Smith et al. (2009) suggest is important in order to get deeper within the participant's lived experience. In the analysis, rigour is highlighted by the fact that themes are supported with appropriate quotes to illustrate the findings.

- **Transparency and coherence**

Yardley's (2000) third criterion, transparency and coherence, refers to the clarity of the description of the stages in the research process. Transparency is established through describing thoroughly how participants were recruited and selected, how the interview schedule was structured and how interviews were carried out, as well as detailed steps in the analysis process. Smith (1996) suggests that internal coherence and the presentation of evidence are two important aspects to take into account when determining the validity of a qualitative research. The researcher has endeavoured that the arguments presented in this study are coherent, themes flow together logically and the ambiguities and contradictions that might have arisen were clearly explored. In this study, the researcher aimed at transparency thorough reflexive statements regarding the researcher's own values, interests and assumptions in understanding the participants' experience of working with survivors of domestic abuse.

- **Impact and importance**

Yardley (2000) highlights that no matter how well research is conducted in terms of other validity criteria, the impact and importance constitutes "the decisive criterion by which any piece of research must be judged" (p. 223). As an IPA researcher, the researcher aimed to present through this research a very important and useful reflection on how the work in a specific field might affect the therapist. Domestic violence continues to be an issue that receives attention due to its prevalence. This study aims to increase understanding of the meaning and complexity of the lived experience of therapists who work with clients who have been affected by domestic violence. In this way, it is hoped that this study's findings will assist psychologists and other professionals that work within the domestic violence field to reflect on the changes that this type of work might have on them.

2.2 Procedures

2.2.1 Sampling and participants

Sampling for this study aimed to be theoretically consistent with qualitative paradigms, especially that of IPA. Following Smith et al.'s (2009) guidance in finding a sample, I selected purposely professional therapists who are or have been working with survivors of domestic violence on the basis that they can grant access to their lived experiences of working with this particular client group.

The inclusion criteria for the study were chosen in order to fulfil a methodological requirement for the research sample within IPA (Smith & Osborn, 2003): finding a homogeneous sample for which the research question will be meaningful.

The inclusion criteria specified that the participants will be will be BACP/UKCP/BPS/HPS accredited Counselling/Clinical Psychologists/Psychotherapists/Counsellors who have been working therapeutically with victims of domestic violence for at least 5 years. I considered at least 5 years of experience in working with survivors of domestic violence a criteria that provided a guarantee that the experiences of the participants would be relevant to the study and some assurance that their experience will be a source of rich data.

Another criterion requested that the therapists should be in an intimate relationship or have been in intimate relationships whilst they were providing therapeutic support to victims of domestic abuse. For the purpose of this study, Miller et al.'s (2007) definition of intimate relationships has been taken into consideration. They suggest that intimate relationships consist of the people that we are attracted to, whom we like, love, have romantic and sexual relationships, live with or those whom we marry and provide and receive emotional and personal support from (Miller et al., 2007).

There were no restrictions in terms of age, sexual orientation or therapeutic approach. Although in the first stages of sampling considerations the gender of the participants were not specified in the inclusion criteria, all participants expressing interest in participating in the research were female and this strengthened the homogeneity of the sample. A homogeneous sample is in accordance with IPA research (Smith & Osborn, 2003) where the aim is to gain an in-depth understanding of a particular group rather than obtain untimely universal claims.

A sample of eight was decided upon, in keeping with the recommendations of Smith et al. (2009). They highlight the fact that sample size is contextual and must be considered on a study-by-study basis. However, as a rough guide they suggest between four to ten data points for professional doctorates. IPA studies with a sample size between one and fifteen have been published (Smith & Osborn, 2003). Following on from these guidelines, a small sample of eight was considered to provide a considerable amount of data that can be examined at a greater depth.

2.2.2 Participant recruitment

The process of recruitment, in the first instance, involved contacting the London voluntary and statutory organisations that offer counselling services to survivors of domestic violence. I had a good knowledge of these services as I have been working over the past 3 years as a support worker for survivors of domestic violence. Preliminary informal discussions with representatives of targeted organisations that offer counselling services to survivors of domestic violence have focused on identifying ethics approval from the institutions in which the research might be conducted. There were nine organisations identified that provided counselling services to survivors of domestic violence and that have been contacted.

The managers were informed of the purpose of the study, the phenomenon being studied, what would happen during, and after, the interview, and the amount of time that would be required of the therapist. A copy of the email sent out to the managers of the relevant organisations is attached in Appendix A. Managers were asked to identify therapists that met the criteria presented above and request their permission for the recruitment material (see Appendix B) to be disseminated amongst the therapists.

The therapists that agreed to be contacted were sent the information sheet (see Appendix C), as well as the consent form (see Appendix D). The identified possible participants were given the opportunity to get in contact and ask any additional questions prior to agreeing to take part. Those therapists that provided consent were sent a sheet on which to record

demographic information (see Appendix E), which was collected on the day of the interview. All the materials had ethical approval for use from City University, as part of the proposal for the study. The participants were contacted to arrange an appropriate time to conduct the interview.

Despite several requests to the above organisations, it proved impossible to recruit a sufficient number of participants from these organisations. Four participants working within the nine organisations contacted the researcher and were recruited for the study. It is perhaps the sensitive nature of the subject of this research which resulted in the relative poor take-up rate from this form of recruitment. Further participants were sought through the researcher's own contacts (i.e., professionals met during workshops, trainings or conferences in the domestic violence sector or direct referrals from supervisors and other professionals in the field of domestic violence). Three participants were directly contacted by the researcher and were informed about the present research. All three of them were recruited for the study as they were willing to take part and they met the inclusion criteria.

The Internet was also identified as a possible tool of recruiting participants. According to Mann and Stewart (2000), the Internet provides a useful method of research recruitment; therefore, this study employed this option. General information about the research conducted was posted on the groups for counselling and psychotherapy professionals on sites such as Linkdin (www.linkdin.com) and in the Facebook group Counselling Psychologists UK (www.facebook.com).These virtual communities represent instantly accessible networks of professionals in the counselling and psychotherapy arena.

Recruiting participants through these kind of sites for this study was considered ideal as it represented the opportunity to target a hard-to-reach population directly, since the inclusion criteria was quite specific in terms of years of work in the domestic violence field. All the websites and the groups in which the recruitment material was posted were based in the United Kingdom. The researcher was already a member of these groups and permission to post on these groups was granted upon joining groups. An initial post was made to explain the purpose of the study, the inclusion criteria and invite group members who think they meet criteria to participate (see Appendix F). A number of replies to these posts were received, the majority being supportive and offering to disseminate the post to fellow work colleagues as

they did not meet the criteria. The therapists who responded to the post were thanked for their expressed interest and any questions were answered. Only one therapist out of three who replied to the post met the inclusion criteria and was contacted by email. An information sheet detailing the research study was emailed and the participant was invited to confirm participation once she had read the material provided. The information sheet about the research as well as the consent form were initially sent and the participant was asked to confirm if she had read and understood this information before any interview was arranged.

I hypothesised as to why there was such a poor response following the recruitment on the socialising networks. Despite these networking sites having direct access to the possible therapists that might want to take part in this study, the inclusion criteria was quite specific, which might have reduced the number of possible participants. Another possible explanation could be that those who might have met the criteria might have considered it too difficult and perhaps too intrusive to discuss their emotional experiences regarding intimate relationships with a stranger.

2.2.3 Positioning the sample

Participants were eight women aged between 31 and 55 years of age who had been working therapeutically with survivors of domestic violence for at least five years. Demographic details that are relevant to the study can be found in Table 1 below. All names have been changed to preserve anonymity. The demographic information requested from the participants had the role of ensuring the homogeneity of the sample and that the participants met the criteria.

Table 1. Participants' demographic

Participant	Age	Occupation	Ethnicity	Marital status	No. of years in the relationship	No. of years since last been in a relationship if single
Anna	48	Psychotherapist	White British	Married	16	n/a
Claudia	55	Clinical Psychologist	White British	Married	20	n/a
Emily	45	Psychotherapist	White British	Married	5 years	n/a
Sarah	53	Counsellor	Indian	Divorced	n/a	15
Mary	52	Counsellor	Pakistani	Divorced	n/a	2 years
Jo	51	Counsellor	White British	In a relationship	6 months	n/a
Caroline	31	Counsellor	Indian	In a relationship	7 months	n/a
Helen	35	Counselling Psychologist	Indian	In a relationship	3 months	n/a

2.2.4 Interview procedure

In accordance with the IPA methodology, a semi-structured interview was devised (see Appendix G). This allowed me to engage the participants in the dialogue and to guide the interview by the schedule, but at the same time, provided the freedom and flexibility to follow interesting issues that arose (Smith & Osborn, 2003).

Interviews were conducted at an agreed time and location convenient and suitable for participants, with the consideration of safety for both parties. Three interviews were conducted at the participant's home. One interview was conducted at City University in a pre-booked room. One interview was conducted via Skype due to their distant location within the UK. Three therapists were interviewed at their workplace. A safety procedure was implemented that involved informing a significant other of the time and location where the researcher would be travelling to. Arrangements to "check-in" and "check-out" were established by telephone. In this way they would know that the researcher was safe and nothing that would jeopardise her safety had happened. Seven of the interviews were conducted face-to-face and recorded on a digital recording device (extra device for back-up purposes). One interview was conducted via Skype, being able this way to accommodate my participant's schedule and overcome the geographical distance. This interview was also recorded on a digital recording device.

Skype (www.sype.com) (Cater, 2011) is an internet tool and a software application that allows users to communicate with peers by voice, video, and instant messaging over the Internet. Calls to other users within the Skype service are free of charge, whilst calls to landline telephones and mobile phones are charged via a debit-based user account system. On the Skype screen, the person calling can see a full screen image of the person or person(s) on the other computer through the web camera. Calling a person on Skype is similar to using a speakerphone, as both voices are audible. Thus, it was easy to run a digital recorder to record the interview.

The participant requested an audio call conference and the limitations to that are described below. A more detailed reflexive account of using this method of interviewing will be explored later on in the methodological and procedural reflexivity sections.

Whilst I would have preferred to conduct a video interview in these circumstances, I wanted to respect my participant's wish that preferred the audio call. I wanted my participants to feel comfortable participating in this study. It was, however, challenging to develop a "working alliance", as described by Ivey and Ivey (2007). I had to rely primarily on voice cues and was unable to observe language cues such as uneasiness and apprehension that might have been communicated by body language.

Informed consent was obtained from all participants for both participation in the research and for the recording of the interview. Prior to conducting the interview, demographic information was collected using the form that can be found in Appendix E. I decided to gather demographical data regarding age, ethnic origin, number of years working with clients experiencing or who have experienced domestic violence, relationship status and number of years being in the current relationship status. I believed that this information will help me contextualise the therapists' experiences.

As suggested by Smith and Osborn (2003), the scheduled interview (see Appendix G) allowed participants the opportunity to talk freely about their experiences. It allowed me to be flexible in following up the material at a deeper level (Smith & Dunworth, 2003). The interview schedule was constructed having in mind the issues that I wanted to cover, following a review of the literature on vicarious trauma. The issues that deserved consideration were beliefs about self and others, intimate relationships, worldview with regard to family/couple life, burnout, recognising stress and coping strategies.

The beginning of each interview constituted of a "warm-up" which allowed the participant and myself to build a rapport. The participant was asked to describe the work they are doing and reasons for choosing to work with this particular client group. As suggested by Smith and Dunworth (2003), more sensitive questions were left for later, by which time, the participant had relaxed. The interview schedule was constructed very early in the process of the research and I feel it reflects my naivety as a researcher in qualitative methods. In designing the interview schedule, I tried to remain open-ended; however, on reflection, some of the questions might be too directive. Nevertheless, the interview still enabled the gathering of rich and distinctive data and I feel very grateful to my participants who have been very thoughtful and reflective and did not need much prompting from me.

I ensured that the interview schedule was followed as closely as possible during each interview whilst also allowing participants to tell their story. Smith et al. (2009) claim that the interview schedule is used as a guide and is therefore flexible. The semi-structured interview in an IPA study should be led by the participant but guided by the researcher. I aimed to abide by these guiding principles and felt that these were generally achieved.

The interviews lasted between approximately 45 and 60 minutes depending on the participant. I recorded these with the participants' consent on an Olympus WS-100 Digital Voice Recorder. I ensured that interviews were concluded with a verbal and written debrief, should they want to discuss anything that had emerged during the interview. The interview recordings were transferred to a USB and stored in a locked cabinet at my home. They will be destroyed when the research and assessment are fully completed.

2.2.5 Pilot phase

The interview schedule was initially tested in a pilot interview with a therapist who met the research criteria. This provided the opportunity to clarify questions, pre-test the interview schedule, with particular focus on the wording and order of the questions. The pilot also provided an opportunity to estimate participants' responses to the questions, receive input regarding content and allow technical rehearsal and troubleshooting. Holloway (1997) argued that in qualitative approaches, separate pilot studies are not necessary. The qualitative data collection is often progressive (Holloway, 1997), the interviewer gaining insights from previous interviews, which allows a more in-depth collection of data.
Following the interview, I decided to use the pilot interview as data for the main study. This was due to the rich data collected from this interview. I followed the identical procedures regarding the entire interview process for the pilot study. Seeing that all ethical and methodological considerations were the same, and the data obtained in this pilot interview was rich and meaningful, I have chosen to include the transcripts in the main body of data.

2.2.6 Ethics

The proposal for this study was granted full ethical approval by the Department of Psychology of City University (see Appendix I). In addition, I gave full and due consideration to the ethical implications of the proposed research, in accordance with the British Psychological Society Code of ethics and conduct (2009). These standards require

that participants are protected from possible psychological or physical harm, preserve their dignity and rights, and also assure their confidentiality and anonymity.

The therapists who expressed an interest in participating were given a written information sheet (see Appendix C) which provided them with details about the project aims and what participation involved so that they might give informed consent. Informed consent was obtained once it was clear that the participant fully understood the information provided, and involved the signing of the consent form appended (see Appendix D). The consent form explained and reiterated all information regarding supervisor contact details, the purpose of the study, anonymity, the right to withdraw at any time and the researcher's contact details. Participants were assured that they had the right to refuse to answer any questions should they desire.
All signed material such as consent forms and other material related to participants, such as demographic forms, have been kept securely in a locked cabinet at the researcher's home and will be destroyed when the research and assessment have been fully completed.

Although this study did not anticipate involving any physical risk to participants, I took into consideration the possibility that taking part in an interview which focuses on the experience of hearing traumatic events in one's life, as well as how this has affected the participant's intimate relationships, could be a distressing experience. I presumed that therapists have a certain emotional robustness which will help reduce their distress if that happens. My aim was to minimise this possibility by ensuring that participants are informed about the aims of the study from the first contact. Participants also received a written debrief (see Appendix H) at the end of the interviewing process. The written debrief contained information regarding the nature of the study and details of relevant resources that could be accessed in the event of participants needing support following the interview. It also contained contact details for the researcher and supervisor should participants have wished to raise any other issues regarding the conduct of the interview. I conducted a verbal debriefing in order to discuss the experience of participating and to monitor for any unanticipated negative effects.

2.2.7 Transcription

The researcher transcribed each interview verbatim. I gave significant attention to non-verbal behaviour such as gestures, laughter and noticeably long pauses, as Smith and Dunworth (2003) suggest. The transcripts included “umm” and “you know”, “aham” so that the transcript was as close to the original dialogue as possible for the purposes of analysis. Smith et al. (2009) mention that transcribing is an interpretative activity. Transcribing the interviews was an opportunity to re-live the interviews, hearing the emotions and allowing myself to immerse myself in the data.

All identifying features of participants were changed at the time of transcription in order to maintain anonymity. This included names, other individuals that were mentioned, place names and other identifying details as far as possible, in order to protect anonymity. A document describing which participant corresponded to which pseudonym and transcript has been kept securely, but separately from the research data, at the researcher’s home and will be destroyed when the research and assessment have been fully completed.

2.2.8 Analytic strategy

An interpretative phenomenological approach was used to analyse the data (Smith & Osborn, 2003). IPA seeks to understand the complexity and meaning of the participant’s world via their narrative (Smith & Osborn, 2003). Phenomenological research allows the researcher to gain an insight into the participant's world through the analysis of the content and meaning behind what the participant says. It focuses on the uniqueness of an individual's thoughts and perceptions about their experiences, as opposed to making objective descriptions about these experiences (Smith et al., 1999). As IPA is not a prescriptive methodology (Smith & Osborn, 2003), each researcher might have personal ways of working. I describe below my personal way of working so that the transparency of the analytic method is enhanced.

In analysing the transcripts, I endeavoured to follow Henwood and Pidgeon’s (1994) suggestion to be "sensitive to the complexities of behaviour and the meaning in context"(p. 227). I tried to incorporate Smith’s (2004) recommendations in "checking ones reading again against the local text itself, and verifying it in the light of the larger text" (p. 46).

Each transcript was analysed individually. As IPA is idiographic in nature (Smith & Osborn, 2008), the initial focus in the analysis was on the issues arising from each individual transcript, and they were worked through one by one. The transcripts were formatted in landscape with a wide margin on the right-hand side and a smaller margin on the left-hand side to allow for notes to be made. The lines were numbered for ease of reference throughout the analysis.

Each transcript was read and re-read a number of times. Notes regarding initial thoughts about the transcript were made on the right-hand margin. At this stage, the aim was to stay close to the text and its meaning (Smith & Dunworth, 2003). My notes consisted of comments on quotes that I found meaningful, summaries of the narrative, connections and speculations, links to other aspects of the account and some preliminary interpretations at a very basic level. This initial interpretation of data was based purely on themes emerging from the transcript.

Following this, I wrote in the left-hand margin emerging sub-themes summarising each small section. These words or phrases captured the essence of the quote. Transcripts were line-numbered in order to ease referencing. In the column beside each line, exploratory notes were written, remaining as close to the participants' meanings as possible. The notes varied on three different levels: descriptive (comments describing what has been said); linguistic (the use of language); and conceptual (interrogative questioning of the data) (Smith et al., 2009). Appendix J is an example of an extract from a transcript of the analysis where the descriptive and interpretative comments are made. In the present study, a list of themes, together with a representative quote for each theme, was prepared in a spreadsheet document for each interview. An example of a list of themes and quotes is presented in Appendix K. Once this list was printed, each theme with the corresponding quote was cut onto a single strip of paper. I spread the strips of paper over a large area of empty floor space so that each one could be seen. This method made it easy to move themes around until it felt as though they were positioned in the most appropriate clusters and super-ordinate themes. Throughout this process, the transcript was re-read a number of times in order to ensure that the emerging sub-themes were still embedded in the original text and therefore truly representative of the participant's narrative.

The labels were not considered to be fixed at this point as I was aware that they might change during the cross-case analysis and indeed even during writing up. It should be noted that later on in the analysis, these themes were reviewed again, in light of the new themes that emerged from the other interviews. In addition, most of these summary tables were reviewed by the research supervisor, and discussions about the integration of cases and the final emergent themes followed. The themes that emerged from each transcript were used to inform the interpretation of subsequent transcripts and a final table of superordinate themes was created. A master table of superordinate themes can be found in Appendix L.

I acknowledged that the process of analysis is subjective on the researcher's part and is very much influenced by the researcher's perceptions. I aimed during this process to be aware and reflect on my own conceptions as well as my participants' and define them clearly. This was accomplished by revisiting the contents of transcripts and making consistent use of supervision. I also followed Silverman's (2000) and Robson's (1993) recommendations to keep a research diary in order to record the progression of thoughts and ideas, and maintain a reflective stance. A brief extract of the reflective diary is found in Appendix M. The final stage of the analysis involved writing up the themes into a narrative account of participant responses where the key themes were presented. The emergent themes are presented here, supported by excerpts from participant interviews to lend validity to their interpretation and allow the reader to evaluate their reliability. The quotes were edited in order to improve fluency for the reader. Extreme care was taken not to alter the meaning of the quotes so as to remain true to the original dialogue and to distinguish what participants actually said from the interpretations made by the researcher.

2.2.9 Methodological and procedural reflexivity

One of my main concerns during the research process was the interview process and the quality of data collected.

The interview schedule was structured early in the research process, and on reflection now, it reveals my inexperience as a qualitative researcher. I feel that some of my questions were too directive at times, regardless of me trying to stay open-ended. I was concerned that some participants' accounts provided a rather dry, factual account of their experiences without the

use of metaphor that can provide a deeper level of interpretation. Perhaps if I were to write a different interview schedule now, when my experience and knowledge in qualitative research is at a different level, I would be more explicit in prompting the participants to talk freely, to be more of an exploratory experience during the interview process. Despite these limitations, however, I believe the interview schedule still provided the opportunity to collect rich data. The participants were reflective, introspective of their experience and I feel privileged that they allowed me a glimpse into their world as therapists.

An additional source of reflection has been my assumptions regarding the experience of the therapists. The more I explored the data during the analytic process, the more clearly I came to understand that I had expected and assumed that the therapists would have a negative experience. I was surprised to discover that the participants described what is known in the literature a post-traumatic growth: they describe their relationships as being enhanced in some way, and they changed their views about themselves, having a greater acceptance of their vulnerabilities and limitations.

Skype audio interviewing also brought a fresh set of challenges very different from conducting interviews face-to-face and it proved to have a number of limitations. There seemed to be more room for misinterpretations without non-verbal cues because I was not able to see interviewees. I also had concerns again about the quality of the data as the responses online participants gave lacked the richness and spontaneity of the data from face-to-face interviews. When the interviewer is relying primarily on voice cues, it is critical to listen intently to build rapport. I have tried to minimise these limitations and to create a "working alliance" without face-to face contact by ensuring that the protocols for the interview, including basic logistics, were followed. These included confirming time frame, anticipated length for interview, scheduled times as needed to try the Skype connection prior to data formal collection, agreement on signals to indicate need for more time to answer or time for a break. I also ensured that both the participants and the researcher are in a quiet, confidential and safe environment.

I found at times the process of analysing overwhelming, long and demanding, requiring much greater commitment than I had initially anticipated as a beginner in qualitative research. Whilst Smith and Osborn (2003) provide a reasonable guide to the process of analysing the

data and acknowledge the challenge of prioritising and reducing the number of themes, there are no clear guidelines for this stage of the process. I had a dilemma when it came to choosing which themes to focus on in the final write-up. There was so much of the original material that I could not include and I felt that, to some extent, inevitably, something of the individual stories was lost in this process. Given the opportunity to perform the study again I would be far more selective and try to identify an area of focus much earlier on in the process.

The process of research and writing up at doctorate level whilst also juggling full-time work has proved an intellectual and emotional challenge for me that stretched my capabilities to their limits. There were times when I felt an overwhelming emotional pressure similar to the one described in the literature for burnout and described as well by some of my research participants. In order to cope with these emotional times, I took advantage of my three years' training as a psychologist, which allowed me to use methods like relaxations techniques and mindfulness to help regulate my own emotions. My regular meeting with my research supervisor and my therapist also provided me with the opportunity to reflect on these feelings and to discuss ways of coping with them.
Last but not least, the information provided by the participants with regard to their own ways of coping with burnout has also been a source of great inspiration.

3. Analysis

3.1 Overview

The analysis of the transcripts produced data that provided a rich description of the experience of the therapists working with survivors of domestic violence. This chapter describes the three super-ordinate themes and sub-ordinate themes derived from the analysis of all eight interview transcripts and recordings, using the analytic strategy described in the previous chapter.

In developing an interpretative account of the therapists' experiences, priority was given to those themes which seemed most pertinent to answer the research questions, covering areas that previously were neglected by the literature (intimate relationships of the therapists), as well as some unexpected and new aspects of these experiences.

A number of themes describing these experiences were identified during the process of analysis. The following section will present these themes organised under three super-ordinate themes: ***The journey of listening to clients' stories, When work hits home*** and ***The dawn of a new self.*** These three super-ordinate themes have been constructed for the clarity of the presentation and they intend to highlight some of the most interesting and meaningful extracts that have surfaced as a result of the research process. The structure of the themes is, of course, the result of a unique interaction between the researcher and the data, and would not be entirely matched by another researcher. The objective of these themes is to provide a rich portrayal of the breadth and complexity of the experience of working with adult survivors of domestic violence and to capture the essence of therapists' experiences. It is important to draw the reader's attention to the fact that these super-ordinate theme groupings are not necessarily distinct but have much overlap between and within themselves.

Each sub-ordinate theme will be presented and explained using verbatim quotations from the interviews. In the quotations, empty brackets indicate material that has been omitted. Participants are referred by pseudonyms throughout. The source of quotation is indicated by pseudonyms and line reference numbers.

This section presents the results only with the interpretative analysis, without further theoretical discussion and integration of the literature. The next chapter of this research will

integrate theoretical elements and literature. The discussion section attempts to provide a more interpretative account in the context of existing literature and theories. The researcher felt that this style of presentation would better embody each individual participant's narratives as they were experienced during the process of analysis.

3.2 Overview of super-ordinate themes

The first super-ordinate theme titled ***The journey of listening to clients' stories*** describes the initial impact of hearing traumatic materials from survivors of domestic violence. It aims to portray how they have responded to the initial contact of their clients' stories. This can be seen as the beginning of a journey through which the therapists rediscover themselves and their values and beliefs in light of new knowledge gained from working with survivors.

The next super-ordinate theme, ***When work hits home,*** seeks to explore what kind of changes have occurred in the therapists' intimate relationships, how they have re-positioned in their intimate and social relationships and what kind of changes their work has brought in their household. This super-ordinate theme investigates therapists' new-found reflections on their intimate relationships as a result of their work with survivors of domestic violence.

Finally, the last super-ordinate theme, ***The dawn of a new self,*** draws the reader's attention to the new perspectives and views of the world that the therapists have reflected upon and assimilate whilst doing their work. For the participants, it is a time of re-assessing their identities following a journey of self-discovery.

3.3 Super-ordinate theme – The journey of listening to clients' stories

The first super-ordinate theme describes the beginning of the journey and some of the initial reactions of hearing clients' traumatic experiences. Listening to their clients' accounts, the therapists seem to experience a range of emotions, such as anger, shock, disbelief in humanity, anxiety and lack of trust in themselves. Their clients' narratives seem to activate the therapists' own trauma, most of the participants sharing some of their own experience of domestic violence in their own intimate relationships. Whilst this work has proven to have a crushing impact on the therapists' self, the participants have also developed successful strategies that have helped alleviate the negative effect of hearing traumatic accounts,

managing in this way to replenish the shattered self. Within this super-ordinate theme, three sub-themes were identified**: The work resonates within the therapist**, **Remembering own trauma,** and **Protecting and sustaining the self**.

3.3.1 Sub-ordinate theme – The work resonates within the therapist: "*The work chips away parts of yourself*"

The participants' account of their first reactions to the material brought in the sessions by their clients revealed a wide range of experience, shifting from anger, shock, stress, sadness, numbness, detachment, to an increase sense of responsibility towards their clients as well as distrust in humanity.

Helen describes her initial thoughts when starting her work in this field:

> *I remember feeling…initially feeling so shocked and quite upset for them, to start with. It was hearing the stories you would be thinking about them outside of work, you would also take it to supervision; it would take off a lot of your space, because there are sometimes feelings of guilt as well. [] These people that I'm working with, they are not necessarily going home to a safe environment…you can experience feelings of guilt, and you feel stressed, because you're hearing these stories []it's very easy to fall into feeling guilty of perhaps your life, you know, being okay and these other women, you know, they're going back to such a difficult time or you know, you can get so stressed from being absorbed in that, and to tell yourself that's not your life, that's their life, and sometimes you have to be brutal with yourself (Helen, 66-72; 472-476).*

There are several important issues to note within this brief extract. Helen's initial reaction to her client's story was distress and sadness, emotions that were extremely invasive, making the boundaries between work and personal life blurred. Helen's work would often take a lot of space in her own private life and she is starting to take a lot responsibility for her clients. Helen even feels guilty at time for her life being "ok" whilst her clients return to a situation where their safety might be in jeopardy. The work appears to be so overwhelming and so draining at times that Helen finds it difficult to keep boundaries clear. She feels she needs to remind herself that she is not responsible for her clients outside her work.

Anna has similar concerns for her client's safety, just like Helen:

> *Very concerned for their safety, very shocked, angry, angry with the perpetrator, and maybe afterwards angry with them, particularly if children were involved, helpless, powerless, all this things you have to contend with, very protective, all sorts of things (Anna, 46-48).*

Moreover, Anna describes feelings of anger directed not only at the perpetrator but also with her clients as well. This particularly happens when children are involved in the abusive relationships and it could be interpreted from her account that she perhaps holds the client responsible for not being able to keep herself and her children safe.

Sarah felt as well extremely protective of her clients, wanting to rescue them:

> *I used to feel that I want to rescue them. Basically, in my heart that was the case, that I want to rescue them (Sarah, 43-44).*

The presence of children within these abusive relationships has also been very painful for Sarah to come to terms with:

> *I used to be affected by children's stories, of children's suffering, how fearful they are, I used to perceive all that and I used to take it home at the beginning and sit and cry and cry and cry and used to hate it (Sarah, 161-163).*

Emily is subject to an overwhelming feeling resulting from caring about the clients' pain, which results in a spectrum of emotions:

> *That level of information and pain, caring all the pain of all the people, is just managed. [] I quite often cry , sometimes there are tears about clients and sometimes of my own, which makes me think day to day I either recognise the pain I am carrying or don't feel it (Emily, 245-250).*

One hypothesis for not feeling the pain is that, in order to cope with the impact, the therapist goes through a numbing process, similar to symptoms of posttraumatic stress.

Claudia explains how she had experienced some of the feelings that her clients have experienced, giving a sense that the therapist has become one with the client and both experience a profound transformation:

I felt sadness about the extent of physical, sexual and, psychological harm that the women had experienced. And caring their pain, I had some flashbacks, nightmares associated with things that they have told me and got increasingly aware that I was experiencing some of the things that that client population feels such as feeling helpless, sad, angry by having no way to focus it (Claudia, 73-77).

Claudia's experience indicates that she sees herself as the bearer of her clients' pain, and just like in Helen's case, the client's account overcome her and post-traumatic like symptoms, like flashbacks and nightmares, seem to emerge. Claudia makes sense of her experiences and rationalises that she is re-experiencing her clients' emotions following trauma. This meaning-making is concerned with the process of transference resulting from the therapeutic process.

The emotional impact that the trauma has on the therapists continues to be revealed with the mention of anger, though in a different context for Claudia.

Claudia also experiences anger, just like Anna, however, Claudia's anger appears to awaken in her the desire to reveal the abusers, to expose them. She describes her automatic thoughts on her way back home from work on the train:

Coming home on a crowded tube train one day and looking up the carriage thinking: "five of you bastards are abusing your wives, I wonder who you are" and I was like my God! What have I turned to… I was so shocked that the humanistic-Rogerian counselling conditions that I once believed in have been fundamentally changed by recognising that there were abusive men (Claudia, 58-62).

Claudia's use of strong language indicates an outburst of resentment towards perpetrators and Claudia feels that her worldview on human kindness has undergone a profound transformation: the stories of Claudia's clients follow her outside her workplace and distrust in humanity seems to take shape.

Emily depicts also her disbelief in humankind and she identifies a change in her broader understanding and view of the world. Most shocking for Emily is that these atrocities can happen very close to her home:

Initially, I felt like I couldn't believe that there were so many different ways hat people, that women were being abuse in my home area. It...it... I suppose it was disbelief that these women are going through things that you are reading in the

newspaper. Actually, they might have just lived next door to me. So I guess disbelief, was the first thing (Emily, 62-65).

Caroline seems to have heard in her sessions the absolute extremes of the abuse inflected on her clients by perpetrators:

I used to find it quite unbelievable, that people would do this sort of stuff to other people, and the more I started to hear it, the common themes and different clients I worked with, I found that quite surprising…especially when they describe how the person is normally, in front of other people. Yes, I was quite surprised and shocked I think, at first (Caroline 73-79).

Caroline's exposure to the trauma leads to new understandings of how perpetrators might be perceived outside their relationships, and these new revelations are astonishing for her.
In contrast with the accounts of Anna, Helen, Claudia and Emily, Mary has difficulties in recalling how she experienced her first encounter with her clients' narratives:

You know I felt ...I remember...I think in the back of my mind I was feeling ...you know...I can't actually...is very hard to recall what I was feeling because I ..in my own self-awareness work, I worked through a lot of emotions myself , so I could stay with the client, but I would feel emotional as well. I know that sometimes I would feel emotion but I wouldn't let it get in the way of my therapy with the client. So I had that awareness that yes, this is painful, but also remained detached stayed with the client. So I wouldn't start crying or anything....aham…I might have had some tears, but continued to remain detached...you know...so just having that awareness, but yes, I would feel emotional (Mary, 70-82).

The extract above illustrates the struggle that Mary has in recollecting her initial reactions. Mary finds her words with difficulty and pauses in her speech highlight her strive in making sense of her feelings. Mary clearly wants to show that her clients' material has not affected her and that she was able to empathise with her clients, being aware of their suffering and remaining congruent with them. There are a few contradictions in Mary's extract: whilst she mentions staying with the client, "feeling" their pain and even shedding some tears, Mary also describes feeling detached at the same time. There is almost a disconnection that is perhaps used to protect Mary's self.

Caroline also discovers that recollection of the initial impact is a struggle; however, she acknowledges an evolving affect through time:

> *It's quite hard to remember exactly how I felt, but I know it's different from how I feel now, it was more…I used to feel that I was getting too involved, not like give advice or get upset in front of them, I used to feel it inside me, kind of feel a bit…that that's terrible, you know, kind of…not taking it home, but thinking about them after the session and worrying about them (Caroline 66-73).*

> *I don't think I feel as…as I did before. I feel…I don't want it to sound cold, but I feel...that's "their stuff" and the best I can do is help them through it (Caroline 89-91).*

During Caroline's account, it is important to engage with the passage of time in understanding the reported changes in managing to keep the boundaries clear between herself and her clients' material. It can be hypothesised that the impact on therapist changes over time, depending on the experience and the ability to set clear boundaries. The impact is evolving, it is not static. Just like the other therapists, Caroline shared her initial concerns about her clients' safety and her involvement with her work. The work became part of her, part of her Self, to the point that she was feeling it "inside" her. It appears that Caroline has succeeded in stopping work invading her life outside the therapy room.

Later in her narrative, however, Caroline maintains the theme of being "flooded" by her clients' material and her clients' pain weighs her down:

> *Is like a sinking feeling, like they would explain an incident while they were physically abused and they go into detail, I kind of feel very uncomfortable, kind of…you know, when your heart sinks, I feel…it's quite hard to hear (Caroline, 81-85).*

Anna's reaction to the clients' material also evolves through time, and just like Mary, the reader can sense a detachment from the clients' narrative:

> *You do get used to it and is not as shocking, however I think getting used to it, becoming a bit hardened to it in a way, I could respond, which sounds bizarre, I could respond more authentically, in the sense that I am not shocked by it, so I can say "Oh my god, are you hearing what you are saying?" which is quite weird, because is not a*

shock, you respond more authentically to the story rather than coping yourself with the horror of it (Anna, 66-70).

There is a sense in Anna's account that she began to normalise her initial shock reaction in order to be able to "survive it" and to be able to respond to her clients in the therapy room. She describes this de-sensitisation as having a positive impact on the therapeutic relationship, being able in this way to be more congruent with the client and to respond more adequately to the trauma. It is remarkable, however, to notice the contradictions in Anna's account, as she perceives "being hardened" by her client's material as a way to respond more genuinely.

The extracts above highlight the fact that therapists have to walk a fine line between empathy and detachment. Whilst every therapist interviewed for the present research wants to be emotionally attuned to their client's suffering, they do not want to lose their objectivity.

The psychological impact that the work with survivors has on the therapists is demonstrated in the above extracts; however, the assault on the self is also manifested physically, as most of the participants witness the effects of hearing traumatic accounts on their bodies.

Physiological changes are felt by Helen and illustrated below:

There's a feeling of tense in your own muscles, you can often pick up some very psychosomatic symptoms, even when you're listening to a story being told, you can feel almost some of the anxiety from the other person as well (Helen, 72-76).

In this way, the therapist becomes the container of the clients' feelings, emotions, struggles that can manifest through psychosomatic symptoms.

Anna feels tired, fatigued and her body is tense, and she acknowledges how this affects her life at home. A more in-depth account of this aspect will be discussed later on in the chapter:

Tiredness, being touchy, being more sensitive thinking outside of work too much, not being able to leave it behind, causing arguments at home for no reason at all...sometimes you feel stress in your body, you feel tense, maybe working too much but I do like to work so I work hard anyway (Anna, 138-141.)

Mary has similar experiences:

> *Sometimes I would feel pain in my heart…and actually sometimes, at the end of the session I would feel pain and I was just have to stay with it to see if it is about me or about the client, because I have learned to do that a lot. And through transpersonal work I did I learned that if I am feeling pain, am I feeling the client's pain or am I feeling my pain? That's where I learned to discriminate. So if I had ongoing issues it could be my pain that the client's issue has stirred up for me...(Mary, 88-97).*

Mary processes her experiences and ruminates on possible transference and countertransference with her clients. Just like Helen, Mary sees herself as a possible container for the pain of her clients, but that does not exclude that some of the pain she is feeling might be her own pain. By repeating the word "pain" in the above extract, Mary highlights the ache she is facing not only on an emotional and psychological level, but also on a physical level. Unlike Anna, who is "hardened" by her client's stories, Mary appears to cope differently, by allowing herself to experiment, to question and ruminate on the interaction between her and her clients.

Jo also feels the physical tension:

> *I get stiff in my back and my shoulders, and I feel like carrying stuff , emotional stuff on my shoulders. That is sort of physical I most get, mostly in my sort of plexus area (Jo, 278-280).*

In summary, this theme has highlighted the range of emotions, psychological and physiological symptoms that can impact on the therapist's self. All of the participants related how, as a consequence of listening to clients' trauma, they had experienced a sense of internalised trauma, symptoms similar to those of their clients. As Helen describes, there is a sense from all of the participants' accounts that *the work chips away parts of yourself* (Helen, 481-482). It is perhaps dissolution of what is the known self for the therapists because the therapeutic work involves, as Emily points out, *giving a bit of yourself to the client to take away with them* (Emily, 132-133).

3.3.2 Sub-ordinate theme – Remembering own trauma: "It was exactly like two wires coming together...mine and hers"

The journey of listening to the clients' stories continues with participants recollecting the past trauma that they have experienced in their own intimate relationships. These disclosures have been unexpected during the research process; therefore the decision was taken to allocate a theme to them.

Mary had a revelation whilst doing therapy with one of her clients:

> *I discovered what was happening with me in my relationship... [] it just blew up and that is when something clicked. When I got home and I realised that this (domestic abuse) was happening to me...you know…and I actually ...my children were there , everybody was there, I felt that I collapsed on the sofa…you know...I didn't actually collapsed...I actually sat…lean down…but it feels like ...suddenly like something was pulled from under my feet. It was like that...and I stayed there and…I just couldn't believe it...this is what happened. I had been in the marriage for 12 (counting)...been marriage for 12 years...umm…I just remember being in a daze for 4 days (Mary, 120-145).*

> *It was exactly like two wires coming together...mine and hers...you know (laughs)...and is just like I had like a shock and I couldn't stand...I had to sit down and lie down. It was like...because the issue was exactly the same…That is what is clicked (Mary, 218-223).*

It appears that, for Mary, the therapy with her client provided the opportunity to reflect on her own relationship with her partner. It came into her awareness that what her client was describing was something that she was experiencing in her own relationship as well. The realisation was so shocking that, on the one hand, she felt a strong connection with her client, but, on the other hand, her world, as she knew it, started to fall apart. Mary was so taken aback by her revelation that she did not know how to react. Being in a state of shock was a coping mechanism that she needed to use in order to process what happened and tried to maintain a sense of normality with her children:

> *I was still in a daze but I forced myself to get up…and I made cookies with my children…(laughs)..and I just had to give them my attention (Mary, 149-152).*

Caroline started to ruminate on her relationship as well and identified the emotional abuse that she was experiencing from her partner at the time:

> *I first started to do this work when was with him, and it was with him that I started to think: alright, not physical abuse, but you know, he lies a lot, that's emotional abuse (Caroline, 161-166).*

Claudia also recollects her own trauma and describes how this work can be a trigger for remembering traumatic events:

> *Is one of the things that happens, that people who come in the field they recollect things that have happened that I previously thought are completed...One thing that happened to me was that I was sexually abused by a friend of my father's when I was 14 and I was engaged to a guy when I was 20, he hit me I think ...now that my memory is fuzzy, at least once, probably twice, ... And he also trashed my mother's flat at one point, but that is all... that I have experienced (Claudia, 105-110).*

For Jo, her own abusive relationship has helped her connect and empathise with her clients on a deeper level. Jo uses her traumatic experiences as a tool in establishing a therapeutic relationship. She feels perhaps she would not have established this connection if she had not had this experience of abuse:

> *I think it was quite difficult because some of the situation I have been personally experiencing myself, so I have some empathy there if I hadn't have the experience, may have been more shocked.[].Some of my experience was perhaps not as severe as these people. But they were elements around it that I had experienced. So although the material presented can be quite shocking I was not overly shocked as I had some experience of it. [] Because you have an experience of something you can always get on a deeper level with you clients, because you have experienced similar things. I think if I hadn't, then may have been more shocked. Or view things a bit differently (Jo, 37-52).*

Unlike the other participants, Emily's recollections about her abusive relationship are triggered by the training in domestic violence that she took part in, in order to become a counsellor in this field , and not necessarily by her clients' stories:

My previous, my previous partner, my daughter's father was abusive. It was violent and it was emotionally and financially abusive. And just lots of things in between. I remember they(in the domestic violence training) were talking about stalking, they were talking about being prevented from leaving the house...and I actually thought about our relationship...and the smug when we split up...he actually sat on the doorstep, so that I wouldn't go out (Emily, 92-107).

Like Jo, Emily uses her personal experience to relate with her clients and feels this will strengthen her relationships with them, which will lead to their growth and empowerment:

So I was able to use my circumstances but make them as someone else's. It shows understanding which is hugely important because clients feel like they are the only person in the world and they are weak or stupid in some ways...and actually as I was telling you about my first husband....I was aware of that feeling of being stupid... and suddenly I remembered that relationship I had which was only for 6 months...and I could feel myself starting to hesitate because I had the feeling of: "I can believe I am telling this woman this, what is she going to think of me" ...and all these feelings that clients feel coming up (Emily, 119-126).

Emily acknowledges the parallel process present during the interview. Recollecting her own trauma, she suddenly began to have similar feelings to those of her clients. She is shocked that she is able to share her experience with the researcher, and her automatic thoughts and assumptions make her feel uncertain and cautious about her disclosure.

In summary, this theme illustrated how sometimes the client's story can trigger memories of a therapist's own trauma. This is not seen entirely as a negative experience but as an opportunity to reflect upon it and use it in building and strengthening the therapeutic relationship. Claudia and some of the other participants believe in the "wounded healer" and its ability to connect with the clients on a deeper level:

I think that lot of women want to give back and share their learning and feel grateful for their recovery and want to help other women. I certainly think is the primary drive in the domestic violence sector for frontline workers (Claudia 115-117).

3.3.3 Sub-ordinate theme – Protecting and sustaining self: "Giving a bit of yourself to the client to take away with them, then you need to regenerate"

As the reader can notice in the extracts from the previous themes, hearing the trauma might shake the therapists, their personal sense of omnipotence as a human being, and their professional confidence and skills. Working with domestic violence will create intense reactions and vulnerability, especially if the worker has personally experienced abuse. No one should work with trauma alone, and the therapists' experiences must be understood and contained within an ongoing support system. The therapists interviewed have described various self-care strategies that they have found beneficial and that can be identified in the extracts below.

Helen talks about the importance of self-care and the duty as a professional towards your client:

> *The work chips away parts of yourself and you need to keep replenishing that. So you don't want it to chip away in a point where you can't replenish yourself, because there is dangerous and then you're not really helpful, because you're in a state, so that would be about protecting yourself (Helen, 481-485).*

This extract draws our attention to the intensity of the work and how at times it can damage the therapist's self. Helen acknowledges this impact; however, she also depicts how important self-care is during this process and how as a therapist you are responsible for taking care of yourself in order to provide your clients with the best service.

Helen reminds us about the personal and professional responsibility of the therapists to attend themselves not only on a psychological level but also on a practical one in terms of safety planning due to the clients' perpetrators still being "out there" looking for their victims:

> *But also protecting yourself in many ways, I mean this can be a hardest area to work in. there could be some incredibly dangerous men, that are attached to the clients you're seeing, so you need to protect yourself in a practical way as well, in terms of where you're working, how you are working, is the client safe, are you safe as well, so there's something about your own safety too (Helen, 481-490).*

Similar to Helen, Claudia illustrates in her account her fears for her safety:

Well I certainly remember in the first couple years being more vigilant about my safety, feeling afraid of abusive men tracking me or stalking me or ...whatever. I did some very particular things, put a lock on my bedroom door, panic alarm beside my bed when my husband is not here, but, actually, on the whole, I don't think about it anymore...(Claudia, 230-233).

All the participants have acknowledged the extreme importance of good supervision. Jo adds that supervision is an opportunity for the therapists to "heal" and to process and work over the feelings that their clients' stories have awakened within themselves :

Supervisions are also monumental in our work, that is something which contributes in our self care, getting in to the bottom of something [], go to hunt different emotions, that is good self-care, because then you can heal from that, you can work from that (Jo, 303-305).

For Claudia, supervision allowed her to express her anger that she was feeling towards the perpetrators, make sense of this anger, and she felt that expressing it was beneficial for her. Overwhelming tears transformed into laughter once she realised she is allowed to feel angry and to hold the abuser responsible for her clients' distress. Claudia's reaction draws attention to the importance of having a good working relationship with your supervisor:

The manager really help me when I was crying all over her in supervision and she just quietly and firmly said: "those bastards" and made me laugh ...so one pivotal moment for me was to recognize that I had to be angry, rather than overwhelmed and having angry reactions. The manager knew it was a healthy thing to do. And the second was to be clear about holding the abuser responsible (Claudia, 87-91).

For Helen, creating clear boundaries between work and home has been a useful strategy to address burnout:

I've learned how to really switch off, and obviously, if I was thinking about anything like that, I'm sure it wouldn't help, but I know I'm very clear about separating my space from work and home, and I think that must clearly be something that's the key []I think sometimes it's important to not be around other people from that working field as well, and to have friends that aren't in this arena, because you actually don't want to talk about it outside of work (Helen, 239-242; 437-441).

Maintaining psychological and physical boundaries between work and home has also been addressed by Caroline when talking about self-care strategies:

> *I manage the stress and I try and do …a lot of activities, not a lot, but you know, after work, I'm trying to do something that has nothing to do with work, such as talking to friends, going for a walk, when the weather is nice, going out to a cinema, and I just try to look after myself (Caroline 449-453).*

Self-care for the therapists interviewed does not only mean implementing strategies from the area of the professional self-care like supervision, taking breaks, setting limits and clear boundaries, and finding a balance between life and work. For the majority of the participants, spending time with people they love and like, practicing relaxation and meditation, spending time in nature, allowing themselves to laugh or cry are a few of the approaches they use to replenish the "bruised self". In the extract below, Anna's techniques to unwind are shared by most of the participants:

> *I exercise, I know is good for me, I spend a lot of time doing my nails, because is sooths me and is silly and allow myself to do silly things...self-care...I keep in touch with my sister, with my mum, with friends I trained with...so I have a good balance. [] I go on lots of holidays, so I get away from work a lot. I also read a lot of therapy books who have helped me understand my process, my clients' process, I am around positive people...I love a lot and I am silly. I laugh a lot...and that is important in self-care (Anna, 164-170).*

Overall, ***The journey of listening to client's stories*** has proven to be for the participants a journey of discovery. And like any journey of discovery, it has not been without challenges. The clients' accounts have had a distressing effect on the therapists' self where signs of burnout and secondary trauma can be recognised. Whilst these indicators are more or less recognised by the therapists, there is a general accord that the work can be traumatic and the need for self-care is vital, especially when the therapists have to deal with their own trauma as well.

3.4 Super-ordinate theme 2 – When work hits home

The second super-ordinate theme continues to look at the experience of the participants but focuses on the changes that have occurred during their intimate relationships and their new positioning in these relationships because of their work. Four themes have been identified here: ***Questioning own intimate relationships, Becoming the abuser, Permeable boundaries between work and private life*** and ***New insights on intimate relationships***. There is a consensus that the work provided the therapist the opportunity to reflect on their own relationships and their dynamics and, of course, the role they are playing within these dynamics.

The reader's attention is drawn to the thread that passes through all four themes in this section. This can be described as the participants' experience of their newfound positioning towards their own intimate relationships and will be highlighted throughout.

3.4.1 Sub-ordinate theme – Questioning own intimate relationships: "I do test my partner constantly"

The data revealed interesting experiences regarding spousal/partner relations and how being exposed daily to the trauma of their clients made the participants ruminate about their own intimate partners and future intimate relationships.

Helen acknowledges this rumination and there is a sense that the clients' circumstances allow the therapist a parallel work on self, highlighting the therapist's own revelations about assertiveness in relationships:

> *Working with individuals that have had extremely negative experiences in their relationships, would certainly make you question and reflect upon your own relationships. []But it does…it does make you question things; it makes you think about the type of relationships that you want and you deserve, so definitely it's a spotlight of what's okay and what's not okay, what you're prepared to tolerate and what you're not prepared to tolerate; and what you deserve as an individual (Helen, 117-129).*

In light of the revelations from the sessions with her clients, and perhaps with a new understanding about the way that a relationship can be controlling, Caroline is uncertain about certain aspects of her own relationship:

> *Sometimes I think: "Is this person trying to control me? Wants to change me or mould me? Is it about compromising? Is it that I spend too much time with my friends, or too much time doing other things and not give this person attention?" So, I kind of battle between the two, so what is it? Is it, to make it work, I need to compromise or is it person trying to control? I kind of do find myself questioning a lot, of what are his intentions, are they good or are they for us, it's our benefit or his benefit, you know? (Caroline, 334-346).*

Within Caroline's narrative, there is an evidence of struggle to make sense of her partner's behaviour. She demonstrates her inner conflict by her rhetorical questions and there is a strong sense of her wrestling with her doubts. Earlier on in her account, she describes similar struggles and there is a sense of self-blame, being concerned that her partner might take advantage of her sensitivity:

> *I do question: is there mental abuse or emotional abuse, and I think that it depends on the personality a lot. I am someone that can feel guilty quite easily, so then I think does the person pick up on that and play on that to get on their own ways sometimes (Caroline, 242-246).*

> *Sometimes when you have arguments, I do kind of think: "Okay, is he using his power to try to control me?" and I kind of try to stop myself (Caroline, 139-148).*

The therapists' accounts in terms of intimate relationships capture the sense that they have acquired a heightened attention to the dynamics of their own intimate relationships and they have become hypervigilant when engaging in intimate relationships.

Jo describes how her work, combined with her personal experience of being in an abusive relationship, made her alert when starting new relationships, lacking trust in possible new partners:

> *When I did start going out and socialise with men, my radar was so up so high, that I just hear one word and just disappear from that situation that environment, it was like me ears was constantly pinned back, it sort of left me with issues of trust, severe issues of trust. To the point where I was, sort of I was almost careless towards people who wanted to get close to me (Jo, 85-87).*

For Jo, her past experiences and listening to her clients' stories left her "bruised" to the extent that even now, when she is in a happy relationship, she does not stop questioning and "testing" her partner:

> *In my current relationship I do test my partner constantly. He is so committed to the relationship and to me and because he sort of gives me so much support and encouragement, slowly my barriers are breaking down with him, but I do question, what goes on for me (Jo, 89-91).*

Mary adds to this way of thinking in describing her anxiety in starting new relationships. She constant challenges her beliefs rooted in her personal and professional experience of domestic violence:

> *I still feel fear of meeting somebody new. And there is a fear, but I challenge myself a lot. So this is like another challenge. And if I really wanted, which I do, I would like to experience a good positive, loving relationship. I would have to take a risk. But I am getting to a place where I can take a risk but I don't need to get hurt, you know... because I am going to be in a different place from where I used to be. Whereas I have been hurt because of something, something that has been said, or did or didn't do, but now I know that this is what I want. If someone else doesn't want it doesn't mean is because of me. Is not taking anything personally, but this is how it is at the moment (Mary, 319-334).*

Unlike Caroline, where a sense of self-blame is depicted, Mary learned from her experience that she is not to be blamed for her failed relationship. Ambivalence can be noticed in Mary, who acknowledges her fear, but she is willing to take risks in a safe way. She is open to challenge her beliefs and to explore and re-experience relationships. Mary loses that self-blame and is in the process of rediscovering herself.

Hypervigilance in her relationship is something that Helen describes as well:

> *It has certainly made me cautious, and I'm very careful and I would sit back and I will observe people, perhaps more than I would have done before I was involved in this field. So, I suppose it does make you a little bit more suspicious, and I suppose the bars are set high for people, and that they need to prove themselves a little bit more (Helen, 188-192).*

In summary, this theme illustrated the changes in participants' cognitive schemas regarding intimate relationships, finding themselves less secure in their relationships, more observant with their intimate partners and quite wary and alert when attempting to start new relationships.

3.4.2 Sub-ordinate theme – Becoming the abuser: "I realised how abusive I could be in my relationship"

Becoming the abuser/controller in their own intimate relationships has been one of the most interesting aspects that have surfaced during the analysis process.

For example, Anna became aware of certain aspects of her behaviour towards her partner whilst participating in awareness trainings on domestic abuse:

> *I realised how abusive (whispers)...how abusive I could be in my relationship ...I was quite shocked...and we were doing this role play and I was thinking "Oh my god (whispers), I do that"..(laughs)...and I would come home and tell my husband what happened..and he would go around the house and say "I am abused, I am abused, don't abuse me" (laughs)...so it did make me think about how I was with him, and how not being nice to our partners can sometimes border on abuse...but it brings you up short...so it makes you think what am I doing...(laughs) (Anna, 75-80).*

Anna is stunned to realise that some of her behaviours towards her husband are typical behaviours of abusive partners and her laugh during the interview indicates perhaps her awkwardness at her disclosure. Anna's whispering the word "abusive" suggests shame for her behaviour. It appears that working in this arena has allowed Anna to re-assess not only her relationship but also her interactions with her husband. She observes her process and shares her revelations with her husband, which indicates their closeness and the good communication in their relationship.

Jo observes the following when describing her relationship with her partner:

> *I become the controller in my current relationship, it is about pain, and it is about hurt, it is not personal towards him, I can get angry with him, because he loves me, because sort of understand the situation is very different. He comes from long marriage, and there was not sort of domestic violence as such, sometimes I get quite resentful with him, for having not had the experience I did, although I couldn't tell him that because I would feel bit humiliated. I feel resentful that his ex-partner had him, very supportive man, just everything I ever wanted in a man, he ticks all boxes for me, I feel a bit resentful, a bit jealous and a bit angry and I don't want to tell him that (Jo, 105-112).*

Several aspects are to be noted in the above extract. Jo describes a lot of anger, which comes because of the pain and hurt she has previously experienced in her relationship. Her controlling behaviour is perhaps a shield set up to prevent possible future pain that she was accustomed to in her past relationship. Jo experiences contradicting emotions when thinking about her relationship: on the one hand, she feels angry, resentful and jealous of her current partner's past relationship, and on the other hand, she feels embarrassed for having these emotions. Being angry with her partner for loving her denotes how much her previous abusive relationship has marked her, as she does not feel worthy of her partner's love. Although there is a sense that her partner might understand her reactions, and there is this awareness of a silent understanding from his part, Jo feels unable to openly discuss with him her processes.

For Caroline, just like in Anna's case, work has also been an eye-opener about how she conducts herself in her relationship:

> *Very early when we started to work, I was just looking at him, thinking: "You said it this way, and you're trying to control me, and you're trying to make me feel guilty, bla bla bla", but then I started to look at myself and think: "Actually sometimes I do that, so does that make me a bad person? Sometimes I am stubborn and twist things a little bit", so I started to look at myself more, be more self-aware, and aware of my actions and how that impact on people (Caroline 228-236).*

In this passage, Caroline describes how the work has changed her view in terms of relationships and the impact that each partner has in a relationship. Whereas at the beginning her focus was on blaming the partner, in time, self-awareness work helped her realise that there are occasions when she might play the abuser's role in her own relationship. Caroline says she has *become more aware that I have it in me too* (line 219) when ruminating on her relationship.

Just like Jo, Caroline describes how her fear of having an abusive relationship transformed her into the controller in the relationship, attacking for fear of not being attacked first:

> *I know, before I used to try and take the control, so in my head I was trying to get the power back, you know, for fear was being controlled (Caroline, 364-366).*

Overall, this theme shows how some of the participants have discovered how, at times, they might have found themselves playing the abuser's role in their own relationship. This new-found positioning might be a result of not only the impact of the work in this arena, but also a result of their own trauma or perhaps a combination of both.

3.4.3 Sub-ordinate theme - Permeable boundaries between work and private life: "I had no boundaries; I was talking to my friend, my family"

This theme illustrates how boundaries between work and private life become permeable and how the work in this field affects other aspects of private life, not only the spouse/partner relationships. As described above in the theme ***Protecting and maintaining self***, Helen and Caroline were able to separate work from their private lives and found this a very useful strategy to cope with the overwhelming effect that work has had on them. In contrast with

Helen and Caroline, maintaining boundaries between work and private life has proven to be more challenging for Claudia and Anna.

For Claudia, social relationships become problematic and work invades her relationships to the extent that it isolates her from her friends and family:

> *I had no boundaries, I was talking to my friends, my family, I thought I was doing a good job about raising awareness ...we would go to dinner and people would go crying...but 9 months into working into the sector, we didn't have any more invitations to dinner because it was too traumatic (Claudia, 157-161).*

Claudia's account suggests an enmeshment of her work with her private life to the extent that she felt she was on a mission to educate and raise awareness about the domestic violence to her friends and family. To a certain extent, there is a hidden desire in Claudia to expose the horrific accounts that she witnesses in her work.

However, Claudia becomes aware of the impact that her lack of boundaries has not only on her social relationships but also on her relationship with her husband:

> *I was working very hard and seeing a lot of women and was distressed by the stories and one day I came home and I was talking about one of the stories and my husband looked at me furiously and said: " I do not want to hear one more story about those women until you cured them all!!" And I was shocked and surprised really about how upset and angry he was and that's the point where I realised that I actually needed supervision and support to process my emotions with that (Claudia, 132-137).*

Her husband's reaction was a wake-up call for Claudia that her lack of boundaries is a sign of burnout that she needed to address. It can be hypothesised that Claudia's husband's reaction could be a sign of his anger towards the perpetrators and perhaps his own frustration that this abuse is allowed to happen in the world. It also creates the sense that he believes Claudia can "cure" her clients, suggesting that domestic abuse is a disease to which his wife has the treatment.

Anna also talks about her work with her husband at home, suggesting permeable boundaries:

> *I would talk to my husband about it telling him, "I had this poor woman today, and this is driving mad." He just listens, and says that must have been hard for you, it was*

a hard day...encouraging…he is very good, very supportive, naming it is defusing it. And also saying stop going on about it. And I thank god he says that...because you know when you go on and on (Anna, 150-160).

Just like Claudia's husband, Anna's husband's reaction to her accounts about her work makes her aware of her crossing her boundaries between work and private life. It can be suggested that the partners of the therapists involved in this type of work have the role of creating a balance for the therapists when work starts to invade their private lives.

3.4.4 Sub-ordinate theme – New insights on intimate relationships: "I have definitely added more to what I want in a relationship"

So far, the reader has had the opportunity to become aware of the way working in the domestic violence arena as a therapist resonates and shakes their lives on more than one level. The work has had a profound effect on the therapist, who experiences a range of emotions listening to the trauma stories, and one can perceive this as having a negative impact on the therapist's life.

Despite the challenges that the work awakens in the participants, almost all of them have explained that the work experience, combined with their personal experience of abusive relationships, has allowed them to develop tighter personal boundaries in terms of intimate relationships. The participants became more confident in expressing what they can or cannot accept in a relationship. Moreover, through their work, they have become more aware of the special relationship they have with their partners/husbands.

Claudia says:

I feel very lucky that my husband is both respectful and enormously supportive about me doing the work, that makes a difference, so I would say he is proud of me and tells me that on a daily basis...and that is wonderful (Claudia, 171-173).

I think I am much more confident or secure in the way that I live my life being the person that I am and the way that my husband and I relate to each other is the foundation. And as long as we live that way, is a bit of a cheesy thing to say, but it pushes the shadow of evil out. I am not a religious person, but it is something about

> *staying in the loving space and is a protection in itself and it drives the evil away, rather than being overwhelmed about that violence which is frightening at the beginning (Claudia, 289-294).*

For Claudia, the support she receives from her husband empowers her and gives her strength. Her husband's support and love gives her the ability to cope with the horrific stories of violence heard from her clients. Claudia feels that their love protects her from the "evil", as she names the violence against women. Her choice of language suggests how strong the work resonates within herself and perhaps the impact that it has on her intimate relationship. Her account implies that love conquers evil and a fulfilling relationship protects her from this "evil".

Jo is also grateful for her relationship with her partner:

> *I have grown to really love myself, and I am confident, and for most of the time I am positive, and my partner helps me to see my qualities, which I sometimes sort of not dismiss. I perhaps hid them away, and that really gives me a lot of confidence, it is great, and he is forever telling me how beautiful I am, what he thinks of me , how gorgeous I am, he makes me feel like a woman, like a lady and that is so wonderful (Jo, 118-120).*

Jo speaks about how the caring nature of her partner helped rebuild her confidence, accept herself the way she is and replenish her "bruised" self which resulted from her previous abusive relationship. Her previous personal experience of abuse, as well as her work with clients who experience domestic violence, has perhaps allowed her to appreciate more her current relationship and regain her femininity.

Anna talks about her relationships as a "treasure" (line 112) and coming home at the end of a working day where she has been exposed to accounts of traumatic relationships makes her appreciate even more the relationship she has with her husband: *it made me appreciate him more* (Anna, 111).

There is a strong sense that the participants have become more confident in their relationships, more assertive in expressing their needs and wants in their intimate relationships.

Caroline says:

> *Since I've started this work, I think I feel much stronger, a bit more firm, so you know that whole thing of not being afraid to say "no", not that I had an issue before, but I've…I feel a lot more firm and confident, and I feel I understand people more, yes, more understanding (Caroline, 189-194).*

Caroline feels empowered in her relationship and it is interesting how she correlates this with her work. It can be interpreted that, to a certain extent, she has developed this strength as a way of possibly protecting herself from some experiences that her clients have had.

Anna's past experience also "hardened" her in her intimate relationships and again with her there is a sense of wanting to protect herself from future possible pain. Therefore, she sets her boundaries with her partner from the beginning of their relationship:

> *I was going to be completely honest with him..he had to fit into my life...rather than me in his...you fit into my life otherwise is not going to work. So I was very aware of how he is with my son, I wouldn't compromise, I was very clear about how someone should be with my son and wouldn't agree with anything else. Made me very choosy because I have really been burned (Anne, 200-205).*

Mary has new expectations from her future intimate relationships and she is not prepared to make concessions like she did in the past:

> *I would definitely want more equality, more respect, trust, things like that (laughs) and of course love is very important. I think it must start with love and build up. I am defiantly looking for something completely different from what I had (Mary, 301-305).*

> *For me I think definitely, I can't compromise on it. I can't compromise this second time around it or third time. I have to decide if this is something I want or not. And I think I will be very clear about what I want from a relationship now. And I think there will be no room for compromise. Because I think there has been a lot of compromise*

before and I think there is no need to compromise really. So why compromise? If that compromise can bring me down then I won't compromise (Mary, 400-409).

This extract seems to represent the determination in Mary not to make perhaps the same errors she did in the past; it depicts new ways of approaching future intimate relationships.

Whereas Mary's most important "ingredient" for a relationship is love, Caroline's most important aspect for a relationship to work is the mutual respect and communication between partners:

I think, before, I used to say, you know, the key in a relationship is about love and friendship, and that's sort of thing, whereas now, definitely I don't. The respect that you have for each other, being mindful to the person's feelings, and being able to communicate what your feelings are important. I've definitely added more on to what I want in a relationship. So, it has developed I'd say (Caroline, 299-306).

Caroline's account suggests that she has developed a certain maturity with regard to intimate relationships; what a relationship involves; and the responsibilities that both partners have. Helen speaks about her independence and her strength in being able not to enter into a relationship that she feels might not offer her the space to grow and develop:

I'm extremely pleased with myself on some level that, you know, I'd rather not be in a relationship, and enjoy my own space and time, as opposed to be in a relationship that's abusive; or even slightly controlling to the point that I'm uncomfortable, or that's violating me on some level. And I'm proud of that. I'm proud of the fact that I believe that this is what I deserve, and…but its taking a lot of time to get there, of course (Helen, 304-310).

With the work, it's certainly impacted…I'm ferociously protective of what's mine, and to keep that safe and secure. So the idea of entering a partnership on a serious level in terms of commitment, that's quite scary (Helen, 386-389).

It could be hypothesized that the work with survivors of domestic abuse has made Helen wary of possible abusive relationships to the extent that she has developed a sense of independence that allows her not to enter in a controlling relationship. There is a sense of

dignity in the first passage above, with Helen proving to have strong self-esteem and confidence in herself.

Later on in her account, however, Helen displays her fears of entering in new relationships because of the awareness of how that relationship can develop. For Helen, her independence allows her to feel safe and secure and it can be interpreted that entering in a relationship can cost her independence, and, therefore, in her view, her security.

> *I suppose there is almost a fear and, almost a sense of being petrified at the thought of not making some of the little, in my eyes, mistakes that some other women have made and it's almost like learning from other people's experiences. Because you sometimes listen to this stories and you think: "Oh, if only she had her own place, or if she had this or she had that", she is now me, in a sense (Helen, 398-404).*

> *It's really scary and I think on one level, I suppose there's some fear involved with my view and how that's developed, you know, relationships can be a wonderful thing, but they can also be a complete nightmare from where I'm sitting, from what I've seen over the years (Helen, 282-285).*

For Helen, her clients' experiences are a learning opportunity and she almost feels paralysed with the fear of ever experiencing what her clients have experienced. It can be assumed that the therapeutic work has produced a change in Helen's cognitive schemas, feeling less secure and, consequently, her behaviour and views on intimate relationship alters. It is almost a contradiction with her earlier accounts when she spoke about her independence and her strength and ability to choose not involve herself in a controlling relationship.

Helen acknowledges that for a relationship to work, both parties require self-awareness work. There is almost an advisory, motherly tone in her account:

> *Relationships are great, but I think there's a lot of work that need to be invested in ourselves, to make sure that we allow ourselves to have something positive and good, and to be really aware when it's not, and to stop that early on, before it can become something disastrous if not fatal at times (Helen, 292-297).*

Overall, the theme ***When work hits home*** has allowed the reader a glimpse into the private lives of the therapists and the struggles that face when the work invades their intimate lives. The participants' inner world starts to shake and they found themselves in new positions vis-a

vis their relationships. Their outlook on their intimate relationships suffers a transformation in the sense that they become warier, questioning and reflecting on their interactions with their partners from a new-found perspective.

3.5 Super-ordinate theme –The dawn of a new self

This super-ordinate theme draws the reader's attention to the wider impact that the work with survivors of domestic violence has had on the therapists, moving slightly from the inner world of the therapists and their intimate relationships to the other aspects of their new-found identities. The themes below will describe how therapists identified a broader understanding and view of the world, as well as developing a feminist perspective.

3.5.1 Sub-ordinate theme – Re-assessing identity as a therapist: "Everything I thought I knew about psychology got turned on its head"

Working in the domestic violence field has proven challenging not only because of the impact that it has on the therapists' self but also because of the stigma that surrounds this topic.

Caroline recalls:

> *At first I used to be very honest and say: "I'm a domestic violence counsellor" and a lot of the times I'd notice men that they'd be like…you know, sometimes it would be like: "Oh, God, you're one of those." Or sometimes men would be like: "Alright, okay." And I would notice that there'll be something there. I am not saying they are perpetrators but they are intimidated in some way. And now I'm just saying: "I'm a therapist." I don't say what I'm specialised in, and it's different (Caroline, 501-510).*

> *The reactions were so strong, like, even if they didn't say it, the facial expression… It started to make me feel a bit uncomfortable, feeling the need to explain myself. Should I explain myself or should I say "I am not judgmental, I'm not against men, I don't hate men" (Caroline, 518-524).*

The reactions that Caroline witnessed when she explained her work made her re-assess the way she introduces herself and her work. She has been assumed to be "one of those" (implying one of the feminists who hate men), suggesting almost a loathing towards her and to what she represents through her work. On another note, she has also encountered a sort of wariness from the people she has had conversations with. These reactions have left Caroline to a certain extend guarded in revealing her identity and her specialty as a therapist. There is a sense of struggle within Caroline and perhaps a self-blame suggested by her desire to explain herself.

Jo interprets the reactions to the work she is doing slightly differently:

> *When I say that I work with domestic violence and some people go very very quiet, and it is usually because in my own personal opinion I think they have experienced it or are experiencing it. Because, there is quite an element of shame around it. I think that's what happens, so I just sort of leave it that, if they want sort of to bring it to me then I am more than happy to talk with them []I think if you talk generically to people about things, they often offer you a little bit of their experience , because I am fairly trying sometimes to engage with them if it's appropriate (Jo, 142-146).*

Jo acknowledges that domestic violence is still a taboo subject and that shame and self-blame are still challenges that the workers in this arena are facing. Jo talks about establishing a relationship with her dialogue partners and allows space for exploration if they wish to do.

Similar to Jo, Helen is very passionate about the work that she is doing and her identity as a domestic violence therapist is apparent in the following extract:

> *I still like to be very clear about what I do, and if people want to know that I'm happy to tell them why I do it, because I believe in it [] There are mixed reactions to it. And if those reactions are negative, and offer a conversation, because, you know, sometimes it's about talking about it, people are afraid of what they perhaps don't understand, and maybe after dialogue, they could feel at ease or "actually, it's not quite like that" and you know, at the end of the day, if we still don't see eye to eye on that point that's not somebody I'd want to associate with, anyway (Helen, 450-464).*

Helen's passion for her work is something that she would like to share with others and there is a sense that she would like to educate on issues that her clients experience and to tackle some of the assumptions and pre-conceptions surrounding domestic abuse.

During the participants' accounts, the researcher has noticed not only a shift in the identity of the therapists but also changes in the ways they offer therapy to their clients. Because of the nature of their work and the specific challenges of working with trauma, the therapists had to re-assess their ways of working.

Claudia describes in detail how the work with this client population has made her rethink the way she uses certain techniques in therapy:

> *Everything I thought I knew about psychology got turn on its head. First would be that I used to use a relaxation technique. Right in the middle of the relaxation technique, I used to say, part of technique script, "Now tense your stomach muscles as if you are prepared to receive a blow." Of course, this was entirely inappropriate to say to someone who knew exactly what a blow in the stomach was, so I started to re-write the materials and that was one of the things that I had to re-think; what I had understood as psychological distress in the context of experiencing abuse. Challenging and a big up upheaval in the way I thought about psychology. Some other examples will be, rather than treating people with depression as if it was irrational thoughts, I learned of course as they were telling their stories to think they have absolutely have the right to be sad and the problem is the abuser rather than the woman and offering her antidepressants or medications, or treating her thoughts as irrational. This would have invalidated her experience. Therefore, I did a lot of thinking in reconsidering the way I thought about psychology and the way I thought about people (Claudia, 45-56).*

The above extracts depict the challenges that the therapist faces when working with the survivors of domestic violence. It also allows the reader to acknowledge Claudia's empathy and care towards her clients' needs. The knowledge and skills acquired so far in her profession require adjustment in order to be relevant to present work.

Mary has gone beyond professional boundaries and, in her case, there is a sense of duty to care beyond, offering in some cases more sessions than permitted by the organisational setting:

> *I worked with her actually well over the sessions [] with this particular client, I continued support her quietly on the side. I mean my conscious wouldn't allow me not to do that...until I found a place that where she could go to. I actually managed to find another organisation where they could see her without a long waiting period so really she went from me to another place. Referred her on...yes…and I wouldn't ever do that again unless I knew I could work unlimited sessions with that kind of client (Mary, 50-67).*

One possible interpretation of Mary's need to rescue is, to a certain extent, a rescue of her own self. Having been through an abusive relationship herself and being so close to trauma again has triggered in Mary strong responses. Perhaps because of her own experience, she acknowledges the need of the client to be continually supported and she has surpassed her work environment limitations and found further support for her client. This suggests permeable boundaries in Mary's work, a theme that has appeared before in the participants' accounts.

Emily's account reveals changes in the way of working with this group of clients as well. She founds that humour and a directive style is more appropriate:

> *Working this client group is not as person-centred as working with other client groups. I was able to use real life stories about impact of domestic abuse without identifying myself and is very ...it is just more directive that other kinds of counselling I do. So I was able to able to use my circumstances but make them as someone else's (Emily, 117-120).*

One possible interpretation of Emily's account is that she is using therapeutic stories to address very painful issues with her clients and to help them create a therapeutic relationship. Having in mind Emily's personal experience of abuse, this way of working in the therapy room might lessen her pain of recollecting her own experiencing of abuse. Alternatively, Emily's need to share some of her experiences, even anonymously, may be, perhaps, an indicator that she still needs to process some of her experiences.

Overall, this theme allows the reader to reflect on the changes that the therapist faces in their professional life and how their identity as domestic violence counsellors/therapists/psychologists has been challenged. Not surprisingly, the participants

showed a remarkable ability to change and adapt to the needs of their clients, confirming in this way their passion for the work they are doing.

3.5.2 Sub-ordinate theme – Expanding worldviews

3.5.2.1 Theme – Developing a feminist perspective: "I think I have become a feminist"

When asked to describe any behaviours or thinking patterns that they have noticed since starting to work in the arena of domestic violence, the therapists identified a desire to promote women's rights and interests.

Helen talks with enthusiasm about the changes she has experienced:

> *I've developed a greater feminist perspective on things, and I am more aware that the experiences of women are all different, and things in society can be incredible difficult for women. The systems they're in, the circumstances they can be in can perpetuate, you know, the things they're going through, they're always almost often left trapped in these situations that they may want to break out of the things preventing them to break out of them. I think the circumstances for women can be incredibly difficult in this particular arena (Helen, 269-275).*

> *I would like to see women that are empowered, I would like to see women from a young age being socialised with the right messages, of "actually, this is not okay; you don't have to tolerate this". We are seeing more and more younger women, teenagers that are accepting high levels of violence and abuse from their boyfriends, and I'm thinking: "Where are these women going to be fully grown adults?"(Helen, 277-282).*

The extracts above encapsulate the complexities of working with clients who have experienced abuse and the wider context of the clients' situations. Helen has become aware of the constraints of the system to which her clients are required to conform. Helen feels these constraints, feels how women are "trapped" in the system, and her use of language depicts her passion and her desire to educate younger generations on women's rights. There is a hint of sadness in her account, realising how more and more often younger women are subject to domestic violence, which makes her wonder about the safety of their future.

Helen sees herself as an agent of change in raising awareness about domestic violence, not only in the therapy room, but also on a large scale, in society:

> *There is definitely the issue of how women affected by domestic abuse are viewed, the stereotypes, the stigmas, and you can spend time educating people on what you do, and why you do it, and how they might be wrong about certain things, or actually it's not like that, it's a little bit more complicated than that. So, I think that it takes time for people to understand what you do, why you do it and how it works [] people, don't always completely comprehend; there's always this, you know: "Why does she go back to him" – scenario (Helen, 160-170).*

Emily perceives herself, similarly to Helen, as an agent of change, an activist who fights to address the barriers that women who experience domestic violence face:

> *I think I have become a feminist...laughs... I think my view of the world has changed and I spend quite a lot of time actually highlighting to other people how, what is wrong in the world as being a female. I suppose almost any group has multiple barriers, so I suppose I become a bit of an activist. I would guess that is the biggest change in me (Emily, 216-227).*

One hypothesis for developing this perspective can be that, due to being witness to the atrocities that humans can inflict on other humans, the therapists developed a desire to protect and rescue their clients, a theme that has been encountered earlier in the chapter. It can be interpreted that the theme of developing a feminist perspective is very much linked with the impact the work has had on the therapist.

3.5.2.2 Theme – Heightened awareness on power dynamics within relationships: "Since doing this work the power and control element really stayed with me"

The participants report changes in cognitive schemas with regard to their awareness of power and control dynamics within relationships in general.

Caroline speaks about how "the power and control" facet of an abusive relationship "stayed with her". The term "stayed with me" implies that her new knowledge of controlling relationships was carried forward with her and was added to her experience:

Since doing this work, yes, the power and control element has…really stayed with me. The power and control. That speaks out for me a lot. Not just in domestic violence, but in lots of different types of relationships, I look at the issue of power, and how people try to gain the power, and sometimes you use to give the power. I've noticed that a lot and it's something I didn't used to be aware of before (Caroline, 311-316).

Helen goes further in examining the role that she plays within other relationships, not only intimate ones. Knowledge is assimilated and the world is seen through the lenses of power and control.

I found myself aware of dynamics between myself and other people, it is not just intimate relationships, but it is in many contexts as well (Helen, 105-111).

Jo's account captures a similar depth of awareness of the power dynamic within the relationships she encounters outside work or intimate life:

I think that quite often if I meet a couple I can usually see straight away the dynamics in the relationship and I am not sure if it is good or not. I am pretty sort of clued up with it now, and you know sometime you listen how people speak to each other , you could think "That doesn't sound right, doesn't sound to work to me",[] although I may pick up things it is not my place to tell it to anybody, what to do, not that I do anyway (Jo, 194-197).

Jo struggles to understand if this new "skill" "is good or not" when perhaps outside the therapy room. There is a sense that being tuned to what can possible happen within a relationship can at times be a burden, as she is unable to act upon it outside the room. One interpretation of her stance could be that she is respectful in keeping the boundaries and not wanting to be perceived as forceful if she were to highlight her concerns.

Anna also speaks about her alertness in discovering elements of abuse in relationships and this almost becomes something that she is not in control of. The reader can notice in Anna a tendency to withdraw from social gatherings, isolating herself. One hypothesis for this behaviour could be that Anna has been affected so much by the traumatic experiences of her

clients that seeing this outside of the therapy room as well can be too much for her to cope with:

> *You are seeing people who come to work through their issues themselves you can tend to think that relationships are troubled generally, because of the client group you are working with, rather than most people are ok, doing all right. []I don't have many friends and couples, because I think I would pick up on things[] makes you a bit more vigilant...seeing the signs more, although you are not really looking for it (Anne,119-124).*

3.5.2.3-Theme – Compassion for abusers: "I have enormous empathy and compassion for people who are abusive"

Jo attempts to understand the position of the perpetrators, trying to make sense of their behaviour:

> *I've changed my outlook, I have enormous empathy and compassion for people that are abusive , because they are coming from a painful place themselves,[] I wouldn't judge people because they are abusive, I would say their behaviour is not acceptable, but you know what is going on for you. I know that they are hurting, just as I know that I am hurting when I lash out. I know that is not acceptable but I know there are ways to deal with it, to combat it, so I changed in that way (Jo, 132-137).*

Jo's extract creates an explanation for the perpetration of abuse, being concerned with the understanding of their hurt and pain. She identifies with their feelings and this can be linked with the theme of ***Becoming abuser*** described earlier in the chapter where she recognises that at times she becomes the controller in the relationship. One possible interpretation for compassion is that it seems to serve, for her, a comfort in creating a broader understanding. Moreover, unconsciously, Jo might want the others to have compassion for her and to understand her reactions because of her painful previous experience.

3.5.2.4 Theme – High regard for the clients' resilience: "I have always been amazed by women's courage and hope"

Many therapists hold a great admiration for the strength and resilience of their clients who have experienced domestic violence. Emily and Claudia share this with the researcher:

> *It is enormously humbling and a privilege that people who have been so abused within intimate relationships still have the capacity and willingness to form therapeutic alliance...that's a wonderful thing...I have always been amazed by women's courage and hope. I think I have learned something very profound in working with women, paradoxically in contrast with the depravity in woman's condition, something about the human spirit (Claudia, 271-277).*

> *I still can't believe how much women can accommodate the resilience they have to carry on and get up in the morning (Emily, 69-70).*

> *An incredible pool of resilience...incredible brave to talk about what happens in their life and feel safe enough...and to get back up, go downstairs and go back home to take it in. Incredibly brave to talk about things that they know that by talking about it , we can't just leave it in the room and Social Services need to be involved, and police need to be involved and there is so much trust...yeah...I think they have such a lot of trust that someone will help them (Emily, 239-243).*

One interpretation of these accounts may be that there is a sense of hope in the therapists: whilst violence does happen, survival is possible and humankind has that strength to overcome the consequences of abuse.

- **Summary**

In summary, the analysis has sought to present the three superordinate themes that reflected the changes the therapists working within the domestic violence field face. Within these superordinate themes, a diverse range of areas have been introduced. The psychological and physiological impact of trauma work, the therapists' self-care, the impact on therapists' intimate relationships and their new ways of making sense of their own intimate relationships are some of the areas the therapists have reflected upon in their accounts. Finally, this section portrayed the changing worldviews of the therapists and the shifts in their identity as therapists.

4. Discussion

In this chapter, I will make a synthesis of the themes that have emerged from the therapists' interviews. I will aim to identify any connections between them, referring to the literature on which I based my interpretations of their accounts. I will explore each superordinate theme, attempting to go beyond data offering more interpretation and reflection. Following the discussion of the themes, I will explore the implications of this study for the field of Counselling Psychology. Finally, I will examine the limitations and the strengths of the study, make suggestions for future research and discuss methodological and procedural reflexivity.

Overall, the participants indicated through their accounts that they experienced changes and they were influenced by their work on several levels: individual, professional, intimate relationship and worldviews. These findings are consistent with the research in the field of trauma conducted by McCann and Pearlman (1991), Pearlman and Saakvitne (1995), Clemans (2004), Iliffe and Steed (2000) and Goldblatt et al. (2009), to mention a few.

4.1 Super-ordinate theme – The journey of listening to clients' stories

This superordinate theme consists of three subordinate themes: ***The work resonates within the therapist, Remembering own trauma*** and ***Protecting and sustaining self.*** This superordinate theme describes in essence the psychological and physiological impact that the trauma work has on the therapists. The participants reflected on their responses to the initial contact to their clients' stories and the changes they encountered at an individual level. One of the main ideas debated in the literature (Goldbatt et al., 2009) was the concept of the trauma therapists working with survivors of domestic abuse being vulnerable in experiencing vicarious trauma and countertransference. The authors acknowledged that treating trauma within these specific populations was one of the most demanding therapeutic interventions.

- **The work resonates within the therapist**

This study's findings support studies such as those by Illife and Steed (2000), Schauben and Frazier (1995), McCann and Pearlman (1990), whose findings show that trauma therapists experience a range of emotions as result of this work. The therapists that took part in this study seem to experience a range of emotions because of trauma work, including anger, shock, anxiety, numbness, avoidance, disbelief in humankind, flashbacks and nightmares.

These responses concur with past research on vicarious trauma (Iliffe & Steed, 2000) which identifies the impact on therapists in various aspects, such as a loss of confidence, sense of responsibility for the client's safety, a sense of loss in security, worldview changes, trust, isolation and powerlessness. Schauben and Frazier (1995) found that similar to their clients, service providers report an increase in posttraumatic stress disorder (PTSD) symptoms, such as intrusion or avoidance of clients' trauma stories, sleep disturbances and psychological reactivity.

Indeed, the journey of listening to the clients' stories resonates profoundly within the participants, giving them the sense that work "chips away" parts of them, suggesting the pain born out of the work. Helen's metaphor of the work chipping away part of the therapists can also suggest a transformation, through pain, of the therapists. Just like a sculptor who cuts off pieces from the raw material he works with in order to reveal a masterpiece, the trauma work re-modulates the therapists' feelings, emotions and the views they have on the world and personal relationships.

As recognised by Scauben and Fraizer's (1995) research with counsellors of sexual violence, participants often experienced feelings of anger. Pearlman and Saakvitne, (1995) also identified anger as an impact of working with trauma clients.

The uniqueness of the present study is in the anger mentioned in different contexts. The therapists' accounts of their experience support these findings. For example, Helen describes feeling angry with the perpetrators and with the victims. For Claudia, anger is awakened from her desire to reveal the perpetrators, to punish them. When anger towards perpetrators is present, one can interpret this as a way for the therapist to create an alliance with her clients and as a possible compensation for the clients' feelings of powerlessness. The therapists want to fight the perpetrators who inflict the pain on the victims, but also want to expose them, to make society aware of them (see Claudia's account in sub-ordinate theme 1.1, lines 58-62). This might motivate the therapists to work towards raising awareness of the issues of domestic abuse, and advocate and address the stigma surrounding this subject. Indeed, this can be observed in the superordinate theme 3, ***The dawn of a new self***, where the theme of ***Expanding worldviews*** and ***Developing a feminist perspective*** are discussed. Anger with the clients supports the Constructivist Self Development Theory regarding the disruptions in the

cognitive schema, which, in this case, might result in the therapist holding accountable the client for their own experience of traumatisation.

To understand further how the trauma work impacts domestic violence therapists, one can consider the findings of the present study within McCann and Perlman's (1990) Constructivist Self Development Theory (CSDT) (see section "Vicarious trauma" for an overview). The authors offered a theoretical conceptualisation of the profound impact of working with trauma victims, which they refer to as vicarious traumatisation. McCann and Perlman (1990) argue that the work with victims permanently alters the therapists' experience and the theory they propose aims to makes sense of the unique effects of this type of work. Changes within the areas of the self, psychological needs, cognitive schemas and physiological responses correspond to some of the areas of impact described by the therapists.

The model of Constructivist Self-Development Theory (CSDT) (McCann & Pearlman, 1990) addresses the alterations in the imagery system of therapists' memory. The authors describe how the therapists experience their clients' traumatic imagery returning as fragments, taking forms of flashbacks, nightmares or intrusive thoughts. One therapist in the present study reported having flashbacks and nightmares associated with the clients' stories. Other participants found themselves having difficulties in recalling how they experienced their first encounter with the traumatic stories of their clients, suggesting perhaps a withdrawal in the face of trauma stories as a mean of protecting themselves.

Further evidence for the disrupted frames of reference is therapists' accounts of disbelief in humankind, reshaping in this way their worldview. The therapists spoke about how, following trauma work, they became more aware of the ability of humans to inflict pain on other humans. This strengthens McCann and Pearlman's (1990) findings regarding the disruption of schemas around safety and security, the therapists experiencing a heightened sense of vulnerability and awareness of how fragile life can be. Emily's account illustrates this vulnerability: *"I couldn't believe that women were being abused in my home area. Actually they might just live next door to me"* (Emily, 62-65).

The nature of the feelings and reactions evoked in response to listening to domestic violence experiences can be interpreted from a more psychodynamic perspective looking at the process of countertransference. Lindy and Wilson's (1994) modes of empathic strain in countertransference reactions is a model that can offer further insight into the therapists' reactions. According to Lindy and Wilson (1994), the types of countertransference reactions can be divided into two main categories: Type I countertransference reactions, which are associated with avoidance/counterphobia and detachment; and Type II countertransference reactions, in which clinicians display an active over-identification stance. The combination of the two axes of countertransference processes produces four distinct modes of styles of empathic strain, which Lindy and Wilson (1994) identified as: empathic withdrawal, empathic repression, empathic enmeshment and empathic disequilibrium. It can be interpreted that therapists' accounts clustered in superordinate theme ***The journey of listening to the client's story*** are an expression of a countertransference strain.

Empathic enmeshment (Lindy & Wilson, 1994) is the most common reaction found in the participants of this present study. The authors explain how in this mode of empathic strain, the clinician leaves the therapeutic role, becoming overinvolved, overidentified with the client, and a loss of boundaries in the context of treatment is present. Loss of boundaries will be further discussed later in this chapter when I will reflect on how work penetrates the private life of the therapist. Sarah describes how she became overly protective of her clients, wanting to rescue them. One explanation for this need of rescue can be Sarah's countertransference reaction. She perhaps feels an increased sense of responsibility to compensate for the abusive perpetrators' actions. Mary also becomes overinvolved, puts her client's needs first, even to her detriment, going beyond organisational policies and offering extra sessions to the client.

Following Lindy and Wilson's (1994) modes of empathic strain, it can be argued that the therapists taking part in this study have also experienced an empathic disequilibrium. Empathic disequilibrium is a mode of empathic strain characterised by somatic discomfort, feelings of insecurity and uncertainty with how to deal with the client. For instance, most participants reported feeling emotionally drained and, at times, physically exhausted by their work, experiencing tension in the muscles, fatigue and tiredness.

Witnessing the distress, but not being part of the traumatic experience can generate, according to Herman (1992), the "witness guilt". According to Berger (2001), the counsellor sometimes feels witness guilt when the client projects doubt that the therapist can manage the material or that the therapist won't understand, not having suffered too. Helen describes feeling guilty for being "ok" (meaning safe), whilst she is aware that some of her clients might not return to a safe environment when leaving the therapy session. I wonder, however, to what extent this guilt emerges because the therapist considers herself part of the system that has failed to protect the client.

Straker and Moosa (1994) argued that, when working with clients who are at risk of further violence, counsellors will inevitably feel preoccupied with each client's safety. Bergger (2001) argues that the need to rescue and to heal the client is hidden in most therapists and is particularly awakened by the desire to be rescued experienced by trauma clients. The traumatised client is looking for rescue and nurture from the therapist (Herman, 1992) and this can show behaviourally with the therapist blurring boundaries. For instance, as mentioned above, Mary finds herself offering extra sessions to one particular client until she found a service to refer her to.

The findings explored within the theme ***The work resonates within the therapist*** have important implication for the practice of domestic violence therapists. The findings highlight some of the aspects that can be subject of reflection in supervision or personal therapy for therapists that already work in this field. Furthermore, they can raise awareness about the challenges of the domestic violence trauma work to the agencies that employ these therapists. This can lead to creating policies and procedures that focus on therapist self-care.

- **Remembering own trauma**

This theme has been an unexpected finding in this present study and has not been depicted in previous research that looked at the impact of domestic violence work on the therapists. Therefore, these findings are valuable as they add to the previous research that looked at the lived experience of the domestic violence therapists.

Lindy and Wilson (1994) draw attention to the therapist's vulnerability during the empathic enmeshment, especially if they have experienced personal trauma and victimisation. Interestingly, for five of the participants, listening to the clients' stories triggered the remembrance of their own traumatic experiences of domestic abuse within their intimate relationships. The theme ***Remembering own trauma*** can only generate reflections around the "wounded healer" concept. The wounded healer is an archetype that suggests that a healer's own wounds can carry restorative powers for clients (Zerubavel & O'Dougherty Wright, 2012). Jung (1963) was the first therapist to reference the wounded healer. Jung (1963) described the experiences in the relationship between the analyst and their patient, where the analyst would examine themselves and experience the depths of their own pain in order to probe, understand and heal the pain of their patient. Gelso and Hayes (2007) advise that it is critical that a therapist's wounds are mostly healed or at least understood and processed accordingly and sufficiently in order to prevent interference in the therapeutic relationship. The transparency of the participants, their honest accounts regarding their own experience of domestic abuse, can be an indication that they have reflected on their "wounds" and the possible impact on the work with their clients.

It has been well documented (Zerubavel & O'Dougherty Wright, 2012) that many psychotherapists arrive at their profession of choice through a "journey that involves a history of pain and suffering" (p. 483). The wounded healer is recognised as beneficial in certain areas of mental health treatment (e.g. substance use treatment programmes and eating disorder treatment programmes), as it is believed that those who have a personal experience similar to that of the client know in more depth what the recovery entails (Zerubavel & O'Dougherty Wright, 2012). Simlarly, Hayes (2002) argues that healer's woundedness can be beneficial (Hayes, 2002) as an internal reference point for understanding a client's pain.

I wondered to what extent this is applicable in the field of domestic abuse. Following a literature search, I found one study (Ben-Ari & Dayan, 2008) looking at the experience of mental health professionals who have experienced domestic abuse. The participants in Ben-Ari and Dayan's (2008) study could not seem to be able to integrate their two selves: the professional who lived with abuse in the past and the present empowered professional. Integration was only possible after they created a splitting between these two selves. In light

of Ben-Ari and Dayan's (2008) research, it can be interpreted that the therapists in this study were interviewed at the stage where this integration might have been completed. This is suggested by the fact that the majority of the participants seem to have assimilated and made use of their experience in creating a deep connection with their clients, stating that because of their experiences they could empathise more with them. The participants found that their own experiences of domestic abuse have facilitated a strong therapeutic relationship that facilitated their client's growth and empowerment. Indeed, Gelso and Hayes (2007) argue that the most common effects of woundedness on clinical work include a greater ability to empathise with clients, a deeper understanding of painful experiences and more patience and tolerance when progress is slow, which supports these findings.

Nevertheless, in light of the emphatic enmeshment identified by Lindy and Wilson (1994) as a countertransference reaction and the disclosures around therapists' own trauma stories, one can argue that the deep empathy that the therapists claim to experience is perhaps an over identification with the client. One can only wonder to what extent the therapists want to rescue their clients because they have not dealt with their own personal conflicts. Previous research (Gelso & Hayes, 2007; Sedgwick, 2001) indicate that wounded healer's countertransference can have a positive influence on therapy, as long as they are sufficiently recovered and their own trauma processed.

This finding addresses the necessity for the therapists and the clinical supervisors that work in the domestic violence arena to address openly possible woundedness of the therapists and be aware of the possible impact this might have in the therapy room.

- **Protecting and sustaining self**

The sub-theme ***Protecting and sustaining self*** refers to the protective mechanisms that the therapists put in practice in order to minimise the impact of trauma work. Following the analysis of the therapists' accounts, it can be argued that the therapists are engaging in a variety of self-care strategies. These results are supported by past research. For example, McCann and Pearlman (1990) published some helpful strategies for self-care. These included firm boundaries around caseload, supervision, regular breaks, balance between one's clinical and non-clinical work, as well as providing time for self-care (exercise, non-work-

related interpersonal relationships. Similarly, Iliffe and Steed (2000) found that the most effective strategies in dealing with secondary trauma are debriefing (peer support), physical activity and self-care, monitoring the level of caseloads and being able to identify clients' strengths.

Indeed, the participants recognised self-care as an ethical responsibility towards themselves and their clients, attempting to prevent in this way the cost of caring mentioned by Figley (1995). It appears that the therapists are aware that the vicarious traumatisation is an invasion into all areas of a therapist's life. This supports McCann and Pearlman's (1990) findings that counsellors' heightened awareness of the needs resulting from trauma will support them in processing the trauma material and, consequently, decrease the impact of trauma work. The participants' self-care includes supervision sessions where they can address needs resulting from trauma work. The therapists shared their attempts to create clear boundaries between work and home; however, this aspect is discussed in more depth within superordinate theme ***When work hits home***.

The findings of this study conclude that in accordance with previous research on trauma counsellors (McCann & Pearlman, 1990; Schauben & Fraizer, 1995), the therapists have the ability to access positive coping strategies when they identify they have been affected by their work.

In summary, it appears that therapeutic work with survivors of domestic abuse can generate an emotional turmoil for the therapist. This study suggests that these emotions are worth considering for clinical and supervision work, especially when the therapists are "wounded healers".

4.2 Super-ordinate theme – When work hits home

All the participants expressed changes within their intimate relationships as a result of the trauma work. The themes ***Questioning own intimate relationships, Becoming the abuser, Permeable boundaries between work and private life*** and ***New insights on intimate relationships*** allow for reflection on new-found positions within the therapists' intimate

relationships. The exposure to accounts of intimate partner violence challenges the reality around couplehood and intimate relationships as was known to them, offering a new perspective through which they reflect on their intimate relationships. This is consistent with Goldblatt et al.'s (2009) study that indicates social workers in the field of domestic abuse question more their relationships with their partners, which leads to a reshaping of their views on intimate relationships.

- **Questioning own intimate relationships**

This sub-theme echoes Steed and Downing's (1998), Goldblatt's (2009) and Ben-Porat and Itzhaky's (2009) findings of an increased wariness towards men, a decrease of trust with their partner and seeing spousal relationships through the power and control lenses.
Most of the participants in the present study began to question their own intimate relationships, re-examined their partners' attitudes and behaviours, and they became hypervigilant to the dynamics within the relationships and this affects their trust in starting new intimate relationships. The hypervigilance experienced by the therapists with regard to their own intimate relationship is very much entwined with the ***Heightened awareness of the power and control dynamics*** sub-theme, described in ***The dawn of a new self*** superordinate theme. The therapists report becoming more aware of the power dynamic within relationships in general, not only intimate ones. Knowledge acquired through the work is assimilated and the world is seen through the lenses of power and control. One therapist described feeling more attuned to the dynamics within a couple and the possible presence of control or coercive behaviours, from simple observations of their behaviours towards one another.
These findings are consistent with Constructivist Self-Development Theory (McCann & Pearlman, 1990) around changes in cognitive schemas around safety, trust and power. It can be argued that a disruption in the therapists' schemas results in hypervigilance to cues of threat as well as either feeling helpless or attempting to excessively control aspects of their life.

- **Becoming the abuser**

The sub-theme ***Becoming the abuser*** is perhaps one of the most interesting findings of the present research, adding to the previous research in the field. The literature review conducted

before the present study has not encountered such change within the therapists working with survivors of domestic abuse. The presence of a controlling behaviour towards the therapists' partners can generate future research ideas on how therapists' partners experience the changes in their partners because of trauma work.

This fascinating aspect of the changes that the therapist might experience can be interpreted as a disruption within the cognitive schemas around power. Indeed, the trauma work with survivors facilitated the reflection around their own behaviour within their intimate relationships. Some participants shared in their accounts how, in time, they came to the realisation that they have become more controlling and emotionally abusive towards their partners.

McCann and Pearlman (1990) offer a possible explanation for this change in behaviour. They explain through their Constructivist Self-Development Theory how disruptions in cognitive schemas around power can lead therapists to become more dominant in social or work situations. The authors describe how sometimes therapists need to reaffirm their beliefs in their own personal power.

I wonder, however, to what extent this controlling behaviour identified by the therapists is a self-protective action when their power needs are threatened. It is possible that the therapists in this study, who identified themselves as becoming more controlling and abusive towards their partners, want to reaffirm their position within their relationship for fear of possible future abuse. It was interesting to observe that some of the therapists, who identified themselves as becoming more controlling, are the ones who have experienced domestic abuse within their own intimate relationships in the past. Therefore, is it that the exposure to the traumatic stories of abuse, together with their own experience of abuse, leads to this abusive behaviour in an attempt to regain the control that perhaps the clients did not have the chance to do?

Disruptions in cognitive schemas around independence (McCann & Pearlman, 1990) also offer a possible explanation. It is known that trauma survivors suffer a diminishment in personal autonomy, especially in cases of intimate partner violence. It is possible that the therapists exposed to this loss of independence identify themselves with the client's loss of

independence and therefore they experience a threat to lose personal control and freedom within intimate relationships. It can be argued that the therapist reacts to this threat and tries to prevent this possible loss by affirming their power and position in the relationship.

- **Permeable boundaries between work and home**

This sub-theme is consistent with Goldblatt et al.'s (2009) findings that indicate the boundaries between the workers' private and professional lives are distorted, the work challenging the therapists' intimate relationships, facilitating a re-examination of these relationships.

Indeed, for the participants in this study, the effects of the trauma work leave the therapy room invading couples' lives. In addition to reflection upon their reactions towards their partners, the participants describe their partners as being fellow travellers on the journey of rediscovering their new self emerging from trauma work. The partners were also active participants in therapists making sense of the trauma stories they have heard from their clients.

Whilst some therapists were able to separate work from their private life, others found themselves with "no boundaries", bringing accounts of the trauma stories within couplehood and social life. This generates different reactions from their partners. These reactions allowed the therapists to become aware of the loss of their boundaries, the over involvement with their work and the need for more supervision. For example, one therapist described how her partner became angry at the behaviour of men abusing women and his perceived inability to stop the atrocities. Others allowed the therapists to talk about their experiences at work; however, the therapists identified, eventually, how overwhelmed their partners felt when they heard the traumatic stories.

It is interesting to observe the parallel process when therapists bring their work within their intimate relationships: just as the therapists are impacted by the trauma stories, the therapists' partners are also affected through the accounts of their spouses/partners. These findings concur with Pack's (2010) study on the effects of trauma on significant others of sexual abuse therapists. Pack (2010) advocates for significant others to be educated on vicarious trauma as

well as developing self-care programmes where they will be able to gain understanding of the vicarious trauma. This will allow them to reflect with their partners, the therapists, when and how vicarious trauma might impact their relationship.

- **New insights on intimate relationships**

Developing new insights within intimate relationships was another strong theme found in the data. Hearing the repeated accounts of abuse and violence within the intimate relationships allowed the participants to develop tighter personal boundaries with their partners, enhancing the trust, the collaboration and the communication within the relationship. The therapists experienced more confidence in expressing their needs within the relationship and they became more appreciative of their partners and the positive aspects of their relationships. It is perhaps that through their reflection, they felt the need to stress the difference between their intimate partners and the partners of their clients. The therapists' accounts around the support and love they receive from their partners are similar to Goldblatt et al.'s (2009) findings. They argue that the anxieties generated from hearing traumatic stories around intimate partner violence allowed the therapists to develop strategies for moving the abuse into the background and bring into the forefront their violence-free intimate lives.

A possible way of looking at these findings related to the new insights into the intimate relationships is from the growth perspective. Previous research (Bell, 2003; Calhoun & Tedeschi, 2006) indicates that, following trauma work, the therapists are more appreciative with significant others, reporting changes in one's self-image, in interpersonal relations and in philosophies about life.

4.3 Super-ordinate theme - The dawn of a new self

It can be argued, looking at the present findings, that trauma work is a transformative process in which the therapists rediscover themselves adding to their previous experience both personally and professionally. Whilst the initial impact with the survivors' stories might create disequilibrium within the therapists, generating strong emotional responses, it appears that they learned to manage, respond and assimilate their new experience. Almost all the participants were able to use their new insights and transform the trauma impact. The result

of this transformation concluded in the expansion of their worldview, allowing new insights on the power dynamics within the relationships, seeing perpetrators of abuse in a new light and reflecting on their clients' resilience. In addition, they developed a feminist perspective, wanting to generate changes at a socio-political level, raising awareness around issues of domestic violence.

These findings are similar to previous research in the field (Illife & Steed, 2000; Steed & Downing, 1998; Bell, 2003; Goldblatt et al., 2009). Furthermore, the present study adds to previous research by bringing to light new aspects of the therapists' experience, such as shifts in identities as therapists or seeing perpetrators of violence in a new light. These aspects will be explored later in the chapter.

- **Re-assessing identity as therapist**

The therapists noticed a shift in their professional identity following trauma, an aspect that has not been uncovered in previous research. Therefore, it can be argued that the present findings present a starting point for possible future research in this area. Despite its prevalence (see Introduction chapter), domestic violence is still surrounded by stigma and therapists encountered different reactions when they introduced themselves as domestic violence therapists. For instance, one of the therapists described her uncomfortable feelings when one of the participants that took part in a discussion around the clients she sees in her practice assumed she is a "man hater". This reaction left her somehow guarded in revealing her expertise in future conversations. In contrast, other therapists are very open in putting "out there" their domestic violence expertise and they are open in challenging attitudes, beliefs and assumptions in this area.

Another aspect brought into light by the results of this study was the changes in counselling practice of the therapists taking part in this research. This concurs with Iliffe and Steed's (2000) findings, who noticed that, with experience, the therapists found themselves more attuned to the signs of domestic abuse and felt more competent in working with domestic violence issues. Adding to Iliffe and Steed's (2000) findings, the therapists in this study reported having to adopt certain techniques used in therapy in order to address the needs of the client accordingly. This can be interpreted as being an aspect of growth, the therapists developing new techniques that are specific for working with survivors of domestic abuse.

One participant noted more flexible work practices offering more number of sessions than the organisation was initially able to offer, in order to meet the safety need of the client. It is, however, arguable to what extent this benefits the client or is an expression of a loss of boundaries through empathic enmeshment, discussed previously within the theme of ***The journey of listening to clients' stories.***

- **Developing a feminist perspective**

Most participants talked about how increased awareness of domestic violence issues has resulted in developing a feminist perspective, seeing themselves as agents of change, activists who work to challenge myths and realities surrounding domestic abuse, advocates in raising awareness on the challenges the survivors face not only emotionally but also on a practical level when facing domestic violence. These findings concur with those of Iliffe and Steed (2000), who argue that the therapist provides more than therapy, providing education on domestic abuse and, at times, practical support.

Referring back to the Constructivist Self Development Theory developed by McCann and Perlman (1990), one can argue that this feminist view developed following trauma work with survivors of domestic abuse is again a confirmation of the disruption in the therapists' schemas about self and the world. However, it is important to notice that the therapists perceive these changes as a positive transformation and not a "disruption". They became passionate about the issues surrounding domestic abuse and they wanted to challenge the stigma surrounding this subject.

I wonder, however, how much influence has the organisation in which the therapist works has on the developing of this feminist perspective, in addition to the impact of trauma work. From my personal experience with specialist domestic abuse agencies, domestic violence is explained from a feminist perspective. Feminist theory in domestic violence emphasises gender and power inequality in opposite-sex relationships. Pence and Paymar (1993) argue that the feminist perspective focuses on the societal messages that sanction a male's use of violence and aggression throughout life, and the proscribed gender roles that dictate how men and women should behave in their intimate relationships. The Duluth model (Pence & Paymar, 1993), widely used in explaining domestic violence from a feminist perspective, is a treatment approach that revolves around the power dynamics inherent in opposite-sex

relationships, which is a reflection of the different ways men and women are socialised on issues of power and equality. It will be, perhaps, interesting to observe if, for example, cognitive behavioural therapists develop a similar feminist perspective when working with survivors. According to Todd and Bihart (1994), for cognitive behavioural therapists, the most important aspect in the acquisition of certain behaviours is how a person perceives, interprets and processes the events in any given situation. Therefore, one can argue that domestic abuse behaviours are being influenced by thought patterns – what they perceived and interpreted – prior to the behaviour. Unfortunately, no data regarding therapists' approach has been gathered for this study; however, it is useful perhaps for future research to look into the experience of therapists with different theoretical orientations and notice if there are differences in how they perceive the work with survivors of domestic abuse.

- **Compassion on abusers**

Another interesting aspect in the findings of this study is one therapist's report of attempts to understand the abusers, to make sense of their behaviours. These findings add to Arnold et al.'s (2005) study, which found that therapists had come to view those who inflict abuse as "wounded rather than evil, with more compassion" (p.258). Bell (2003) has also found that the therapist working with domestic violence became less judgmental. From a growth perspective, this new-found position towards the perpetrators might have the purpose of creating a broader understanding of human behaviour and, therefore, offering room for personal and professional development.

- **High regard for clients' resilience**

The therapists described not only being aware of the violence that the perpetrator can inflict on their victims, but also the remarkable ability of their clients to overcome such atrocities, resulting in a deeper appreciation of the client's resilience. These findings are comparable to those found by Arnold et al. (2005), who introduced the term vicarious posttraumatic growth", highlighting in this way positive changes in self-perception, perception of others and interpersonal relationships and the philosophy of life. Illife and Steed 's (2000) study

reported the therapists felt increased respect for their clients and the challenges they face when faced with an abusive relationship.

In conclusion, by witnessing clients' resilience and strength as a result of the trauma, the therapists are witnessing the positive transformation of their clients, being their fellow travellers on the journey towards healing. This allows the therapist to maintain a hope that the atrocities resulting from intimate partner violence can be overcome, which in turn encourages them to continue to provide hope to other clients in a state of despair.

The results of this study can only strengthen previous research that has been conducted in the field of domestic violence and the impact the work in this field has on the therapists. Moreover, it adds to the previous research by offering a glimpse into the private lives of the therapists and the transformations they are facing in their different roles as practitioners and as intimate partners. Themes like ***Remembering own trauma, Becoming the abuser,*** and ***Compassion for abusers*** offer new perspectives on the lived experiences of the therapists who work with survivors of domestic abuse. The findings of this study generate useful and important reflections about therapeutic work with domestic violence survivors, raising awareness on possible aspects of trauma work that can be further pursued in clinical supervision and personal therapy. Moreover, the findings provide new insights that can generate changes within policies and procedures of the organisations who offer therapy to survivors of domestic abuse.

4.4 Implications for Counselling Psychology and Counselling Psychology practice

In this section, the implications of the present study for Counselling Psychology as a field and for Counselling Psychologists as individual practitioners will be addressed.
Much of the research carried out in the last twenty years has focused on the negative impacts of trauma work and how to best prevent its negative impact. McCann and Pearlman (1990), who introduced the term "vicarious trauma", initiated a discussion about how to best support and care for counsellors engaged in trauma work. Whilst the psychological consequences of working with traumatised clients are often discussed under the terms of burnout (Maslach, 1982), compassion fatigue (Joinson, 1992) and vicarious trauma (McCann & Pearlman, 1990), one can only notice that these draw attention to the therapist's internal world, however limited within the therapeutic relationship.

This study suggests that the therapist working with survivors of domestic violence trauma do experience a change in their interaction with the world, themselves and their intimate partners. Du Plock (2010) asserts that the ethos of Counselling Psychology maintains that all areas of a person's life need observing in order to help that person. Expanding on Du Plock's (2010) idea, I hoped that my study provided a sound parallel to this ethos by taking into account areas of a therapist's life that previously have briefly been looked into, like the impact the work has had on their intimate relationships.

From a Counselling Psychology perspective, these findings are vital as they draw attention to and a call for reflection on how vicarious trauma can shape the professional practice of a Counselling Psychologist. The findings emerging from this study can have considerable implications for training and supervision of the Counselling Psychologists and therapists with different therapeutic orientations choosing to work with this client group. It became clear that working with survivors of intimate partner violence inevitably creates internal conflicts for the therapist that have an impact on both their professional and intimate lives. Therefore, training should prepare the therapists for the emotional challenges arising from this kind of work and the possibilities that the work will penetrate their private lives. Given the central role of reflexivity in Counselling Psychology, the findings of the present study can be used as a starting point for reflection. The themes that emerged from the therapists' accounts regarding the impact of trauma work in the field of domestic abuse raise reflections about how we can address this is in our clinical and supervision practice. Some of the questions that perhaps counselling psychologists can reflect on are listed below. It is vital that from early on in working with this specific client group such questions and dilemmas are identified and reflected upon, rather than avoided:

- How do I respond to my clients when I listen to their stories?
- What aspects of my personal self are present while with the client?
- What kind of memories do the clients' stories invoke in me and how do I make sense of them?
- What are my strengths and limitations in working with this client group?

- How permeable is the boundary between myself and my client and between my work and my private life? How do I balance this distance? How does this affect the therapeutic relationship and my intimate relationships?
- In which situations do I find that the boundaries between myself and the client get blurred? In which situations do I choose to break the boundaries?
- How do I address these blurring boundaries?
- How does this work transform me as therapist? How does it affect my identity?
- How does this work allow me to become an agent for change in other areas relevant to my professional practice as a Counselling Psychologist?

Within Counselling Psychology, professional practice not only refers to the therapy with a variety of clients within different settings, but can also mean "management/leaderships, supervision, assessment, research, writing, policy development, social justice work and community intervention" (Kasket, 2012, p. 65). As a result, Counselling Psychologists who find themselves in different roles within their professional practice can be pioneers in developing self-care programmes for therapists and other mental health workers within the domestic violence field, by highlighting challenges, impact and the transformation one can encounter when working with this client group. Moreover, self-care programmes can be extended to significant others of the therapists and other mental health workers (e.g. spouse, partner), raising awareness on issues of vicarious trauma that their partners might experience and perhaps on the possible transformations they are likely to notice in their partners.

Within diverse roles, Counselling Psychologists can also inform organisations that support survivors of domestic abuse about the need for ongoing staff training and supervision, including information on vicarious trauma and self-care strategies.

4.5 Limitations and future research ideas

There were a number of both strengths and limitations to this study. The study considered a small number of participants, in line with IPA methodology. The small sample, however, prevents this study from being generalised to the larger population of therapists working with victims who have survived domestic violence. Furthermore, the sample was purposive,

criteria for participating in this study being somewhat restrictive (e.g. having over 5 years of experience working with survivors of domestic abuse and being in an intimate relationship whilst providing therapy to this client group). Therefore, this research does not assert that all the therapists who are or have been working with survivors of domestic violence have similar experiences with the participants in this study.

Nonetheless, the findings of this study do show similar results to the ones produced by Iliffe and Steed (2000), Steed and Downing (1998), Bell (2003) and Goldblatt et al. (2009). Thus, this study adds weight to their findings and goes further by adding additional findings from the data, looking more in depth on the impact of working with survivors of domestic abuse on UK therapists.

Another limitation identified in the study was that of gender. The therapists who agreed to participate in the study were all female. The literature does suggest that female therapists report more vicarious trauma symptoms (Brady et al., 1999). This serves as a limitation, since we are unable to see if the perceptions of males vary from that of females when working with the same populations. Despite this, the gender of the participants can also be viewed as a strength for this study, a homogenous sample being required for IPA research (Smith & Osborn, 2003). It seems that more research looking at gender issues and male therapists who work with victims, specifically, would add significant information. Interviewing male therapists may provide a broader view of how male and females perceive the experience of working with survivors and the impact this has on their intimate relationships. Future research on males' perspectives would be valuable either in conjunction with, in comparison to, or separately from studies investigating female therapists' experiences. This will further substantiate the current and preceding studies on the experience of domestic violence therapists.

Additionally, it might have been useful to interview therapists who work in non-specialist domestic violence agencies to compare the accounts provided. It is possible that the therapists' experiences may differ according to many elements. For example, working in a specialist domestic violence agency allows the therapists to have specialist training on domestic abuse and its impact on their clients. Is it that the extensive knowledge in the field affects their experiences with their clients and the way they perceive the impact of the trauma work? Furthermore, does a therapist who has less knowledge in the issues of domestic abuse

experience the work with a client who survived domestic violence in a different manner? All these questions and many more may be answered upon carrying out studies in both specialist and non-specialist settings. Although I did wish to recruit participants who work in a variety of settings, I was not able to do so, as there were no participants who met this study's criteria outside non-specialist agencies at the time of recruiting the participants.

The restrictive nature of a single interview for each participant could be argued to be another limitation of the present study. It may have been more valuable to examine the experience of the participants longitudinally, such as interviews repeated on two or three occasions, for example, a few months into working within the domestic violence arena. Additional interviews could have been conducted and later on, when the therapists would have gained more experience in the field. This longitudinal research would have provided the opportunity to gather more in-depth data and to notice changes regarding views on the intimate relationships throughout time.

Another limitation of the current study, similar to other qualitative research, is the researcher's biased interpretation of reported findings. Despite the researcher making an effort to utilise an unbiased approach to analysis, interpretations of reported findings remain subjective.

Despite considerable research being done on the issue of vicarious traumatisation, there has been less research conducted on the positive aspects of transformation following trauma work, more in particular on posttraumatic growth on therapists working with trauma. The findings of this study highlight the need for considering the concept of vicarious trauma in more depth, looking more into the meanings that the therapists ascribe to their experiences of trauma work.

4.6 Final reflexivity – methodological, procedural and overall research process

In this section of the research, I will consider how I have been implicated in the research process. This aims to be a self-reflection in order to understand how my personal experiences and assumptions have influenced and shaped the research process and the findings, as well as a reflection on how the research has affected me (Willig, 2001).

I have described my position in terms of my interest in the topic and the assumptions that I believed I held at the beginning of the process within Chapter 2 of this research.
I have been very fortunate in having interviewed some extraordinary professionals in the field of domestic abuse and I cannot thank them enough for their honesty and openness in sharing their experience. Thanks to their transparency, I have come to reflect on my assumptions regarding trauma work in the field of domestic abuse. I tried to enter the dialogue with the participants as open-mindedly as possible so that the participants' views were respected, valued and explored.

Due to my previous experience of domestic violence work, I did assume at the beginning of this research that the therapists would focus more on the negative impacts of the work. I did presume that they would be reluctant to share and describe their relationships with their intimate partners; that they perhaps would find it difficult to shift their focus from discussing their clients' experiences to their own experiences of working with this client group. These assumptions, when not confirmed, revealed a number of personal insights, including a realisation of the extent to which I am personally affected by the trauma work, more specifically, how my own cognitive schemas around power, independence and trust have transformed over the past four years because of working in this field. In a parallel process to my participants, I have reflected upon the changes that I have experienced over these three years, and it was interesting to observe how my transformation has been similar to that of my participants. I found it emotional listening to some participants remembering their own experience of domestic abuse, as it triggered memories of my own. I had to treat this very cautiously during the analysis phase of my research, as I endeavoured, as Finlay (2003) suggests, moving beyond the partiality of my previous understandings and to "bracket" my feelings from those the participant was conveying. I made notes in my reflective diary of how I was feeling and spoke with colleagues and my supervisor about what I was experiencing. This helped the "bracketing" process during the analysis, but I was aware that I am part of the analysis and I cannot fully bracket myself off completely.

Doing the research has fundamentally changed the way I think about the experience of trauma work within the domestic violence field as well as using a qualitative methodology. Through immersing myself in the participants' accounts, I have been privileged to reach a better understanding of an experience that I have not gone through to such extent as the

participants in this research. Although I have worked in the field of domestic violence for the last four years, my therapeutic experience with this client group is rather limited. I hope this research may therefore illuminate this experience for other Counselling Psychologists or therapists who want to start working in this field and provide reflection for those who are already working in this field. Additionally, I was insecure about using a methodology that was new to me. Despite this, I felt that a qualitative methodology is the best suitable method as its principals are similar to the principals underpinning Counselling Psychology.

In addition, I believe my experience in the field of domestic abuse both personally and professionally, as well as my assumptions regarding the impact of this type of work, have inevitably impacted upon the analysis and construction of meaning from the data. I aimed to be as open as possible in analysing the transcripts, acknowledging my assumptions and reflecting on possible influences on the data. I found that writing a reflexive diary, conversations with my supervisor in-person or via email and discussions with my fellow colleagues have helped my reflexive process. In order to give the reader a sense of my reflexive journal, I provide in Annex M excerpts that mirror the reflexive process. Despite this, this has been a very challenging process and I am unsure to what extent I managed to follow Finlay's (2008) suggestion not to enforce preconceived ideas on the phenomenon. It is without a doubt that my research results have been influenced by my personal and professional circumstances and my experiences. A totally naive or neutral position can never be assumed as a Counselling Psychologist researcher.

The interviewing process has also been an opportunity for reflection. The interviews were an opportunity for the participants to tell me their stories. Before starting this research, I was warned, so to speak, about the possibility of not being able to recruit participants, due to the subject of my research and because I chose therapists (known to be challenging to recruit) as my participants. I was pleasantly surprised at their openness and willingness to take part in the research and their interest in the subject. I found that during the interview process, participants were also interested in my story and my rationale for conducting this research. My position as a Trainee Counselling psychologist who had a few years' experience in the domestic violence field is likely to have shaped the research process. The participants who were interested in my background and knowledge of domestic violence field were briefly informed about it. Talking to someone who had experience in working with survivors of

domestic abuse may have encouraged the participants to elaborate more on certain aspects of the work and disregard others. At the same time, I might have also been perceived as a "trainee", one yet who cannot understand fully this type of work. It is difficult to say how these aspects have affected the interview process. I can also only speculate on how the interviews might have been different if I hadn't had previous experience in the domestic violence field. Certainly, the phenomenon is a co-creation of the interview by participant and myself; therefore, consideration needs given to my contribution to the phenomenon.

The process of conducting this research has required an engagement and concentration that I must admit I was at times overwhelmed by. There was a challenge in making decisions about what parts of the interviews revealed interesting themes, what themes to include that were relevant for the research questions and what theories to use to explain my findings. Although anxious at the beginning about not knowing what would surface out of my data, I have learned how to accept the subjectivity of the process through regular discussions with my supervisor and my colleagues who found themselves in similar positions. I reminded myself during the research that I was part of the process of analysing and interpreting from the lens I have taken to view the data. The findings of this research are the result of a unique interaction between the researcher and the data, and, therefore, another researcher analysing the data might have come up with different findings, or if undertaken again, the data would not be the same.

It also became apparent to me how the experience of conducting a qualitative research has facilitated my growth personally and professionally. Just as my participants found themselves on a transformative journey following trauma work with survivors of domestic abuse, I found myself on a journey of discovering myself as a qualitative researcher, adding to my reflections on my identity as a Counselling Psychologist.

I have reflected, throughout the research process, on some of the complexities involved in responding to domestic violence and possible challenges that we, as therapists face when we try out new approaches or interventions. My transformative journey, which saw me developing from a pro-feminist to a feminist psychologist, allowed me to reflect on, accept, and incorporate into my stance and therapeutic practice different theories that aim to

understand the roots of domestic violence and possible ramifications and reverberations of each intervention at whatever level of context.

The research process has also allowed me to re-consider the phenomenon of domestic violence and how is interplayed between gender, culture and experience. I considered my own position vis-a-vis domestic violence as a researcher, therapist and last but not least as a woman born and raised in an Eastern European culture where domestic violence and abuse has been an issue that society "does not talk about" and is often "swiped under the carpet". I must confess my naivety regarding this arena when I first came in the UK, as domestic violence was a subject that was hardly discussed and rarely publicised in the country that I grew up in. In recent years, however, this issue has started to be discussed more openly and feminist views on domestic violence are highly promoted following several incidents of domestic violence, victims being well-known public figures in my country of origin. Cultural contexts are vital in the analysis of domestic abuse, because culture defines the spaces in which power is expressed, gender roles are defined and redefined and relationships are negotiated. Culture can be seen accountable for how the issue of domestic violence is viewed and addressed.
The process of conducting this research and working in parallel as a domestic violence advocate for a feminist organization here in the UK, generated for me a more comprehensive understanding of domestic violence and I appreciated more the cultural discourses around gender roles, relationships and the role of each partner in an intimate relationship.

With no doubt, the participants' experience has been greatly influenced by the way domestic abuse is addressed within a westernized culture. The participants who took part in the research were all trained in the UK where domestic violence is seen as an unacceptable act, a crime and is punishable by the law. Therapeutic interventions in cases of domestic violence are often facilitated through gender specific group programmes based on feminist, psycho-educational and Cognitive Behavioural Therapy (CBT) principles and perspectives. The healing and recovering process is focused empowering through voicing experiences, non-pathologising and non-blaming women, and reinforcing confidence and self-esteem. I embraced these feminist perspectives and incorporated them in my practice both as an Independent Gender Violence Advocate and as a psychologist and this has influenced without a doubt the way I have analysed the participants' data. I cannot help wonder what kind of experiences would have been revealed

through the accounts of therapists that work within a different culture norms and where perhaps domestic violence is not a "spoken" issue.

I have found this process concomitantly a pleasure and a difficult task. I found myself more interested in how we experience ourselves, the others and the world, how we perceive these experiences and how this contributes to what we already know.

I hope that this study is a valuable contribution to the field of Counselling Psychology as it offers valuable knowledge of the subjective experience of the therapists who are working in the domestic violence arena. Given the high prevalence of domestic violence around the world and in the United Kingdom, it is very likely that more and more therapists will come across clients who are survivors of domestic abuse. It can be essential to have an awareness of the impact that the work with this type of client group might have on the therapists, and the transformations that one can experience when working with these clients. This study hopes to trigger reflection on issues that therapists might want to explore further with their supervisors, managers or colleagues in their workplace.

For the therapists who work in the domestic violence field, the findings of this research suggest that the "work chips away" parts of the therapist's self, resulting in profound changes both within the private and professional lives of the therapist.

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Appendix A

Email sent to the managers of the relevant organisations

Dear Sir/Madam,

As we agreed, following our telephone conversation today, please see below a short summary of what my research aims are and what are the criteria of the participants that are required for this study. I would really appreciate if you could circulate this e-mail to everyone who you think might be interested.

I am conducting a study that plans to investigate the experience of therapists who are working with victims of domestic violence. It aims to deduce what these experiences reveal about the challenges and the impact of domestic violence work, with emphasis on secondary trauma and the impact on the therapists' intimate relationships.
I am looking for participants who:

- *Are a BPS/HPC/BACP/UKCP accredited Counselling/Clinical Psychologists/ Psychotherapists/Counsellors*
- *Have experience in working with victims of domestic violence (male or female) for at least 5 years*
- *Are in an intimate relationship or have been in intimate relationships while providing therapeutic support to victims of domestic abuse.*

Participation in the research involves taking part in an audio-recorded, semi-structured interview lasting about 90 minutes. Your anonymity is totally assured and you can speak freely without any professional risk.

The participation is voluntary and the person is free to withdraw at any time, without giving any reason. The interview will take place at a location at the participant's convenience and by the end of it, there will be enough time for questions and relevant information. The study has been reviewed by the City University London Research Ethics Committee and received

full approval. Research Supervisor: Dr. Jacqui Farrants, Head of Psychology Department, City University, e-mail: J.Farrants@city.ac.uk

Thank you very much for taking time to read this email and I am looking forward to hearing from you if you wish to take part in this study. My contact details are: 07738099032/ e-mail: Alina.Radu.1@city.ac.uk

Best wishes,

Alina Radu

Trainee Counselling Psychologist, MBPsS

Appendix B

Recruitment material

- **Would you like to participate in a study exploring your experiences as a domestic violence therapist and the implications of your work on your intimate relationships?**

- ***Are you a BPS/HPC/BACP/UKCP accredited Counselling/Clinical Psychologist/ Psychotherapist/Counsellor?***

- ***Do you have experience in working with survivors (male or female) of domestic violence?***

- ***Are you in an intimate relationship? or***

- ***Have been in intimate relationships while you were providing therapeutic support to victims of domestic abuse?***

Take the opportunity to share your experiences in a 90-minute interview at a time and place convenient for you!

Discussing the impact that domestic violence work has on personal and professional life can generate recommendations for best practice with this specific client group and can identify needs for further training!!

Your anonymity is totally assured and you can speak freely without any professional risk.

Call/email me for further information or if you wish to take part: 07738099032/ Alina.Radu.1@city.ac.uk

Research Supervisor: Dr. Jacqui Farrants, Head of Psychology Department, City University, e-mail: J.Farrants@city.ac.uk

Appendix C

Information sheet

"The impact of working with victims of domestic violence on therapists' intimate relationships: A Phenomenological Study"

My name is Alina Radu and I am a Trainee Counselling Psychologist on the Doctorate in Counselling Psychology at City University London. This is a 3-year programme leading to a practitioner doctorate and registration as a Chartered Counselling Psychologist.

I am conducting a study that plans to investigate the experience of therapists who are working with victims of domestic violence. It aims to deduce what these experiences reveal about the challenges and the impact of domestic violence work, with emphasis on secondary trauma and the impact on the therapists' intimate relationships.

I am looking for participants who:

- Are a BPS/HPC/BACP/UKCP accredited Counselling/Clinical Psychologists/ Psychotherapists/Counsellors
- Have experience in working with victims of domestic violence (male or female) for at least 5 years
- Are in an intimate relationship or have been in intimate relationships while providing therapeutic support to victims of domestic abuse.

Procedures

The research involves taking part in an audio-recorded, semi-structured interview of approximately 1.5 hours. This will be arranged at a time and place at your convenience. You will be asked to share your experience about the therapeutic work with domestic violence clients; the initial impact of hearing traumatic material from your clients; your intimate relationships; your views with regard to family/couple life and life in general following your work; how you recognise stress-related work and what coping strategies you might use.

Possible risks or benefits

There is no risk involved in this study. There is no direct benefit to you also. However, the results of the study may help us to formulate personal challenges that are encountered in this field of work. Discussing the impact that domestic violence work has on personal and professional life can generate recommendations for best practice with this specific client group as well as identifying needs for further training.

Right of refusal to participate and withdrawal

You are free to choose whether or not to participate in the study and your treatment will not be compromised if you choose not to participate in this research. You may also withdraw at any time from the study and any materials will be destroyed. You can choose not to answer some or all of the questions if you don't feel comfortable with those questions.

Confidentiality

The information provided by you will remain confidential. Nobody except the researcher and the research supervisor will have access to it. Your name and identity will also not be disclosed at any time. If you have any further questions or if you are interested in taking part, please contact me on 07738099032 or via e-mail: Alina.Radu.1@city.ac.uk. My Research Supervisor is Dr. Jacqui Farrants, Head of Psychology Department, City University, tel. 020 7040 0172, e-mail: J.Farrants@city.ac.uk

Appendix D

Consent form

"The impact of working with victims of domestic violence on therapists' intimate relationships: A Phenomenological Study"

Please tick:

1) I consent to take part in the above titled research project, the particulars of which have been explained to me. I can confirm that I understood the information sheet about the study and that I had the opportunity to ask additional questions. ☐

2) I understand that the only requirement will be for me to participate in an audio- taped interview that will take no more than 1.5 hours of my time. ☐

3) I understand that the data that I will provide be kept secure, anonymised and will be destroyed when the research is completed. I understand that its results may be published in psychological journals or otherwise reported to scientific bodies, and that I will not be identified in any such publication or report. ☐

4) I have been informed that I am free to withdraw from the study at any time and to withdraw any data previously supplied. ☐

5) I understand that discussing the impact of my work on my intimate relationships can potentially cause some distress. I acknowledge that my participation in this study is not expected to involve any risks of harm greater than I encounter in everyday life; however, all possible safeguards will be taken to minimise potential risks. ☐

6) I have read and I understand this consent form, and I volunteer to participate in this research study. ☐

If you have any further questions, please contact me on 07738099032 or via e-mail: Alina.Radu.1@city.ac.uk. Research Supervisor: Dr. Jacqui Farrants, Head of Psychology Department, City University, tel. 020 7040 0172, e-mail: J.Farrants@city.ac.uk

Name of participant (please print)	Researcher: ALINA RADU
Signature:	Signature:
Date:	Date:

Appendix E

Demographic form

Please complete:

NAME	
AGE	
OCCUPATION/PROFESSION	
ETHNIC ORIGIN	
NATIONALITY	
MARITAL STATUS (please tick one)	Married In a relationship Single Separated Divorced Widower
If married/in a relationship- How long for?	
If single/separated/divorced – How long has it been since you were last in a relationship?	

Appendix F

Recruitment material posted on Counselling Psychologists in UK Facebook Group and on Linkdin.com

Hello everyone! As part of my Doctoral Thesis at City University, I am conducting a research looking at the impact of working with domestic violence clients on therapists' intimate relationships. I am interested in interviewing therapists who have been working with survivors of domestic violence for at least 5 years and who are in an intimate relationship or have been in intimate relationships while providing therapeutic support to survivors of domestic abuse. For more information or if you would like to take part, feel free to contact me on Alina.Radu.1@city.ac.uk Thank you!

Appendix G

Interview schedule

1. **I would like us to start by telling me a little about your work as a therapist working with domestic violence victims:**

Prompts:

What made you want to work with this particular group of clients?

Tell me some of the issues that these clients are bringing into sessions? /Describe your work?

What would you say is the most challenging part of your work?

How do you remember feeling when you first heard clients describing the abuse that brought them into therapy? (physiological effects, emotional responses? feel the need to rescue? protect? feelings of helplessness?)

How do you feel now after X years of experience?

Have you ever experienced personal life events that are similar to those of your clients?

2. **Some research suggests that working with survivors of domestic violence has been an opportunity for domestic violence workers to reassess and reflect on their intimate relationship. What do you think about that?**

Prompts:

How would you describe your relationship with your partner? What kind of changes (if any) have you noticed in your intimate relationships since you started work with domestic violence clients?

How do you think this work has impacted your relationship since starting working in this field? (awareness of feelings towards partner after a working day in which you were exposed to stories about abuse, intrusive thoughts during intimate moments)

How have you dealt with these changes (crisis)?

Some therapists in the field of trauma reported that case material sometimes negatively affected their sexual relationships with partners at home. What do you think about that?

How do you view yourself in terms of relationships now?

3. **What sort of behaviours or thinking patterns have you noticed since starting working with this client group?**

Prompts:

safety, trust, awareness of power and control issues, gender identity?

What do you think you have learned from your clients in terms of intimate relationships?

4. **How do you recognise the impact of stress on yourself?**

   Prompts: (symptoms? psychological, bodily sensations? Risk factors?)

5. **How do you take care of yourself?**

   Prompts(coping strategy, positive/negative /preventive?)

6. **Anything else you would like to add? Any aspects that you think I have not covered? Is there anything that you would like to ask me? Would you have asked anything differently?**

Appendix H

De –brief information

"The impact of working with victims of domestic violence on therapists' intimate relationships: A Phenomenological Study"

Dear Participant,

Thank you for your help and participation in this study.

The study in which you have just participated aims to investigate the experience of therapists who are working with victims of domestic violence and the implication of this work on therapists' intimate relationships.

In this study, you were asked to share your experiences about the therapeutic work with domestic violence clients; the initial impact of hearing traumatic material from your clients; your intimate relationships; your views with regard to family/couple life and life in general following your work; how you recognise stress-related work and what coping strategies you might use.

In the event that you may need to raise any concerns regarding uncomfortable feelings that occurred as a result of your participation in this research, below is a list of organisations where you could address these issues:

Mind, Tel. 0845 766 0163, www.mind.ork.uk

Samaritans, Tel. 08457 90 90 90**,** e-mail: jo@samaritans.org**,** www.samaritans.org

Saneline, Tel. 08457678000

National Domestic Violence Helpline 0808 2000 247

If you are interested in learning more about the research being conducted, or the results of the study of which you were a part, please do not hesitate to contact me on 07738099032 or via e-mail: Alina.Radu.1@city.ac.uk.

My research supervisor is Dr. Jacqui Farrants, Head of Psychology Department, City University London, tel. 020 7040 0172, e-mail: J.Farrants@city.ac.uk

Please again accept our appreciation for your participation in this study.

Alina Radu

Trainee Counselling Psychologist

Appendix I
Ethics release form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) *Guidelines for minimum standards of ethical approval in psychological research* (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc D.Psych√ n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

The impact of working with victims of domestic violence on therapists' intimate relationships: A Phenomenological Study

2. Name of student researcher (please include contact address and telephone number)

ALINA RADU
Contact address: 52 Southfields, London, NW4 4NB
Email: Alina.Radu.1@city.ac.uk
Telephone number: 07738099032

3. Name of research supervisor

Dr. Jacqui Farrants

4. Is a research proposal appended to this ethics release form? Yes√
No

5. Does the research involve the use of human subjects/participants? **Yes**√
No

If yes,

a. Approximately how many are planned to be involved?

8

b. How will you recruit them?

The therapists will be recruited from the UK voluntary and statutory organisations that offer counselling services to survivors of domestic violence. The researcher has a good knowledge of these services as she has been working over the past two years as a support worker for victims of domestic violence. Preliminary informal discussions with representatives of targeted UK organisations that offer counselling services to survivors of domestic violence will focus on identifying ethics approval from the institutions in which the research might be conducted. The recruitment material will be sent to relevant institutions and will be disseminated amongst the therapists. A copy of the recruitment flyer is attached in Appendix 3.
Sampling will also be conducted through the participants that took part in the pilot interview who will be asked to identify others that might be willing to take part in the study and the recruitment process can be initiated.

c. What are your recruitment criteria?
(*Please append your recruitment material/advertisement/flyer)*

The participants will be BACP/UKCP/BPS/HPC accredited Counselling/Clinical Psychologists/Psychotherapist/Counsellors who have been working therapeutically with victims of domestic violence for at least 5 years. Therapists should be in an intimate relationship or have been in intimate relationships while they were providing therapeutic support to victims of domestic abuse. The therapists taking part in this research can be either male or female and there are no restrictions in terms of age, sexual orientation or therapeutic approach used in their practice.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? **Yes**
No√

d1. If yes, will signed parental/carer consent be obtained? Yes **No**

d2. If yes, has a CRB check been obtained? Yes **No**
(*Please append a copy of your CRB check*)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Each participant will take part in a taped semi-structured interview, lasting no more then 1.5 hours. The interview will offer the opportunity for an open dialogue through which data of the lived experience of the therapists working with victims of domestic abuse, and the impact that this work has on their intimate relationships will be collected. The main areas that the interview will cover are: the therapeutic work with domestic violence client; initial impact of domestic violence counselling on therapist; therapists' intimate relationships; changes in therapists' worldview in regards to family/couple life and life in general (safety, trust, awareness of power and control issues, gender identity); burnout- recognizing stress and coping strategies (self-care). The interview will be conducted by the researcher.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes√ No

If yes,
a. Please detail the possible harm?

Although this study does not anticipate involving any physical risk to participants, there is however the risk of minimum distress when exploring participants' intimate relationships.

b. How can this be justified?

It is possible that taking part in an interview which focuses on the experience of hearing traumatic events in one's life, as well as how this has affected the participant's intimate relationships, could be a distressing experience. It is assumed however, that the therapists have a certain emotional robustness which will help reducing their distress if that happens.

c. What precautions are you taking to address the risks posed?

In order to minimise the possibility of an upsetting experience, the participants are informed about the aims of the study from the first contact with the researcher. The participants will be provided with contact details of

psychological services that they can access in order to reduce distress if necessary. A copy of the debrief form is included in Appendix 6. During interviews, the researcher will be aware of the possibility of distress and will be sensitive to the participants' experience.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes√ **No**

Information sheet is attached in Appendix 2.

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes No√

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes√ **No**

A copy of consent from can be found in Appendix 4.
If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Audio recordings with the interviews, transcripts of the recordings, consent forms and demographic forms will be the records kept of the participants in this study. These records will be complemented by summary notes after each interview and reflective notes throughout the research process.

12. What provision will there be for the safe-keeping of these records?

The audio- recordings will be added to a CD ROM disk and will be stored in a locked file cabinet. The recordings will be transcribed and coded so that the identity will not be attached to the information the participants contributes with. *The name of the participant and code number allocated will be kept securely* and separately from the research data in a locked file and will be destroyed when the research is completed. The research data and all reflective notes will be saved securely in password protected files and a password protected computer.

13. What will happen to the records at the end of the project?

All the data (including transcripts and recordings) will be kept for a year after the end of the project and then it will be destroyed.

14. How will you protect the anonymity of the subjects/participants?

The consent forms, the audio-recordings and the transcripts will be kept secure and separate from the research data in a locked file. All the identifying information will be changed in order to protect the anonymity of the *participants*.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

A de-brief information sheet will be provided to the participants at the end of their interviews. Following the interview, each participant will be offered the opportunity to give feedback and to ask any further questions they may have about the nature and the purpose of the research. It is acknowledged that discussing private and personal issues might leave participants feeling distressed and in need of further support. Information about relevant support services including relevant internet addresses are included in the de-brief sheet. Participants will be also invited to contact the researcher by telephone or email should any issue arise as a result of their participation. A copy of de-brief from can be found in Appendix 6.

(*Please append any de-brief information sheets or resource lists detailing possible support options)*

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher: ALINA RADU Date: 28/01/2011

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal√
Recruitment Material√
Information Sheet√
Consent Form√
De-brief Information√

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes √
   No
If yes,

a. Please detail possible harm?

There is minimum risk of psychological distress for the researcher. No physical risk is anticipated.

b. How can this be justified?

It is expected that the present research will be a challenging experience for the researcher. The researcher will have to be prepared to respond effectively in the eventuality of unexpected disclosures from the participants during the interviews (i.e. participants might have been victims of domestic violence at one point in their life).

c. What precautions are to be taken to address the risks posed?

The researcher has a great interest in the field of domestic violence, as she has been working in this field for over two years. The researcher has been attending intensive training in the field of domestic violence for the last two years and has a good understanding of the issues surrounding domestic violence. The knowledge acquired so far and the intensive work with survivors of domestic violence for the past couple of years proves the researchers emotional robustness and the ability to respond appropriately around issues concerning domestic violence. Therefore, minimum distress is anticipated for the researcher.
Interviews will take place at a time and place convenient for the participant. Participants will identify a familiar place where they feel relaxed and no interruptions are expected. Therapist's homes will not be considered a suitable location because of the privacy of the participant and the personal safety of the researcher can not be guaranteed. Study rooms at City

University Library can also be booked for interview in case therapist would prefer an alternative location.
The researcher will be supervised by a Chartered Counselling Psychologist to whom any concerns may be addressed.

Section C: To be completed by the research supervisor
(*Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.*)

Please mark the appropriate box below:

✓ Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature ---------- Date 1/4/11.

Section D: To be completed by the 2nd Departmental staff member
*(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature ---------- Date 1/5/11

Appendix J

Extract from the transcript for Helen

nutshell what I do, but the moment I start overseen one service and supervise other trainees working in the field as well.

Q: What made you want to work with this particular group of clients?

A: Well, interesting...I almost fell into it, accidentally. I was working for an organization, in substance misuse, and they started a new project, and I got involved in the project and then just developed a real passion for working in the arena, from some of the stories I've heard, and the time being a trainee it was really amazing to hear this shocking stories, and it really hits home when it's there, right in front of you, and to see what really can go on and, you know, learning about domestic abuse and how common it actually is. And also the fact that lot of courses don't make you aware of that as a separate issue, when it could be...it's so rife; so we can be seeing clients in many different contexts, they can be affected by relationships that are centered around power and control, and yet we don't always pick up, the therapist will focus on that. So it became quite an area of interest and a passion for me, you know, and I've been in there since.

Q: What would you say it's the most challenging part of the work?

A: I think one of the greatest challenges sometimes, not knowing what happens to individuals after they finish therapy. So there's something about not knowing what happens to the children, because you are a part of that person's journey, you don't get to necessarily see the ending, you can only hope that they're taking all they need to...from that time with you, and they've been able to empower themselves, to seek some sort of resolution and move forward, in a safe and positive way; but it's often that some of the children we work with they can be moved into care, they can be out for adoption and so, really ...you're not seeing the final aspect of where they end up or what happens to them. So, I think that that can always be very difficult when you've been working with anybody

who is really traumatized, and you know, you don't really get to see the end, and you don't necessarily get to see the impact of your work.

Q: You mentioned that you also work with mothers and children. How do you remember feeling when you first heard clients describing the abuse that brought them to therapy?

A: Yes, I remember feeling...initially feeling so shocked, and quite upset for them, to start with, it was hearing these stories you would be thinking about them it outside of work, you would also take it to supervision, it would take off a lot of your space, because there're sometimes feelings of guilt al well, somewhere, when you feel that you're okay, but you know, these people that I'm working with, they are not necessarily going home to a safe environment, so there is...you can experience feelings of guilt, and you feel stressed, because you're hearing these stories and there's a feeling of tense in your own muscles, you can often pick up some very psychosomatic symptoms, even when you're listening to a story being told, you can feel almost some of the anxiety from the other person as well. So, there are feelings with the client that you experience and there are also feelings after seeing the client, that you can experience when you're starting off, you're working with trauma and before you start to learn how you can manage that and deal with that, safely.

Q: And now, you have more than 5 years experience. How many years have you been working in this field?

A: I've been working in this field about 9 years now...

Q: So, it's quite a long time...how do you feel now, when you hear the stories from the clients?

A: I think it's always...in every therapy you always invest a part of yourself and, and in order to have that relationship with the client, you do invest that aspect of empathy, you know, so there is a part of you that is feeling some of that still.

But hopefully I feel that I'm able to do a safe distance, where I can...you know, to emerse part of myself, so I'm there present with the client, but at the same time there's still a part of me that isn't almost making their trauma my trauma, because, with time, supervision, learning in the field, learning, actively learning about self-care, and implementing it has been a way to learn how to do this job in the safest way possible, but also being very self aware, is the key. So, being really aware if you're in a particularly stressed place, being really aware of how many clients you've got, and how you're feeling, is that you always got to keep that...actively engaged in that self awareness process.

Q: Have you ever experienced in your personal life events that are similar to your clients?

A: I'm sure, when I was younger. When I look back, that I could certainly identify relationships where there were issues of power and control, and I think that, you know, I think a lots of relationships in life can be abusive, if we sit down and analyze them. So, I would say: *"yes, of course"*. But I also would like to think that this feel has also helped me to identify what is control and what is abusive, when I'm feeling violated in any way, whether it was just my space, whether it was just my independence, whatever that may be. So, you know, on one level I would say yes, but also that I feel that I found myself aware of dynamics between myself and other people, it's not just intimate relationships, but it's in many contexts as well.

Q: Some research suggests that working with survivors of domestic violence has been an opportunity for the workers, the therapists to reassess and reflect on their own intimate relationships. What are your views on that?

A: My view would be that it definitely affects your personal relationships, as working with individuals that have had extremely negative experiences in their relationships, would certainly make you question and reflect upon your own relationships. To understand where you stand, because I think, in order to...it's

(5)

the classic of being in personal therapy, when you're training for example, that in order to support the clients that that you're supporting and working with, and engaging with, in a therapy related relationship, I think you do need to have some clarity about your own relationships. So that you can maintain an awareness of what is your stuff and what is your client's stuff as well, so for those purposes it's essential. But it does...it does make you question things; it makes you think about the type of relationships that you want and you deserve, so definitely it's a spotlight of what' okay and what's not okay, what you're prepared to tolerate and what you're not prepared to tolerate; and what you deserve as an individual. So, it does put the focus back, on your self esteem because you're doing that with your client as well.

Q: In a way, it makes you reassess your own views and needs in a relationship.

A: Absolutely. Which I think it's quite a positive thing. It's a difficult thing to do, and it can have a cost in that you may make choices that might be difficult to start with, if for example if you decide of not proceeding with a particular relationship because, you know, you've decided that that's not how you feel you should be treated, or you just feel that certain things are not acceptable, that's a difficult thing to face up to, and move forward with, but ultimately I think it's quite a assertive thing and quite a place of empowerment as well.

Q: Now, I noticed, at the moment you are in a relationship, over this past 9 years, have you been in other relationships? (Yes) Okay, and at the moment, how would you describe your relationship with your partner?

A: At the moment, I would say it's very new, because it's in its early stages, but I would like to think it's quite it's very positive, because I probably wouldn't have stayed in it, or would be in it at the moment, if I didn't think that I was reasonably happy and like I was saying before there is something about you kind of have this standards for yourself as well, and so it takes time for people to meet them; so, when they do meet them, you know, it's quite a positive thing, so

Thought vs. client

Questioning relationship

Boundaries

Parallel work on self!

Ambivalence

Growth. Empowerment

Feeling strong in not compromising?

Content/satisfaction that relationship is complying standards

Parallels over relat → clients outside room

Transf./Countertrans. (in ... also!)

Awareness of own needs in term of relat.
"a spotlight"
Self-awareness.

Positives of working.

Growth/positive of working with this type of clients!

What makes it empowering?

Did she put these standards following work?

(6)

I'd like to think that it was a respectful relationship, because I think that's incredibly important, and a caring relationship, and one where I'm free to continue to be myself and respected for being me, and something I can offer in return.

Equality in give/take rel.

Freedom to be herself

Q: From my previous interviews, with other therapists, some of them suggested that maybe their partners have slightly…have a different view on the work that they're doing. Have you experienced anything like that, or how do you think your partner sees the work that you're doing?

A: Because he's in a completely different field as many people are often not necessarily in contact with this arena or know much about it, there is definitely the issue of how women affected by domestic abuse are viewed, the stereotypes, the stigmas, and you can spend time when you're getting to know always educating people on what you do, and why you do it, and how they might be wrong about certain things, or actually it's not like that, it's a little bit more complicated than that. So, I think that it takes time for people to understand what you do, why you do it and how it works, some of the research tells us about: what women go through, why they might stay in relationships, why they leave and they go back, you know, all this things, just generally lay people, don't always completely comprehend; there's always this, you know: *"why does she go back to him – scenario"*. I think it's an all-round lack of understanding, and you can find that in your own partner. And sometimes, I'd also like to think that, you know, that I'm with someone that hasn't had those experiences and grown up with them, and isn't abusive in a way that they can doubt themselves, so it's almost hard for them to understand as well, how this takes place. There is this believe for people that this things go on and they happen and sometimes people like to distance themselves from the reality as well.

* It appears i need to educate partner? althou starts talking ab him she then generalises to people not in this arena'
* Extrapolates what might happen at society level

Educating partner?

Empathy with partner

Lack of understanding

Q: Now, how do you think this work that you're doing has impacted your relationships, since you started working in this field?

A: I think you're extremely cautious, and in this field you hear...is just a classic, you know, just thinking of a book, *"Charming men, dangerous lovers"* comes to mind, and really, what you realize is that, you know, a lot of women would describe a very positive relationship at the beginning, and that's...and then, scraggily that relationship can become abusive, so for many women, it doesn't start off abuse, you know, individuals can be really charming...It's until she's in a particularly place, of potentially being vulnerable or dependent, you know, whatever the circumstances are, you know, violence or abuse can begin to manifest. So, for me, it has certainly made me cautious and I'm very careful and I would sit back and I will observe people, perhaps more than I would have done before I was involved in this field. So, I suppose it does make you a little bit more suspicious, and I suppose the bars are set high for people and that they need to prove themselves a little bit more.

Q: And how have you dealt with these changes?

A: I think it's a difficult experience in that, because you are suspicious and because you would like to think that you have high standards as well, you can be very quick to...so let's say:"oh no, I'm not going down that particular root", so often it feels like there are not many people in the world...as I --- a sense of...you can feel disheartened, because you feel that...well sometimes I'd sit back and think: *"oh, how do all these women, how are all these women in these relationships? Are they all putting up with something, or are they, you know, putting up...are they tolerating things that I wouldn't?"* And I guess it means that your net is narrower of people you would consider being in a relationship with. Because the standards are...I wouldn't necessarily say that the standards are high, because I wouldn't like to think that, you know, everybody deserves a relationship that's free of abuse, so, if that's high standards, then...that's high standards. But often it means that you can go quite disheartened through the process, obviously until you find someone that you feel, you know, that has actually met those basic requirements for any relationship.

(8)

Q: Well, I was just wondering, were there any times where you started a relationship or during your relationship, when you kind of worried that your partner may have some tactics that usually men have to abuse women, or...?

A: Yes, yes I can recall a relationship just like that. And, in those situation, is it very difficult to...it's hard to describe the experience, so I think that sometimes you go along with it, because you are wondering if you've got it right or you not, so you observe; but then, there is something about stepping back and saying: *"okay, what are the things that are good in this relationship, what are the things that are bad, and you know, is that okay, is that not okay, is that what I want for my future?"* So yes, I can recall times when I'm thinking: *"oh, actually this person is quite controlling, actually they're really pushing me now, and I don't like it"*...and I am not going to be involved in it.

Q: And have you, at that time, discussed with your partner about your worries and concerns?

A: I would say less so, I think I've just...made my brake, to be honest, I think where it's possible, I think when you have that kind of communication, there's already something there about that person which is enabling cooperation and respect. And I think when we don't have that communication and that respect isn't there, that it is a relationship you wouldn't want to be in? That makes sense? So, well, for me, I think, if I'm ever in that position, I might try to discuss something, once, and then if I would clearly see that this isn't a matter for a discussion, then it's something I completely reject.

Q: Some therapists in the field of trauma have reported that the case material the clients bring in, sometimes negatively affects their sexual relationships with their partners somehow.

A: I'm surprised by that. I am surprised by that. And I couldn't say that's impacted me, I think...I don't know if it's because I've learned how to really

Difficult to describe interaction

Evaluation

Cognitive Processing relationship

Communication in relationships

Clinical - pro/con's of the relationship - awareness of what boundaries are an how far she can allow boundaries to be broken

Allows opportunity, offers options, recognise importance of communication.

switch off, and obviously, if I was thinking about anything like that, I'm sure it wouldn't help, but I know I'm very clear about separating my space from work and home, and I think that must clearly be something that's the key to...you know, I think you do have to switch off, if you're not switching off I think there's a clear problem there. Because obviously the more you identify with someone's trauma, the higher the possibility for secondary traumatisation. Or, if you hear someone's trauma as if it were your own, and you start to put yourself in that place, to that degree, you are going to take it home with you, you are going to experience somebody else's trauma as your own.

Q: There were some researches where the therapists have flash-backs of the events that the clients were telling in the session, while they were with their partner at home, that's why I was thinking asking this question.

A: Well, it's probably a very good question, based on some of things you've been finding already. But to me that's flagging up. A serious place for supervision, and are this individuals taking the supervision and they are adequately dealing with that, or are they snowed under it with such a case-load that isn't safe? You see, the thing in trauma is something has to give, in my opinion. You have to make that. The decision is...you know has to be made. People I think, in their work, life, can take on more and more and more, and then there is a point when all the supervision in the world or the techniques in the world are unlikely to be helpful, because you just have a case-load that is ridiculously unmanageable in terms of the level of trauma, in comparison to the maybe same number within a different field, that may not have the same trauma-exposure. So, I think, there's something about safety and working there, that's coming up for me, because I can honestly say I haven't experienced that.

Q: How would you say, your view on intimate relationship has developed during your work with survivors of domestic abuse?

(10)

World-view

A: I've developed a greater kind of feminist perspective on things, and that the experiences of women are all different, and things in society can be incredible difficult for women, the systems they're in, the circumstances they can be in can perpetuate, you know, the things they're going through, they're always almost often left trapped in these situations that they may want to break out of the things preventing them to break out of them, so there's a lot of...I think the circumstances for women can be incredibly difficult in this particular arena, and so, I suppose...in terms of my views of relationships, intimate relationships in general, I guess I would like to see women that are empowered, I would like to see women from a young age being socialized with the right messages, of *"actually, this is not okay, you don't have to tolerate this"*. We're seeing more and more younger women, teenagers that are accepting high levels of violence and abuse from their boyfriends, and I'm thinking: *"when are these women going to be fully grown adults?"* It's really scary and I think on one level, I suppose there's some fear involved with my view and how that's developed, you know, relationships can be a wonderful thing, but they can also be a completely nightmare from where I'm sitting, from what I've seen over the years. So, I think, we have to have in our...I think women in general need to be educated to...and I think we can all deal with revisiting this on personal level as well, of self empowerment and, you know, looking at our own self esteem, because it' not, you know, all women from a range of backgrounds can be affected by domestic abuse, and it could be sometimes we could be going through a phase where we may not be feeling so great, and the wrong person is around us at that very moment. So, for me, yes, relationships are great, but I think there's a lot of work that need to be invested in ourselves, to make sure that we allow ourselves to have something positive and good, and to be really aware when it's not and to stop that early on, before it can become something disastrous if not fatal at times.

feminism perspective
Diversity
Feminism
Fear
Ambivalence
Self-awareness in relat.

Large-scale word view: feminism, empowerment, say NO to abuse.

Fear of ~~not being able to~~ what?

Appendix K

List of themes and quotes from Mary's interview

Theme	Sub-theme	Line number	Quotes
	Long-term professional goal	5, 13-14	knew that I was always wanted to work with women so I just waited for an opportunity
	Instinct-driven	16-18	Somewhere inside me I just wanted to work with women ...I just felt is it what I wanted to do...I still do (laughs)... I am not finished.
Challenges in work	Trauma	43-49	I think it is the actual dealing with the trauma is very challenging. Because it is a lot self-blame and anger with the client feels for herself for having stayed and put up with it...so , to get the client to the place where they can accept they could not do anything at the time..and then start building on their self- worth..it can be fairly long process... With the limitations we had with sessions that was challenging
	Limited number of sessions	49-50; 56-58	With the limitations we had with sessions that was challenging; our organisation don't understand that you can't just stop a client after 16 sessions simply because the sessions are done...

	Reassessing way of working	51-55	Serious trauma…I think is not something I would agree to work with now...
Impact	Sense of duty to care beyond	59-62	I worked with her actually well over the sessions; I continued to support her quietly on the side, because I simply can't do that, I mean my conscious wouldn't allow me to do that...until I found a place that where she could go to
	Professional boundaries stretched	59-62	
	Need to rescue, help		
Initial impact-psychological	Struggle to recall	70-72	You know I felt ...I remember…I think in the back of my mind I was feeling ...you know...I can't actually...is very hard to recall what I was feeling
	Emotional	74-82	but I would feel emotional as well. I know that sometimes I would feel emotion but I wouldn't let it get in the way of my therapy with the client. So I HAD THAT awareness that yes, this is painful, but also remained detached stayed with the client. So I wouldn't start crying or anything....aham…I might have had some tears, but continued to remain detached...you know...so just having that awareness, but yes, I would feel emotional
	Painful		
	Detachment		

	Crying/no crying		
	Congruence with the client	74	I could stay with the client
Initial impact-Physiological	Painful	88-90	Sometimes I would feel pain in my heart. and actually sometimes, at the end of the session I would feel pain and
	Self-awareness, congruence with self	90-92	I was just have to stay with it to see if it is about me or about the client, because I have learned to do that a lot.
	Transference/Countertransference reflection	92-94	If I am feeling pain, am I feeling the client's pain or am I feeling my pain? That's where I learned to discriminate. So if I had ongoing issues it could be my pain that the client's issue has stirred up for me.
Impact-Growth from work	Love for work, sense of fulfilling	103-105	I still love the work…I mean something ...is a huge...is such…is so fulfilling to see people actually take control of their lives
	Hope	111-113	I know that with every client that may present with so many problems there so much hope as well.
Impact-relationship	Reflection on own relationship/reassessing	120-121; 153-158	I discovered what was happening with me in my relationship; I think from that moment, I had to...I began to reassess what is my relationship about. What is a relationship supposed to be like...because this doesn't seem to be right...you know...whatever I have been

			experiencing doesn't seem to be what a relationship should be
	Shock, overwhelming, making a connection	131-136, 136-142; 218-219	One day , over something, ...it was always something very small...it was a minor thing You know...I asked my partner to do something and instead of responding in an adult way...it just blew up and that is when something clicked; I realised that this was happening to me...you know...and I actually...my children were there , everybody was there, I felt that I collapsed on the sofa…you know...I didn't actually collapsed...I actually sat…Lean down...but it feels like...suddenly like something was pulled from under my feet; it was exactly like two wires coming together...mine and hers...you know (laugh)…and is just like I had like a shock and I couldn't stand..
	Losing balance/control?	140-142	I felt that I collapsed on the sofa; it feels like...suddenly like something was pulled from under my feet
	Unimaginable, surreal	142-143, 145; 149	I just couldn't believe it...this is what happened. I had been in the marriage for 12 (counting)...been marriage for 12 years...umm...I just remember being in a

			daze for 4 days; I was still in a daze
	Physical symptoms	146-147	I had actually developed a stomach upset…you know I had a running stomach
	Questioning self/trying to find a rational explanation	147-148	and I said...what is going on?...cause it wasn't anything I've eaten...
	Forced to keep a sense of normality	149-152	I forced myself to get up…and I made cookies with my children...(laughs)…and I just had to give them my attention…it was holidays...I remember we were having some holidays
Coping with new revelations	Spirituality	158; 249-253	I actually went to my religion actually. Because there is a wealth of literature on how...what a woman's duty are and what a man's duty are, and in a relationship how they should be with each other. So actually I did a lot reading for about 2 years, yeah…I had to find out first what it was all about. So I read quite a few books and by scholars; religion was more important in the sense I used it to support me, spiritually, though my prayers and the practices I did, reciting the Book and prayers...and...and not just you know...it wasn't just reading and praying...is understanding...So really understanding, not just parrot fashion type of thing. Internalising it...it was very much

			intermingled with my transpersonal course...cause at the end of the day is all about you, is about how you develop
Changes in self	New job	176-186	I got a job...that particular incident happened...and he had...you know...suddenly our relationship sort of broke there...and from that point he had no control over my money. He couldn't tell me what to do with it. That made him very angry. But, he then began to see how I was using that money for myself. I was beginning to shop for more clothes, things which I had always denied myself because I was being good by saving money...you know, that kind of thing.
	Financial independence		
	Self-care		
	Rebellion against "being the good wife"		

Impact relationship	Difficulties to communicate with partner	187-190	But unfortunately, we found it very difficult to communicate. I mean…before that happened, long before I realised that point...when I collapsed on the sofa, I had suggested to him that we go for counselling, but he was never agree to that.
	Desire to rescue the relationship		I said "Ok, it seems like we can't understand each other, so let's go and talk to someone.
	Disappointment		
	Detachment/lack of emotion	192-194	I shut down in the relationship early on and he knew I was emotionally cut off from him; he felt I was not connected emotionally
	Relationship degradation	200-204	it was really downhill because he was not really willing to...he didn't think there was anything like to work on a relationship...unfortunately that was his culture...and it was mine
	Painful emotionally/hopelessness	209-214	Until it got to a point where it was too painful to be in a relationship…and I didn't realise I had a choice..until I did all the transpersonal work when I realise that I have a choice and is only cultural problem, is not a religious problem at all, only cultural
	New meanings/illuminated		

Coping with new revelations	Self-awareness course	232-235	I started the transpersonal course. Now I had no idea what actually would happen…is like when I started counselling I had no idea where I was going, I just knew that it was something that I liked
	Self-care/doing something that she liked		
	Disorientated?/no direction		
Finding of real self	Looking for inner self/who is she?	238-241	Through that I recognise that my personality is just build up from all my cultural conditioning, social conditioning, need of approval, from my parents specially...all these things it what makes my personality
	Discover inner self	241-243	And working cutting away that personality to who I really am …aham..that has been the most challenging period of my life
	Pain	243-249	And that was really a year before I decided...in the year before I finally decide to divorce. Very, very painful because I had to face all my cultural beliefs, thinking that I will lose everybody's support and actually working though all that and say " No I am more important, I can't go on living like this and I know there is more to life

	Struggle/inner fight		
	Challenge cultural beliefs		
	Fear of losing family through this process		
Impact on relationship	Sexual difficulties	263-266	I know that sometimes, I know that in my sexual relationship because I was emotionally cut myself off, I did feel ...although it wasn't his fault...it was my fault because I didn't express myself
	Detachment		
	Loss of communication		
	Duty to be a wife	266-267; 276-278	I gave in because I thought that was my duty as a wife; it was me giving in and in a way against my desires. Not wanting to, but giving in, because I felt it was my duty
	Empathy with clients		
	Understanding the dynamics of abusive relationships	285-289	I said I could empathise with them about...there is control in the relationship, there's abuse, and there is control in the relationship...and there is abuse...and there is all abuse.
Impact of work on self	Awareness of own expectations in a relationship	296-297; 301-305	I learned from my work, that I know now what I want in a relationship; I would defiantly want more equality, more respect, trust, things like that (laughs) and of course, love is very important. I think it must start with love and build up.

			I am definitely looking for something completely different from what I had
	Reflection on past relationship: unloved, no communication, no cooperation, conflict, lack of awareness, stuck	307-314	There was no love to start with, but, we could have built on something we had. If there been more communication, or cooperation or willingness to work out problems rather that just to accept that I am the wife he is the husband and he say whatever he likes to me and I have to listen. Although it didn't happen…there was conflict, but for me to carry on, to carry on in that relationship for so many years is part of my lack of awareness, about being stuck in my condition really.
	Continuous self-work	319-326	I am working on myself continuously, but I still feel fear of meeting somebody new. And there is a fear, but I challenge myself a lot. So this is like another challenge.
	Wariness in starting new relationships		
	Challenges herself		
	Taking risks		
	Desire for new relationship	324-326	And if I really wanted, which I do, I would like to experience what a good positive, loving relationship is, then I

			would have to take a risk.
	Development/in a different place now	326-329	I am getting to a place where I can take a risk but I don't need to get hurt, you know,…because I am going to be in a different place from where I used to be.
	Finding self	329-334	I know that this is what I want but if someone else doesn't want it doesn't mean is because of me. Is not taking anything personally, but this is how it is at the moment.
	Loses self-blame		
	fear of rejection/struggle	336-341	The fear is about rejection. I am very much aware of that. Being aware is half the problem isn't it? Half of the problem solved anyway. Is to be aware of it doesn't have to be that a person rejects me because of own problems, but because of me you know and I shouldn't take that personally. But I am still getting there
Impact of stress	Bodily symptoms	344-347	it will show in my body. I can feel low in energy. If I had particularly difficult session or a very emotional session when the client has been very emotional and then I will feel tired, drained
	Tiredness		
	Drained		

Coping with stress-related work	Supervision	348-353	supervision is very important to me so, I have in-house and external supervision. Almost like 3 slots of supervision in a month. So I have plenty of supervision. My health is very important. I gave a lot of attention to my health, breathing practices yoga, meditation, and leisure.
	Self-care		
	Spirituality: yoga	374-378	body is temple which is a temple of the soul and that is way you need to look after your body, and that is why the yogis used to look after the body, not to look slim and pretty, so that they could meditate and connect with the divine nature
	Meditation		
View on relationships	No compromise	400-404	For me I think definitely, I can't compromise on it. I can't compromise this second time around it or third time. I have to decide if this is something I want or not. And I think I will be very clear about what I want from a relationship now. And I think there will be no room for compromise
	Clear understandings of what she wants		
Impact on self	Guilt for leaving	449-450	I actually went through a bit of guilt after that, because I wish I hadn't gone
	Family unit shaken		

	Fear/shame/guilt	455-458	family unit was shaken and you know...the relationship we had was not the same, because we were different with our friends. It just changed; completely and it made me feel maybe guilty, maybe scared that "look at what I have done".
	Empowerment	460-469	
	Different family life quality	460-469	
	Fake/keeping the appearances		Obviously that missing underneath…it was all show, it was all just to present a picture that everything is fine for everybody
	Sense of relationship never happened	471-479	
	Self not being there/detached		

Appendix L

Master table of themes

KEY

Bold, UPPERCASE,ITALIC e.g ***THE JOURNEY OF LISTENING TO CLIENTS' STORY*** =super-ordinate theme

Regular, black e.g The work resonates within the therapist=sub-ordinate theme

Numbers= line number-line number

THEMES/PARTICIPANTS	ANNA	CLAUDIA	MARY	EMILY	SARAH	HELEN	JO	CAROLINE
THE JOURNEY OF LISTENING TO CLIENTS' STORY								
The work resonates within the therapist	42-44; 46-48;51-61; 63-65; 67-71; 100-103; 139-142	65-71; 73-77; 84; 97-99; 160-165; 227-232;264-269; 279-281;287-289;291-292	70-82; 88-97; 103-11;263-266; 347-348;	55-59; 62-65; 83-86; 245-243	39-44; 79-90; 92-95 ;108-111; 113-116;161-163; 206	66-79; 87-95; 257-265;322-328;433-441	41-45; 78-85; 276-280;	38-45; 66-79; 81-85; 89-94; 98-102;189-194; 197-202; 256-267; 419-426;
Remembering own trauma		103-108	131-158; 218-223	92-99; 111-114	70-74; 118-125		35-37; 48-51;126-130	

Protecting and sustain self	135-137; 163-173	79-81; 87-89; 213-218;301-315;324-326	349-353;365-368	131-133; 259-263	200-205	239-248; 328-333; 467-476; 508-520	70-72; 240-243;268-272; 283-288; 298-303; 306-309	442-453; 464-468
WHEN WORK HITS HOME								
Questioning own intimate relationships	201-202;206-207	132-133;	160-170;199-204	78-81; 203-206	132-136; 185-189;	116-131;133-139;214-222; 420-428	99-115	137-152; 240-251; 327-346
Becoming the abuser	75-81; 91-93			88-90	179-184		105-115; 180-183;187-197	219 224; 364-371
Permeable boundaries between work and home	106-107; 144-149; 151-157	150-160	59-67	176-186				273-276

New insights on intimate relationships	75-81; 87-89; 110-112; 159-161	125-127; 196-199; 221-224; 251-253; 332-337	242-249;301-305; 400-404	196-200	142147	144-154; 180-193; 195-209; 301-316; 350-356; 365-376; 396-404	89-97; 118-122; 149-153;211-217; 245-252	109-128; 160-176;228-236; 299-306; 399- 409
THE DAWN OF A NEW SELF								
Re-assessing identity as therapist		51-64; 95-96	186-189	117-126	97-106		163-171; 174-177	501-514; 518-524;
Expanding worldviews								
Heightened awareness of power dynamics within relationships	123-125;	329-331	209-214; 321-322; 392-397;	211-214		102-112	227-237	311-323
Compassion for abusers							132-137	208-214
High regard on client's resilience		271-277		68-74; 239-243				
Developing a feminist perspective				216-220; 222-227		269-296	140-144	

Appendix M

Extract from the reflective diary

It is interesting to observe how this participant makes sense of her position of power within the therapeutic relationship with her client. Does she feel that the clients are looking for the next person to exercise their power on them? There is a subtle sense of fear: perhaps she is scared of the power she might have over the clients due to their position. I wonder how this impacts on the therapeutic relationships. It feels like she finds challenging the expectation that the clients have from the therapeutic relationship. What does that say about how clients see how counselling? Does the participant feels the sessions a challenge because of her awareness how much faith clients have in her? Does she feel the need to fulfil these expectations? The clients seem to put her in a position of knowledge; she is seen as an expert who has the answers. It does make you reflect on the importance of the therapeutic relationships with clients who have suffered intimate partner violence. The painful experiences of the clients created scars and wounds to the core of their self. As therapists, we need to create a safe sanctuary where the client can recover and where they can confront safely their struggles.

I never cease to be amazed and grateful for the willingness of these participants to share some of the most intimate details of their lived experiences. I would never have anticipated how many of them have experienced domestic violence within their own relationships and how emotional I would feel at times during the interview. It did strike a chord, as it made me recollect my own experiences and it made me aware of how far I have come in the last three years. Are we all wounded healers, I wonder? Or is it that domestic violence is so common that is present in most of our lives?

Part C: Critical literature review

The effectiveness of couple therapy in domestic violence cases: A critical review of the literature

1. Introduction and rationale for review

Domestic violence has received considerable attention in the past decade, as it has become a widespread concern in our society. Counselling Psychologists and other mental health professionals are often confronted in their practice with clients who are either in a current abusive relationship, or who have experienced, at one point in their life, domestic violence (Harris, 2006). Domestic violence is a very complex issue and a complicated social problem with a great deal of controversy surrounding treatment of abusers and their victims.
The research suggests that violence is particularly common amongst couples seeking couple therapy, with estimates of half to two thirds of couples seeking treatment reporting some incident of aggression in the previous year (Holtzworth-Munroe et al., 1992; O'Leary, Vivian & Malone, 1992).

Over the years, the body of research in the area of domestic violence has grown as the focus has shifted from domestic violence as being mainly a criminal justice system problem, to domestic violence as a social and a healthcare problem (Gerlock, 1999). There has been considerable research in the domestic violence arena. Most of the research is looking at the health impact of domestic violence on survivors (Gerlock, 1999; Jones et al., 2001; Saunders, 1994; Astin et al, 2993; Dutton-Douglas, 1992). Other studies in the domestic violence arena focus their attention on children who have been exposed to domestic violence (Wolfe et.al, 2003). Walker (1999) has conducted an extensive research that looked at psychology and domestic violence around the world, acknowledging the contributions of the psychologists to research, clinical assessment, intervention and prevention of domestic violence. The effects on the professionals who are working with survivors of domestic abuse have also been extensively researched (Baird & Jenkins, 2003; Ben-Porat & Itzhaky, 2009; Illife & Steed, 2000). A more comprehensive literature review on this subject can be found in the research component of this portfolio where burnout, secondary trauma and vicarious trauma, as effects of domestic violence work, are explained thoroughly.

Domestic violence prevalence has been widely researched, Walby and Allen (2004) finding that 45% women and 26% men had experienced at least one incident of inter-personal

violence in their lifetimes. The authors also established that, in any one year, there are 13 million separate incidents of physical violence or threats of violence against women from partners or former partners(Walby and Allen, 2004).

Given the high prevalence of domestic violence, it is of no surprise that relationship aggression is a common phenomenon that therapists are faced with when seeing couples presenting in therapy (Simpson et al., 2007). The research suggests that violence is particularly common among couples seeking couple therapy, with estimates of the half to two thirds of couples seeking treatment reporting some incident of aggression in the previous year (Holtzworth-Munroe et al., 1992; O'Leary, Vivian, & Malone, 1992).

There is a lot of debate on what is appropriate when counselling individuals and their families who have been experiencing domestic violence. There has been effort involved in finding a treatment plan that is successful in cases of domestic violence (Saunders, 1996). The victim/perpetrator conceptualisation is one of the most common models (Harris, 2006), which gave birth to several treatment interventions. These interventions clearly separate “victim” and “perpetrator” and these two groups are treated separately. However, Allan and St. George (2001) argue that the success of these interventions is moderate and sometimes inconclusive. Cooper-White (1996) also supports separate treatment for victims and perpetrators, and she even suggests that counsellors should focus on the protection of the female victims, collaborating with shelters, police, Social Services and church communities.

Most perpetrator treatment programmes (Stith et. al., 2003) incorporate different theoretical approaches and interventions (cognitive behavioural approaches, feminist approaches and attachment-based approaches). However, although batterers' treatment appears to produce a moderate reduction in recidivism of domestic violence when compared to control groups, no intervention has been shown to be differentially more effective than the other within the same sample. Perpetrator treatment programmes have many limitations with regard to methodology, consistent outcome measures and the fact that the high dropout rates are not considered in their outcome statistics (Rosen et al., 2003; Stith et al., 2003).

Not much research that has been conducted on programmes that focus only on the victim of domestic violence (Stith et al., 2003). There are many services offered to the victims of domestic abuse. However, these services do not offer the opportunity for couple therapy. On many occasions, the victim chooses to return to the perpetrator and this has been reported to be challenging for the providers of these types of services (Bouchard & Lee, 1999).

Recently, there has been research that suggests that in certain situations, couple treatment may be beneficial (Fals-Stewart & Clinton-Sherrod, 2009). The experts in the field of couple therapy and domestic violence have outlined guidelines for the assessment of domestic violence and the determination of whether couple therapy is an appropriate treatment modality (e.g. Gauthier & Levendosky, 1996; Holtzworth-Munroe et al., 1992; Jacobson & Gottman, 1998; Stith, Rosen & McCollum, 2003). Although these guidelines differ in some regards, there are core components that are common across published reports, including how to structure the screening process, what clinical domains to assess and what factors to consider in making decisions about the appropriateness of couple therapy. Although very divisive, the suggestion of couple therapy in domestic violence has led to much interest and a number of research studies can now be found addressing this topic.

2. The aim of the review

The aim of this review is to examine the studies that look at the effectiveness of couple therapy in domestic violence, considering the findings and limitations of each. The review will reveal the complexity of the issue of conjoint therapy in domestic violence cases. The necessity for Counselling Psychologists to be aware of the issues presented is highlighted so that they will be able to address it accordingly should they encounter it in their client work. The studies chosen for this paper focus on heterosexual couples, where the male is the perpetrator, whilst the female is the victim. It is clear from literature (Saunders, 1996) that for the majority of couples requesting treatment, violence is male to female and the most female to male violence is done in self-defence.

Hester et al. (2006) reported that the vast majority of domestic violence perpetrators recorded by the Police were found to be men (92%) and their victims mainly female (91%).

Same study conducted by Hester et al. (2006) found that many more repeat incidents were also recorded for male than for female perpetrators. Povey et al. (2008) has also found that a fifth of men, 22%, and a third of women, 33%, had experienced abuse from a partner since the age of 16, and that the physical and emotional impacts on female victims were significantly greater than on male victims. For this reason, this review focuses on heterosexual couples in which male abuse females and the effectiveness of different models of couple therapy when counselling couples affected by domestic violence.

The terms domestic abuse, domestic violence, interpersonal violence, family violence, battering have been used interchangeably throughout this literature review. A detailed note on the terms used throughout the portfolio including this literature review can be found in the Preface section.

The literature review was obtained via psychological search engines such as PsychINFO, PsyArticles, Medline. Keywords used to attain journals and articles about the topic were "domestic violence" "domestic abuse", "couple therapy" and "therapeutic approach".

The review will focus on the effectiveness of different models of therapy when counselling couples affected by domestic violence.

3. Reviewing the literature

3.1 Considerations when using conjoint therapies in domestic violence

Gauthier and Levendosky(1996) advocate that couple therapy is a feasible approach with some couples if it integrates feminist, behavioural, systemic and psychodynamic views. The authors review in their paper (Gauthier & Levendosky, 1996) how different approaches relate to the phenomenon of domestic violence. Gauthier and Levendosky(1996) claim the systemic therapists view domestic abuse as a symptom of a larger systemic problem; the behavioural therapists assume there is an equal balance of power; and feminist authors argue the fact that no conjoint therapy should be done when abuse has been happening in the relationship. They highlight the necessity of a thorough assessment of the violence as an ethical responsibility of the therapist. It is interesting to notice, however, that although the authors may consider couple therapy as a possible option, assessments and interviews with both partners of the

couple are conducted separately, in the first instance. The authors recommend in the initial stage a referral to a shelter for the woman and perpetrator's group for the man. Treatment only begins once violence has stopped and the man has shown an authentic desire to change (Gauthier & Levendosky, 1996). When considering Gauthier and Levendosky's suggestions about the assessments and treatments of couples with abusive male partners, certain issues need considering. It is critical that therapists have a very good understanding of all the issues surrounding domestic violence. The therapists should be aware of their own attitudes and reactions to these types of clients and constantly evaluate whether they feel comfortable and competent in working with these couples.

In light of the recommendations of Gauthier and Levendosky (1996), Allan and St. George (2001) attempt to further fill in the gap in the research looking at how the couples affected by domestic violence have experienced the therapy and their insight and views on how effective couple therapy was. This ethnographic study adds new professional insights about the effectiveness of domestic violence counselling. Three Caucasian married couples, ranging in age from 18 to 38, attended between one and seven sessions at a rural counselling centre in Kentucky. The couples have been referred to counselling by courts following incidents of domestic abuse. After the completion of the counselling, the couples were asked to reflect on their experience in therapy, what stood out for them and what was most helpful for both of them. The interviews lasted between 15 and 30 minutes. Following a through thematic analysis, Allan and St. George (2001) identified four emergent themes: *Seeing Things Differently, Doing Things Differently, Caring for the Couple*, and *Going Together. In Seeing things Differently*, the three couples reported that the counselling offered them the opportunity to see things from a different perspective and to be aware and acknowledge the issues that came between them (Allan & St. George, 2001). Overall, the couples reported an awareness of their problems and the solutions by just simply being in a counselling setting. Within the theme of *Doing Things Differently*, the couples acknowledged their new-found unity and their focus on the relationship, rather than their individual differences. According to one of the couples, "teamwork" had been the most helpful experience over the course of therapy. A sense of unity developed amongst couples and they focused on creating solutions as a team. In *Caring For The Couple*, the participants reported more interest in each other's feelings that led to a more sensitive communication in the couple. The couples described making an extra effort to think about their reactions before confronting their spouse. The final

theme, *Going Together*, addressed the issue of going to therapy together. All the couples that had been interviewed felt that separate counselling would have prevented them from talking and working things out as a couple, and that the problem would not have been addressed as something they had in common. In general, the couples affirmed that counselling had offered them a "comfortable atmosphere" in which they felt free to share their feelings and thoughts (Allan & St. George, 2001).

Whilst the results of this study appear encouraging, there are a number of serious limitations to this study. Firstly, there is limited information about the kind of approach used in counselling these couples. Secondly, the authors' multiple roles (therapist and researcher) might have significantly biased the couples' answers and participation. Thirdly, this study has a small sample of participants (three couples). Although there were another three couples willing to take part, limited transport and communication in the rural area where the study took place prevented them from finalising the interviews, which might have revealed significant data. This study relied greatly on the memory of the couples about their experience of the counselling, rather than measuring it during the course of the sessions offered to them. Furthermore, it is unknown whether the counselling prevented domestic abuse once they had completed the sessions.

Similar to Gauthier and Levendosky (1996) and Allan and St. George (2001), Harris (2006) presented a paper in which he examined the research surrounding treatment approaches for domestic violence, in particular, reflecting on the promising research supporting a conjoint approach for treating domestic violence issues. Harris acknowledges the messages that currently exist in the field of domestic violence: the accountability of the perpetrator and the protection of the victim. Following the review of the literature (Stuart & Holtzworth-Munroe, 1995; Stith et al., 2003; Strauss,1993; Gondolf, 1998), Harris (2006) advocates the idea that, in certain circumstances, couple therapy could be an option for treatment for several reasons. Firstly, Harris agrees with the authors (Stith et al., 2003; Strauss,1993) who claim that reciprocal violence can occur between partners and this needs to be addressed in order to reduce overall the violence in the relationship. Secondly, couple therapy will be an opportunity for partners to address the underlying dynamics within the relationship, an aspect that is not addressed within mainstream perpetrator groups (Harris, 2006).Thirdly, the stigma surrounding domestic abuse might stop the couples to seek treatment, whereas a couple

therapy label might be more appealing (Shamai,1996). Finally, Harris (2006) advocates that couple therapy is beneficial, agreeing with Geffner, Barrett and Rossman (1995) in believing that conjoint therapy gives the opportunity to practice techniques with each partner offering the chance to correct the problems, practice the techniques, learn how to implement it, and find the technique that best suits the individuals.

Concluding his literature review, Harris (2006) rightly draws the reader's attention to several aspects that need considering when attempting to use conjoint therapy for domestic violence. The client's and therapist's safety is a priority that needs addressing in the first instance before even starting couple work. There are certain essential conditions that have to be met before starting domestic violence conjoint therapy (Geffner, 1995). It is important that each partner wants this treatment and understands the implications and the dangers that this approach has. A thorough assessment of the level of violence should be conducted and the danger to the victims should be low. A safety plan is put in place for the victim, therapists (two in number, one male and one female for the couple) have a good knowledge of domestic violence issues, they are trained in a systemic approach, and the couple has no substance misuse problems (Harrris, 2006).

3.2 Studies looking at different therapy approaches

- **Walker's Model**

Harris (1986) published an article presenting findings of forty case studies of couple counselling where Walker's model (1979) of conjoint therapy for battering couples was used. Walker's model presumes that the male is the major perpetrator of violence, although does not exclude the fact that female partners may resort to violence too. According to Walker (1979), there are two main objectives for therapy in cases of domestic violence: to stop abuse happening and for both parties to take responsibility for the violence. The model helps perpetrators to realise that violence is under his control and not caused by his partner. The victim is supported to stop blaming herself for her partner's behaviour and not to tolerate abuse from her partner any longer. Walker's model reflects an early cognitive marital orientation in which emphasis is placed on controlling maladaptive thoughts as assumptions brought into the sessions by both partners.

Forty cases were randomly selected from two hundred couples attending Family Violence Counselling Services in Montana between 1978 and 1983. Follow-up was conducted on the forty cases selected. The time elapsed from the last session to follow-up ranged between three years to two months. At the follow-up, only thirty couples could be contacted.
Following Walker's model (1979) of using both male and female co-therapists, Harris found that the presence of both co-therapists is important in building trust amongst the victims. The couples were seen initially during individual sessions, followed later by conjoint sessions. These individual sessions were aimed at building a relationship, gathering information, raising awareness on the cycle of violence, offering clients the opportunity to explore their emotional state or sharing any information that might be difficult to discuss in the future conjoint sessions. During the conjoint sessions, Harris (1986) reports that the couples learnt to cope with anger, recognise patterns of behaviour and the cycle of violence. The conjoint sessions addressed the problems of the relationship and offered the therapists the opportunity to see how the clients interact and for the couples to be aware of their communication patterns.
Harris (1986) found that anger management skills, problem-solving skills, challenging maladaptive thoughts and assumptions of each partner were useful in addressing couples' presenting problems. The couples were reminded during the first conjoint session that violence is a very serious problem in the relationship and time-out procedures are very important. The therapists worked at the beginning on controlling the violence, contracting with clients to agree not to engage in violence before contacting the therapists.
Following the treatment, 73% of the couples reported success (reduction of violence in the relationship), whilst 23% reported failure after the treatment (Harris, 1986). Statistical analyses were conducted to establish what differences were significant between couples who reported success and those who reported failure. The factors associated with success were: increased age of the perpetrator, higher income, later onset of violence in the relationship and more sessions attended. Although the use of alcohol and drugs could be seen as associated factors, in the analysis they were shown only as trends.

Whilst informative, Harris's study does have its limitations. Firstly, the time elapsed from last session to follow-up contact ranged from 3 years to 2 months. It is unclear how time and perhaps other significant life events in the couple's life might have affected the outcome of the treatment. The authors fail to address the length of time between finishing therapy and

follow-up. Secondly, the authors were unable to establish clear ways of measuring the success of the therapy. They indicate factors that led to therapeutic success and factors associated with failure to stop violence, but they fail to specify how they measured these factors. Moreover, were the follow-up sessions individual sessions or conjoint sessions? In both cases, how might this impact the results?

- **Individual Couple Therapy vs. Multi-couple Therapy**

Brown and O'Leary (1997) vigorously advocate for couples treatment in domestic violence cases. The authors reviewed the literature in order to establish which interventions were successful in couples where husbands were aggressive towards their female partners. After comparing paired combinations of couple groups, gender-specific formats and individual couples treatment modalities, the authors found that couple treatment proved to be the most beneficial, as violence decreased by 56% to 90% in seven reviewed outcome studies.
Stith et al. (2004) tested individual couple therapy versus multi-couple therapy administered after gender-specific treatment. The study focused on the couples that chose to stay together after mild-to-moderate violence had occurred. Forty-two couples were assigned randomly to either individual couple or multi-couple group treatment. Nine couples, considered the control group, completed pre-tests and follow-up tests but did not participate in the treatment. The theoretical approach was the same in both individual groups and multi-couple groups. Before and after completing every session, the therapists met each partner individually and respectively the men's/women's group to discuss safety in and outside the session. If there were any reasons for concerns (i.e. risk of violence increased), sessions were interrupted until partners were safe (Stith et al., 2004).The couples were asked to participate in 10 to 12 sessions to be considered as having completed the programme. 70% of the randomly selected couples that took part in the individual couple treatment completed the treatment. 73% of the randomly selected couples that took part in the multi-couple treatment completed the programme.

Conflict Tactics Scale-revised (CTS2) (Strauss et al., 1996), Kansas Marital Satisfaction Scale (Schumm et al., 1983) and The Inventory of Beliefs about Wife Beating (IBWB) (Saunders et al., 1987) were administered before and after 6 months of treatment. Three of the CTS2 subscales were used in the present study: Psychological Aggression (e.g. "My

partner called me fat or ugly"), Minor Physical Aggression (e.g. "My partner pushed or shoved me") and Severe Physical Aggression (e.g. "My partner used a knife or gun on me"). The Kansas Marital Satisfaction scale (KMSS) consists of three items that assess relationship satisfaction. The Inventory of Beliefs about Wife Beating (IBWB) was used to measure participants' beliefs and attitudes about the acceptability of wife-beating.
Follow-up was at six months and at two years after treatment. The female partners were contacted to find out if the couple was still together and if there had been any physical aggression after treatment. Six months after treatment, the rates of violence for the males that participated in the multi-couple group were significant lower (25%) than the individual groups (43%). The couples in the comparison group reported a 67% recidivism rate. Recidivism rates were significantly lower for those who completed multi-couple group therapy than for those in the comparison group (Stith et al., 2004).
In addition, marital aggression decreased significantly amongst individuals who participated in multi-couple group therapy, but not amongst those who participated in individual couple therapy or the comparison group. At the two-year assessment, only one woman reported that her partner had been violent to her since the last 6-month follow-up, which shows a 5.4% recidivism rate. In contrast, in the comparison group, there was a 50% recidivism rate (Stith et al., 2004).

These positive outcomes, as promising as they may be, need to be interpreted with great consideration, and it is necessary to speculate on possible causes that can also be considered limitations of this particular study. Firstly, there were certain conditions that participants had to fulfil in order to be able to take part: participants did not have any substance use problems and the ones who were considered “batterers” were excluded from the programme. The authors fail to define how “batterers” are different from the perpetrators who inflict mild-to-moderate violence. This creates the assumption that in cases where domestic violence does not involve physical abuse, the probability of a successful no-violence relationship is higher following therapy. Secondly, sample sizes were small (forty-two couples) and the length of time between the follow-up sessions might have had an impact on the results. Thirdly, the comparison group was made up of volunteers who were not randomly assigned to this group. Therefore, future research can focus in addressing these limitations.

Simpson and Christensen (2005) assessed two hundred and seventy three married, heterosexual couples seeking treatment for aggression in their relationship using the Conflict Tactics Scale-2 (CTS-2) (Strauss et al., 1996, cited in Simpson et al.).The couples were selected following two screenings. In the first stage, both spouses completed a phone interview in which they reported, amongst other demographic information, their marital satisfaction. In the second stage, both partners were asked to complete separately amongst other measures the Conflict Tactics Scale-2 (CTS-2) (Strauss et al., 1996) and The Marital Satisfaction inventory, Revised (MSI-R; Snyder, 1997). The results revealed low to moderate levels of agreement in the couples, both husbands and wives reporting lower levels of aggression for themselves than their partners attributed to them, though this discrepancy was generally stronger for husbands. Simpson and Christensen's (2005) hypothesis was confirmed when both husbands and wives reported that their partner had committed more acts of violence than the partners reported about themselves. This finding was attributed to the desire of the partner to present oneself as a victim when reporting intimate partner violence.

When considering the results of this study, several limitations need addressing. The main limitation of this study is the nature of the sample: the participants were married, heterosexual, primarily Caucasian middle-class couples. It would be interesting to see if the results were different if the sample was more diverse. The results might be biased by the fact that some partners feared legal persecutions and they under-reported aggression, despite the confidentiality discussed during screening. Another limitation is that the study only relies on Conflict Tactics Scale-2 (CTS-2) and the issue of reporting domestic violence has not been addressed. It has not been explored why the couples were not agreeing and when they did not agreed. It may be that wives with a low history of aggression do not remember sporadic incidents of aggression because they do not consider them important, whilst the ones with severe levels of aggression in their marriage may not report for fear of legal action and revenge from their partners. Simpson and Christensen (2005) agree that the limitations of this study highlight the complex issues that need to be taken into consideration when domestic violence within the couple occurs.

- **Network Therapies**

Galvani (2007) disputes that network therapies (practice methods that involve families and social networks) do not effectively address the issue of domestic abuse in the couples with substance misuse; however, there are elements in these approaches that are useful for couple therapy in domestic violence cases. It is estimated that 40-80% of women that access substance use treatments have experienced domestic violence at some point in their life (Bury et al., 1999). Galvani's article describes three approaches: Social Behaviour and Network Therapy (SBNT) (Copello et al., 2002), Community Reinforcement and Family Training (CRAFT) (Meyers et al., 1996) and Behavioural Couples Therapy (BCT) (O'Farell & Murphy, 2002). The author investigates and addresses the benefits of and the concerns that these approaches bring about in relation to domestic violence.

Social Behaviour and Network Therapy (SBNT) (Copello et al., 2002) is a method of working with the substance users and, later, with their family and social network. The method, developed within the British culture, emphasises building a positive social network around the client that will support their attempt to change their substance use. It acknowledges the impact of the client's environment on his substance use and vice versa. This allows the domestic violence to be included as one of the environmental factors (Galvani, 2007). Despite this, Galvani (2007) criticises the approach as it makes little attempt to understand the dynamics in a couple where domestic violence occurs, despite the high prevalence rates of domestic abuse amongst substance users presenting for treatment.

(CRAFT) therapies (Meyers et al., 1996), unlike SBNT, work in the initial phase with the family member who is thought techniques that have the purpose to convince the substance user to enter the treatment. CRAFT originated in the United States and works around identifying triggers and behavioural consequences of substance use (Galvani, 2007). In this context, domestic abuse is seen as a behavioural consequence of substance use. The method is limited, however, as it interprets the violence as physical violence only. Moreover, Galvani (2007) identified that the communication skills that are a vital component of this approach are based on specific rules and some of these rules are inappropriate for a victim of domestic abuse (i.e. offer understanding when the partner is abusive or accept partial responsibility when it is appropriate). Another limitation of this approach is the initial phase of this

treatment, which aims to persuade the partner (the perpetrator in cases of domestic abuse) to enter treatment. This may escalate the abuse and may be seen by the perpetrator as a way of controlling from their partner, and, consequently, the user might need to re-establish control through domestic abuse. One can conclude that although the CRAFT acknowledges the domestic abuse, there is a need for deeper evaluation to establish if the method supports or if there is a safety risk in access where domestic abuse is present (Galvani, 2007).

Behavioural Couple Therapy (BCT) (O'Farell & Murphy, 2002) is based on principals of behaviour therapy, including daily sobriety contracts, attending Alcoholic Anonymous/Narcotic Anonymous and medication compliance. The method involves a full assessment of domestic abuse and there is an evaluation of violent behaviour at each session, together with tasks relating alcohol and drug use. If the therapist makes the judgment of severe risk of domestic violence, the sessions will not continue. Some issues need to be raised when using this method. Firstly, reviewing the abusive behaviour during couple therapy may increase the risk of revenge from the perpetrator and, therefore, puts the victim at higher risk of further violence. Secondly, it is unclear how the therapist establishes the level of abuse and who set this level and for what purposes this has been set. More so, what measures are put in place for the victim in the event that the therapist identifies an escalation in risk?

Taking into consideration the high level of domestic abuse that is present in the treatment populations, Galvalni (2007) concludes that these methods can increase the risks of domestic abuse to the family members that are taking part. Therefore, there is a need to address domestic violence in network therapies without putting the victims at an even higher risk.

- **Behavioural Couple Therapy**

O'Farell et al. (2004) examined the occurrence of partner violence before and after Behavioural Couple Therapy (BCT) on 303 heterosexual couples, married or cohabiting, with a male alcoholic partner. The research investigated partner aggression between alcoholic males and their female partners in the year before and two years after Behavioural Couple Therapy (BCT). A baseline against which to compare levels of aggression was provided by a sample of a demographically matched, non-alcoholic sample group that also received Behavioural Couple Therapy (BCT). The Behavioural Couple Therapy programme consisted

of 20-22 weekly sessions over a 5-6-month period: 10-12 weekly one-hour conjoint pre-group sessions, followed by 2 hours of couple group sessions. Partner aggression and violence were measured as well as frequency of drinking, abstinence, relationship adjustment and BCT treatment involvement by the alcoholic patient. In the year before BCT, male alcoholics and their partners had an increased risked of partner aggression compared with the baseline sample. 60% of alcoholic patients had been violent towards their female partners, five times the comparison sample rate at 12% (O'Farell et al., 2004).

O'Farell et al. (2004) concluded that, following BCT, partner aggression decreased significantly (24% in the BCT group), but it was still significantly higher than in the comparison sample. In the couples where alcoholic men were remitted after BCT, aggression levels were similar to the comparison sample, suggesting that violence reductions were clinically significant. In the couples where alcoholic men were relapsed, after BCT, their aggression levels were higher than the comparison sample and the remitted patients. The findings revealed a dramatically reduced violence associated with abstinence in the two years after BCT (O'Farell et al., 2004). These results sustain O'Farell et al.'s (2004) hypothesis that recovery from alcoholism in the context of couple therapy is associated with a reduction in risk of partner violence, to a level similar to the non-alcoholic population.

When considering the results of this study, O'Farell et al. (2004) addressed several limitations. Firstly, the present results cannot support the conclusion that following BCT only, the levels of aggression lowered. O'Farell and his colleagues sensitively acknowledge that that other factors, such as legal system involvement, might have caused the reduction of intimate partners' violence. Secondly, in looking at the reduction in violence among remitted patients and the persistent violence amongst relapsed patients, the authors cannot conclude that continuous drinking caused the continued violence. Finally, O'Farell et al. (2004) critically observe that the collection of data regarding levels of aggression was different from one sample to another. The alcoholic group was followed longitudinally, one and two years after BCT, whereas with the non-alcoholic group, data was collected only once, after a national survey.
Although findings are relevant, one cannot conclude about the efficacy of the BCT interventions in couples where domestic violence occurs.

Simpson et al. (2008) also examined the effectiveness of focused BCT for couples who engage in mild-to-moderate physical aggression but want to remain in the relationship and end the aggression. The sample consisted of 134 couples, 45% of whom had experienced low-level aggression in the year prior to therapy. The couples completed up to 26 sessions of couple therapy and 2 years of follow-up assessments. The study measured relationship satisfaction, individual adjustment, well-being and relationship aggression using the Dyadic Adjustment Scale (Spanier, 1976), COMPASS-OP (Compass Outpatient Treatment Assessment System) (Howard et al., 1997) and the Conflicts Tactics Scale (CTS-2)(Straus et al., 1996).

Simpson et al. (2008) determined that psychological aggression (i.e. yelling, swearing, threatening, calling names) did not increase during or after therapy and decreased when relationship satisfaction improved. The researchers noticed that at two-year follow-up some physical aggression (i.e. slapping, punching, kicking, beating up) was reported, indicating that even if therapy did not increase the risk of aggression, it did not completely prevent it either. The data also indicated (Simpson et al., 2008) that couples with a history of psychological aggression or mild physical aggression can begin the therapy more distressed; however they do not significantly differ from the couples where there were no records of aggression.

With the results offering significant evidence that couple therapy may be appropriate and suitable for couples with a history of mild aggression, there are certain limitations to this study that need to be taken into consideration. Firstly, the authors identified that measures of aggression were limited as many forms of abuse were not taken into consideration: financial abuse, isolation, threats to harm family and friends. Therefore, a quantitative method can reveal significant findings; however, a full picture of abuse cannot be uncovered using this methodology. The second limitation fairly addressed by Simpson et al. (2008) refers to the fact that physical aggression amongst these couples, although existent in low levels, was infrequent. For that reason, the sample taking part in this study is not representative of the full levels of abuse that exist within the couples looking for therapy. Furthermore, the sample is not ethnically and socioeconomically diverse, with most of the participants being Caucasian, highly educated and heterosexual, so the findings cannot be generalised to other populations.

Fals-Stewart and Clinton-Sherrod (2009) have also highlighted the importance of couple therapy in the treatment of intimate partner violence among substance-abusing couples when BCT was used as therapeutic approach. Their study looked at whether participation in couple therapy compared to individual therapy had an effect on the relationship between substance use and the rate of intimate partner violence amongst married or cohabiting substance abusing men. 217 heterosexual couples were recruited and assigned to either behavioural couple therapy (BCT) in conjoint sessions with non-alcoholic female partners, or individual-based therapy with male partners only. Fals-Stewart and Clinton-Sherrod (2009) interviewed the couples using Timeline Followback Interview (Sobell & Sobell, 1996) and Timeline Followback Interview - Spousal Violence (Fals-Stewart, Bircheler & Kelly, 2003) twelve months post-treatment. The authors assessed that the couples participating in BCT reported lower levels of intimate partner violence as well as substance abuse, compared with couples having individual-based therapy. It has to be noted, though, that both treatments seem to be effective in terms of reducing intimate partner violence when the male partners do not drink or use drugs. However, there is a significant advantage of couple therapy with regard to reduction of intimate partner violence on the days of substance use.

Although the data retrieved from Fals-Stewart and Clinton-Sherrod's study supports BCT as a successful intervention for intimate partner violence amongst clients who misuse substances, some factors require consideration. The authors took into great consideration the fact that the efficacy of BCT is due to teaching the women strategies to avoid being victimised by their partners when they are under the influence. Despite this, they fail to ask the victims if they have used any skills that they have acquired throughout the therapy when facing aggression from their partners.

4. Summary and conclusions

Regardless of existing research, the effectiveness of conjoint therapy in domestic violence cases remains unclear. One cannot conclude which therapeutic approach is more effective in counselling domestic violence couples. The studies presented in this paper highlight the effectiveness of conjoint therapies in certain circumstances; however, the results cannot be extrapolated to all couples in which domestic violence occurs. Couple therapy in cases of domestic violence remains a controversial approach. In spite of the growing awareness of the

problem of domestic violence, there is little agreement on suitable interventions. Bouchard and Lee (1999) acknowledge that, in most cases, a review of the literature details the impact that the interventions have on the abusers, but do not give details on women and couple functioning.

This review has considered various studies and articles that reflect on the effectiveness of couple therapy in cases where domestic violence is present.

It can be concluded that prerequisites for potentially successful couple treatment would include a low level of aggression in the couple (Simpson et al., 2008), the abuser taking full responsibility for the abuse, willingness to change and to gain better control of his actions. The abuser should also be willing to comply with safety check-ins and reports by the victim. Individual therapies with both partners before starting couple therapy is preferable, including constant assessment of the risk of violence and no substance misuse in the couple (Sith et al., 2004).

Harris (2006) identified safety as a priority in all work with domestic violence clients and this should be considered when exploring the possibility of couple therapy in this area. Cervantes (1993) calls for Counselling Psychologists to work ethically and assess for relationship violence in all couples who request therapy. Much of the controversy in implementing conjoint therapies in domestic violence could be due to a number of limitations associated with this area of research. Firstly, many of the studies did not include large enough samples of participants, therefore the results cannot be generalised for all the couples that experienced domestic violence. Secondly, a majority of the studies did not include couples where the level of aggression was high and, furthermore, the measures of aggression were limited.

Consideration must also be given to the diversity of these studies. There is a major difference in the research papers themselves, making them difficult to compare. Some studies (O'Farell et al., 2004; Galvani, 2007; Fals-Stewart & Clinton-Sherrod, 2009) chose to focus on couples where alongside domestic violence, substance misuse also occurs. Others chose to focus on the type of therapy approach that the couples attended: behavioural couple therapy, couple counselling using Walker's model (1979), social behaviour and network therapies or

community reinforcement and family training. The interventions varied in respect of duration, content and format (individual couple therapy or multi-couple therapy).

Additionally, in most of the studies conducted in the area it appears that there is no control group so is difficult to assert if couple therapy is more effective than one to one therapy or group therapy. Furthermore, the results of all the studies that involve couples in which domestic violence occurs need to be treated with caution. It is also vital to acknowledge the participants who took part in all these studies and how might they differ from couples in which domestic violence does not occur but they do attend couple therapy (e.g are they motivated to attend couple therapy? do they see domestic violence as an issue in their relationship?).
Domestic violence is a complex area of research and although some of the studies that look into the effectiveness of couple therapy where domestic violence occurs, findings are unlike to be representative of domestic violence couples as a whole.

Due to the controversy surrounding the subject, Counselling Psychologists must understand that work with domestic violence cases is never easy. Golden and Frank (1993) call for awareness around issues of domestic abuse, reminding the professionals that even under the most intensive treatment conditions (individual, educational, group or couple therapy), although physical abuse may diminish, psychological and emotional abuse might still be present. Therefore, therapeutic gains may be limited.

5. Future research ideas

With a current gap in definite studies that are reliable indicators of the efficacy of couple therapy in domestic violence cases, there is an opportunity and need to increase the understanding in the area of domestic violence. Galvani (2007) consider that there is a need for basic domestic abuse awareness training among the professionals offering couple therapy.

It will be interesting to explore in further studies how the cultural differences within the couple affect the perception of domestic violence. Currently, this area has been little explored, and it is important to establish in which way cultural differences can influence the couple where domestic violence occurs.

Fals-Stewart & Clinton-Sherrod (2009) identified the need to develop, implement and evaluate interventions that address domestic abuse and the couples that experience it. The future research can focus on perfecting specific interventions (individual- and group-based) that have the purpose of reducing the violence within the couple.
Whilst some forms of therapies proved successful in cases where couples reported a low level of aggression, there seems to be a gap in data about the usefulness of these therapies in couples where levels of aggression are higher (Simpson et al., 2008).

Counselling Psychology has a major interest in subjective experience, therefore more studies of a qualitative nature would add to the existing research in providing insight into couples' experience of the domestic violence and therapists' experience of working with this particular client group.

Counselling Psychologists have the opportunity to practice in a variety of settings and given the prevalence of domestic violence, it is very likely that they might encounter in their practice clients experiencing it. It is a necessity that Counselling Psychologists should take responsibility in educating themselves about the issue of domestic violence and all the implications in providing services to this specific client group. That way, they can respond to their clients in an adequate and ethical manner. Thorough assessment of the violence in the relationship is vital and should be reviewed constantly during the course therapy.

In summary, whilst there is still a lot of controversy and debate surrounding the conjoint therapies in cases where domestic violence take place, the papers discussed in this review have helped to raise awareness of different aspects that need to be taken into consideration when encountering clients presenting this issue. Although not providing a definite answer regarding the effectiveness of conjoint therapies in domestic violence cases, this review helped to highlight the necessity for future research in this field.

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Final Note

> *"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."* Rachel Remen (2006).

This portfolio represents a step further in my journey towards growth and development personally and professionally. Our work transforms us and the experiences of trauma and abuse affects us on different levels: physically, mentally, and emotionally. As a consequence, our perception of the world is re-shaped. Working with abuse and trauma allowed the participants that took part in this research and I, in my roles as researcher, therapist and domestic violence advocate, to reflect upon the changes that we faced as result of this work.

My hope was to bring into the awareness of the reader the transformative power of working with trauma and abuse and its particularities by giving a voice to the participants in the research and witnessing at the same time my transformation throughout writing this portfolio. I wish to think that my voice and my participants' voice found its strength and we have been heard.

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