DECONSTRUCTING PRACTITIONERS' UNDERSTANDINGS OF INTIMATE PARTNER VIOLENCE AND ABUSE: IMPLICATIONS FOR PRACTICE AND SUPERVISION

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ABSTRACT

Against a background of often acrimonious debate among researchers, and contradictory research evidence, the most influential perspective in deciding criminal justice policy and the organisation of services across North America and Western Europe for those involved in intimate partner violence continues to be the gender paradigm. Approaches to practice based on the view that women are always victims and men perpetrate violence against them to maintain patriarchy have been criticised as reductionist and prescriptive. However, calls by researchers to bring more psychological theory and relational awareness to understandings of domestic violence and its practices have tended to be ignored. In the UK, services are predominantly offered to either 'survivors/victims' or 'perpetrators', and many co-ordinated community responses take a gender perspective.

Using a thematic analysis, this study aimed to deconstruct the understandings and approach to practice of 20 UK practitioners, who primarily offered services to either 'perpetrators' or 'survivors/victims'. Practices were found to be mainly informed by the gender paradigm, reflecting assumptions that men's abusive behaviour was instrumental and chosen, whilst women behaved aggressively in retaliation or defence. However, some participants integrated a relational perspective, deliberately moving away from either/or approaches that allocated blame, and endorsing practices that held both partners responsible for their choices and facilitated understanding of their motivation.

Whilst not eschewing the advances that feminist theory has brought to this field, the author concludes that segregating services contributes to the re-production of gendered assumptions that downplay the impact of the relational context and individual motivation. Evidence-based approaches are needed that engage more effectively with clients' attributions of blame, recognise the potential for reciprocal abuse, and move away from understandings and practices premised on the now out-dated assumption that intimate violence and abuse is only a gender issue.

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LIST OF ABBREVIATIONS

BCS	British Crime Survey
BME	Black and minority ethnic
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
CCR	Co-ordinated Community Response
CCV	Coercive Controlling Violence
CCV	Common Couple Violence
CRP	Crime Reduction Programme
CTS	Conflicts Tactics Scale
DA	Discourse Analysis
DAIP	Duluth Domestic Abuse Intervention Projects
DH	Department of Health
DV	Domestic Violence
DVA	Domestic Violence and Abuse
FDA	Foucauldian Discourse Analysis
HO	Home Office
IDAP	Integrated Domestic Abuse Programme
IPV	Intimate Partner Violence
IT	Intimate Terrorism
LA	Local Authority
MARAC	Multi-Agency Risk Assessment Conferences
NHS	National Health Service
PD	Personality Disorders
PT	Patriarchal Terrorism
PTSD	Post Traumatic Stress Disorder
PV	Partner Violence
SCV	Situational Couple Violence
VAW	Violence Against Women
VAWI	Violence Against Women Initiative
VR	Violent Resistance
WHO	World Health Organisation

PREFACE

Bowlby (1969; 1988) proposed that human beings are innately predisposed to seek out and be in relationship with others in order to experience both a sense of belonging and a validation of their separateness. From this perspective, relating to others can provide opportunities for personal growth and intimate connections that enhance well-being, but can also be a source of anxiety, or self and other-blame when fear of intimacy or separation are difficult to tolerate. The capacity to relate to others in ways that facilitate connection and allow the experience of loss and pain without feeling destroyed or destroying the other may represent a challenge to us all as human beings. Strong feelings of anger, fear, humiliation, guilt or shame aroused by our interactions with others may be an uncomfortable reminder that we have needs and expectations of others that are not always met. At such times, we may feel close to being out of control and only more or less able to recognise, think about and tolerate the discomfort without blaming or attacking the other (Zulueta, 2006). If we do respond angrily to the other who is different and seems to be depriving or thwarting us we may seek retrospectively to excuse, defend or justify our action as an attempt to right a wrong, or try to forget that it happened, in order to minimise the feelings of shame this can trigger (Brown, 2004).

How and whether we express anger and how appropriate we judge this to be may depend on our understanding of the rules and moral code of the society we live in (Burr, 1995). Expressions of anger that occur in the context of an intimate relationship 'in which abuse appears to be inextricably linked with intimacy' may appear paradoxical and particularly difficult to explain (Godbout *et al.*, 2009; Henderson *et al.*, 2005, p. 219). Similarly, why it is that some people remain in, or return to, abusive relationships appears to defy commonsense (Borochowitz & Eisikovits, 2002). Attempts by researchers and therapists to understand the paradoxical coexistence of love and violence can result in either/or explanations that construct men as 'tyrants' and women as 'passive victims' (Goldner *et al.*, 1990). On the other hand, 'it has sometimes been argued that looking at psychological factors associated with the receipt and perpetration of abuse implicitly blames victims and excuses perpetrators' (Bartholomew *et al.*, 2001, p. 61). Burman, (2005, p. 541) suggests also that the 'popular' question, "Why doesn't she leave?" 'ignores the state and institutional barriers' that can prevent women leaving.

Against a background of often acrimonious debate among researchers, and contradictory research evidence, the most influential perspective in deciding criminal justice policy and the organisation of services across North America and Western Europe for those involved in interpersonal violence continues to be the gender paradigm (Dutton, 2010; Straus, 2008). In the United Kingdom (UK), services are predominantly offered to either 'survivors/victims' or 'perpetrators', and many co-ordinated community responses take a gender perspective (Hague & Bridge, 2008). However, approaches to practice based on the view that women

are always victims and men perpetrate violence against them to maintain patriarchy have been increasingly criticised as reductionist and prescriptive, and counter to evidence from methodologically sound research (Carney *et al.*, 2007; Dutton *et al.*, 2009; Dutton, 2010; Frieze, 2005; Hamel, 2010; Straus, 2009). Consequently, there have been calls from researchers to develop multi-faceted models which are gender-inclusive and encourage practitioners to be open to the potential for men and women to be 'perpetrators' and/or 'victims' in intimate relationships (Dixon & Graham-Kevan, 2011; Dutton & Corvo, 2006; Ehrensaft, 2008; Hamel, 2007; 2009; McHugh *et al.*, 2005). However, Rivett (2006, p. 206) argues further that domestic violence services are a 'closed world', so research evidence may not always inform practice.

Therapists/practitioners make sense of problems in a particular organisational setting, bringing their own theories and personal experience to the process (Willig, 1999). Their engagement with clients may be understood in the context of a relationship that itself creates multiple and often conflicting 'potentials for action' (Gergen, 2008, p. 336.). From a relational perspective, therapy constitutes a special bi-directional conversation that is potentially transformative of clients' views of self and others, and their ways of relating (Safran & Muran, 2000; Wachtel, 2008). However, given the vulnerability of clients, therapists are the more powerful agents in the therapeutic relationship, which is considered fundamental to the outcome of therapeutic work (Norcross, 2002). Furthermore, approaches to problematising clients' presenting issues represent the operation of a particular 'therapeutic' moral order which holds that 'certain forms of conduct are appropriate or inappropriate in particular circumstances and accountable in particular ways' (Hodges, 2002, p. 476). Therapists' judgments concerning what is normal, or healthy, may serve to shift accountability, relocating individuals within this moral order as responsible for their 'problem'. Therapeutic conversations may therefore introduce new potentialities or 'truths', but they may also play a role in creating and legitimating ways of understanding that can contribute to re-producing existing ideas and practices.

Across the fields of psychology, psychotherapy and counselling training, it is acknowledged that therapists 'display ambivalent attitudes toward incorporating research into their practices and do not produce research' (Owenz & Hall, 2011, p. 21). Research ideas are unlikely to be taken up by practitioners in the domestic violence sector unless disseminated and seen as ways of working that are relevant, safe and effective (Proctor, 2004; Murray, 2009). Understanding how practitioners engage with the phenomenon of intimate violence and abuse and what difficulties they face in their practice is, therefore, crucial if we are to bridge the research-practice gap and develop more effective, informed approaches to dealing with the problem, and provide clinical supervision that supports this work. The focus of this research is therefore on therapists/practitioners' talk about intimate partner violence and abuse and their approaches to practice.

CHAPTER 1: INTRODUCTION

1.1 Intimate Partner Violence: a Historical Perspective

The World Health Organisation (WHO) presents evidence that intimate partner violence occurs in many countries, irrespective of social, economic, religious or cultural group. Although women can behave violently in relationships with men, and violence is also found in same-sex partnerships, the overwhelming burden of partner violence is considered to be borne by women at the hands of men (Krug *et al.*, 2002). Violence between intimate partners has not always been regarded as a serious problem, however. Looking back to post-Renaissance Britain, violence between spouses was seen as a private, domestic matter and a predominantly patriarchal view of marriage supported husbands' rights to dominate their wives, legitimating 'necessary marital chastisement', whilst holding to public ridicule husbands who were abused (George, 1994, p. 137). It was not until research evidence in the 1970s in the United States (US) presented violence in marital relationships as a widespread social problem, that public concern was aroused and women's advocates began to focus on violence against women as a 'feminist issue of gender inequality' (Gelles, 2000, p. 298). Straus & Gelles (1986) reported that 2 million women every year were 'battered' by their spouses or partners; evidence of an equally high rate of violence by women did not arouse similar concern as it was considered to be less dangerous and mainly committed in self-defence (Young, 2005).

The initial conceptualisation of interpersonal violence which began to emerge was of a unilateral, male-perpetrated and hetero-sexual phenomenon, engendered by patriarchal views that supported a husband's dominance over his wife (Dobash & Dobash, 1978; Dobash *et al.*, 1992). Though bilateral physical assault within an intimate relationship referred to as 'family violence', was recognised, the term 'battering', used to represent a pattern of domination, and coercive control by men over women, became regarded as the most frequent and dangerous type of interpersonal violence (Anderson & Umberson, 2001; Dasgupta, 2002; Dobash *et al.*, 2009). Consequently, psychological research on the topic initially tended to focus on men's aggression and was underpinned by gendered assumptions which have provided labels, such as 'victim', 'perpetrator', 'batterer' and 'survivor' to represent the experiences of those involved in interpersonal violence (McHugh *et al.*, 2005).

1.2 Overview of Current Debates

The concept of intimate partner violence has been challenged, and changing, over the past 35 years as awareness has grown of the different kinds of violence used in different contexts in different types of relationships, including women's use of violence (Allen *et al.*, 2009; Archer, 2000; 2006; Carney *et al.*, 2007; Coyne *et al.*, 2010; Dutton, 2010; Dutton & Corvo,

2006; Fiebert, 2009; Follingstad *et al.*, 2002; Frieze, 2005; Johnson, 2006; Johnson & Ferraro, 2000; Graham-Kevan, 2009; Graham-Kevan & Archer, 2009; Hamel, 2009; Hines, 2008; Kimmel, 2002; Laroche, 2005; McHugh *et al.*, 2005; Richardson, 2005; Straus & Gelles, 1986; Straus, 2006; 2008; 2009; Stets & Straus, 1989; Watson & Parsons, 2005). This has been reflected in changes in terminology from 'wife abuse' and 'wife battering', as it was increasingly acknowledged that violence did not only occur between married couples (McHugh & Frieze, 2006) but also, for example, between dating couples (Kaura & Lohman, 2007; Lewis & Fremouw, 2001; Lloyd & Emery, 2000), and violence in lesbian and gay couples was recognised (Burke & Follingstad, 1999; Renzetti, 1988).

Current use of the generic term 'domestic violence' (DV) in the UK can encompass a wide range of experiences and different kinds of relationship (D'Ardenne & Balakrishna, 2001); 'domestic' has become synonymous with the concept of an 'intimate', though the meaning and context may differ depending on whether a couple are married, separated, divorced, co-habit or otherwise live apart as partners and it tends to be associated with patriarchal explanations of violence (Dobash *et al.*, 2007). Current terminology generally encompasses physical, psychological and sexual harm and may make a distinction between violence and abuse, as in the terms, domestic violence, intimate abuse or domestic violence and abuse (DVA); Archer (2000) makes a distinction between violence, which has damaging consequences and physical aggression, which may not; and others refer to 'partner violence' (PV) (Graham-Kevan, 2009), or 'interpersonal violence' (Thapar-Bjorkert & Morgan, 2010). Other researchers distinguish between psychological and physical aggression (Capezza & Arriaga, 2008; Jordan *et al.*, 2010). Intimate Partner Violence (IPV) is the preferred term used in US and Canada and those researchers who study both male and female violence; Domestic and Family Violence are terms used in Australia (Murray & Powell, 2009).

Disagreements amongst researchers and practitioners continue, nevertheless, as to how to name the phenomenon, some preferring more specific terms such as 'dating violence' or 'lesbian battering' (McHugh & Frieze, 2006). These differences reflect the ongoing debates within the field as to how gender is implicated in our understanding of violence and abuse between intimates, and what it means to stay with, or leave an abusive partner (Anderson, 2007; Bell *et al.*, 2007; 2009; Murray, 2008). Disagreements tend to manifest in hermetic ideas, polarised between gendered explanations, which, on the one hand define intimate violence as unilateral, perpetrated by males and on the other, define it as perpetrated equally by men and women. Current approaches to working with the phenomena of intimate violence and abuse nevertheless tend to reflect the dominance of feminist discourses, which prioritise the safety of women and children and the bringing of male 'perpetrators' to account (Dutton, 2010).

This positioning of men as responsible for the victimisation of women informs the rationale for providing support and therapeutic interventions for female 'survivors' and group programmes designed to change the beliefs of male 'perpetrators'. Gendered approaches continue to constitute best practice in the domestic violence sector (Respect, 2008), in spite of research evidence that brings into question the effectiveness of group 'perpetrator' programmes, and poses a challenge to their underpinning assumption that women are 'victims' and never, or rarely, 'perpetrators' (Archer, 2000; Babcock *et al.*, 2004; Corvo *et al.*, 2009; Graham-Kevan & Archer, 2005; Langlands *et al.*, 2009; Laroche, 2005). Indeed, no single approach to treating perpetrators has been found to be better than another, and 'one-size-fits-all' approaches have been criticised (Hamel, 2010; Rivett, 2006; Stith *et al.*, 2003). Fenton & Rathus (2010, p. 149) suggest that male perpetrators tend to be cast as 'one-dimensional, blame-evading and untrustworthy', even though males' accounts reveal a wide range of reasons for violent behaviour.

Some researchers have looked for explanations in the individual characteristics and typologies of victims and perpetrators, or the impact of previous victimisation (Brownridge, 2010; Holtzworth-Munroe & Stuart, 1994; Johnson, 2006; Kelly & Johnson, 2008; Sullivan *et al.*, 2005; Swan & Snow, 2002; 2003; Walsh *et al.*, 2010). Others have researched the intergenerational transmission of intimate partner violence and abuse, identifying the influence of family-of-origin violence, and mechanisms such as self-appraisals, mental health and substance use that might be associated with adult perpetration or victimisation (Hines & Saudino, 2002; Stith *et al.*, 2000). However, as new information has emerged, some researchers have been calling for a more complex, gender-inclusive and multi-layered conceptualisation of the problem, which takes account of relationship context and individual differences as well as gender norms and the wider socio-historical context and does not ignore the evidence of female aggression and male victimisation (Chornesky, 2000; Dixon & Graham-Kevan, 2011; Dutton 2008; 2010; Ehrenshaft, 2008; Fitzroy, 2001; George, 1994; 2007; Hamel, 2007; 2009; 2010; Hines, 2008; McHugh *et al.*, 2005; O'Leary *et al.*, 2007; Richardson, 2005). Flynn & Graham (2010) point to inconsistencies in researchers' use of terms and the lack of a conceptual framework, causing gaps in our understanding, for example, with regard to the reasons both men and women give for behaving abusively.

Nevertheless, some researchers contest the incidence of, and reasons for, female aggression, arguing that women's violence needs to be understood in the context of their victimisation (Allen *et al.*, 2009; DasGupta, 2002; Dobash *et al.*, 2009; Dobash & Dobash, 2004; Dobash *et al.*, 1992; Hamberger & Guse, 2002; Kimmel, 2002; Swan & Snow, 2006). Also, the notion of violence in relationships as a potentially bi-lateral phenomenon in many cases continues to be strongly contested, despite evidence to the contrary (Archer, 2000; Bartholomew *et al.*, 2001; Follingstad & Edmundson, 2010; Graham-Kevan & Archer 2003; Próspero & Kim, 2009; Stets & Straus, 1989; Thornton *et al.*, 2010; Whitaker *et al.*, 2007).

Evidence that mutual abuse is common in couples who attend for general counselling, whether or not couple therapists are aware of this, has nevertheless highlighted a need for more screening and understanding of the relational dynamics that may be maintaining the violence/abuse or contribute to couples staying together (Stith *et al.*, 2003; 2004).

Feminist-relational approaches to working with interpersonal violence have been proposed, moving away from 'either/or' positions that cast men as villains and women as victims to one in which a subjective understanding of the experiences of both is sought (Goldner *et al.*, 1990; Stith *et al.*, 2002). However, whilst IPV is 'common among therapy-seeking couples' (DeBoer *et al.*, 2012, p. 28), couple therapy remains controversial because of the alleged risk this might pose to female victims, where violence is moderate-to- severe (Bograd & Medros, 1999; Stith *et al.*, 2002). There is some recent though sparse evidence that carefully thought out treatment for couples can be at least as effective as treating individuals, and no empirical evidence to support fears that women are put at more risk by conjoint work in violence-focused therapy (Stith *et al.*, 2003). Also, other research supports the efficacy of conjoint treatments for low-level relationship aggression, or mild-to-moderate couple violence (Horwitz *et al.*, 2009; Simpson *et al.*, 2008).

1.3   Future Directions for Practice

Recognising the potential for both men and women to initiate abuse as well as to behave abusively in defence would necessitate the development of practices which take account of male to female abuse, female to male abuse, same sex abuse, mutual abuse and those who may switch from being victimised to perpetrating abuse. It would also require therapeutic approaches that open up new ways of speaking about intimate abuse in relation to gender, each individual's personal history and both partners' experience of abuse in the context of their current and past relationships. However, calls by researchers to bring more psychological theory and relational awareness into our understanding of domestic, or intimate partner violence and its practice have tended to be ignored (Corvo *et al.*, 2008; Ehrensaft, 2008). It is important, therefore, that there is a bridge between academic knowledge and professional practice, so that stultifying 'either/or' debates characteristic of recent research are not re-produced in a disjunction between research and practice, resulting in well-intentioned, but ill-informed and ineffective practices.

CHAPTER 2: NAMING CONFLICT IN INTIMATE RELATIONSHIPS AS A PROBLEM

2.1 Introduction

Some societies may be considered as having been slower than others to identify domestic violence as a problem (Walker, 1999). However, social, political, religious and cultural beliefs and financial resources may differ across time and countries, and support differing practices with regard to the perpetration of violence against individuals. 'Cultural justifications for violence usually follow from traditional notions of the proper roles of men and women' (Krug *et al.*, 2002, p. 95). Differences between societies with an individualist or collectivist outlook and the implications for the victimisation of women have been noted by Archer (2006). He points out that most research has been conducted in western nations which have an individualist outlook so debates and research findings are not necessarily applicable to nations with cultures that are more collectivist. Walker (1999) also highlights how the use of state-sanctioned violence in the form of civil conflicts and wars may contribute to the notion in some parts of the world, that violence is a legitimate means of gaining power and controlling others, as well as increasing the vulnerability of the most disadvantaged who migrate either within or across countries. In recent decades, governments throughout the world have come under increasing pressure to consider domestic violence not only as a legal, psychological or social problem, but rather as a human rights issue and identify common dynamics of violence across the world (United Nations, 1989, 1993, 1996).

2.1.1 The impact of naming: research, policy and practice

The way in which a phenomenon is named is likely to shape, as well as reflect understanding, as it directs attention to some experiences rather than others, influences research aims and determines how data are interpreted (McHugh *et al.*, 2005). The assumptions that underpin different definitions of interpersonal violence reflect and espouse different epistemological and methodological positions, providing justification for who should be studied, what counts as violence, how this can be measured and what kind of interventions are required. These competing constructions of the problem influence the development of policy and practice, leading to decisions that will determine what is addressed and what remains unproblematised (McHugh *et al.*, 2005; Murray & Powell, 2009). However, some understandings of domestic or intimate violence are more widely recognised and legitimised in policy and practice than others, and those which are not named remain invisible and may not count. The dominance of a gender discourse invites the naming of males as 'perpetrators' and females as 'victims' and research sampling derived

from self-reports of females in refuges and men in treatment (Graham-Kevan, 2009). This may help to explain why Straus & Gelles' (1986, p. 472) statement made 35 years ago remains relevant:

> 'Violence by wives has not been an object of public concern. There has been no publicity, and no funds have been invested in ameliorating this problem because it has not been defined as a problem'.

Nevertheless, what happens in practice may differ from policy and vice versa. Murray & Powell, (2009) point out that policy on intimate partner violence may voice contested values and commitment to new, but not generally accepted understandings. Furthermore, new ideas generated by research may not be disseminated to practitioners so a gap between research findings and clinical practice may develop (Proctor, 2004; Murray, 2009). Ehrensaft (2008, p. 276) suggests that 'new data accumulating from numerous rigorously designed studies challenge existing theories and are largely overlooked or discounted'. Dutton & Corvo (2006, p. 478) argue that these new understandings may similarly not be reflected in policy: 'the science has moved well beyond the policy'.

2.1.2   Social constructions of domestic violence

A postmodern perspective acknowledges the role of language in the construction of psychological and social life and recognises the multiplicity of discourses that it constitutes (Billig, 2001; Willig, 2008). Discourses are located in contexts or social institutions, such as the National Health Service (NHS), whose healthcare practices are determined by policies that emerge through a 'policymaking process involving dialogue, argument and influence' that may serve particular interests (Shaw & Greenhalgh, 2008, p. 2506). These practices may reflect and sustain particular political, social and cultural norms and values and moral judgments about what constitutes the best approaches to research and interventions. Similarly, counselling and psychotherapy discourses and practices exist in a particular therapeutic domain governed by codes of ethical and professional practice that produce 'particular options for action' (Crocket, 2007, p. 19).

The therapeutic self of the client is understood in the context of a particular regime of knowledge, referred to as the 'psy-complex', which shapes ideas as to what constitutes a problem and specifies how this might be thought and talked about (Parker, 1998). Parker (2008) argues, for example, that psychoanalysis is a particular source of 'dubious' explanations which become true because they are so often repeated. In this way, women who were sexually abused as children may take up gendered identifications as blameworthy victims, pathologising their survival (Reavey & Gough, 2000). Similarly, knowledge of

domestic violence may be conceptualised as a set of constructed ideas, rather than uncovered truths. These constructions become legitimised in particular practices, giving authority to, and facilitating the production and dominance of, some knowledge and meanings over others, which may be discounted or marginalised (McHugh *et al.*, 2005). Bettman (2009, p. 15), for example, proposes that it is 'ultimately a discursive phenomenon and that patriarchal discourse remains the fount of domestic violence'.

It may be argued that therapeutic practices produce 'certain kinds of person with certain kinds of responsibilities' (Hodges, 2002, p. 455). More particularly, discourses about 'domestic violence' produce, through different practices of representation, a particular knowledge about interactions between males and females which may be reproduced in the power relations of those practices. Power involves knowledge, representation, ideas, culture, authority, and coercion, but 'also seduces, solicits, induces, wins consent' (Hall, 2001, p. 339)**.** From a Foucauldian perspective, power is ubiquitous, circulating at both a micro and macro level, so, in the context of representation, both the powerful and the powerless (in domestic violence terminology: 'perpetrators' and 'victims') are part of the circle though they are not engaged on equal terms. Stereotypical views of women as vulnerable and more likely to be victims, and men as protectors or perpetrators, may influence both public and professional perceptions (Dutton, 2007b).

However, individuals' lives may be more complex than academics and policymakers assume and they may not identify with dominant discourses (Gadd, 2002; 2003). Men may deny or justify abuse (Dobash & Dobash, 2011); some 'victims' may not label their experiences as abuse (Hammond & Calhoun, 2007), and resist positioning themselves as passive victims (Jackson, 2001), particularly if their narratives do not fit socially constructed norms of victimisation, whilst others may achieve validation and empowerment through the way they position themselves in their story (Montalbaneo-Phelps, 2003). Enosh & Buchbinder (2009) argue that participants in domestic violence re-construct their stories to place violence in a context that normalises and gives meaning to their life experiences, whilst achieving emotional distance. Furthermore, Boonzaier (2008, p. 202) concluded from a study of interviews with 15 heterosexual couples that narrative constructions of 'victims' and 'perpetrators' are ambiguous: 'categories of 'victim' and 'perpetrator' were neither static nor clearly distinguishable'. The meaning of interactions and practices are thus not fixed (Mehan, 2001).

So, whilst power structures may constrain and prevent they can also be productive in that they have the potential to produce new discourses and new kinds of knowledge, when new understandings emerge through individual or collective actions that challenge existing ideas and open up possibilities for change (Tew, 2006). Nevertheless, Girard, (2009, p. 20) suggests, '...policy generally reflects dominant voices, silencing others.' In effect, this may

'limit, enable and constrain what can be said, by whom, when and where.' (Lavis *et al.*, 2005, p.442). This may be relevant, for example, when domestic violence constitutes a crime (Home Office (HO), 1999) and a label is given to an individual as a 'victim' or 'offender', or where service providers have particular guidelines to adhere to in their work with either 'victims' or 'perpetrators' from a position of authority. When service providers enter into relationships with clients there is the potential, therefore, for them to deploy power in ways that may be experienced as oppressive rather than protective or co-operative (Tew, 2006).

The understandings and practices of different organisations dealing with 'domestic violence' are in this way constituted by discourses which prescribe their role and the focus and intention of interventions in a particular context: 'a particular way of representing events in discursive language influences the way we think about events represented and the way we act towards them' (Mehan, 2001, p. 361). Different modes of representation in different contexts may be institutionally sanctioned as facts that are not negotiated, especially where technical language signifies expertise. For example, police, doctors and therapists are likely to talk differently to, and about, someone who has been involved in a violent incident. So, it is perhaps unsurprising that mental health services and domestic violence services in the UK do not have a history of collaboration. This is despite evidence for co-occurring substance misuse and mental health problems for both men and women involved in domestic violence in the UK and US (Rhodes *et al.*, 2009; McMurran & Gilchrist, 2008; Rivett, 2006).

Rivett (2006) argues that this disconnect between services occurs because each institution has policies and practices based on different paradigms. Mental health services, he contends, take a therapeutic, recovery-oriented individual perspective. On the other hand, agencies that support 'victims' and re-education of 'perpetrators' generally reflect a pro-feminist perspective, and, in the UK and US, practitioners may have a range of professional backgrounds, not necessarily mental health, or be 'expert-amateurs' with specialist training in domestic violence (Thapar-Bjorkert & Morgan, 2010, p. 35; Morran, 2008; Hamel, 2010). An unintentional consequence may be that stereotypical ideas about masculinity and femininity are reproduced, resulting in discriminatory practices (Barter, 2006; Thapar-Bjorkert & Morgan, 2010; Hamel, 2010).

2.2   Definitions of Domestic Violence

Though violence between intimates is recognised as a widespread problem, there is no universal agreed definition[1] (Flynn & Graham, 2010). Differences in the way that it is defined may determine what is found and how this is understood (McHugh *et al.*, 2005). Nevertheless, acknowledgement of the seriousness of the problem and its medicalisation, has been reflected in changes in mental health classifications by the American Psychiatric Association ([*DSM-IV; DSM-IV-TR*] 1994; 2000) where there is reference to 'victims' and perpetrators' of domestic violence (D'Ardenne & Balakrishna, 2001). Generally, definitions refer to physical and psychological abuse, and are non-gendered, as in the Home Office definition, though they may differ in detail. Other definitions are listed in Appendix 1.

2.2.1   Home Office 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.' (HO, 2011a).
>
> This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour killings' and forced marriage.

2.2.2   Defining a violent act

Statistics used to quantify abuse or violence in support of arguments over the direction of partner violence, are based on measures of acts of violence or incidents. Debate centres on how a violent act is defined (particularly where statistics are based on self-reports), how the level of severity of violence is assessed, the implications of the meaning and intention of a violent act and who initiated it. Furthermore, 'Research suggests that physical violence in intimate relationships is often accompanied by psychological abuse, and in one-third to over one-half of cases by sexual abuse', and psychological abuse may be even more difficult to define and quantify, so the use of these measures for research is often strongly contested (Krug *et al.*, 2002, p. 89)

The revised Conflicts Tactics Scale (CTS; Straus *et al.*, 1996) is currently the most frequently used measure of violence, particularly in the US, for quantifying 'acts' of

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[1]   Whilst acknowledging the impact of naming, different terms have been used interchangeably throughout the thesis, following usage in the references (e.g. 'domestic violence', 'domestic violence and abuse', 'intimate partner violence', 'partner violence', 'interpersonal violence').

violence as evidence for research and for assessment purposes in clinical practice: 55 of the articles reviewed by Fiebert & Gonzalez (1997) employed this scale as did 76 studies referred to by Archer in his meta-review (2000). People are asked to report on their own and their partner's use of violent acts or aggression from a list of behaviours, comprising four sub-scales which assess different kinds of tactics (Vega & O'Leary, 2007). This includes measures of psychological dimensions (cursing, demeaning, stalking, threats etc), physical violence (slapping, shoving, kicking, biting etc), sexual violence (rape, unwanted sexual behaviours), and financial control (withholding money etc) (Kelly & Johnson, 2008).

The CTS has been criticised for not accounting for context, motive or meaning or identifying general patterns of behaviour and being used erroneously to justify arguments that partner violence is symmetrical (Dobash *et al.*, 1992; Kimmel, 2002; McHugh *et al.*, 2005; Kelly & Johnson, 2008). Archer (2000), however, counters that it is sensitive to measuring frequency and severity of acts of violence and does not only measure acts of self-defence, and Vega & O'Leary (2007) reported excellent test-retest reliability of most scales. Classifying actions as a 'push' or a 'slap', nevertheless may imply that these are clear-cut, unambiguous categories. However, the intention, severity of the impact and the consequences are open to individual interpretation and the same action may be differently experienced, so, it has been contended, misclassifications can occur, including underreporting of the respondent's own violence and over rating of their partner's (Graham-Kevan & Archer, 2005; Vega & O'Leary, 2007). Kimmel (2002) cites evidence that women may slap or push partners to get them to pay attention rather than hurt them. Comparisons between the CTS and other measures also provide examples of how respondents' perceptions of an act may differ from researchers', particularly with regard to whether an act counts as violent. When both partners in a couple are interviewed they may not agree on the occurrence of violence in their relationship (Shafer *et al.* 2002; McHugh *et al.*, 2005). DeHart *et al.*, (2010) investigated contextual influences and found that people's judgments as to whether behaviour was abusive were made mainly on the evidence of harm caused.

2.3   Incidence and Prevalence

A number of factors influence both the quality and comparability of statistics on the incidence and prevalence of domestic violence: inconsistencies in the way that violence and abuse are defined make it difficult to distinguish between psychological or physical violence; differences in selection criteria e.g. age, marital status; differences in the population e.g. participants from a 'community' sample or clinical population; and differences arising from the use of either surveys or self-reports about self and/or a partner, both of which depend on the degree of honesty and openness of participants (Krug *et al.*, 2002). As a consequence, the direction of violence between men and women and what counts as an 'incident', or reciprocal, continue to be contested in the UK and elsewhere. It

is, however, generally agreed that intimate violence is under-reported (George, 1994; 2007; D'Ardenne & Balakrishna, 2001; Dewar, 2008; Emery, 2010); but that violence is more likely to be reported when the assailant is male and the victim female, due in part to commonly held beliefs that women should be protected (Felson & Feld, 2009). It has been argued that different statistics may be presented in support of different conclusions (Archer, 2000; Kimmel, 2002; McHugh *et al.*, 2005; Kelly & Johnson, 2008; Brownridge, 2010). Intimate partner violence has, for example, been found to be more common and more severe in cohabiting couples than in both dating and married couples, though others argue that the reported problems differ (Hsueh *et al.*, 2009; Stets & Straus, 1989). Critics of feminist perspectives have accused domestic violence activists of inflating the numbers of female 'victims', and feminists have, on the other hand, accused their critics of a backlash against battered women (Young, 2005; Girard, 2009).

2.3.1   UK incidence and prevalence

Up to 2001 the British Crime Surveys (BCS) provided estimates of the numbers of incidents of domestic violence in England and Wales, every two years. Since then the Home office has published estimated numbers in annual publications. As these estimates are based on people reporting actions they perceive as crimes, and since not all people regard domestic abuse as a crime, Dewar (2008; 2011) suggests that HO figures may underestimate the actual extent of domestic violence, particularly against young men. For example, the proportions of the numbers of male victims reported in the supplement to BCS 2007/8 were more than double the 15% for the number of incidents estimated by the routine BCS 2007/8 (Dewar, 2011). Furthermore, a pilot study of 9 police forces in 2007/8 showing a disparity between HO and police reporting of male victimisation suggests 'either a substantial level of under-reporting by male victims to the police, much more than that of female victims, or that the police are responding inadequately, or inequitably, to male victimisation' (Dewar, 2011, p. 10). Hester (2009, p.3) reports that 'little is known about the nature of incidents where men are recorded as victims', and her research exploring, 'who does what to whom', in 96 cases where men, women or both were 'perpetrators' found differences by gender e.g. men more likely to engage in physical violence and create a context of fear, and women were more likely to use weapons and verbal abuse.

Prevalence and incidence rates across HO studies have tended to vary, but it has not been possible to determine how much difference can be attributed to changes in behaviour or reporting, given that there have been some methodological differences in the surveys up to 2001 when the questionnaire was changed (Walby & Allen, 2004). However, changes in reporting incidents to the police have been found: in 2001/2 35% of domestic violence incidents were reported to the police; by 2008/9 this had risen to 47% and at the same time there has been a fall in the incidence of domestic violence and an increase in the use of

services. The increase in service take-up has been linked to the extension of injunctions and legal remedies, changes in media portrayal of domestic violence and other policy developments, such as more health service screening, that have encouraged people to seek help (Walby, 2009).

Eight detailed surveys of domestic violence, specifically intimate violence, in England and Wales have been carried out since 1995 as supplements to the BCS, using a computerised self-completion questionnaire to maximise 'victims'' willingness to report domestic assaults and threats and thus provide a 'reliable' report of the incidence and prevalence of domestic violence (Mirrlees-Black, 1999). All the studies showed a higher incidence of intimate partner violence overall than indicated in the BCS and 'a substantial level of female abuse and violence in intimate relationships, with a correspondingly high level of male victimisation'. The first detailed report on the supplement to 1996 BCS, revealed an 'almost equal culpability between men and women': 4.2% of men and women reported an assault by a partner and there were an estimated 3.29 million incidents against women and 3.25 million incidents against men (Dewar, 2011, p. 4; Mirrlees-Black, 1999). But, women's chances of serious assault were reported as greater than men's, on average and, women far more likely than men to be repeatedly assaulted.

Findings from the BCS supplement to the 2001 BCS, presented in a second detailed report, indicated that 1 in 5 women and 1 in 10 men were victims of domestic violence and there were 'extremely high levels of repeat victimisation, in particular, of domestic violence' (Walby & Allen, 2004, p. i). It was estimated that 6% of women and 4.5% of men experienced domestic violence during the previous 12 months, where domestic violence is defined as non-sexual abuse, threats or force. In the third detailed report it was found that incidence of domestic violence had fallen 59% between 1995 and 2004/5 and differences between male and female victimisation were less marked. However, rates of stalking reported by both men and women were higher than domestic violence, at 9% for both (Finney, 2006).

The 2006/07 BCS reported that 4.3% of men and 5.6% of women were victims of domestic abuse (ratio of 43.4%: 56.5%) 1.7% of men and 1.8% of women were victims of 'severe force' (ratio of 48.6%: 51.4%). There was no statistically significant change in either the proportion of men or the proportion of women experiencing domestic abuse between the 2008/09 and 2009/10 BCS. In 2009/10, as in previous years, (non-sexual) partner abuse was the most common type of domestic abuse, experienced by five per cent of women and three per cent of men in the last year. The BCS 2009/10 supplement indicated 4.6% of women and 2.6% of men reported non-sexual partner abuse, excluding stalking, a proportion of male victims of 36.1% (Dewar, 2011).

The prevalence of alcohol-related domestic violence has been reported (Mirrlees-Black, 1999; Finney, 2004). Research has found links between domestic violence and both drinking at the time of the incident and what was defined as problem drinking. Men and women who drink heavily were found to be more likely to report domestic violence (Mirrlees-Black, 1999). The likelihood of violence escalating and being more severe was found to be related to levels of alcohol consumption by the perpetrator. Though victims were found to be less likely to be drinking, some may have developed drinking problems as a response to being victimised (Finney, 2004). According to the 2009/10 BCS, victims believed the offender(s) to be under the influence of alcohol in half of all violent incidents, similar to the level in the 2008/09 survey.

Prior to the Home Office call to end violence against women and girls (2011b), the HO website provided figures based on reported incidents of domestic violence in the UK: 1 in 4 women and 1 in 6 men will be victims of domestic violence in their lifetime with women at greater risk of repeat victimisation and serious injury; 44% of victims were involved in more than 1 incident; domestic violence claims the lives of about 2 women per week, killed by a violent partner, or ex-partner (HO, 2011a). In the UK, according to the government Annual Progress Report on the National Domestic Violence Delivery Plan (HO, 2009), domestic violence accounts for 14% of all violent incidents and has more repeat victims than any other crime, accounting for 66% of all incidents of domestic violence. The Department of Constitutional Affairs (2004) estimated that 16000 male perpetrators of domestic violence had contact with the civil court system in any one year. Stanko's (2001) 'snapshot' of the impact of domestic violence and abuse on a day in 2000 found that police received a call about domestic violence at a rate of one per minute and that it was mentioned as an issue in the relationship in 1 in 5 counselling sessions held in Relate centres across England.

2.4   Impact of Violence and Abuse in Intimate Relationships

Research evidence indicates that intimate partner violence is a health care issue, causing negative impact on the psychological functioning of women who have been victimised even after the abuse has ended (Allen *et al.*, 2007; Tower, 2007). Indeed, the impact on the mental health of both male and female victims in abusive or violent relationships has been described as 'daunting' (Hines & Saudino, 2002, p. 212), although couples may not perceive IPV as their main problem (DeBoer *et al.*, 2012), and a meta-analysis by Stith *et al.* (2008) found the association between relationship satisfaction and violence to be only small-to-moderate.

The health effects resulting from domestic violence have been recognised by the WHO and the HO (Taket *et al.*, 2004; Krug *et al.*, 2002). Immediate and long-term, cumulative effects on the physical health, behaviour and psychological functioning of female victims have been

identified and these may be direct in terms of physical injury, or indirect, manifest in poor mental health or substance misuse as a means of coping. Victimised women were found to have had more surgery, more doctor and mental health consultations in their life-time than non-victimised women (Krug *et al.*, 2002); and be at increased risk of depression, psychosomatic disorders, anxiety, panic attacks, self-harm and attempted suicide, as well as a variety of physical health consequences (Taket *et al.*, 2004). Low self-esteem, past year Post Traumatic Stress Disorder (PTSD), and past year alcohol dependence were significantly associated with intimate partner violence after controlling for other self-appraisals and mental health disorders, using data from a national sample, n=590 (Whiting *et al.*, 2009); greater use of drugs, disengagement, denial, and self-blame as coping mechanisms in a sample of 100 'battered' women were associated with increased dysphoria and low-self-esteem (Clements *et al.* 2004).

There may also be adverse effects on children who witness domestic violence (Kernic *et al.*, 2003): a recent study of 7865 children in the UK who had witnessed violence between parents, of which 4% witnessed severe violence, were found to be more likely to develop conduct disorders (Meltzer *et al.*, 2009). From a meta-analysis of 41 studies in Canada, forty of these studies indicated that children's exposure to domestic violence was related to emotional and behavioural problems, showing a small overall effect (Wolfe *et al.*, 2003).

The impact on men is less well-documented, but a recent US study in which 1669 men seeking healthcare were screened found co-occurring mental health and substance use problems, in particular for men who disclosed both perpetration and victimisation: cumulative risks of depression, PTSD, suicidal ideation and substance misuse were found to be related to violence in relationships (Rhodes at al, 2009). Studies have found that both men and women who have been victimised may suffer depression, PTSD and psychosomatic symptoms as a consequence (Hines and Malley-Morrison, 2001; Hines & Saudino, 2002); and men and women with poor health are more likely to experience intimate partner abuse than those in good health (Watson & Parsons, 2005; Finney 2006).

Research suggests that people may perceive psychological aggression as a normal part of couple conflicts (Carroll *et al.*, 2010), and not as harmful as physical violence (Capezza & Arriaga, 2008). Indeed, Follingstad & Edmundson (2010) found that those who engage in psychological abuse towards a partner may under-rate the impact. However, the effects of psychological aggression, which include emotional withdrawal and verbal aggression, have been rated by women who have been victimised as having a more negative impact than physical aggression (O'Leary, 1999; Jordan *et al.*, 2010). For both women and men, being victims of psychological aggression was associated with greater psychological distress, anxiety, and physical health symptoms beyond the effects of physical aggression in a community sample of 145 heterosexual couples (Taft *et al.*, 2006). Analysis of data from the

National Violence Against Women telephone survey which included questions about violent victimisation and health status indicators found that 28.9% of 6,790 women and 22.9% of 7,122 men had experienced lifetime physical, sexual, or psychological IPV and that emotional abuse, which involved use of control tactics, had more negative consequences than verbal abuse (Coker *et al.*, 2002). Researchers holding different perspectives on domestic violence have called for more research that collects evidence of abusive behaviours in addition to acts of physical violence (Dobash *et al.*, 1992; McHugh & Frieze, 2006; Langlands *et al.*, 2009).

Although there is much evidence indicating the serious impact of domestic violence on health, various reports suggest that victims of domestic violence may receive a poor response from mental health services in the UK (Robinson & Spilsbury, 2008; Department of Health (DH) 2002). Research in the UK has questioned the benefit of screening women for abuse despite Department of Health (2000) advice to do so (Feder, 2005; Ramsay *et al.*, 2002). It has been suggested that health professionals may fail to recognise problems as domestic violence, or may appear to blame the victim (Humphreys & Thiara, 2003; Tower, 2007; Corbally, 2010); feel uncomfortable about interacting with 'victims' (Allen *et al.*, 2007); or may rate same-sex violence as less serious than heterosexual violence (Brown, 2008; Brown & Groscup, 2009) and that practitioners may recognise the importance of screening but few actually do this (Briere & Jordan, 2004; Feder, 2002; Samuelson & Fox, 2003). Furthermore, social norms about female violence may be unclear and can mean that health professionals may regard violence by women as less serious than when perpetrated by men (Follingstad *et al.*, 2004).

Taket (2004) recommended that health services should aim to identify and support women experiencing domestic violence. A UK review (Taket *et al.*, 2003; 2004) highlighted the importance of education and training of clinicians in promoting disclosure of abuse and appropriate responses and made a case for routinely inquiring about partner abuse in many healthcare settings. Another review, of 10 studies of screening for domestic violence in healthcare settings in the UK, US and Australia, concluded that victims had difficulties when accessing health services and found that they perceived these difficulties to be attributed to 'inappropriate responses by healthcare professionals, discomfort with the healthcare environment, perceived barriers to disclosing domestic violence, and a lack of confidence in the outcomes of disclosure to a health professional' (Robinson & Spilsbury, 2008, p. 16).

2.5 The Role of Government Policy in Naming the Problem and Determining Good Practice

Policies and resources in the UK have centred on the provision of services to support and protect women and children, taking the view that domestic violence is perpetrated by men and that it is also 'an indicator of violence towards children' (HO, 1999, p.3 and 7; DH, 2000; 2005). More recently, the Home Office introduced a plan to end violence to women and girls (2011b). Over the past 10 years there has also been more focus by the HO on developing treatments for male perpetrators (Hester *et al.*, 2006). Approaches to working with offenders or perpetrators of domestic violence initially involved anger management programmes, focused on the development of self-awareness and ability to inhibit anger arousal. These fell out of favour as, from a feminist perspective, increasing male perpetrators' skill in control was considered dangerous for victims and did not address the pattern of purposeful violence and controlling behaviours that was believed to characterise male violence (Langlands *et al.*, 2009).

The predominant approach used in the UK since the 1990s is based on the original Duluth model developed by activists in the battered women's movement (Pence & Paymar, 1993; Rivett, 2006). Programmes include the Duluth Domestic Abuse Intervention Projects (DAIP) and the Integrated Domestic Abuse Programme (IDAP) (HO, 2005b) in the Probation service. These are generally 26 week 'open' group-work programmes for male perpetrators informed by feminist ideas and Cognitive Behavioural Therapy (CBT), widely used in the probation service, domestic abuse programmes run in prisons and in services where treatment is not mandatory (Rivett, 2006). The approach is based on the assumption that violence is perpetrated by men purposefully to maintain power and control over women and aims to challenge beliefs about entitlement and power informed by patriarchal ideas. It has become the basis for good practice guidelines by Respect (2004), the UK organisation supporting perpetrator programmes, though reviews suggest these programmes have limited effectiveness (Babcock *et al.*, 2004; Langlands *et al.*, 2009). High attrition rates, methodological limitations due to differences in terminology which make comparisons between studies problematic and the emphasis on physical violence are some factors these studies mentioned.

The Domestic Violence, Victims and Crime Act, (HO, 2005a) has placed more emphasis on treatment of perpetrators, and assessment, which, Rivett (2006) suggests, points to the need for more involvement by mental health practitioners and hence a reduction in the divisions between these services. Recognition by government that domestic violence was a 'major public health issue' may be seen as informing a move towards integration of practice and provision of services (DH, 2000, p. 2). This was evident in the development of multi-agency domestic violence forums and Multi-Agency Risk Assessment Conferences (MARAC) as

part of a coordinated community response to domestic abuse, incorporating representatives from statutory, community and voluntary agencies working with victims/survivors, children and the alleged perpetrator. Indeed, the Government's stated intention with the launch of the 'Violence Against Women Initiative' (VAWI), was to place domestic violence firmly on the public and social policy agenda with a funded programme for a range of domestic violence projects (DH, 2000), and reviews (Walby & Myhill, 2001). This followed 'Living without Fear- an Integrated Approach to Tackling Violence against Women' (HO, 1999) which located domestic violence in the Crime Reduction Programme (CRP). These projects were based on Co-ordinated Community Responses (CCR)(Hague & Bridge, 2008) and, more comprehensive than the multi-agency approaches referred to above, their commitment was to create institutional and social change. 'Woman/women' was the term used throughout the subsequent report, for those victimised as few projects provided services to and/or had referrals from male victims of domestic violence, reflecting what appeared to be pro-feminist agenda (Hester & Westmarland, 2005).

Defining domestic violence as a crime and referring to it as a healthcare issue for women and children would seem to mark a shift in perception away from constituting violence and abuse between intimate partners as a complex social problem, towards an emphasis on treating the individual, whilst continuing to conceptualise domestic violence as the exercise of patriarchal power and control. The potential re-positioning of the problem, in the context of the medical model of care, for example, means that the issues are medicalised and become the responsibility of the NHS and other healthcare professionals (Lavis *et al.*, 2005). Lavis *et al.* (2005) argue that whilst on the one hand this has led to more funding for research and some development of service provision, on the other the categorising and pathologising of individual behaviours suggests that the social context may be obscured or minimised and at the same time, socially sanctioned representations of men as naturally aggressive and women as naturally passive and powerless may go unchallenged. The authors suggest that the process of naming and diagnosing the problem has the potential to be oppressive and blaming of female victims, whilst preserving the clinician's emotional detachment, despite the prevalence of female professionals making these clinical judgments.

2.6   Provision of Services in the UK

The Map of Gaps: the postcode lottery of Violence Against Women (VAW) support services in Britain (Coy *et al.*, 2007; 2009) was produced in partnership with the Equality and Human Rights Commission for VAW to set out the provision of domestic violence services for women and children across the UK. The findings were:

- Nearly one in four local authorities has no specialised domestic violence service.

- Only 22 Local Authorities (LA) out of 408 could claim to have a range of provision (defined here as four or more services).

- Of the new services opened in 2008, 60% were in statutory sector. Since the majority of women still choose not to report the violence to the police, statutory provision only deals with a fraction of the problem.

- A total of 500 voluntary sector domestic violence services were identified, including specialised BME projects and perpetrator programmes with associated women's support services. Whilst comprising the majority of services, voluntary domestic violence provision was not found to be comprehensive across Britain. Levels of provision were found to have remained static since the first Map of Gaps and many faced closure in 2009/10 due to lack of funding (Coy *et al.*, 2008).

No equivalent map has been produced to document service provision for men. According to the Mankind Initiative (2008) there is a clear mismatch between the proportions of men and women who are victims of severe force within a relationship and the help available to them. There are only a few organisations in England and Wales (none in Scotland or Northern Ireland) with specific refuge provision for male victims (only 10 refuges with about 50 spaces with 18 of these for gay men)(Coy *et al.*, 2009).

2.7   The Role of Practitioners and Therapists in Naming the Problem

The practice of 'talking therapy' has evolved in a particular social, cultural and historical context that values individual autonomy and self-expression. A social constructionist perspective provides a framework for understanding the role of language and the therapist in this process of helping another person to make sense of their experience and to understand concepts such as the self and human agency (Neimeyer, 1998). When research and therapy practices name women as 'victims' and men as 'perpetrators', they play a role in prescribing the discourses and potential positions available to those who are involved in intimate partner conflict. Therapists may thus become instrumental in influencing the dynamics of responsibility by positioning themselves as the one who knows. This may be experienced as supportive to 'victims', but dismissive or confrontational to 'perpetrators'. Therapeutic interventions may thus be understood as relational acts, whose consequences will depend on the context (Safran & Muran, 2000).

Psychological knowledge and therapeutic understandings of the self, legitimising certain ways of understanding personal distress, bring into the public domain suffering that may formerly have remained private. The therapeutic culture this has generated has been criticised as encouraging a preoccupation with the self and giving rise to a cult of

victimhood (Wright, 2008). On the other hand, whilst therapists may see themselves as enabling clients to find a voice, their practices are regulated by social institutions that determine who can be a client and what focus is relevant and ethical, so legitimising certain ways of speaking and marginalising others (Zavos, 2005). In this way, therapists may be accused of serving a regulatory function as ethical agents, drawing on theories and codes of practice that guide the joint construction of the problem and an understanding of how it can be solved. In this process, the inequality of power relations inherent in the relationship between therapist and client may be concealed and constructed by the exercising of a professional role which sanctions the expert view and diagnosis of the problem (Neimayer, 1998). Practitioners may thus unintentionally impose their own constructions of reality on their clients (Peled *et al.*, 2000).

However, it could be argued that a view of therapy practice as either a form of social control or contributing to a moral collapse is unduly pessimistic (Wright, 2008). Such a view underplays the potentially constructive outcome of drawing attention to hidden, private suffering such as may occur within intimate relationships. It also appears to ignore the way in which morality may be constructed in domestic violence counselling and to negate the liberal intentions of good practice as fostering client autonomy (Kurri & Wahlstrom, 2001). Theories about ethics of care, justice and what constitutes the 'good life' and a healthy relationship contribute to constructed understandings of how things 'should' be. Therapists' constructions of the 'facts' presented by the client are guided by their understanding of how these ethical issues apply to domestic violence. Kurri & Wahlstrom (2001) suggest that therapists try to manage the moral dilemmas that arise in accordance with 3 rules: respect the client's decision; violence is always wrong; help the client in their situation.

In practice, tensions may arise when therapists are faced with complex or confusing material, causing an impasse, which they may resolve by reification or avoidance (Safran & Muran, 2000). For example, when a client in an abusive relationship chooses to remain, the wish to empower the client and respect their right to make their own decisions about their life may conflict with normative judgements about violence being wrong and violent relationships, bad. Research indicates, nevertheless, a slight general tendency to attribute blame and responsibility to female victims, by both non-therapists and therapists, particularly in cases of alleged rape, though this tends to vary in accordance with the degree of identification with the victim (Idisis *et al.,* 2007). Safran & Muran (2000, p. 37) suggest that therapists 'constantly struggle with the temptation to hold onto fixed conceptions of what is taking place between us and our patients', in order to 'deal with the anxiety and discomfort of ambiguous situations' and impose some order. Because therapists working with abused women will expect to empathise with their clients and not be judgemental, they may avoid potential tension and regulate an intense emotional response by taking an overly judgemental stand about a 'perpetrator's' behaviour, and suppressing negative feelings or

judgements about the 'victim' (Goldblatt, 2009). Questions concerning a client's responsibility for choosing their behaviour may therefore be avoided because they seem to point out a moral failure and shame the client, violating the first rule, or because they seem to violate political correctness (Hamel, 2010).

Consistent with Festinger's (1957) cognitive dissonance theory, practitioners may be understood as striving to maintain consistency in their world-view and the system of beliefs they hold about their own and others' behaviour, and when these are not in harmony tension is produced, which they would seek to reduce (Idis *et al*., 2007). Defensive manoeuvres, such as a bias in perception or judgement may function to inhibit or eliminate the experience of cognitive dissonance or emotional unease and keep unacceptable thoughts and feelings out of awareness. Pyszcynski *et al*., (1993) argued further that these dissonance processes may occur outside awareness and therefore people may not be consciously aware of the tension or, what has contributed to the tension should they experience this. It may be, for example, that blaming 'perpetrators', functions to emphasise difference and thereby keep out of awareness a practitioner's own capacity for aggression. Nevertheless, denial or avoidance of an emotion, or strategies that distance or protect from perceived attacks on one's beliefs can lead to inaccurate perceptions of reality, self-defeating behaviours, harm to others and evoke an array of emotions and strong sense of responsibility for protecting victimised clients, referred to as 'emotional labour' (Pyszcynski *et al*., 1993; Goldblatt, 2009).

Furthermore, Thapar-Bjorkert & Morgan (2010) argue that tensions between non-blame and responsibility may result in female 'victims' being explicitly told by practitioners that they are blameless, whilst being implicitly blamed for provoking a partner, or in some way causing the abuse. Others also suggest that professionals' common sense understandings convey gendered discourses that blame women (Barter, 2006), or that psychoanalytic discourses inappropriately locate responsibility in victimised women when they have experienced repeated abuse (Reavey & Gough, 2000). This may represent an expression of tension between, on the one hand an attempt to preserve belief in a 'just world' theory that people get what they deserve, emphasising difference between therapist and client, and on the other hand, an intention to empathise, that requires some identification with the 'victim's' perspective. However, not addressing issues of personal responsibility may also preclude the possibility of looking at options which might encourage autonomy (Lamb, 1996). Kurri & Wahlstrom (2001) suggest that skilful therapists manage these complex issues by preserving the client's status as a moral agent rather than taking up a position of offering prescriptive advice or not addressing issues of responsibility.

Working with female 'victims' to challenge self-blame, empower them and enable them to make choices has, nevertheless, been the main focus of therapeutic work (Milner, 2004;

Peled *et al.*, 2000). Though some researchers and clinicians have begun to argue a case for working with some couples, this remains contentious because of concerns about the risk this may pose to women (Stith *et al.*, 2004). Interventions with 'perpetrators' continue to be mainly carried out in group programmes designed to address patriarchal beliefs about entitlement and power and the specific cognitions and behaviours arising from those beliefs (Babcock *et al.*, 2004; Langlands *et al.*, 2009). Therapists confront victim blaming, denial, minimisation or attempts to explain the abuse and may discourage discussion of personal histories as this is seen as justifying the abusive behaviour (Taft & Murphy, 2007). It would appear that the focus of work with 'perpetrators' has primarily been on rule 2: violence is always wrong and holding 'perpetrators' to account, rather than respecting their decisions, fostering client autonomy and understanding the context. The justification for this approach has been that therapeutic work with individual male 'perpetrators' or couples was considered dangerous for 'victims' since understanding the causes of the violence or abuse would provide an excuse for the 'perpetrator's' actions and put 'victims' at further risk (Bograd & Mederos, 1999; Brown, 2004). However, it may be tempting to hold onto routinised ways of understanding the problem, as this avoids dealing with what may be ambiguous or contradictory material (Safran & Muran, 2000), and the potential dissonance this might arouse.

Research has increasingly brought into question the habitual, taken-for-granted assumptions underpinning the approach that there is a prototypical abuser (Holzworth-Munroe & Stuart, 1994; Rivett, 2006). This highlights a need for more flexible ways of working that take account of individual differences, eschewing a tendency to grasp premature formulations of the problem (Safran & Muran, 2000). Furthermore, clinicians and researchers have begun to argue that though it may be difficult to develop rapport and collaboratively agree the tasks and goals of therapy with angry clients who behave abusively, forming a working alliance is critical to enabling them to make changes (Bordin, 1979). Gadd (2002; 2003) suggests, for example, that we need to understand conflicts within masculinities, by attending to the individual accounts of abusive men and their different motivations.

Research consistently demonstrates that a positive working alliance/therapeutic relationship is predictive of successful treatment across a range of client groups, accounting for more variance in outcomes than specific therapeutic approaches, or indeed differences in clients' interpersonal skills, or therapists' skills (Taft & Murphy, 2007). Better working alliance ratings by individuals in domestic violence programmes have been found to distinguish completers from those who drop out (Rondeau *et al.*, 2001). Other research suggests that group programmes' use of confrontational strategies is likely to impact negatively on the client's perception that the therapist intends to help them and on their commitment to working towards change and may even increase their anger, denial and abusiveness (Scalia, 1994). Rosenbaum & Leisring (2003) also note that males who have been victimised as

children stop being treated with understanding if they become abusive adults, and the question as to why they might want to gain power and control is rarely addressed.

It has also been argued that confrontation demonstrates the power of male professionals to impose their will on others and to know what they think and encourages stereotyping and constructions that 'demonise' men who behave abusively, as 'no use', irrelevant' and a 'threat' to women and children (Milner, 2004). Dutton & Corvo (2006, p. 461) refer to the atmosphere generated in Duluth-based programmes as one of 'judgement and humiliation' and not conducive to developing trust and honest engagement. Since many abusive clients were themselves abused as children, (Dutton, 2008), treating them in a non-judgmental, empathic and respectful manner may be crucial to overcoming mistrust and enabling them to express emotions and explore the unresolved past trauma, which may be maintaining their problems. It has been argued that the continued use of approaches found to be ineffective, coupled with concerns that 'perpetrators' often have serious mental health and substance abuse problems that are not addressed in these programmes mean that professionals may be accused of violating their codes of ethics (Corvo *et al.*, 2009).

2.8   The Role of Supervision in Naming the Problem

Clinical supervision is recognised as a separate activity from counselling and psychotherapy practice but one that is integral to its professional and ethical delivery (British Psychological Society (BPS), 2007; DH, 1998). Research indicates that practitioners, particularly trainees, regard supervision as important for their professional development, but may be dissatisfied with the quality of supervision they receive and may even perceive it as harmful when they feel criticised (Jacobsen & Tanggaard, 2009). There is a lack of clarity as to what 'good' supervision would constitute, how this is defined and how it is understood by practitioners (Milne, 2007). Hawkins & Shohet (2006) refer to 'good enough' supervision, like Winnicott's (1991) concept of 'good enough' mothering, as providing the support that enables a therapist to withstand their own and the client's disturbance. It has variously been defined as: 'to oversee... with connotations of authority and line-management.' (Carroll, 1996, p. 6); a reflective space that facilitates learning and promotes the welfare of both client and supervisee through a focus on relationship dynamics (Gilbert & Evans, 2000); Educative, (formative) supportive (restorative) and administrative, (normative) (Inskipp & Proctor, 1995); 'enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients he, she, or they see, and serving as a gatekeeper for those who are to enter the particular profession' (Bernard & Goodyear, 2004, p. 8).

What constitutes good enough supervision may vary according to the experience, development and competencies of the therapist, so trainees' needs may be very different

from what a more experienced practitioner requires (Hawkins & Shohet, 2006; Rønnestad & Skovholt, 2003). Whatever their experience, however, therapists are expected to bring difficulties to supervision and talk openly about these, and awareness that they are being evaluated can create tension and conflict. Similarly, supervisors may experience pressure and conflict regarding their responsibilities for monitoring and supporting trainees. Research suggests that whilst all new trainees want a supervisor who has relevant experience, sound theoretical knowledge and gives clear advice, support and affirmation, they may differ in terms of their ability to handle perceived criticism (Jacobsen & Tanggaard, 2009). They may be particularly prone to being caught in a therapeutic impasse when complex or confusing material seems to challenge their competence and sense of worth as a therapist (Safran & Muran, 2000).

More experienced and competent therapists may be open to discussing disagreements or conflicts that may emerge due to transference issues from either the therapeutic or supervisory relationship and more able to acknowledge and learn from their own mistakes. The way supervisors manage this conflict and model the handling of ruptures to the alliance provides important learning for the therapist about their own ability to survive misunderstandings and tolerate the making of mistakes, which, in a parallel process, is likely to be re-produced in the client-therapist relationship (Nelson *et al.*, 2008). However, there is power asymmetry inherent in both relationships. In the supervision context this creates the potential for supervisors to set the agenda, imposing their own ideas and blurring boundaries between supervision and therapy, which for trainees may be difficult to contest. Trainees who may fear that their training or career may be compromised by admitting mistakes or difficulties may feel constrained and also fearful of being embarrassed or shamed by their lack of knowledge or understanding (Pack, 2009).

Whilst there is a moral imperative to take precautions to protect vulnerable people from further harm in therapy, the emphasis on monitoring for safe practice in supervision has been criticised (Crocket, 2007). In assuming moral authority it may be understood as reflecting the culture of counselling and psychotherapy as being one of control or surveillance. The supervisor may be seen as the one with the answers, who knows what is good practice. In their practice they may thereby reproduce taken-for-granted notions about responsibility being uni-directional, which means that just as the supervisor takes clinical responsibility for the supervisee, the therapist may feel totally responsible for their clients. The shaping of the therapist's ideas in this way in supervision has implications for clients too, as a therapist may learn from supervision to reproduce the same relationship dynamic in which he/she is the one with the answer and knows what is 'right'.

These issues have particular resonance for working with clients involved in disturbed relationships in which attributions of blame and denial of responsibility feature (Overholser

& Moll, 1990). Clients' material can provoke intense, and often contradictory, emotions of distress and anger in practitioners (Goldblatt, 2009). Some may experience this tension as cognitive dissonance arising from the competing perspectives of an empathic therapist and a judgmental observer, from which they may escape by becoming overly judgmental, or by distancing from their own and their clients' emotions (Idisis *et al.,* 2007). Whilst some therapists may bring such issues to supervision, Pszcynski *et al.,* (1993) suggested that sometimes people may remain unaware of this tension, or what elicited it, unless invited explicitly to express their feelings. The proposition that the expression itself of this tension may reduce the effect of, and need for, any defensive dissonance-reducing cognitive bias, supports the role of supervision in helping to mediate a tendency for therapists to either over-identify with clients or become overly judgmental as means of reducing, or avoiding dissonance. Furthermore, West *et al.* (2012) argue that blind spots can arise because people tend to make judgments about others based on behaviour, but rely on introspection to evaluate themselves, often failing to notice unconscious processes that may be the source of a cognitive bias. Engagement in a reflective process with a supervisor provides an opportunity to raise awareness, by inviting consideration of alternative ways of conceptualising a problem.

Nevertheless, making judgements about who, or what, is the cause of a situation or outcome in an interpersonal context is not straightforward, and a number of factors may affect such attributions, influencing people to attribute cause to situational or dispositional factors (Klein *et al.,* 2011). For example, therapists may draw on their professional and personal experience or 'just world' beliefs to make erroneous causal inferences when deciding who is responsible. In addition, therapists may feel pressured into instrumental problem-solving discourses because of feeling responsible for ensuring the safety of those at risk of harm or holding to account someone who has behaved abusively and denies or minimises the impact of this. Crocket (2007) suggests that supervision that understands responsibility as constructed in relationships would re-conceive responsibility as multi-directional rather than held by one person. This would have implications for supervisors and therapists working with domestic violence where initial naming of the problem can close down the potential for understanding the relational context.

2.9   Personal and Professional Impact: Implications for Training and Supervision

It may be particularly difficult to remain non-judgemental when hearing clients talk about abusive behaviour (Morran, 2008). Risk issues and the presence of intense emotions can create pressure to feel and act rather than reflect. The ongoing work may pose particular challenges with regard to therapists managing fear for the safety of their clients and themselves, issues of confidentiality and the power dynamics re-produced in the therapeutic

relationship. There has been limited research conducted about the personal and professional impact of working with domestic violence and still less said about supervising this work. Studies include one in Australia, exploring counsellors' experiences of working with perpetrators and survivors (Iliffe & Steed, 2000) and a UK study of 30 practitioners, including probation officers, support workers and therapists, working in domestic violence offender programmes (Morran, 2008). Both studies suggest that the emotional consequences of doing this work can be high and that having support to enable offloading of feelings, reduce isolation and to address the personal impact on self and other-perceptions were found to be crucial in enabling therapists to maintain professional practice and guard against burn-out. The effects were similar to those found in studies exploring the impact of working with traumatised clients, where the terms, 'secondary' or vicarious trauma have been coined to describe the various symptoms and disruption to their beliefs and emotions in relation to issues of safety, trust and intimacy in relationships, esteem, personal choice and autonomy and power (McCann & Pearlman, 1990).

In common with studies about counsellors working with other forms of abuse, some female practitioners reported experiencing 'anger, rage and even loathing for the men they worked with' and persistent 'perceptions of men as abusive, controlling and oppressive' (Morran, 2008, p. 146). Both men and women reported becoming more aware of how power and control issues affected their own relationships whilst men reported that they began to recognise aspects of the clients in themselves. Male workers were more inclined to perceive the clients as frightened whereas all but a minority of the women experienced them as frightening. Whilst for both men and women the work resonated with their personal lives, past and present, females were particularly affected by the expression of demeaning attitudes towards women and identified with the female partners of the clients. There were implications for both training and needs for supervision: participants considered the training to be inadequate in helping to establish meaningful relationships with clients and understand the nuances and complexity of working with domestic violence; the quality and amount of support/supervision made available for workers was rated as reasonable but left some feeling unsupported, compounding feelings of isolation and that their work was not valued or taken seriously enough (Morran, 2008).

2.10   Summary

This chapter has set out ways in which the practices of researchers, policy-makers and clinicians contribute to the naming of the problem of intimate partner violence, how it is reported, and the development of particular kinds of services. It highlights how these understandings and practices are constructed in a particular social, cultural and historical context and re-produced in both private and public domains, generating representations and evidence in support of accepted 'truths' i.e. that men are 'perpetrators' and women are their

'victims'. In the next chapter, different ways of conceptualising the problem and their implications for clinical practice are set out.

CHAPTER 3: CONCEPTUALISING THE PROBLEM OF INTIMATE PARTNER VIOLENCE AND ABUSE: IMPLICATIONS FOR PRACTICE

3.1   Introduction

> 'Once domestic violence had been given a name, different theories and explanations concerning it began to emerge' (Kurri & Wahlstrom, 2001, p. 188).

This chapter sets out how the initial naming of the problem both reflects and reinforces particular assumptions as to its cause and how to intervene in practice. O'Leary *et al.* (2007) identify three broad perspectives on the problem: feminist; those which emphasise individual problems; and those which focus on the dyadic relationship.

3.2   A Socio-cultural Feminist Perspective

Public concern and a more law-enforcement-oriented approach to domestic violence began first in the US in the 1970s when the assault rate on wives by their husbands was first documented (Stets & Straus, 1989; Young, 2005). This movement for social change emerged in the context of anti-war protests and a growing feminist movement, that sought to re-conceptualise what had previously been considered a private family dispute, as a social and political problem and create service provision for women and children (Young, 2005; Lehrner & Allen, 2009). Explanations of domestic violence as the 'natural' expression of women's wish to be kept in line and men's need to be in charge were reinterpreted by feminist theory as being related to issues of power and the relative dependency of women (Kurri & Wahlstrom, 2001).

3.2.1   The gender paradigm or battered women's movement

From its inception over 30 years ago, the battered women's movement claimed that male violence against women was motivated by a belief central to a patriarchal discourse, that men were entitled to have power over and control women and this has generated a body of research in the gender paradigm (Dobash *et al.*, 1992; Walker, 1999; Dutton, 2008; 2007a; Dutton & Corvo, 2006; Murray & Powell, 2009). From this perspective, in any domestic violence situation a clear, gender-based distinction can be made between the abuser and the victim (Young, 2005; Dobash *et al.*, 1992). Dobash *et al.* (1992, p. 83), described the context within which violence occurs between partners as one of 'perceived entitlement and institutionalised power asymmetry' and hence female violence was explained as retaliatory or committed in self-defence.

It has been contended that society is organised structurally to support and perpetuate patriarchy, legitimising male dominance and oppression of women and tacitly approving the use of violence to keep women in a subordinate position, with which they may sometimes be complicit. This notion of ''just cause'' is found in much qualitative data on violence from low and middle income countries, amongst women who believe that if they do something wrong, they deserve to be punished by their husband (Krug *et al.*, 2002). From a feminist perspective, this explains 'victims' tendency to blame themselves, which has been found to compromise their coping strategies, whilst blaming the partner is associated with more active and public coping strategies (Meyer *et al.*, 2010). On the other hand, men's sense of entitlement results in denial of their violence, blame of their female partners, and a misplaced belief that they are the 'victims' (Jukes, 1999).

Gendered theory, therefore, proposes that men need to be brought to account and require re-education in batterers' programmes, whilst women are in need of protection and empowerment, their capacity for agency, and to make choices, compromised. This has provided a rationale for supporting women to leave their partners, but increasingly, 'Why don't men leave?' is being asked (Murray, 2008). Feminist research, responding to the question, 'Why doesn't she just leave?' has rejected the question as inappropriately shifting blame from the 'perpetrator' to the 'victim', and proposed that the reasons are multi-faceted and that structural gender inequality affects their capacity to leave (Anderson *et al.*, 2003; Anderson, 2002; 2007). Others have questioned whether the act of leaving is in itself necessarily associated with improved well-being for 'battered' women (Bell *et al.*, 2007; 2009).

3.2.2 Unintended consequences

Whilst the movement for social change has thus been successful in criminalising domestic violence and establishing a range of services for female 'victims' and male 'perpetrators', there have been some unintended consequences. The change in criminal law and police practices both in UK, US and Australia, for example, has meant that more minor incidents of 'push-and-shoves' and 'yelling matches' are ending up in court cases and more women are arrested (Swan & Snow, 2003; Young, 2005). This has generated debate as to whether treatments for male 'perpetrators' are suitable for women who behave aggressively, and questioning of who is to blame (Carney *et al.*, 2007). Shaver & Drown (1986) point out that in the desire to hold someone to account for a crime, the constructs of causality, blame and responsibility can become muddled. As the authors outline, therapists working from a feminist perspective have tended to treat responsibility as a dichotomous concept, rather than a variable one, and to confuse this with blame, which applies to deliberate wrong-doing for which there are no mitigating factors.

Lamb (1999) suggests that 'either/or' approaches that assign men and women to pejorative categories invite both clients and therapists to engage in blaming or excusing abusive behaviour. She argues that feminists may be guilty of pointing the finger at 'perpetrators', inducing shame which is counter-productive in motivating them to change, and at the same time, exonerating female victims from responsibility or making choices, thereby disempowering them. She proposes that the same arguments should apply to 'victims' and 'perpetrators': both are morally responsible for their actions regardless of whether these were consciously chosen, or done in defence or retaliation; prior abuse may help explain but not excuse behaviour. She also challenges the therapeutic practice of separating out the abusive behaviour, suggesting that this both contradicts the idea that 'perpetrators' control their behaviour and discourages acceptance and integration of behaviours by externalising the cause.

3.2.3   Violence against men

During the past 35 years the dominance of patriarchal discourse coupled with alleged underreporting of violence and abuse against males and what Dewar (2008) referred to as 'bias' against male victims, has meant that evidence that rates of female violence were apparently similar to males' tended to be discounted or ignored by academics and health professionals (George, 1994; 2007; Frieze, 2008). Explanations for this include perceptions that female violence was considered less dangerous and women were presumed to have acted in retaliation, or in self-defence (Dobash *et al.* 1992; Dasgupta, 2002; Swan & Snow, 2002; Kimmel, 2002). 'Victims' who respond with violence/abuse have been more likely to report self-defence as a reason (Stuart *et al.*, 2006), though Flynn & Graham (2010, p. 249) found in their review that constructs such as retaliation are not uni-dimensional, and suggest that 'imprecise specification of perceived reasons' makes it difficult to draw conclusions.

Whether or not in self defence, research suggests that women are more likely to use weapons than men (Brown, 2004; George, 1994) e.g. 'hitting with an object, throwing an object and biting the victim' (Melton & Belknap, 2003, p. 345). However, given that male violence is condemned in western society, and female violence is regarded as less dangerous and relatively acceptable, gender stereotyping tends to give social credibility to females as victims, but not to males as victims (Bartholomew *et al.*, 2001). This may deter men from admitting their victimisation and seeking help: 'society does appear to condone the use of violence by a woman against a man' (George, 1994, p. 12). It has been suggested that health professionals may not be sufficiently sensitive in dealing with male victims and that male victims may be deterred from seeking help because of fear they will not be believed (Lawrence, 2003; Barber, 2008; Platt & Busby, 2009).

There have been criticisms voiced that there has been too much emphasis on male violence against women and insufficient acknowledgement of the problem of female violence and victims in same-sex relationships (Carney *et al.*, 2007; Dewar, 2008; 2011; Dutton, 2008; Graham-Kevan, 2007; Hamel, 2007; 2009; Straus, 2006; 2008; 2009; Young, 2005). Research indicates that women are capable of aggression (Allen *et al.*, 2009; Fitzroy, 2001; Graves, 2007; Ridley & Feldman, 2003; Richardson, 2005), though they are more likely to be labelled as mentally ill so incidents may be under-reported (Day *et al.*, 2003). Indeed, a review of over 200 studies by a British psychologist presented evidence supporting the view that women were slightly more likely than men to be perpetrators of violent acts against intimate partners, though slightly more likely to be hurt than men due to differences in size and strength (Archer, 2000). Fiebert (2009) also carried out a literature review, finding 79 studies demonstrating 'gender symmetry', though Kimmel (2002) strongly criticises the methodology of some studies on which the conclusions are based.

Whilst research findings support a general link between instrumental beliefs and aggression across student and shelter samples, this does not only apply to men (Archer & Graham-Kevan, 2003). Laroche (2005), using a nationally representative sample of 25,876, found that women use instrumental abuse i.e. to gain control over a partner, nearly as much as men, and Graham-Kevan & Archer (2009, p. 450) argue that men and women demonstrate similar degrees of controlling behaviour in intimate relationships 'counter to an evolutionary view that the link between partner violence and control is exclusively male'. Furthermore, other research has found reciprocity in intimate violence, though differences in the way this is defined mean that it is not always clear whether the term refers to behaviour occurring in the same situation, or at any other time (Follingstad & Edmundson, 2010). However, findings from a national on-line survey in the US, using reports on respondents' own and their partners' psychological abuse, indicated that psychological abuse was highly reciprocal, whilst overall, individuals tended to construe their partner's abuse as more frequent (Follingstad & Edmundson, 2010).

Whitaker *et al.*'s (2007, p. 941) study, using data about IPV from 11370 US adults, found that 'almost 24% of all relationships had some violence, and half (49.7%) of those were reciprocally violent. In non-reciprocally violent relationships, women were the perpetrators in more than 70% of the case'. Other research has found that where there is violence in relationships, the perpetrator is male in 25%, and female in 25% and in approximately 50% of relationships violence is mutual (Hines & Saudino, 2002); other studies found that 66% of men had wives who were also violent and 40% who hit them first (Dutton & Corvo, 2007; Dutton, 2008). Research from an attachment perspective using a community sample of 1200 men and women in Vancouver, found that individual reports of receipt of partner abuse were highly associated with their own perpetration of abuse (Bartholomew *et al.*, 2001). Other studies have also found that the most common form of domestic violence was

mutual, regardless of whether severe or minor violence was reported (Rhodes *et al.*, 2009; Dutton, 2008; Hamel, 2009); that women initiate violence as well as acting in self-defence (Straus and Gelles, 1986; McHugh & Frieze, 2006; Frieze, 2008) and that men are disproportionately the ones arrested (Brown 2004; Dutton, 2008). Furthermore, research suggests that 'a substantial number of women seeking services for victimisation may also be 'perpetrators' of IPV' (Williams *et al.*, 2008, p. 245).

3.2.4   Gendered explanations: asymmetry or symmetry

Some male activists claim there is gender bias against men in the provision of domestic violence services and use evidence of gender symmetry to further their own call for greater equality (Girard, 2009). Typically, two kinds of data have been used to document violence in intimate relationships and fuel what has been at times 'vituperative ideological debates', characterised by accusations and justifications between two polarised positions: pro-feminist or gender symmetry (Archer, 2000; Kimmel, 2002, p. 1336; Young, 2005; Dutton, 2008; 2010; Straus, 2008). Feminist activists/practitioners referred to evidence of severe physical and emotional violence/abuse against women in clinical samples drawn from hospital, shelter and police data; family sociologists studied intimate violence using large-scale community/representative samples which indicated that women were as violent as men in intimate relationships. Feminists strongly rejected evidence of female violence as it was counter to their experience as advocates of female victims and feared that funding for women's services would be affected. The contention that all domestic violence is 'battering' i.e. a coercive pattern of violence, intimidation and control by men, was the dominant discourse, and has remained influential on policy and practice (Kelly & Johnson, 2008).

Each position conceptualises, reports, or accounts for violent acts differently and it is their power to convince that determines what counts and shapes the potential understandings of, and response to, those acts (Murray & Powell, 2009). Thus, questions as to what counts as violence between intimate partners, what is meant by 'abuse' and who has the power to identify the 'abuser' and decide what behaviours in a particular context are violent are not just of theoretical interest. All have implications for how those who seek help are categorised by those who provide support services, and implications too for the kind of help they will receive. For example, police reports tend to use the term, 'victim', whilst support services for women who have left a 'perpetrator' of DVA generally used the term, 'survivor' (Hester & Westmarland, 2005); legal services may use the terms, 'offender', 'perpetrator' and 'criminal assault' (Fitzroy, 2001); therapists may refer to men as 'abusers' or 'perpetrators' and females as, 'victims' or 'survivors. As indicated in Chapter 1, in research and practice people tend to be divided into categories of 'perpetrator' or 'victim', so providing a framework for the construction of their experience.

Despite growing evidence of female aggression, McHugh & Frieze (2006, p. 135) argue that in effect feminist research continues to treat gender as a 'dichotomous categorisation equivalent to sex', and an 'inherent characteristic of individuals', so reflecting the dominant research paradigm in psychology and paradoxically supporting the status quo. This creates the notion that the dynamics of gender relations are natural, rather than socially constructed and open to challenge and change (Hamby, 2005). Some researchers argue that the 'either/or' arguments miss the point: research data identifies mutuality and not symmetry in male and female aggression, and that equal rates of violence do not necessarily have the same meaning (McHugh *et al.*, 2005; Hamel, 2007; 2009; Dutton, 2008).

3.3   Explaining Individual Differences

Socio-cultural theories offer a way of understanding how individual perceptions and behaviour are influenced by dominant social norms and values, so legitimising and reproducing particular ways of seeing the world. However, they do not explain individual differences in responding to apparently similar circumstances, or differences in types of relationships. In relation to domestic violence, it is evident that patriarchy does not result in every man behaving abusively towards their female partner, or every woman responding passively to males (Zosky, 1999). Gadd, (2002, p. 65) for example, suggests that we are 'not simply conditioned by social forces' and that most men do not use violence against women as a means of achieving masculinity. However, this may rarely be questioned, due to a 'fear of violating political correctness' (Hamel, 2010, p. 86).

3.3.1   Differentiating between types of violence and types of relationships

A growing body of research has attempted to identify differences in types and patterns of violence with regard to partner dynamics, context and consequences, in order to better understand factors influencing the severity of aggression (Kelly & Johnson, 2008). There have been attempts to create a typology of male batterers. Holzworth-Munroe & Stuart (1994) categorised men into family-only, borderline and anti-social types, whilst Jacobsen & Gottman (1998) represented men as 'Pit Bulls or 'Cobras'. Others have proposed a typology of women's use of violence as retaliation, in the context of male violence (Swan & Snow, 2002; 2003) and attempts have been made to distinguish between instrumental and impulsive, or expressive, violence by men in recognition of individual differences (Hamel, 2009).

In an initial attempt to reconcile the viewpoints of the gender symmetry and asymmetry positions, Johnson (1995) proposed that the violence found in agency data was asymmetric, exclusively male battering, termed 'Patriarchal Terrorism' (PT). This was later changed to 'Intimate Terrorism' (IT) in recognition that not all violence is rooted in patriarchal attitudes

and subsequently changed to Coercive Controlling Violence (CCV) (Kelly & Johnson, 2008). He proposed that violence in community samples was gender symmetric, termed 'Common Couple Violence'(CCV) – a less frequent, context-specific violence, not used to control a partner and subsequently renamed Situational Couple Violence (SCV) (Johnson & Kelly, 2008). He concluded that researchers disagreed because they were studying different samples in different contexts and using different methodologies. Johnson (2006) concluded that CCV (IT) was almost exclusively male though their female partners were sometimes violent in response (Violent Resistance (VR)); SCV was relatively gender-symmetric and only rarely involved severe violence; within each type of violence there was a range of severity, mutuality and frequency and in some relationships women were the more frequent aggressors; both types of violence were found in both samples.

Nevertheless, Johnson's typology has been influential in supporting a dichotomy in which serious violence is attributed to men and female violence is regarded as less serious. Dutton & Corvo (2007, p. 664) have called the common couple versus intimate terrorism typology a 'false dichotomy' as it appears to ignore the evidence of female- initiated abuse. Dutton (2010) criticised Johnson's methodology as based on an atypical sample of women in shelters and instead argued that context and motivation determine the difference between male (CCV) and female (VR) violence. Dutton (2008) also argued that coercively controlling women tended not to be arrested, were often ignored and not sent to perpetrator programmes, so may not figure in clinical samples. However, Graham-Kevan & Archer (2008) concluded that their data (n=264) from women in shelters, male and female students and male prisoners provided some support for Johnson's contention that the type of relationship is the main distinguishing factor rather than sex of the perpetrator. Nevertheless, at an individual level they found that the use of controlling behaviours predicted physical aggression by categories of IT, VR and 'common couple violence', though there were differences in the type and range of controlling behaviours used in each category. In another study investigating several evolutionary hypotheses, they found gender-symmetrical controlling behaviour across a sample of men (n=399) and women (n=951) not selected for high rates of intimate aggression (Graham-Kevan & Archer, 2009), whilst, in community samples, Rehman *et al.*, (2009, p.475) found that 'power gridlocks' were not specifically linked to male violence, and Ross & Babcock (2009) found that women reported using control as much as their partners, though there were gender differences in meaning and impact.

3.3.2   Personality disorder and attachment insecurity

Some researchers argue that there is little evidence to support the notion that patriarchal beliefs cause men to be violent (Stith *et al.*, 2004; Dutton & Corvo, 2007); or that men believe it is acceptable to retaliate against women (Feld & Felson, 2008). Dutton (2008)

contests the notion that there is a cultural 'norm of acceptance' for IPV as claimed by Dobash & Dobash (1978; 2004), referring to the findings of research by Simon *et al.* (2001) that only 2% of N American men accepted violence as a means of controlling women. He also argues that a gender analysis approach is overly simplistic, rigid and narrowly defined and that to change the incidence of IPV there must be more recognition and treatment of the individual and interpersonal aspects of the problem (Dutton 1994; 1999; 2008; Dutton & Corvo, 2007), suggesting: 'We need to put the psychology back into our understanding of IPV, not dismiss it either by fiat or conceptual ignorance' (Dutton 2008, p. 132). He proposes a number of factors contribute to IPV and that the 'batterer' profile, of males using 'repeat, severe and unilateral' violence against an innocent female victim' fits only a minority of cases.

Dutton *et al.*, (2009) argue that personality disturbance is a better predictor of IPV than gender. Recent research has begun to identify psychological factors that show similarities and sex-differences in motivation and behaviours. For, example, whilst it has long been accepted that domestic violence has an impact on the mental health of 'victims', research suggests that mental health disorders in late adolescence are a risk factor for later involvement in violent relationships for both men and women (Ehrensaft *et al.*, 2006). Using a convenience sample of 14,154 students from 67 University sites around the world, Hines (2008) found that traits of borderline personality disorder, such as instability of self and relationships, anger, jealousy, impulsivity, fear of abandonment and emotional volatility were risk factors for perpetration of physical, psychological and sexual intimate violence for both men and women. Another study found an association between psychopathic traits and relationship aggression in a non-clinical population (Coyne *et al.*, 2010). There is also continued debate as to whether low or high self-esteem are risk factors for aggression (Bushman *et al.*, 2009; Murphy *et al.*, 2005; Ostrowsky, 2010).

Other studies suggest that 'assortative mating' occurs i.e. that abusive people find abusive others or elicit abusiveness, resulting in shared co-morbidity of IPV, substance misuse and personality disturbance in couples where there is mutual abuse (Whitaker *et al.*, 2007; Dutton, 2008). In Dutton's (2007b) review of a number of methodologically sound, longitudinal developmental studies of men and women, based on large community samples that do not require people to self-report as crime–victims, he concludes that female violence is found to be common, occurs at equivalent rates to men and, similarly to men, has a developmental history. Furthermore, Ehrensaft's (2008) study of men and women in their early 20s found evidence that Personality Disorders (PD), with the exception of avoidant, dependent and obsessive compulsive PDs, were important etiological factors for intimate violence and suggested that theories needed to include the developmental and psychological characteristics of both partners. However, other studies indicate that different PD traits may be predictive of male and female perpetration (Thornton *et al.*, 2010).

Dutton (2008) suggests that there is an attachment basis to the personality disorders of abusive men and women. Research has shown differences in relating as between violent and non-violent men, with violent men exhibiting strong dependence on their partners, termed, 'traumatic bonding' (Dutton & Painter, 1993). Some researchers have identified attachment insecurity and traumatic bonding i.e. a bi-directional tendency for partners to remain in abusive relationships, as features of male and female abusiveness (Dutton, 2008; Goldenson *et al.*, 2009). Other features include borderline functioning; shaming experiences; dysfunctional early family experiences/physical abuse. Dutton (2008) has carried out studies to distinguish between impulsive or instrumental abusers: impulsive abusers were more likely to be angry, lack self-awareness, empathy, and have a fearful attachment style, in other words, fit a borderline personality pattern. Dutton (2008) cited results from a series of studies of emotional reactivity in response to 'abandonment' scenarios, finding that men who used IPV but not other forms of violence reacted more angrily and became more anxious than other groups of generally violent or non-violent men. This finding provides support for the link found between infant attachment and adult attachment styles and highlights the role of anger in domestic violence as a response to separation or abandonment fear (Hazan & Shaver, 1987).

3.3.3 Social learning theory: Intergenerational transmission of relationship violence

Whilst personal understandings about the self and our relationships to others develop in the context of socially and culturally prescribed ways of seeing the world, the formative learning occurs in relationships with those who look after us. The first relationship with parents/caregivers is, therefore both, a source of comfort and nourishment, and a starting point for learning about the self, how the world is structured and how the self can cope in the world, all of which has lasting developmental significance (Weiss, 1991).

Many studies over the past 30 years have demonstrated that children who witness inter-parental abuse or experience abuse in their family of origin are more at risk of being involved in abusive relationships as adults (Stith *et al.*, 2000; Hines & Saudino, 2002; Ehrensaft *et al.*, 2003; Whiting *et al.*, 2009; Kwong *et al.*, 2003). This has been explained from a social learning perspective, that children who grow up in an abusive household learn from observation of their parents that aggression or violence are the ways to deal with conflict and so are more likely to use aggression themselves. Conversely, those who grow up in a non-violent background are less likely to tolerate abuse, have more effective conflict-resolution strategies and more positive models of relationships (Kwong *et al.*, 2003).

Some studies have looked for gender-specific or role-specific associations, such that father to mother abuse would predict male perpetration and female victimisation in later life, or for differences between witnessing and experiencing violence. Stith *et al.* (2000), for example, found an association between children who either witnessed and/or experienced violence and later perpetration of violence and, that experiencing violence was more predictive of victimisation than witnessing violence. On the other hand, Kwong *et al.* (2003) found that all forms of relationship violence in family of origin were predictive of all forms of abuse in adult relationships e.g. mother's violence as well as father's violence, consistent with social learning theory. However, the associations were not strong, indicating that other factors may be implicated. The authors also suggest that failure of other studies to recognise the bi-directionality of abuse or psychological abuse may account for inconsistent findings and propose that future research should take a relational focus.

Some researchers have suggested that social learning theory is limited and overly simplistic in the assumption that violence begets violence (Bevan & Higgins, (2002). They argue that it fails to account for the majority who do not perpetrate violence, and the contribution of various sometimes co-existing factors, such as neglect, sexual abuse and psychological mistreatment in childhood, associated with perpetration of physical or psychological abuse in adulthood. Corvo & deLara (2010, p. 8) propose that there is 'a continuum of victimisation-perpetration' underlying domestic violence, arguing that there are multiple developmental pathways to adult domestic violence. They, and others, suggest that more attention needs to be given to potential risk factors such as engaging in, or being a victim of, bullying behaviour as a child, in order that the developmental roots of violence, and protective factors, are better understood by practitioners (Basile *et al.*, 2009). Others have also concluded that there may be a number of potential mediating factors, such as the influence of cognitive appraisals, mental health and substance use (Hines & Saudino, 2002; Whiting *et al.*, 2009); or the effects of traumatisation in childhood (Dutton, 1999; Kwong *et al.*, 2003).

3.4   Dyadic Approaches: Attachment Theory

Bowlby's (1969) attachment theory shows how the experience of early relationships can have a lasting impact on our expectations of, and capacity for, intimacy in adult relationships. More recent research from a neuropsychological perspective provides support for his proposition that the early mother-infant relationship is of crucial importance during what is now understood to be a sensitive period for brain development, and in particular for the development and maintenance of synaptic connections in the right brain (Schore, 2012). From this perspective, a 'good enough' maternal response can create the conditions necessary for brain development and emotional growth, and thereby, facilitate the developmental capacity to self-regulate affects, crucial to the formation of intimate

relationships in adult life (Green, 2011). Conversely, lack of attunement or dysregulation in these early relationships can affect a child's capacity to manage emotions and lead to difficulties understanding the mental states of self and others, manifest in attachment insecurity and interpersonal difficulties more generally (Fonagy *et al.,* 2004; Green, 2011).

In his early theorising, Bowlby observed that throughout life and particularly at times of distress humans try to attain and maintain proximity to someone who is better able to cope, so meeting a basic survival need. He proposed that we are essentially social beings innately predisposed to seek out others who provide us with both a sense of belonging and a validation of our separateness. From this perspective, a child's emotional and physical well-being depends on the protection and nurturance provided by attachment figures and the maintenance of a desired level of proximity. Anger behaviours were conceptualised by Bowlby (1988) as a form of protest when the child was separated from a caregiver who was slow to respond or rejecting, serving a function in infants' communications to caregivers that their attachment needs are not being met.

It was hypothesised that where attachment figures were experienced as responsive to the child's needs a positive model of the self and the self in relation to others would develop, and conversely, where attachment figures were not experienced as reliable and responsive, negative models of the self and other would develop. This was referred to as an 'internal working model' of relationships which formed the basis of the child's capacity for empathy, theory of mind, and the regulation of emotions and the source of continuity between early and later feelings and behaviours in relationships (Hazan & Shaver, 1987). Expanding on this theory, Schore (2012) proposes that these unconscious 'internal working models' of attachment relationships are stored in the right brain, in implicit-procedural memory and used to guide behaviour and maintain a coherent and unified sense of the self. Therefore, expectations about the availability and helpfulness of others would guide subsequent adult attachments, and there would be a tendency to seek out relationships that are congruent with the working model, so maintaining a sense of self as consistent and the world as predictable. This means that the early experience could be repeated as each subsequent relationship creates an opportunity to 'maintain, enhance or change established patterns' (Bartholomew *et al.*, 2001, p. 60).

When these early relationship experiences were 'good enough' (Winicott, 1991) a child learns to tolerate separation, feels securely held by the attention of the caregiver and begins to experiences themselves as having agency and power in their relationships. When early attachment is insecure, children may display avoidant, ambivalent or disorganised behaviour along with high levels of aggression on separation from caregivers, conceptualised as an expression of protest intended to re-instate the relationship connection (Ainsworth, 1991). Attachment theory was extended to include adult intimate relationships, demonstrating

parallels between infant and adult attachment, whilst highlighting the shift over time from asymmetric attachments to more symmetrical, reciprocal ones in adulthood romantic relationships (Hazan & Shaver, 1987). Expressions of anger in adult romantic relationships were understood as an indication that the attachment system had been activated when separation anxiety or fear of abandonment may appear to threaten the relationship. Anger could in this way be functional in regaining proximity to the loved one and preserving the relationship.

However, Bowlby (1988, p. 75) stated that adult relationships may become abusive when each partner is 'deeply but anxiously attached to the other and had developed a strategy designed to control the other and keep him or her from departing'. Furthermore, he proposed that 'the strength of an attachment bond is not related to the quality of the attachment relationship', so that the sense of loss of someone who is unkind or abusive may be just as keenly felt as if they were kind (Bartholomew *et al.*, 2001, p. 60). This provides a way of understanding why people may strike out angrily at those they love when they fear abandonment, and the evidence of repeat victimisation (p16), suggesting some people stay in abusive relationships (Henderson *et al.*, 2005). It might also explain the low correlation between relationship satisfaction and violence (Stith *et al.*, 2008), and highlights how our need for attachment and our vulnerability to loss are shaped by early experiences and continue to influence adult interactions (Bowlby, 1988; Hazan & Shaver, 1987; Chornesky, 2000; Bartholomew *et al.*, 2001; Lafontaine & Lussier, 2005; Allison *et al.*, 2008; Godbout *et al.*, 2009).

'Assortative mating' suggests those who suffer early losses, abuse or trauma may be said to be particularly liable to re-create the insecurity in their adult intimate relationships that they are most seeking to avoid (Bartholomew *et al.*, 2001; Dutton, 2008). Perceived slights, or threats of separation or abandonment in adulthood may evoke old pain, triggering unbearable and overwhelming fear and anxiety, whether or not the threats are real (Zulueta, 2006). Fears about maintaining the integrity of the self, when separate or being intimate, can manifest in protest behaviours that create disconnection in adult relationships by being invasive towards others or rejecting. Schore's (2012) work offers a neuropsychological explanation for such reactions, suggesting that early disorganised attachment may manifest later in emotional regulatory failures, such as overwhelming anxiety, or dissociative states that function as self-protective.

Bartholomew identified individual differences in adult attachment styles using a two-dimensional model based on the intersection of Bowlby's self and other conceptualisation and concluded that 'preoccupied' and 'fearful' attachment patterns, were at greatest risk of both receipt and perpetration of violence (Bartholomew, 1990; Bartholomew & Howitz, 1991). These insecure attachment styles are associated with a negative model of self and a

tendency to be anxious about intimacy (Bartholomew *et al.*, 2001). 'Preoccupied' patterns are characterised by dependency on others, an over-investment in relationships and an approach orientation that is overtly demanding and needy; 'fearful' patterns are characterised by dependency on others combined with a fear of being rejected which causes high anxiety and avoidance of intimacy, similar to the category 'disorganised' attachment observed in children (Clulow, 2001); 'dismissing' patterns, characterised by distant behaviour and a de-activation of the attachment system and 'secure' patterns, characterised by comfort with intimacy and autonomy and demonstrating good conflict-resolution, are at lowest risk for abuse (Henderson *et al.*, 2005).

3.4.1 Research and practice from a relational perspective: understanding why people stay in abusive relationships/hurt those they love

Schore (2012, p. 8) suggests that there is a paradigm shift towards relationally oriented psychotherapy, paralleled in neuroscience studies which have identified 'the essential role of the right brain in social interaction'. Indeed, a growing body of research has pointed to the relevance of relationship dynamics and context and the need to understand the inherent paradox present in relationships where violence may co-exist with love and love may be used to explain why people stay together (Lloyd & Emery, 2000; Borochowitz & Eisikovits, 2002; Godbut *et al.*, 2009). It can seem that the more that outside forces try to separate such a couple, the more strongly bound together they can become, perhaps particularly because their relationship and their motivation to stay together, may be viewed by others as perverse, even though meaningful to them.

Relational approaches to therapy integrate humanistic and psychodynamic approaches and are concerned with meaning-making and 'being with' rather than 'doing to', representing a shift from a one-person psychology to a relational two-person psychology (Safran & Muran, 2000; Wachtel, 2008). They focus not only on beliefs about self and others but are interested in exploring early relationship experiences and the implications for current attachments and interpersonal transactions, including the therapeutic relationship; they may be conceptualised within a gender paradigm (Chornesky, 2000). Nevertheless, partners' violent or abusive behaviour may be seen as attachment strategies to regulate intimacy and distance in an intimate relationship rather than an expression of patriarchal entitlement or need to control a partner. Some researchers suggest a dyadic approach to domestic violence 'may be desirable as long as neither partner is at risk for serious injury' (Allison *et al.*, 2008, p. 147).

Hazan & Shaver's (1987) earlier attempt to understand romantic love as an attachment process highlighted how attachment styles may represent a learned response in adaptation to particular circumstances and so the same dynamics may underlie both healthy and unhealthy forms of love. Goldner *et al.* (1990, p. 343), also identified common relational dynamics,

but from a feminist and systemic perspective, proposing that 'abusive relationships exemplify in extremis the stereotypical gender arrangements that structure intimacy between men and women generally'. In their therapy work with couples they tried to unpack the premises that they believed underpinned intimate relationships and created dilemmas that could escalate into violence. This requires a move beyond what they referred to as reductionist views about men as 'tyrants', using power to abuse, and women as 'masochists', 'colluding in their victimisation' by staying in abusive relationships. They advocate a move away from 'either/or' positions of constructing victims and villains to one that facilitates an understanding of the subjective experience of both partners: a 'both-and' position. They identify the moral dilemma this poses if violence is being explained away, but conclude that psychological explanations need not exclude holding abusers responsible for their actions. Their multi-faceted approach to conjoint work draws on psychodynamic, systemic, constructivist and feminist thinking and focuses on deconstructing both the loving and abusive aspects of the couple's bond as well as identifying the context or transactional sequences that led to violence.

Goldner *et al.* (1990, p. 356) speak of the 'stickiness' of abusive relationships and the surprising presentation of female victims as, 'not timid, self-deprecating, fragile victims. They were victims, but they were in nearly every case, women of substance who had strong opinions and conveyed a sense of personal power'. This is echoed by Chornesky (2000, p. 491) who draws on attachment theory and relational approaches to explain the abuse of women by their partners and focuses in particular on trying to understand why abusive relationships tend to persist: the abused woman is seen as a 'participant in the abusive relationship and that her participation is a function of her history, anxious attachment and fear of being abandoned'; her yearning for connection and belief that leaving the relationship is a failure may be seen as providing reason for staying. The author concludes that understanding the violence of abusers and why women may remain in abusive relationships need not mean excusing abusers and blaming victims if the perspectives of men and women are seen as socially constructed, drawing on prescribed social roles.

Lloyd and Emery (2000) draw on quantitative and qualitative studies to suggest that the way we talk about relationships and aggression and how the meaning of specific incidents is constructed play a part in sustaining intimate violence. They highlight, for example the surprise experienced by women who believe, 'it will never happen to me' because it does not fit their expectations and beliefs of loving relationships and the reluctance of women to name more common occurrences of physical aggression as abuse. They suggest that analysis of discourses of intimacy is crucial to understanding the context within which meanings of abuse and violence are constructed. These often taken-for-granted ideas, socially and culturally embedded, may be drawn on by 'victims', 'perpetrators', researchers and professionals to explain aggression in intimate relationships. Discourses about equality,

romance and sexuality may be used to justify, forgive or comply with abusive behaviour and discourses of excusing the aggressor, blaming the victim and debates over terminology, the direction of violence and what counts may serve to support 'either/or' accounts. Borochowitz & Eisikovits (2002) also looked at the impact of violence on loving and the role of love in the violence. They interviewed 14 couples, consisting of 'battered' wives and their husbands and found that violence was seen as serving a number of functions in preserving intimate relationships through communicating dissatisfaction, expressing need and creating opportunity for reviving romance after a violent incident.

Flinck & Paavilainen (2008) interviewed 20 Finnish males with a history of intimate partner violence using a phenomenological design. They found that the men at first denied, understated or justified their violent behaviour and then gradually came to admit their responsibility, experiencing bewilderment, shame and guilt. Violence was interpreted by the men as a response to feeling humiliated and not heard, and a desire to regain control. The authors conclude that domestic violence is 'a moral, personal, and inter-relational problem, not only as a problem of men' and that gender should not be the starting point for understanding the problem (p. 250). They questioned whether negative, blaming attitudes towards men by professionals may serve to sustain the problem by reducing men's willingness to admit their responsibility and seek help. They conclude that the development of gender-sensitive, flexible integrative practices that take account of the pair relationship and adopt a supportive, empathic stance, would help men to face and address their guilt and shame, whilst also recognising their moral and legal responsibility.

3.5 Taking a Gender-inclusive Approach: Focusing on Individual Differences and the Interpersonal

> 'Domestic violence is a human and relational problem, not a gender
> problem.'(Hamel, 2009, p. 41**)**

Some researchers take a gender-inclusive perspective, identifying gender as but one of many potential factors implicated in intimate partner violence (Dixon & Graham-Kevan, 20011). Richardson's (2005) findings from studies exploring the effects of relationship and gender on aggressive behaviour, indicated that, whether male or female, participants reported more direct aggression with romantic partners than with same or opposite sex friends. The author concludes that relationship is a more important determinant of aggressive behaviour than gender and that violence does not reside in individuals but 'in interactions among individuals who provoke and are provoked' (Richardson, 2005, p. 246.).

3.5.1 Recognising female violence

Fitzroy (2001) argues that gender explanations of male violence do not account for women's violence, suggesting that new ways of hearing and understanding the experiences of male victims need to be found and women's agency named. Such approaches would need to acknowledge the oppression of women in society but recognise that they too have learned to construct their own and others' experience in the context of oppositional dichotomies. Women also 'participate in, benefit from and perpetuate power relationships which maintain the dominant capitalist and patriarchal order' (Fitzroy, 2001, p.27). The author suggests that women may also abuse power, for example with their children, and should expect to be made accountable for their abusive behaviour in the same way that men have. Recognition of women's agency points to a need for understandings that move beyond gender, and for more sophisticated assessment and treatment methods, that address psychological risk factors (Graham-Kevan, 2009).

Research from an attachment perspective has found that 'attachment preoccupation in either partner' may increase the likelihood of abuse and that gender did not moderate these associations (Henderson *et al.*, 2005). Bartholomew *et al.* (2001) found that relationships between two 'preoccupied' individuals tend to be mutually abusive, highly volatile and conflictual (Bartholomew *et al.* 2001); fearfulness is strongly associated with men in receipt of, and as perpetrators of, violence in clinical samples (Dutton *et al.*, 1994); fearfulness was found to be common in women who left abusive relationships whilst 'preoccupied' patterns were common in women who remained in or returned to abusive relationships (Henderson *et al.*, 1997); no consistent associations between dismissing patterns and abuse were found as dismissing individuals may be expected to defensively down-play the importance of intimacy and leave unsatisfactory relationships; relationships between preoccupied females and fearful males were predictive of the most severe abuse which was characteristically mutual or perpetrated by females, in both community and clinical samples (Bartholomew *et al.*, 2001).

3.5.2 Understanding needs for agency and relatedness

Both attachment theory and Bowen's family systems theory provide a framework for examining the interpersonal and intra-psychic aspects of human relating that contribute to the development of healthy and satisfying relationships. According to a Bowenian approach, the capacity to experience autonomy and emotional intimacy in relationships without feeling smothered or fearful of abandonment is related to the degree of differentiation of self each partner achieves and demonstrates in terms of emotional reactivity and emotional cut-off in response to their own or their partner's anxiety (Peleg, 2008). At an intra-psychic level less

differentiated individuals have difficulty distinguishing between feelings and thoughts, experience more difficulties in self-soothing, and are more likely to become overwhelmed by the anxiety of others (Zosky, 1999). Expression of anger and conflict in an intimate relationship may be seen from this perspective as functioning to manage shared anxieties by often complementary strategies of pursuing-distancing or attacking-withdrawing that serve to maintain connection and distance. Achieving a balance between needs for agency and relatedness has been found to be crucial to promoting satisfaction in relationships (Skowron, 2000; Peleg, 2008; Perez & Rasmussen, 1997; Woike, 1994; Wright, 2009). Safran & Muran (2000) suggest that the resolution of this tension is central to the purpose of therapy.

Both Skowron (2000) and Peleg's study of Israeli couples (2008) found that emotional cut-off by men may be a key factor in accounting for relationship distress, suggesting there may be gender differences in the relationship between differentiation and marital satisfaction, though limitations due to using self-report data from one spouse only in Peleg's study pointed to a need for further research. It was hypothesised that this finding may be accounted for by men and women holding different expectations of relationships due to biological and social gender differences, which concurs with other research suggesting men and women socially orientate themselves differently: men strive to be independent agents whilst women seek close relationships and communion (Woike, 1994). Nevertheless, according to Bowen's theory each partner's strategies contribute to the development and maintenance of the problem and are consequent upon people seeking out partners who are at a similar level of differentiation.

Lafontaine & Lussier (2005) carried out a quantitative study with 316 French couples and found that anger in couples moderated the strength and direction of the association between attachment and intimate violence in 'common' couple violence (Johnson, 1995). Experience and expression of anger was found to be related to both male and female anxiety about abandonment and avoidance of intimacy i.e. insecurely attached individuals expressed dysfunctional anger in comparison with securely attached. Use of violence by men was found to be directly related to discomfort about intimacy leading to attempts to create distance from a partner trying to get close and use of violence by women was directly related to dysfunctional attempts to keep the partner close. They concluded that therapeutic interventions should focus on fear of intimacy and abandonment in the context of past and current relationships rather than anger management.

3.5.3   Explaining self-blame and other-blame and the denial of responsibility

From an attachment perspective, those with fearful or preoccupied patterns, who operate with an internal model of themselves as unworthy of love, are likely to be hyper-vigilant and highly sensitised to perceived abandonment or rejection by intimate partners and may

become angry, controlling, jealous and demanding in an attempt to get their needs met (Clulow, 2001). It is easy to see why they may deny their responsibility for abuse when the other is perceived as withholding, unreliable or untrustworthy. On the other hand, those with anxious attachment in receipt of abuse may see abuse perpetrated against them as justifiable and blame themselves, containing/owning what is bad in the relationship, so maintaining in between the bouts of abuse the illusion of the other as good. They are more likely to have low self-esteem and a high need for approval and dependency on others so be likely to be accepting of an abuser's apology or excuses and remain in the relationship (Henderson *et al.*, 1997). Henderson *et al.* (2005) found that 'preoccupied' individuals tend to perceive negative interaction as evidence of intimacy and could be at risk for not only tolerating abuse but also eliciting abuse from their partners and remaining in the relationship.

Findings from studies using Bowen's framework suggest that couples experiencing high levels of distress and conflict in their relationships are less well-differentiated and manage anxieties at the expense of the other, tending to develop increasingly rigid, polarised roles. Typically in 'fused' relationships there may be a shared sense of each holding absolute responsibility for the other's happiness and pain, causing repeated cycles of guilt and blame when the other does not meet expectations (Skowron. 2000).

3.6   Summary: Dilemmas for Feminist Theory, Policy and Practice

Evidence of females engaging in reciprocal partner violence poses a challenge to feminist theory, policy and practices (Allen-Collinson, 2009; Allen *et al.*, 2009; Archer, 2000; Dixon & Graham-Kevan, 2011; Fitzroy, 2001; Frieze, 2008; Graves, 2007; Laroche, 2005; Richardson, 2005; Straus & Gelles, 1986; Swan & Snow, 2002; 2003; 2006). Arguably, too, questions about the efficacy of treatment programs, rooted in patriarchal ideology, such as the Duluth model, have highlighted the limitations of a radical feminist position invested in the belief that there is only one type of intimate partner violence (Babcock *et al.*, 2004; Corvo *et al.*, 2008; Dutton & Corvo, 2007; Dutton, 2010; Frieze, 2005; Hamel, 2010; Johnson & Kelly, 2008; Young, 2005). Recent research supports the view that 'women as well as men perpetrate acts of violence and control, although the meaning and impact may be different by gender' (Ross & Babcock, 2009, p. 618). Furthermore, studies indicate that personality disturbance is overrepresented in both male and female perpetrators and these may have their origin in early attachment or shame experiences (Brown, 2004; Chornesky, 2000; Dutton, 1999; Godbout *et al.*, 2009; Goldenson *et al.*, 2009); and that there may be psychological differences between women who are abused (Dutton, 2008).

Increasing acknowledgment of male, gay and lesbian victims as well as females, has brought growing pressure to explain women's violence toward their partners, dating violence, violence in same-sex relationships and 'the violence of men who did not like what they were

doing', and move beyond a unitary explanation (Renzetti, 1988; Young, 2005, p. 28; Gadd, 2002; 2004; Graham-Kevan & Archer, 2005; Brown, 2008). Furthermore, Chornesky (2000) argues that theories need to explain the persistence of abusive relationships and the different perspectives of women who leave abusive relationships and women who choose not to. However, there are tensions between institutional theories and personal views of domestic violence, over questions of who is responsible (Thapar-Bjorkert, 2010). These are manifest in what may be seen as the challenge of providing services for women categorised as 'victims' without pathologising their experience and, counter to feminist aims, seeming to blame and potentially disempower women who have been victimised (Chornesky, 2000; Tower, 2007; Lehrner & Allen, 2009; Girard, 2009; McDermott & Garofalo, 2004; Reavey & Gough, 2000; Thapar-Bjorkert & Morgan, 2010).

Changes in Government policy which de-politicise the problem may be seen as disadvantaging those offended against by creating labels and constructing subject positions which define them as passive victims. Wright (2008) questions whether the transforming of public problems into personal ones obscures structural disadvantages through a rhetoric of individual responsibility, or instead can facilitate a more complex conceptualisation of gendered arrangements. Lavis *et al.* (2005) argue that this would appear to be counter to the feminist intention underpinning the policy, as those who are victimised may be condemned to further alienation and potentially oppressive practices. However, Lamb (1996) proposed that therapists have gone too far in trying to avoid blaming victims and that new practices are needed that address female 'victims' responsibility and choices.

Similarly, the treatment of 'perpetrators' is not without controversies and dilemmas, concerning the disputed efficacy of programmes based on the Duluth model, the role of anger and substance misuse in domestic violence and the degree to which there is homogeneity in males who behave abusively (Babcock *et al.*, 2004; Dutton & Corvo, 2007; Gibbons *et al.*, 2011; Gilchrist *et al.*, 2003; Gondolf, 2004; Jacobson & Gottman, 1998; Langlands *et al.* 2009; McMurran & Gilchrist, 2008; Rivett, 2006). The standardisation of these practices has been questioned in the UK as being policy-led rather than evidence-based (Gadd, 2004). The Deluth model has also been criticised on methodological and philosophical grounds in the US for its 'gender-shaming' approach and 'extreme, negative and polarised view of both men and women and abusive men.' and for its narrow focus on physical violence, excluding psychological and sexual abuse (Dutton & Corvo, 2007, p. 659).

More recent research reviews in the US have shown 'little or no effect on domestic violence perpetration' and current approaches have been criticised as being 'at odds with the codes of ethics of the various mental health professionals as regards obligations to provide evidence-based or effective treatments'(Corvo *et al.*, 2009, p.325 and 335). McCurran & Gilchrist

(2008, p. 113) call for a 'risk-needs model of domestic violence' and a 'debunking of the notion that ''batters'' are a breed apart to whom science does not apply', arguing that understanding the role of anger and alcohol in domestic violence need not provide 'an excuse for avoiding personal responsibility'. Murphy & Ting (2010) have also found that the integration of supportive interventions and those designed to address substance use have shown favourable effects in reducing violence.

Ehrensaft (2008, p. 276) argues that data countering existing, traditional ways of understanding domestic violence are not 'penetrating the field' in the US. The situation may be similar in the UK. According to the UK Mankind Initiative (2008), evidence of male victimisation in British Crime Survey statistics has not changed policy or practices:

> 'Support for men is 35 years behind the support available for women and the Government can no longer continue to turn a blind eye to the plight of male victims. The figures are a wake-up call, especially when they are the Government's own figures. For far too long domestic abuse has been seen by the Government, local authorities and the police as only a problem that affects female victims, when in truth, it is a social and family problem where both men and women can be victims.'

3.7   Rationale for the Research Aims

Whilst there is consensus that safety considerations are paramount, best practice for working with those who are involved in intimate partner violence remains a matter of contention, among researchers. Although research in domestic violence has begun to generate more nuanced understandings of the problem, recognising its complexity and the ineffectiveness of a one-size-fits-all approach, these developments are not yet evident in changes in policy or practice. The dominant paradigm shaping approaches to therapeutic practice and the organisation of domestic violence interventions continues to be feminist. In the UK, multi-agency approaches, including CCRs and inter-agency domestic violence forums, informed by a gender perspective have become widely accepted as the best way of finding viable and effective ways to tackle the problem (Hague & Bridge, 2008). However, the research literature suggests that understanding domestic violence in the context of the relationship (Bartholomew *et al.*, 2001; Chornesky, 2000; Dutton, 2010; Ross & Babcock, 2009), and gender differences in motives for IPV (Flynn & Graham, 2007; Caldwell *et al.*, 2009) could contribute to the development of more effective practices.

Therapists working in institutions informed by particular codes of practice engage in discursive practices from a powerful, expert position. When therapists identify 'victims', 'survivors' and' perpetrators' of violent acts they may be seen as instruments of social structures that set societal norms and, in doing so, limit the possible explanations and

meanings available to their clients when describing their experiences. This carries the risk of therapists reinforcing and perpetuating taken-for-granted ideas and unequal social relations and, at an individual level, of pathologising clients' experience and constraining the options available to them. However, there is also the potential for therapists to challenge unequal, unfair social norms and practices and interrupt this process by moving away from 'either/or' ways of understanding the problem and instead helping clients to craft new understandings of their experiences. From a social constructionist perspective, these alternative constructions may sustain different knowledge, realities, and collective and subjective actions.

The role of the therapist is critical in creating these new possibilities for growth and change, particularly as this process unfolds in the context of a relationship, through the therapist's capacity to relate. There is well-documented research evidence pointing to the importance of the therapeutic relationship in outcomes and client satisfaction (Norcross, 2002). With cases of intimate partner violence and abuse the therapist must form and maintain a relationship with someone who has particular difficulties in relating and presents with issues that can evoke strong feelings of revulsion or pity (Morran, 2008). It may be said, too, that all therapy requires therapists to recognise and hold in mind their own theoretical and personal assumptions and the agenda this might impose on the process (Safran & Muran, 2000). However, working with domestic violence and abuse may pose particular challenges not only because of the emotive charge it may generate, but also because of the complexity of practical, ethical and practice issues it presents.

This qualitative study aims to explore, through a constructionist methodology, the ways in which violence in an intimate relationship is explained and understood by practitioners working in organisations where specialist services for domestic violence are provided. The views of practitioners working with either 'victims' or 'perpetrators' or couples will be deconstructed with the intention of explicating a range of perspectives across the field, rather than a more fine-grained analysis of the understandings of practitioners who work with one client group, given the research evidence that current approaches are not reducing the incidence and impact of violence and abuse in relationships. The overall intention is to learn more about differences and similarities in approaches to practice, the ways in which practitioners negotiate the dilemmas that arise in practice and how they use supervision to support them, as a necessary first step in identifying areas for practice improvement. These current approaches will be explored in relation to the ways in which certain understandings construct certain versions of reality whilst marginalising others, and shape the intended focus and direction of the therapeutic process, including issues arising in supervision. More particularly, the aims of this study will be:

1. To learn more about ways of working with DVA that move away from 'either/or' paradigms
2. To consider the implications for supervision when moving away from 'either/or' paradigms.
3. To make recommendations for practice development in working with DVA, and for further research.

3.7.1   Research questions

1. How do practitioners/therapists working with DVA talk about the phenomena and their approach with their clients?
2. What challenges do therapists face in working with DVA?
3. What other potentialities are opened up when therapists take a relational approach?

These research questions address the first aim of learning more about an approach to working with intimate partner violence and abuse that moves away from 'either/or' paradigms and attempts to address the complexity of abusive relationships through seeking to understand the inter-subjective space where relating takes place.

CHAPTER 4: METHODOLOGY

4.1 Introduction to the Research Design

The purpose of this chapter is to set out the paradigmatic context for the research and provide a rationale for the qualitative empirical method used for the collection, analysis, and interpretation of data to answer the research questions set out in Chapter 3. The research paradigm provides a conceptual framework, underpinned by philosophical assumptions, which guides the selection of methodology and the more specific goals, methods and procedures for addressing these questions (Ponterotto, 2005). These assumptions include the position taken by the researcher on fundamental epistemological questions regarding how we come to know things about the world, and ontological concerns about how the nature of reality is viewed (Sullivan, 2010; Willig, 2008; Morrow, 2007). The conceptual framework is, in this way, implicated in shaping the ideas and strategies that have guided the procedure as well as the development of the research questions (Punch, 2006).

Since there are a number of different possible paradigms and qualitative approaches, it is considered essential that the perspective adopted in this thesis is clearly explicated and owned in order for the purpose and outcomes of the research to be evaluated (Elliot *et al.*, 1999; Holliday, 2002; Morrow, 2007). In the following sections, therefore, I will be setting out the guiding paradigm, methodology and personal orientation of the research. This will include an outline of the postmodernist framework within which the study is oriented and, more particularly, a consideration of the chosen social constructionist epistemology and rationale for the critical realist ontological position taken in the design of the study. The decision to adopt a thematic discourse analytic approach as an appropriate methodology for answering my research questions about the phenomenon of interpersonal violence and abuse will be explicated in the context of dilemmas and setbacks that shaped the decision-making process.

I turn first to a consideration of the relevance of my own experience, expectations, biases, and values as potential influences on the design and conduct of the study.

4.2 Reflexive Preface

As a practising Counselling Psychologist, I recognise the importance of the therapeutic relationship in the conduct of therapy and am interested in the process through which we give meaning to our experiences in a particular social, cultural and historical context. I therefore begin this chapter by saying something about the personal context that gives this research meaning for me and its influence on the chosen design.

Fifteen years ago, I first had training in, and experience of, working with domestic violence as a presenting problem with couples when I became a Relate counsellor and subsequently a supervisor. My training taught me to prioritise risk issues and this informed the initial assessment and the counselling process throughout the work that I did with individuals and couples. From my experience, I came to see violence and abuse as a problem in relating, that could be initiated by men or women, and, could be mutual. When viewed from this relational perspective, the focus would shift from behavioural acts to transactions, inviting the question, "Who does what to whom, and why?" when seeking to understand the meaning of what had happened. I became aware of the sensitivity required to acknowledge and negotiate dilemmas arising, when it might be unclear who is at 'fault'; for example when the person in receipt of abuse would speak about deliberately 'winding up' their partner. There were particular aspects to the work that I found challenging: when someone loved and wanted to remain with a partner who behaved abusively; when clients' behaviours and beliefs were shaped by a history of previous abuse; or when self-blame, or blaming-the-other, predominated.

Since then, I have worked in the NHS, where assessment and treatment from a medical model perspective can tend to construct ways of understanding that categorise people and problems, focusing on the individual's pathology. I became interested in the effect of labelling, for example, when a person who has been abused as a child might become involved in abusive relationships, taking on the label of 'victim' and seeing themselves as powerless and dependent on others for support. Furthermore, I began to question how organisations and therapists, including myself, might be implicated either, in reinforcing the notion of victimhood by 'doing to', or, alternatively, in helping to challenge this construction by engaging in a relationship that models ways of 'being' that recognise but do not re-produce disempowerment. I also became aware that therapists may feel personally and professionally challenged when engaging with clients who behave abusively, and may hold many different perspectives on the significance and nature of abuse in intimate relationships. It seemed to me that therapists require a coherent theoretical framework and appropriate supervisory support to navigate through the assumptions and biases often associated with abuse.

In these ways, my clinical experience and theoretical understanding of intimate partner violence and abuse have informed, though not determined the direction, focus and conduct of this project. Additionally, my personal experiences and interests have inevitably helped to shape my perspectives. As a human being, I have my own experience and understanding of abusive behaviours in relationships with others and awareness that both the meaning I ascribe to these events, and their emotional salience, are dependent on the relational context within which they occur. If someone were rude or dismissive to me in a shop it would matter less to me than if they were an intimate partner, for example. As a woman, I also

have my own understanding and experience of the impact of gender norms on my behaviour and relationships in different contexts. I recognise, too, how social and cultural values and beliefs have influenced my own life choices, opening up some opportunities and closing down others.

4.3   Paradigms and Conceptual Frameworks

4.3.1   A positivist paradigm

Research questions are framed in ways that reflect a paradigm or model of how the world works and what we can know about it (Silverman, 2010). When choosing an approach to investigate these questions, the way we conceptualise our social world needs to fit with the designs and methods used so that the chosen methodology can generate the kind of knowledge we are aiming to produce (Willig, 2008). Therefore, the selection of a qualitative or quantitative approach is not a matter of which is intrinsically 'better', but should be judged on the basis of the appropriateness of a methodology to answer the research questions (Punch, 2006).

Traditionally, research within psychology, including Counselling Psychology, has been conducted within a positivist paradigm based on the analysis of numerical (quantitative) data (Sullivan, 2010; Hayes & Kenney, 1983). Positivist approaches are underpinned by a realist epistemology, which assumes that representations of the world, through language, knowledge of thoughts, for example, are relatively straightforward reflections of the 'real' world out there (Sullivan, 2010). From this perspective, objective knowledge is value-free and gained through direct experience or observation with the aim of identifying causal explanations and unitary knowledge. Researchers from this paradigm tend to subscribe to the empiricist view that the acquisition of knowledge depends on the systematic collection and analysis of data, whilst recognising that access to 'facts' is not uncontaminated (Willig, 2008).

Some researchers argue that a realist approach to psychological concepts is problematic, positing instead that our knowledge and understanding of the world is representational and subjective, constructed through social processes (Burr, 1995). From this perspective, researchers can only access representations of reality and in doing so can never be truly objective, because it is assumed that they bring their own values and biases to the interpretation of others' accounts (Sullivan, 2010). When researchers take the philosophical stance that knowledge is contextualised and local, and they are interested in investigating ways in which people construe their worlds, they tend to adopt qualitative approaches, which are suited to exploring the role of meaning and context (Smith, 2008; McLeod, 2003). Though the field of qualitative research is considered more fragmented in comparison with

quantitative approaches, and hence there are points of conflict over methods and reflexivity, nevertheless, qualitative research methods provide the detail and depth of analysis of others' understandings or experience that make its findings particularly relevant to counselling practice (McLeod, 2003).

4.3.2   A postmodern paradigm

The framework for the research is consistent with postmodern thinking that emphasises the potential multiplicity of ways of viewing the world and notions of indeterminacy (Cromby & Nightingale, 1999). Postmodern thinking has generated an interest in qualitative methodologies that aim to try to understand how individuals construct their reality, rather than seek to produce grand theories and 'objective knowledge' (Willig, 2008). A common theme in postmodernist research is an interest in how, and what, social forces are implicated in people coming to understand and accept certain representations of reality as legitimate or true (Silverman, 2010). It offers ways of understanding and challenging approaches to clinical practice that label and pathologise people's experiences, by deconstructing traditional oppositions such as abnormal/normal and examining their power to oppress and marginalise (Parker *et al.*, 1995).

Figure 4.1 sets out in diagrammatic form the concepts, theories, methodology and specific research methods derived from this framework, to address the research questions (Silverman, 2010). These interlinked levels of analysis are explained in more detail below.

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                          ┌─────────────┐
                          │    Model    │
                          └─────────────┘
                                │
                  ┌─────────────────────────┐
                  │  Social Constructionism  │
                  └─────────────────────────┘
                                │
                                ▼
                          ┌─────────────┐
                          │   Concepts  │
                          └─────────────┘
```

Definitions of the phenomenon of interpersonal violence and abuse are produced in,
and by, different contexts, and re-produced through language and related practices
in a relational context

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                          ┌─────────────┐
                          │    Theory   │
                          └─────────────┘
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Interpersonal violence and abuse is socially constructed in the context of
personal and social histories and the material reality of abuse

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                      ┌─────────────────────┐
                      │  Research questions  │
                      └─────────────────────┘
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How do therapists name the problem of DVA and their subjects?
What tensions do therapists have to negotiate when working with DVA?
What other potentialities are opened up when therapists take a relational approach?

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                          ┌─────────────┐
                          │ Methodology │
                          └─────────────┘
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Thematic DA

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                          ┌─────────────┐
                          │   Methods   │
                          └─────────────┘
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Semi-structured interviews

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                          ┌─────────────┐
                          │   Findings  │
                          └─────────────┘
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Identify dominant ways of constructing DVA which re-produce best practice.

Identify the potentialities in marginalised constructions and related practices.

Source: adapted from Silverman, 2010.

Figure 4.1: DVA as a Socially Constructed Phenomenon in a Relational Context

4.4   Social Constructionist Epistemology

Within this framework, social constructionist approaches to research take a critical stance towards taken-for-granted ways of making sense of the world and those reductionist research practices, which seek to categorise people and behaviours, and provide evidence in support of dominant understandings (Willig, 1999). Instead, the world we experience is conceptualised as the product of social processes and relationships with others, rather than a reality wholly determined by the way the world is structured (Coyle, 2007; Silverman, 2010). From this perspective, knowledge about a phenomenon is linked to social actions and therefore different social practices will be implicated in the emergence and legitimating of different understandings in a particular cultural and historical context (Cromby & Nightingale, 1999).

Qualitative methodologies adopting this social constructionist epistemology place emphasis on the way 'social reality' is constructed through language. From this perspective it is assumed that people use a range of resources to actively construct particular versions of their worlds that can 'do things', such as blaming or justifying (Potter & Wetherell, 1987, p. 6). Language is seen, therefore, as not a merely descriptive medium for representing reality, but rather as playing an active and fundamental role in constituting events, objects and 'truths' as people draw on available ideas or meanings, referred to as 'discourses' to perform particular functions (Burr, 1995). Discourses, 'facilitate, and limit, enable and constrain what can be said, by whom, where and when' and some discourses will be more dominant, reinforcing particular ways of seeing the world (Willig, 2008, p. 107). So, a research approach to violence and abuse in intimate relationships, informed by a social constructionist epistemology, would question how this phenomenon is defined and given meaning through talk and would take a critical view of the ideas and theories which inform accepted understandings and best practice.

4.5   Taking a Critical Realist Ontological Position

Gergen (1999, p. 42) suggests that the meaning we ascribe to written or spoken texts arises through their function in relationships, arguing that we should avoid the 'deadening consequences of reducing the word to pure words'. He proposes instead that we focus on the purpose of these constructions in relationships, recognising that the function of words and how they are communicated 'depends so very much on the way they are embodied' (Gergen, 1999, p. 85). Although most people writing from a social constructionist perspective would not deny the existence of a material reality, some would question the degree to which we can have direct knowledge of this and would therefore place greater emphasis on the role of language in constituting our view of the world (Burr, 1995; Potter & Wetherell, 1987). Those adopting a relativist ontology would question whether emotions or

material things have an existence independent of language and therefore would tend to downplay the influence of the functional aspects of the body that make physical behaviours, such as 'hitting' or other forms of physical abuse possible, and might give particular meaning to interactions (Cromby & Nightingale; Taylor & Ussher, 2001). Others would argue that when a person is physically assaulted or emotionally hurt this generates material consequences for the body and society: bones can break; skin can be bruised and cut; emotional pain affects constructions of the self. In their discourse analytic account of sadomasochism (S & M), Taylor & Ussher (2001, p. 311) make this point:

> 'The reduction of a given phenomenon to the level of discourse tends to deny its operation on a more material level, individually and collectively, biologically and politically. The social constructionist approach tends to carry with it a denial of the existence of anything real beyond the level of narrative. There is a negation of the material world, and of the body, which are lost in a kind of 'constructionist solipsism'. This can be discounting of many people's realities…'

A social constructionist epistemology may be used from a critical realist ontological position, which recognises the existence of a material reality whilst also accepting that there are different ways in which this may be understood (Willig, 1999). This approach remains interested in how the meaning of a phenomenon such as interpersonal violence is negotiated through language, as opposed to conceptualising such problems as being determined by an individual's biology or their cognitions (Potter and Wetherell, 1987; Gergen 1999). Nevertheless, it takes into account ways in which both personal and social histories are implicated in the construction of different subjectivities and understandings (Willig, 1999). From this perspective, the material world is seen as being implicated in the production of discourses which are rooted in daily activities in a particular historical context, creating both possibilities and constraints which open up some ways of seeing the world and close down others. Power relations may be understood as embedded, though often implicit, in the social structures and relationships which make subject positions and particular discursive constructions more or less available, and more or less influential in what we do and what is done to us (Burr, 1995). A critical realist ontological approach to social constructionism would, therefore, attend to 'the materiality of power within which discourses are generated, enacted and received', which then can determine the dominance of some discourses above others (Taylor & Ussher, 2001, p. 312).

4.5.1   Conceptualising 'truth'

Whilst some ways of seeing the world achieve more acceptance than others, it is also the case that some versions can seem more true than others and achieve the status of truth-

telling (Gergen, 1999). Relativist and critical realist ontology differ in their approach to the concept of truth, and the question of whether some understandings and practices can be construed as more valid than others. Relativists would argue that the external world is 'inaccessible to us in both principle and practice,' so they accord different constructions of social reality equal validity, rejecting the notion of truth (Cromby & Nightingale, 1999, p. 6). However, this can become problematic when it means that all points of view are equally respected, regardless, for example, of whether these promulgate racist or other discriminatory beliefs. This standpoint both disregards the 'real' consequences of ideas that can generate oppressive actions or conditions, even if unintentional, and disables people from making judgements regarding the consequences of their own actions and those of others. It also appears to undermine the critical function of a researcher, and the rationale for taking a critical approach to some regimes of knowledge or practices, identifying ways in which they might be harmful to individuals. Whilst recognising that it is not possible to know what is true, some social constructionists who adopt critical realist ontology would argue, nevertheless, that some things are more true or right than others, rejecting the notion of moral relativism (Cromby & Nightingale, 1999; Kenwood, 1999).

4.6   Method of Data Analysis

4.6.1   Discourse analytic approaches

Epistemological and ontological assumptions provide a philosophical framework for research, determining what counts as a topic (Silverman, 2010). These methodological issues also underpin the choice of method, which in turn determines what kind of knowledge can be produced and what research questions can be addressed (Willig, 2008). Taking a critical realist approach to social constructionist research requires a methodology and methods of data collection and analysis that explores how a phenomenon is constructed and what material conditions contribute to generating particular understandings, whilst being sensitive to tensions, contradictions and potentially discriminatory practices. It is underpinned by an assumption that activities are transactional and purposeful, and both create and realise potentialities for future actions:

> 'For example, an action such as getting drunk can be a response to
> an event such as losing one's job, but can in turn become the cause
> of future developments, such as not getting another job' (Willig,
> 1999, p. 41).

Language, in the form of discourses, is seen as the means through which these understandings are constructed and so research methods that analyse spoken or written texts are required.

A discourse analytic methodology does not attempt to treat participants' accounts as providing evidence of a person's beliefs or attitudes (Potter & Wetherell, 1987). Instead, the way in which an individual construes a given action, whether their own or another's, and responds to it, would be understood as depending on the opportunities that a particular social context offers and on the subject positions an individual takes up. This means that we would expect there to be variation and contradictions in individual accounts and different consequences for different constructions. From this standpoint, research does not provide direct access to the social reality that participants are constructing and necessarily involves the researcher in a process of construction in which they must be careful not to extrapolate from 'performance to competence' (Potter & Wetherell, 1987, p. 73). We cannot assume, for example, that therapists' talk about their practice translates directly to what they do, since they will construct understandings with each of their clients in different contexts (Lyons, 2007). Nevertheless, it is anticipated that it can facilitate a better understanding of the range of resources therapists draw upon, their potentialities and the potential consequences for those in receipt of different approaches to therapy.

4.6.2 Discursive psychology and Foucauldian Discourse Analysis

Research questions about the discursive constructions of phenomena can be addressed by methodologies informed by a social constructionist epistemology. There are two main approaches to the study of discourse: discursive psychology and Foucauldian Discourse Analysis (FDA). They differ in their concern with either 'how' or 'why' questions and their emphasis on either discursive practices or resources: namely, how people construct particular understandings and why they draw on some ways of understanding the world rather than others (Potter & Wetherell, 1987; Willig, 2008). These approaches differ in their particular focus according in part to the different ontological positions researchers from each approach tend to adopt. Whilst, discursive psychology tends to adopt relativist ontology, FDA may be used by those taking a relativist or critical realist position (Sims-Schouten *et al.*, 2007; Walton, 2007). They differ too in which aspects of agency they emphasise: discursive psychology is interested in how individuals use language to manage social interactions to achieve particular objectives, whereas FDA focuses on what subjects are constructed through the use of available discourses and the ways-of-being this affords.

FDA sees the world as having a structural reality which consists of social structures and a network of power relations that influence the ways we understand the world and how we position ourselves in relation to the discourses we have available to draw on (Burr, 1995; Willig, 2008). Arguably, this approach would be consistent with critical realist ontology when studying phenomenon, such as interpersonal violence and abuse, where the material reality of someone having physical or psychological power over another is implicated in the availability of discursive resources. So, FDA can be used to address questions concerning

how we come to accept certain representations of reality as legitimate or true and how power relations are implicated in the processes and relationships through which these particular versions of reality are constructed.

FDA has particular relevance when we think about how identities are constructed through language and how someone can take up a particular subject position by labelling themselves, or being labelled by others as, for example, a 'victim' of interpersonal violence or abuse. It is also relevant when we want to investigate the understandings therapists bring to their relationship with such clients: relationships between professionals and their clients may be seen as unequal and talk is the medium by which an understanding of the client's problem is constructed. From this perspective, therapist's use of language can play an active role in re-producing existing power relations, but also has the capacity to contribute to transforming subjective experience and creating new understandings (Gergen, 1999).

4.7   Selecting a Research Method to Study Therapists' Understandings of Intimate Partner Violence and Abuse

From a social constructionist perspective, therapy practice may be conceptualised as being implicated in wider social processes that position people in diagnostic categories and having problems that require others' intervention (Parker *et al.*, 1995). This medicalising of distress can contribute to the marginalisation and oppression of vulnerable people through discourses that reinforce existing power relations and ethics of care in institutional practices. The institutions and the organisational practices themselves also provide validation and support for prevailing discourses. In this way certain understandings and practices can seem like 'commonsense' truths that defy challenge. This results in dominant discourses and related professional and social practices becoming accepted as the norm, whilst other versions are obscured or minimised. Prevailing discourses tend to offer understandings of the world in terms of binaries such as good/bad, normal/abnormal, that invite the division of experience into polarities (Parker *et al.*, 1995). This applies to the use of terms such as 'survivor, 'victim' and 'perpetrator' in domestic violence sector organisations for the purpose of assessing clients and naming the services provided. Whilst this serves to simplify the process of making sense of experience, it also invites ways of categorising, which powerfully determine what may be a limited set of choices and subject positions for people to take up (Parker *et al.*, 1995).

A social constructionist take on therapy emphasises the not-knowing stance of therapists, which places the client as expert on their problem and in this way might appear to dissolve an imbalance of power in the therapeutic relationship (Kenwood, 1999). Parker *et al.* (1995) point out the inherent contradiction in this stance, when a therapist's role is one of helping clients to reach different understandings, reflecting socially accepted norms of behaviour.

Nevertheless, even were therapists successful in bracketing their theoretical knowledge as well as their personal values, clients bring expectations, values and previous experiences to the encounter. All these factors will influence the way clients tell their stories, what they focus on, how they position themselves and how their problems are understood (Harre & van Langenhove, 1999). These accounts may be only partial representations of a problem, but none the less valid to each individual, for whom the process of making sense of their own and others actions has purpose and meaning. However, as with theorists and researchers, therapists may be faced with moral questions that require judgments to be made as to which version of an event is 'better' or more just than another, particularly when a client's version of reality is one of being controlled, or abused by someone they have an intimate relationship with. Therapists, like researchers, may wish to respect all viewpoints but when confronting the real consequences of violence or abuse they might find themselves taking a stance in favour of one view or another (Kenwood, 1999).

4.7.1 Positioning theory

Harre & van Langenhove (1999) proposed that when people converse they construct stories that are personally meaningful and in doing so they position themselves and the other speaker in ways that make their own actions intelligible, specifying particular moral or personal attributes, such as authoritative, powerful, nervous, confident. Positioning is thus a discursive practice that occurs in all contexts, including research, whether or not people deliberately position themselves, and is related to the more static construct of role. Roles such as therapist have a specified position, located in institutionally and culturally sanctioned practices which determine the conduct of specific social acts to be therapeutic in that context (Crocket, 2007). The other speaker is simultaneously positioned as a client whose actions in engaging in therapeutic tasks are also specified. Each position carries rights, responsibilities and duties to make certain kinds of remarks and this may be more or less explicit, but will nevertheless, determine and be determined by the authority of each speaker. Positions may emerge, or one speaker may force another into a speaking position, which they may then occupy, or seek to challenge or subvert, depending on their capacity, willingness or perceived moral authority to do so.

In the telling of their story, clients involved in abusive relationships may be understood as positioning themselves and the partner in ways that explain, justify, or blame self or other in order to make the behaviour meaningful. The same behaviours may be differently presented and understood, depending on the position taken up: behaving aggressively may be understood as intentional perpetration of violence by a 'perpetrator', or an act of self-defence by a 'victim'. Therefore, as the more dominant speaker in the therapeutic relationship, the positions that therapists assign to their clients in DVA practice have

implications for what can be said, which understandings are generated and what outcomes are possible.

4.7.2   Refining the research design

The initial intention in this study was to analyse data using FDA in order to critically examine ways in which therapist drew on discourses to construct certain versions of reality whilst marginalising others, and thereby influenced the direction of the therapeutic process. More particularly, the objectives of this initial proposal were to deconstruct professional talk about "victimhood" and "relatedness" with regards to DVA in order to map out the possibilities opened up, and closed down, for clients, in terms of the meanings available to explain their clients' experiences of DVA. Also by deconstructing professional talk about therapeutic practice the intention was to examine the interplay between current DVA related professional practices and social norms. This appeared to be an appropriate methodology to interrogate the data for the purpose of identifying tensions and contradictions that might arise in the understandings participants draw on to explain their views.

The initial proposal was designed to undertake an explorative study with relationship counsellors from a particular organisation, looking at the way in which they talked about DVA and, more particularly, their approach to practice using a new DVA assessment tool. This idea had arisen partly because my interest in working with relationship issues and my previous clinical experience had opened up this opportunity. To some extent, therefore, the sampling opportunity presented influenced the choice of topic, but appeared serendipitous in potentially enabling me to explore my interest in how therapists construct the notion of victimhood, in relation to the problem of intimate abuse in relationships. So, I was disappointed when the proposal was turned down by the organisation's ethics committee because it was decided that the position I was taking was inconsistent with their model and would, therefore, not be a helpful exercise for them.

This initial setback, although disappointing, turned out to be a useful and transformative event that helped to shape the eventual design of the research. In revisiting the research design and thinking again about the topic I was interested in addressing and the framework to be applied, I reconsidered the research questions and the utility of the methodology and research methods I had previously proposed. This necessary change in objective also led me to reflect on how some ways of understanding intimate partner violence had come to be accepted as normative, not open to question and even institutionalised in therapy settings. This highlighted a dilemma: I could see that in seeking to explore some of the more sensitive and controversial aspects to understanding of the phenomena I would be implicated in construing some approaches as better than others, and that this might be found challenging of accepted therapeutic models and practices. Moreover, an FDA approach

would explicitly focus on inconsistencies in people's accounts, identifying perhaps unintended consequences of what was being said (Wiggins & Riley, 2010). Nevertheless, I remained interested in deconstructing therapists' ways of understanding intimate partner violence and abuse, whilst wanting to recognise the practical realities within which they worked and so I sought other ways to operationalise my research questions. With ethical considerations in mind, I decided there would be less risk of particular institutions, or individual participants being identified, if I were to widen my sample to include a range of agencies (Wetherell *et al.*, 2001). In addition, focusing solely on one organisation with its specific culture and practices would immediately challenge the relevance of the analysis to other organisations and practitioners working in the DVA field.

4.7.3   Rationale for using a thematic analysis informed by the theory of discourse

Whilst the use of FDA appeared at first to be relevant to research questions designed to find out more about therapists' take on DVA practice and the relational space within which therapy is conducted, as I weighed up some of the methodological issues, I began to question my initial plan. It became clear, that FDA may not be the most appropriate method to apply to the data corpus, when the intention was to investigate 'either/or' understandings and generate a rich analysis of ways of understanding DVA from the potentially different points of view of therapists who work with 'victims', 'perpetrators', or a couple.

In subjecting participants' interviews to a highly structured discourse analysis I had some concerns regarding the extent to which participants would feel their 'real' difficulties in engaging with people who have been abused, or abusive, had been respected, if I were focusing exclusively on discursive constructions (Walton, 2007). Moreover, since variability in conversations is an expected feature, from a social constructionist perspective, inconsistencies in participants' accounts might be identified which participants might not have noticed and might object to (Potter & Wetherell, 1987). As a fellow therapist, with some experience of the challenges posed in doing this work, I felt a sense of responsibility towards my participants and wanted to ensure that I gave recognition to the material realities within which they practised, whilst neither colluding with the notion that best practice cannot be subjected to scrutiny, nor producing an account that is dismissive of their intentions. Moreover, I was concerned to ensure that if participants were to read the reported findings, they would recognise their contribution and not see it as lost in an esoteric discussion of little relevance to their actual practice.

In any event, some researchers argue for a more eclectic approach to discourse analysis, suggesting that the two main versions need not be used separately. They advocate instead the taking of a twin focus on both the situated aspects of discourse and the wider social and institutional frameworks within which discursive constructions are produced (Potter &

Wetherell, 1987; Willig, 2008). Approaches tied to either, or both, analytic method will necessarily share a focus on language as the object of enquiry since they share the social constructionist perspective that social reality is constructed through interaction. It follows, therefore, that the knowledge they produce must itself be a discursive construction by the author and as such, can be criticised for having limited, or no, application in a 'real' world outside the discursive framework. As a therapist, I had some concerns, therefore, about how a discourse analytic approach could be used to generate research findings of both theoretical and practical value, which would be meaningful to therapists, without seeming to be dismissive of the particular demands of working with this client group.

Nevertheless, some researchers do argue that social constructionist theory can inform professional practice and achieve a practical application: scrutinising what is said about a phenomenon and examining taken-for-granted notions about ethics of care can generate recommendations for practice (Stainton Rogers & Stainton Rogers, 1999). Using constructionist ideas as a conceptual framework can increase our understanding, for example with regard to child abuse, of how certain concepts are applied in practice, supporting some definitions of abuse and discriminatory practices towards women. More particularly, other researchers advocate the use of a thematic discourse analytic approach which affords a more flexible application of methods from within this same broad theoretical framework (Braun & Clarke, 2006; Taylor & Ussher, 2001). A thematic analysis is a method for 'identifying, analysing and reporting patterns (themes) within data' that is not wedded to a particular conceptual framework (Braun & Clarke, 2006, p. 79).

A thematic analysis that is informed by discourse theory can be used to examine constructions and narratives of DVA and how therapists engage with these in their talk about therapeutic interventions with clients. Approaches coming from within a constructionist framework, that theorise what is spoken about as being underpinned by broader assumptions may overlap with some forms of Discourse Analysis (DA) and may be specifically named as 'thematic DA' (e.g. Taylor & Ussher, 2001). Such an approach does not negate the role of the researcher in constructing the analysis, foregrounding some views and coming to particular conclusions, and indeed attempts to make personal, theoretical and epistemological orientations transparent:

> '...as with any research, is clearly still tied intrinsically to the subjective positions of the researchers. 'Discursive themes' do not just lay about waiting to be discovered, they do not simply emerge, but must be actively sought out. The process, in terms of data collection and analysis, is unavoidably informed by the researchers' disclosures, comments and choice of questions and by their preconceptions and their personal, theoretical and political orientations' (Taylor & Ussher, 2001, p. 311).

Using a thematic analysis, themes may be organised and analysed at either a semantic or latent level (Braun & Clarke, 2006). A semantic analysis may be conceptualised as a process involving a development from a merely descriptive level in which the material is organised to show patterns in the semantic content, to an interpretive level whereby there is an attempt to identify broader meanings and the implication of these patterns/themes. Where there is a further progression which involves going beyond the explicit content to examine the underlying ideas and assumptions that inform and give meaning to the semantic content, the resulting analysis sits within a constructionist framework and is therefore most compatible with my research aims (Braun & Clarke, 2006; Taylor & Ussher, 2001).

Thematic analysis has been proposed as a useful method when 'investigating an under-researched area, or you are working with participants whose views on the topic are not known' (Braun & Clarke, 2006, p. 83). A thematic analysis would therefore be consistent with the more specific aims of an exploratory study designed to explicate the views of a heterogeneous sample of therapists working across the sector. Patterned responses across the data corpus would be identified in relation to the research questions, and in the context of theorised debates around understandings of DVA in the research literature.

The particular value of a thematic analysis for this research lies partly in the flexibility of the method to identify constructions of DVA and the conversational tasks of therapy, whilst remaining appropriate for the epistemological and ontological position. Whilst not being tied to an application of FDA, for the reasons stated above, a thematic discourse analytic approach would be relevant to the broad aim of examining how therapists talk about their engagement with DVA, and how this use of language about DVA is performative (Smith, 2008; Walton, 2007). Within this conceptual framework, underpinned by the proposition that constructions bring with them certain realities and ways of seeing the world that open up and close down certain ways of understanding a phenomenon, my interest is also in how speakers' constructions position them and others, contextually, in relation to the phenomenon of DVA and the tasks of therapy.

4.7.4   Summary

It was proposed to use a thematic analysis to interrogate the views of a sample of practitioners from across the DVA sector, in relation to approaches to DVA practice and identified dilemmas, and to consider the potential implications for the conduct of therapy and supervision. The more specific aims were to examine 'either/or' constructions of DVA and the tasks these make possible, and how these in turn position clients, relationally, in the therapeutic space, for example, as 'victims' or 'perpetrators'. It was anticipated that a thematic analysis informed by discourse and positioning theory would generate a rich overview of different understandings and their implications for practice, identifying both

predominant themes and those that are marginalised. A further analytic interest was in the extent to which these might be indicative of discursive constructions informed by wider social norms, theory and research, in the context of material aspects of therapists' social reality, including personal and professional histories and relationships with clients and others (Willig, 1999).

4.8 Data Collection

4.8.1 Sampling strategy

The intention was to conduct semi-structured interviews with therapists who worked with DVA in dedicated settings, or specialist agencies, on the basis that they would have developed particular expertise and understandings of the phenomenon through their experience and training. For ethical reasons, having decided not to limit the focus to therapists in one agency, it was intended that the sample be as broad and inclusive as possible (Taylor, 2001). I had to consider the parameters that I wanted to apply in order to find a sample of therapists from what was a vast number of organisations. I made an initial search of organisations in the domestic violence sector and also approached some Relate centres and NHS services, seeking out settings where therapists would be working with clients presenting with problems of violence and abuse in intimate relationships.

I initially planned to interview 10-12 participants, to include therapists who worked with different client groups. However, to achieve a representative sample of this population of therapists working with DVA, I became increasingly aware that I would need to conduct more interviews. All had to have a professional qualification, enabling them to work with this client group, but length of experience was not specified. My approach to gathering the data was determined by 'theory based' sampling, so organisations and individuals were approached on the basis that I was aiming to construct a data set that would be of relevance to the current theoretical debates about best practice in the DVA literature (Punch, 2006, p. 51). Having found that most organisations worked with either female 'survivors/victims' or male 'perpetrators', I wanted to have a sample from each of these and if possible, a sample of therapists who worked with both groups or with couples, so I adopted a 'stratified purposeful' approach to sampling in order to facilitate comparisons between the different grouping of clients (Punch, 2006, p. 51).

I was initially interested, if possible, in having a sample across both voluntary and statutory sectors. The funding of many organisations was complex and though this was not the topic of my research, many practitioners referred to funding difficulties and staff shortages and this was relevant in relation to whether some practitioners could spare time to participate.

Ultimately, I was able to interview three participants who had local government funding, whilst all the others received funding from a range of other sources.

To some extent the sample size was also determined by being given permission to access individuals. Convenience/location was not an issue as I travelled to different parts of the UK in order to expand the number of potential participants and to reduce the possibility of individuals being identifiable. I made approaches to individuals or organisations by telephone where possible and then followed up with emails. Whilst gender is a relevant concept in relation to the research topic, it was not a characteristic that influenced the selection of the sample, though it became of interest in terms of the way participants spoke about gender relations and how they saw it impacting on their relationships with clients. Age and ethnicity were also characteristics that did not influence the selection of the sample.

Ultimately, constructing a sample was not a problem and indeed having a much greater response than I had anticipated created its own challenge. Having completed a number of interviews, it became possible to expand the sample to include some individuals from agencies who were trying out new approaches to the therapeutic work, resulting in the undertaking of 20 interviews in total. Some of these practitioners spoke about approaches that, for example, included working individually with male 'perpetrators', providing groups for female 'perpetrators' and working with 'victims', who could be male or female.

4.8.2   Participants

It became apparent from the adverse reaction to the first proposal, that the position I was taking in exploring ways of understanding DVA could be construed as challenging existing best practice. I was therefore initially concerned that it might be difficult to find participants. I cannot be certain how many people, if any, did not take up the invitation to participate because the research framework did not fit with their preferred paradigm, as this was not mentioned. I did not succeed in attracting a sample from the NHS, for example. In the main, those who did not participate gave reasons of being over-stretched and under-resourced.

For the purpose of maintaining anonymity, ethnicity and actual ages of the participants have not been reported and other information regarding participants' personal experience is only mentioned in the analysis, where relevant2. Of the 20 participants, 16 were female and 4 male, representing the predominance of women working as therapists with female 'survivors'/'victims': 3 of the 4 males were working with 'perpetrators', whilst 3 of the 16

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2   Participants' background information by gender, age, ethnicity, training and experience is available if required.

women worked mainly with 'perpetrators'. Additionally, one of the female participants provided therapy for children affected by their parents' abusive relationships, and 3 participants worked in more than one agency. Figures 2-4 illustrate the differences in experience and training of the 20 participants, and the range of their clinical practice.

Thirteen participants worked in agencies that specialised in either working with those identified as experiencing abuse from a partner, or with those identified as behaving abusively, and the agencies were funded accordingly. Of these, 6 worked in agencies that provided services only for women, and their clients were referred to as 'victims' or 'survivors'; 4 worked in agencies where male and female 'survivors'/'victims' could be referred/could refer themselves; 1 worked in an agency for male victims. 2 participants worked in agencies offering 'perpetrator' programmes and/or therapy for men and women, though they mainly saw male clients, and 2 agencies saw male 'perpetrators' only. 5 of the participants worked in an agency where services were offered for both 'perpetrators' and 'survivor/victims' and 3 participants worked in agencies where some clients were seen as couples. 5 participants indicated that they would work or had already worked with both 'victims' and 'perpetrators' and all the therapists working with 'victims' indicated that they would work or had already worked with male as well as female clients. All participants said they would work with clients in same-sex relationships.
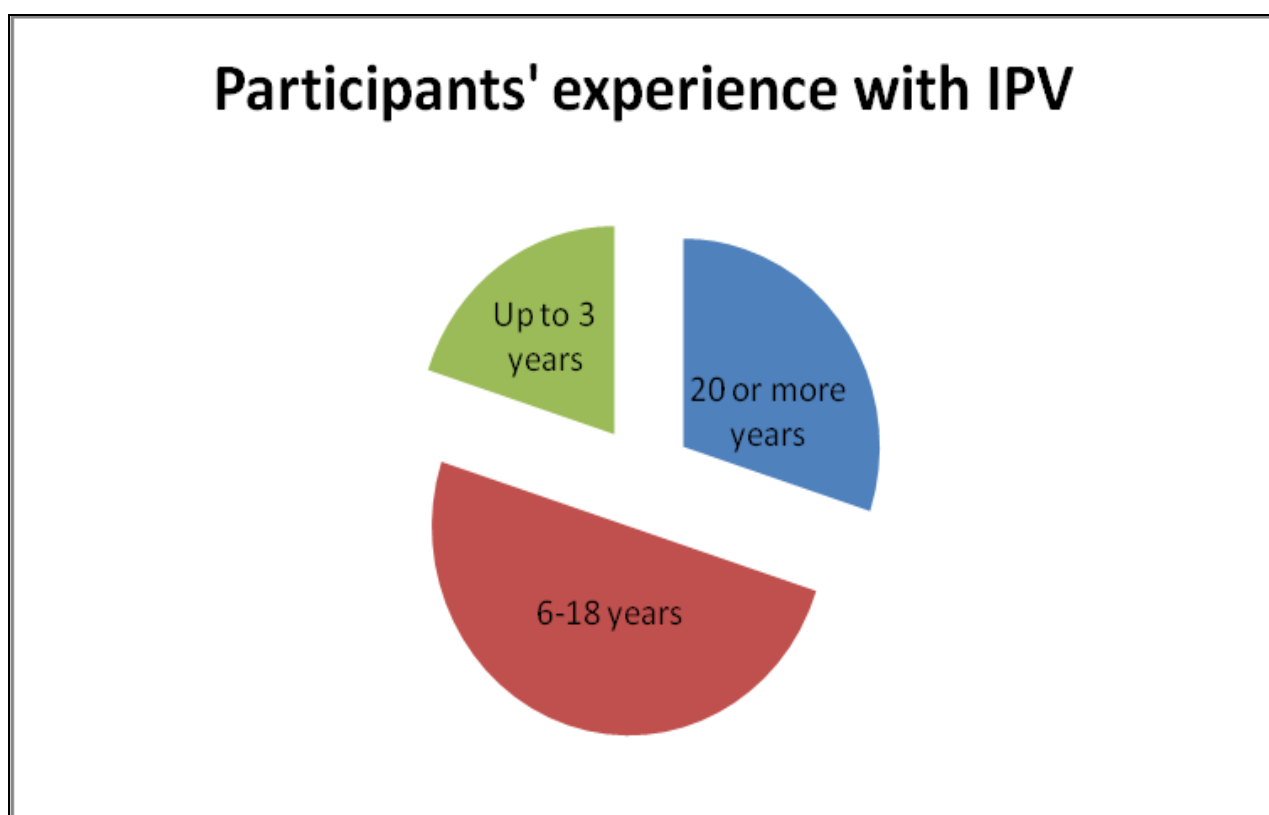
Figure 4.2: Participants' Number of Years' Experience of Working With Clients Presenting With Intimate Partner Violence and Abuse

Figure 4.3: Participants' Reported Main Training, Informing Their Work With Intimate Partner Violence and Abuse
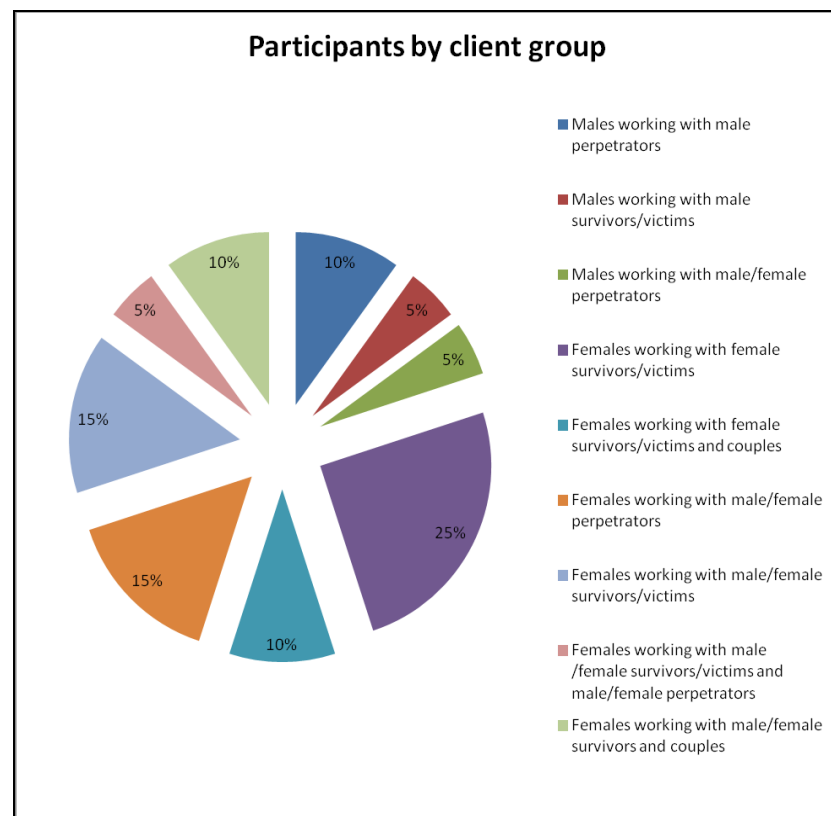
Figure 4.4: Percentage of Participants Working with 'Survivors'/Victims' and/or 'Perpetrators', by Gender

4.8.3 Issues of validity and reliability

Whilst these are criteria derived from empiricist approaches based on a striving for objectivity and therefore not applicable to a qualitative method of enquiry, the issues remain, as to whether the research accurately represents the phenomena under investigation and has been analysed in a consistent way (Silverman, 2010; Coyle, 2007). This poses particular dilemmas for qualitative researchers since much research from this paradigm is underpinned by an assumption that there are many, equally valid, ways of seeing the world, and thereby undermines notions of there being true perspectives on evaluating the worthiness of the findings (Yardley, 2008). Nevertheless, Yardley (2008) argues that we do all make judgments about quality and validity, so it is important that the basis on which decisions are made about the value of a study is as transparent as the conduct of the study itself.

Some researchers have attempted to set out criteria for the evaluation of qualitative research (Elliott *et al.*, 1999; Yardley, 2000). Elliott *et al.* (1999) derived criteria considered to be common to both quantitative and qualitative research, and some 'particularly pertinent to qualitative research (owning one's perspective; situating the sample; grounding in examples; providing credibility checks; coherence; accomplishing general versus specific research tasks; resonating with readers)'(Coyle, 2007, p. 21). Yardley (2000; 2008) produced a framework which sets out four core principles for evaluating qualitative research: 'sensitivity to context'; 'commitment and rigour'; 'transparency and coherence'; 'impact and importance'. Whilst recognising that there are many different approaches to qualitative research, Yardley (2008) suggests that these represent common criteria, which can be flexibly, rather than prescriptively, applied to demonstrate that a qualitative study has been rigorously conducted. These principles, recognised and applied in this research, are concerned with recognising contextual influences on the conduct of the research and demonstrating the rigour and appropriateness of the method through a careful and transparent detailing of the data collection and the process of analysis.

Being transparent about the contingent and socially constructed nature of the researcher's own views through use of personal and epistemological reflexivity is, according to some researchers, an important way in which qualitative research achieves validity (Willig, 2008). The interpretation of the data, the identification of themes and the selection of extracts will all be influenced by the researcher's own values, and take on the topic, so it will be important to demonstrate that the findings are not merely arbitrary but based on a critical and rigorous process of analysis of what others have said. This in turn will be demonstrated by a clear and in-depth explication of the themes and relevant use of extracts indicating how an interpretation was constructed.

4.8.4   Ethical considerations

4.8.4.1   Ethical approval

Ethical approval was sought and obtained from the University of East London School of Psychology Ethics Committee before data collection commenced (Appendix 2).

4.8.4.2   Ethical responsibilities of the researcher

As part of the recruitment procedure, participants were given an information sheet, which set out some of the theoretical ideas guiding the research and its aims. This ensured that their decision to participate was informed by an understanding of the purpose of the study (Appendix 3). Steps were taken to protect the anonymity of participants by sampling from a number of different agencies across the UK. Bearing in mind that participants work in specialist services, and two participants raised concerns about making comments that might be misconstrued as 'victim-blaming, or might put their registration with Respect at risk, it was important to limit the degree to which they could be identifiable. One participant worked in a refuge and wanted assurances that its location would not be revealed. Pseudonyms have been used and other identifying information changed or removed to further protect their anonymity.

Informed consent was obtained from participants in advance of the interview, regarding their involvement in the research, taking part in an audio-recorded interview and the subsequent use of the data (Appendix 4). This included issues of confidentiality and participants' right to withdraw without explanation at any point in the process. Participants were invited to request a copy of their transcript and a summary of the findings, should they wish.

Following the interview, participants were given a debrief sheet which set out some of the theoretical ideas informing the study with some references, for their information (Appendix 5). It was not anticipated that participation in an interview about their work with clients would likely cause distress to therapists. However, given the nature of the topic and the possibility that some participants might have had personal experience of abuse, they were encouraged to seek support from their clinical supervisor in the event that they found the process upsetting.

4.8.5   Interviews

If interviews are considered a form of social interaction, use of semi-structured interviews as a means of gathering data is compatible with a social constructionist framework and a discourse analytic method of data analysis (Hugh-Jones, 2010; Potter & Wetherell, 1987). Potter & Hepburn (2005) argue that appreciating the interactional nature of an interview is

essential both to the analysis and to the representation of the transcript, for example, by including the interviewer in the reporting of the talk and being clear about how the task was represented to the interviewee. From this perspective, interviewer and interviewee are understood as co-constructing the process, since the choice of research questions determines the topic and steers the focus of the interview, and the interviewee chooses how they respond to the questions (Willig, 2008). Whilst there may be many potential ways of responding, it is assumed that people do so in a way that is consistent with their ways of organising their views and understanding of a particular topic, whilst being sensitive to the perceived demands of the context (Silverman, 2010). In particular, interviewees are likely to be influenced by their perception of the person asking the questions and why they think they are being asked particular questions, and this will affect the positions taken up (Harre & van Langenhove, 1999). The resulting data are, therefore, understood as being co-produced ideas formulated in interaction and dependent on a number of factors, rather than a direct representation of the interviewee's thoughts on the topic (Hugh-Jones, 2010).

It is suggested that interview schedules should be designed to include a relatively small number of open-ended and non-leading questions to best enable the interviewer to elicit an account that is not heavily shaped by the question, but can generate detailed, complex responses that answer the research questions (Willig, 2008; Hugh-Jones, 2010). To aid participants in giving comprehensive responses, questions may be followed up by prompts, or probes or requests for examples. As with any interaction the degree of engagement will depend on the extent to which rapport has developed, so it is important that interviews are designed to begin with less searching questions that both orientate the interviewee and help them feel comfortable to speak about the topic. For this study, an interview schedule was used as a guide to maintain a structure and focus on the research questions during the interviews, but it was employed flexibly to enable participants to expand on particular themes or to move to issues relevant to another question in a different order, in order to generate discussion and a relatively smooth exchange (Appendix 6).

4.8.5.1 *Pilot study*

A pilot study was conducted with Sara (participant 1) in order to find out whether the interview questions generated discussion and relevant information. Having completed the interview, from my point of view, I was bringing the interview to a close, when Sara asked me a question relating to a leaflet I had been sending out to recruit participants (Appendix 7). She told me that the question to do with your understanding of, 'Why people stay with abusive or violent partners', was, in her view, one 'that most people in the DV sector would really absolutely hate' and went on to expand on this and give her views on current research.

Following this interview, I stopped using the leaflet and I revised the interview schedule (Appendix 6) to include 2 additional questions related to issues debated in the research

literature, which I either included at appropriate points in the discussion, or added at the end of subsequent interviews. My rationale for not using the leaflet again was that the question was, unintentionally, perceived as 'victim-blaming' and insensitive by this participant and I concluded that others might be deterred from talking about their practice if they construed the statement in the same way. I decided to include the interview in the analysis as it was formative in my approach to subsequent interviews and my understanding of what were accepted approaches to the phenomenon of DVA.

This interaction heightened my awareness of the controversial and sensitive nature of the topic and how participants' expectations and positioning of the researcher will affect the interview process. Thereafter, I tried to strike a balance between, on the one hand asking searching questions that might be construed as offensive and, on the other, maintaining rapport to the extent that controversial issues were not raised. In subsequent interviews I tried to ensure I adopted a more 'naive' questioning style, suggested by Willig (2008), by which I posed such questions with a preface of, 'Some people/researchers might say...'. Since there were occasions when strong views were expressed on similar issues by many other participants, I concluded that they did feel able to speak openly.

4.8.5.2 *Interview procedure*

Participants were recruited by email with an information leaflet (Appendix 3). This was sometimes preceded by a telephone call or followed up by one in order to answer questions, check their suitability and provide further information about the study before arranging an interview date and time.

All but one of the participants agreed to be interviewed at their place of work; one arranged to meet in a mutually agreed place where we could talk uninterrupted. At the start of the interview, participants were reminded of the information leaflet already sent and provided with another one should they wish to read it again. They were asked to read the consent form (Appendix 4) and sign this if they were comfortable with proceeding.

As a prelude to the interview questions (Appendix 6), participants were asked for some demographic information, namely their age, qualifications and number of years of practice with interpersonal violence and abuse issues. The interview schedule was used to guide the interview process, which was recorded using a digital recorder and took between 45 and 70 minutes (the latter interview included two participants for part of the time). Questions were used to promote a two-way interaction with which to explore key themes. Each participant, as part of bringing the interview to a close, was asked whether they wanted to add anything. When the interview was completed, participants were thanked and given a de-brief form (Appendix 5).

4.9 Data Collection: Personal Reflexivity

Whilst I aspire to being a reflective practitioner, and to being aware of what influences me and my responses to others, I am conscious nevertheless, that there may be blind spots, of which I am unaware. This has relevance to the interview process which delivered the data for my research. In recognising that my personal and professional experience and theoretical understanding have influenced my approach to this topic, and the specific questions I asked, I acknowledge that this will have impacted in some way on the relationships I formed, albeit briefly, with my research participants and on the meanings and particular understandings constructed in each interview. Participants were made aware in the information leaflet sent to each of them in advance that I was a practising psychologist with some experience of working with DVA, so they, too, will have brought their own expectations and intentions to the interview process.

Although most of the participants were experienced practitioners, some were relatively new to the field (Figure 4.2), and their professional trainings differed (Figure 4.3), so, there was a potential for a power imbalance if the researcher was thought of as having more, or different, knowledge than the participant, as a practitioner psychologist (Taylor, 2001). This could have meant that some responses would be compliant with what was construed to be my expectations, despite my intention to minimise my influence on the course of the interviews by asking open questions and encouraging participants to expand on their own views. At the same time, with the intention of promoting validity, I aimed to be transparent about my intention to explore some controversial issues, in order to ensure that participants would be free to challenge any assumptions embedded in the research or interview questions. It was apparent, however, that participants construed these issues differently, so for some these were 'tricky' issues, whilst for others they were unambiguous. Therefore, my own understanding of these issues as being controversial and difficult to negotiate did influence the way in which these ideas were presented, in addition to being guided by the reaction of participant 1 in the pilot study. When introducing what I understood to be more controversial questions for practitioners in this sector, as indicated in the interview with participant 1, Sara, I sought to distance myself from taking an explicit position by deliberately phrasing questions for example, as, 'some therapists might say...'.

Having carried out several interviews, the theoretical concerns raised more specifically with regard to using FDA became 'real', confirming the value of my decision to use a thematic analysis. It became apparent that there were inconsistencies, for example, as between the expressed intention of some participants to take a gender-neutral approach and/or not categorise clients, and their repeated references to 'perpetrators' as male, and 'victims' as female. However, I was struck by the 'real' impact of the work on the participants, aware

that personal, and wider contextual influences shaped their understandings and practice, and were implicated in the challenges they faced, and their responses.

I was also struck by how easy it was to engage with the participants and I wondered to what extent this was to do with having a shared language about therapy and their sensitivity as therapists to the interactional context of the interview (Hugh-Jones, 2010). I reflected on how participants might assume a shared understanding with me and consequently, perhaps, reveal things that they might otherwise not have said. I became mindful of how I could become implicated in taking up a position of being an arbiter of truth and imposing this on the data in ways that could give weight to one version of reality, and in so doing, reproduce the 'either/or' ways of seeing the world that I was seeking to explicate. In other words, I was also mindful of the potential for the 'interrogation' of their views to be perceived as persecutory and the participants victimised, thereby re-producing the relational dynamics present in the client work. In conclusion, however, I sought to understand meaning as constructed in an interpersonal and social context, whilst adhering to the notion that not all representations are equally valid even if believed by the speaker to be 'true', (Kenwood, 1999).

4.10   Phases of Thematic Analysis

The analysis of the data follows the outline guide summarised in Table 4.1 below, which has been taken from Braun & Clarke (2006).

Phase		Description of process
1	Familiarising self with the data	Transcribing data; reading and re-reading the data and noting ideas
2	Generating initial codes	Coding for interesting features of the data, systematically across the data set
3	Searching for patterns and themes	Reviewing codes and beginning to collate these into potential themes across the data set
4	Reviewing themes	Checking whether the data supports the themes i.e. at the level of the coded extracts and across the data set; generating an initial map of themes
5	Defining and naming themes	Refining the thematic map in relation to specific themes and how these link to tell a story; generating clear definitions and names of themes
6	Writing the analysis	Selecting vivid extracts to illustrate themes; analysing these in relation to the research questions

Table 4.1: Phases of Thematic Analysis

The transcription of 20 interviews in phase 1 was a time-consuming, but essential, part of the process of engaging with the detailed content of each interview. Whilst there are various conventions for transcribing spoken texts, the approach to transcription appropriate for a thematic analysis is 'orthographic' i.e. a verbatim account with some punctuation used to retain the sense of what was being conveyed (Braun & Clarke, 2006). During the transcription phase and the subsequent process of re-reading the written texts, I noticed that I had particular memories of each interview, which influenced what I found interesting or surprising, and this also drew my attention to other ideas that I might have not been so aware of at the time. I marked some text in bold, and made brief comments in a notebook about each interview as I transcribed it. I noticed that I might recall the interaction between us, the journey and context in which the interview took place or, more specifically, something that was said by the participant. For example, I visited a women's refuge for one interview and was impressed by how well disguised it was and hence difficult to find, but also left with an enhanced understanding of the potential seriousness of the issues and my responsibilities in reporting on it; participant 6 spoke specifically about some of the more extreme and subtle examples of violent and abusive behaviour by women and I recall reflecting on the complexity of the issues as well as feeling shocked by their 'real' impact; participant 7 spoke frequently about 'choice' and her role, as she saw it, in giving her clients 'choice', and initially I considered this as a potential theme as it occurred in other interviews.

Having familiarised myself with what the participants were saying, and generated a list of ideas for each interview, I returned to the transcribed interviews to code manually in detail for interesting features at phase 2. Interviews were coded electronically and extracts collated by printing the data and using highlighters to mark the codes. I would describe this stage as an integration of both a bottom-up and top-down approach, as the initial coding process was driven by what was said by each participant but, having engaged with the literature, my approach to coding and generating themes was influenced by my awareness of the theoretical debates in the research literature. See Table 4.2 for an example of the process of coding and generating themes).

Data extract	Descriptive coding (phase 2)	Theme
58. Sue: (unclear) I I I loathe those terms. I find it disrespectful in terms of there's an area of their lives that they have a problem with. It doesn't make them bad people it just means they've behaved extremely badly in a criminal manner	Talk about terminology. Seeing terms as disrespectful, labelling people as bad who have a problem(58)	Theme: Naming the Problem. Sub-theme: locating responsibility

Table 4.2: Example of Data Extract With Initial Coding at Phase 2 and Final Theme

As I moved recursively between phases 2 and 3, alternately looking in detail at the transcripts and re-focusing at the broader level of themes, I became more aware of what Yardley (2008) refers to as 'disconfirming instances' to what were the predominant patterns in the data. In addition to contradictions and tensions within participants' talk, there were extracts showing some differences between participants' perspectives, which led to a more systematic search for data that did not align with the themes already identified. So, after some initial empirical work an additional research question was included, "What other potentialities are opened up when therapists take a relational approach?" This decision to include an additional research question is compatible with an exploratory approach that allows the development of the research questions to be refined during the early phase of analysis by the initial trends/patterns identified in the data (Punch, 2006).

At phase 3 of the thematic analysis, all the potential themes were listed and these were then mapped into 3 main themes and potential sub-themes:

Theme 1:

How therapists talk about DVA

- Naming the Problem
- Locating responsibility
- Setting the agenda
- Validating 'survivor'' experience
- Re-educating 'perpetrators'
- Creating a context for the therapy

Theme 2:

What is problematic or missing

- Constructing the present in the context of the past
- 'Who did what to whom'?
- Making choices
- Empathising with the self as abusive
- Taking responsibility
- 'Why doesn't she just leave?'

Theme 3:

Taking a relational perspective

- Understanding the relational context
- Holding ideas in tension
- Relating to the whole person
- One size doesn't fit all

Figure 4.5: The Initial Identification of Themes at Phase 3 of the Analysis

Across the phases 3 and 4, when re-visiting the coded extracts it became apparent that some sub-themes e.g., "Locating responsibility", needed to be collapsed into other sub-themes, e.g. "Naming the problem", and some needed to be discarded, e.g. "Empathising with the self as abusive". Further refinement involved combining and separating some sub-themes resulting in the devising of another Sub-theme, "Decoding what is relevant", which incorporated 3 of the sub-themes in Theme 1. The overall aim was to ensure that the themes formed a coherent pattern, representative of the data, and that the extracts fitted within the themes. This resulted in a provisional map of 3 themes, based on Figure 4.5 with an expanded Theme 1 and refined and elaborated sub-themes in Theme 2, renamed, "Getting stuck".

Phases 4, 5 and 6 overlapped as I found it helpful to begin to write summaries of the themes and sub-themes, determining what the themes were capturing and how each sub-theme was linked. Alternating between writing and re-reading the extracts in each theme and sub-theme helped to clarify whether the themes were telling a coherent story. During this process it became apparent that Theme 1 was too diverse and so, "Decoding what is relevant", became a separate theme and some extracts were discarded and some moved or added to other sub-themes. The map (phase 4) (Figure 4.6) was devised after revisiting the data set and re-reading each theme and sub-theme to check how accurately the themes and sub-themes reflected what participants were saying across the data set as a whole. This shows that some sub-themes were re-named e.g. sub-themes in Theme 3 and the 4 sub-themes in Theme 4, which were collapsed into 3.

The final thematic map (Figure 4.7) was derived from a repeated recursive process of revisiting the themes and reading for internal consistency and coherence across the data set. Though in the main, the content of the sub-themes were not changed at this stage, there was a re-organising of the structure of each of the themes. The aim of this was to show more clearly, for example, how constructions of DVA in "Naming the Problem", Theme 1, were linked to the conversational tasks identified in the sub-themes within that theme, and in this way demonstrating the hierarchy of meaning within each theme. A detailed analysis was written for each theme, identifying the sub-themes that they contain and what was of interest about the chosen extracts used to illustrate the story the theme is telling. Each theme was considered in relation to the overall story of the data and each sub-theme was considered in relation to its part in telling that story and developing a coherent and logical argument in response to the research questions.

Figure 4.6: Thematic Map (Phase 4)

Theme 1: Naming the Problem

- DVA as a gender issue
- Assessing risk
- DVA as happening outside awareness
- Deciding who gets help
- DVA as wrong
- Constructing blame
- Locating responsibility

Theme 2: Decoding what is relevant

- Creating a context for talking
- Enabling clients to change
- Shifting their thinking
- Enabling clients to take responsibility
- Enabling clients to cope
- Creating a context for change

Theme 3: Getting Stuck

- When 'naming' is challenged
- When the work impacts on therapists
- When 'decoding' is challenged
- When scapegoating 'resolves' who has agency
- When choice & responsibility are challenged
- When scapegoating 'resolves' who is responsible

Theme 4: Taking a relational approach

- DVA as a problem in relating
- Deliberately expanding the picture
- Holding ideas in tension

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Figure 4.7: Thematic Map

Theme 1: Naming the Problem
- DVA as a gender issue
- DVA as happening outside victims' awareness
- DVA as wrong
  - Locating responsibility
  - Constructing blame
  - Deciding who gets help
  - Assessing risk

Theme 2: Decoding what is relevant
- Creating a context for supporting 'survivor/victims'
  - Enabling clients to cope
  - Shifting clients' thinking
- DVA Creating a context for changing 'perpetrators'
  - Enabling clients to take responsibility
  - Enabling clients to make changes

Theme 3: Tensions and dilemmas
- When 'naming' is challenged
- When 'decoding' is challenged
- When choice and responsibility are challenged
- When the work impacts on therapists
  - scapegoating 'resolves' who is responsible
  - scapegoating 'resolves' who has agency

Theme 4: Taking a relational perspective
- Understanding the relational context
- DVA as multi-faceted
  - Moving away from blaming
  - Holding ideas in tension
  - Deliberately expanding the picture

CHAPTER 5: HOW THERAPISTS TALK ABOUT DOMESTIC VIOLENCE AND ABUSE

5.1 Introduction to the Analytic Chapters

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The intention of the analytic chapters is to represent the participants' constructions of DVA and how they talked about their therapeutic approach when working within this field. The structure of the themes both illustrates and represents the complexity of the issues therapists negotiate when they work with clients who have been abused or are abusive in their intimate relationships, giving voice to participants' struggles to define the problem and to work ethically with questions of risk, responsibility and agency.

Taken-for-granted assumptions that DVA is a problem of gender predominated across the data; these understandings and the implications for working therapeutically with either 'perpetrators' or 'survivors/victims' are illustrated in Themes 1 and 2. Here, participants speak about DVA as having a single explanation which invites prescriptive approaches to resolve the problem. However, questions as to whether a social level of understanding could be sufficient to elucidate the complexity of issues therapists encounter in their practice, were explicitly raised by some participants, whilst accepted ideas about best practice with DVA were sometimes implicitly challenged by the contradictions in others' talk, as we see in Theme 3. Theme 3 provides a rich account of some of the dilemmas therapists might face when trying to make sense of contradictions in their clients' presentation or in their own formulation of the problem. Finally, Theme 4 sets out what was a partially articulated account of a different understanding and approach to working with clients who have been in receipt of abuse, or behaved abusively in an intimate relationship. This was manifest in some participants' unresolved questioning of current practices informed by a gender paradigm, whilst a striving for more nuanced understandings was illustrated in the accounts of a few participants who had begun to generate constructions of intimate partner violence and abuse as multi-directional and multi-faceted.

5.2 Introduction to the Chapter

In this chapter, we see how violence and abuse is talked about by participants who work in the domestic violence sector, or in organisations where therapeutic work takes place with those in receipt of, or who perpetrate, violence and abuse in intimate relationships, when DVA is constructed as a problem of gender. More particularly, in the initial assessment process when clients seek help, when clients are categorised as 'perpetrators' or 'survivors/victims' we see how this shapes the way in which the phenomenon is understood by therapists and their clients, and the way in which they are positioned relationally in the therapeutic relationship. The potential implications of this naming of the problem for how

therapists talk about their approach to their work, what they regard as a relevant focus and how they might intervene with their clients, will be explicated in Theme 2.

5.3   Theme 1: Naming the Problem: Knowledge and Awareness of DVA

5.3.1   Introduction

In the first theme, Naming the Problem, we see how constructing DVA as a gender issue can open up particular ways of speaking about and understanding DVA, defining what counts as a violent or abusive act, and beginning to position clients with regard to the taking of responsibility, who gets help and how risk is assessed. The diagram below sets out the 7 sub-themes which constitute the first theme, as discussed and illustrated in this chapter. The sub-themes consist of three constructions of DVA and the four conversational tasks of therapy which ensue when DVA is construed in this way.
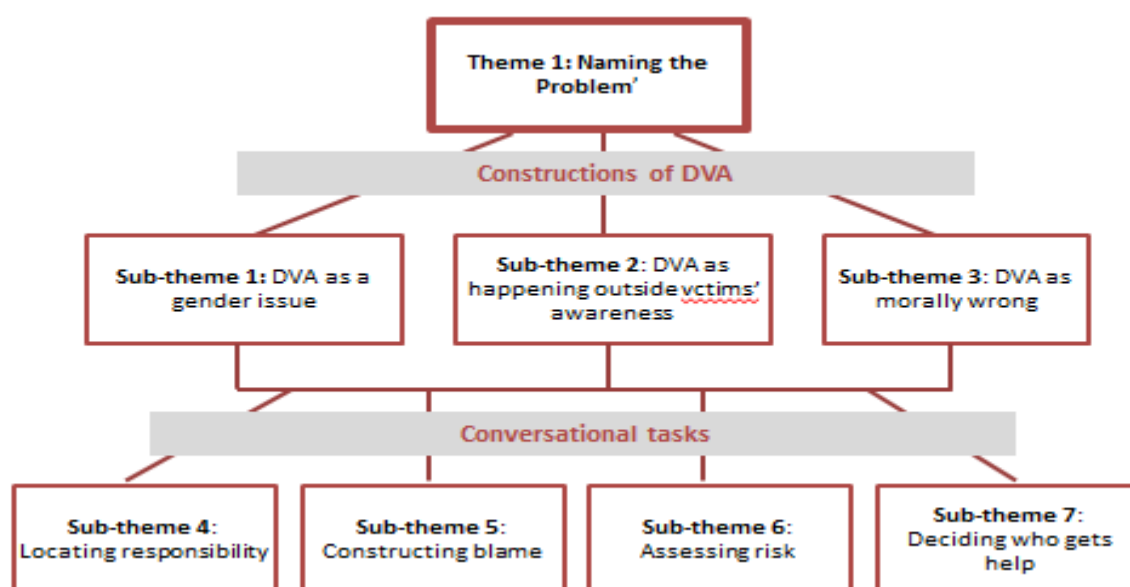
Figure 5.1: Theme 1: Naming the Problem

In this theme we see how the knowledge and understanding of DVA that therapists bring to their work influences the initial assessment process, what counts as DVA and decisions taken as to who is offered an intervention and what kind of intervention this will be. Implicated in the decision-making process are the dynamics of responsibility and ethical issues about right and wrong, which may appear deceptively straightforward when we accept the principle that DVA is morally and ethically wrong. Some participants spoke explicitly about having a moral duty to act in the best interests of a client, keeping in mind any potential risks and the need to protect the vulnerable. However, as Themes 1 and 2 will illustrate, this aim may come into conflict with the counselling intention to be empathic and

non-judgmental and thereby call into question the apparently simple process of naming the problem. We begin to see, too, how difficulties over use of terms may be illustrative of a more pervasive struggle about how to define the problem.

5.3.1.1 Use of terms

> *Sara: Yeah yeah and it's a struggle in the sector about getting that word right really (24)*

There was no consensus across the data as to what term to use when referring to violence and/or abuse between intimate partners. Some participants used the term domestic violence or domestic violence and abuse and others, domestic abuse, whilst others preferred shorthand, such as DV or DA. One participant expressed a concern that people may not identify with the labelling of their own problem as 'violence' if they have not been physically hurt and so the term, 'Domestic Violence' could put off some people from seeking help:

Extract 1

> *20. JL: .... the terms used um for um violence between intimate partners vary in America it's IPV and here it can be DV or DVA what term do you prefer?*
>
> *21-22. Sara: I tend to actually say DV stroke abuse and often when I'm working with women I'll say that cos whilst some argue that DV encompasses everything often women em who I'm working with where em emotion and psychological abuse is the most er prominent they don't actually recognise that they're being abused so when you put violence up they think physical and so if it's lots of psychological etc if it's financial abuse they wouldn't see themselves as wanting help or needing the help so I interchange both components.*

Whilst recognising that differences in the naming will have different implications, Domestic Violence and Abuse (DVA) will continue to be used throughout, except where participants use another term, as this term encompasses different kinds of abusive experiences, both psychological and physical and in this respect represents the phenomenon as described by all the participants.

5.3.2 Sub-themes 1-3: constructions of DVA

5.3.2.1 Sub-theme 1: DVA as a gender issue

> *Dana: I just use a very very simple term which is about power, that's power and control (55)*
>
> *Jas: it's something like 97% men against women anyway so in terms of the rate of it and that's not to deny that that violence doesn't happen the other way round (48)*
>
> *Ian: ... 8 out of 10 women have experienced domestic violence. It's massive (26)*

All the participants were working in agencies providing therapy services for clients who had been involved in abusive intimate relationships, or, in some cases, were currently in abusive relationships. Whilst they shared a common purpose in wanting to reduce the incidence and impact of DVA there were differences in approach, reflected in a choice by most participants to work with either people who had been in receipt of, or who perpetrated, DVA. Their training and theoretical orientations differed and they brought different amounts and types of clinical experience to their current work.

Services that participants worked in tended in the main to be segregated for male 'perpetrators' and female 'survivors/victims', reflecting an understanding of DVA from a gender paradigm, originating in the feminist movement of 35 years ago when feminists fought to raise public awareness of domestic violence. This was spoken about by a few participants, who recalled the struggle then to raise awareness of men's violence towards women, as in this extract:

Extract 2

> *28. JL: ... what what do you think about the terminology that's used, perpetrators, victims? (...)*
>
> *41-44. Sam: Well ok you may remember it was everybody talked about DA but but it wasn't it was it you know I mean in America they would take it seriously, but Erin Pitzey was the first one here, even Erin I mean you know what she did I mean she did a complete about face and said women asked for it I mean extraordinary you know I could understand where she was coming from to some extent, I think she felt that she'd unleashed a tiger and it had turned into a monster (...) But the point is in I think in the 80s and in the 90s we were fight we were really fighting a battle to make people pay attention you know that this was going to this was ubiquitous, it was omnipresent and and it wasn't some stranger out there you know, that if you look at any if you if you've got 100 men in a room 10 of them are regularly beating up their partner and I used to say this you know in conferences and I used to say I know that in this audience there are whatever proportion of men who are beating up women and some of the women in this room some are being seriously physically abused on a regular basis and*

This extract captures the notion that raising awareness of DVA required a *'fight'*, but that there might be some risk of the '*battle*' escalating. From this feminist perspective, certain assumptions are made about men being more violent and women being unconsciously complicit in the social and cultural construction of gender roles and gender abuse, as the following extracts further illustrate:

Extract 3

> *31. JL: ... how best to work with this client group. Where are you at now with your model? (...)*
>
> *38 - 39. Dede: Again with the women it is very complicated. We are looking at 2 and a half thousand years at least of gender abuse on this planet where it's somehow been given the ok light for this to go on and laws haven't really, they've helped, they haven't stopped it. And so for the women there is this*

unconscious element there is this element of being born into a culture of psychology that says ok this is acceptable, this isn't even if it's unconscious and we carry the weight of that unfortunately

Extract 4

93. JL: ... there's quite a debate at the moment in the literature about whether men and women are equally violent (...)

97. Dana: a lot of the differences as far as I'm concerned are you know it's to do with socialisation and then it's gender and if nobody told us about gender and we were brought up in different other societies and you know their ways then women would be aggressive hunting all of those things so that's why I believe you know in our (society) that it's just men

Extracts 3 and 4 vividly capture the view that socially prescribed norms of behaviour powerfully determine that men are the aggressors and that it may be regarded as almost acceptable for women to be victimised. When understood from this gender perspective, DVA is seen as a specialist issue and most participants expressed the view that therapists in the field required specialist training and knowledge. In the following extract being '*fixed*' in the field is presented as advantageous as therapists who specialise would be likely to have more awareness of the issues and access to relevant knowledge and training:

Extract 5

35. JL: Ok and how have you kind of arrived at that understanding?

36. Sara: I guess it's a lot of the um the training that I've had I'm constantly I'm I'm I'm almost whilst I'm a counsellor um I'm sort of fixed in the DV sector so very aware of what's going on and the trends and what's happening all the time and often going to lots of different training courses so always keeping abreast of what's happening in the sector really and knowing what's new and what's out there

When clients are referred or self-referred to a dedicated service for DVA, the presenting problem would be assessed by specialists in the field who have training in, and/or have experience of, working with these issues and whose views would be likely to reflect and disseminate current thinking in the field. Lack of training and understanding of the field was seen by some as problematic as therapists who were not trained in DVA might ask what could be considered an inappropriate question, for example, about why a person remained in an abusive relationship. The following extract illustrates the position taken by some participants that specialist training is necessary for therapists to know what are the right messages to send a client and how to work in a safe way:

Extract 6

164. JL: Is there anything else that we haven't talked about that you you would like to comment on? (...)

170-171. Sara: Yeah counsellors cos I think some people I think if you're a counsellor and you don't know anything about DV I think potentially you get cos I've had I've had um clients come and say um I worked with a counsellor and

you know the partner wants to come and see them and they say yes and couple counselling takes place and things like that. Had they been in the DV had DV training they'll know that for a client to start sharing when a perpetrator's there you're actually putting them in danger and you're also sending them a message that it's a relationship issue and actually it's not it's about the perpetrator so it's sometimes it's things like that if you don't really understand it for yourself you can send those messages like you know why are you still in this abusive relationship and a counsellor can communicate that if they're not um you know trained in DV.

Extract 6 illustrates the argument that clients could be put at risk if therapists are not trained to understand the gendered nature of DVA, which places responsibility for the problem solely on the 'perpetrator'. It makes clear that seeing DVA as a relationship issue is an indication of misunderstanding and lack of knowledge.

From this gender perspective, acts of intimate abuse are understood as being committed by men towards women in an attempt to gain power and control over them. This was a commonly expressed view across the data, illustrated in the following three extracts. The third extract also illustrates the view of many participants that all therapists should have training in DVA. In this example, training for all is justified on the basis that these issues are ubiquitous, experienced by 1 in 4 women, and so may occur across other contexts where people seek therapy for other problems.

Extract 7

62. JL: ... what's the model that that underpins those (groups)?

73-75. Sam: we started coming out with a pro-feminist model, that was how the writing of our own programme started, looking at violence and controlling behaviour, cos we hadn't actually seen violence as part of a whole continuum of controlling behaviours that men use, so the whole issue of power became the issue and of men's dominance and seeing it as expressive of of the wider world-wide problem of the su-subordination of women. It was as simple as that and once we had that in place really it was just like knocking down dominoes (...) but er it took a long time to start thinking you know how how I could integrate those wider social variables with what was going on in the privacy of the marriage and I do believe I've done that

Extract 8

25. JL: Yeah ok so if we stick with DV/A in your understanding what is it?

26-30 Sarah: It's it's abuse violence and it could be psychological emotional sexual financial with-within an intimate relationship (...) essentially it's about power and control and it's um it's a pattern and behaviour that's sustained over a period of time um but essentially it's about power and control and what's unfortunate is many women don't really understand that a lot of peo- a lot of people out there think it's about managing anger and perpetrators can manage their anger very very well and that's why um anger management programmes don't work because essentially um it's not about managing anger it's about power and control

Extract 9

26. JL: ... I'm just wondering what you draw on or what kind of training you've had specifically? (...)

29-31. Jas: ... it's about you know 1 in 4 women in a lifetime and there's something fundamental about power and dynamics within any abusive system and abuse is prevalent throughout relationships throughout you know if you look at things from a power and control angle, power dynamics angle it's very revealing and and informative so it it these are transferable skills as well, it's not just about looking at DA as a completely separate entity, although I think it's vital for therapists to have because it can be so dangerous I believe to not have that knowledge in the background because you don't know when you could be working with somebody who's affected by those issues in whatever context, whether it's you know whether you're working in substance abuse whether you're working in relationship counselling, what whatever context you may be working in, whether you are working with adult or child, there might be something very significant

A view of men as powerful, controlling and dangerous is set out here, presenting a threat which is not readily recognised, even by therapists. The idea that DVA is '*prevalent*', suggests a need for everyone to be vigilant and suspicious. The extracts illustrate a persuasive rationale for treating DVA as a '*separate entity*' and for all therapists' need to understand the threat and have knowledge of gender issues and training in DVA. Extract 8 captures a much debated issue about whether men are in control of their anger, or whether DVA is to do with men having a problem with anger management and it again points to the perceived lack of understanding of people generally, and women in particular, about DVA, juxtaposed with the expertise of therapists working in the sector.

In the extracts so far men and women are spoken about as behaving in predictable, socially prescribed ways, without mention of individual differences. Whilst most participants spoke about DVA as a social problem a few expressed an essentialist view of men and women as having innate characteristics. In the two extracts that follow we see men portrayed as fundamentally different to and more violent than women. In the third extract there is an example of a view commonly expressed that DVA occurs across all boundaries of class, income, age and education i.e. is ubiquitous, but that nevertheless there are some groups of men, such as servicemen, who are more violent than others:

Extract 10

99. JL: ... I think we covered how to define DVA and I just wondered from your experience how you'd describe your understanding of this?

104-105. Ian: I take stats with a pinch of salt but I think some women will be as I say I think it probably switches from time to time as I say obviously men are more violent I mean there are some fundamental differences aren't there? Um (unclear) whereas guys like produce like testosterone you know so there are some basic differences that change how they react in the moment

Extract 11

> *7. JL: ... what would you say your understanding of DVA is, how would you define it? (...)*

> *24. Sam: (...) the man will do whatever he has to do to make himself feel potent (pause) but anger there's nothing like anger for making anybody feel potent, man or woman, it's more readily available to men of course and then we have all of these models don't we, that's when we kick into the learnt behaviour you know social learning theory stuff you know we're surrounded by as children images of men dominating women, women, our mothers, often hitting them, if not hitting them shouting at them. We know that 40% of men will tell you they've hit a woman, really quite freely, Yeah she was flirting so I slapped the bitch*

Extract 12

> *28. JL: ... what do you think about the terminology that's used, perpetrators, victims? (...)*

> *45. Sam: I used to say it's not you know the stereotype, the alcoholic, the unemployed, council house dweller, you know the (unclear) cos I used to say to tell you the truth I worked with judges, I worked with psychoanalysts who do it, it doesn't, it has no barriers of class or income or education or anything, it really doesn't. Some groups are more violent than others, the uniformed services is still the case.*

5.3.2.2 Summary of sub-theme 1

When DVA is constructed as a gender issue, violence and abuse in relationships is understood as a ubiquitous social problem with private consequences, that, nevertheless, some people are ignorant about. From a feminist perspective, DVA is understood as a socially acceptable way of men, as the aggressors, gaining power and control over women, who may be complicit in their victimisation through lack of understanding. This provides a rationale for the problem being addressed in specialist services, which bring men to account and provide support for women, and, because it is a problem that is 'ubiquitous' and taken-for-granted, for all therapists to have knowledge of gender issues. It also positions men as the cause of 'the problem,' and, as the next sub-theme illustrates, positions women as unwitting 'victims' who need help in raising their awareness from therapists who have expertise in this domain.

5.3.2.3 Sub-theme 2: DVA as happening outside victims' awareness

> *Sara: ...often women um who I'm working with where um emotion and psychological abuse is the most er prominent they don't actually recognise that they're being abused (21)*

> *Anita: Some people aren't aware that actually it's not healthy, they kind of think oh well you know I don't know what's healthy I've been a victim all my life (45)*

This sub-theme illustrates how, in the DVA field, those in receipt of DVA are positioned as often unaware that they have been abused, because they may not know what constitutes a 'healthy' relationship, whilst it is assumed that 'perpetrators' act in a controlled and deliberate manner to gain power over a female partner. One of the aims of an initial

assessment in a service providing interventions for 'victims' of DVA is to enable a client to talk about their problem and establish whether DVA is the main presenting issue and whether therapy would be suitable. According to a number of participants, the knowledge and understanding clients have of DVA can vary and this may depend to some extent on the referral procedure as well as on their self-awareness. The referral procedure might include some psycho-education if clients were referred to a specialist DVA agency, as the following extract illustrates:

Extract 13

> *67. JL: What do you think particularly enables them to to engage with you ...*
> *(...)*
>
> *69-70 Sara: but they would've what would've happened anyway with (agency) cos it's a DV agency they would've had an assessment and they would've talked them through all the different behaviours and things like that um so I guess they know that they're here to to talk and and share if that's what they they want to do. I and I just feel most in the same way the research says um clients just want to be asked the question ...*

Clients may not always present with this understanding and knowledge about DVA, however, if they self-refer or have not already been assessed by other health professionals. Whilst the client may be an expert on his/her life, therapists tend to be seen, and may position themselves, as experts in terms of their knowledge of DVA and what is 'normal' behaviour in a relationship. Knowing what counts as DVA, recognising what is abusive and raising clients' awareness of this was, in the view of most participants, germane to the initial assessment process. Many participants justified taking on the role of giving this expert knowledge to clients, positioning the therapist as the one who knows and the client as lacking awareness, on the basis that this knowledge would give clients back the power to choose (e.g. Extract 20).

Most participants said that physical violence was more readily recognised by clients as a DVA problem but that for most clients, psychological abuse was a more ambiguous concept and more difficult to deal with. It was a recurring theme across the data that participants might struggle over the terminology they use with clients to talk about the problem and was particularly evident when participants talked about raising awareness that DVA is not only physical, but can be psychological. In this extract one participant's use of the term 'abuse' in preference to 'violence' reflected a commonly expressed view that in general the understanding of DVA was that it meant physical violence, whereas in their experience it could more often be other forms of abuse that clients presented with:

Extract 14

> *17. JL:... how we define DVA and I'm wondering what your understanding of it is?*

18-19. Beth: Yeah I prefer the term abuse because it's not always violence and you know depending on how you define violence but I think generally we we think of violence as a physical act um whereas abuse can be of course psychological or emotional. Um how I understand it in very simple terms is is invading someone else's being in some way transgressing their boundary um trying to dominate or injure or overpower another person with with intent you know so either with cruelty verbally or with cruelty physically or um or with cruelty by withholding or all sorts of

Extract 14 refers to an 'intent' and motivation to cause harm, which fits with a gendered view of men as using violence or abuse as a means of dominating/controlling a woman. The following extract illustrates the view of many participants that clients find psychological abuse harder to manage than '*a slap*' and harder to recognise, and we can see how this can influence the way both clients and therapists might refer to the problem:

Extract 15

109. JL: ... there's also a lot of debate about that, what DV is and how you define it. What would you say it is? What counts as DV from your point of view?

110-11. Ken: Well I sort of tend not to use the word violence at all now, I just use the word Domestic Abuse, because I think there's various forms of abuse and violence is one of them, but then you've got the emotional, psychological type of abuse, the sort of put downs, the power and control, the the fear and intimidation, threats, manipulative type, it's all that that comes under the sort of emotional, psychological banner and then most people I think, would acknowledge that they can deal with with you know a slap, because it hurts for half an hour and then it goes away, but the hardest thing to deal with is the ongoing sort of emotional stuff, treading on eggshells, being afraid to speak, having to think about what they say or do for fear of how that person will react

In Extract 15 we begin to see how potentially complex the assessment of DVA can be when it includes such a wide range of behaviours, which can include quite subtle means of manipulating or intimidating someone. Whilst some clients' problems may have already been named by them or others as DVA, for others the assessment process may confirm that they have come to the right place or may serve to raise their awareness that the problem may be understood as one of DVA. The idea that clients may not be aware that they were being abused was commonly spoken about across the data, illustrated in Extracts 16 and 17:

Extract 16

274. JL: ... if someone comes in and they're so used to that it's hard for them even to be able to tell you about it because they may not even see it as abusive? (...)

276-278. Ann: I mean we get a lot of clients that actually they'll come in and say well I don't really know if it is DA, they might be being put down being called loads of names you know being controlled and what have you but they don't think it's DA cos they're not being hit or they're not being you know beaten up on a day to day basis (...) And we will class when I explain to someone what DA is, it's emotional, psychological, physical, financial, sexual or controlling behaviour and I'll always add that or controlling behaviour because most people

won't perceive that control being controlled, being told what to wear or where you can go or where you can't go as abuse

Extract 17

35. JL: ...about what counts as DVA what what would you say to that?

36. Jenny: Um I suppose I would say um you know things can count as abuse when the person the victim of it isn't necessarily aware of it so the kind of retrospective realisation of what they went through was abusive I think is quite important to acknowledge the victim's experience

In these extracts, we begin to see how a therapist role as educator is being taken up, in response to a construction of victimised clients as unknowingly complicit. Implicit here also is the notion of the public having a perception of DVA as being physical violence on a regular basis, whereas therapists have a more nuanced understanding. This suggests, too, that therapists and clients may not necessarily agree as to what counts as DVA. A different take on clients as 'not knowing' is seen in Extract 18, for example, where this is conceptualised instead as denial that functions to sustain the relationship. The participant speaks of the importance of naming the abuse as a *'reality'* for a client because in her experience people might want to deny the reality that intimacy and violence can go together:

Extract 18

50. JL: ... what's your take on the use of words?

60-62. Helen: sometimes I've had clients speaking of a situation which I might identify as DV and they haven't and I might say to them and sort of in the work that I do my understanding is that would come under that umbrella and whether they choose to pick that up or not it's up to them but it feels important to me to say this is the reality of the situation really um because I think very often there's there's a lot of denial there and nobody wants to think that somebody that they're in a relationship with would do anything to to hurt them but they do

We begin to see the dilemma that a client's 'not knowing' can pose for therapists, both in terms of explaining and responding to this, illustrated here when the participant speaks of letting the client choose whether to *'pick that up or not'*. Another common explanation for clients' lack of awareness could be long-standing victimisation which might have happened gradually over time only becoming more obvious when the abuse had escalated, as the following extract illustrates:

Extract 19

42. JL: And in your experience to what extent are people aware of that erosion you talked about?

43. Helen: ... I think the picture is it's quite a slow process so they don't recognise it in the happening and sometimes it seems oh he loves me so much he just wants me to himself or whatever or I guess the other way round um and it may be quite a way down the road where they realise that actually they've ended up in this situation and they haven't got an escape route does that make sense yeah

This extract illustrates how therapists might draw on a relational perspective and narratives about love to understand longstanding abuse. As a consequence of clients' perceived lack of awareness, some participants spoke of seeing their role as one of giving clients knowledge about DVA and helping them to understand that they are 'victims' of abuse. The reference in the following extract to knowledge as giving 'choice' was a recurring theme across the data:

Extract 20

> *275-277. Ken: That's what we do quite well actually cos we help people to understand that, help people to understand that actually they are a victim of abuse and then once they understand that it gives them back some power and control, so they can start to make some choices, they may choose to stay but they've still got that knowledge and they've still got the knowledge that there are tools around them they need to make those changes (...) I just say I always say to people if you feel if you have to stop and think before you say what you really think or feel for fear of what the other person may do or say the chances are you're a victim of DA*

In the above extract a distinction is drawn between clients being unwitting 'victims' when they present for assessment and afterwards being enabled to make an informed decision to stay with an abusive partner, if they choose. In the following extract there is an illustration of an opposing, minority view, in which this positioning of clients as not knowing is strongly contested:

Extract 21

> *32. JL: ... about how DVA is defined. So what would you say your understanding of it is? (...)*
>
> *41-42. Sarah: Often they want to they they ask me often, oh you know maybe if I have a list of abuse I will recognise it and to me that's just to think women don't recognise abuse is so patronising so I just think they always recognise it they always know they're being abused so we don't do (unclear) and*

A view of clients as always recognising abuse, but nevertheless, still inviting the therapist to tell them, was expressed by only one participant. This perspective invites a re-positioning of therapists as in a more equal relationship with clients, objecting to the practice of therapists informing clients about DVA as patronising and unnecessary.

5.3.2.4 Summary of sub-theme 2

We see in this sub-theme how a construction of DVA as happening to 'victims' out of awareness begins to position them as blameless and therapists as experts, able to define and recognise what counts as DVA. Whilst this may serve to explain why some clients choose to remain in a relationship in which they have been abused, particularly where they may be deemed to have misconstrued controlling behaviour as love, it has implications for the therapeutic relationship: the unintended, and paradoxical, outcome of positioning the

therapist as' the one who knows', and the client as in need of guidance, may be to repeat the unequal power relations in the client's intimate relationship. The further implications of this positioning can be seen in the following sub-theme, "DVA as morally wrong", and in how this influences the focus and aims of therapy as illustrated in the conversational tasks identified in Theme 1 and Theme 2.

5.3.2.5 Sub-theme 3: DVA as morally wrong

> *Helen: It shouldn't have happened (59)*

> *Dana: it's wrong it shouldn't happen (79)*

Therapists' constructions of the 'facts' presented by the client may be understood as being informed by their codes of ethics, ideas about what constitutes a good relationship and a good life, and how these issues apply to DVA. These ideas may be made explicit in speaking about matters of right and wrong or what is normal and acceptable behaviour in intimate relationships and may be used to foster empathy and understanding with clients who have been harmed by others. Conversely, when working with clients who have perpetrated DVA, therapists may experience a moral imperative to hold someone to account, which could conflict with the counselling intention to be empathic. Having an agenda about what is right and wrong in terms of specific behaviours may close down ways of working that embrace the client's perspective; a view voiced by one participant (Extract 28). However, there was a general consensus across the data that DVA is wrong in principle and 'shouldn't happen'. In the first extract the idea that the wrongness of DVA is taken-for-granted is illustrated and in the other two extracts that follow we see examples of the view that a clear moral message should be given to a client who has experienced victimisation:

Extract 22
> *58. JL: ... how do you approach the the notion of the if you like the moral issue of the wrongness of DV?*

> *59. Sarah: In some ways it's interesting you ask that because I think it's just so taken-for-granted that it's wrong to abuse and attack someone.*

Extract 23
> *134. JL: How do you approach that in the session, the moral issue if you like about the wrongness of DVA?*

> *136-140. Jas: I'm very transparent about it and I think part of the therapy, when a woman is in a situation when her self-esteem is crushed it's very important to hear that voice that says actually that was wrong, that shouldn't have happened to you (...) there are clear messages that we send and that's part of correcting the myths, correcting you know addressing we do have a moral obligation I think within within this arena especially when people are abused...*

Extract 24
> *58. JL: ... I was wondering how you might approach the wrongness of DV with your clients?*

59. Helen: (7 secs) Well I I suppose I notice a term I use very often is, 'and it shouldn't have happened'. It did that's the reality and it shouldn't have happened

As discussed in the previous section, many participants spoke about clients not recognising abuse. In this sub-theme many participants spoke about clients not knowing the difference between right and wrong. Many also believed it was part of their role to take a position on this in order to empathise with a victimised client or set clear boundaries with a client who has been abusive. Not being absolutely clear with the client as to whether a specific behaviour was right or wrong could be equated with giving mixed messages and seen as being unhelpful by many participants. For some participants there was an explicit awareness of knowing 'where I stand' and having a moral responsibility to convey their concerns to clients, particularly if clients were perceived to be at risk or putting others at risk. The following extract provides an illustration of what was a commonly spoken about view of DVA as a clearly defined criminal act. It also provides an example of the conviction and passion that many participants displayed and the clear stance that many participants took when speaking about ethical issues:

Extract 25

54. JL: ...What would count as DVA? (...)

56. Dana: It doesn't matter about country of origin it doesn't matter about your beliefs these things are encased in law so therefore they are wrong fine you can disagree with them all you like but it's illegal and for a man to do that to you for a parent or anybody it's that becomes because otherwise if I get into the whole cultural it's ok and kind of thing what what people want is clarity when they've come from domestic abuse it's about being clear black and white not about the greys cos they've had I'll hit you but I love you with those kind of mixed messages they don't need those from me

Therapists are, in effect, positioned here as making moral judgments, informed by an understanding of the law, and as able to bracket any social or cultural beliefs they might hold that could undermine the clarity of the message that DVA is wrong. The following extract elaborates on this point, vividly illustrating how the impact on the therapist, personally, of the 'reality' of DVA when working with a 'perpetrator', can mean that taking a position on moral questions of right and wrong takes precedence over professional constructions of the problem.

Extract 26

76. JL: How does the um therapeutic intention sit alongside the kind of taking a moral position if you like about the wrongness of DV?

77-94. Sam: I I sit quite comfortably with that I you know I I think that er therapeutic neutrality is a myth and I think in any case if you're if you're sitting with a man who's picking his child up by the neck you know fuck I'm annoyed I'm not interested in what my supervisor in my head is saying I'm just interested

in stopping that guy from potentially killing his kid and er the fact is that we live in a real world and and er I'm happy to give people firm guidelines because they've never you know it's a it's a it's a failure of moral thinking. (...) you actually have to say to people, that is wrong, because that's what parents do for kids, you know and a lot of what we do is re-parenting (...) I don't feel uncomfortable about parenting people I don't I mean there are other ways of doing it, you can say to them you do realise that this behaviour's illegal do you? You can just say do you do you know that this is against the law, cos often they don't know that, they say really? I say yeah and and do you realise you could be charged with GBH or assault, they say no and I say things like well you could actually get 4 years for what you did. If she chooses to report you to the police you could get 4 years for this and then so they don't know, you know.

So, in this extract therapists are positioned as having a moral duty to set clear guidelines to their clients when there are risks to others, by taking on a parenting role to teach what is right and wrong. This provides a clear illustration of many participants' expressed views on the need to prioritise risk. By contrast in the following extract we get a sense of the range of behaviours that could count as abuse and be perceived as morally wrong. It provides a specific example of a question posed by the participant to a client regarding whether it is normal to be told by a partner what they can and can't do:

Extract 27

171. JL: And you were saying somebody who's been in successive relationships or somebody who's only had one where it's been abusive they don't have anything else

172. Ann: somebody said to me the other day about um I think their partner had said something to them and it was obviously abusive and it was a newish partner um and you know was telling them that they couldn't do something that they'd wanted to do you know then it's about working on and they were like ooh is that normal? Would your partner say to you that no, you can't do this? You know and stop you from doing it and get cross if you tried to do it and so sometimes it's about explaining that.

In the above extract there is an explicit positioning of the therapist as having a responsibility to explain what counts as normal or abusive behaviour. A different take on how to manage the wrongness of DVA with clients was spoken about by one participant, who expressed awareness of having a moral position, but might not say this to the client.

Extract 28

81. JL: What about the kind um what you might call the issue of the wrongness of violence. How do you kind of approach that with clients?

82-83. Sara: I haven't really got a set agenda with the clients again because I'm person-centred it's about what the clients want to share and so I don't sit and talk to them about what's wrong or what's right about violence it's really about what it's like for them and what their feelings are and what their thoughts are and what it's like for them rather than it being it's right or wrong I mean I know it's wrong (laughs) but I'm not going to say necessarily to them this is wrong, they shouldn't be doing this and cos I think they know that but it's about what it's like for them and their experience rather than what's right and what's wrong

95

We can see in this extract how such an approach might distance the self from making judgments and emphasises respect for the client's experience as being more important than having an agenda about what was 'right and wrong', re-positioning the client in a way that recovers their dignity and agency.

5.3.2.6   Summary of sub-theme 3

This sub-theme illustrates the moral and ethical questions therapists face when working with the phenomenon of DVA and how constructions of this as morally wrong influence the way therapists might position themselves and their clients. Many participants spoke about having a moral responsibility to teach both 'victims' and 'perpetrators' about right and wrong, positioning therapists as experts, as in the previous sub-theme. Whilst those in receipt of DVA are, again, spoken about by most participants as lacking awareness, 'perpetrators' are also commonly positioned as needing lessons in moral thinking, and perceived to be in denial of responsibility. We begin to see how therapists might focus their interventions and provide support for those victimised when they intend to give clear messages about what counts as DVA and seek to differentiate between right and wrong. However, as Extract 28 illustrates, when therapist take up a position as arbiters of truth, they may move away from understanding a client's frame of reference, and may, unintentionally, confirm a client's experience and position them as someone who is told by others how to behave.

5.3.3   Sub-themes 4-7: initial conversational tasks

5.3.3.1   Introduction

In the following 4 sub-themes we see how the constructions of DVA, explicated in the first 3 sub-themes, lead on to a set of conversational tasks focused on locating responsibility for the DVA, constructing blame, deciding who gets help and assessing risk. Many participants expressed a view of violence and abuse in relationships as unidirectional, reflecting, and reflected in, the way that most services are organised into separate ones for either victims or perpetrators. In this context, making the 'right' decision at assessment included the location of responsibility and accountability for the abuse, which would have implications for whether the person was offered help and the kind of interventions which would be considered appropriate.

5.3.3.2   Sub-theme 4: locating responsibility

Jenny: If someone is um abused then there has to be an abuser (49)

Eva: um there is a client who recently told me, well I don't like either victim or survivor, I like fighter so it's it's really quite interesting and it doesn't it doesn't sit comfortably with me at all (56)

> *Sue: ...Every one presents here with anger management. Who wants to say they're a perpetrator of domestic violence? (14)*

Terms such as 'victim', 'perpetrator' or 'survivor' are widely used in the DVA sector, on websites, in research papers and in organisations that provide support and therapeutic interventions. Labelling may occur as part of an initial screening or risk assessment and hence would be implicated in the process of identifying who receives support and what kind of support this could be. The terminology used to name the problem tends to divide people into two categories, reflecting a particular understanding of what has happened and who is responsible. The following extract provides an illustration of a commonly held view that, whilst the use of the term 'victim' is considered contentious amongst those working in the sector, 'perpetrator' and 'survivor are preferable terms, on the basis that they are more accurate descriptors of what happens when power and control is misused:

Extract 29

> *52. JL: ... I noticed you used the word perpetrator and victim and I wondered what your take is on use of the terminology?*
>
> *53-56. Jas: Again a very er a very contentious area um I for example our sometimes our group is called the men's programme or um but I think it's really clear to for me personally I would use the term perpetrator because somebody who is a perpetrator they are you know misusing power and control um and there will be some clear evidence from the woman whether it's what she says during therapy about you know her having been abused, the person that abuses is the perpetrator and that's very much about them taking responsibility and there being some element of accountability within that definition um of something that's happened that shouldn't really have happened. Um the victim term is is quite a contentious one er a lot of people in the arena would prefer to use the word 'survivor' and I say survivor even for women that are in these situations because for some of these individuals staying is surviving and it's not just about being a victim. So and here's something far more empowering and maybe accurate about the term survivor. So I you know that's also and it depends on what text you're reading but the general consensus within the field is we like to refer to them as survivors*

We see in this extract the rationale for using the term, 'survivor', particularly where this refers to a woman who has 'stayed', suggesting qualities such as resilience, not captured in the term, 'victim'. There is an explicit concern expressed here about using terms accurately, common across participants' accounts. Nevertheless, whilst the term 'survivor' was the preferred term to 'victim' for most participants, many tended to use the word 'victim' when speaking about clients.

When asked about their views on terminology, it was apparent that most participants' take on the word 'victim' was critical and some disliked the term 'perpetrator'. In the following extract one participant expands on reasons why the use of the term 'victim' can be unhelpful for clients and also speaks about the term 'survivor' as being more apt.

Extract 30

> *21. JL: and could you tell me what your take is on terms like survivor, perpetrator, victim?*
>
> *22-24. Beth: Oh they're all inadequate really um (5 secs) well I certainly prefer survivor to victim because I think victim has a certain kind of connotation er I mean it's difficult to generalise about any word because we all have our own take on them but or term but I think that term specifically indicates a kind of um state of victimhood which you know I mean I don't work with survivors so I'm not really saying this from personal experience but you know my my take is survivor is a much more apt description because you've survived a lot and yes you're a victim of something but you're not a victim in life per se and I think it has that connotation*

Giving people labels has implications, and the inference here is that the aptness of these may be judged partly from the standpoint of our own experience. Most services are organised to provide interventions for either 'perpetrators' or 'survivors/victims' but, less commonly, services might offer programmes for both, as is illustrated here:

Extract 31

> *9. JL: Could you tell me something about your role here with regard to taking DVA clients?*
>
> *10. Eva: Ok um well as as you know this programme is divided into perpetrators programme and victims or survivors programme And what I'm working with at the moment is the perpetrators programme um so um we see the so-called perp-perpetrators people who have been labelled as perpetrators and that means that um they have um been violent whether that's physical or um verbal or sexual and they have committed this er violent act against their partner (mm) so that's how clients come into this perpetrators programme*

In this extract there is a more subtle distancing from the responsibility of naming 'perpetrators' where the use of terminology is attributed to the organisation – '*so-called perp-perpetrators*'- and the participant is hesitant and makes several repetitions.

A few participants expressed general dislike of using labels and perceived labelling a client as either a 'victim' or a 'perpetrator' judgmental and objectifying and antithetical to the role of a therapist, as illustrated in the following extract:

Extract 32

> *38. JL: Ok what's your take on words like victim, survivor and perpetrator? ...*
>
> *39-40. Anita: They're generic words aren't they I kind of struggle with the word victim. I think it's the person who's experienced you know the kind of you know it kind of takes it away from it's actually a person in it so 'victim' just labels that person. The same with perpetrator because inevitably they've got issues as well probably similar to that with what they're doing*

This captures the therapeutic intention of understanding the individual, positioning the therapist as empathic towards people who have '*issues*', whatever these may be, and

struggling with making judgments. It was a less commonly expressed view amongst those working with 'victims' when they were speaking about 'perpetrators', however. On the other hand, some participants working with 'perpetrators' also spoke of not finding labels useful, because of the negative connotations:

Extract 33

53. JL: So would you use the word perpetrator with women then?

54-55. Tim: No I don't like using it with men either I don't think it's very useful. I don't think it's useful um in terms of labelling it's it's er I tend to work from a what we call a strengths strengths-based approach so if you're labelling a man or a woman as a perpetrator that sticks them in a box straight away um we try to work with the human being underneath the one who behaves abusively.

The idea of sticking someone in a box straightaway suggests the potential closing down of the therapist being able to see and relate to a client as a human being, once a label has been given to the client. However, we can see how therapists may seek to move away from making judgments of a person, as illustrated in the following extracts, by positioning a client as having behaved badly or having been done wrong to. The following two extracts are from a participant who works with both 'victims' and 'perpetrators' and one who works only with 'perpetrators'. They illustrate the view that labelling of the behaviour is more useful than labelling a person:

Extract 34

5. JL: Yeah I wanted to ask you about that um what your take is really on those those terms? (...)

8-12. Sarah: to me victim is the only word we have it is actually the only word in the dictionary we have to describe someone who's been done wrong to who's had a crime committed against them been badly treated or been wronged and to me to pervert it the meaning of it to describe an internal state I think is very objectionable and (...) I really feel strongly that we need to reclaim the word victim to be er find a word to use that is not derogatory that just just states the fact that someone's been done wrong to

Extract 35

57. JL: and what's your take on the terms used like victim, abuser, perpetrator?

58. Sue: I I I loathe those terms. I find it disrespectful in terms of there's an area of their lives that they have a problem with. It doesn't make them bad people it just means they've behaved extremely badly in a criminal manner

In both extracts DVA is referred to as a crime, emphasising the act of wrong-doing and, in contrast to Extract 32, seeming to deliberately move away from a focus on the personhood of the individual 'victim' or 'perpetrator', by separating out their behaviour. However, despite most participants expressing reluctance about using labels, the identification of who was responsible was for the most part implicit in the initial assessment process. As we see from the final extract, locating responsibility with 'perpetrators' could be challenging.

Clients named as 'perpetrators' were spoken about as rejecting the label because they were in denial of their responsibility. One participant speaks here about social and cultural norms that make it acceptable to men and women for men to *'slap'* women:

Extract 36

> *28. JL: ...what what do you think about the terminology that's used, perpetrators, victims?*
>
> *30. Sam: men hate it men hate being called perpetrators because you know they're er controlling of women is normalised isn't it? And if they step out of line it's appropriate to give them a slap, I mean a lot of men think like that. So they they hate being criminalised, they don't they think, most people even women if, you know from doing this you'll know that even women tend to normalise marital violence (pause) it's extraordinary isn't it I mean they a lot of women expect to get a slap occasionally if they step out of line*

From this perspective, therapy is conducted in a wider social context that normalises marital violence and the controlling of women, so has implications in terms of the understandings therapists, and their clients, bring to the therapeutic process.

5.3.3.3   Summary of sub-theme 4

In this sub-theme we saw how, despite the common usage of the terms, in the public domain and the legal system, some participants working with either 'victims' or 'perpetrators' may be reluctant to use labels, as their usage conflicts with the therapeutic intention to be non-judgmental and focus on the individual. There was some overt resistance to using these terms expressed in words like, *'derogatory'* (Extract 34) and *'loathe'* (Extract 35) and some participants spoke about clients disliking the terms too. There were differences too as to whether participants separated out clients' behaviour, labelling this as opposed to labelling the person. The implications of this will be considered in Themes 3 and 4, where questions about whether people might be perceived as having 'good' and 'bad' parts are addressed. Nevertheless, judgments were being made as to whether a client was in receipt of abuse or behaved abusively, as part of the initial assessment process, and it was evident that the way in which responsibility was located was implicated in setting the agenda and establishing the 'facts' of the abuse.

5.3.3.4   Sub-theme 5: constructing blame

> *Sue: And they when they first come so many of them are convinced they are the victim and if someone hadn't done or said what they did, so it couldn't be their fault (laughs) (...) they're in the blame zone (15 &19)*
>
> *Sarah: often they blame themselves for staying staying with the perpetrator so I explore that with them (17)*
>
> *Helen: I guess in terms of blaming the to me there's one person to blame and that's the person that's um being abusive however feeling that it's their fault is very well yeah probably pretty much across the board (103)*

In the previous sub-theme we saw how constructions of responsibility can be intrinsic to the way in which participants name the problem (e.g. Extract 29). In this section we see how this might be expressed by both clients and therapists in terms of, who is to blame? All participants commented on the tendency of 'perpetrators' to blame a partner, often presenting themselves as the 'victim', and for 'victims' to blame themselves. Most participants' expressed views indicated that, having identified the 'perpetrator', they would hold this person to be wholly responsible for the problem, which was the act of abuse itself and, if they were working with those in receipt of abuse, would try to shift the locus of responsibility onto the 'perpetrator'.

When speaking about clients' tendency to misappropriate responsibility for the abuse, some participants took the view that clients needed to be told or educated. This echoes the position therapists might take up when clients were perceived as being unaware of being abused or did not know the difference between right and wrong, as illustrated in Sub-themes, 2 and 3. It seemed that participants could get caught up in the dynamics of responsibility and 'either/or' ways of understanding the problem, whilst distancing themselves from taking a blaming stance by staking a claim to knowing the truth. This is illustrated in the following short extracts where there is an implicit assumption that 'perpetrators' will not accept responsibility and try to put the blame on the partner: it is said that the initial goal in working with 'perpetrators' could be to '*get them to admit it*', or the focus might be on a 'choice' between two options of being 'wound-up' or walking away:

Extract 37
> *196. JL: … some therapists say that they get caught up in trying to work out the truth and I'm just wondering how that plays out in a group or whether it does at all*
>
> *197. Ian: That's very much what we what we did, who's to blame, we know and we had to get them to admit it (laughs) cos once we got them to admit it everything's going to be fine (laughs) er yes it was always about apportioning blame*

Extract 38
> *20. JL: What kind of things do you say to get them to talk about what they're doing?*
>
> *21. Sue: …The other thing that we say that they don't like is that no person can wind you up. At the beginning of being wound –up you have a choice, you buy in or you walk away and they look at us as like we're mad!*

The therapist's engagement with 'perpetrators' is portrayed as an argument, rather like a reversal of the 'perpetrator'/'victim' interaction, in which the therapist would need to impose their own view of the situation on a disingenuous client in order for there to be a good outcome i.e. with the implicit rationale that it is in the best interests of the client. What

is also interesting, is the way that the 'perpetrator's' choice is presented as a simple 'either/or' one, suggesting that the problem has an easy resolution. By contrast, in the following extract, perceiving a woman's dilemma in simple terms is viewed as blaming and inaccurate:

Extract 39

20. JL: ... in the literature there's quite a debate about whether it's a valid question to ask how why why women might stay in abusive relationships. What's your take on that?

21-22. Sarah: er well my take I get furious with that kind of question because I feel the question is blaming and first of all it's inaccurate because most women leave so when you say why women stay you're making out that most stay. They don't, most women leave. That's real, in research you can see that. So the the to me I mean I get angry with that kind of question because it's blaming, it seems like women don't leave and it's also implying that there's something wrong with them for staying um

This extract is also illustrative of how the process of constructing blame could be emotive and strongly contested. Here the questioning of why women might stay in abusive relationships is spoken about as inappropriate and wrongly used as evidence of women being complicit in their victimisation. Asking the question is regarded in itself as an attempt to shift blame and responsibility onto women and elicited anger in this participant and one other, on behalf of females who had been victimised. A few participants working with female 'victims' also reported experiencing anger specifically towards the 'perpetrator', or were aware of other support workers feeling angry, as these two extracts show:

Extract 40

142. JL: And what what do you think is most challenging about this work?

143-144. Helen: (10 secs) (laughs) um (12 secs) It's quite difficult to pinpoint any one thing (15 secs) Probably keeping calm about the things that I hear people can do to other people um and I guess for that reason I I know I wouldn't be able to work with perpetrators at all um I'd probably want to rip their heads off which wouldn't be very good (laughs)

Extract 41

38. JL: Ok what's your take on words like victim, survivor and perpetrator? (...)

42. Anita: I do hear obviously from the support workers that you know god, you know they'd like to rip the perpetrator's head off and I kind of find that quite difficult

The strength of feeling a few therapists had towards 'perpetrators' is captured in the phrase, '*rip the 'perpetrator's head off*'. Here we can see that, whilst most participants spoke about their reluctance with regard to the use of terminology in the previous sub-theme, at times when empathising with victimised clients they might engage in a process of constructing blame, using the term 'perpetrator' in a pejorative way. Furthermore, when clients who have

been victimised blame themselves for what has happened to them, some participants said that naming a person's partner as the 'perpetrator' or 'abuser' could help these clients to locate responsibility outside themselves, as illustrated in this extract:

Extract 42

> 44. JL: What's what's your take on terms like victim, perpetrator and abuser? (...)
>
> 48. Jenny: I think in terms of using abuser perpetrator if somebody really seems to be quite self-blaming you know they brought it on themselves I think in context and explaining why I would use those words you know actually can help to shift the some of the feeling of responsibility I suppose.

So, naming the 'perpetrator' could shift responsibility away from the 'victim'. The locating of responsibility and the construction of blame is, in this way, presented as a straightforward and morally desirable task, especially when participants who were experienced in working with 'perpetrators', said that clients who had been abusive tended to be in 'denial'. This denial of responsibility was represented in a 'perpetrator' explicitly presenting the self as a 'victim', *'no matter what they've done'* according to some participants, and as this extract illustrates:

Extract 43

> 106. JL: I was asking you about women's violence (...)
>
> 108. Sam: I've worked with a lot of abused men, I've never found one who was a genuine victim, not one, ever and I must have worked with a couple of hundred men who identify themselves as victims. Every abused man I've ever worked with identifies himself as a victim. Every single one, without exception no matter what they've done, including ones who've murdered and I've worked with a few of those, they see themselves as victims and her responsible for the fact that he killed her. The the denial that men can get into is extraordinary

With the weight of his extensive clinical experience, this participant emphatically positions men, '*without exception*' as lying about their responsibility for violence or abuse towards a partner and having an extraordinary capacity for misrepresenting the truth. At the same time, it is implicit in the use of the term, '*genuine victim*' that the partner is positioned as blameless and their behaviour seen as irrelevant in this process of determining who is to blame.

5.3.3.5 *Summary of sub-theme 5*

This sub-theme captures ways in which participants respond to 'victims' and 'perpetrators' who are both construed as misrepresenting their responsibility for the DVA, either blaming themselves for their partner's behaviour, or blaming their partner for their own behaviour. Implicit in some participants' responses was an emotional investment in defending 'victims' and naming the 'perpetrator', which could result in the positioning of all 'victims' as wholly

blameless and all 'perpetrators' as wholly to blame. Whilst the reasons for women remaining in abusive situations were considered complex, so leaving a relationship was difficult, it seemed equally taken-for-granted that men could easily walk away and perpetrated DVA out of choice.

5.3.3.6 Sub-theme 6: assessing risk

The identification of risk and keeping clients safe were key concerns for all therapists, both at the assessment stage and during on-going therapy and could outweigh other ethical issues, for example about maintaining confidentiality for clients. Having specialist training and knowledge about DVA was spoken about by some participants as essential to being aware and able to recognise risk issues and knowing what would be an ethically appropriate intervention, as we saw in Sub-theme 1 (Extract 6). This view is expanded on here in the following extracts, where the message is that therapists need the right knowledge about DVA in order that they provide quality care that protects women and children and keeps them safe:

Extract 43

> *164. JL: Is there anything else that we haven't talked about that you you would like to comment on*
>
> *168. Sara: I think in terms of working in the sector I think some counsellors who don't know enough about DV can actually put them in danger as well so I think it's really important when counsellors are working in this sector that um they really do keep up to date with training and things like that because um they need to know you know about MARACs they need to know about all the different other agencies that are involved and how it's supposed to work to keep women to keep women and children safe*

Whilst this identifies the need for therapists to keep up-to-date with what might be considered relevant information in the sector, in the following extract we see how being aware of risk also requires specialist therapeutic knowledge and skills in order to provide appropriate interventions:

Extract 44

> *1. JL: ... if we could just start with you telling me something about the service?*
>
> *16. Jas: It takes a long time to establish yourself and and to be able to ensure that you're providing quality because obviously working with trauma it er there's all these risks of re-traumatisation and various other things so if it's not if it's not being carried out by an adequate group of professionals then it could almost be harmful*

From this perspective, demonstrating awareness of 'victims'' vulnerability would include maintaining contact with the female partner of a 'perpetrator' on a programme. All participants working in specialist services for 'survivors'/'victims' spoke about this as good practice and essential for the safety of female clients. It might, for example, become evident

to a therapist that a 'perpetrator' posed a risk to their partner and the therapist would then act to alert the partner and the service offering them support. We can also see that from the perspective of those with specialist knowledge about DVA, intervening with a 'perpetrator' without offering services to the partner or ex-partner would be considered as potentially dangerous. The following two extracts illustrate the concerns of participants who work in settings where there are services for 'survivors' and 'perpetrator' programmes:

Extract 45
> *1. JL: Could we start by you telling me something about your role here with regard to taking um Domestic Abuse referrals? (...)*
>
> *9. Dede: I also support all of the women that can't come into the project but whose partners might be in the programme so I keep in regular contact with them cos if there is anything that is alerted on the perpetrators side to us I immediately contact them*

Extract 46
> *31. JL: Ok um in in the literature there's er a kind of debate about whether it's appropriate to work therapeutically with perpetrators. What what's your take on that? (...)*
>
> *35. Eva: She might be seeing someone else yeah and I think that's essential because um when you work with just one partner that's got to have hugely damaging repercussions*

So, once someone has been named as a perpetrator, this could have implications for the way in which issues of disclosure and confidentiality are handled. Maintaining contact with their partner would also provide a means of checking whether the 'perpetrator' was telling the truth as to his behaviour, for example. The presence of risk could mean that confidentiality would apply to females who had been victimised, but not to male perpetrators, as we see in this extract:

Extract 47
> *196. JL: ... some therapists say that they get caught up in trying to work out the truth and I'm just wondering how that plays out in a group or whether it does at all*
>
> *204. Ian: you know if a guy came here for assessment the first thing I would get him to sign a a statement of confidentiality which basically says he's got no rights of confidentiality whatsoever there were so many clauses in it, over at CAFCASS, they know whoever we're working with, that's to cover us with the data protection act, so he's got no confidentiality at all. His partner's got all the confidentiality in the world.*

5.3.3.7 Summary of sub-theme 6

In this sub-theme we see that participants commonly spoke about the need to prioritise risk issues for women and children. The implications of this were manifest in how services were generally segregated. Some participants spoke about there being specific issues to be aware

of when dealing with DVA e.g. confidentiality would not necessarily apply to 'perpetrators' whereas it would apply to the 'victim'. This provided a rationale for practitioners in this sector having specialist training and knowledge about DVA to ensure that they practised safely.

5.3.3.8 Sub-theme 7: deciding who gets help

> *Sue: how can we help you in a constructive way where nobody gets hurt? (84)*

A number of factors would be taken into account in coming to the decision as to whether a particular service could offer therapy for this presenting problem at this time, for this person, including the assessment of risk. As Helen, in Extract 52, says, '*life doesn't happen in neat little packages*' so, from this perspective, deciding who gets help might not be a simple process and some factors could carry more weight than others, depending on the therapist's perception of risk for example and the perspective they take on what is in the client's best interest (Extracts 48, 49, 50). This decision-making process appeared to be shaped by the understanding of each therapist in the context of the protocols of the particular organisation and the wider context of government policy regarding best practice for working with 'victims' and 'perpetrators'. Clients themselves played a part in the initial process as they would need to present to the 'right' agency, depending on whether they perceived themselves as having been victimised or abused. They might decide, '*I don't want this*' as the therapeutic approach is '*not for everyone*' (Extract 49). On the other hand, as participants' extracts illustrate, if the abuse is not considered by the therapist to be the main issue (Extract 52), or, if the abuse is considered to be '*too much*' (Extract 53), or, the timing of the referral is not right, they may not be offered help.

When risk issues for women and children are prioritised some participants spoke about the risk that counselling could expose a vulnerable client to further risk:

Extract 48
> *7. JL: … how would you describe the kind of referrals that you work with? (…)*
>
> *10 - 11 Jenny: … it's something we take into account for assessment in terms of whether you know coming to the counselling is actually going to put them at further risk from their partner. Also if they're not able to contract for 15 sessions obviously if people miss a couple of sessions we consider each case individually and can reimburse those sessions but in order for someone to really benefit they need to be um in a space where they can engage*

Here we see how the assessment could also include a judgment by the therapist as to whether a client is in the right '*space*' to use the therapy and could benefit. On the other hand, one participant said that therapy represented the offering of a space to think about themselves in a '*very particular way*' which could help them decide whether they wanted therapy or whether it was the right time.

106

Extract 49

> *21. JL: How has that prepared them for coming here would you say? (…)*
>
> *23- 24. Lyn: it is a it is a particular form of help and it's not for everyone and some people decide or we might decide with them that this isn't the right time or the right form of help um and I don't I mean wouldn't say that's wasted time because I think the assessment is is probably having a opportunity to think about themselves in a very particular way which they may not have had with the psychiatrist even um I say even but you know there's so it it gives them that space which can then lead them to say well actually this is too much for me, I don't want this*

For some participants, then, the assessment process was about helping the client to make choices, deciding for themselves whether therapy was likely to be helpful and whether they wanted this. However, it seemed that procedural and organisational protocols were the main factors that shaped the process of deciding. Knowing about legal issues and potential risk to a client who may attend therapy was regarded as important by all participants, as illustrated in this extract from a participant who worked in a 'survivor' service. The risk of the courts becoming involved is raised, in the context of what would be in the client's best interests:

Extract 50

> *1. JL: if we could just start with you telling me something about the service? (…)*
>
> *22 - 23. Jas: there are lots of legal issues that are going on often. There might be issues around contact, there may be issues around risk um there may be injunctions, all kinds of things that are that are that are happening and there might be fights over custody, fights over contact um within the court arena and that doesn't necessarily make it an adequate time to begin therapeutic work. Firstly because of how it can end up being used re-regardless of it being a confidential process sometimes if it's put between a judge and maybe a judge isn't so well informed, might decide that we have to go and disclose information about the therapy. So part of our assessment for therapy is very much about looking at the risk or the threat of it ending up in the court arena, which may not be in the best interest of the client from our perspective, from the therapeutic perspective*

Knowledge about domestic violence and what might put someone at more risk would influence the assessment of risk, how safety plans were implemented and ultimately determined decisions as to whether an intervention was appropriate. The concerns expressed in the following extract about there being increased risks for clients still in abusive relationships were common across the data:

Extract 51

> *23. JL: What would help you decide whether there were DV issues? (…)*
>
> *25. Anita: for me it is to make certain are they out of the relationship cos I think that's where we're finding now that's where the risk is for us as a service and for them so um it's identifying that now um so we've had at least 4 people come through who were still in DV relationships so we're having to tackle that side,*

how safe is it for you to be here, does your partner know that you're coming here for counselling? So we're now looking at safety planning and risk assessments cos if the risks are too high then it's not safe for them to be in this service really because we have to think about risk to counselling clients themselves

So, counselling/therapy may not be considered appropriate when the risks were rated as high, where, for example, someone was still in an abusive relationship. Even where risk issues were not present, for some participants it might not be '*that simple*' to say whether it was the 'right' place, because other people might decide this for clients, or they might want to talk about many issues which, for them, are related to the abuse. This issue is expanded on in the following extract where one participant speaks about people being referred to DVA agencies when other issues are perhaps more pertinent:

Extract 52

> *127. JL: If you were thinking about your work with um DV referrals is there anything particular about that work that you'd say you have difficulties, difficulties come up that you don't perhaps have in other work that you've done?(...)*

> *130-131. Helen: um but yeah I I think that very often is the main thing that somebody else will think oh this is a good idea for you and because they hear DV or sexual abuses oh those agencies do that oh go there um it might be that I guess in most cases it is probably the right referral but sometimes it might be the person's had a bereavement and that that's the thing that's really to the forefront of them and yeah they've got this whole other history but at that moment in time it's um my mum's died and in that case then we wouldn't be the right agency and it's not that simple because there are alwa I think when people come sometimes they think they can only speak about the abuse and I'm very clear it's not because life doesn't happen in neat little packages like that um so it will be everything impacts on everything else so if there is a bereavement in there then yeah that is important but if I'm hearing somebody coming and saying, well my mum's died and I just I can't get over it and that is the main issue then we're not the right place*

We can see here how therapy may seem to be a mysterious process for clients not inculcated into what is an appropriate topic and how therapy works. For example, a decision to offer an intervention might depend on how violence was assessed and whether a person was considered too violent, as illustrated in this extract:

Extract 53

> *1. JL: Could you start perhaps by telling me something about your role here with regard to taking DVA referrals? (...)*

> *11. Ruth: ... we have to refer them on to somebody else often. You know if the violence is too much obviously we can't work with them*

Clearly there are issues about the safety of therapists implicated in such decisions. Furthermore, these participants indicated that decisions would be based on an assessment of risk, which identified the number of abusive behaviours committed, using a checklist

designed by the service and that the risk posed could be disputed by either or both partners. So, whilst there was general agreement that support and therapy should be available for those who had been victimised, subject to the provisos mentioned above, this was not so with regard to working with 'perpetrators':

Extract 54
> *19. JL: So how do you work with that? (...)*
>
> *30. Tim: Politically um in the last 20 years of working with male perpetrators it's been very questionable whether whether you support the men at all because the problem is he may use his experience of trauma to justify his violence*

The provision of services for 'perpetrators' can thus be considered to be controversial when offering support might seem to excuse the abusive behaviour of someone with a traumatic past history. Other participants argued that working with abusive men was necessary for the protection of women and children. In Extract 55, twin aims of domestic violence interventions as, changing men and getting women out of destructive relationships are clearly set out. In Extract 56, a view that working with men is essential to feminist aims of supporting women is illustrated:

Extract 55
> *28. JL: ... what what do you think about the terminology that's used, perpetrators, victims? (...)*
>
> *47. Sam: I don't think the politics or programmes for men has really it's kind of gone underground a little bit, but it hasn't really gone away. In the 80s though it was a huge conflict because the feeling from the women's um end was that if any funding goes to programmes then it's going to be taken away from support services for women and there may have been some truth in that, but I've always felt that whatever you do, yes you need to have women supported you need to counsel them about how to get out of these very destructive, damaging relationships, how to protect their children, all that but at the end of the day it's men we have to change*

Extract 56
> *1. JL: Could you tell me something about the service here and your role? (...)*
>
> *12. Jay: after spending many many years of putting women into refuge who almost invariably end up going back for all sorts of reasons because it was so damned difficult to be apart um you know I just thought no, the men ought to be leaving not the women, the men ought to be the ones we work with*

The stated agenda in both extracts is on shifting the focus more towards working with men and helping them to change. There is an implicit acknowledgment that providing resources mainly for women has not created a reduction in the problem because women may stay with, or return to, abusive partners even when they have support.

5.3.3.9   Summary of sub-theme 7

The process for clients and therapists of help-seeking and referral, resulting in the offer of help was a complex one, requiring a therapist's expertise in weighing up risk issues and other factors to decide whether therapy was appropriate and would be beneficial. These decisions were framed in terms of what was considered by the therapist to be in the client's best interest. A perhaps counter-intuitive finding was that clients could be deemed too abusive, or too much at risk of further abuse to be offered help, even when they wanted this. Paradoxically, then, the prioritising of risk could close down some options as too risky, leaving some people without help or support and perhaps unsure why. This could also be the case when '*life doesn't happen in neat little packages*' and clients might present with a number of interwoven issues, including DVA: attempts by therapists to prioritise or separate out the issues, might not make sense to clients.

5.4   Summary of Theme 1

Theme 1 provides an illustration of ways in which the phenomena of DVA and the initial tasks of therapy that follow, are constructed by therapists when the problem is understood as a gender issue. From this perspective, DVA is perpetrated by men, and women and children are their 'victims'. Unequal gender relations are seen as deeply embedded in our social understanding and, it is assumed that women can be unwittingly complicit in their victimisation and that men will use DVA deliberately to gain power and control over women. A construction of DVA as morally wrong similarly underpins the conversational tasks that therapists initially engage in when assessing risk and deciding who gets help, and serves to position them as experts who know what counts, and 'victims' as lacking awareness, whilst 'perpetrators' are in denial of their responsibility, and their choice to behave abusively. In so doing, therapists, like clients, can get caught up in the dynamics of locating responsibility and constructing blame, manifest in some participants seeming unaware of the potential bias in their own constructions. It seemed paradoxical too, that, whilst participants spoke about not wanting to judge or categorise their clients, this occurred in the context of approaches to DVA that were defined by the division and naming of services as either for 'victims' or 'perpetrators'.

It appeared that therapists demonstrated and gave legitimacy to their expertise in the making of judgments as to who was responsible for the abuse and in their ability to recognise a *'genuine victim'* (Extract 43). These constructed judgments might be expressed to clients but could remain implicit in the naming process and the offer of services. Clients were seen as not liking and sometimes not identifying with labels, whether that be 'victim', 'perpetrator', or 'survivor', and this might, for example, be seen as an expression of denial of responsibility on the 'perpetrator's ' part or, a pejorative interpretation of the experience of victimised clients (14. Sue; Extract 34).

There was an unspoken positioning of the therapist's take as more considered and carrying more weight than the 'blaming' stance of clients and those who were not knowledgeable about DVA. In the main, clients tended to be represented as either lacking knowledge or a sense of responsibility and so all were in need of instruction. For many participants locating responsibility could be a straightforward matter as in one participant's assertion that '*in terms of blaming… there is one person to blame*' (Helen. 103). On the other hand, some participants spoke about these issues as being more complex than was at first apparent, an issue taken up in Theme 3. The presence of ambiguity and uncertainty when making these judgments was evident in the way some participants spoke about the struggle they experienced in giving someone a label that was '*disrespectful*' or '*derogatory*', or '*sticks them in a box*'. (Extracts 33, 34, 35).

Nevertheless, decisions as to who would be offered an intervention appeared straightforward, and as we will see in Theme 2, the process of categorisation would determine the aim of the intervention: women were offered support services, whilst '*it's men we have to change* '(Extract 55). A surprising finding, nevertheless, was that, in the context of prioritising risk, some participants might consider clients to be at, or to pose, too great a risk to be offered therapy, and it was unclear what services were available for such clients, unless they met the criteria to be referred to a forensic setting. There was an assumption, mostly implicit, that working therapeutically with individuals, or couples, who were still experiencing abuse from a partner, could itself render the victimised person, or their children, vulnerable to further abuse, unless carefully monitored, and would therefore be contra-indicated in some cases. This provided a rationale for men being '*the ones we work with*' (Extract 56).

5.5   Theme 2: Decoding What is Relevant: Validating 'Survivors'/'Victims' and Re-Educating 'Perpetrators'

5.5.1   Introduction to Theme 2

As we saw in Theme 1, "Naming the problem", constructions of DVA occur in a particular organisational context, which together with the funding remit of the different services could determine the nature and length of client contracts, who could access therapy and what its purpose would be. Theme 1 illustrated how these constructions of DVA could shape what was said and the conversational tasks therapists might engage in during the initial assessment process. More particularly we saw how a gender perspective could influence participants' understanding of what 'facts' are relevant when people are assessed and decisions are taken as to who needs help and what kind of help would be appropriate.

In Theme 2, "Decoding what is relevant", we look more specifically at what participants say they talk about in the on-going therapy when a gender perspective is taken, and how their therapeutic model might also influence their approach to understanding what is in their clients' best interests. We will see how participants position themselves relationally with their clients and how this shapes the therapeutic tasks of the on-going work, and what is of relevance to their particular approach. Most participants chose to work with either 'perpetrators' or 'survivor/victims' and some made explicit their reasons for doing so. In the context of talking about what was relevant when working with DVA, a few participants spoke about their personal experience of DVA, or other abuse, for example, or being interested in understanding aggression, including their own.

The second theme is structured to map out how participants speak about DVA in practice with either 'perpetrators' or 'survivors/victims' of DVA. More particularly the theme illustrates the way in which therapists' constructions of DVA, set out in Theme 1, open up particular ways of talking and relating to either a 'survivor/victim' or a 'perpetrator', reflecting different therapeutic intentions. Participants' talk about the ways in which therapists might create a context for the work and the different approaches they might take in relation to their understanding of the presenting problem are underpinned by constructions of who is to blame and the location of responsibility, already mapped out in Theme 1.

The two sub-themes, "Validating survivors/victims" and "Re-educating perpetrators", thereby represent pivotal aspects of the described therapeutic process, justified by, and justifying, the relational positioning and therapeutic, conversational tasks that ensue as a logical consequence of the initial referral process. In this way they map out the procedural aspects of therapy denoted when clients are positioned as either 'survivors'/'victims' or 'perpetrators'. Sub-theme 1 shows how 'Creating a context for providing support' invites two main conversational tasks, reflecting the therapeutic intention when working with 'survivors'/'victims' and Sub-theme 2 maps out how 'Creating a context for making changes' invites two different therapeutic tasks when working with 'perpetrators'.
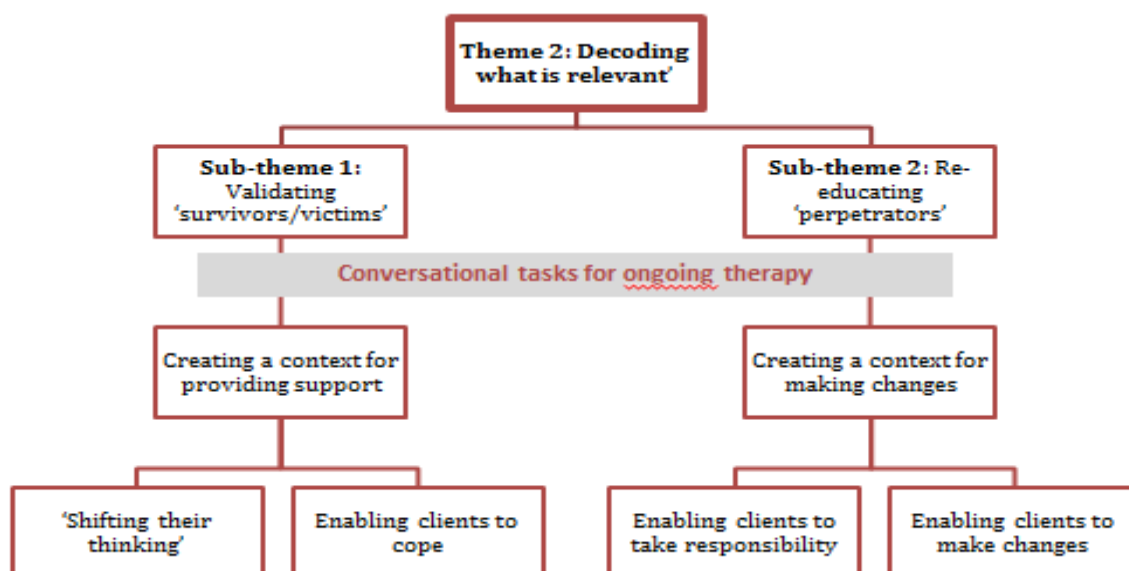
Figure 5.2: Theme 2: Decoding What is Relevant

5.5.1.1 Introduction to the participants' theoretical positioning

Across the data there was broad agreement as to the intention of therapeutic work with either 'perpetrators' or 'survivors/victims', but there were differences in participants' take on the specific work necessary to achieve the different aims. Psychoanalytic, person-centred and feminist perspectives were identifiable in the positions taken by participants and are represented in the following extracts. These illustrate differences in the perceived role of the therapist and what might be a relevant focus and also show how a number of therapeutic orientations and theories might inform practice:

Extract 1

> *38. JL: ... some people have said to me you need specific training in DV issues to be able to do the work, so what what would you say to that?*
>
> *39-42. Lyn: I'm not sure I would agree with that really I think it if you if you're good well I mean I'm not saying that you you you know you might not want to think about the issues which are um the the dynamic issues and the internal processes which might be going on in DV and I don't want to you know the other thing to say is of course everybody's situation is different and the meaning of the violence is different for them so you know I can't I'm not one to say you know it's all because of this, this and this, but I think if you are I mean for me my my original training was in um psychodynamic counselling um so there's notions of the unconscious and projective processes um all those kind of things help you to think about you know what the internal world give you a particular take on the internal world that it's not all nice (laughs) so that to me is is is really helpful in particularly in working with um you know violence and aggression and abuse*

In this extract, understanding individual differences and the notion of unconscious processes are spoken about as being more pertinent than having specific knowledge of DVA. This has implications for training, suggesting that some theoretical models may be more helpful than others in understanding violence and abuse, and that DVA could be understood in the wider context of problems in relating. It contrasts with the views expressed in Theme 1, sub-themes 1 and 3. A less common theoretical and relational position is illustrated in the following extract, where there is an overt intention to 'be' with the client and gender theory is de-emphasised:

Extract 2

> 19. JL: And how has your training prepared you for this work would you say?

> 24. Jenny: the kind of I suppose my training is quite sort of just be with the client where they're at you know hold the hope for them rather than for me to be working on an agenda

This positions clients and therapists as working collaboratively, moving away from the therapist as expert. It reflects a person-centred theoretical approach and this participant's view that specialist training in DVA was not necessary. By contrast, Extract 3 represents an explicitly feminist approach to working with 'perpetrators', drawing on psychodynamic theory, emphasising the importance of underpinning therapy work with a gender paradigm:

Extract 3

> 62. JL: ...what's the model that that underpins those? (...)

> 66. Sam: ... the basic underpinning of the groups was pro-feminist so it was (unclear) about perpetrators, it was no triggers, the responsibility theory, all the usual stuff, unacceptable, criminal, so given that the men already knew that that was the kind of paradigm that was being used we worked in a psychodynamic way and in a in a relationship way from from that perspective

Other approaches, such as Transactional Analysis reflect similar assumptions to psychodynamic theory i.e. the origin of the current problem lies in an early experience of inadequate parenting, as illustrated in this extract. This has implications for the required focus of the work, which, from this perspective is on re-parenting and building self-esteem:

Extract 4

> 42. JL: So you're drawing on a range of models to decide how to engage? (...)

> 47. Dana: Sometimes it's affirmation you know it's esteem building that kind of stuff so they're looking for er sometimes I think it's a re-parenting it's what I call from TA it's that parent-adult child where they've gone in to they haven't had appropriate parenting so they don't know how to be appropriate parents parents have told them to do something and they've got they're in child state generally they're coming from child state

Finally in Extract 5 is an example of an integrative approach, drawing on different theories:

Extract 5

> *111. JL: Um I was wondering about that you know what your thoughts are on whether there's a a more helpful theoretical approach than than others with this client group?*
>
> *112. Eva: Let's see. I started out quite psychodynamic and then became increasingly more integrative integrating CBT, solution-focussed, response-based um I would say that an integration of all these um have been helpful to me*

As we can see, participants may draw on different theories, each reflecting different assumptions as to the origin of the problem and inviting a particular focus for the therapeutic work. This provides a rationale for approaches that might differ in terms of whether they were overtly supportive or more focused on facilitating change.

5.5.2 Sub-theme 1: validating 'survivors'/'victims'' stories

5.5.2.1 *Introduction*

> *Ken: Um I think that fundamentally the impact is the same, whether you're a victim of DV, DA or a victim of any sort of crime. You know the sense of being a victim and what goes along with that I think fundamentally is the same for everybody. I think people show that, deal with it, manage it in different ways, that's where the difference lies (53)*

In this sub-theme we see how participants' talk about working with clients who had been victimised emphasised the overall therapeutic aim of all participants to validate clients' abusive experiences and its impact on them, positioning them as vulnerable and in need of support. As the quote above suggests, participants commonly tended to conceptualise the consequences of being victimised as fundamentally similar, often reflecting gendered explanations of DVA, whilst at the same time acknowledging there might be individual differences in the way people coped. This suggests that therapists would aim to be responsive to clients' individual needs and might contribute to their rationale for adopting a particular focus, as illustrated in the two tasks, 'Shifting their thinking' and 'Enabling clients to cope'. The emphasis on one or the other task might also depend on whether clients have left, or are still with, an abusive partner.

Having named the problem, participants spoke about giving support by empathising, and providing a safe space to think, from which a focus could develop that enabled the client express their feelings, make choices and develop a sense of agency and empowerment.

5.5.2.2 *Creating a context for providing support*

> *Jas: '...creating the right conditions' (91-92)*

Whatever theoretical approach was taken, forming a therapeutic relationship was commonly considered essential to creating a safe context for therapeutic work to take place, as this extract illustrates:

Extract 6

> *123. JL: So there's something there about the relationship between you and the client?*
>
> *124. Helen: Yeah and I guess all the research says that it is it's not about which theoretical background you work from but it is about being able to form that relationship and I suppose with something like DV even more so because of the issue of trust*

This suggests that DVA clients may be more disabled than others in forming relationships and so therapists working in this field need particular skills to engage these clients, given the loss of trust in their intimate relationships. In this respect, participants differed in how directive they said they might be when seeking to engage a client:

Extract 7

> *13. JL: And what led you to work with this client group? (...)*
>
> *18. Lyn: Exactly yes yeah um perhaps being a bit more I suppose being more pro-active in just in terms of the actual relationship as well it's not the kind of blank er and also that I think that operates very much in terms of the assessments um where we're looking I mean my my view about assessments is that we are looking at what the woman needs not what we can just what we can offer ...*

Here we see an illustration of the view that victimised clients have individual needs and that the therapist's role is to be pro-active in establishing what these are, differing from the person-centred approach taken by some participants, where the emphasis was on '*being with*', rather than '*doing*' (Extract 2). Nevertheless, there was agreement across the data that part of forming a trusting relationship with clients who had been victimised was in communicating empathy and conveying that their story would be believed. All participants working with victimised clients spoke about their aim being to create a space in which their clients felt able to talk and, through being heard, their experience was validated, trust was developed and reparative work could take place. The following two extracts illustrate the importance all participants placed on creating a context in which a victimised client would feel at ease and believed:

Extract 8

> *48. JL: ... I was wondering how that might impact, the use of terminology on the engagement, from your point of view? (...)*
>
> *51-54. Sara: sometimes it's quite frightening for um women to come for counselling. One, they don't always know what it is um and and two, they don't they really don't know what to expect and there's a whole process that takes place before they get here so I just need to be aware of that and um and it's the*

secret that they're holding they're holding this secret that they've been carrying around for a very long time and they want to know that when they share that they're gonna be believed often it's about being believed um I think that's a really big thing so I do try as much as I can to make them feel welcome sort of even before they've got into the room really

Extract 9

98. JL: How do you think you get that high level of engagement? (...)

100. Ken: I think once you sit down with somebody face to face and they you know it's the sorts of skills that I have I suppose from being a nurse sort of counselling skills that I've got (unclear) but to put them at their ease and to make them feel straight away that I believe them and that I'm not here to judge them um and listen to what they've got to say and demonstrate that I've heard what they've got to say and I'm taking it seriously

These extracts convey the enormity of the step taken by some clients in trusting a therapist with a long-held secret, placing the therapist in a privileged and responsible position. Both also emphasise the vulnerability of victimised clients, highlighting the need to treat them with care and build rapport from the start, to enable them to feel safe to '*share*'. Extract 9 exemplifies what all participants said about the relating skills therapists have and their ability to convey that they are not being judgmental. However, when it came to talking about how the therapeutic space was used, the different emphases, illustrated in Extracts 2 and 7, were repeated. The following two extracts again illustrate these two broadly different approaches. In the first, emphasis is placed on being with the client and going at their pace, guided by what they want to talk about:

Extract 10

52. JL: ... Is there anything else that you do that you think helps them makes them better able to talk about their experiences? (...)

67. Jenny: because for some other women they're may be not ready to be making huge changes but they will just need that space to be listened to and to get their immediate experiences shared with you

This positions the client as someone vulnerable who may not be able to make changes, illustrating a view expressed by a few participants. In contrast, in Extract 11 one participant speaks about creating a reflective space, that would be different from other spaces as it would be one in which the therapist might ask challenging questions. This approach expands on the idea of putting people at ease, paving the way for clients to feel that it would be safe to talk about behaviours, such as angry protest, that might not be consistent with the view of themselves as a 'victim', acquired perhaps from their initial support.

Extract 11

30. JL: and and you used the word perpetrator and I'm just wondering what your take is on the terminology perpetrator, victim, survivor (...)

32-35. Lyn: I think what we find is that a woman may come from Women's Aid say very often Women's Aid and um has been in a refuge, has been supported very much by them but with that sort of label if you like as victim um and it can be helpful in some ways but I think it can also be very it can then make it very difficult for a woman to talk about other aspects of herself um you know (...) Um I think you know you're providing a space where or hopefully creating a space um um a space between you, an internal space for her where which is different perhaps from where she's been referred from and I'm not just talking about Women's Aid, um where anything can be spoken about you know introducing the idea that anger is normal for example, healthy protest all those kind of things um er that people do what they have to do to survive as children all you know it's it's creating that sort of atmosphere really. I suppose asking questions that nobody else asks

This represents a view of 'support' as helpful but potentially disempowering when it closes down the possibility for speaking about the self as other than a 'victim'. So, there are implications for the therapy process and the therapeutic relationship when a therapist takes a more active, educative role or a mainly supportive approach, overtly manifest in the extent to which a therapist might bring their own agenda to the process. In Extract 12 one participant refers to '*educating*' in a '*counselling way*' that would have a problem-solving focus that fosters decision-making. This explicitly positions the therapist as someone who is not advice-giving but puts things to clients in a way that is facilitative of them reaching whatever conclusion they choose.

Extract 12

171. JL: And you were saying ... (...)

173. Ann: I see our counselling as counselling and educating, but in a counselling way you know cos for some people they don't know and they've nobody else to turn to, so again we don't give advice and it's all the way we put it to them, that lets them consider and make up their mind and come to the conclusions whatever conclusions they want to and that's still educating in a way because they're allowing being allowed to educate themselves

It is also implicit in the desire to teach that the client is in need of education and the therapist is more expert. A different approach, emphasising the importance of understanding and supporting the person and creating the right conditions to enable a client to choose what is spoken about is illustrated in the following two extracts. Here there is an emphasis on the client's frame of reference, which could mean that the abuse is not spoken about at all.

Extract 13

164. JL: Is there anything else that we haven't talked about that you you would like to comment on

165-166. Sara: ... I don't really sit here and talk to sort of educate the women in a way around violence or the abuse or anything like that. For me it's about um the woman who's in front of me this is a person and she'll share whatever she wants to share so I'll comment on it and um so if somebody comes and doesn't talk cos I've had a woman that's been raped before and sort of 6 7 weeks in

she's not shared anything about that rape. I might comment that you know you've not said anything but I wouldn't necessarily you know right, You're here to talk about DV and sort of work in a sort of an AA way they talk about whatever they wanna talk about

This positions the therapist as not trying to educate a client, or taking a prescriptive approach by setting an agenda that focuses the therapeutic work on the abuse against the wishes of the client. This view is expanded on in the following extract, where the client's agenda is spoken about as taking precedence, meaning that the details of the abuse may not be spoken about:

Extract 14

90. JL: ...When might you kind of shift into wanting perhaps to get them to talk about it?

91-92. Jas: Um um well this is the this is the interesting thing I think when we look at sort of even working with survivors of sexual abuse, adult childhood sexual abuse or DA there is something about creating the right conditions and doing the preparation aspect of the work ... there'll be clients that will never tell you about the incident but they will tell you about everything else surrounding it, their feelings, what their worries are, what their concerns are and coming from a Counselling Psychology perspective it is about the client's frame of reference and I think that's very important when you're looking at power dynamics

In this extract a gender perspective is evident in the reference to power dynamics, suggesting that therapists need to understand the impact of abuse on a 'survivor/victim's' capacity to relate, so they know what kind of response to expect from clients. It is implicit in the emphasis here on the client setting the agenda that therapist and client are in a relationship which has the potential to empower the client and thereby create a dynamic that is not abusive.

5.5.2.3   *Summary of creating a context for providing support*

In creating a context for supporting victimised clients, there were differences across the data in terms of participants' intention to direct the therapy process. Some spoke explicitly about inviting a client to share what they wanted to talk about, whilst others spoke about providing a space in which issues that might not be possible to speak about elsewhere could be addressed, and they might take a more overtly educative approach. In the next two sections we see how these broadly different approaches might be put in practice.

5.5.2.4 Shifting their thinking

Sara: ...shifting their thinking (128)

Helen: ... I think very often the work is around unpicking that blame and and questioning well how was it your fault? (108)

Dana: what is a good relationship that actually becomes a huge part of the work (60)

As we see in the way participants speak about the focus of the work with their clients, however the agenda was decided, therapists might have specific intentions in mind. When participants engaged in the therapeutic practice referred to as 'Shifting their thinking', power dynamics were implicit in the relational positioning of 'survivors'/'victims' as needing guidance, particularly when a client was still with an abusive partner.

The space in which the counselling takes place might be potentially difficult to contain, as we see illustrated in this extract:

Extract 15

> *85. JL: ... What would you say is most challenging about the work that you do?*
>
> *86-87. Dana: It's actually the context of the work (unclear) uncertain very little control over their (unclear) or world so in a way you're trying to do counselling in a state of flux is what I call it it's the only way I can liken it there's nothing stable there...You know people are just (laughs) in a space and it's shifting you you're one entity and there's another entity and there's almost nothing to hold onto. You don't really know very very hard in terms of the counselling. What are you doing? Why are you doing it? How to do it- those sorts of things are hard.*

The client and therapist are referred to as two '*entities*' that shift and seem unconnected. This illustrates the intensity of feelings brought to the therapy space by clients and the confusion this can elicit in a therapist at times, causing them to question what they are doing and why**.** The extract gives a sense of how difficult it can be for therapists to form and maintain a relationship with some clients whose lives are unstable, suggesting that therapists might need points of reference or a clear structure/agenda to help them stay grounded and focused. For example, even though the explicit intention was to not impose an agenda on a client, some participants spoke about wanting to enable clients to choose good or healthy relationships and so would begin by exploring a client's understanding of what this might mean to them. The following extract exemplifies this intention, expressed by many participants, of finding a way to raise awareness and shift a client's thinking. As we see in this extract, when seeking to raise a client's awareness, therapists may need to be sensitive to individual differences:

Extract 16

> *85. JL: So is that part of the work then with some clients, raising awareness?(...)*
>
> *87. Helen: it would be perhaps slightly different with each person in me trying to ascertain what can this person hear what can they take on board almost ...but definitely I think for me if I feel that I'm hearing something that isn't a healthy relationship I'd be wanting to question well why is that really?*

This extract highlights how therapists seek to balance being supportive of the client's frame of reference with being appropriately challenging. This is further illustrated more explicitly

in the following extract, which sets out the kind of questions a therapist might ask a client when seeking to raise their awareness:

Extract 17

> *48. Anita: people aren't aware of what's healthy and not healthy*

> *49. JL: So is that something you work with?*

> *51-56. Anita: with women who have are experiencing DV to some degree and for them to it's kind of highlighting or noticing with them this particular behaviour and kind of wondering what that's about maybe going through what do you think is a healthy relationship? What is caring, what what does caring mean to you, trying to get a sense of what that does mean to them, then establishing actually you know what you know there's something about equality here so that power dynamic (...) it can be quite you know rewarding in sense for both the client and myself to kind of get to that place where it's kind of really looking at it from childhood to where they're at now, then recognising unhealthy behaviour patterns for them to be able to kind of notice that and how they could possibly do things differently or what kind of possible routes would they take in future*

The importance of unpacking the client's experiences of relationships and identifying how healthy they were is highlighted, with an intention of facilitating change. Implicit here is the assumption that the therapist knows what a healthy relationship is, and can therefore raise the awareness of the 'victim' who is positioned as not knowing. In the following extract, one participant speaks about having to be careful not to impose her own definitions of a good relationship onto the client.

Extract 18

> *69. JL: ...and I was wondering whether that might be one of the questions whether they're asking you what you think a good relationship is?*

> *70-71. Dana: Absolutely that's it yes and that's the bit I need to avoid cos it's not what my definition of a good relationship is right and that's why I've got this very clear that's against the law and everything else is up to you and there's a whole range there of what works. and usually I've got you know I kind of use the ET and RB example and people can have on and off relationships etc that aren't abusive but not be right for each other*

Here we see how therapists might try to distance themselves from seeming to make moral judgements about what is a good relationship or directing the client. This participant refers to '*the law*' and provides illustrations of celebrity relationships as points of reference and comparison for clients, seeming thereby to normalise the experience of relationships not working and defining what is abusive without expressing her own view explicitly. In the following extract, another participant speaks in a conflicted way about the issue of whose agenda provides the focus of the work:

Extract 19

> *52. JL: ... Is there anything else that you do that you think helps them makes them better able to talk about their experiences? (...)*
>
> *59-60. Jenny: going in without an agenda but I suppose my agenda at the end would be that they choose healthier relationships for themselves um but you know that's that's entirely up to them but what a healthy relationship looks like for them what the woman decides might be and the other half for me is probably trying to heal some of that the pain from past experiences to give them a chance to be witness a chance to let them get some of that emotion out and*

So, as this extract illustrates, whilst the explicit therapeutic intention may be to not set an agenda, many participants took an active approach to shifting the way clients viewed relationships. Some focused more overtly on naming the wrongful behaviour of others and challenging the self-blame that 'survivors/victims' commonly might take on as a consequence. Many participants spoke about their passion for their work with 'survivors/victims' and we can see in the following extracts how a desire to shift a client's thinking might affect a therapist's agenda and the focus of the work. When a therapist positions him/herself as having knowledge about DVA and an understanding of the reasons why people might behave abusively, they might justify a need to dispel 'myths' and socially constructed ideas about 'victims' and their 'abusers'. We can see in the first and third extracts that, despite a stated commitment to not being directive, (Extracts 13 and 19), a therapist might have an implicit agenda, influenced by their knowledge of DVA.

Extract 20

> *127. JL: So that meeting together then in addition to say the counselling work you say*
>
> *128. Sara: ... very very powerful cos I think that's when they sort of realise oh it's not just me and actually it does the same whereas a lot of women will put it down to managing anger or or because he always has a drink they'll be somebody else in the room who'll say well mine don't drink and did the same thing and then it starts shifting their thinking a little bit well actually it's not it's not a drink problem it's actually about their control*

In this extract, we see how therapists might position themselves as knowing the true reason for the man's abusive behaviour, when they have an understanding of gender relations, and, concomitantly, female clients as not having this knowledge and so being inclined to excuse their partner's behaviour.

Extract 21

> *13. JL: So what what do you think best enables um a client like that to talk about their experience to you? (...)*
>
> *16-19. Sarah: so very often for me that leads into a conversation of challenging self-blame which is very much part of my work so I look at how people who are victimised have been presented socially, how I think that it's it's believed that's*

true and then I engage in a discussion sometimes about um understanding um making decisions for them often they blame themselves for staying staying with the perpetrator so I explore that with them and then of course I explore how they respond to the violence and then get to an understanding of how they resisted and rejected that er this violence and that very strongly disproves they were passive and it also disproves they were weak and so through all that process then I get to challenge the ideas, that victim doesn't mean passive and deficient and weak. It simply means someone who has been done wrong to

In this extract, we see how therapists might re-frame a client's experience, inviting a more positive take using the concept of 'resistance' as an alternative to a construction of victimised women as passive and weak. This explicitly seeks to re-position victimised clients as strong and resilient and having agency, thereby challenging accepted 'truisms' about 'victims' and self-blame arising from staying with an abusive partner. This is echoed in the following extract, which also positions 'victims' as having made the right choices:

Extract 22

114. JL: ... if there are any changes that you think need to happen?

118-119. Jenny: what's really struck me is you know the effect on women's self-esteem is can be so overwhelming that any kind of intervention that actually compounds that that they're somehow in the wrong or somehow should do something differently to me is the way not to go (laughs) so I think that's you know kind of much more empowering and compassionate and you know it's not you know absolving anyone for the responsibility for their choices or their actions but it's it's I think it's the way in which that's done

We begin to see here the complexity of the problem that therapists are grappling with: if 'victims' choices are framed as the most appropriate in the circumstances, and any challenge to this is seen as a further attack on their depleted self-esteem, then it becomes inappropriate to suggest they change their thinking or behaviour, thereby implying they are in the wrong. At the same time, as this extract illustrates, therapists might nevertheless, want 'victims' to take responsibility for their choices and make better ones in the future (Extracts 17 and 19), or change their understanding of self, or other (Extracts 20 and 21). This perhaps helps to explain why an explicit focus on change might be construed as blaming, and hence why therapists might choose to shift 'victims' thinking in a less overt way.

5.5.2.5 *Summary of shifting their thinking*

For many participants there was a deliberate intention expressed that they were not trying to set an agenda, as they felt that imposing an agenda could repeat the experience of being controlled, and so instead wanted to empower victimised clients by giving them choices. Nevertheless, deciding what to do and how, could be challenging and *'very very hard'* and could create tension around whose agenda therapists were working with (Extract 19). Whilst some participants spoke explicitly about educating their clients about 'healthy' relationships, or, challenging self-blame and seeking to re-frame and re-construct the experiences of

victimised clients, it seemed that even those participants who expressly aimed to work with their client's agenda might want to shift their clients' thinking, in more subtle ways. The intention to support and preserve the integrity of clients' choices seemed to underpin both approaches.

Differences in approach evident across the data may be partly understood as participants using different theories, though most spoke about trying to address the individual needs of clients, and drawing on their personal and professional experience when deciding on the focus for the therapeutic work. As we see in the next section, whilst some participants referred to doing reparative work, understanding the decisions clients made and recognising '*unhealthy*' patterns of behaviour in their relationships (Extract 17), others focused more on self-development in relation to decision-making, and building self-esteem and confidence.

5.5.2.6 Enabling clients to cope

Jenny: there's a lot of reparative work to do (81-82)

Helen: thinking about it I guess across the whole range is the whole of their self and their self-esteem is is worn away (41)

Jenny: most women as you talk and drill down they actually have a history of other forms of violence or childhood abuse (18)

When clients' self-esteem and confidence are construed as having been shattered by the experience of DVA, then reparative work or identifying strengths may become the main focus of work rather than the DVA itself. Here there is a more explicit focus on moving on and making changes and this was most commonly spoken about when participants were working with women who had left an abusive partner. Clients' difficulties with decision-making, self-esteem and confidence were issues mentioned by most therapists as being relevant to helping clients to cope now and to move on, particularly those who were feeling guilty about decisions they made or concerned about the impact of their lack of confidence in a new relationship. In the following four extracts participants speak about the need, as they see it, for reparative work to help clients increase their self-esteem and rebuild their lives:

Extract 23

148. JL: OK so then you talk over it?

149. Ann: And then we talk you know we go, counsel them on the DA or it may be that they've gone into a new relationship and it's affecting the new relationship, so we'll counsel them with that so it's DA that gets them in to us but that's not always the most relevant thing for them that they need counselling about. It's the self-esteem and confidence, the decision-making um guilt um they might feel over children that they didn't leave sooner or the impact or just difficulties with the children and then generally they'll go back to the domestic

*abuse at a later date. I would say that happens more than actually talking about
what happened specifically with DA*

The focus here is in making sense of past choices in the context of now, so the impact of these does not continue to affect their new relationships, and as we see from the following extract, male and female 'victims' may similarly be concerned to ensure that they do not repeat their experience:

Extract 24

158. JL: And how do the issues between the men and women compare... (...)

*166-167. Ann: ... they are somebody who's experiencing or has experienced DA,
you know and that's it and that's what we work with or whatever they want to
bring, cos that's their choice and as I say you have some clients that don't ever
talk about it, because they feel that actually they don't need to, they need to
learn how to live today and you know and how to make sure it never happens
again when actually talking about what has happened it's almost like I'll deal
with that later, now how do I cope today? How do I deal with today and what's
going on?*

Again, as illustrated in the previous sub-theme, we see that the focus of the therapeutic work may not be specifically on DVA, but, instead, on developing better coping skills. Some participants spoke about the impact of DVA on 'victims'' mood and that it was common that 'victims' would be clinically depressed and have low self-esteem:

Extract 25

*79. JL: ... why are women are in a relationship that's abusive and how do we
explain that as therapists?*

*81-82. Jenny: the other thing has been the sense of being decent lovable that
anyone else would choose them or be with them has been so undermined by the
constant psychological abuse that actually better the devil you know and who
else would have me anyway so in terms of us they possibly come in a clinically
depressed state as well as you know self esteem work throughout the whole kind
of underpins the whole therapy the whole therapy with most women actually
there's a lot of reparative work to do that's the thing most commonly that comes
up when I ask you know what would you like from counselling*

As illustrated, most female 'victims' were construed by most participants as likely to be experiencing a predictable range of psychological problems and difficulties in functioning, pointing to a need for more generic counselling skills to be deployed. Alternatively, consistent with an overall therapeutic intention of raising self-awareness and improving self-esteem without seeming to attribute blame, therapists might focus on strengths, similar in approach to the re-framing of 'passive' behaviour, illustrated in 'Shifting their thinking':

Extract 26

31. JL: and that's one of my questions, how best to work with this client group...?

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44. Dede: and we get to know them as people how they function what their strengths are so as they can actually tap into their own self-esteem and self-worth and all of these ingredients that are so important in them being able to move on to a healthier life.

Implicit here is the assumption that therapists need to gain an understanding of the whole person, not only the abusive aspects of a client's experience, in order to facilitate self-awareness and greater capacity to be self-reliant and make healthier choices.

5.5.2.7 *Summary of sub-theme 1*

Having named the problem, participants spoke about giving support by empathising, and providing a safe space to think, from which a focus could develop that enabled a victimised client express their feelings, make choices and develop a sense of agency and empowerment.

Creating trust in the therapist and the therapeutic relationship was considered essential by all participants, as many clients could have a history of abuse preceding the intimate relationship abuse and might therefore have longstanding difficulties trusting others (Extract 6). Conveying to clients that they would be believed, taken seriously and that they were safe to talk, were initial steps considered instrumental to the development of rapport and trust (Extracts 8 and 9). Jenny (Extract 10) and Sara (Extract 13), for example, spoke of clients being enabled to 'share' their problems with the therapist. Some participants also spoke about ensuring that clients would not be put at risk of further harm by therapist intervention: this could include making inappropriate judgments about 'victims' (Extract 22).

Commonly participants positioned the self as in a caring, responsive relationship with their clients and sensitive to their individual stories. Most participants' talk exemplified an individualist orientation, regardless of theoretical perspective, in the focus on clients' personal stories and their own role as facilitators of healing. Ways of speaking about the clients' problems also illustrated some tensions or contradictions around not wanting to have an agenda, but also wanting to shift their clients' thinking (Extracts 12, 19 and 20).

Participants expressed different views as to what was the role of the therapist and a helpful focus for the work and it seemed that a number of factors could influence their approach: theory pertaining to their role as listeners/educators/enablers; ideas about 'good' relationships; theory about the relevance of past experience. In making connections between past and current abuse, some participants took up abuse narratives that construct women as having been damaged by their early experiences and as unconsciously making unhealthy choices of partner, as a direct consequence (Extract 17). This appeared to justify helping clients to understand what a healthy relationship might be and '*educating in a counselling way*' (Extract 12).

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On the other hand, some participants re-located the individual experiences of their clients in a social context in which constructions of gender legitimate the subordination of women and their control by men (Extracts 20 and 21). In so doing, there appears to be an attempt to shift responsibility from the individual, '*get to an understanding*' and help them '*sort of realise oh it's not just me*', so providing a rationale for the focus of the work on '*shifting their thinking*' and '*challenging self-blame*'.

5.5.3   Sub-theme 2: re-educating 'perpetrators'

5.5.3.1   *Introduction*

In contrast to the approach of participants working with people named as 'victims', those working with 'perpetrators' spoke about their role and agenda explicitly in terms of 'teaching', 'educating', 'telling', 'changing negative beliefs' and making clients accept that they were in control of their behaviour and had made choices to behave abusively.

5.5.3.2   *Creating a context for making changes*

> *Ian: Yeah they can come in very angry or upset, not with us (181)*

Similar to participants working with victimised clients, participants who were working with 'perpetrators' created a context for the therapeutic tasks. Tasks for this client group were explicitly focused on teaching and facilitating changes in thinking and behaviours, rather than supporting clients to share their stories or discharge emotions. The aim of therapeutic interventions from this perspective was to enable clients to manage their anger, and not act this out in violent or abusive behaviour.

Some participants said that clients might be '*extremely nervous*' and fearful of being criticised when they first present to a therapist, or they might be very angry, seeing themselves as wrongly accused (181. Ian). One way of enabling clients to behave differently might be for therapists to model the kind of behaviour they want clients to learn. The aim would be to convey to clients that they are respected and that they are engaging in a collaborative endeavour with the therapist, with the expectation that clients will feel respected and want to behave respectfully in return. The longer-term aim would be that the behaviour will generalise to other relationships and so reduce the abusive behaviours. This approach is illustrated in the two extracts that follow:

Extract 27

> *20. JL: What kind of things do you say to get them to talk about what they're doing? (...)*
>
> *29-30. Sue: they're extremely nervous when they first come and they're convinced they're going to be read the riot act and for all of us here it's crucial*

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that they recognise they will be treated with absolute respect because how else can we teach them to respect others if if we just. So it's not an 'us and them' situation

This illustrates how therapists might position themselves as more powerful than their clients, but as choosing not to abuse this. In so doing, they may seek to model behaviour that is not reactive or retaliatory, but understanding and empathic. The challenge this might pose, particularly when a female therapist is working with a male 'perpetrator', is captured in the following extract:

Extract 28

62. Beth: but you know certainly as a woman it can be tough listening to how some of the men talk about women um I am a woman (laughs) you know I can't completely divorce myself from that

63. JL: How do you manage that?

65.-66. Beth: sometimes I have to manage it when it gets difficult but predominantly I use it and I use it to offer the men a different female model um hopefully what I'm modelling for them is I don't I'm not reactive... and also it's very important in the group that we're modelling a partnership, a different kind of partnership to the one they may be used to so that you know we can have a disagreement or we can make fun of each other or you know we can relate but in a in a kind of respectful er and and caring way.

We see how the focus here is on managing interpersonal issues, reflecting feminist theory about gender inequality and men seeking to gain power and control over women. For the female therapist the relationship may be experienced as a forced positioning into a subordinate role, which they challenge by behaving in a caring way that is respectful but not reactive, and, by seeking to take up a role as an equal. More explicitly, a 'victim' position is rejected by the therapist, by dint of their professional position as being 'in charge' of a group, though this may create some tension with the intention to be an equal.

The rules of engagement may be embedded in the structure of a 'perpetrator' programme, which is designed to challenge existing accepted unequal power relations. Group perpetrator programmes may, for example, have a structure that doesn't include talking about the past or clients' feelings because this might risk colluding with clients justifying or excusing their abusive behaviour. As this extract illustrates, it may therefore be considered inappropriate to give space to 'perpetrators' for offloading feelings:

Extract 29

75. JL: ...how do you broach the issue about it's wrong what you're doing yet engage with the counselling intention as well (...)

79. Ian: we're not here to talk about your terrible childhood or whatever cos we've got a programme and we've got to get on with it. This is a group. So we would totally ignore their feelings and so they would bury all of that

The potential consequences when therapists decide what is relevant to the work of the group, may be that 'perpetrators' do not give voice to their feelings but hold onto them. This imposition of the therapist's agenda seems to conflict with the emphasis placed by most participants on developing a collaborative relationship and may be experienced as a forced positioning of the client into a passive 'victim' role. However, regardless of approach, most participants placed importance on listening, being non-judgmental towards 'perpetrators' and building their confidence because of the shame they might feel about having been abusive, as this extract illustrates:

Extract 30

> *94. JL: I was just wondering at that point how you kind of manage being non-judgmental with the challenging of that?(...)*
>
> *98. Sue: I think the thing that turns it for many is they hate themselves, they're really ashamed and they they won't sit and tell you that in the first 6 months but a newcomer er an experienced group member will, he'll say, he won't hesitate and say how ashamed and and er embarrassed he felt about himself and his behaviour, he didn't like himself,*

This seems to portray 'perpetrators' as vulnerable and having low self-esteem, which, unlike victimised clients, it is assumed they may not want to talk about at first. The potential complexity of the dynamics of shame and its role in DVA is captured in the next extract, where the idea is voiced that the experience of shame itself can contribute to men behaving violently:

Extract 31

> *58. JL: I wondered about the shame element as well because when you mentioned about working therapeutically I wonder how much the shame comes into it?*
>
> *59-60. Tim: I think shame's a massive driver um particularly for men it's um there've been some studies in the states by a man called James Gilligan. Gilligan um he's been work he's done a lot of work um with very violent men in prison... he identified on on the wings there are great high levels of violence. Gilligan went in and worked with the warders and the prison officers and got them to treat the inmates with respect and levels of violence just dropped completely it was almost zero and he worked with the inmates, these are kind of lifers um and they almost invariably reported that the reason why they were violent, why they were murderers, why they were abusive was because they felt disrespected, they felt shamed, and they felt put down either by partners or wives or somebody else or*

This extract represents a controversial idea, in relation to gender theory, namely that another person's behaviour might impact on a 'perpetrator's' self-esteem in a way that might seem to explain why they behaved violently. The putting down by another seems to position the 'perpetrator' as having a history in which they had been victimised, which conflicts with the

notion that a person can be labelled as one or the other. It also highlights the challenge of balancing support with being challenging: most participants working with perpetrators spoke about the need to listen with respect and be non-judgemental, whilst also being challenging, as many of these clients might not have felt listened to by others. In the following extract, an explicit link is made between not being heard and using violence as a means of communicating frustration and trying to resolve a conflict:

Extract 32

> *70. JL: yes what is it that you bring to this that helps you to do that?*
>
> *71-73. Sue: Yeah. It's not judgmental here. It doesn't mean we're not challenging but we do er the thing that strikes so many is that we listen. So often they've said nobody's ever listened to me before. The feeling of not being heard, the sheer frustration and resorting to violence or abuse cos they don't they they believe they have no other means of resolving what's going on. Yeah I think that's probably it that um it's non-judgmental and it's very respectful to all of them*

Here 'perpetrators' are depicted as having few resources, using violence as a desperate last resort to attempt to make themselves heard, rather than in a calculated means of controlling others. Though they are positioned as deserving of empathy and needing to be listened to, this does seem to conflict with the expressed intention in Extract 29, and the following extract:

Extract 33

> *218. Sue: there are some things we won't challenge with a newcomer cos it might be a bit too much for them but if it's a regular and he says something like calling a woman a bird or something I'll pounce on him straight away for a derogatory term*
>
> *219. JL: So language...*
>
> *220. Sue: Oh um yeah but I wouldn't necessarily do it with a newcomer because the newcomer will be dropping clangers left, right and centre and he wouldn't come back so it it has to be gradual because we're trying to build his confidence to help him feel comfortable because at the end of the day if we can do that he can reduce the violence and abuse, whatever he's doing, wherever he is.*

This suggests that judgments made about what is acceptable behaviour may be initially unspoken: behaviours which break the rules of engagement may be tolerated at first whilst rapport is being built, but then a stricter, more overtly judgmental approach may operate once the client has engaged. The view that every therapist is making judgements all the time is illustrated here:

Extract 34

> *76. JL: How does the um therapeutic intention sit alongside the kind of taking a moral position if you like about the wrongness of DV? (...)*

90. Sam: every time I choose to make an intervention I'm making a judgment about my patient's behaviour er I I'm I've got to be pathologising something, if it's not my own judgment it's a received judgment, well why do you save all your old newspapers, who gives a fuck? If she wants to store her old newspapers, who cares, do you know what I mean? Well we have to care because we've been told we should care about these things, but the world is full of people who save old newspapers and don't end up on analytic couches. We we can get a very narrow view obviously

Whilst most participants spoke about their intention to remain non-judgmental, we might understand therapists' interventions as being informed by a judgement, whether or not this was made explicit. From this perspective, a therapist's view could be a narrow one that would tend to pathologise clients' behaviour, as illustrated here.

5.5.3.3 Summary of creating a context for making changes

Creating a context for change with 'perpetrators' can pose challenges for therapists with regard to finding a balance between listening, being non-judgmental and beginning to challenge abusive behaviours. An awareness of relational dynamics informed most participants' approach to engaging clients and their intention of modelling more collaborative relationships, in which others were treated with respect and their views valued. However, in positioning the client as having less power than the therapist to set the agenda, it seemed that therapists positioned themselves as more expert in making judgments about relationships and more powerful in the therapeutic relationship. This meant that participants commonly spoke about working in a structured way that might preclude discussion of clients' feelings or their past experiences, because this might lead to excusing their abusive behaviour. As we see in the next sections, this provides a rationale for an educative approach focused on challenging 'perpetrators'' denial of responsibility and changing their behaviour and beliefs.

5.5.3.4 Enabling clients to take responsibility

Sue: learning the lessons (24)

Sue: it's about re-educating, exploring any negative attitudes or beliefs you have any behaviour and er responses that are negative that caused you to (25)

Working from a position in which 'perpetrators' would be held responsible for what they do was a common theme in participants' talk. 'Perpetrators' motivation to control others might be assumed, and so matters of intention or context were not considered by some participants as relevant issues to explore with clients. For some participants a 'perpetrator's' perception of the problem might be seen as '*unnecessary stuff*' that shifts the focus onto their own issues and so gets in the way of focussing on their abusive behaviour:

Extract 35

> *34. JL. You said about them having to take responsibility. I was just wondering about how you kind of manage the issue of the moral issue if you like of the wrongness of DV and holding respect too as you say (...)*

> *47. Sue: at the beginning I don't ask them why they're here or what they've done. They'd talk to you for days about all their problems, also minimising and denial ...at the beginning they'd just keep they'd keep you sidetracked with all their problems how .. .so it can tie you down to a lot of er unnecessary stuff really um*

'Perpetrators' are depicted here as likely to deny their responsibility at first and move away from the proper focus of the work. Taking this perspective justifies not enabling clients to discuss their problems, and creates a forced positioning which clients are unlikely to challenge, given that doing so would seem to confirm that they are controlling. On the other hand, many participants spoke about 'perpetrators' as not so much being deliberately in denial as not knowing the difference between right and wrong and not having learnt how to respond appropriately to anger. This way of understanding 'perpetrators' is illustrated in these two extracts from practitioners who both have many years experience of this client group:

Extract 36

> *76. JL: How does the um therapeutic intention sit alongside the kind of taking a moral position if you like about the wrongness of DV?(...)*

> *80. Sam: you spend half your time telling these people what's wrong and right because nobody's ever told them before. You actually have to you have to get in there and teach them how to think morally because if you sit and wait for it to develop it's not going to happen*

This positions therapists as educators and 'perpetrators' as needing to be taught basic moral values. This is expanded on in the following extract which illustrates a view of 'perpetrators' as believing in the '*nonsense*' they talk and invested in finding someone else to blame for their behaviour:

Extract 37

> *57. JL: and what's your take on the terms used like victim, abuser, perpetrator? (...)*

> *64. Sue: nobody teaches them so how can they know? The times I have to listen in here to the red mist came over me (laughs) it's nonsense but it's not nonsense to them because that's how they er negative emotions are allowed to soar through their body unchecked because nobody's told them how to put the breaks on and how to say, hang on a minute, what's going on here? Let me take responsibility for this and move away from it so I can start looking at what's going on rather than what's the usual procedure which is to blame someone else*

So, in contrast to those who work with 'survivors/victims' as we saw in the previous section, all participants working with 'perpetrators' spoke about having an explicit agenda for change or '*certain things in our head*' that they would focus on. As we can see from the previous extracts, when 'perpetrators' are perceived as not knowing what is right or wrong and therapists position themselves as teaching this difference, there is an implicit assumption that therapists have a moral compass. There is also a contradiction evident (Extract 37) in both dismissing 'perpetrators'' claims of not being aware of what they are doing as '*nonsense*', yet also taking the position that '*nobody teaches them so they don't know*'. These clients may thus be perceived as stuck in rigid 'either/or' ways of thinking and need help to find a '*middle road*' by which the meaning of the behaviour is unpacked, as we see illustrated here:

Extract 38

> *89. JL: I was wondering if you could tell me something about the rationale for the way the group is run and how it comes to follow the individual? (...)*
>
> *116-117. Beth: quite often they're stuck in the passive/aggressive they're either in one or the other: she didn't let me so I had to whack her. Like somewhere there's a middle road possible maybe you know so so we have a kind of certain things in our head. We want them to think about envy um we want them to think about control. We want them to think about authority and respect, what are they? What do we want to be respected for? How do we get respect? What does respect mean?*

In the following extract an approach consistent with the Deluth model is described:

Extract 39

> *63. JL: What do you think you do that best enables them to engage with*
>
> *64-66. Ian: Get them to acknowledge it. Normally with the Deluth model it would be about challenging their beliefs... Your beliefs are all wrong and mine are all right and yeah (laughs) you know it's all yes you've just have got it wrong really you know yes*

This is interesting in that it adopts an 'either/or' approach similar to the behaviour of the 'perpetrators' that is the target of the therapy. Just as 'perpetrators' are seen as caught up in polarised behaviours that position themselves and others, closing down other, 'middle' options, so-to-speak, so therapists positioning 'perpetrators' as completely wrong, in effect position themselves as completely right.

Many participants spoke about 'perpetrators' as being in denial of their abusive behaviour as we saw in Theme 1, so not seeing a need for therapy especially when they had been referred by others. Most participants said that for this reason they preferred to see clients who had self-referred. One participants spoke about 'perpetrators' as needing to have a 'wake up'

call, such as losing a relationship, before they are ready to see themselves as at fault and work on making changes:

Extract 40

> *94. JL: I was just wondering at that point how you kind of manage being non-judgmental with the challenging of that? (...)*
>
> *101. Sue: Put your relationship on hold because you cannot she, why would she have you back? What have you brought to that relationship other than abuse? Put your relationship on hold and let's work on what you need to change about you for the level of fear to go. And it often, in many cases it's too late, they've lost everything. Not all of them, though that's the trigger that may wake them up and think, is it me?*

Here we see 'perpetrators' depicted as unknowingly taking a path to losing everything, which is reminiscent of the view of victimised clients as not recognising they are being abused. This seems to suggest that, despite their overtly controlling behaviours, they are not in control, or even perhaps behaving intentionally. So, this way of understanding 'perpetrators'' behaviour points to a need for them to not only be told what is right/wrong, but also for them to understand the consequences of their actions.

For most participants the re-education work with 'perpetrators' was aimed at changing negative beliefs and behaviours and enabling 'perpetrators' to take responsibility for their actions. Whilst all spoke about having a structured approach to working on attitude and behaviour change, some emphasised the facilitation of client understanding as also being a goal. In these two extracts, we see the difference in emphasis, underscored by the repetition of the word, 'understand' in the second extract:

Extract 41

> *20. JL: What kind of things do you say to get them to talk about what they're doing? (...)*
>
> *24-27. Sue: If they can hold their hands up and say yeah it was me, it was out of order that's very empowering because then you can work towards learning the lessons that you you know established at the incident to ensure you don't repeat them and ... Yes that's really the first step, to take responsibility. They don't like it and we don't push it.*

Extract 42

> *9. JL: ...Ok so could you tell me something about your role here with regard to taking DVA clients? (...)*
>
> *15. Eva: what we do in the in the 1-1 is um try to um help the client um understand their actions and in what way they could be seen as violent and er try to understand where their responsibility lies and also own their behaviour and their attitude yeah and there's there's a structure to it so we um give them work after the session then it's discussed at the next session*

For most participants a fundamental part of the work was getting 'perpetrators' to take responsibility for their behaviour. As we see in Extract 41, naming this may be considered the first step, or as in Extract 42, the first step may be to help them understand their actions as violent/abusive so they understand where their responsibility lies.

Issues of agency, motivation and control are central to the understanding of DVA from a feminist perspective. A particularly controversial issue is the degree to which people might be in control of their anger and decision to behave abusively. From a feminist perspective 'perpetrators' are seen as in denial of both their desire to control their partners and their making a choice to use violence in pursuit of this. So, a therapist working with this understanding of DVA would conceptualise 'perpetrators' as having control over their violence and might aim to get to this 'fact' by exploring occasions when violence was not chosen as a response. In the following extracts issues of choice, control and intention are taken up, illustrating this perspective:

Extract 43

> *65. JL: And when you hear that how do you work with it? (...)*
>
> *67-68. Sarah: So trying to get into the limits of their violence and where they got to that attitude and say so if it's ok for you to stop a punch it means that you really know when you hit out what you are going to give out, so then I'm also trying to get to the fact that they have control because by saying I never punch a woman they're saying not only that they have limits to their violence but also they can control the limits that they use. So I will use that and then unpick that*

By contrast to Extracts 31, 32 and 40, 'perpetrators' are portrayed in this extract as having control and deliberately choosing to behave violently, positioning them as powerful and calculating. Many participants expressed similar views, though as the following extract illustrates, some were less certain that DVA could be so clearly defined:

Extract 44

> *17. JL: ... how we define DVA and I'm wondering what your understanding of it is?*
>
> *20. Beth: of course it manifests in lots of ways but yeah I think intent is relevant er what's the intention um and if your intention is to either er put someone else down or injure them in some way emotionally or physically then that's what I would challenge really*

Therapists might seek to distinguish between acts of violence/abuse that are done deliberately and potentially those that may be reactive. It represents the idea that people might act impulsively without thought, and as such challenges taken-for-granted views of 'perpetrators' as necessarily all threatening, dangerous and calculating.

5.5.3.5 Summary of enabling clients to take responsibility

When 'perpetrators' are perceived to be in denial of responsibility, or not knowing the difference between right and wrong, therapists may take a structured approach in which they set the agenda and the focus is on challenging clients' wrong beliefs and teaching basic moral values. This positions therapists as experts and having more power than 'perpetrators', who are portrayed as devious and might need to be forced into accepting their responsibility. Different takes are illustrated, as to whether, on the one hand, 'perpetrators' are in control of their anger and choose to use violence, or, on the other, lack awareness of what they are doing, in the same way that 'victims' might be construed as not knowing they were being abused.

5.5.3.6 Enabling clients to make changes

Re-education was represented by some participants as a difficult and sometimes lengthy process that might not work because some clients might not be able to take responsibility, or they might lack control over their behaviour. In contrast to the approach to working with victimised clients, there is a sense in all the following extracts of this being a hopeless endeavour with some people, who might be unavailable, or unaware. In contrast also to the view of 'perpetrators' as having control over their behaviour, here we see a view of them as deluding themselves when they think that they can gain control over their violence, rather like someone with addiction issues. This is a view that appears to categorise 'perpetrators' as essentially abusive and out of control, reflecting a view of violence as innate or a trait, that has to be constantly monitored and managed and might suggest a need for longer-term interventions, as illustrated here:

Extract 45

> *157. JL: I was wondering if there were any changes you would like to see in terms of service provision (...)*
>
> *159-160. Sue: After they've stopped coming if they get if they have a bit of a wobble later on down the road they know they can come back for a top-up just to er re-focus them you know because we categorically state over and over again the day you finally think you've cracked it is the day you're at you're most dangerous because you've lulled yourself into a false sense of security*

The view that it was not always possible to get some 'perpetrators' to take responsibility and make different choices that would affect change was one that was commonly expressed by participants. In these extracts, three participants speak about the challenging nature of this work and how it can take a long time to make changes:

Extract 46

> *31. JL: ...in the literature there's er a kind of debate about whether it's appropriate to work therapeutically with perpetrators. What what's your take on that?*

32. Eva: Um well I think it's hard um and the most challenging bit is to get to this understanding of responsibility um and that's not always possible so from the people I've seen um most have been able to come to the point where they can um take on responsibility, but not all

Extract 47

166. JL: How do you think that would fit with the counselling intention, working with the abuser? (...)

170. Anita: we inevitably find as well that I'm just using perpetrator but I don't particularly like the word yeah it is that um they don't want change sometimes so they see any intervention as a threat so if someone's that closed off then actually you have to say this person can't be worked with so they just go into the same cycle of relationship again.

Extract 48

31. JL: How long do they stay in the group?

32-33. Sue: I strongly recommend they stay a year but I'd say the average is 3-9 months but many do stay over a year because to get the maximum benefit it requires that commitment because you're not overnight going to change any negative attitudes, beliefs, behaviour and responses. It's a long process of change, of looking at what baggage you're carrying around with you triggering off your arousal. There's just a huge amount of work into what's going on

From a gender perspective, 'perpetrators' may not be able to make changes as they may remain in denial, believing they are wrongly blamed. As these extracts illustrate, 'perpetrators' may be unwilling clients, hard to engage and reluctant to change.

5.5.3.7 *Summary of sub-theme 2*

Consistent with feminist theory, most participants who worked with 'perpetrators' referred to male clients and spoke about focussing the work on getting clients to take responsibility for their behaviour and facilitate change (Extracts 36, 37, 41 and 43). Whilst judgments about what was right and wrong behaviour underpinned this approach, all participants spoke about needing to be non-judgmental in order to engage the client in the change work and find a balance between being empathic and challenging. The findings suggest that this was challenging work for participants as 'perpetrators' might not want to engage or make changes and if they did, these might be difficult to sustain. Understandings of 'perpetrators'' response to therapy drew on patriarchal notions of gender relations and individual pathology, suggesting that both clients and participants' engagement was limited by taking up 'either/or' positions. These were characterised by the creator of the rules of engagement, whether that be the therapist or 'perpetrator', having power to impose an agenda that diminishes the other. It seemed that this may leave 'perpetrators' with feelings of frustration, shame and low self-esteem, similar to those experienced by 'victims'.

For some participants, the 'perpetrator's' version of events was regarded as irrelevant or '*nonsense*' and so they would be discouraged from speaking about this (Extracts 35 and 37). The justification for this approach was that the '*usual procedure*' for 'perpetrators' was '*to blame someone else*' and to try to deny the impact of, or control over, their own behaviour, so not taking responsibility for what they had done. This appeared to be a powerful and overt positioning of therapists and group facilitators of perpetrator programmes as taking moral responsibility for holding these clients to account and in so doing, taking control and imposing a ''correct'' version of events.

In placing moral, ethical and risk issues to the fore in both the naming process and decisions as to what was relevant to work on, however, other aspects of the presenting problem were minimised or obscured, such as the past experience of the client and the behaviour of their partner. Nevertheless, some participants emphasised a need to foster understanding of 'perpetrators'' current behaviours and beliefs, so focused on unpacking this with clients with a view to getting clients to accept responsibility but also to get to '*the limits*' of their violence (Extracts 42 and 43).

5.6   Overview of Participants' Relational Positioning

Humanistic assumptions, prioritising the meaning of experiences and endorsing notions of self-development and agency were common in talk about working with 'victims'. Creating a context in which clients would feel safe to talk was regarded as key to developing a relationship that could enable a recovery process to take place. The emphasis of the talk about this work was on validating clients' stories, challenging constructions of self-blame and acquiescence in relation to abuse, and on reparation of their self-esteem. Narratives about abuse, embedded in therapeutic practices and wider discourses about victimology that locate responsibility for abuse in a 'victim's' characteristics and behaviours were also present in the focus by some participants on identifying unhealthy relationship patterns and understanding the present in relation to the past (Extracts 4, 17, 19). Participants' focus on 'shifting their thinking' was a more subtle and less overt agenda than for the work with 'perpetrators', positioning therapists in a caring, protective role that was nevertheless active in its intention to foster change (Extracts 20, 21 and 22).

Participants' talk about working with 'perpetrators' positioned therapists explicitly as educators whose role was to challenge and change the patriarchal beliefs and attitudes that justified men's use of violence to control women. Though the therapeutic intention of forming a relationship of mutual respect was emphasised, the work was structured to get perpetrators to take responsibility for the abuse, so there were contradictions in some accounts (Extracts 35, 39 and 43). It was noticeable that participants working with

'perpetrators' might distance themselves from appearing to blame by employing explanations such as clients being unaware of right and wrong because *'nobody's told them'* (Extract 37).

Though there were intended differences in the positions therapists might take up, depending on which client group they were working with, there were some similarities. Across the data participants commonly spoke about their role, sometimes explicitly, in enabling clients to recognise what was right or wrong behaviour, or what counted as abuse. This implicitly positioned participants as experts in DVA and clients as needing instruction, with different implications for 'victims' and 'perpetrators' as discussed in the summary below.

5.7   Summary of Theme 2

The theme in general sets out approaches to working with DVA from a gendered perspective of DVA, which necessitates a different focus and set of therapeutic tasks, depending on whether the work is with 'survivors/victims' or 'perpetrators'. There were some similarities evident in the way therapists spoke about their concern for clients and wanting to help them to develop better relationships. There were also inconsistencies apparent in both approaches, occurring outside the awareness of many participants.

In contrast to work with 'perpetrators', therapists said they would be sensitive to 'survivors'/'victims'' wish to not speak about their abusive experiences, so the focus of the work may not be on the abuse. Nevertheless, it was apparent that therapists might implicitly take up a role as educators of 'survivors/victims'- a role, by contrast, taken up explicitly with 'perpetrators'. Victimised clients were thereby positioned as lacking awareness of what abuse constituted, and as lacking agency, so relatively powerless and vulnerable to exploitation by 'perpetrators'.

The expressed intention to validate clients' stories and enable choice may, therefore, come into conflict with the more expert position therapists might take up as knowing, for example, what is a good relationship and using this as a standard against which a client's experience was measured. The moral imperative and ethics of responsibility that explicitly underpinned approaches to working with 'perpetrators' was also evident, but more implicit, in relation to understandings about the unhealthy choices victimised clients might make. However, recognition of the potential dissonance that these competing perspectives might arouse was not evident in these participants' talk.

Though it seemed that educating talk about what was a good relationship was a logical necessity arising from having identified clients' lack of awareness or experience of 'good' relationships, it was a somewhat surprising finding in relation to a therapeutic intention

expressed by some participants to not have an agenda. This implicit intention to influence and direct victimised clients was also evident in the sub-theme 'Shifting their thinking', where we saw how clients may be helped to move from self to other-blame, locating responsibility in the 'perpetrator'.

With regard to the work with 'perpetrators' we saw how therapists' recognition of 'perpetrators'' needs to be listened to can come into conflict with the positioning of 'perpetrators' as people who use all means to gain control over others, including lies, so credence should not be given to their explanations. However, similarly to those who worked with 'victims', many participants did not speak about experiencing ambivalence or dissonance, and justified taking a judgmental stance. In the drawing on constructions of individual pathology as a reason for participant's non-compliance or lack of motivation, clients may unintentionally be further positioned as 'bad' people, who may choose to behave abusively and not accept help. A more surprising finding was that when therapists position themselves as knowing and making judgments about their clients' culpability and need to take responsibility, the resulting practices may mirror the conceptualisation of DVA as one partner controlling another. We see how from this perspective 'perpetrators'' references to a partner's behaviour, and claims that they were not in control and did not intend to harm their partner, were likely to be framed as excuses and denial.

CHAPTER 6: THEME 3: HOW DO THERAPISTS GET STUCK? DILEMMAS AND MISSING NARRATIVES IN WORKING WITH DVA

Dede: Nobody's got the answers around gender abuse, nobody, we're still trying to work out what form it might be, how best to work with people that are subjected or are perpetrators of this intimate abuse (30)

6.1 Introduction

Theme 3 illustrates the main difficulties therapists may experience when the problem of violence and abuse in intimate relationships is conceptualised only as a gender issue. As Themes 1 and 2 illustrated, from this perspective, clients' problems tend to be named and decoded in accordance with a particular set of assumptions and 'either/or' ways of understanding responsibility and choice, such that 'perpetrators' are seen as blaming, to blame and having agency, whilst 'survivors/victims' are self-blaming, not to blame and have no agency. Particular ways of working are also legitimated, meaning that services are set up in the main to provide individual support and therapy for female 'survivors'/'victims' and re-education programmes for 'perpetrators'. This approach arguably inculcates clients into therapeutic narratives that position them as either 'survivors'/'victims' or 'perpetrators', opening up particular ways of talking about intimate partner abuse, and determining what can and cannot be said in the therapeutic process. As we will see in this theme, whether working with those in receipt of, or perpetrating DVA, some therapists may experience tensions and dilemmas, whilst others may avoid experiencing dissonance when justifying their existing view, when inconsistencies in clients' stories or their own understandings challenge the naming and decoding processes and relational positionings, illustrated in Themes 1 and 2.

Figure 6.1 maps out, in Sub-themes 1-4, the main challenges that can arise in therapeutic practice when questions of responsibility, choice and risk are being weighed and DVA is understood as a gender issue. Sub-themes 5 and 6 set out potential resolutions to the dilemmas posed and their outcomes. The intention is not to impose a structure on what the participants are saying, but to reflect and illustrate the complexity of issues in a way that is both coherent and representative of the challenges that were often implicit in participants' talk about their struggles to understand and help their clients. The analysis also seeks to explicate the potential impact of negotiating these intellectually demanding challenges and, at the same time, of managing often intensely emotional and disturbing material. As we will see, when clients are both disturbed and disturbing and often 'stuck' in abusive relationships, therapists can also reach an impasse, caught up in the relational dynamics of the presenting problem, in which 'either/or' solutions tend to prevail and one person may be 'scapegoated'.
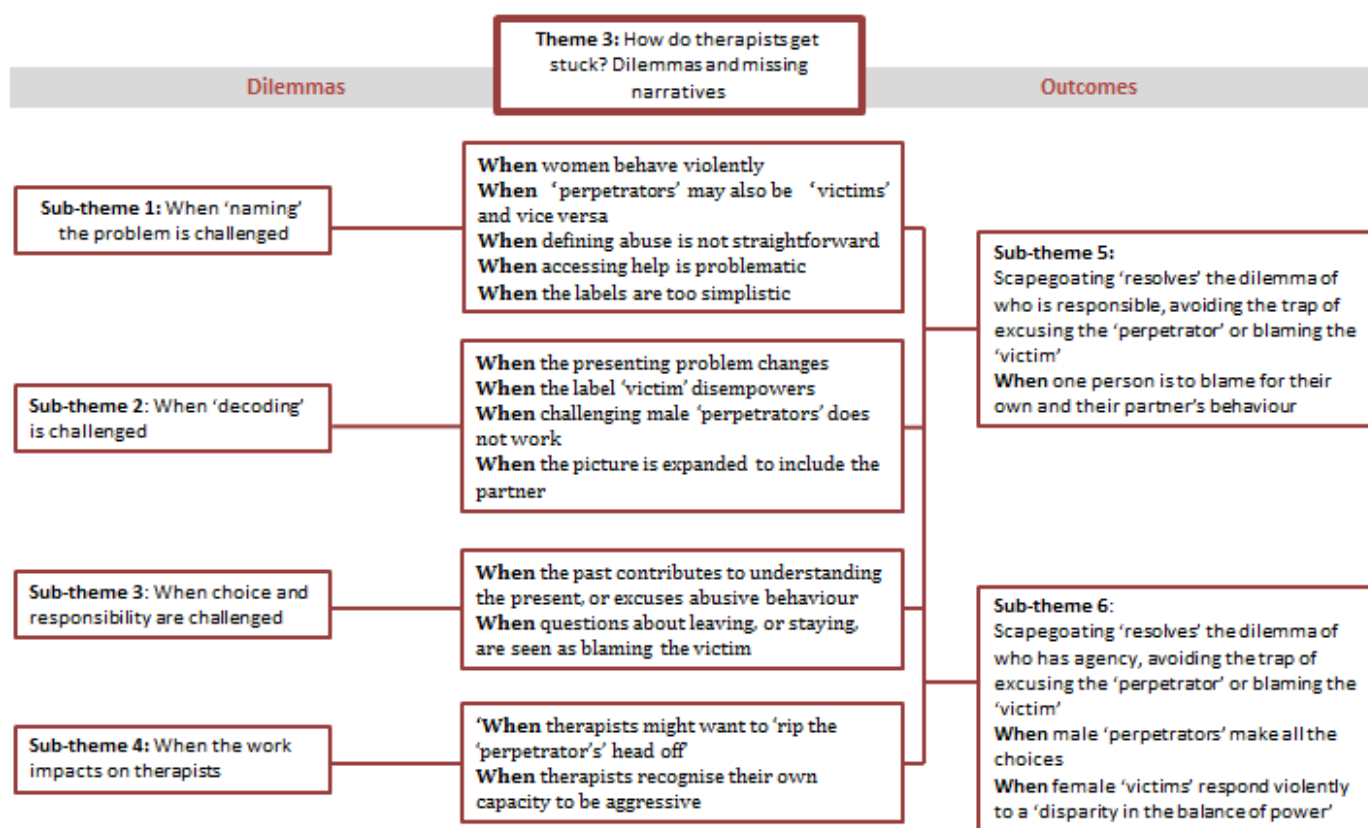
Figure 6.1: How do Therapists Get Stuck? Dilemmas and Missing Narratives When Working with DVA

6.2   Sub-theme 1: When Naming the Problem is Challenged

> **When** women behave violently
> **When** 'perpetrators' may also be 'victims' and vice versa
> **When** defining abuse is not straightforward
> **When** accessing help is problematic
> **When** the labels are simplistic

6.2.1   Introduction

This sub-theme explicates the principal ways in which the initial naming of the problem, mapped out in Theme 1, may be challenged by new information, or new understanding, suggesting the issues are more complex than was first thought. When defining what is an

abusive act and deciding who is responsible are not necessarily straightforward, this can begin to call into question accepted practices that categorise and offer services for either 'perpetrators' or 'victims'.

6.2.2   When women behave violently

> *Sam: women's violence is mad (108)*
>
> *Sue: only giving you it back (107-109)*

Evidence of DVA by females to males may be perceived as a challenge to both the dominant ideology about violence and abuse in intimate relationships, and cultural norms about female behaviour and hegemonic masculinity, or it may be reframed or disregarded. Disagreements over the sufficiency or accuracy of the evidence can shift the terms of the debate away from a focus on understanding how it is that women may behave abusively, and how best to work therapeutically with this phenomenon. In the following two extracts, there are accounts given of women's violence towards men. In the first example a man reported being in receipt of verbally abusive behaviour, initiated by his female partner, which escalated to physical violence:

Extract 1

> *35. JL: ... whether or not there is mutual violence in relationships. In your experience what do you think about that? (...)*
>
> *40. Dee: she started being quite verbally abusive and it gradually built built up. He would come in with scratch marks all down his face and he'd had um a teapot, hot tea poured over him and um hit with a cat litter tray I think*

In the second extract, a devastating escalation of violence from an argument, to 'stabbing', to genital mutilation is described:

Extract 2

> *68. JL: What what do you think needs to happen to to get more support available for men? (...)*
>
> *72. Ken: ...one of my first referrals actually, whose female partner and him had had argued on New Year's Eve and she stabbed him in his arm a couple of times and he called the police and the police told him, they told him to sort of pack it up and stop drinking. The police took the knife away and they just left it at that um within a week, he'd gone to bed, she'd run out, she'd bought a can of petrol, she came back, she poured the petrol over him whilst he slept and she ignited the petrol and he's got 70% (unclear) burns including the loss of his penis um and she was arrested and she was charged with GBH and released on unconditional bail*

Here we see how gendered assumptions as to who is responsible for DVA may be understood as influencing constructions of culpability, and, by implication, that the gender

of the person making the assessment may be relevant, as well as that of the participant. In this example, the speaker implies that the woman's violent behaviour is not taken seriously and the man is assumed to be the more dangerous, given his physiological advantage. However the 'facts' may be presented, or debated, the outcome described here is shocking and would seem to be indefensible.

A further example of how cultural norms about masculinity and femininity may inform the way male and female violence is portrayed can be seen in the following extract, where the tendency to apply labels of 'mad' to women and ' bad' to men who behave abusively is spoken about:

Extract 3

106. JL: I was asking you about women's violence (...)

108. Sam: ...so I I just although I know there must be some women out there who are mad and that's also the big difference I mean you know that don't you? About men's violence is bad, women's violence is mad, I mean that's the typical existing gender distinction isn't it? Cos we can't tolerate the idea of a violent woman, it's a moral failure, it's development, it's a failure of her femininity, so it's got to be a sickness.

This illustrates a view that violence by a woman is an anomaly, occurring outside the norms of gender behaviour and explained by individual pathology and, therefore, not seen as representing a challenge to explanations of DVA based on patriarchy. However, another view of violent behaviour by women, common across the data, was that it was an understandable response to male-perpetrated violence. In this context, educating clients about what was a 'healthy' response from their partners was also spoken about by a few participants as part of the work with 'perpetrators', when helping them to make changes in their thinking and behaviour. This included the normalising of violence and abuse from female partners who are portrayed in the following two extracts, from the same participant, as becoming understandably 'madder', and more vengeful as they become less afraid:

Extract 4

181. JL: There's one question that is the way abusive relationships can tend to last and how we understand that (...)

210. Sue: it's part and parcel of this process, and sooner or later 6 months down the road he'll say she's behaving like I used to. It's not right, that's disgraceful (laughs) Tough. It's temporary

Extract 5

104. JL: Speaking about when it doesn't work so well, what kind of difficulties do you come across?(...)

107-109. Sue: They're bewildered and confused because their partner, they expect their partner to say, congratulations and well done, I I think you're doing well. That's not what happens. As her level of fear starts dropping, cos he's

implementing ways of trying to manage situations differently, as her level of fear starts dropping, her level of rage starts rising for everything he's ever said or done to her since since these incidents started occurring. So she's getting madder and madder and she lets it go, lets it all out and it's usually all in Anglo-Saxon and it's poisonous and it's vitriolic and we say, What you're seeing is the visible evidence of the amount of emotional and psychological damage to her. You put er she's only giving you it back and it's healthy, what's happening is healthy even though it feels unfair. She needs to do this in order for you both to start with a level playing field.

Female verbal abuse is justified in this context as necessary in order to even things up and therefore should be tolerated, however 'unfair' it would appear. This is said without acknowledgment of the inconsistency in judging some violence as '*healthy*'.

6.2.3   When 'perpetrators' may also be 'victims' and vice versa

Dede: Men are always perpetrators, women are always victims, it's just not as clear-cut as that at all (28)

Ian: ... they do take it in turns often to be the persecutor and the rescuer for instance, certainly victim (61)

Ken: It is about victims it shouldn't be about the gender (243).

Gendered understandings of DVA, as we saw in Theme 1, tend to assume that men are the 'perpetrators' and women are the 'survivors/victims'. However, as we see in this section, when some participants became unsure whether a client was a 'perpetrator' or a 'victim' this could cause confusion about the focus of the work and raise questions about prescriptive approaches. As illustrated in the extract below, Home Office statistics report that whilst violence against women is higher, there is a significant incidence of violence against men in intimate relationships, whether from male or female partners. The accuracy of statistics about DVA was not questioned by other participants, so the example here gives voice to a marginalised view that under-reporting by men and over-reporting by women distort the figures. In repeating the word 'believe' credence is given to the statistics despite potential inaccuracy due to perceived reporting bias:

Extract 6

6. JL: I'm kind of wondering how that squares with the statistics you read on the websites from the HO etc (...)

8. Ken: They suggest the HO suggest 40% of all incidents are against men and I believe that statistic and I also because I believe that men under-report I think it's probably higher than that and I also I believe women over-report

Different statistics were used by other participants, as we saw in Theme 1, reflecting a fundamental disagreement as to the incidence of female initiated DVA, and if women were behaving abusively whether this could be conceptualised as 'perpetration'. In this extract

one participant explains this kind of disagreement in terms of feminist thinking getting '*sort of fixed in those places*':

Extract 7
> *20. JL: Ok. If you had to um pick out the main aspects to this new model what would you say they they are? (...)*
>
> *41. Jay: and I think they were they were the first people they pioneered a lot of this work and you can get sort of fixed in those places and I think I take a little bit of credit at chipping away at that kind of saying yeah hang on but have you thought about this and have you thought about this.*

Getting stuck in thinking that 'perpetrators' were only men could lead to dilemmas in practice when trying to understand and explain the incidence of DVA in same-sex relationships for example. When it came to explaining the incidence of female violence/abuse, most participants conceptualised the problem in the same way as they did male to female DVA, as one of a person exercising power and control over another. Understandings as to why a woman might behave abusively or, why a man might be victimised commonly tended to draw on explanations based on patriarchy, as these extracts illustrate:

Extract 8
> *126. JL: ... more in the past than now, but tends to try and explain or explains DV in terms of gender issues um what do you think about that?*
>
> *131. Ken: ...I don't believe it's a gender issue. I believe the issues of power and control are the issues. So in any relationship, whether it's a same sex relationship, male or females, father, mother, whatever, that it's if one person has all of the power and control then that relationship is an abuse of that power and control*

The reasons why men would seek power and control over other men or, similarly, why women might want to control their partners, whether male or female, are not made clear. Nevertheless, there is an explicit recognition here of abuse occurring in same-sex relationships, which itself brings into question explanations of DVA as a gender issue. The difficulty of generalising and applying terms that come from a critique of patriarchy is apparent in the next extract:

Extract 9
> *18. JL: Can I ask you a a general question about DVA um what what would you say your understanding of it is? (...)*
>
> *20. Eva: I think my understanding of it now is when someone er I'm trying not to use er general terms I'm trying to be very specific um I think when someone takes power over another person er in a in a violent way um so (pause) when someone's power is taken away from them in order to make the other person feel powerful now in my experience that that could be reciprocal er*

In these two extracts, the insufficiency of explanations based on gender only is apparent. In Extract 9, the participant expresses a less common view across the data, that DVA may be bi-directional, or reciprocal. In the following extract, another participant tries to make sense of having heard that some men are in receipt of DVA, by implying that power and control may be achieved by psychological means not physical strength:

Extract 10

> *25. JL: There's quite a big debate in the literature about the um extent to which men may be victims*
>
> *26-28. Helen: ... the men that I saw it was very specifically sexual abuse when they've been younger and probably DV in the household as well um but yeah I seem to hear bits and pieces more of it where where men are experiencing it and the picture I get is that they find it much more difficult to disclose because obviously they're seen as being the stronger um and it's not about strength it is about power and control um and yeah I guess it must be really difficult for them to and there aren't the organisations there for the support in the same way as there are for women*

This illustrates a view, expressed by a few participants, that violence perpetrated on men may be not disclosed by them and hence not known about, or hidden, in effect. It illustrates one of several comments from this participant which are indicative of some dissonance being elicited by information that contradicts gendered understandings of DV. The participant also alludes to sexual abuse happening to males in the context of there also being DV in the household, an issue taken up in Extract 13.

Whilst participants commonly drew on ideas of power and control to explain male to male and female to male violence, a few participants questioned whether existing gendered models of DVA could apply to men and women who behave abusively. One participant said that in his experience and practice with both male and female 'perpetrator' groups, gendered notions of power and control do not apply to female to male violence:

Extract 11

> *10. JL: I'm just wondering what you think about that from your experience? (...)*
>
> *15-16. Tim: whereas I I don't know where women are in terms of gender (unclear) I know there has been a huge change for women as well in the last 30 40 50 years but I don't have a felt sense of where women are at with that um I know where I am I know my confusion as a man so I can again empathise with the male clients and so when I first started doing this work with women I tried to use a lot of the exercises we used with the men it didn't it just didn't translate it just didn't sort of like you know it just didn't work because that sense of power and privilege and entitlement just did not apply um*

It is interesting that whilst the participant questions whether existing gendered explanations of DVA can apply to female violence/abuse, he acknowledges the different position he takes up as a man. For many participants it seemed that they chose to work with clients of the

same sex, though the reasons for this were commonly not articulated. Here, however, a male therapist struggles to make sense of female violence and abuse, acknowledging that for him it is easier to empathise with males, perhaps due to shared hegemonic concepts, such as *'power and privilege and entitlement'*.

In the following extract another participant questions whether gender issues in DVA are as clear-cut as they had perhaps been presented in models like Deluth:

Extract 12

> *25. JL. And I understand the project here was designed to be holistic and look at families*
>
> *26-28. Dede: ...we looked at the whole model and introduced different things in an informed way but also in the way that gender violence has actually changed in this country it's not this prescriptive manner in which the Deluth model originally set up you know men are always perpetrators, women are always victims. It's just not as clear-cut as that at all and I'm not sure that it ever was but it certainly isn't now...*

This is interesting with regard to the question of change, suggesting that whilst ways of constructing notions of gender, arguably, may have become less prescriptive in practice, it is unclear whether what is being described has actually changed at all. So, whilst explaining violence by females was difficult for most participants, it was even more challenging when female clients who behaved abusively had a history of victimisation. This could cause confusion about the focus of the work and raise questions about prescriptive approaches, creating uncertainty as to how best to intervene.

In the next extract, one participant, who worked with women who had behaved abusively, speaks about how seeing them as 'victims' too could lead to getting *'really confused about what we're doing'* with clients. The extract illustrates a view that *'nearly all the women'* in 'perpetrator' groups and *'most of the men'* have experienced some kind of abuse:

Extract 13

> *3. JL: How do you feel about that? (...)*
>
> *5.-7. Tim: a lot of the clients we've got the women clients we get are also um their anger, their violence is in retaliation to having suffered a great deal of abuse. Nearly all the women in that room have probably suffered abuse, I should imagine or are suffering so it tends to be a mixture of kind of anger management/perpetrator/support group um so sometimes we get really confused with what we're doing I mean we end up that they often go to survivor's support groups as well for women who are survivors of abuse um and that's also sometimes the case for the men, most of the men have survived or experienced some kind of abuse but it's not as overt, not spoken about as much men don't tend to speak about it that's how they present...*

The view that women who perpetrate violence do so having themselves been abused was commonly expressed. Less commonly spoken about – as this participant also says - was the idea that men who perpetrate violence might similarly have been survivors of abuse. What is interesting is the way in which it is assumed, as reported here, that a female 'perpetrator' of DVA was also a 'survivor', whilst, the idea that a male 'perpetrator was also a 'victim' tends to be strongly contested, as we saw in Theme 1 (Extract 43 and 15. Sue). Reluctance to use the term, 'perpetrator' for women, also illustrated in Theme 1, may be seen to reflect the same distinctions being made here.

Most participants who worked in organisations set up for either male 'perpetrators' or female survivors/victims' either did not work with people of a different sex, or had limited experience of this. In the following extract, one of the participants whose views reflected a feminist position in her talk about DVA, illustrates this point when she mentions her experience of working with a couple of male victims:

Extract 14

> *152. JL: Do you ever work with perpetrators yourself?*
>
> *153. Sara: No I've worked a couple of times with male survivors um was interesting they said very similar things yeah they said very similar things to what women will say yeah yeah very similar to what women will say.*

It is noticeable that '*very similar*' is repeated three times, with regard to there being an apparent similarity in what male and female 'victims' said to her, suggesting some surprise, though a surprising lack of dissonance given that this experience did not fit with her strongly voiced gendered view of DVA. It also suggests that when therapists work only with 'perpetrators' or 'survivors/victims' they do not have the opportunity to challenge stereotypical ideas about the other and getting 'fixed' in one way of seeing the problem of DVA may be more likely.

6.2.4   When defining abuse is not straightforward

> *Jenny: what may feel abusive to one woman may not feel abusive to another'*
> *(42-43)*

For some participants, there were grey areas to negotiate with regard to matters of moral responsibility and deciding what was right and wrong. When decisions about moral responsibility can depend on a number of factors, the principle that violence is always wrong begins to seem less straightforward to implement in practice. In the following extract a participant uses the example of her own relationship in which her husband '*calls me lots of names*', which she does not consider to be DVA, as justification that '*if two people argue that isn't necessarily an abusive situation*':

Extract 15

> *31. JL: Ok so if someone were talking to you about DVA experience what would count as DV more specifically? (...)*
>
> *34. Sara: For me um what would count would it it depends it's it's it's it's about a pattern of abuse and it's about the power and control so you know I could have an argument with my husband and he calls me lots of different names but that wouldn't be classed as domestic violence it needs to be um a pattern and it's about wanting to have power and control over me and that would then be an abusive situation. If two people argue that isn't necessarily an abusive situation it's about um a pattern of behaviour over a period of time generally*

As we saw in Theme 2, this positions the therapist as expert in making moral judgments and deciding when an action is intended to control another, namely deciding what counts as DVA, on the basis here of her own experience. This explanation serves to differentiate and distance her from clients who behave abusively, thereby reducing any potential dissonance generated by identifying her own behaviour as similar to that of 'perpetrators' or 'victims'. This also applied to the focus of work with victimised clients on understanding what would be a healthy relationship, illustrated in Theme 2. The idea that 'healthy' is a concept that is subjective and open to negotiation between people is illustrated here:

Extract 16

> *87. Helen: ...hearing something that isn't a healthy relationship I'd be wanting to question well why is that really?*
>
> *88. JL: And the idea of healthy relationships is that something that might be talked about? (...)*
>
> *91. Helen: so it is a kind of what is normal and actually maybe there's no answer to that but I guess my answer to it is if there's 2 adults and they both agree to do something and they both enjoy doing that then maybe that's ok but if one person doesn't then it's not ok*

As we see here, mutual consent may determine what a couple agree is '*ok*', whilst one person objecting to a behaviour means it is not. This represents a challenge to the notion that boundaries of right and wrong behaviour are clearly defined and easily recognised. However, it may also be illustrative of an attempt to move away from taking an overtly judgmental stance with a defensive manoeuvre that, in effect, though perhaps unintentionally, offers unconditional support for a 'victim's' judgment. For example, if both partners think it is 'ok' to slap each other does this mean it is not abusive? Furthermore, what counts as abuse may be even more unclear when it comes to questions of psychological abuse as referred to in Extract 17, or, when what counts as physical or psychological abuse could be conceptualised in terms of each person's perception of their capacity to '*stand their ground or fight back*' as illustrated in Extract 18, by the same participant:

Extract 17

> *25. JL: ... In terms of um understanding what DV is what would you say in your understanding what is it, DVA? (...)*
>
> *26-28. Jenny: I mean I think it's it's a really broad range and you know I think all of us can identify with it obviously the violence is the the most obvious form of DV but I think you know starting with the kind of psychological controlling of somebody, undermining them, isolating them from their friends, withholding of support, withholding of money all those you know the line between whether a relationship is relatively controlling to whether it is abusive is is quite difficult to check and I think it's more about how the the person themselves*

Extract 18

> *38. JL: And how would you say you've reached that point? (...)*
>
> *42- 43. Jenny: but it was only really when I started seeing women that I got a feel for each woman's different experience and you know the behaviours that I saw what they're up against you know what may feel abusive for one woman may not feel abusive to another in terms of how able they feel to stand their ground or fight back so it's very it's a difficult thing to take away from the individual's to take outside from the individual's experience*

From this perspective the same behaviours could be seen as perhaps unremarkable by some and abusive by others, and it would be difficult for a therapist to apply so-called objective judgments about what was an abusive act without imposing their own agenda. This approach reflects the humanistic stance of this particular participant, which would explicitly prioritise the judgment of an individual client, rather than a therapist's, though as we saw in Theme 2, in practice she might still want to promote her own agenda of the client developing healthier relationships but seemed unaware of this contradiction.

The extracts so far illustrate participants' attempts to make judgments based on their own or clients' understandings of what counts as abuse. In the following extract we see how attempts to use objective measures of violence and abuse at assessment can also be difficult to implement in practice:

Extract 19

> *12. JL: How do you assess whether 'the violence is too much'? (...)*
>
> *17-19. Ruth: I didn't feel that there was any time for any sort of pleasantries isn't the right word really, but there was no time to be human about it, whereas it was more human in the police station (laughs) I felt. I I still feel that this is too clinical you know we're asking people things that they may never have done and we're saying that you know we have to ask you questions that may not apply to you at all, however I need to ask them. But there isn't time for them to come back with anything because you've got to do it in a set piece of time and there are a lot of questions. Some of them are repeated I feel and you think well, I don't know what this is about really and then you have to say after that, I may not be able to counsel you*

As was noted in Theme 1, the safety of all parties is taken into account when making decisions to offer therapy. However, here we see an example of a prescriptive approach to assessment, which could categorise someone as too violent to work with, which the therapist did not, from her experience, agree with. Other participants also spoke of using a set procedure that screens, assesses risk and uses a list of specified behaviours, defined as abusive e.g. pushing, shoving and hitting, to determine who the 'perpetrator' is. Whilst this may be presented as an objective measure, Extract 19 provides an illustration of the potential outcome when the relational context is missing in the assessment. When behaviour is assessed out of context and clients are positioned as beyond help, the potential for alienation of both therapist and client is apparent, leaving the therapist feeling de-skilled and confused, and the client, dismissed and likely, angry, as this example suggests.

The idea that there could be '*degrees of abusiveness*' is controversial in that it represents a challenge to commonly expressed views about all violence and abuse being unacceptable and was spoken about explicitly by only one participant. In this extract, we see the idea referred to as something '*we're not allowed to say*' as it might seem to condone abuse or render some acts of violence more acceptable than others:

Extract 20

> *124. JL: But doesn't it also depend on how you define being abusive?*
>
> *125-128. Sam: Oh of course it does, so violence is the first one, but then you have to go into controlling behaviours, you have to go into emotional, psychological, sexual, financial, all of the other forms of abuse and control, of course you do (...) you can't there aren't it's not it's not pc to say it but you know there are degrees of abusiveness you know a man who slaps his wife in a jealous fit is not as bad as a man who batters, he's not, it's just a fact you know it doesn't make what he does any more acceptable but it does enable you to differentiate between people who need the resources and those who don't, but we're not allowed to say stuff like that publicly*

This participant speaks the unspeakable: therapists are not '*allowed*' to openly acknowledge that, whilst abusive behaviour is unacceptable, some acts of abuse are worse than others. The rationale for a need to maintain that all DVA is equally wrong is that voicing an awareness of '*degrees of abusiveness*' could imply that some acts of abuse are considered excusable, or even acceptable, and so, the harm done to 'victims' would be minimised. It might also imply therapist discomfort in unpacking 'degrees' of abuse, once the problem has been named.

When the category of 'perpetrator' and of 'victim' may incorporate a wide range of behaviours this may help elucidate why some clients might object to being given the label, and might be reluctant to present for therapy, as we saw also in Theme 1. This may mean

that resources could be misappropriated, or not taken up by those in need, as we see in the next section.

6.2.5 When accessing help is problematic

> *Ken: ...they refuse to accept that men can be victims, so therefore they refuse to support them (129)*

When services are set up for female 'survivors' and male 'perpetrators', this could determine the approach to assessment and mean that accessing the right services, at the right time, may be difficult for some clients, for example, women who behave abusively, or men who have been victimised. This echoes the idea that these constitute missing narratives, highlighted in the following extract where difficulties around accessing and offering appropriate therapeutic interventions at the right time is referred to as, '*a huge issue for our sector*', which, '*we don't talk about overtly*'.

Extract 21

> *94. JL: And I'm wondering from your point of view how you'd see the benefit of having both in the same building (...)*
>
> *99-101. Jay: some of the women come back later and say now I'm ready for it because I think timing is a huge issue in DV services um you know if you hit if you if you go to somebody at the wrong stage and offer them the wrong service they're not going to be in a position to use that and I think it's a huge issue for our sector for example when I worked in the women's centre um you know a woman would come in for advice and she might be so traumatised that I didn't think that she could actually hear me um or you could be offering her counselling when she was actually needing housing so I think you know I think it's really something we don't talk about overtly but something very important in our field that we need to think very carefully about at what stage is somebody ready to receive that help and it would be much more cost effective if we got that right cos you could be throwing money away by throwing services at women they aren't ready to receive or it's not the right time*

This extract voices concerns that the initial assessment may not recognise and respond to individual needs, meaning that individuals do not get the help they need. As we saw in Themes 1 and 2, the way that organisations are set up and their underpinning philosophy can determine who is offered help and what kind of help this will be. One participant who works with male 'victims' voices a view not commonly spoken about that this can be discriminatory against men:

Extract 22

> *54. JL: And differences between men and women do you think in the way ..?(..)*
>
> *57. Ken: ... all services set up are set up fundamentally to support women and they're set up by women and they're set up generally by feminist women and this they're all set up with the philosophy that women will automatically be believed and that includes the police and housing and they they all have this philosophy*

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that they will automatically believe a woman if she says that she is a victim of
DV and believe her

Reference is made twice to women who present as having been victimised as being '*automatically*' believed, with the implication that men who present as having been victimised will not be believed. The implications of this are spoken about in the next extract from the same participant. This illustrates the view, expressed by a few participants, that initial screening might be inadequate, particularly when screening tools used to assess suitability for therapy were based on expectations that males were more likely to be 'perpetrators'. This could result in some female clients not being screened and some men not being believed and being mistreated by services as well as their partners:

Extract 23

54. JL: And differences between men and women do you think in the way ..?(...)

61-67. Ken: I see it in terms of the all all organisations, the police, my organisation, the IDVA organisation, we carry out perpetrator screening assessment on people um and that's done on every man but it's not done routinely on women, so women are automatically believed, they're not screened to check to see if they're actually a perpetrator, masquerading as a victim, they're automatically believed whereas the men are screened routinely (...) there are some women who are perpetrators who are receiving the support and the advice and the shelter, whatever, from services set up to help victims and then they're using that position of being a victim to um to gain more power and control over the partner by by getting them arrested, getting them released on bail, putting out restraining orders on them, all those sorts of things.

The suggestion here is that some women may behave in a manipulative manner that is colluded with by services when assumptions are made that women can only be 'victims'. This is expanded on the in the following extract where one participant speaks about the difficulty one of her client's experienced in convincing an agency that he was not the 'perpetrator':

Extract 24

35. JL: ... whether or not there is mutual violence in relationships. In your experience what do you think about that?

42-43. Dee: ... he struggled to be believed by any other agency in terms of you know this woman's being violent to me and he didn't reciprocate at all and he was gradually getting more and more low and depressed and she eventually left she'd been having an affair for quite some time and went with her new partner and this new partner actually attacked my client physically attacked um assaulted him ... it wasn't just about what she inflicted on him, it's the fact that all the other agencies he was coming I to contact with were putting into question his behaviour you know it was that that idea that well it must be something that he's doing, women don't behave in that way, but she certainly did

Here we see that when DVA is conceptualised only as a gender issue, violent behaviour by a woman may be mistaken as a defensive response, meaning that a victimised man may be

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labelled as a 'perpetrator', even when he has not reciprocated, and so, refused services, as in the example given. Clients may also be refused services when screening results in their being deemed too abusive to be offered therapy in some contexts, as we saw in Theme 1, (Extract 53).

A serious consequence of the practices that result when services are set up for male 'perpetrators' and female 'victims' may be that some people will be deterred from approaching these organisations and so the plight of those who do not fit these labels may be hidden. An example of this view of men's understanding and response to the current organisation of services is given in the extract below by a participant who works with both men and women who have experienced abusive relationships:

Extract 25

> *158. JL: and how do the issues between the men and women compare then, because you do both, which is quite unusual, I think (...)*
>
> *160. Ann: you know whereas the men aren't so keen on getting help but that's because services aren't predominantly for the men, so there hasn't really been a lot for men, especially in C to do with domestic abuse um and so I think they feel that there's not services out there for them um and then they'll find you know they might find it a bit difficult to contact that service*

Socially prescribed ideas about masculinity may be influential in determining how men understand their experience of being abused by men or women and could mean that men would keep abuse 'secret' because they might see this as unmanly. The following extract illustrates a view of therapists as potentially having a different understanding of DVA to '*Joe public*':

Extract 26

> *108. JL: And I suppose that's looking at it from the point of view of the woman being abused by the man. If it's the other way round or if it's mutual, is your explanation different? (...)*
>
> *113-114. Dee: and I think it is different for men if they've been abused because I think the whole idea of abuse if you ask Joe public out there it's that the man's the perpetrator, the the woman's the victim. I still think that continues even though I've read articles and you know and particularly when I was working with this guy looked into it more that there are lots and lots of male victims out there but a lot of them keep it secret because it's not seen as manly you know your partner's doing that your partner's doing that to you,*

From this perspective, we might expect that admitting a woman had been violent towards them could be shaming for men, making them reluctant to access help. Contrary to more commonly expressed views about men, this positions them as also potentially vulnerable, disempowered and marginalised, challenging stereotypical notions of men as powerful and controlling. However, when men do not seek help, or feel misunderstood and rejected when

they do, their difficulties are likely to remain hidden and the current arrangement of services is legitimised.

6.2.6   When the labels are simplistic

> *Lyn: it's much more complicated than those terms (31)*

> *Lyn: ... I think it's a label really and that's something we would avoid because I mean that might be a label that they use themselves but it wouldn't be one that we use because it's then it's it's just closing off so many other avenues (44)*

When labels are used to categorise behaviour this serves to simplify the experience and reduce the apparent complexity, if not the actual complexity. As we have seen in previous sections in this sub-theme, some participants feel confused when information seems to challenge an understanding of DVA as a gender issue, whilst others may be less aware of contradictions. Though most participants expressed dislike of labels, they were, nevertheless, often engaged in an organisational process that categorised clients at assessment as a person in receipt of DVA or a person who has perpetrated DVA. The extent to which an assessment or screening process could accurately determine who was responsible for DVA was questioned by a few participants, particularly when someone presents as a 'survivor/victim' but may also have perpetrated abuse. As we saw in Extracts 22 and 24, screening alone may result in mistaking a 'perpetrator' and 'victim'. As we can see in the following extract, the process of deciding whether someone is a 'victim' or a 'perpetrator' may likely involve subjective judgments based on 'instincts' as to whether a client is telling the truth:

Extract 27

> *79. JL: So what what's your role here?*

> *80-81. Ken: ...First of all I listen to what what their story is and as part of my questioning process is that I will screen them, so I do a perpetrator's screening and that's not a formal sort of tick-box thing, it's it's a sort of, it's all about how you how you take the history and the questions you ask and how they respond because there are certain characteristics that a victim how a victim um relates their story and certain characteristics of a perpetrator (unclear) and that combined with your own sort of instinct if you like gives you an idea whether you think this person is really a victim or whether they're as bad as each other, or whether they're they're the perpetrator.*

Here we see a therapist's experience valued as contributing to judgments made about whether a client's story is truthful and the label accurate. However, other participants challenged the use of labels, and as we saw in Theme 1, many participants expressed dislike of labels even though they used them. It seemed that the use of labels might be more acceptable in some circumstances than others: the use of the label 'victim' for men, or 'perpetrator' for women could be contested in some settings and by some participants, as

illustrated in these two extracts, one about male 'victims' and one about female 'perpetrators':

Extract 28

> *68. JL: What what do you think needs to happen to to get more support available for men?*
>
> *69. Ken: Well education fundamentally, so I'm only thinking about C, because a lot of the institutions that we deal with, the sort of hospitals, police, local government, housing um they they have policies on DV, but they're all worded in from a feminine point of view and they're not familiar with the with the male victim and I think that some individuals in in institutions perhaps even doubt that men are victims or can be victims*

Extract 29

> *4. Dede: We have male survivors as well as female survivors as we have male perpetrators and female I don't like to call them perpetrators because the psychology is not quite the same in my view*
>
> *5. JL: You don't like to call them perpetrators?*
>
> *6. Dede: I don't like women perpetrators actually because it's a different nature and er so what I would say on that is that females find themselves being angry and aggressive in their relationships and it's not in the same category as far as my thinking is concerned*

Extract 28 represents a challenge to essentialist views about the 'nature' of men, in its explicit use of the term, 'victim', for men. On the other hand, Extract 29 draws on these ideas to justify not applying the label, 'perpetrator', to women. A forced positioning of women is described here in them '*finding themselves being angry*', suggesting that, unlike men who are 'perpetrators', this behaviour is not intentional, but reactive.

As we saw in Theme 1, many participants expressed concerns about the terms used to refer to those who have been victimised, struggling to get it 'right' or find the 'real' word that captures the client's experience accurately. A few participants spoke about the connotations attached to the terms and the potential for misrepresenting a client's experience when using a particular label. When labels mean different things to different people their use can be unhelpful or create misleading generalisations about everyone being in danger of their life, as the following extracts illustrate:

Extract 30

> *50. JL: ... what's your take on the use of words?*
>
> *51. Helen: I find that in doing the counselling it it's become really important to me to pick the right words um I notice very often when I'm with a client that I'll stop and I'll be thinking for what's what is the real word (laughs) that I want here um I guess because I've worked in the organisations that I have um and they don't like the word victim and and it yes somehow it doesn't I guess I see while the person is in that situation they perhaps are a victim of of the abuse but*

actually they're even at that point they're also surviving it so for me survivor is um (3 seconds) yeah a much more preferable word

Here we see some distaste voiced when organisations make generalisations about clients. Though the preference by most participants for the use of the term 'survivor' was expressed in Theme 1, here the point is expanded on. In her emphasis on the importance of using language accurately to convey empathy and understanding we see how the nuances of the terms can influence the relational positioning of therapist and client: the term 'survivor' carries notions of resilience and strength, and a capacity for agency, that are missing in the term, 'victim'.

Extract 31

37. JL: ... I was wondering if you could say a bit more about what your take is on the terms like victim survivor perpetrator...

38-41. Sara: Yeah um the term I certainly don't like victim but sometimes I understand in a sense when someone perhaps in the sector talks about someone being a victim or surviving they're very 2 different things Sometimes the victim is the person that you get right at the beginning but you could also argue that's a survivor because they're still alive because we know over 2 women a week are killed because of DV um and often the survivor is when they've really moved to a very very different place um a perpetrator can sometimes be complex as well because sometimes the perpetrator is is a child so you can sometimes be um you know the survivor of DV and often they're the hidden they're the hidden survivors of um DV as well. So again it's difficult when you're using the terms without real explanation really because they they mean different things to different people and they can conjure up all sorts of different ideas I think

The potentially different meanings attached to the terms, 'survivor' and 'victim' are again teased out here, suggesting that different terms may be applicable at different stages of therapy. This participant positions herself as knowing and being expert about DVA, stating 'facts' about how many women die each week, which seems to lend weight to her opinions. The extract also illustrates another controversial issue, touched on in previous sections of this sub-theme, regarding the possibility that a 'perpetrator' could also be a victim of DVA, in this example, a child. Implicit in what is said, with regard to the logical consequence of terms being so imprecise, is that they can mislead and oversimplify. It is notable, however, that the possibility of men being potentially both 'victims' and 'perpetrators' is not spoken about.

The following extract illustrates a view, voiced by only this participant, that the use of the term, 'survivor' is also potentially misleading if applied too generally:

Extract 32

5. JL: Yeah I wanted to ask you about that um what your take is really on those those terms?

6. Sarah: It's very important for me um because the word survivor I think is very important if the women or the people who are call themselves survivors use this term but not everyone is in danger for their life um so I think it can be misrepresentative you know

Nevertheless, despite the expressed concerns or ambivalence about categorising people, most participants used the terms, 'survivor', 'victim' or 'perpetrator' during the interviews. Several participants referred to the use of terms as a form of shorthand, which could be a useful way of communicating with other professionals, as these extracts illustrate:

Extract 33

30. JL: and and you used the word perpetrator and I'm just wondering what your take is on the terminology perpetrator, victim, survivor?

31. Lyn: Um it's shorthand um I think it's much more complicated than those terms myself er because they can be any you know one person can encompass a whole gamut actually um and that that's as I say where the difficulty in the work and the complexity in the um can can come in,

Extract 34

3. JL: And how would you describe the referrals that you have? (...)

7. Beth: some of the perpetrators I will probably say men or perpetrators I would imagine it's fairly obvious that the majority of perpetrators are men but we do work with female perpetrators so I tend to describe myself as working on the men's side of the project but I mean that's not strictly true so forgive me for whichever one I say

Whilst the use of shorthand may aid communication by simplifying a complex picture, in so doing we see here that it also has the potential to both construct and reinforce accepted understandings, particularly if these are assumed to be '*fairly obvious*' e.g. that '*the majority of perpetrators are men*'.

When the picture is more complicated than the terms, an 'either/or' take on naming the problem may miss the nuances of what one person can encompass, making it more difficult to intervene in a helpful way that facilitates change. As we can see illustrated in this extract, there may be practice implications when a therapist speaks only to '*the side*' of the person who has behaved abusively, as if this were the sum of who they were:

Extract 35

162. JL: ... people have been talking about ... how they might grapple with the terms as well of using perpetrator and victim (...)

165-167. Jay: Well people are multi-faceted they're not just one thing, none of us are just one thing or another and that there's elements of us that can be strengthened or encouraged or allowed to run out of control, the bad bits you know if you don't handle them right that would be the side that's encouraged to flourish (...) Perpetrator is a legal term perpetrator is a legal term I don't think survivor is a legal term but you know it's a it's just it's just saying that people

are not just that there's more and recognising that that's the side of them that
you need to appeal to or you won't be able to change them

This voices the idea that labels, such as 'perpetrator', only capture an aspect of a person and that ignoring other aspects can have the paradoxical effect of increasing the abusive behaviours that are the target for change.

6.2.7 Summary of sub-theme 1

The overall message of this sub-theme is that initial naming of the problem of DVA as a gender issue opens up particular, deceptively simple ways of understanding men and women's experience and motivation in intimate relationships, that tend to categorise and deliver services for men as 'perpetrators' and women as 'survivors' or 'victims', which may not encompass the complexity of some clients' experiences and motivations. In practice, therapists may find that abuse is a slippery concept that is difficult to define as it can mean different things to different people in different contexts.

When therapists hear about women behaving abusively, or men being victimised, this challenges accepted notions of masculinity and femininity and both experiences can manifest as disturbing realities that can be difficult to tolerate. However, as we saw throughout this sub-theme, behaviours that challenge existing understandings or practices may become marginalised and hidden, excused or pathologised, rather than being acknowledged by, or eliciting dissonance in, some participants. For example, when female aggression is perceived as being only in response to male aggression, this potentially reduces dissonance, inviting prescriptive ways of working that also close down opportunities for understanding female motivation and agency in their intimate relationships. So, when females behave abusively the impact may be minimised, and their behaviour justified or excused, as being retaliatory or done in self-defence (Extracts 5, 13, 18 and 29). Similarly, when men claim that they have been victimised either in their past, or by a current partner, the impact may be minimised and they may not be believed (Extracts 2, 4, 5, 25 and 26).

6.3 Sub-theme 2: When Initial Decoding is Challenged

> **When** the presenting problem changes
> **When** the label 'victim' disempowers
> **When** challenging male 'perpetrators' does not work
> **When** the picture is expanded to include the partner

6.3.1 Introduction

In this sub-theme we see how an 'either/or' approach to naming the problem at the assessment stage can potentially generate simplified conceptualisations and ways of working, when these are based mainly on what was known about a problem initially and on the perspective of the person victimised. As we will see, some therapists may experience dilemmas in the on-going work with their clients when prescriptive approaches seem to be ineffective in facilitating lasting change in 'perpetrators'' behaviour, or, when the unintended consequences of supporting victimised clients is to further disempower them.

6.3.2 When the presenting problem changes

> *Jay: we just don't know what we're dealing with right away' (139)*

> *Ken: but I do believe that some of the people I've seen as victims have been co-perpetrators if you like with both as bad as each other or have been perpetrators in the past (288)*

Having named the problem as DVA and accessed the 'right' service, the issues could become more complex as the work progresses and initial understandings may be challenged. A few participants spoke about their experience of finding that the complexity of the presenting issues may not be immediately apparent and that the problem may change as therapy progresses. From this perspective, therapists would need to be flexible in their approach rather than holding onto a fixed view of the problem, a point illustrated here:

Extract 36

> *126. JL: Is there anything else about the service... (...)*

> *138-140. Jay: it's very important that people are skilful in their assessment that they are looking out for what is going on that they're alive to possibilities that are different and that they don't freak out if they see something that's not the standard thing that they can actually hold that and they can deal with that and they can say ok you know it's possible that this woman is say she's using substances she might be when she's drunk she might be abusive when she's sober she might not be, same for him I mean I think you know we just don't know what we're dealing with right away and I think one of the problems of things like risk assessment it's very it's a static thing that's the risk that day but it could be very different the next day it could be very different an hour later and so if you only base all your service on that's how they were that day and that's how we've assessed it and that's what it is that's not actually the reality you know and it can change and I think that's very important so there's flexibility that people have enough training to understand that things change that this isn't you can't read it out of a text book how to deal with this*

This echoes Theme 2, Extract 15, describing the therapy process as a state of flux, emphasising the instability of a client's '*reality*'. It goes on to position therapists as needing

to not be forced into a fixed and rigid response, but rather be able to be open to thinking about both partners in the relationship.

Several participants spoke about the initial naming process as the '*easier bit*' and it could be that as you '*get into the work*' other perhaps contradictory information may emerge. In these two extracts participants speak about how therapy becomes more complicated when it emerges that a 'victim' of DVA is also a 'perpetrator', or when a therapist has an understanding that female 'perpetrators' may also be 'victims':

Extract 37

> *19. JL: ... I was going to ask you about how you engage the client group because of the sensitivity of the issues (...)*
>
> *27. Lyn: it can be a very complex process and it it you know unpacking it and thinking about the violence um I think the the the the the easier bit if you like is you know I've been a victim of DV but then it becomes more complicated once you get into the work um and women who are perpetrators as well or who've been violent to their children I think that's that's still very difficult for women to talk about although obviously we do get (pause)*

Extract 38

> *49. JL: ... why don't other people do it (work with groups for women who are abusive)?*
>
> *50. Tim: Um I think because as I say probably the woman who'll present might get um it might become clear very quickly that they are actually also survivors or victims of domestic abuse*

In both examples, when the decoding of the problem is challenged by new information this creates a dilemma for the therapist with regard to the focus of the therapeutic work and the relational positioning that followed from the initial naming of the problem, as was illustrated in Themes 1 and 2.

6.3.3   When the label 'victim' disempowers

> *Eva: ... the thing that I really didn't like was this assumption that um women in violent relationships were always victims and only victims and I thought that was um it was quite helpful for some but it it was it was really disempowering for others (59)*

Many participants said that there may be unintended and unhelpful consequences for those being named and treated as 'victims', as we saw in Theme 1. However, a few participants spoke about the particular effect on a woman who is assumed to be a 'victim' when it becomes apparent that this is not wholly representative of her behaviour. In the first extract below, the same participant goes on to speak about her own experience of clients who have been victimised as accepting of the label, and then expecting things to be '*done to them*' by

the service, so that there was a risk of the service itself repeating the client's experience of victimisation.

Extract 39

> *60. JL: In what way was it disempowering?*
>
> *61. Eva: Well some people really I felt latched on to this label of being victims and things being done to them and it was very hard to get the sense of where they were in this relationship and um yeah what what where their their motivation lies and their will was so um I felt they were apart from being victimised by their partners they were also victimised by the agency which was giving them help. That was that was quite hard to go around it in a sense*

In the next extract another participant speaks about the use of the label 'victim' as being helpful in some ways but unhelpful when it closes down the possibility of talking about other aspects of the self:

Extract 40

> *30. JL: and and you used the word perpetrator and I'm just wondering what your take is on the terminology perpetrator, victim, survivor (...)*
>
> *32. Lyn: I think what we find is that a woman may come from Women's Aid say very often Women's Aid and um has been in a refuge, has been supported very much by them but with that sort of label if you like as victim um and it can be helpful in some ways but I think it can also be very it can then make it very difficult for a woman to talk about other aspects of herself um you know*

The initial relational positioning creates and limits potentialities for future actions between client and therapist (see 4.7.1), evident in the 'difficulty' spoken about here of, in effect, subverting these positions, by acknowledging that a 'victim' has been abusive, or a 'perpetrator' has been abused.

An example of contesting what might be regarded as accepted ideas about victimhood, and the relational positioning of a victimised client, is given below. Whilst most participants spoke about 'survivors/victims' as having low self-esteem, one participant challenged the assumption that being in receipt of DVA could cause low self-esteem. As we can see in this extract she speaks about self-esteem as another misused label, which can cause suffering to women and in her view women should be shown that they do not have low self-esteem:

Extract 41

> *45. Sarah: I think sometimes some of those lists I mean some of the programmes are very very undermining of people who are victimised, very patronising (...)*
>
> *48. JL: What what do you think is most um undermining about them? (...)*
>
> *50-51. Sarah: Telling them that once they have been victimised oh that of course people like them have low self-esteem. That is so-o that is appalling and women lots of women I've seen have suffered from that, they suffer from the label of low*

> *self-esteem and when I challenge that and I show them they don't have low self-esteem the relief is enormous*

From this perspective, re-positioning a victimised client as not having low self-esteem might enable the client. Nevertheless, this participant acknowledged that such re-positioning was not commonly done, because, in her view, socially constructed ideas about 'survivors/victims' were embedded in both public and professional perceptions.

6.3.4 When challenging male 'perpetrators' doesn't work

> *Jay: but if you just, they're just bad people, there's nothing to work with then and you can't and people won't feel listened to and they won't change (158)*
>
> *Ian: … if it's all about challenging people they're defensive aren't they you know? Um they're either the victim or the persecutor (45)*

In this section, participants speak about the potential consequences, in terms of its effectiveness, of working with 'perpetrators' only at a cognitive level and not addressing emotional issues, particularly when clients had been traumatised in their early experience. Best practice is informed by feminist and CBT theories with the intention of re-educating 'perpetrators' in order to stop further violence and thereby protect women and children, as we saw in Theme 2. This was referred to by some participants as a prescriptive, rather than therapeutic approach that might be experienced by 'perpetrators' as ignoring their needs, so they would not feel listened to and would not listen. This could have implications for clients' engagement and their willingness to change, as illustrated in the following short extracts:

Extract 42
> *162. JL: … how they might grapple with the terms as well of using perpetrator and victim (...)*
>
> *168. Jay: you know even from a just a purely effectiveness point of view I just don't think people listen to you when you're just treating them like a bad person*

Extract 43
> *75. JL: ...how how do you broach the issue about it's wrong what you're doing yet engage with the counselling intention as well. How do you put those together do you think?*
>
> *79-81. Ian: … we would totally ignore their feelings and so they would bury all of that and so how you know how could we work with them while we were ignoring their needs? (...) Oh it would come out in most sessions. They'd have a dig at their partner oh she's hurt me oh but she does this. It would keep coming out*

As we see here, if clients do not feel listened to they may keep bringing up the same issues, which might subvert the focus and progress of the therapeutic work. However, the idea of

taking a more overtly supportive approach, similar to the work with 'survivors/victims', could be considered contentious, as this extract illustrates:

Extract 44

> *28. JL: So if you can't use the same sort of approach with women as you do with men you're doing something different? (...)*
>
> *31-33. Tim: ... practice and research is finding more and more and more that if you have to do any effective work with men then you have to start addressing the emotional issues, the underlying traumas. And that is kind of contentious but it's gaining more ground*

The participant alludes here to the idea that understanding why people behave abusively has been conflated with excusing it, but is increasingly found to be '*effective*' practice. Furthermore, the effectiveness of challenging abusive behaviours from a relational position of, 'I'm right and you're wrong', has been questioned, as illustrated below in the two extracts from a participant who works with male 'perpetrators' in groups and individually:

Extract 45

> *88. JL: So as a therapist or a group facilitator your goal is to? (...)*
>
> *91. Ian: your challenges were just I'd say we we had all the answers so we could challenge you know we wouldn't allow sort of criticism of partners. It was just not very productive and I couldn't see it while I was right in it (laughs)*

Extract 46

> *35. JL: That's to do is that to do with the input from your own training? (...)*
>
> *39. Ian: You know as long as we've been working with CBT in groups which is the Deluth model which has been going for years and years and years it's kind of a temporary fix and and it's superficial. It's ok but it doesn't go deep enough. It doesn't explain to people. It's a very challenging programme. The guys would be blaming their partners in the group and we'd be saying set pieces um with them and show them that they were the one in the wrong ... the partners are not here to defend themselves ... it's not going to help you etc etc So they'd be very defensive we'd spend a lot of the sessions basically arguing with them about whose fault it was ...it was just ridiculous.*

From this perspective, when therapists take up a position as if on the side of the client's partner, this could engender antagonism and a defensive response not conducive to working collaboratively on goal-setting and tasks, or, facilitating lasting change. The potential to repeat the existing pattern of clients' relationships is not made explicit though, as can be seen in Extract 46, this participant speaks about getting into an argument with male clients about right and wrong. This suggests that the therapist may, in so doing, be positioning the self as controlling of the 'perpetrator', imposing an agenda and re-positioning the 'perpetrator' as not in control, and potentially a 'victim'. These extracts are illustrative of a critique of current best practice based on the Deluth model, with regard to the possible

impact on the therapy/group process when the therapist has all the answers, sees things as 'either/or' and is using CBT to challenge clients' way of thinking about the problem.

Furthermore, focusing on the level of violence and looking at alternatives to hitting someone on the basis that the violence occurred as a result of a rational decision could be seen as unproductive, and even potentially dangerous, in enabling people to say the 'right' things whilst not being enabled to make changes. This was a controversial view expressed by a few participants among those working with 'perpetrators'. The following extract illustrates this position, challenging the idea that violence is a rational choice, a key tenet of the theory that underpins perpetrator programmes based on the Deluth model:

Extract 47

> *75. JL: ...I was just thinking how how how do you broach the issue about it's wrong what you're doing yet engage with the counselling intention as well. How do you put those together do you think?(...)*
>
> *77. Ian: what we used to do was concentrate very much on their violence their abuse, the level of violence or how they were violent. Although it's bad and it's wrong ... it's wrong it serves little purpose to spend weeks and weeks looking at alternative ways to hitting someone. If they could think that rationally they wouldn't have hit someone they love in the first place. It's about acknowledging.*

The same participant offers a critique of how he used to work in ways that he did not find to be effective in facilitating change, suggesting instead that clients need to acknowledge the wrongness of violence. It is implicit that 'perpetrators' are seen as not being able to think rationally, or they would not have harmed people they love, so there was, therefore, no point in adopting approaches that rely on an ability to think rationally. The following extract illustrates the idea that this way of working could put the partner at greater risk of harm, so could be counter-productive to the therapeutic aim:

Extract 48

> *45. JL: So there's a shift towards more acceptance that working therapeutically...?*
>
> *48-56. Jay: I think that you know that is a huge hurdle to get over but I think more and more people when they really think about this can instinctively understand that people don't just think about things they feel them and that they have emotional reactions ... and you know some some people actually in our project think you can make people more dangerous by only working with the thought levels because you're not addressing the actual triggers and you're actually not really they talk the talk but they don't walk the walk and I think we need we really feel very clear that you need to do that you need to work on other levels*

The key point made here is that cognitive approaches to working with 'perpetrators' might make some more dangerous when change is only superficial and misleads their partners and

therapists into believing they are able to manage their emotions. The learning to '*talk the talk*' could, in effect, make controlling behaviours more plausible.

As we saw in Theme 1, participants commonly spoke about psychological abuse as being more concerning and damaging for those clients who experienced victimisation. So, a further dilemma raised by a few participants was regarding interventions for 'perpetrators' which were focused on reducing physical violence. This might be seen as unhelpful to the victimised partner whose concerns could be about psychological abuse. It was common across the data that participants spoke of psychological abuse being more damaging in their clients' view than physical violence, and here is one example:

Extract 49

> *46. JL: ... I was wondering if you could elaborate on on what you would see as the controversial element.*
>
> *117. Dede: for many um courts in this country the physical abuse is the worst thing and you know you get a lot more reaction if there is physical abuse. For the survivors it's psychological, they always say the same thing you know if he was if he was going to whack me at least I know what's coming and I know how to deal with it but it's the psychological abuse that does the most damage, it really messes them up.*

As the above extracts have illustrated, a prescriptive approach could be seen as ineffective in facilitating fundamental, lasting change when it focuses on cognitions and physical violence, and positions clients as 'bad'/in the wrong. Similar to the view expressed in Extract 47, one participant also expressed a view that some traumatised clients would not be able to grasp these techniques, even should they want to, as we can see in the extract below:

Extract 50

> *169. JL: Can you say what you mean by that? (...)*
>
> *174-176. Dede: we were saying actually that doesn't work cos if you've got somebody who is consistently traumatised from the age of 3 you are not going to stop his behaviour by saying don't do this and on week 3 do this and on the next week do that. It doesn't make a ha'peth of difference. They might want to get hold of that stuff and might say yeah I can really see the sense of this and I'm gonna try this. That's good that they try it but those trigger mechanisms are already in there so 3 seconds in (snaps fingers) bang they've already been violent and they go oh god I've done it again and it just powers it all of the time. So unless you're going to look at something that really deals with the underlying pathologies, the underlying early traumas, early situations, current situations, current choices in a more complex and deep way basically you're ticking boxes.*

This extract portrays male 'perpetrators' as potentially wanting to change and trying hard to do so, but, hampered by what was often a traumatised past, they may be unable to manage the emotional responses that trigger abusive behaviours. This illustrates a critical take on prescriptive approaches, not commonly spoken about by other participants, and provides an

expanded rationale than that noted earlier in Extract 44, for addressing emotional issues. Nevertheless, the more general point justifying this approach was commonly made by those working with 'perpetrators', that although a focus on a practical level could affect change in behaviours, this might not be sustainable when underlying emotional issues were not addressed. This view is illustrated in the next extract:

Extract 51

159. JL: CBT? Does that still come into it?

160. Ian: ... it was always called a CBT programme because we were always looking at alternatives, everything, they'd check in and, I was violent in the week and ok at the end of it we'd say right what could you have done differently, how could you have handled that differently so it was very much on a practical level, ok we'll go home and see if that works and of course they hadn't changed fundamentally you know it was a change in behaviour but it's still there underneath

The message with regard to the dilemmas raised in this section is that emotional issues maintain problem behaviour and, if not acknowledged, this may potentially close the possibility for helping clients to gain insight into their abusive behaviours and engage collaboratively in making changes.

6.3.5   When the picture is expanded to include the other

Eva: sometimes I would I would sit with the so-called victim and think, 'Mmm but who is doing what to whom? (21)

When talking about their approach to working with DVA, many participants focused on the individual client, and, more specifically, spoke about ways in which they might re-educate 'perpetrators' and support those who had been victimised, as we saw in Themes 1 and 2. Participants differed as to whether and how the other in the relationship was used as a reference point: some participants spoke about their role in educating clients about healthy relationships, and a few spoke about taking a more relational perspective, as we will see in Theme 4.

Looking at the interaction between the couple might challenge the initial naming of the problem, and the decoding of what is relevant to work on. In this extract, we can see an example of less-spoken-about concerns that there may be potential for both partners in a relationship to behave abusively and that it could be difficult to untangle fault. This is exemplified below when one participant speaks about a client not walking away but '*having a go at the person*' who is then violent in response. As we can see illustrated here, therapists may be concerned about being seen as making judgments that might be perceived as excusing abusive behaviour and blaming 'victims':

Extract 52

> *176. JL: ...some people I've talked to have talked about trying to work out the truth of what's happened you know that they don't like getting caught up in that or they think about it in terms of hearing one side of the story. What what do you think about that? (...)*

> *182. Anita: I think sometimes in relationships there is just an unhealthy pattern going on and it can be both people so that then um I'm not, there's no excuse for hurting anyone or abusing in any way yeah you know sometimes it can be both of the the behaviours that you know inevitably bring about more abuse so it can hide the abuse so you know that person if someone isn't prepared to walk away and they're still having a go at the person and maybe they should just give them the space you know then then who's at fault then? You know it's really hard to pinpoint it's a 2-way system as well so it may be that you know both of them have to tackle that that behaviour so recognise it so yeah*

As we see here, looking at the behaviour of each partner can lead a therapist to question what counts as abusive behaviour and to review an initial understanding of who is at fault. From the point of view of the client, when the behaviour of only one of the partners is taken into account we can see how this may engender misunderstanding and resentment when a client believes their view has been marginalised, and they might keep bringing this up as we saw in Extract 43. In the extract below the point is illustrated that if a man feels blamed when he and his partner have been having a row this can generate an unhelpful confrontation between client and therapist:

Extract 53

> *196. JL: ... some therapists say that they get caught up in trying to work out the truth and I'm just wondering how that plays out in a group or whether it does at all*

> *206. Ian: well you can see that guy in that group has got a huge beef cos when they row they row, they both think they're right I mean it's like a couple of children isn't it at the end of the day they both think they're right, they think everyone else behaves in the same way that they do, they often say well you all row don't you, you row you know um so he's going to feel really badly wronged, he's going to come out fighting from his corner all the time and that's what it gets like.*

The couple are represented here as like '*children*', both thinking they are right and there is an implication expressed in, '*that's what it gets like*', that this relational dynamic can be repeated in the therapist's interaction with the client too. It is also notable that clients might challenge the positioning of themselves as different from therapists, contesting the implied idea, for example, that therapists do not row. It highlights the difficulty therapists might experience in finding ways to challenge 'perpetrators'' behaviour without getting caught up in an argument.

Similar dilemmas can also arise when working with victimised clients. When a client feels love for a partner who is abusive, this can pose difficulties as therapists might want to

empathise, and, at the same time, offer an appropriate challenge regarding the risk to their safety. Understanding why a woman continues to love someone who behaves abusively poses a challenge to gendered theories of DVA, which may not fully account for the apparent strength of some women's, or men's, attachment to an abusive relationship. The first extract gives an example of the dilemma this might pose when a therapist wants to maintain the engagement with a client and find a way of saying something potentially unpalatable:

Extract 54

83. JL: How do you do that in that kind of situation?

84. Helen: ...it would depend very much on the person I'm with and what I'm picking up and what feels appropriate for me to say to that individual because it might be somebody I'll think maybe they can hear this and somebody else maybe they can't so it's a careful process um because obviously if I was sitting with somebody and she's telling me oh this person loves me so much that and I turn round and say well actually no he doesn't and that's really controlling she's going to be out of the door and I'm not going to see her again so it wouldn't be helpful um and at the same time it feels important that I find a way of may be raising it or questioning it even sort of

Whilst the dilemma is acknowledged, it remains unclear how this participant might seek to resolve this. Being able to empathise with the client in this situation may depend on having an understanding of the investment made in the relationship and how women might get 'stuck', hoping their partner will change, as illustrated in the following extract:

Extract 55

83. JL: ... something you said earlier about um how we understand the way abusive relationships can persist. What do you think about that?(...)

88. Dede: women can be stuck in these situations for years and years and years and of course they hope that it's going to get better. They hope that the guy that they met and fell in love with is going to turn good. That has got to be a very real hope and that's that again is very deeply entrenched because once you lose that hope what what have you got? You've lost everything. The children have lost a father, you've lost a lover, a partner

The emphasis here is on female clients' need to hold onto hope, to avoid losing '*everything*'. In the next extract, the idea that abusive relationships are not always 'bad' is illustrated, further explaining why some women may stay with a man who has behaved abusively:

Extract 56

1. JL: Could you tell me something about the service here and your role? (...)

9. Jay: Obviously some men were incredibly horrible, violent, vicious, nasty men and they just needed to be in prison but a lot of them were not always like that and it struck me over and over that these women still had some feelings for these men and sometimes their relationship was good and sometimes it was horrible

and that this was a very complicated situation that was not um something that you could just understand in black and white terms

This sets out the idea that 'perpetrators' may not all be bad people, though some may, indeed, be vicious and need to be treated as criminals. It suggests too that when the picture is expanded to include the other partner's perspective, approaches that categorise behaviours as good/bad may be inadequate to explain the resulting complexity.

A potentially major dilemma for therapists working in 'perpetrator' services is to do with managing information they might receive from the partner, particularly when this might contradict what their client was saying. As indicated in Theme 1, confidentiality can operate one way where services consider a woman to be at risk from a male 'perpetrator' and the woman is seen as the one who tells the truth. As we can see from this extract, it could be challenging for therapists when they have reason to begin to question who is doing what to whom, particularly when there may be risk issues:

Extract 57

198. Ian: er obviously we get huge problems occasionally where the guy says there's no violence, everything's fine and his partner's saying quite the reverse and that's a problem obviously a massive problem

199. JL: How do you deal with that?

200. Ian: Well if we're about Deluth we can't challenge him because where would that information have come from? And then the only time we would challenge him is when she's safe and she says it's ok to do so

This last, and other extracts in this section, highlight the potential ethical dilemmas that can arise when it is assumed that 'victims' tell the truth and 'perpetrators' do not, and information from a 'perpetrator's' partner may be used as evidence of whether he poses a risk to others.

6.3.6 Summary of sub-theme 2

When participants talked about their work with individual clients, decoding what was relevant, there was commonly an implicit assumption that DVA was uni-directional, a process in which 'perpetrators' acted on and controlled 'survivors/victims'. In other words, 'survivors/victims' would be affected by and, respond to, 'perpetrators, whilst 'perpetrators' were conceptualised in the main as unresponsive to those they victimised. This understanding of the process tended to underpin the way they spoke about their approach and interventions in Theme 2. For example, one participant spoke about using a response-based approach to explore resistance to violence by victimised clients and other participants focused on unpicking the self-blame, or noticing abusive behaviour in others (Extracts 17 and 21; 108. Helen). Work with male 'perpetrators' could involve, for example, unpicking

the limits of their own violence to establish that they had control over this, without reference to the other's behaviour (Extract 43). Questions about, 'Who did what to whom' might arise only when the other is included in the picture, if a relational approach was explicitly taken, which most participants did not. Such an approach could be seen as antithetical to a view of the problem as a gender issue where '*it's about the perpetrator*', as we saw in Theme 1 (Extract 6).

In this sub-theme, we saw how the initial decoding could be challenged when further into the therapy the presenting issues changed, or therapists had information about the partner that might lead them to question who was doing what to whom, or to wonder why a victimised client loved a partner who hurt them. However, issues of motivation, responsibility and choice for female 'survivor/victims' may not be spoken about when this was construed as victim-blaming. Similarly, therapists might not address 'perpetrators'' emotional issues, when empathising with their current frustrations and past hurts might risk colluding with, or excusing their behaviour. As we saw also, some therapists might begin to question whether their approach was effective in achieving anticipated outcomes, when changes in 'perpetrators'' behaviour were temporary and victimised clients might take on the identity of a 'victim' with connotations of being helpless and disempowered.

6.4   Sub-theme 3: When Issues of Choice and Responsibility are Challenged

> **When** the past contributes to understanding the present, or excuses abusive behaviour
>
> **When** questions about leaving, or staying, are seen as blaming the victim

6.4.1   Introduction

It was apparent in Theme 2 that naming someone as a 'victim or perpetrator' had implications for what was relevant to focus on and what was not spoken about. Embedded in many participants' talk of victimhood were assumptions about 'victims' having no power or choice and, so, not being responsible for what had occurred or their responses to the violence or abuse. Similarly, there appeared to be a set of assumptions about 'perpetrators' as powerful and in control and using current or past abuse as an excuse to justify their behaviour and deny their responsibility. These assumptions were particularly evident in participants' talk about the relevance of clients' past experience and explanations as to why abusive relationships continued and the dilemmas some spoke explicitly about having to negotiate. With regard to both these controversial issues it seemed that an intention of

understanding the problem and working with it could come into conflict with participants' concerns not be seen as excusing 'perpetrators' and 'victim-blaming'.

6.4.2 When the past contributes to understanding the present, or excuses abusive behaviour

> *Ian: invariably they'll have a few burning issues that have been going on for years and never resolved so it's about looking at it again(166)*
>
> *Ian: Perhaps people have felt like I have for years that I can't face it until I know what the problem is (131)*

Exploring the past to understand its impact on the present was commonly an accepted part of the work with 'victims' to facilitate understanding of the current problem. However, it could still be a difficult and controversial area to tackle with victimised clients. This extract further illustrates the view, introduced in Theme 1, that clients may lack awareness:

Extract 58

> *49. So is that something you work with? (...)*
>
> *53. Anita: ... she was very reluctant to engage with that side so defences naturally do come up cos it's quite difficult to notice things within your own upbringing and in your relationships so yeah I think it's yes it can be a quite difficult area to tackle I think*

The idea that victimised clients might be '*naturally*' defensive echoes the perception of 'perpetrators' as being in denial, illustrated in Theme 2. Exploring the past with victimised clients could also be seen as creating a potential for seeming to blame the person for being abused, and shift the responsibility away from the 'perpetrator', a view illustrated here by one participant:

Extract 59

> *85. Can you tell me about any difficulties you come across in in your work doing therapy? (...)*
>
> *87-88. Sarah: One difficulty for me with er women who are victimised that I work with is when they endorse the idea that they have er repetitive compulsion pattern and that um because I I don't buy into that idea at all (sighs) and I have one woman at the moment and she's definitely fixed yes she is repeating a pattern and she really believes she is and so I have to I find that hard but often I try to disprove and challenge these kind of ideas but with her I haven't managed that so I have to accept it and think that for her it's a useful concept even though I don't agree with it but it still bugs me a bit*

As noted for Extract 41, abuse narratives that position women as complicit in their victimisation may be strongly embedded in the way women's experiences are understood. There is a contradiction evident here, though not acknowledged by the participant, in her

attempts to disprove that women lack awareness of their choices, whilst at the same time telling them they are wrong. Conversely, male 'perpetrators' were not commonly spoken about as repeating a pattern, perhaps because they were more generally perceived as making conscious choices. Nevertheless, all the participants who worked with both female and male 'perpetrators' said that in their experience many of these men and women have had an 'abusive background', as this extract illustrates:

Extract 60

> *115. JL: ... are there any differences between the processes you're describing in this group and the women's group?*
>
> *117. Sue: it's just my own personal experience of working with them that that there's a rage within them often often cos of that but then in saying that often it's the case with the men as well you know not not exclusively, but many of them have come from abusive backgrounds*

Participants differed as to how clients' anger was understood in relation to the current problem and the extent to which it might become a focus in the work. Some participants spoke about finding it helpful to look at patterns of violent behaviour that they might understand as having been learnt by 'perpetrators' from their past experience in their families of origin, as illustrated in this extract:

Extract 61

> *79. Ok. Can you tell me about any difficulties you experience in doing the work? (...)*
>
> *85. Eva: Yeah especially if it's been a pattern kind of or learnt from parents way of relating yeah I would definitely look at the past. I know that not all people would agree with this but I've found it helpful to understand why people respond to certain things in a in a violent way.*

However, as the above extract alludes to, an approach which looks into a 'perpetrator's' past is considered controversial. For many participants, seeming to acknowledge the impact of the past on 'perpetrators' behaviour now could pose a dilemma: when understanding men's abusive behaviour might appear to excuse them from taking responsibility this could become '*another form of abuse*'. Two participants, who have many years of experience with male 'perpetrators, illustrate this point in the following two extracts.

Extract 62

> *62. JL: ... what's the model that that underpins those (groups)? (...)*
>
> *71. Sam...where we were coming from, typical of the psychodynamic point of view, undo the trauma and she said don't you realise that if you're saying these men are are abusive because they're insecure or traumatised you're giving them permission to go on being abusive until they resolve the trauma or insecurity, she said that's just completely it's just another form of abuse what you're planning to do.*

Extract 63

> *70. JL: ... whether it's appropriate to work therapeutically with um perpetrators. What's your take on that? (...)*
>
> *76. Sarah: ... I think perpetrators or those who use violence are very clever at picking up you know it was my childhood, I didn't know any better, my father used to beat me and my mother, so they are very clever at psychologising their motivations for violence er giving explanations for violence*

Seeming to disregard the possible impact of nurture and implicitly perhaps drawing on nativist ideas that violence by men is hard-wired, male 'perpetrators' are positioned here as manipulative in using violence by their fathers as an excuse for their own perpetration. The belief that 'perpetrators' may also be 'victims' is thus a controversial one, posing a challenge to existing 'either/or' understandings of DVA, and rejected by some participants when naming the problem, as we saw in Theme 1. The suggestion can elicit an angry response, especially when conflated with the notion that DVA is a problem of anger management, as this extract illustrates:

Extract 64

> *298. Um so you might run groups here then? (...)*
>
> *301. Ken: I put some anger some anger management stuff on the website ...the women's service made this big deal about the fact that for years we've been trying to get women to see that it's not a crime of anger, now we've got somebody telling the world that it is all about anger. That wasn't what I was saying at all. I'm saying that a lot of people that I see have been victims they are a symptom if you like of that even if they were victims in childhood it's unexpressed it's a loss of control so the management of it's quite useful. I'm not saying that men only hit women when they're angry*

Representing 'perpetrators' as having anger issues, may thus be seen as minimising the problem and missing the point. However, some therapists spoke about trying to address underlying feelings of shame that might drive someone's anger. Working with these feelings of shame men might have about their past was spoken about as being particularly difficult, both in terms of naming this and addressing it. In this extract we see how one participant speaks about the feelings this can evoke in the therapist and the potential for shame to be re-evoked, creating a double-bind and the potential for avoidance by both client and therapist:

Extract 65

> *58. JL: ... when you mentioned about working therapeutically I wonder how much the shame comes into it?*
>
> *63. Tim: it's a tricky one shame because to talk about shame kind of brings shame out, it gets into the room and it gets you kind of re-evoke it and I'm still I still don't feel very happy the way I work with it I've still got a lot of work to do on it um we try and name it, we try to address it and try and say look this is what has been driving you, how does it feel? And from then to actually admit that you feel ashamed is shameful in the first place so you get to a real double bind if you're not careful. So they say, no man, I feel fine it's not a problem but you*

know you've just started it, so something's happening, you've tapped into it. So all you can do again is try and name it, say it's in the room and just be aware of it yeah. How do you feel?

This illustrates some of the difficulties therapists must themselves overcome if they are to name and address these emotive issues and enable clients to own their problems.

6.4.3   When questions about leaving, or staying, are seen as blaming the victim

Jay: after spending many many years of putting women into refuge who almost invariably end up going back for all sorts of reasons because it was so damned difficult to be apart um you know I just thought no, the men ought to be leaving not the women, the men ought to be the ones we work with (12)

Dana: Why do I always meet men who are gonna do this to me? (103)

In this section, approaches to the issue raised above are illustrative of the same dilemma, highlighted in the previous section: how can we understand behavioural responses to abuse, without seeming to blame or excuse? Two participants became angry when posed the question about why abusive relationships might persist or asked for their take on the debate about this, and one rejected the premise of the question, saying that most women do not stay in abusive relationships. Both expressed a view that '*most people in the DV sector*' would '*absolutely hate*' the question because it was blaming of the 'victim', as the two extracts illustrate:

Extract 66
> *20. JL: ... in the literature there's quite a debate about whether it's a valid question to ask how why why women might stay in abusive relationships. What's your take on that?*
>
> *2-23. Sarah: er well my take I get furious with that kind of question because I feel the question is blaming and first of all it's inaccurate because if you look at this that she was trying to leave (pause) most women leave so when you say why women stay you're making out that most stay. They don't, most women leave. That's real, in research you can see that. So the the to me I mean I get angry with that kind of questions because it's blaming, it seems like women don't leave and it's also implying that there's something wrong with them for staying um I mean my take on that is that er women stay in a relationship with a violent partner for a multitude of reasons um sometimes they um are so financially repressed, they are threatened, if you leave I'll kill you and if you look at the level of violence used against them yah it's they really have good reasons to believe that may be the case*

Extract 67
> *111-114. Sara: ...this bit about what's your understanding of why people stay with abusive or violent partners I think that's a question that most people in the DV sector would really absolutely hate. It just makes you so angry because it's the victim blaming. You know what's wrong with asking the question why do perpetrators behave that way rather than why do women stay. It's victim-*

blaming um and it's so complex this you know um so I think that question automatically it's a question that um clients are asked all the time and it's (...)

117. JL: ... it sounds like you you've got quite a strong view on that

118-120. Sara: Yeah cos it's the question that we ask you know when you think of any other crime do you ask the victim why is this happening to you? It it's the one crime where we kind of victim blame so it's almost you put the blame on on the woman because it's main usually the woman that you've stayed um and it's a question that's just not helpful for somebody in that situation um and you know it is just so complex the reasons why I mean the research says it's generally mostly because you know they stay because of the children and they leave because of the children. But also a lot of it is around fear um and we know that when women leave they're most likely going to be killed and so when you're asking that question you're really blaming them (unclear) there's already lots of issues around blame and it's their fault because this is what the perpetrators are saying to them as well so it just adds to um what they're already experiencing.

As these extracts illustrate, questions about why women might remain in abusive relationships and the degree to which this might be construed as a choice are contentious issues that could arouse strong feelings for therapists working in the DVA sector, and elicit defensive responses that seek to justify women's behaviour as rational. As we can see in the above extract, and the following one, when DVA is likened to other crimes or random acts of violence such as mugging in the street where the relational context is removed, 'victims' are positioned as blameless.

Nevertheless, victimised clients do tend to blame themselves, as we saw in Themes 1 and 2, and this can create another double-bind for therapists. When clients remain in abusive relationships and blame themselves, it can be understood as an attempt to shift the focus away from the person who is to blame, the 'perpetrator, and by implication, also shifts the locus of responsibility: the act of self-blame may thus be seen as contributing to the misrepresentation of the problem, keeping 'victims' in the relationship and thereby maintaining the problem. As illustrated in this extract, a therapist could feel stuck and frustrated when they want to point out the consequences of self-blame, particularly when staying may put a woman at risk, but, may be cautious of saying this for fear that it could sound blaming:

Extract 68

194. JL: I was just wondering if you felt it was something that can't be said?

195-200. Sue: Oh no no. I'm just more cautious. I wouldn't say it in a Women's Aid meeting cos they'd just all jump on you, because the woman is the victim and that's it and I and yes, but also unless she says get out and that puts her at further risk because women fleeing violence are at the most their their risk of being harmed is increasing when they're in the process of leaving or leaving. So I would ideally want all women in future to know that if it's happened once – all women and men in abusive relationships, if they've assaulted you more than once there is a problem that can only get worse, it will not get better (...) um whilever she er women start blaming themselves and think, the longer it goes on,

I I must be doing something wrong, why else would he be hitting me? We don't apply that same argument to someone that mugs us, we don't say it's because I was carrying a bag of shopping. And and I think it's it's pointing out these um cos I do feel um awful about saying it. I don't mean they deserve it that's not what I'm saying at all

The dilemma for a therapist that, on the one hand, a woman might be safer if she leaves, but, on the other, is at risk if she does, is set out here. By implication, when a therapist shifts blame and responsibility completely onto the 'perpetrator', the 'victim' is blameless, but as we see here, when questions about the choices made by 'victims' are raised, this shifts some of the locus of responsibility back to the 'victim'. The discomfort this elicits in the participant is almost palpable, manifest in an attempt to distance the self from seeming to suggest that women deserve to be hit, by shifting responsibility back to the 'perpetrator'.

Other participants also expressed a view that it might not be easy for women to leave abusive relationships and spoke about how they could get very 'stuck' in them. The frustration this can elicit in therapists and those looking in from the outside is alluded to again in the next two extracts, as is the need for therapists to be able to tolerate and '*sit with that*':

Extract 69

> *83. JL: ... something you said earlier about um how we understand the way abusive relationships can persist. What do you think about that?*
>
> *84-99. Dede: There's all sorts of reasons, all sorts of reasons I mean they persist because women still don't have anywhere to go, I mean who would want to go into a refuge with 2 or 3 children? Um it probably wouldn't be their first choice and to leave is very very scary um what most of them do very strongly is once the abuse is over because it doesn't happen 24/7 in most cases they normalise it and this is a very strong thing I think in women generally that they will make the best of situations. (...) These are not easy relationships to get out of you know many people looking from the outside will say, well why don't you just leave him, why don't you just get up and leave him. It's not easy. It's not easy to do that.*

We get a sense here of the double-bind victimised women may experience, caught between the fear of being abused by a partner and the innumerable difficulties of going into a refuge. Making the best of the situation can involve a normalising of abuse that enables them to see staying in the relationship as a preferable decision to leaving. Recognising that these decisions are not easy and that it is not uncommon for women to leave and then return, therapists working with a victimised client need to be able to cope with sitting with the client's stuckness, and being stuck themselves, as illustrated in this extract:

Extract 70

> *110. JL: What do you think enables you as a therapist um to do this work? (...)*

112. Jas: I think you do have to have some element of enthusiasm for the work because it can be a very frustrating arena um even front-line women's work because it might be around her being very stuck in her relationship and as a therapist you almost need to be offering the willingness to be stuck with her and to sit with that

Implicit here is the idea that therapists need to contain their own frustration and wish for the client to leave the relationship, if they are to enable the client to reach a decision that is safe and sustainable in the longer term. Whilst participants came up with many reasons why abusive relationships might continue (e.g. Extracts 66, 67, 68, 69) and one refuted the premise, on the other hand, some did speak about being baffled as to why women might return to abusive relationships or have repeated experiences of abusive relationships with different partners. In this extract one participant recalls this being common in women's services:

Extract 71

211. Ian: I remember when I started in this business it was really different then for women's services cos they were trying to support and work with a client who'd just been beaten up for the umpteenth time and she wants to stay with him and they're baffled, they don't understand why

212. JL: Still still a big question isn't it that some people are struggling with

213. Ian: Well yes they really are and I feel we've answered it (laughs)

Although this participant voiced the view that he had found an answer to the question, therapists might struggle not to sound blaming when seeking an explanation for someone having been in several abusive relationships. A controversial view voiced by a few participants, but rejected by one as blaming, was that 'victims' might be seen as attracting predators because their past experience was such that they found abusive partners familiar. In the following extracts these two positions are taken up as to why some people stay with an abusive partner or repeatedly go into abusive relationships:

Extract 72

98. JL: Another question that comes up is that abusive relationships tend to persist and how we explain that

99-102. Dana: That is a cycle and a repetitive going into (unclear) how I explain that is that there is a cycle of behaviour and habits and (unclear) and therefore you stay in an abusive relationship because of that er if that's all you've ever known if your parents were abusive that's what you experience then to find a partner because that's familiar. You're more likely to attract attract predators is how I describe it.

Extract 73

72. JL: How do you think they are or might be linked then when someone's had experience of abuse in their family of origin?

> *73-74. Helen: That's one that I really struggle with because I I know the literature says that where somebody's grown up in um in a violent household it's likely that they will get into relationship that are unhealthy and controlling and probably violent um and I know one of the issues for many of the clients because that does happen they grow up with it they get into a relationship and it's violent or controlling in other ways, they get out of that they get into another relationship that so by the time I get to see them it's like have I got it written across my forehead and my response to that would internally definitely would be of course you haven't and yet it's led me to question well why how does this process happen?*

The double bind and dissonance this dilemma can generate is clearly articulated in this extract, where one participant tries to reconcile her theoretical knowledge with her clinical experience, yet struggles to understand why someone may be victimised by different partners a number of times in an apparently similar way.

6.4.4   Summary of sub-theme 3

Intrinsic to the processes of naming and decoding the problem of DVA are broader moral and ethical concerns for therapists with regard to their responsibility for safeguarding those at risk and practising in ways that are valuing and respectful of others. It is implicit in gendered understandings of what it means to be a 'victim' or a 'perpetrator' that 'victims' have been wrongly harmed and neither chose nor are responsible for this, and that 'perpetrators' made choices and should be brought to account for them. So, it may be difficult to value 'perpetrators'' perspectives, or talk to 'victims' about taking responsibility for safeguarding themselves and their children, without appearing to undermine the morally responsible position that DVA is wrong.

Indeed, when therapists work with only the 'victim' or the 'perpetrator', it may become difficult for both client and therapist to speak of behaviours that are not consistent with the label given. Positions taken by therapists as to what harm has been done, who was responsible and whether the harm was intentional may reinforce an over-simplified understanding of the problem, categorising one person as blameless and the other as blameworthy, thereby avoiding or lessening the dissonance that contradictory information can generate. This is relevant to both an understanding of the risk factors for abusive behaviour and to the controversial question of why people might stay in abusive relationships.

Some participants spoke about the potential for victimised clients and 'perpetrators' to become stuck in double binds, for example, when talking about the past can re-evoke shaming experiences, or leaving an abusive partner can put someone at more risk. It was apparent too that therapists could get caught up in experiencing double binds that could keep them stuck and reluctant to address these issues for fear of being perceived as blaming, or

insensitive to 'victims', or excusing of 'perpetrators'' behaviour, sometimes outside their awareness. We can see that these dilemmas might seem to be resolved when they are avoided i.e. when therapists do not speak about a 'perpetrator's past, or, do not ask victimised clients about their motivations to stay with an abusive partner, or about their relationship histories.

6.5 Sub-theme 4: How the Work Impacts on Therapists

> 'When therapists might want to 'rip the perpetrator's head off'
>
> 'When therapists recognise their own capacity to be aggressive

6.5.1 Introduction

There was an acknowledgment by all participants in Theme 2 that whether the work was with clients in receipt of DVA or perpetrating this, forming a therapeutic alliance that could enable work to take place was essential. As we have seen, the expectations, motivation and intentions that therapists bring to this relationship are likely to be influenced by their theoretical knowledge and their personal and professional experience. These factors will also contribute to the way in which clients' experiences are constructed by therapists and how they respond to what may be disturbing material.

6.5.2 When therapists might want 'to rip the perpetrator's head off'

> *Anita: ...to rip the perpetrator's head off (42)*
>
> *Dede: 'it's starting to alter how I think' (156)*

Whilst the behaviour and intentions of therapists will affect the therapeutic relationship and the way each are positioned in this, we can see from the accounts of most participants that their clients can also have an impact on them. Male or female clients who have been victimised or have behaved abusively could bring intense feelings to the therapy space, which are difficult for a therapist to hear and contain. From a therapeutic perspective, being able to hear and contain the feelings of someone who has been physically or emotionally hurt would be considered fundamental to facilitating trust and creating a safe space to work in, as is illustrated in this extract:

Extract 74

> 237. JL: It's growing then? (the service) (...)
>
> 238. Ann: once they come through then you know they've got somebody that's focused on them that you know they can just offload to you know and then actually stopping them keeping them in that hour, that time frame actually can be quite difficult because they've got so much to offload that they might not have offloaded to anybody else or they don't because of the guilt or the shame of it.

Here we get a sense of the intensity of feelings clients may bring to therapy, and the concomitant sense of responsibility experienced by a therapist when they are trusted with sensitive material which their client has perhaps not spoken about before. This did not only apply to working with clients who had been victimised. It was commonly said by participants working with 'perpetrators' that they did not experience anger from group members, but that nevertheless they could feel drained or have 'complicated' reactions themselves to deal with. Gender differences as between client and therapist were explicitly mentioned by a few participants: the potential impact on the therapeutic relationship is illustrated in the next two extracts where, firstly, a female therapist speaks about her work with male 'perpetrators' and then a male therapist speaks about his work with female 'perpetrators'.

Extract 75

> 65. Beth: it doesn't really come up I mean you know basically the men wouldn't on the whole act out with you whatever whether you're a female counsellor or not because they know on the whole that you're here to help them so it's not in their interests really yeah it can be challenging especially when the group's at capacity we have 8 members in the group
>
> 66. JL: So what what you've mentioned some of the challenges, are there any others particularly in working with the group or the individuals?
>
> 67-69. Beth: (17 secs) I don't think any more than we've covered really I mean as I say top of the list would be feeling physically intimidated touch wood that doesn't often happen um next I suppose in terms of things to handle are your reactions as to what they're saying um and sort of with that equal with that is is dealing with their projections onto you um be that in the background really they can be equally complicated um for different reasons

In the next extract, a male participant who works with both male and female 'perpetrator' groups speaks about the differences for him in terms of what he focuses on in these groups and his difficulty containing the feelings of the women's group:

Extract 76

> 17-18. Tim: I suppose in I kind of I kind of a a difference in working with women, a colleague of mine pointed out recently was that we spend a lot of our time with the men trying to encourage them to feel, to have feelings, to acknowledge the feelings, to express them inwards and out rather than just using anger or rage. In the women's group they have a lot of feelings very very present, it's almost awash with feeling it's almost too, it's almost uncontainable sometimes and that explained to me why when I come out of that group I'm feeling I'm just drained

This highlights a difference in perception of men's and women's capacity to engage with their feelings, and how gender differences, whether socially constructed or otherwise explained, can impact on the therapeutic work. Nevertheless, some participants of both sexes spoke about a need to contain the feelings aroused in themselves by their work with clients, especially when this was an angry reaction to 'perpetrators' in the therapeutic context or when this might become generalised to their own views of others outside this context. These three extracts illustrate views expressed by many participants:

Extract 77

> *178. JL: So it kind of raised your awareness*

> *179. Ian: Yeah yeah I mean I was aware it was just I was getting very annoyed that's the frustration you know*

Extract 78

> *105. JL: ... what do you find the most challenging about this work?*

> *107 - 108. Jenny: I think you know I don't want to get ever to a situation where I get on a train and start looking around and thinking well half the men in here are perpetrators ...I'm not going to be useful if I keep storing up the righteous indignation,*

Extract 79

> *149. JL: ... what role do you think supervision plays in providing support for say your therapists*

> *156-157. Dede: you can get pretty burnt out doing this it can alter how you think you know clinicians have said this to me, it's starting to alter how I think you know when I look at the guy across the train these are important things that affect us as human beings when we work in these areas*

The potential impact, of working with DVA, on therapists' well-being and their perception of men outside the therapy room is illustrated here. A few participants working with female 'victims' reported experiencing anger towards the 'perpetrator' when hearing their client's stories, or were aware of other support workers feeling angry, as these two extracts show:

Extract 80

> *142. JL: And what what do you think is most challenging about this work?*

> *143-144. Helen: (10 secs) (laughs) um (12 secs) It's quite difficult to pinpoint any one thing (15 secs) Probably keeping calm about the things that I hear people can do to other people um and I guess for that reason I I know I wouldn't be able to work with perpetrators at all um I'd probably want to rip their heads off which wouldn't be very good (laughs)*

Extract 81

> *38. JL: Ok what's your take on words like victim, survivor and perpetrator? (...)*

42. Anita: I do hear obviously from the support workers that you know god, you know they'd like to rip the perpetrators head off and I kind of find that quite difficult

The strength of feeling a few therapists had towards 'perpetrators' is captured in the phrase, '*rip the perpetrator's head off*'. The potentially deleterious impact on the well-being of therapists when working with disturbing material, illustrated in these extracts, highlights their own needs for support. It points specifically towards the possibility of therapists' thinking about men becoming skewed by their professional experience, leading them to see men as potential 'perpetrators'. All participants spoke of their own needs for support and of being able to offload these issues in supervision, as this extract exemplifies:

Extract 82

247. JL: What do you most get from supervision do you think?(...)

249. Ann: Um yes that's about the same with me as well you know, it's that learning, it's that being able to offload… so it's you know somebody to talk to

There is recognition here, as in Extract 79, that therapists are human beings like their clients and that they can be affected vicariously by the material they are hearing. Of concern for all therapists, and an issue taken up explicitly by a few participants, was the extent to which this might impact on their response to a client:

Extract 83

90. JL: Ok and what kind of issues do you take to supervision?

91. Eva: Um well usually my countertransference. So sometimes I would feel quite angry with the client and sometimes I I might also feel I identify with the other person in the relationship um so I would feel that I'm not able to be to really put myself into the client's shoes and try to understand

A therapist's own feelings might be used to inform the understanding of the client through the transference, but sometimes when a therapist identifies with a client this might get in the way of being separate enough to understand the client's perspective. This illustrates ways in which therapists might lack awareness, like clients, and highlights the need for supervision to unpack therapist's issues, separating them from the client's.

6.5.3   When therapists recognise their own capacity to be aggressive

Ken. 'You start to see things in yourself' (261)

Some therapists spoke explicitly about becoming aware of their own capacity for anger/aggression through the experience of their work and identifying to some extent with clients. A few participants spoke about being drawn to the work because of their curiosity about their own aggressive responses, which could elicit some sympathy for males who

behave aggressively. These ideas are illustrated in the following extracts, the first from a male participant, who works with male 'victims':

Extract 84

> *259. JL: ... and you need good support (...)*
>
> *261. Ken: to prepare you. I've worked in it for 18 months and have worked in some very stressful high sort of emotionally charged environment so I thought this would be a breeze (laughs) but actually it's not because it's the sort of subtleties of it if you like and the subtleties of the way people abuse each other but it can be quite hard because you start to see things in yourself you take to supervision. You start to see things in people around you that you love that potentially could become a problem for yourself.*

The idea that we might all have the capacity to behave in abusive ways is perhaps a moot issue, depending on how DVA is defined, as we saw in Theme 1. The understanding of abusive behaviours as subtle and difficult to recognise picks up, nevertheless, on a dilemma mentioned in Sub-theme 1 in this Theme. We see here how therapists might also be unaware of their own abusive behaviours, and indeed others'. This contrasts with the clarity some participants accorded their clients' behaviour, illustrated in Themes 1 and 2, particularly with regard to psychological abuse, where victimised clients might be positioned as unaware, and 'perpetrators' positioned as knowingly behaving in a controlling way. It also brings into question the positioning of the therapist as expert in making such judgments.

The following two extracts are from female participants who both speak explicitly about their own capacity for rage and perpetrating abuse:

Extract 85

> *48. JL: ...I'm wondering what led you to work with this issue, if you like? What drew you to it? (...)*
>
> *50. Eva: I'm quite drawn to to understanding um violence or people who are seen as perpetrators and I guess um that's because I've been quite in touch with my inner perpetrator, if you could call it that.*

Extract 86

> *26. JL: What drew you to working with perpetrators? (...)*
>
> *32-36. Beth: I've never been physically violent in my life apart from that one time but I certainly knew rage you know in my life and and could can be destructive physically not for a very long time but when I was a teenager and in my young days yeah very destructive kicking glass doors um really violence fascinates me I think just full stop because you know I'm I'm a quite passionate person so I mean I sort of understand passion and you know and and appetites of varying kinds um and I think they're quite close and so I I sort of want to understand like where does it tip over and what's that about you know because I mean eating's aggressive yes so there is an innateness so how do we draw the line and where do we draw the line and where do we have healthy expression of our aggressive impulses you know because and sometimes I really sympathise with men about that that they have this pent up you know it's not justified to*

express it through violence but what do they do with their energy and that kind of
frustration if they're not very articulate, they're not very well educated

6.5.4   Summary of sub-theme 4

In this sub-theme, we saw how participants spoke about the impact on them both personally and professionally when they work in the field of DVA, whether with 'perpetrators' and/or with 'victims'. Some participants also spoke about how this in turn can impact on their perceptions of their clients and the way that they understand and work with them. This was particularly evident in the strong feelings and aggressive-sounding stance that the ideas conjured up by the term 'perpetrator' could elicit in a few participants. It was also evident in the way that ideas about men as 'perpetrators' could begin to be generalised to other contexts in participants' lives.

Furthermore, some participants talked, too, about what they might bring to their work from their personal experiences, including their own past experiences of abuse or behaving abusively. As illustrated in Extract 86, some therapists might take the perspective of 'perpetrators', though here we see that the participant '*sympathises*' rather than empathises, suggesting that she may be imagining how *she* would feel in the client's shoes. It seems here that identifying with 'perpetrators'' facilitated a re-naming of abuse as '*passion*', though there was some recognition of her difficulty in drawing a line between these. In addition, it was also implicit in some participants' talk that they may, like clients, act in ways that are sometimes inconsistent with their intentions, or result from a lack of self-awareness.

When DVA is conceptualised as a gender issue, relationships in which DVA occurs tended to be understood as operating one way, However, the therapeutic relationship was explicitly conceptualised by some participants as two-way, and transactional, seeming to differ from the way that many participants conceptualised their clients' problems in relating to their partners, as we saw in Themes 1 and 2.

6.6   Sub-theme 5: Scapegoating Resolves the Dilemma of who is Responsible, Avoiding the 'Trap' of Excusing the Perpetrator or Blaming the Victim

Sue: I wouldn't say it in a Women's Aid meeting cos they'd just all jump on you,
because the woman is the victim and that's it (195)

When one person is to blame for their own and their partner's behaviour

---

6.6.1 Introduction

As the therapeutic process unfolds, therapists understandings of the behaviour or motivation of those involved in the abuse could challenge their initial assessment. Issues of accountability and responsibility as applied to 'victims' could become contentious and the naming of them could create double binds for both clients and therapists, which might result in these issues not being addressed. Some participants spoke about not wanting to blame female 'victims', or to excuse male 'perpetrators'.

This sub-theme aims to illustrate, and to begin to deconstruct in more detail, ways in which issues of responsibility may be understood by therapists and how these may be implicated in the facilitation of particular therapeutic outcomes. When the dilemmas, outlined in Sub-themes 1-4, are resolved by an approach informed by a single explanation of DVA, premised on the assumption that it is uni-directional and perpetrated by men, we see how one person may be 'scapegoated', thereby lessening or avoiding the potential dissonance aroused when holding in mind competing perspectives.

6.6.2 When one person is to blame for their own and their partner's behaviour

> *Helen: there's one person to blame and that's the person that's um being abusive (103)*

A basic premise that DVA is wrong and that there has to be someone held to account provided the rationale for the initial process of naming the person responsible. Work within a gender paradigm often centres on challenging the view sometimes held by both 'perpetrators' and 'victims' that it was the 'victim's' fault, as we saw in Theme 1 and 2. In the following extracts we re-visit the themes taken up in Themes 1 and 2 with regard to 'victims' tendency to self-blame and 'perpetrators' tendency to blame the person they have behaved abusively to, but this time with a focus on the implications when therapists, too, take an 'either/or' approach.

Extract 87

> *99. JL: There's a lot of discussion also about the potential for blaming in this context where an abusive relationship persists. What's your view on that?*
>
> *102-105. Helen: Yeah yeah (4 secs) I would certainly hope that would certainly never be the intention of anything I would say so I would certainly hope that it wouldn't be picked up in that way um I guess in terms of blaming the to me there's one person to blame and that's the person that's um being abusive however feeling that it's their fault is very well yeah probably pretty much across the board, 'It must be my fault' um so a lot of the work is maybe about unpicking that blame um and that will be again because in childhood if they've grown up with it they will have heard it's your fault from a violent or abusive partner um to the partner and probably to the kids as well um within the relationship it's*

very often, 'Well, you made me do it, why did you do that?' So again, 'It's it's your fault'.

Extract 88

12. JL: Where do you get your referrals from? (...)

15. Sue: and they when they first come so many of them are convinced they are the victim and if someone hadn't done or said what they did, so it couldn't be their fault (laughs)

Extract 89

152. JL: Do you ever work with perpetrators yourself?

153-159. Sara: No (...) It's what perpetrators often will do and women do it as well because of that you know a woman might say something like oh his hands were on my neck he was choking me so and they're the kind of things that (unclear) a lot of minimising goes on

As we see in these extracts, illustrating views commonly expressed by participants, clients tend to scapegoat self or other when presenting their story and therapists tend to re-position 'victims' as not to blame, and 'perpetrators' as wholly to blame. From this perspective 'perpetrators' might be viewed by therapists as totally irresponsible and 'victims' as living in '*pointless*' hope that their partner will change, as illustrated next:

Extract 90

181. JL: There's one question that is the way abusive relationships can tend to last and how we understand that.

183-190. Sue; I think victims live in the hope that they're partners will change and it's pointless because they've no vested interest in changing. A perpetrator has no vested interest in changing because he doesn't think he is doing anything wrong, he's just trying to keep his family together, is how he might put it, which in reality is actually pushing them further and further away. (...) I know it's his responsibility as well but he's not doing anything responsible by this stage, he's just abusing.

When women behave abusively or violently, and even when they have been included in a 'perpetrator' group, they and others may understand the abusive behaviour as being in some way different in meaning from that of a man's. In this extract we see an example of a reaction from a perpetrator group of women when abuse towards a man may be seen as something to celebrate:

Extract 91

1. JL: Tell me more

2. Tim: I was saying women's anger feels different. What what do I mean by that um well to illustrate it it's slightly glib but in a men's group of male perpetrators if a man discloses that he's assaulted his partner um the room just goes quiet er in a women's group there tends to be a cheer sometimes and one week I said well just a second but there's a sort of there's very much a sense of, Good on you girl

you got one back, not always but there's a much different atmosphere. It's seen I wouldn't say the men are seen as fair game well yes it's almost like that

Though this notion that men could be seen almost as '*fair game*' was spoken about by only one other participant, as we saw in Sub-theme 1, (Extract 5) some participants did talk about female 'perpetrators' as behaving violently '*in retaliation*' or being primed by past abuse to react aggressively in defence, as the following two extracts from participants working with both male and female 'perpetrators' illustrate:

Extract 92

> *3. JL: How do you feel about that?*
>
> *4-5. Tim Um I'm sort of used to it I quite often do I very often get lots of them you know, men do this men well bloody men, I'm sorry T, it's all right. It's ok so um and intellectually as a man I understand a lot of women I understand intellectually a lot of women's anger against men in terms of patriarchal stuff um stuff that's very deep in the bones perhaps um a lot of the clients we've got the women clients we get are also um their anger, their violence is in retaliation to having suffered a great deal of abuse.*

Extract 93

> *115. JL: Yes, yes. Are there any differences, are there any differences between the processes you're describing in this group and the women's group?*
>
> *116. Sue: Not really because um I think the only thing I've noticed I had a group of 8 women once and it turned out that as children some of them had been raped. Now this was a perpetrator's group it wasn't for victims of sexual abuse but what seems to have happened is that because they recall so vividly feeling helpless and powerless while that was going on, as adults if they get the first inkling that they could be out in that situation again they go straight in*

Here women's anger towards men is explained partly as an understandable response to their resentment about the predominance of patriarchal ideas in society, which legitimate gender inequality. In Extract 93, women are described as reacting quickly to assert themselves if they fear they may be abused again and this is presented as a difference between men and women. It is implicit here that when women have been abused in their past, behaving abusively themselves is understandable and reasserts them as being 'victims' who are righting a wrong, echoing the idea articulated in Extracts 5 and 91. This is reiterated in the following extract by a participant who works only with female 'victims:

Extract 94

> *120. JL: There's quite a lot of debate in the research about the extent to which women are violent ... I was wondering what your thoughts are on that?*
>
> *121. Jenny: Um I mean I do think I think that we would be doing women and men a disservice if we just didn't you know accept that women were capable of being and I think that some of the women I've spoken to have fought back so I haven't actually worked with sort of perpetrators I would see in the same*

189

(unclear) in terms of them being (unclear) on occasion kind of defending themselves or you know they're about to be attacked further um

The expressions, '*sort of perpetrators*' and '*kind of defending themselves*', in effect, minimise and justify fighting back. As we see illustrated in these extracts, although women are considered capable of violence, they are not considered capable of initiating violence and so the notion of responsibility is not addressed, and by omission, others are scapegoated as culpable in inciting violence from these women. The idea that a female 'victim' should take some responsibility for their abuse/violence, or its consequences, is a highly contentious view, not addressed by many participants and explicitly rejected by some. It seemed that reasons for this could be that participants feared seeming to endorse what the 'perpetrator' said or, worse, seeming to behave like a 'perpetrator', views illustrated in the following extracts:

Extract 95

> *117. JL: ... it sounds like you you've got quite a strong view on that (...)*
>
> *120. Sara: and so when you're asking that question you're really blaming them (unclear) there's already lots of issues around blame and it's their fault because this is what the perpetrators are saying to them as well so it just adds to um what they're already experiencing.*

Extract 96

> *96. JL: What enables you to keep going with that? (trying to go against a wave of social representation and social ideas)(...)*
>
> *100. Sarah: What do the perpetrators say, oh she's crazy, she's got low self-esteem that's why I beat her. Oh no, she doesn't resist she lets me do it even though of course they know they resist and withhold their services, you know it's not my responsibility. It's hers, partly. And so she has that socially so so you know the social representation is really quite an impressive match with the perpetrator's talk. That needs to be exposed*

Social constructions of women as complicit in their victimisation are drawn on here, and the assumption is made that men also draw on these to pathologise women's behaviour and deliberately deflect their responsibility for their own abusive behaviour. Just as women are re-positioned in this extract as resisting 'perpetrators', so this participant resists constructions of women as passive and attributes the pathology to 'perpetrators'. On the other hand, a few participants said that 'victims' need to be more assertive in taking responsibility for their choices and behaviour, rather than being reactive. In this extract one participant speaks about the difficulty of addressing this particularly with regard to a decision about a 'victim' leaving an abusive partner:

Extract 97

> *181. JL: There's one question that is the way abusive relationships can tend to last and how we understand that...What are your thoughts on that?*

*186-188. Sue: ...is unless you get out, they will not change while you're waiting
for them to change because they think they're victims and that you're the abuser.
(...) That sounds horribly harsh. I know it does. Because the because the women
by this stage their confidence and self-esteem is shredded,*

The difficulty of striking a balance between empathising about the impact of the abuse, and challenging a decision to stay, is clearly articulated in this extract. The potential dilemma posed by being seen as victim-blaming if these issues are addressed in a '*harsh*' way, could be resolved by both clients and therapists designating one person, the 'scapegoat', as totally to blame. One participant referred to this as the '*mad hypothesis*' which he used with clients to help them think about responsibility:

Extract 98

98. JL: ...Can I ask you what you think about the er the current sort of debate in the literature about women's violence

102. Sam: So I then eventually got into the habit of saying to people well let's assume that whatever she's doing to you that you use to justify your maltreatment of her, you are still responsible for that, so the hypothesis that you maybe you're doing something. They used to say to me but you're saying I'm not only responsible for what I do I'm also responsible for what she does and I'd say yeah and ... they say to me but that's completely mad, I say well it might sound mad to you but you're already doing it, it's just that you're saying she's responsible for your behaviour and for hers. All I'm asking you to do is to turn it on its head and they laugh because it's true, you know, cos they already think in this mad way you know she's responsible for what I do she makes me drink, she makes me hit her, she's whatever, she makes me depressed

In this extract, we see how it may sound 'mad' to a 'perpetrator' when asked to take up the reverse of their position that the other is totally responsible for their abusive behaviour. It provides a paradoxical intervention that also highlights the relational aspect missing when DVA is understood as always being one way.

6.6.3   Summary of sub-theme 5

When DVA is understood as only uni-directional fault tends to be allocated by clients either to the self or the other, and therapists can get caught up in deciding which partner is responsible. In circumstances when victimised clients admit to also having behaved abusively, or are not protecting their children, or, when 'perpetrators' are survivors of abuse themselves, therapists may face ethical dilemmas, though not all participants demonstrated awareness of this. As we have seen illustrated, therapists can experience double binds in which they fear that addressing issues of a 'victim's' responsibility may be perceived as victim-blaming and could position the therapist as behaving like a 'perpetrator'. As we saw in Sub-theme 2, therapists may be equally concerned about seeming to excuse 'perpetrators'' behaviour by acknowledging the impact of past abuse. As a consequence, abusive behaviour by women may be justified or even condoned and male 'perpetrators'

seen as 'fair game' (Extract 91). Conversely, 'perpetrators' may become 'scapegoated', held to be responsible for both their own behaviour and that of the 'victim'. So, just as 'perpetrators' might attribute all the fault to their partner, the notion of one person being responsible for the behaviour of another may be taken up by the therapist.

6.7 Sub-theme 6: Scapegoating Resolves the Dilemma of Whether an Individual has Agency, Avoiding the 'Trap' of Excusing the 'Perpetrator' or Blaming the 'Victim'

> **When** male 'perpetrators' make all the choices
>
> **When** female 'victims' respond violently to a 'disparity in the balance of power'

6.7.1 Introduction

As we saw in the last sub-theme, attempts by therapists to avoid being seen as excusing the 'perpetrator' or 'victim-blaming' can result in scapegoating 'perpetrators' as being responsible for their own and their partners' behaviour and close down opportunities to explore the responsibility of those in receipt of abuse. In this sub-theme we see the potential impact on understandings and approaches to practice when 'perpetrators' are construed as being the only ones with capacity to choose their behaviour.

6.7.2 When male 'perpetrators' make all the choices

> *Ken: What was being said to me was that they've been trying to tell women for years that that being beaten by their husband it's not an act of anger it's it's it's controlled it's their personality it's what men do ...(306)*

'Perpetrators' may be understood from a feminist position as making conscious choices to behave abusively. The following two extracts from one participant illustrate this take on the problem: that 'perpetrators' are making choices to be abusive or not, and to let others wind them up:

Extract 99

> *18-19. Sue: we say violence and abuse is always a choice. At the end or beginning of the incident that occurs, somewhere along the way you made a choice to be abusive or to not be abusive. It makes them responsible and at that time where they are in their head when they first come here their thinking is (unclear) it's not their fault at all, they're in the blame zone*

> *20. JL: What kind of things do you say to get them to talk about what they're doing?*

21. Sue: I'll come to that in a minute. The other thing that we say that they don't like is that no person can wind you up. At the beginning of being wound –up you have a choice, you buy in or you walk away and they look at us as like we're mad!

Extract 100

181. JL: There's one question that is the way abusive relationships can tend to last and how we understand that...What are your thoughts on that?

199. Sue: it's it's what he's choosing to behave like that, he's choosing to abuse them, to disrespect them, to terrorise them. It might not look like that through his eyes but that's the reality of what's happening

From this perspective, male perpetrators behave in ways that they consider acceptable, but others see as manipulative and consciously chosen as a means to hold onto power and control over a woman. Women's violence or abuse is by contrast seen as reactive and an emotionally driven response to a man's abusive behaviour, or, to fear of the likelihood of a man being abusive, as this extract illustrates:

Extract 101

125. Sue: I It was just an instance where the women were concerned that made me realise how um they just went straight in on the attack as adults if they felt there was er any likelihood at all whereas that doesn't happen with the men as a rule um it um

126. JL: It's different?

127-129. Sue: Yeah um maybe they when push comes to shove even if it's a domestic violence divorce lawyer they can still claim they've tried every other way of getting their own way so there is that with men sometimes that comes about here. He'll try and disguise the words and try and make it sound like equality(laughs) It's something that they hold onto, is you're right, that's it and you know and I say well if you are convinced you're right, why do you have to convince her? Why do you have to bully her? What's all that about? Can you agree to differ? It's about making choices in dialogue in terms of which is your priority. Is it winning the argument? So they all say oh no, no it's resolving it (laughs) and then they'll say, I need to win though (laughs). So it's getting out the tweaking out these issues that er are buried.

The role of a therapist, from this perspective, is represented here as almost like that of a lawyer, unpacking a faulty argument in order to prove a point which is already known. This participant had many years' experience of working with both male and female 'perpetrators' and spoke about repeatedly hearing skilful attempts by men to deceive others about their real intention to win and use whatever means to do so. However, there is no awareness here of the inconsistencies in her own arguments. From the same feminist perspective, 'survivors' and 'victims' tend to be perceived and treated as not having control over their lives and not being able to exercise choice. A commonly expressed view as we saw in Theme 1 and re-visited here in this extract, is that 'survivors'/'victims' do not have choices:

Extract 102

> *109. JL: ... one of the issues in the literature is is in treading that kind of line you're talking about. Some feminist writers say there's a risk of blaming them too. What do you think about them repeating their experiences?*
>
> *110-111. Dana: I would say you never blame yourself because people this is where my old hat of studying sociology of that person comes in which is that you know what's your environment and stuff so-o the only time you can do that is if I've had full control over my life and I've been given all of my options and then I'm choosing them then maybe I can be (blamed). Some really haven't had choice*

Some participants made a distinction between the 'reality' spoken about above of 'victims' not having choices and them not knowing that they have choices. In the following extracts one participant explains that, *'logically'*, it is the 'not knowing' that removes the capacity to choose. Here we see how taking a position that someone does not know they have choices can provide a justification for 'victims' not blaming themselves and for others not expecting them to take responsibility. This way of understanding choice and agency could provide a rationale for working with 'survivors' or 'victims' on enabling them to recognise they do have choices, as illustrated in the first extract:

Extract 103

> *58. JL: ... Thinking about you as the therapist what is it do you think that enables you to engage with this client group (...)*
>
> *65-66. Sara: I wouldn't want them to go away feeling that they've failed because maybe they've not you know it's not worked out and it's not what they want at this time. Yes so really leaving it open for them as well because with DV they often feel they don't have choices so again it's already starting to make them know that they do have choices and even if it is something that somebody's suggested and it will help*

Extract 104

> *151. JL: ...people who have repeat relationships, they're going into relationships that she can hear are going to be abusive again and working with that and the difficulty of doing that and about blaming. What do you think about that?*
>
> *152-153. Ann: We don't ever I mean obviously to be honest with you most of our clients blame themselves and say that they should have left earlier or they didn't recognise the signs, but it's we'll sort of say to them that you only know realistically you we all have choices, but actually, logically you only have a choice if you know you've got a choice and when you're in a domestic abuse relationship you don't know you've got choices, then you haven't got them really.*

There is an assumption in these two extracts that clients in DVA relationships who have been in receipt of violence or abuse are stripped of choice, reflecting ideas elaborated in Theme 2 regarding the impact on self-esteem. Those who understand the behaviours of victimised clients as resistance, however, as we saw in Theme 2, position 'victims' as challenging their victimhood by responding in ways that are chosen and active, even though

their options may be limited. The consequences of understanding 'survivors' or 'victims' as not having, or not recognising that they have, choices, on the other hand, is to position them as powerless to help themselves or their children. This could mean, as illustrated in this extract, that agencies can justify making decisions for them, for example, where children are at risk:

Extract 105

> *181. JL: There's one question that is the way abusive relationships can tend to last and how we understand that...What are your thoughts on that?(...)*

> *191. Sue: so social workers these days are cracking down more and more if there's abuse in a relationship and saying to mums, you've got a choice, him or the children, unless he gets help the children are at risk.*

In this extract, we see how the idea that 'victims' have no choices can be turned on its head, when women may be asked to make a choice between their partner and their children where DVA puts the children at risk. A man's failure to get help can thus be couched as the woman's fault, when she is positioned as choosing for both the partner and the family, reminiscent of the mad hypothesis, referred to in Sub-theme 5.

6.7.3   When women respond violently to a disparity in the balance of power

> *Dede: ...there is a real disparity in the balance of power (52)*

Exercising choice may be understood as determined by how much power a person has to make decisions in their relationship. From this perspective, a power imbalance in a relationship could contribute to a person seeing themselves as without choice even when others might perceive them to be exercising choice. Some participants spoke about both 'victims' and 'perpetrators' as not making choices or knowing why they behaved in the ways they did. For women, this may be explained in terms of their relative powerlessness creating subtle, but pervasive, inequality in intimate relationships meaning that they stop thinking. The following extract illustrates this view that there is a long-standing socially accepted disparity in the balance of power as between men and women, reflected in intimate relationships:

Extract 106

> *51. JL: and it sounds complex and very nuanced to negotiate that*

> *52. Dede: Yes it is um because the what happens with the work is that there is a real disparity in the balances of power and these are old words but they're nevertheless very important because they're so subtle. What that does to the survivor is it wears them down. Their thinking becomes encapsulated by the person who's got the power, so they stop thinking for themselves and they disengage to a lesser degree of finding ways that they can possibly do other*

things, they get taken away from it and it's very very important to start to separate that out so as the two are not one

Expanding on this feminist perspective, the same participant proposes that neither men nor women wanted to be violent and in both cases it was '*put on them*' by powerful social mores regarding gendered behaviour:

Extract 107

> *46. JL: ... I was wondering if you could elaborate on on what you would see as the controversial element. (...)*
>
> *65-67. Dede: what we've noticed in this work is that the females start to take on the role of the male's way of dealing with things, which they don't understand because when we ask them questions like, what do you think's going on, she didn't have a clue you know, but he's been violent to me, so this is how I'm now being. So this internalised rage process somehow gets acted out in violence whereas if we say were you choosing to be like this, it's one thing if you if this woman is saying I'm absolutely going to crown him this is what I want to do, they say no I don't want to do this, I really don't. So then you've got almost like this helix effect where the men are saying I really don't want to hurt her and she's saying I really don't want to hurt him but somehow these two are behaving in a way that I believe is uncharacteristic to either of the genders. I think it's been put on them.*

Here both men and women are positioned as without choice, influenced by social and cultural forces beyond their awareness that infiltrate in subtle ways, leaving them acting like automatons. From this perspective, when women retaliate it is not with intent but, like a reflex, an automatic response that unconsciously copies male behaviours. The implications for therapists of this way of understanding DVA is that they need to help raise both men's and women's awareness that they are both being controlled by social norms and values that create forced positions for men and women in relationships.

Lack of awareness of their choices may be used to explain how it is that female 'victims' could end up 'possibly leaning towards being a perpetrator'. When women do not feel they have power in relationships to express their point of view, or the experience of learning to do this, they could become angry and abusive as a consequence. The first extract provides an example of how female abusiveness could be explained and excused when women do not know how to express anger in a controlled way:

Extract 108

> *302. JL: That's another area where there are a lot of strong views that um we shouldn't call it anger management (...)*
>
> *304. Ann: she's experienced DA from her family when she was young and she is so angry you know so much so that you know the last couple of relationships she's had she's ended up possibly leaning towards being a perpetrator because she's so angry about what's happened and it she doesn't know how to express*

196

that in a controlled way and it's almost like you know nobody's going to do that to me again, nobody's going to treat me that way again and it just comes out in this errr because she doesn't know how to express herself

The reluctance many participants expressed of ascribing the term, 'perpetrator' to a woman is illustrated here. When women behave abusively, as we have seen in Theme 2 and 3, their behaviour may be spoken about as if they have been victimised and unwittingly scapegoated by their partners or society. As we have seen in this sub-theme women's abusive behaviour might be defended when positioned as '*leaning towards*', or '*finding themselves*' as '*somehow*' acting in abusive ways that are uncharacteristic and not chosen. The following extract illustrates a view more commonly claimed by male 'perpetrators', that women who behave abusively may lack awareness of their emotional responses and so not know they are angry.

Extract 109

> *70. JL: Ok so you're saying they don't really know why they're doing it?*

> *71. Dede: They don't I mean some don't even know that they're angry. It shocks them because if they haven't been in therapy you know there's no kind of reasoned process of you know this person did this this and this to me and I'm wondering why I'm not going to belt him I'm going to belt somebody else.*

Whilst pointing to the value of therapy in raising awareness, this extract also seems to suggest that women experiencing DVA are unable to reason and may behave in violent ways to partners because of previous experiences of abuse that they have not been able to think about. Though this is reminiscent of explanations of male violence used by some male clients and commonly disregarded as denial, when used to explain female anger it operates to excuse or defend their behaviour. In so doing, women are presented as not choosing to be violent and the culprit is a society that inflicts expectations on both men and women, which they act out unwittingly.

6.7.4   Summary of sub-theme 6

As we have seen illustrated, the potential impact on approaches to therapy when informed by these constructions of male and female behaviours in intimate relationships, is to close down the possibilities for exploring issues of choice, intention and agency for both 'perpetrators' and 'victims', and to scapegoat 'perpetrators'. As we saw too, understanding choice as 'either/or' can be overly reductionist, missing the nuances of perception captured, for example, in Extract 103 and 104, where participants grapple with the notion that people have different awareness of what constitutes a choice. Commonly, participants did not speak about the different ways in which men's and women's choices were conceptualised, suggesting that a 'double-standard' was accepted practice.

6.8   Summary of Theme 3

Sub-themes 1-4 illustrated how dissonance or tensions may arise where the initial naming of the problem is challenged by new information, or new understandings, or where accepted practice does not produce anticipated outcomes (e.g. Extract 11). This was exemplified when a therapist moves beyond the initial assessment, gets *'into the work'* and contradictory information arises such as hearing that a female 'victim' had also perpetrated violence (e.g. Extract 37). The extracts provide further examples of how tensions and dilemmas can lead to a sense of struggle, or impasse in the therapeutic work, though sometimes this was implicit in participants' talk and not explicitly acknowledged. As was illustrated, where approaches to practice are principally dependent on definitive notions of what is right or wrong which de-contextualise acts of abuse, tensions may be resolved by prescriptive responses that, in effect, scapegoat one partner, and avoid or minimise the importance of issues that do not fit with the initial understanding of the problem.

The incidence of female aggression, or evidence of mutual abuse in couples, could be seen as representing a challenge to understandings of violence as gendered and constructions of women as passive (Extracts 1 and 2), though many participants' views seemed unaffected. There were differences in the way participants responded to these issues and positioned themselves in terms of their understandings and the delivery of the therapeutic intention to help their clients, and what they 'knew' about their own practice. These differences were illustrated in the questions and dilemmas that can arise when thinking about issues of responsibility and choice in respect of both 'victims' and 'perpetrators', with regard, for example, to what people 'know' about their behaviour and the extent to which they can be construed as making conscious choices (Extract 48, 50, 51, 107; Theme 1, Extract 21). Resistance to an explicit positioning of 'victims' as responsible for their choices was noticeable in the naming and decoding processes, when lack of self-awareness could justify 'victims'' behaviour but not 'perpetrators'', and when allocating responsibility could become conflated with blaming 'perpetrators'. Some participants placed responsibility entirely on the named 'perpetrator' (Theme 2, Extract 21; 6.6.2 103. Helen) and, as we saw in Theme 1, spoke of 'victims' as not being aware that they were being abused (Extract 1).

Further into the work, concerns about not wanting to blame those who have been victimised could result in the excusing of abusive behaviours by victimised clients, as in the following examples: retaliation by 'victims' might be excused by being re-framed as an unthinking response (Extract 107), or, a justifiable act of revenge to create a *'level playing field'* (Extract 5), or to *'get one back'* (Extract 91). When victimised clients were seen as 'knowing' that they were being abused, and making understandable choices - a position taken by only one of the participants (Theme 1, Extract 21) – this could also create a double-bind, when an acknowledgement of agency might seem to also blame the 'victim' for an

irresponsible choice, with regard, for example, to putting children at potential risk by remaining with a violent partner. This dilemma is also illustrated in the same participant's rejection of narratives about 'why women stay', with a counter assertion that most women leave and, those who don't, only stay because they may be killed if they leave (Extract 66). Nevertheless, these dilemmas were not identified by these participants, who appeared to avoid the experience of dissonance by taking a judgmental stance towards 'perpetrators.

A positioning of people as choosing to be 'victims' is easily understood as an anathema, since the idea that someone chooses to be harmed contravenes accepted social understandings of what is normal behaviour in a relationship. When therapists focus on a 'victim's' options they risk seeming to pathologise the behaviour of those who stay or return to partners who have been abusive, and, let the 'perpetrator' off the hook, so-to-speak, as we saw in Sub-theme 3. Alternative constructions of women as starting to take on the role of the *'male's way of dealing with things, which they don't understand'* can provide a rationale for why they be excused for their abusive behaviour rather than be held accountable (Extract 107). However, when 'victims' are positioned as powerless to choose we see how this can close down the possibility of understanding the meaning of their behaviour as other than reactive and may serve to reinforce stereotypical social constructions of women.

Awareness of the sensitive nature of these issues, particularly with regard to recognising the responsibility and choice of clients, and the tensions and the trickiness in managing them without seeming to 'victim-blame', or excuse 'perpetrators' were features of most participants' talk, though they differed in the extent to which they reflected on their own choices and the implications of these. These tensions were commonly expressed in contradictions, excuses, justifications and minimising, or missing narratives, reflecting the complexity of the issues and differences in participants' awareness of their struggles to maintain a consistent world-view, engage in ethical practices with their clients and manage the impact on themselves of the disturbing material clients might present. This contrasts with the apparent simplicity of a single explanation of DVA as a gender issue, mapped out in Themes 1 and 2, and brings into question the effectiveness of current structured approaches to re-educating 'perpetrators' which discount the relational context of DVA, and approaches to working with victimised clients which do not address issues of responsibility and choice.

CHAPTER 7: THEME 4: HOW THERAPISTS TAKE A RELATIONAL PERSPECTIVE: DEVELOPMENTS AND CONTROVERSIES

Ann: So it's all relationship stuff whether it be the relationship with themselves, their children, friends, family, their ex-partner, their new partner (176)

Eva: … the emphasis on understanding the relationship as opposed to the single separate detached incident (127)

7.1   Introduction

In Chapter 5, Themes 1 and 2 illustrated how DVA was talked about by participants when understood as a gender issue. Understanding was commonly framed by issues around naming the presenting problem and deciding what was a relevant focus for therapeutic intervention, captured in the themes, Naming the Problem and Decoding the Problem. Gendered understandings that prioritised the safety of women and children and the holding of male abusers to account were recurrent in many participants' narratives and explanations of their practice. These dominant ways of representing the problem and intervening could be conceptualised as 'either/or' uni-directional approaches, commonly targeted at changing the beliefs of male 'perpetrators' and empowering female 'survivors' or 'victims'.

Chapter 6 provided an account of what may render 'either/or' approaches to DVA problematic, suggesting that a single explanation of the phenomena was overly simplistic. Indeed, some participants' talk illustrating the tensions and challenges faced in their practice, both explicit and implicit, provided a rich and striking illustration of the complexity of the issues. Nevertheless, the theme also provided examples of how concern not to be perceived as victim-blaming, or excusing of 'perpetrators' behaviour, could unwittingly close down opportunities to expand the picture in order to explore these complex issues of responsibility and choice for both men and women, and to understand the relational context of abuse. It was common across the data that gendered discourses about power and control were drawn upon to explain violence and abuse, whether perpetrated by men or women or construed as retaliatory or defensive; resulting tensions between theory and practice, often not acknowledged, were illustrated in examples of practice interventions that did not achieve anticipated outcomes with both male and female 'perpetrators' and might disempower female 'victims'. Furthermore, when participants unknowingly experienced double binds and became stuck, like their clients, scapegoating one person might seem to resolve questions of responsibility and choice and simplify the issues.

In this chapter, 'either/or' approaches will be problematised further by looking at the implications for practice of expanding existing ways of understanding and working with DVA. More specifically the aim of this chapter is to examine a latent discourse illustrated by

a few participants that brings together feminist thinking and relational approaches with the intention of developing more integrative theories and more effective practices. An attempt is made to map out some of the principles of a relational approach and to consider these in relation to those less common practices that are spoken about by a few participants and as an alternative to 'either/or' approaches. Theme 4 is structured in a similar way to Theme 1: the sub-themes consist of 2 constructions of DVA and 3 conversational therapeutic tasks that take place when DVA is understood from a relational perspective:

Sub-themes 1 and 2 Constructions of DVA: principles and theory of a relational perspective

Sub-themes 3, 4 and 5 Conversational Tasks: how therapists talk about their practice when taking a relational perspective
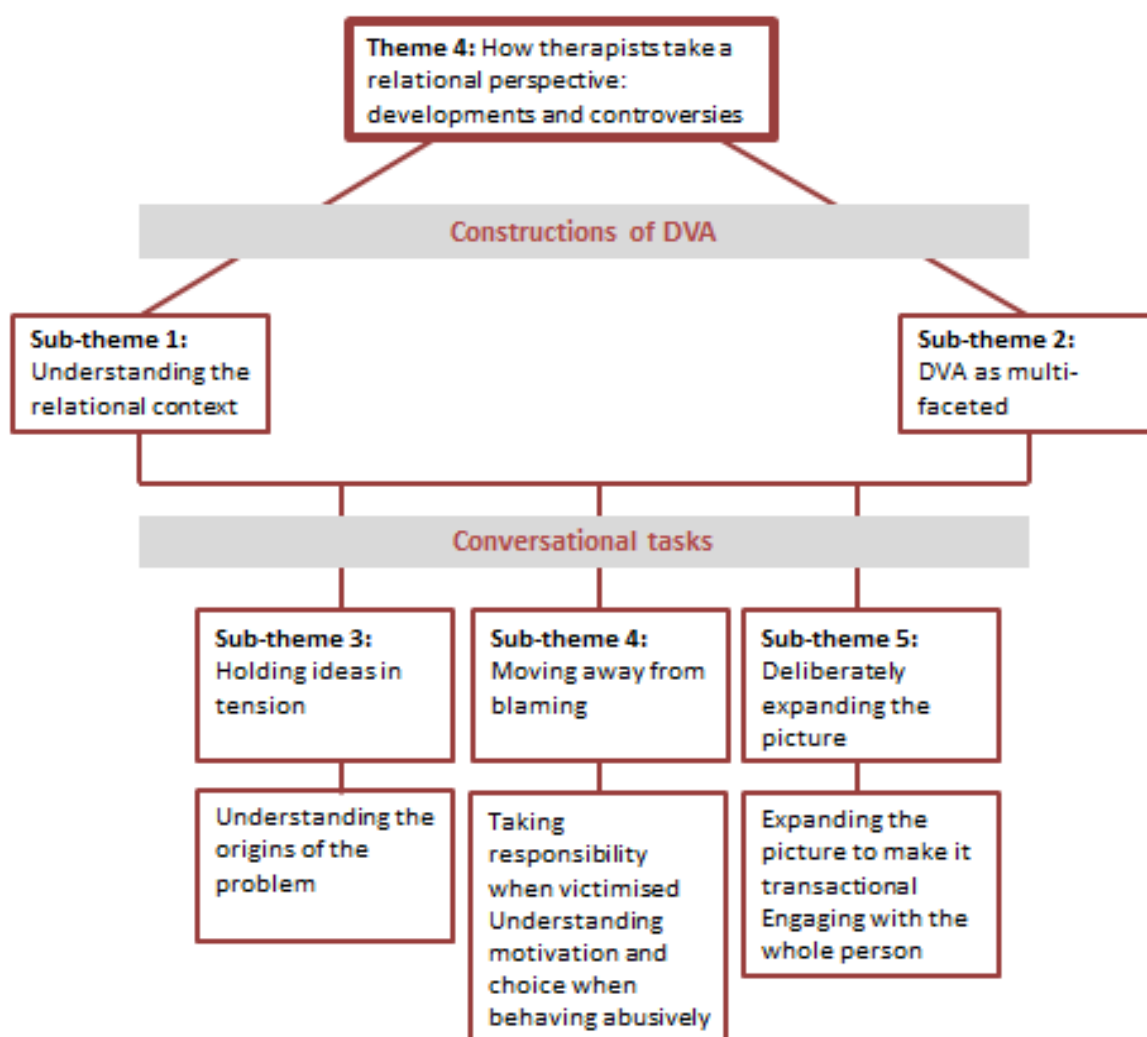
Figure 7.1: Theme 4: How Therapists Take a Relational Perspective: Developments and Controversies

7.2 Sub-themes 1-2 Constructions of DVA: Principles and Theory of a Relational Perspective

7.2.1 Sub-theme 1 Understanding the relational context: working at the intersection of the social and individual

> *Jay: It's not an individual problem, it's not a social problem, it's that interaction (27)*

> *Jay: you know human relationships are really really complex and this is a human relationship problem in my view which is then you know impacted on by all the other issues but at the heart it's a rlps between 2 people who are feeding and hurting each other on all different levels and that's where it needs to be looked at I know that's controversial but to me it's a relational problem which is impacted on by all the other issues so they are at the centre of each circle which gets bigger and bigger and also I think the DV has an impact on the whole family (34)*

As we shall see in this theme, when approaching DVA from a relational perspective the focus is on how people relate intimately and how we might begin to understand the process by which interactions that generate conflict can result in physical and psychological damage to one, or both, partner(s). Minority views will be mapped out, that reject the positioning activities typical of many therapists when adopting prescriptive approaches, which dominate current thinking and practice, and determine the provision of services mainly for male 'perpetrators' and female 'survivors/victims'. From this perspective, there is need to seek a different level of understanding, conceptualising DVA not as primarily a social or individual problem, but as an interpersonal problem, providing a contrasting view to the position taken in Theme 1, Extract 6, that DVA is not a relationship issue. This invites the application of theories that attempt to explain what motivates people to be intimately attached to another and how dependency on an intimate partner can provide emotional security, but also activate intense emotions of both love and hate. A number of participants spoke about attachment as a human need to bond to others, and that this could result in unhealthy attachments that are abusive but strongly bonded, as illustrated in this extract:

Extract 1

> *83. JL: Ok something I wanted to ask you was um something you said earlier about um how we understand the way abusive relationships can persist. What do you think about that?(...)*

> *95-96. Dede: they want to stick with the relationship, they don't want it to break up, again it could be for all sorts of unhealthy attachment reasons but there is behind that as well I think a very organic way that humans link together and attach themselves and bond to each other. It's very powerful. We do it all the time you know if you're on the train with someone for half an hour. We do it all of the time, it's it's in us innately*

The need for humans to connect intimately is assumed and made explicit in this extract, where the use of '*we*' emphasises the shared experience and needs of therapists and clients, who demonstrate this need to bond with others '*all the time*'. In this re-description of DVA as a human problem it is implicit that there is a similar motivation behind all attachment behaviours, whether healthy or unhealthy, and thereby moves away from a positioning of the therapist as expert in defining what counts as abuse, though the tension here between what is 'innate' and what is constructed is not explored. A few participants drew more explicitly on attachment theory to explain, or normalise, difficulties in relating that could engender abusive behaviours. The following extracts illustrate attempts to integrate attachment and feminist perspectives, to explain both men's neediness/jealousy and women's toleration of men's abusive behaviours even across several relationships.

Extract 2

> *99. JL… referring to the literature that that one of the issues that comes up is whether there's a need to understand why abusive relationships persist. What do you think about that? (…)*
>
> *104-105. Eva: I think it is it is a cycle and and I'm also thinking of um people who tend to repeat several several um kinds of relationships. Now I wouldn't say that that person would seek to be um um to be battered or um obviously not, but I I would tend to say that um some kinds of relationships might feel safer for some persons um maybe out of fear of doing something different. So let's say someone grew up in a violent relationship um I think that there's a greater chance that that person might end up in a similar kind of relationship and that's not because she actively seeks it um but because that's a pattern that's quite ingrained and possibly hasn't had this modelling of a different response to violence.*

This participant draws on psychodynamic theory to explain a client's experience of repeated abusive relationships. There is a careful re-positioning of the person as '*obviously*' not choosing to be '*battered*, but rather choosing relationships that are familiar and so feel safe, even though they are evidently not. The following extract illustrates a related idea that abuse occurs in relationships where the patterns of behaviour are characterised by neediness, when both partners are insecurely, but strongly attached, and issues of closeness and being separate are problematic:

Extract 3

> *55. JL: So how does using the terminology help? (…)*
>
> *59. Ian: they're often co-dependent relationships and where both people have got insecure attachment and they're very needy it can make for a very strong and very unpleasant relationship- a very violent one which explains why women can be assaulted more than 30 times before telling someone else about it. They must be getting something out of the relationship it suggests. If for instance she doesn't the woman doesn't have insecure attachment, isn't very needy then the the relationship could be a lot more shorter because she's not going to tolerate it cos we don't (laughs). If we don't need to be in a relationship we walk away*

from it. Um so it helps them to understand the dynamics of it and what's going on

From this perspective, it is assumed that women who *'tolerate'* abusive relationships may be getting their needs met. In this way, female 'survivors/victims' are positioned as not understanding the relational dynamics which maintain the abuse, rather than not knowing that they are being abused, a view illustrated in Themes 1 and 2. When the experience of a victimised client is understood in the context of seeking attachment, and there being something functional about such a relationship, arguably this, in turn, creates a context for exploring their motivation and choices, and moving away from blaming, as we will see in Sub-theme 4. It also presents an alternative to the views, expressed in Theme 1 and 2 that DVA is best understood as a gender issue.

Another participant uses an explanation that seems to integrate the concepts of power and control with psychodynamic ideas about abandonment and separation, in order to explain how abusive relationships might achieve a kind of *'perverse'* intimacy:

Extract 4

78. JL: What do you think about um I guess the feminist view that it's about power and control?

79-81. Lyn: Um well I think it you know it is about power and control there is obviously an element of that in um but I think quite well my my understanding of it is that quite often it's fuelled there's something and again I don't want to generalise cos I do think it's it varies a lot depending on who's involved um but what I've noticed is that there's often issues of separation you know denial of separation so the man is you know often very controlling and jealous and all that kind of stuff and obviously that is fuelled by fear of abandonment so it's a sort of sometimes it can be an attempt to control the woman in terms of keeping her close um and that that that the viol the physical contact somehow (2 secs) I suppose it well first of all the the actual sense of being able to control that woman's body gives you (unclear) they'll not you know they won't leave you've got them but also you know I I've often wondered whether there's something about the physical contact um that is actually quite I mean in a perverse way it it's a way of feeling closer

We get a sense here of ways in which psychological issues can both be manifest, and find a perverse resolution, in the expression of abuse/violence itself as a means of achieving closeness and keeping someone close. This elaborates on the point made in the previous extract, by beginning to try to understand the problem, theoretically, from the individual perspective of a man who is apparently trying to control his partner. In the next extracts, there are examples of two participants taking a feminist-relational approach to understanding men's maltreatment of women. From this perspective, an explanation of how violence might escalate is illustrated:

Extract 5

> *188. JL: There's one question er again there's quite a bit in the literature about why abusive relationships persist and that we need to understand why they do in order to kind of work with them*
>
> *192. Ian: I think it's a co-dependency, the worse a guy treats his partner the more convinced he is she's going to find someone who'll treat her better so he has to restrict her, you know what she wears, who she talks to*

The man's behaviour is conceptualised here as an attempt to stop a partner leaving. It is implicit, however, that the man who mistreats his partner has some awareness of the impact, and, perversely, heightens his efforts to control her because he can see that she becomes more likely to leave him. The following extract illustrates similar ideas, but is more equivocal about generalising, reflected in the use of '*sort of*' and '*some kind of*':

Extract 6

> *43. JL. How do you explain why they do that? (...)*
>
> *47-51. Beth: they do that to um dominate they do that to try and control their environment um and the problem with it I mean I think the first problem is is you know I mean it's very narcissistic really they that's the first problem is that they see their then it's a sort of an attachment problem, they see their partners as objects, part objects of themselves I think you know and and so you know, how dare they not behave in a way that I need them to and want them to so I see the basic problem and you know again the reason I laughed at the question is I think it's so big and I think there are really very individual reasons but I think you can generalise to some extent and in my experience there is some kind of insecure attachment stuff happening and probably has a historical root.*

As these extracts illustrate, a key way in which a relational perspective would differ from ways in which the problem was named and decoded in Themes 1 and 2 is in locating the problem in the dynamics of the relationship, rather than focusing on one person. There is also a recognition, expressed in Extracts 4 and 6 that individual differences contribute to reasons for DVA occurring. Expanding further on this approach, with the aim of developing an understanding of both the individual's history and the socio-cultural context, one participant speaks about how this would require starting from a position of working at the '*intersection*' between the social and the individual. From this perspective, causal explanations, locating the problem either in an individual, or in culturally prescribed gendered norms, may limit our understanding by focusing on one aspect of the problem and offering only a partial explanation. When the starting point is one of not knowing what the problem is and how it began and the focus is widened to take account of the interactions between different factors that may affect an individual's life experience this may facilitate the development of more nuanced understandings. This thinking and approach to practice is characterised by a holding in mind of both gendered and individual aspects of a client's experience with the intention of exploring how they interact rather than foregrounding one

and not taking account of the impact of the other. This point is illustrated in the account below:

Extract 7

20. JL: Ok. If you had to um pick out the main aspects to this new model what would you say they they are?

24-26. Jay: what we've taken maybe further is that we've seen domestic violence is not a social problem and it's not an individual problem it's the intersection between the two and I think you must work on that level and if you strictly go on the social level and talk about gender and all that you miss the individual aspects and if you only look at the individual as in standard therapy you miss all the cultural, social and other gendered aspects so I think I think what everybody's doing now is thinking more deeply and looking at those intersections and to me this is absolutely where we have to go.

Single gendered explanations of DVA may not provide an adequate explanation of abuse across a multiplicity of relationship contexts, which include hetero-sexual and homo-sexual relationships. When individuals' expectations and social and cultural mores differ, the complexity of different kinds of relationships becomes apparent and it becomes important to understand the context within which abusive behaviours occur. The focus of therapeutic work would then be on the meaning of the abusive behaviour for the individuals involved, including culturally prescribed gendered injunctions that may influence this. In this way, constructions of DVA as relational in origin can enable a move away from imposing the therapist's view of what would be a healthy relationship, or allocating blame, as illustrated in the extracts below from a few participants who spoke about the issue of context:

Extract 8

126. JL: Is there anything else about the service ... that you'd like to say, to express views about?(...)

147-148. Jay: People are not the same in every context and I think what we're saying is that you know his behaviour at work or at the football or whatever might be much different to his behaviour at home and it's not right or wrong that's not what I'm saying but I'm just saying that if you don't understand that you will fail to be able to help...

This provides an alternative understanding of male behaviour to the ideas expressed in Theme 1, where from a gender perspective men were understood as having control over their behaviour and, therefore, were choosing to be violent and abusive to their partners. Here the speaker voices a controversial view, not expressed by other participants, that a person's behaviour may differ across context because different relationships have different emotional saliency. So, from this relational perspective, an abusive behaviour, though wrong, is not necessarily done deliberately, or, dispassionately. Cross-cultural differences in expectations and conventions regarding relationships and gender behaviour can also mean

that what counts as a satisfying relationship can vary, whilst there may be universal *'ingredients'* as illustrated in the next extract:

Extract 9

> *109. JL: How do how do you work with that with the women or men er in terms of what is a healthy relationship when they're coming from ones that are destructive? How do you work with that?(…)*
>
> *111-12. Dede: what I certainly encourage is for people to find out a bit about what they want you know to actually look at what that means for them because we're not telling them what a healthy relationship is, we might have our own script of that but we're not suggesting that you know that's the only one. What we're asking them to think of is what's ok for them. What's acceptable to them, what what feels er fulfilling, satisfying for them, then what can they manage because you know culturally we work with a lot of very diverse cultures here and somebody's view of marriage and relationships in one culture might not be the same as another, although there are I think fundamentally there's human ingredients for all you know the care, support, the kindness, there are all of these considerations within the exchanges of the relationship and the gender and how they re relating.*

The idea expressed here is that when the relational context and cultural diversity are taken into account, a therapist might work more overtly with, and be more accepting of, the concept of difference and what relationships mean to a client, whilst identifying some core components of a 'good' relationship. There is a difference in emphasis here from accounts in Theme 1 and 2, where some participants voiced the intention of not following their own agenda with victimised clients as they wanted to give them choice and empower them, but, nevertheless, engaged in attempts to shift their clients' thinking and choose healthier relationships. Being explicit about focusing on the meaning of violence in the context of the relationship can also be seen as enabling a therapist to move away from 'either/or' ways of thinking and working, as illustrated in this extract:

Extract 10

> *87. JL: … I'm wondering what you'd say best enables you to work with this client group either with perpetrators or victims?*
>
> *88-89. Eva: Um (8 seconds) let me see well I think what has helped the thing that's helped me most is um this understanding of violence rather than seeing it as quite separate from and and detached from the rest of the relationship, the rest of the client's past and so on. I try to understand the meaning of the violence and that frees me up from this bad/good/ blame/wrong/right. I think understanding is what has helped me both personally and with the clients yeah*

However, when the safety of a client is a concern it was a commonly expressed view that risk should be prioritised and for many participants a relational approach was considered inappropriate, as in the extract below where the participant speaks of how she *'can't afford really … to just go with the relational'* in some contexts. This highlights how the organisational context in which a therapist works affects the kind of referrals made and

influences the approach of the therapists. If we take the view that meaning and understandings are co-constructed by the partners in a relationship, it follows that the therapeutic relationship and context in which the therapy takes place are also implicated in the meaning-making process and that there may be differences depending on whether the work takes place in a statutory, voluntary or private context. For example, as illustrated below, therapists may expect to deal with more risk issues when referrals come from domestic violence agencies than other organisations and there may be more pressure to hold in mind the safety of the other when working with a person who has perpetrated violence and abuse:

Extract 11

> *37. JL: I was wondering as you were talking what theoretical models you draw on to inform your understanding? (...)*
>
> *52-55. Beth: In my private work of course being integrative and somewhat psychoanalytic um certainly psychodynamic and working with attachment and more things like that um I would in a way the work here is always a balance of because you're not just working with the wounded which predominantly you are in straight psychotherapy practice, you're working with the wounding as well and and you alw that has to be paramount in your head because also there's a there's very much a kind of triangle really where you're you know the the the predominant need is for safety so you always have to have the partner in mind in the room so that's very that's very different to working in private practice. I mean of course everyone has their their relationships um but you you don't specifically have that remit really that you you're all the time you've got the partner in mind because so I can't afford really (2 secs) to just go with the relational in terms of you know I always have to put it in context*

Whether therapists are working with clients in receipt of, or perpetrating DVA, they may be holding the other partner in mind when assessing risk, though not taking a relational approach, as we saw in Themes 1 and 2. As we see again illustrated here, when there are risk issues, therapists may consider more prescriptive approaches to be appropriate. The participant's own tension about managing risk is 'resolved' by externalising this as determined by differences in organisational 'remits', thereby justifying changes in her practice across contexts.

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7.2.2 Summary of sub-theme 1

Conceptualising intimate partner violence and abuse as uni-directional creates a rationale for interventions being targeted at either a 'survivor/victim' or a 'perpetrator', reflecting a causal approach to understanding the problem and down-playing the relevance of the relational context in which abuse has occurred. When DVA is conceptualised as an interpersonal problem, understandings may also be informed by both gendered theory and other theories that seek to explain individual differences in attachment behaviour. This re-description of DVA as arising from difficulties in relating intimately invites therapists to

explore the motivations and choices of victimised clients who remain with abusive partners they love, and of clients who behave abusively, for example, when fearful of being abandoned by a person they love. The shift in focus, foregrounding the relational context and the meaning of abuse, recognises the particular saliency of intimate relationships, moving therapists away from constructing blame and a positioning as experts in determining what is right or wrong behaviour. There is also a move away from conflating understanding with excusing abusive behaviour, towards a less prescriptive approach to what counts as DVA, that nevertheless does not condone actions that harm another person, whether intended or not, and continues to keep safety issues in mind.

7.2.3 Sub-theme 2 Conceptualising DVA as multi-directional and people as multi-faceted: seeing both sides of the transaction

> *Helen: ... I think um if you're working with those issues you've got to understand the complexity of them (117)*

> *Dede: I think it's important to inform ourselves intellectually about the complexities of relationships um and not be fixed in what just our experience of working is (147)*

> *Eva: yet sometimes I think there is a an interesting dynamic where one partner is abusive to the other and vice versa so um I think one could um try to take power and control in different ways (23)*

> *Ann: ... I always said if I smacked a guy if he smacked me back then surely that's cos I smacked him first you know so I shouldn't have smacked him then he wouldn't have smacked me (310)*

7.2.4 Introduction

In the previous sub-theme, we saw how, theoretically, holding in mind both gendered and personal aspects of a person's experience can shift the starting position of the therapist from more prescriptive practices that name the problem as either a gender issue, or, as resulting from the pathology of the individual, to a focus on what is happening between the two partners in an intimate relationship.

In this section, we see how working at this intersection and expanding the focus from the individual to what is going on for a person in the context of their relationships could open up the potential complexity of the problem. This perspective represents an alternative to practices premised on cause/effect understandings of abusive behaviour in intimate relationships, and based on fixed ideas about what men and women are capable of. It suggests that interventions informed by 'either/or' approaches could be limited in scope, oversimplify the issues and produce only partial solutions, as we saw illustrated in some of the dilemmas participants spoke about in Theme 3.

Therapists taking a relational approach would aim instead to start without preconceptions about men and women, remaining open to listening to the experience of each person of their relationship, in order to enable the complexity of the couple dynamics to become apparent. This was a position taken by a few participants and is illustrated by one participant who elaborated on this approach in the two extracts below.

Extract 12

> *110. JL: So what do you think about the kind of gender paradigm debate that goes on in the literature?*
>
> *111.-114. Jay: … I think that we have you know millennium of history showing that men abuse women at a hugely greater rate than the other way um I think that we also know that women are capable of being abusive to their children and to their partners. It is innately possible for anybody to become abusive I think um and I think that it's important that we recognise that women can become abusive as a result of being abused because of the reaction and I think it's important we recognise these women are in pain and need help and we'd like to offer them services and I think it's important to recognise that some women are just not very nice (laughs) you know bottom line some women are abusive and they for whatever reason same as men you know they've just turned out to be abusive characters*

Here the argument is made, with a number of repetitions of it being important to *'recognise'*, that both men and women are innately capable of behaving abusively, although in the main, men may abuse women *'at a greater rate than the other way round'*. Whilst some women may become violent as a reaction to violence from their partners, others may, like men, be *'just not very nice'*, and initiate violence. This presents a view similar to the idea of there being degrees of abusiveness, illustrated in Theme 3, Extract 20, suggesting something like a continuum of abuse, with some men and women at the extreme whose behaviour is pathological and who are innately 'not nice' people. The same participant goes on to talk about the need, therefore, to suspend judgment initially and keep an open mind as to what has been going on between a couple, so the complexity is not missed:

Extract 13

> *126. JL: Is there anything else about the service … that you'd like to say, to express views about?*
>
> *130-3. Jay: I think that's something I think we do very well here you know that we're aware of it. I think it's really one of the really big strengths of our model is that we can recognise that every couple has a different dynamic in it. It isn't this or that, it's every individual every couple has a different dynamic and that what we're looking for is what's going on for that person and that couple. We don't come in assuming we know all about what's happened so I think that's an extremely important starting point so that you can actually have your mind open to what's going on for that couple because we do have mutually violent couples. We do have couples where the woman is actually the dominant abuser. We do have couples where they switch and I think that you know if you have a model*

that's very fixed that says this man is this and this woman is this and this is how we're going to deal with it you will miss out on a lot of that subtlety and nuance

In this, and, in the following extract, individual differences and the potential for there being different kinds of relationships are emphasised. Both participants speak about the multi-faceted aspects of both men and women, manifest in the capacity of both men and women to 'switch' from behaving abusively to being in receipt of abuse and vice versa, in their experience. Both work in contexts where they hear both sides of the story from a couple where DVA is the presenting problem, and perhaps this enables them to see the behaviour itself in a relational context.

Extract 14

> *103. JL: There's also a debate in the research literature about the extent to which women are violent.*

> *104-10. Ian: I take stats with a pinch of salt but I think some women will be as I say I think it probably switches from time to time as I say obviously men are more violent I mean there are some fundamental differences aren't there? Um (unclear) whereas guys like produce like testosterone you know so there are some basic differences that change how they react in the moment I I say certainly in the control is similar absolutely yes. We hear time and time again because we get both sides because we have women's services as well you know. All er partners of our guys are offered a programme of counselling plus safety planning etc (...) We you know (laughs)we get um sort of 2 sides to everything and often um the services will tell us um actually he's done that and the women's done that, you see they'll do anything to keep that relationship alive even though they've split up...*

Here, the ongoing conflict between a couple, when one or both are receiving support or therapy, is understood as a way of maintaining the relationship, reflecting the theoretical explanations based on attachment theory illustrated in the previous sub-theme. The potential for either client to lie about their own or their partner's behaviour, in order to blame the other or minimise the problem, was a topic in Theme 2 and could be the cause of dilemmas for therapists, as was illustrated in Theme 3, particularly when services were separate. A few participants voiced criticisms about the practice of segregating services for those in receipt of, or perpetrating, violence and abuse: they referred to the implications for therapeutic practice and the potential for confirming and reproducing existing taken-for-granted understandings and approaches to the problem. From a relational perspective, influence works in both directions, transactionally, and this applies to a couple, the therapeutic relationship, and more broadly, between the social and individual levels of abstraction. As the two extracts below illustrate, therapeutic practices have the potential to challenge what may be seen as complacency and suspicion and contribute to creating changes that could impact on a much wider audience.

Extract 15

> *20. JL: Ok. If you had to um pick out the main aspects to this new model what would you say they they are? (...)*
>
> *37. Jay: you can't just look at it as them because they will go out to the bar they will go down to the football they will go to work, they will be hearing these attitudes from all sorts of people, so no matter what you do just with that couple you're going to have impact on all those other people and it works in both directions so I think that's maybe something else we introduced this looking at it in just a kind of a systemic way that you know combines all the*

Extract 16

> *150. JL: Well bearing that in mind I was thinking that um research and practice has changed quite a bit over I think it's about 35 years now since DV services began. I was wondering if there's any change you'd like to see happen (...)*
>
> *152-154. Anita: I 'd like to see DV services working with both parties cos it kind of feels like even here we segregate off, it's a women's service and women work with women and I don't believe that I think um even more recently some of the um counselling funding that we er they go for bids here and part of the criteria was that men weren't allowed to work in the service or to offer support work that they had to go with a woman and it's all this well you're causing suspicion, you're actually labelling that support worker who's a man as a perpetrator really, so it's kind of taking a more healthy look at the way we do things, the way we segregate off that sometimes we reaffirm the belief that all men are bad you know and I don't and all women are victims so I think for me some kind of change in the way we do it where we tackle both sides and more education I think um… I think for women in particular it's to say not all men out there are bad you know that you know there are good men out there, it's to challenge beliefs and myths and and with people who are actively being violent towards um other people it's to challenge them so you know where has this come from, where are these behaviours coming from you know to tackle the other side of it otherwise it's just a revolving door you know I think both sides have to be tackled so whether there's a service out there that would do that I I don't know many, they kind of usually stick with one or the other*

In the above extract, one participant speaks about what she regarded as discrimination against men, when they were not allowed to work in the services for clients who had been in receipt of violence and abuse, and how current practices can, in effect, reinforce existing myths about men as '*bad*' and always being the '*perpetrators*' of DVA, whilst '*all women are victims*'. The suggestion here is that services need to take a critical view of their own practices and work to create healthier relationships within their organisations. The following extract voices this point forcefully, whilst additionally expressing a view not made explicit by other participants, regarding the lack of attention paid to clients in relationships other than heterosexual ones:

Extract 17

> *305. JL: It sounds like from a therapeutic point of view you know that that makes sense to you (...)*
>
> *308-13. Ann: but you know you need to step away from the fact that it's only women yeah and you need to step away from the fact that women are so fucking*

hard done by cos actually you know so are men, so are LGBT people, so is everybody to some extent in the world (...) I always think cos like you know when I was younger I was a bit of a hard nut you know people didn't mess with me and what have you but I always said if I smacked a guy if he smacked me back then surely that's cos I smacked him first you know so I shouldn't have smacked him then he wouldn't have smacked me you know but if you want to be treated as equal like a man and say in a service in an agency and you're saying that you know it shouldn't happen to a woman we should have the same rights as men, then men should have the same rights as women you know you can't just pick and choose that and you can't just for progress you have to move forward, you can't just say poor me you know you have to move forward and incorporate everybody and what I don't get is that when we're all supposed to be in the helping profession(...)and caring industry so who made the rules without telling me that we can only care for one sex.

Here the responsibilities and rights of women who '*smacked*' a guy and then get '*smacked*' back are juxtaposed, and a critical view is taken of women who want to claim the rights of a man and the status of a 'victim' with regard to their responsibility. The extract also voices an idea that female therapists, particularly, as a voice of the caring industry should also uphold the rights of men and the responsibilities of women, by arguing for services to be open to help both. There is again an implicit criticism of services that are segregated or are restrictive with regard to whom they will work with, also illustrated in Extract 16.

When it is usual practice for clients to be seen in separate services, the therapist's endeavour to establish an understanding of the presenting problem is likely to be based on one person's version of their own experience of the events. Whilst, in practice, it may be possible, to some extent, in the therapy context to introduce the missing partner's viewpoint, or hold the other person in mind as we have seen illustrated, having both partners in the room may, in some cases, be more helpful in fostering understanding and communication of different points of view. When DVA is constructed as a relational problem, working with a couple can provide an opportunity to watch the interaction between the couple, and arguably, as the following extract suggests, gain a better understanding of the dynamics. This was a view expressed by a minority of participants, of which one extract is given below:

Extract 18

79. JL: Ok um linked to something else I asked earlier that there's quite a debate as well currently in the literature about whether it's appropriate to do couple work at all with um people who present with abusive relationships. What do you think about that? (...)

81-83. Dee: so if the work that you're doing in the room is only with one, I think there can be some, you can get them to look at the behaviour, you can get them to maybe um get in touch with its origins somewhere but there will be nothing like having two people in a relationship in the room at the same time to watch how they interact with each other, to see the body language, to see the sort of response that they they get from each other. Nothing's going to actually come up to what you get from that as a as a counsellor I don't think. I think you have to be quite boundaried and you need to get your safety plan in place and you know talk to them about what responses they're getting from you and be curious and

interested and if it gets to sort of a level where you feel it's getting a bit um heated then you need to be able to diffuse that and hopefully have enough time to talk about it a bit and see what they're going to do with it when they leave the room and put all those things in place that that are reasonable and sensible and and safe

However, this was a controversial view, as best practice in DVA promotes working separately with 'perpetrators' and 'victims' in order to safeguard the 'victim', acknowledged in the participant's emphasis perhaps on having a safety plan in place and having skills to diffuse '*heated*' exchanges. Furthermore, in the view of most participants, mutual violence, which might justify couple therapy, was a misnomer, misrepresenting the defensive behaviour of 'victims' as abuse. One participant spoke about this as a '*very rare*' phenomenon which could be understood in attachment terms:

Extract 19

114. JL. ... I'm wondering what that means in terms of relationships where there is alleged to be mutual violence and how that's accounted for (...)

116-121. Sam: I do work with couples where there's something that you might call mutual violence but it's very rare and it's for me I mean I think of it psychoanalytically as malignant mirroring ... it's where one of the partners says holds effectively holds up a mirror to the other one and says you are you're rubbish, you're appalling, you're bad, you never help me, you're always you know, there's a long string of reproaches and the person having this reflection of themselves, looks at it and thinks Jesus I don't recognise this person I'm being shown to be me, so what they do then is they hold up a mirror and they say do you see how crazy you are reflecting me to myself in this way. You're completely mad. You just don't see me. So what you have then, you have a a projective space between the two and no possibility of Solomon coming along (...) the relationships that I have come across, where there is clearly mutual violence um they're they're the people are very dysfunctional. She will often be a victim of child sexual abuse, she's often a prostitute, drug abuser, he's a pimp, you know they have a completely dysfunctional relationship, they're enmeshed, chaotic in attachment theory terms and they will get into alcohol and drug fuelled fights, that is quite common, but I've never come across that in a middle class couple.

7.2.5   Summary of sub-theme 2

As we saw in Sub-theme 1, when a relational perspective is taken, there is a move away from explanations of DVA based either on gender or individual pathology to approaches that aim to bring together both individual and social levels of understanding. Working at this intersection invites therapists to understand the meaning of the abuse for an individual within a relational context, and move away from prescriptive approaches that construct blame. In this sub-theme we saw how this interest in the interactions between two intimate partners can further open up the complexity of the issues, inviting therapists to consider the additional possibilities that abusive behaviours could also be mutual, or that either or both individuals in a couple may switch from being victimised to behaving abusively.

When individuals are understood as multi-faceted, and abuse between partners, in both heterosexual and homosexual relationships, is conceptualised as multi-directional, there are implications for practice and the delivery of services. Questions were raised as to the role of services, and therapists, in re-affirming stereotypical notions of gender when services are, in the main, segregated to provide services for female 'survivors/victims' from female therapists, whilst gender matching seemed to be less prevalent in services for 'perpetrators' in which some participants worked. Furthermore, a controversial view was illustrated, that working with a couple could be most illuminating in terms of enabling a therapist to gain a fuller understanding of the interaction between partners, and the perspective of each person. Whether working with individuals or couples, participants taking this approach spoke about the need to keep both partners' perspectives in mind, remain open to individual differences and suspend judgments, points taken up in Sub-themes 3, 4 and 5 which begin to map out the implications for practice of taking a relational perspective.

7.3 Sub-themes 3-5 Conversational Tasks: How Therapists Talk About Their Practice When Taking a Relational Perspective

7.3.1 Sub-theme 3 Holding ideas in tension when approaching DVA from a relational perspective in practice

> *Dede: Yes I think flexibility with interventions is very important. You've got to have really good practitioners to do that but within flexibility creativity it it meets the needs of individuals better than a prescriptive way of working (133)*

> *Lyn: ... I suppose what I would say we're trying to do in therapy is to try and um develop the reflective process um so that you can sort of make decisions and stand back from situations rather than feeling everything's overwhelming you (47)*

7.3.1.1 Introduction

This sub-theme provides a take on what the principles of a relational approach might begin to look like in practice, when therapists hold ideas in tension, in order to enable a fuller understanding of the problem. The few participants who spoke about this way of working with DVA tended to do so by comparing it with what were often referred to as more 'prescriptive' approaches. They went on to describe more flexible ways of working that could facilitate the opening up of different perspectives on the problem and the holding of these in mind so they can be reflected upon before decisions are made as to how to proceed.

7.3.1.2 Understanding the origins of the problem

> *Ann: Therapeutic work with perpetrators they believe it doesn't work it's got to be this (claps hands) but it's not that cos if you can help a perpetrator to understand why they're behaving that way and where it comes from, it's like any other issue isn't it?(285)*

Gender perspectives on DVA focus on the way that social, and cultural, constructions of what it is to be a man or a woman influence individual beliefs and behaviour in relationships. In a patriarchal society where men's power over women is legitimised by organisational practices and discourses, so the argument goes, men's use of violence or abuse to control women is instrumental and done in the belief that they are right to do so. This way of understanding the problem makes the individual personal histories of 'perpetrators' irrelevant, whilst at the same time it renders understandable a female 'victim's' history of repeated abuse. In both cases, the origin of the individual's problem is located in the wider social and cultural context but the impact of individual factors, such as the meaning for the individual of their life experience, their own will and agency, are minimised.

Across Theme 1 and 2 it was seen that a majority of participants spoke about exploration of the past as relevant to helping women who had been victimised in relationships, whereas it could be problematic when working with male 'perpetrators' where past experiences might be used to excuse current behaviour. However, there was an example too of a view, expressed by one participant, that the identification of patterns of behaviour of those victimised can also be used to excuse the abuser's behaviour and 'victim-blame' (Theme 3, Extract 59). In this sub-theme we can see how a relational approach to the problem would focus on developing an understanding of what the abuse means now, and in the context of the past, to both partners.

Approaches to understanding other kinds of presenting issues seek to identify where the problem 'comes from' for this particular person, and we might ask, why this would appear to not apply to the perpetration of abuse. With regard to those perpetrating abuse, recognising that some 'perpetrators' may have been victimised as a child, and seeking to understand how this early experience of abuse may have affected them, was spoken about by some participants as not relevant as it could be a means of excusing their own abusive behaviour (Theme 3, Extract 63), though some participants acknowledged that both men and women in 'perpetrator' groups may have been abused (Theme 3, Extract 13). However, when past difficulties are not explored this may mean that the problem is conceptualised in an over-simplified way, that fails to acknowledge how past abuse might affect current behaviour, as the following extracts illustrate:

Extract 20

> *141. JL: ... somebody that I've been talking to here was saying to me about how just looking at acts themselves is not enough and that you need the context you need the relationship and you need to be open to that (...)*

> *155-156. Jay: if you go along to a young offenders institute, full of kids that are criminals. Why are they there? Why are they criminals? What's happened to*

them in their childhood? And one of the things that really upsets me is that we look at little boys and aah poor little boy he's a victim and as soon as like he's like you know 16, 17, 18 then he's like this bad man and it's like we objectify them and I think those are the same people and what what we have to recognise is that those little boys grow up to be those men and that we lose sight of that and that they're multi-faceted people like everybody else and that they've had their own difficulties, their own experiences

The potential for men to be both abuser and a 'survivor' of abuse, and the difficulty this poses a therapist with regard to holding these two ideas in mind, is voiced here. It is implicit that being abused in childhood affects people, but that we can lose sight of this when therapists fear that understanding the past can seem to excuse the present as we saw in Theme 3. In these two short extracts from the same participant, who works with male 'perpetrators', we can see how approaches that consider the past relevant would have a different starting point, focus and intention:

Extract 21

86. JL: And what what I understood you to be saying to start with was that it was the emphasis was much more on challenging to start with

87. Ian: Yes I mean the point is as opposed to challenging is to get them to understand why they are so needy, so controlling because they've got such massive insecurities and all of them have that's the common (unclear) rather than acknowledge that they try to blame and control their partners ....

Extract 22

47. JL: So how do you how does that help do you think?

48. Ian: How does it help? Ok um for example we had a guy (unclear) and he completed (unclear) parenting various modules like parenting etc so we'd often go back to childhood. What was dad like at praising you? What was dad like at disciplining you. How did dad react when mum got angry? How did you react when...? All this kind of stuff. So we'd taken them back to childhood

The emphasis here is on understanding the origin of the client's problem, which could include an exploration of the past without necessarily colluding with the current violence, but holding both ideas in mind, as the following extract illustrates. This provides an example from one participant who speaks about opening up the complexity of the problem and keeping safety in mind, and then goes on to talk about the importance of understanding '*where this is coming from*' for both men and women:

Extract 23

31. JL: And that's one of my questions, how best to work with this client group. Where are you at now with your model? (...)

33-35. Dede: a lot of our clients have had trauma you know consistent trauma through childhood, men and women so it's hugely complicated, so the work is very complex and the more that you open it up you know if you can dare to let go of the prescriptive way of working, if you can dare to do that the work is very complex but it's very real, so you're working with the individual you're not

colluding with any of the violence but you're definitely saying there's a lot to understand here and (...)

41-42. Dede: part of the way that we work here is to make the women more conscious, more conscious of themselves, you can't do much work unless they're conscious of themselves. So making them more conscious of themselves and what's going on for them and why they're responding this way so as they can understand it. They might not be able to immediately change it but where there's an understanding there's a pretty good key to being able to say I've got a choice I know where this is coming from um I could perhaps do this differently

Understanding what is going on may be key to helping clients recognise the choices made and enabling them to make different choices. However, this is spoken about as complex and demanding work, not least in terms of the emotional impact on therapists. In Theme 3, a few participants spoke about their own emotional response to these issues, and how this might affect their view of a client. Managing the emotional response when a client has been abused by someone in the past, or present, whom they love, can be experienced as challenging, as was illustrated in Theme 3, Sub-theme 4. When a therapist feels concern for a client's safety they may feel a need to act, believing the client needs advice or lacks the understanding needed to resolve the problem and keep themselves safe, as we saw illustrated in Themes 1 and 2. It may, for example, be a challenge to a therapist to value a client's relationship when this is abusive and at the same time be open to saying to a client that some behaviours are not acceptable. In both the following extracts the participants speak about 'holding' of two contradictory ideas:

Extract 24

116. JL: And and going back to something you said before that um about experience that um and understanding some of these factors that you've just listed it sounds like it's important to have training to help you do that?

117-120. Helen: Yeah yeah absolutely because I think um if you're working with those issues you've got to understand the complexity of them the complexity of say where I work with people that have maybe been sexually abused in childhood by a parent it's well he's my dad and I love him and then he did this and how do you how do you hold those 2 things? And it it's not about condemning the dad but it is about saying yeah and if you have those positive memories of him it's ok to hold those, you don't have to demonise him if that's the way you choose but actually that was really wrong and being able to sort of separate the 2 out (...) they appear to be things that are opposite and they exist together um and I think that's the part that people find it really difficult to get their head around because it's well if I love him how can I acknowledge this part or if I acknowledge that's really wrong then I can't love him at all and actually maybe a bit of both of him can go on um so yeah

Extract 25

57. JL: What do you think best enables clients to be able to talk about those sensitive issues? (...)

59. Anita: I think we all have a different idea of what relationships are. It's not influencing them to what I think a relationship is but maybe highlighting it so it's

about um for me as a counsellor to hold that part away yet notice it so and to be honest, to be really honest about you know if it's coming up that this isn't ok

Some of the difficulties clients might experience in managing their ambivalence in relationships are explicated here, and we can see too, how therapists may also be challenged when presented with opposing ideas that exist together, or when experiencing this ambivalence themselves as a reaction to the material. One particularly controversial issue that could commonly elicit ambivalence in clients and participants, as discussed in Theme 3 was the question as to why people might stay in abusive relationships. Some participants spoke about the challenge this might pose to therapists with regard to how they manage the feelings this can elicit in them and how they respond to the ethical issues this might raise. Instead of educating the client or taking a position on whether they should leave the relationship, a few participants spoke about how therapists might focus on attachment issues, acknowledging a person's motivation to make good a relationship that is not working, or exploring their reasons for being attracted to certain people, as the following two extracts illustrate:

Extract 26

> *83. JL: Ok something I wanted to ask you was um something you said earlier about um how we understand the way abusive relationships can persist. What do you think about that?*
>
> *92-3. Dede: So I think this is another ingredient, these women work at the relationship they hope that you know they'll come through this, that there will be improvements um because there is a very powerful compelling element in human life not to be alone, not to break the companionship that has been so forged between 2 people, an attachment, a huge attachment, it's a huge attachment, sometimes this attachment can be very unhealthy, but nevertheless it's cleaved to as an attachment, a companionship of kind, albeit a very destructive one. So I think for both and the men say the same thing that they don't want it to be like this but they wanna make this work*

Extract 27

> *101. JL: And what about people you will have seen who have been in an abusive relationship and then they go into another one and another one. How do you explain or understand that?*
>
> *102-5. Dee: Um again I think it is if they've not been able to access someone or some agency that can maybe help them celebrate what a remarkable achievement it was to get out of a a violent relationship and explore the idea that actually they don't have to repeat that again. It's not about somebody being powerful and helping them and wanting to look after them, sometimes it's about somebody being powerful and and using that as a way to abuse them um and the idea about themselves and their own self-esteem and their own self-confidence and actually what do you like, what sort of man would you like, if you could design yourself an ideal partner what would they be like? Cos people don't think like that, you are attracted I do believe that you know that you are attracted to certain types and you have lots of fantasies built up around that sort of person and it just needs to be explored a bit cos they're all they're like that those women*

aren't they, they go from one abusive relationship to another and it might be something to do with that's what their dad was like

Understanding why someone might go from one abusive relationship to another is re-framed here as not victim-blaming, but as an essential process of exploration in facilitating more insight and capacity for self-awareness regarding choice of partner.

7.3.1.3   Summary of sub-theme 3

In Themes 1 and 2 and also in Sub-theme 2 in this theme, we saw that when therapists experience concern for a client's safety their focus may tend to be on, or shift to, the individual rather than the relationship, informed by a desire to protect the client, however limited their ability to effect actual change in a client's circumstances. Nevertheless, when the initial labelling of the problem and the person could be seen as potentially closing down the possibility of talking about behaviours that do not fit with their initial presentation, this has implications for whether therapists might gain a full enough understanding of the problem to assess risk. As we saw in Themes 2 and 3, when therapy progresses, sometimes further information may emerge, or circumstances may change, such that it becomes apparent that a client who has been victimised might be behaving in ways that puts themselves, or others, at risk, or a client who has been perpetrating violence has also been victimised. When these and other issues are contradictory and difficult to integrate, we saw in this sub-theme how therapists might hold these different ideas in mind and not close down the opportunity to explore their meaning by precipitately locating responsibility or constructing blame.

The therapeutic practice of holding ideas in tension, when seeking to understand the origins of the problem, can be understood, from a relational perspective, as enhancing assessment and understanding of risk issues: the expressed intention, illustrated in this sub-theme, is not to ignore, collude with or minimise violence but rather to enable a full understanding of the problem which would inform a risk assessment and facilitate more effective interventions. Whilst on the one hand, this view represents a different, not commonly spoken about approach to DVA, on the other hand it could be argued that DVA is not different in many respects to other issues therapists deal with and therefore the generic skills therapists have already could be employed, including the capacity to hold and work with ambivalence.

7.3.2   Sub-theme 4. Moving away from blaming or excusing

Ann: you can get entrenched in just one way of thinking (165)

Jay: but if you just, they're just bad people, there's nothing to work with then and you can't and people won't feel listened to and they won't change (158)

Ian: ...But the reality is that they act out (laughs) tantrums and that they're perhaps hurting and they're very needy people and they need to recognise that and they need support (40)

Sarah: so so to me there's all sorts of reasons why they stay then there's all sorts of reasons why they want to leave and can't leave and why leaving is very dangerous and very very difficult (26)

7.3.2.1 Introduction

Talk about discouraging self-blame and avoiding victim-blaming was common across Themes 1, 2 and 3 and juxtaposed with the intention of not excusing 'perpetrators'. All the participants positioned themselves as not blaming of 'victims' and it was explicated in Theme 3 what the consequence of taking this position might be in terms of closing down the exploration of 'victims'' motives and responsibility, and demonising 'perpetrators'. This sub-theme represents another way of understanding and speaking about abusive behaviour that seeks to engage in a therapeutic dialogue that opens up the possibility for clients to own their engagement in the problem rather than defending or minimising this. It provides some illustrations of how therapists try to move away from taking a fixed view of those who behave abusively in intimate relationships, and we can also see how in doing so they seek to manage the dilemmas identified in Theme 3 and we get a sense of the sensitivity required to negotiate these.

Understanding how blame may be implicated in perpetuating violence can help therapists negotiate this issue differently and instead work at enabling clients to understand and own their behaviour as this extract illustrates:

Extract 28

40. JL: A number of people I've spoken to have commented on the complexity and difficulty of working with um around this issue of blaming and not being blaming. What how do you think you negotiate that

41-42. Eva: Um well particularly with perpetrators I think it's very easy to be blaming and the way I go around it is to try to understand what is happening so when we er understand the pattern and when violence is most likely to occur and what the triggers are um then it can be understood and integrated and owned. We don't necessarily blaming um and sometimes blaming could be part of the issue I've seen that um perpetrators do sometimes beat themselves up and it only makes the whole thing worse because they feel even more helpless and they would want to regain their control so I think it's a very complex area um yes

From the perspective illustrated here, the therapeutic endeavour is targeted at enabling clients to understand for themselves their patterns of behaviour, rather than the therapist assigning fault. When 'perpetrators' blame themselves or feel blamed this is construed as counter-productive, potentially having a similar, detrimental, disempowering impact on them as it does on 'victims', which may incite further attempts on their part to gain control of a partner through violence or abuse.

7.3.2.2 Taking responsibility when victimised

> *Dede: Under no circumstance will we blame a woman that walks in the door and says she was subjected to DV but we invite her to take control of her own life. There's a difference (48-50)*
>
> *Eva: ... I can't ever say that a violent act is not a violent act and that responsibility has to be owned either way whether it had whether it had been provoked um or not (22)*

In this section, we see how therapists who take a relational approach with female victimised clients speak about moving away from blame whilst addressing issues of responsibility and choice. This approach, with women, is spoken about as controversial and referred to by only a few participants, whilst approaches to working with male victims were less spoken about, and, understandings of males in receipt of violence less elaborated. The expressed aim is both to facilitate understanding of what has occurred between the partners and seek their responsibility for their own and their children's safety, without blaming them for the violence. The first extract provides an illustration from one participant of what the benefit could be for clients and how this might look in practice.

Extract 29

> *46. JL: ... I was wondering if you could elaborate on on what you would see as the controversial element?*
>
> *48-50. Dede: while you say women are victims it places women in a holding bay. It says you're always victims, you're the lesser, you tap in to that historic psychology. You reinforce the fact that they are victims. What we're suggesting that they do is actually look at this and take responsibility for themselves in it. So we're not blaming them for the violence because it can't possibly be that way round but we're saying listen, this is going on, this is going on to you, this is going on to your children. So we we seek for their adulthood. We seek for their level of responsibility that says ok I know that early in my female life that these things have been put in and you know they're very difficult for me to handle but actually as an adult, as a mother I can start to see some of the stuff that I can take responsibility for, keeping myself safe, keeping my children safe, not having them observe this sort of thing going on yeah? That has caused huge controversy because and I think wrongly women have been kept in this place that says you're the victim. I think it's unhelpful and I know that it needs to change gently and gradually and you know people have interpreted it as us blaming the women. That's absolutely incorrect. Under no circumstance will we blame a woman that walks in the door and says she was subjected to DV but we invite her to take control of her own life. There's a difference*

The view illustrated here is that labelling a woman as a 'victim' can create a double-bind in effect, whereby their perceived passivity and need for others' protection reinforces their victimhood, closing down possibilities for them to understand what is '*going on*' and take some control of their life. The alternative approach expounded is to focus on enabling women to become more conscious of the choices they make when, for example, their children are witnessing DVA, in order to enable them to take responsibility. The idea that

this is blaming of women is strongly contested by this participant. From this perspective, a person who has been victimised may be invited to reflect, without blame, on their own motivation to stay in, or leave their relationship and for their part in maintaining the situation.

The following extract illustrates an understanding of male 'victims' as different in their attachment to relationships and more able to take control of their lives to some extent than women, by making a decision to '*walk away*' from an abusive situation.

Extract 30

> *41. JL: How do you explain that? (...)*
>
> *44-46. Ken: I don't know I think I just have a sense that it's easier for men to walk away than it is for women to walk away. Women are far more emotionally attached to the to the home and to the stuff in the home um and it's one of the reasons why women stay in abusive relationships for so long because there's there's an awful lot more to keep them, the men walk away, whereas I think men once once the penny drops, you know something like me, they they recognise that that actually that there is a problem affecting them, that they are at risk, they're much more likely to just up sticks and walk away.*
>
> *47. JL. And and what's the kind of impact then when they do that? (...)*
>
> *48. Ken: The impact is you know there's an ongoing saga that then they become homeless, if they haven't got a friend or family to stay with and there's no refuge for them in C. So then we have to go through local housing to try and get them to find some temporary accommodation for them. Um and then the impact is er contact with the children.*

Here we see how the integration of an understanding of socially constructed gender differences and attachment theory may be important in developing approaches that are relevant for explaining the experiences of individual men and women, recognising both similarities and differences in the genders. Integrative approaches would also invite a more nuanced take on understanding the responses of women who have been victimised and how these might knowingly, or unwittingly, contribute to the violence and abuse.

Whilst it was a common finding across the data that participants spoke about violent or abusive behaviours being wrong in principle, what might constitute violence or abuse in a particular situation could depend on what was deemed 'healthy' or acceptable to the client and/or the individual therapist, as was seen in Themes 1 and 2. One approach represented in the data was that that different criteria could apply to the behaviour of named 'perpetrators' and 'victims': 'perpetrators'' behaviour might be construed as pro-active and de-contextualised, whilst the behaviour of 'victims' might be construed as reactive to the relational context, reflecting stereotypical notions of males as independent and females as dependent in relationships.

As we saw in Theme 3, participants commonly drew on their personal and professional experience in the process of recognising and naming abuse, and this might involve using '*your own sort of instinct*' to identify a 'perpetrator' or 'victim' (Extract 27) or, the making of judgments about '*degrees of abusiveness*' (Extract 20). Those named as 'victims' in receipt of abuse were spoken of as defending, retaliating or resisting (Extracts 5, 13, 91, 94 and 96). However, another approach, illustrated here is to consider the potential such responses may have for perpetrating further violence.

Therapists may experience concerns about not wanting to get caught up in either seeming to blame 'victims' for having '*contributed to the violence*', or seeming to excuse them for behaviours they do knowingly to '*wind him up*' (Extract 31). In trying to negotiate this dilemma, therapists might hold in mind the action of the person and instead of blaming them for 'causing' the violence would be noticing something about the relationship dynamic and how the person's motivation and agency were enacted in the relationship by winding up the other person. The following extract comes from the one of the few participants who spoke about working in this way:

Extract 31

> *43. JL: Ok. So the terminology is is something you said is shorthand but would you use it with clients for example?*
>
> *44 - 46. Lyn: ... I think it's a label really and that's something we would avoid because I mean that might be a label that they use themselves but it wouldn't be one that we use because it's then it's it's just closing off so many other avenues um ok now that's you and that can then you know say for example um (sighs) you know say for example, which isn't unusual somebody comes who has been in a very violent relationship and um they may, it's a very tricky one actually, they may see themselves as having contributed to the violence even if they haven't been violent themselves(mm) so they may have recognised something about the dynamic right? Of course this is not to excuse the violence um but they may say oh you know but I used to wind him up or you know I used to do this and you have to be very careful with that because that can also be part of their you know, It's all my fault, I'm to blame blah blah blah blah but it can also be something about well actually you know I've got my own will and desire and this is how I acted it out in that relationship*

The idea that behaviour by women might 'provoke' partners, or that they may engage in reciprocal abuse, or, resistance that perpetrates further violence, represents a rarely voiced and controversial understanding. Extracts from a few participants illustrate this narrative, one in which the possibility that violence may be 'provoked' is juxtaposed with the stance that it is neither justifiable to provoke violence nor is it justifiable to respond to provocation with violence. In the following example the participant's use of '*so-called victim*' suggests perhaps some blurring of the distinction between a 'victim' and 'perpetrator' in this context:

Extract 32

> *99. JL: ... referring to the literature that that one of the issues that comes up is whether there's a need to understand why abusive relationships persist. What do you think about that?*
>
> *103. Eva: I think that to some extent um both partners contribute not deliberately um but it seems as if a pattern sets in and that's perpetrated so sometimes the victim the so-called victim would try to resist the partner's violence um and with that particular resistance would um perpetrate further violence.*

In the following extracts, two participants give examples of relational contexts in which couples may be caught up, when the woman may be verbally abusive, press the partner's '*buttons*', or be '*winding him up*' knowingly:

Extract 33

> *18. JL: Can I ask you a a general question about DVA um what what would you say your understanding of it is? (...)*
>
> *25. Eva: Um well I'm thinking of of a situation when um the the woman in the relationship is quite verbally abusive and denigrating towards the man and the man is physically violent towards her so I wouldn't say that um only the man has to take responsibility for this violent action*

Extract 34

> *32. JL: Are there particular behaviours then ... that would mean that somebody would be regarded as too risky? Does it depend on how many or is it particular behaviours?*
>
> *34-37. Dee: but again she said she she was aware that she was winding him up um and there was there was violence from her towards him as well (...) women are very good, in my experience of working with them, of of knowing the buttons to press um and I guess there's no excuse and it's not acceptable to react in that way but there is that sort of that side of it as well*

Whilst the position taken that provocation does not justify a violent response is clearly expressed in these extracts, questions about the responsibility of the person who provokes a partner, are also posed, but the response of both participants is more equivocal. The following extract further explicates the challenge for therapists when trying to untangle interactions and identify who did what to whom, when the 'abuser' perceives the other as behaving in a denigrating way:

Extract 35

> *140. JL: Is that what you're working towards?*
>
> *141-5. Beth: Always I think in one way yeah integrate yeah I mean that passive/aggressive/ assertive thing is quite a big thing for me it all seems to come back to that in terms of actual behaviour. It's like ok you go too far that way and you recede too much that way so you know how can we integrate those two you know cos you need to stop punching out and sometimes literally and barking and you know but you also need to (3 secs) you know I mean sometimes I do really I do really I can I sympathise you know the men feel very you know in the in the*

fascination of opposites coming together you know quite often it does sound like their partners are very sometimes they're very educated and much more educated than the men and very articulate and the men feel inadequate and emasculated really you know that's the word, emasculated um and so they (pause) you know they they can't find a way really to to sort of and because they it's self-perpetuating they lack self respect and you know and and quite often that's the dynamic that the couple get locked in then, the woman knows the way to get to them I guess is to make them feel stupid and it works because they believe they're stupid

As in Extracts 31, 32, 33 and 34, this extract illustrates views about the role of provocation in DVA, not commonly spoken about. As we see here, when a therapist attempts to understand the perspective of both partners, the focus might shift to the relational dynamic, and how each partner contributes to this, moving away from blaming one partner, and creating the possibility of empathising with both. However, again we see how this participant '*sympathises*' with 'perpetrators' and is focused on how to '*draw the line*' and achieve a balanced view (Extract 11; Theme 3, Extract 86).

7.3.2.3 *Understanding motivation and choice when behaving abusively*

Jay: I know one of the standard lines that you often hear in DV training is, he doesn't hit his boss, he doesn't hit the barmaid, he doesn't hit the the bus conductor he only comes in and hits her he's in control (143)

Jay: ...I don't actually think that all people walk around consciously going I'm going to hurt her now and not him there. I don't think that's how it works (148)

Jenny: so I think that's you know kind of much more empowering and compassionate and you know it's not you know absolving anyone for the responsibility for their choices or their actions but it's it's I think it's the way in which that's done (119)

When taking a relational approach with those who behave abusively, therapists must negotiate other highly controversial issues, related to those raised in the previous section, regarding the degree to which this behaviour is seen as controlled and chosen, and whether behaviours carried out in retaliation or defence, count as abusive. As we have seen in Chapter 5, when men are categorised as 'perpetrators' and women as 'survivors' or 'victims', men tend to be construed as being in control and making conscious choices to abuse, whereas women are not in control, have no choices and their behaviour may be construed as defensive rather than abusive. In this sub-theme issues of control, motivation and choice are problematised with regard to both men and women in abusive relationships, and a relatively undeveloped narrative, voiced by a few participants is presented.

In the example here, repetition of the word, '*conscious*', suggests the importance of enabling women to become more aware of what they are doing in their relationships and why, so that they can make a choice as to whether to make changes:

Extract 36

> *31. JL: and that's one of my questions, how best to work with this client group. Where are you at now with your model? (...)*
>
> *41-42. Dede: part of the way that we work here is to make the women more conscious, more conscious of themselves, you can't do much work unless they're conscious of themselves. So making them more conscious of themselves and what's going on for them and why they're responding this way so as they can understand it. They might not be able to immediately change it but where there's an understanding there's a pretty good key to being able to say I've got a choice I know where this is coming from um I could perhaps do this differently*

The idea of raising awareness echoes what was talked about in Theme 1, though when taking a relational approach we can see that the focus is on raising awareness of self and a person's own response, in addition to becoming more aware of others' behaviour. This represents an integration of feminist thinking with a relational perspective, which can provide additional insights with regard to how a person might exercise control in relationships, as illustrated in the next extract:

Extract 37

> *45. JL: So there's a shift towards more acceptance that working therapeutically ...?*
>
> *49-52. Jay: and you know power and control is something we'd all agree is a huge factor but then there's other things at play you know what does that actually mean when you say somebody's in control of their behaviour or not in control of their behaviour? At what level can you can you concede that there might be an unconscious level? Do you only see it as a conscious process? (...) to me you know everybody knows perfectly well that you know you get angry and you react and you know in yourself that sometimes you get really angry and you're not conscious of what you're doing I mean I'm not saying you can't stop it but there's levels and levels and levels of control and I think anybody that's being honest with themselves would see that you know there's different levels in your own behaviour, your own motivation*

This idea that issues of power and control are a '*huge factor*', but that there may be other factors in play affecting behaviour is a marginalised view, spoken about explicitly by only this participant. When the apparent exercise of control through angry, abusive behaviour is understood as being motivated by impulses, or triggered unconsciously by intense feelings, this positions those who behave abusively as not necessarily in control or, doing so intentionally. Furthermore, it normalises getting angry and reacting impulsively, as something all human beings are capable of, and might sometimes regret. In the following two extracts, this idea that clients are not so different from anyone else who might push or lash out '*at some point*' is illustrated:

Extract 38

> *95. JL: Ok another question that's cropped up is about how we understand the tendency for abusive relationships to last. What do you think about that? (...)*

99-100. Dee: … probably a lot of relationships if we're being absolutely honest at some point, at some time there's been a push or a kick out or a lash out um and maybe that's human nature that people do lose it on occasions but you know where it's consistent I just think it's a lot about all the other issues it raises about who you are, what you are, what you deserve and and people tend to learn and think they can't do any better, so they stay.

Distinctions may be made, nevertheless, between those who '*lose it*' on occasions, and those who do so consistently, and here again the difficulties of defining what is abusive are apparent, as we saw in Themes 1 and 3. When trying to tease out these complex issues, an understanding of individual differences and the influence of context on behaviour, might help to explain why some situations might upset one person more than others. The idea that people behave in what might be construed as inconsistent ways across different contexts might also appeal to commonsense understandings, based on personal experience, as is illustrated in the next extract:

Extract 39

141. JL: … somebody that I've been talking to here was saying to me about how just looking at acts themselves is not enough and that you need the context you need the relationship and you need to be open to that (…)

144-146. Jay: Now you could look at it that way you could also say that relationship is different and that winds him up in a different way that's a bad choice of words, I don't mean that literally but that's how easy it is that he doesn't have that intimate connection with the barmaid or the bus driver it doesn't hit him in the same way it doesn't upset him in the same way and that if you really really start looking at what relationships mean to people you're going to get different reactions in different situations so yes he may be in control of himself at work or in the pub and he may not be in control in the same way at home and that might not be that he's that manipulative that he can hold off there and not there it might mean that he's actually been triggered in a different way and that's not an excuse and it's not a condoning it's just recognising that people behave differently in different situations. I know from being a mother my children could be little angels at school and they could come home and be awful and you know a teacher would say oh that child's so well-behaved that child's a demon at home sometimes we know that.

When behaving abusively is understood as context-dependent this problematises choice and intention, moving away from blaming, but perhaps inviting accusations that DVA is being excused. In this extract, we see how the participant positions herself as not condoning violence by men, but bringing to bear everyday understandings that people generally might identify with. In relation to this, are questions about whether some violence may be perceived as more acceptable than others, a controversial idea raised in Theme 3, Extract 20, regarding '*degrees of abusiveness*'. The question, for example, as to whether it is relevant and/or possible, for example, to distinguish between a minority who might rationally choose violence and the majority of people who tend to act irrationally when caught up in intense emotions, is taken up in the following extract:

Extract 40

> *37. JL .I was wondering as you were talking what theoretical models you draw on to inform your understanding? (...)*
>
> *42. Beth: you don't think when you're violent it it doesn't involve thinking, it can do I mean in terms of the psychopathic end of the scale it can you know be quite cool planning but on the whole our clients don't tend to be that it's the rash, hot-headed, unthought out our clients really*

We see here and the previous extracts how therapists might empathise with clients who behave abusively, but are unthinking. Therapists might seek to position themselves in relation to their clients as having shared experiences, when most people who commit acts of violence or abuse are understood as not evil people, deliberately and coolly planning to cause harm to others. This stands in sharp contrast to the positioning of some of those who work with victimised clients and might want to '*rip the heads of 'perpetrators off'* as we saw in Theme 3, Sub-theme 4.

Extract 41

> *141. JL: ... somebody that I've been talking to here was saying to me about how just looking at acts themselves is not enough and that you need the context you need the relationship and you need to be open to that (...)*
>
> *148-9. Jay: I'm just saying that if you don't understand that you will fail to be able to help. It's not saying that what he does is right whether he's in control there and he should be in control, it's saying you won't be able to help him gain control if you cannot understand that he does not feel that he is in control. In my experience of being a human being I don't work like that and I know I'm not everybody but my sense is that people aren't that conscious of the processes that they go through when they're angry or they're upset or they're irritated. It's it's an emotion um and that they're that much in control implies that people are that rational, that they can choose when they do this and when they do that and I know some people can (pause) I know that that's possible that there are people that are that manipulative and evil or whatever you want to call it that they can choose that, I know that, but I don't think everybody's like that*

The idea that people are not all capable of making rational choices when upset or angry offers a partial rebuttal to gendered assumptions underpinning prescriptive approaches to working with male 'perpetrators', who are conceptualised as behaving with deliberation and in control of their anger.

7.3.2.4   Summary of sub-theme 4

When therapists try to avoid, or seek to distance themselves from 'victim-blaming', there is a risk of getting caught up in positioning others as 'victim-blaming' and representing 'victims' as blameless, thereby validating constructions of 'perpetrators' as 'bad' and reproducing 'either/or ways' of understanding the problem. This perhaps helps to explain why it may be '*very easy*' to blame perpetrators and difficult to move away from this (Extract 28). An alternative representation of 'perpetrators' as people who, like 'victims',

have a need for support and might 'act out' their hurt if this is not recognised represents a challenge to gendered understandings, even though it remains implicit in many participants' talk that 'perpetrators' are male. From this perspective, when 'perpetrators' blame themselves or feel blamed this can have a detrimental effect on them, as it can on 'victims', and may, for example, incite further attempts to gain control through violence or abuse.

Domestic violence training commonly disseminates the idea that male perpetrators can control their violence and are therefore manipulative and deliberately choosing to be violent towards their partners. This is intended as a rebuttal to what is an often-made claim that those who perpetrate violence will say that they are out of control and act unknowingly, in order to excuse the behaviour. This representation of men as motivated and choosing to behave violently is justified on the basis that they may not be abusive in other contexts. However, it has been challenged for not taking into account the meaning for a person of the context in which their anger is triggered, down -playing the emotional salience to human beings of their intimate relationships and placing moral responsibility for wrong-doing only on those who do so deliberately, rather than negligently or thoughtlessly. Taking the view, that men are not all, or always, choosing to be violent, though some might, i.e. violence is not just instrumental but can be expressive, and that women are not all, or always, acting in self-defence, but some might, invites more nuanced understandings of responsibility and choice.

A relational approach prioritises notions of responsibility, offering an alternative to explanations based only on patriarchy, whilst also raising questions as to the degree to which emotions influence behaviour and whether we are always in full awareness of what we do. In this way, the idea of 'perpetrators' as being different from others or even 'evil' is problematised on the basis that we all experience anger and may have the capacity to behave abusively or feel out of control at times. It highlights, too, how we might use blame and difference as a way of distancing ourselves from knowing something unpalatable about the self.

7.3.3   Sub-theme 5 Deliberately expanding the picture to encompass the multi-faceted aspects of relating

> *Ian: It's not necessarily one person it could be either person at any time (100)*

7.3.3.1 Introduction

In the previous sub-themes, we saw how therapists might take a relational approach to working with those who present as having been victimised or as having perpetrated violence. This involved drawing on both social and individual levels of conceptualisation and developing an understanding of the presenting problem of violence and abuse in a

relational context. The complex nature of the problem was highlighted as was the need for skilled therapeutic work that could be both empathic and challenging. A few participants spoke about how, rather than taking a prescriptive approach, they would negotiate contradictions and tensions in the work by holding these in mind with the intention of capturing the complexity of the problem and enabling more nuanced understandings to develop. In doing so they emphasised the importance of also keeping in mind potential risks and how a deeper understanding of the problem might mitigate these rather than put people at further risk.

In this sub-theme, we see how a relational approach, partly articulated so far, might be developed further in practice. A few participants, for example, spoke about deliberately expanding the picture to focus on the dynamics of the relationship from the point of view of each partner and deliberately focusing on the different aspects of each person, so facilitating a more integrated understanding of the relationship and of the individual. This might be achieved in practice when working with individuals or with couples where the issue of risk is addressed and safety plans are in place.

7.3.3.2 *Deliberately expanding the picture to make it transactional*

When the picture is deliberately expanded by a therapist to include the purpose of the abusive behaviours and the motivation of each partner, this brings the focus onto the relationship with the aim of enabling each to understand the other's perspective. Furthermore, when the interaction between a couple is conceptualised as transactional, each person will be understood as responding to, and influencing the other in a reciprocal process, shaped by assumptions and expectations about relationships in general and this relationship specifically. As illustrated in Sub-theme 3, these may be beliefs about the self in relation to others that have developed over time informed by previous experiences in this and other intimate relationships. From this perspective, in any exchange with another there is the potential for intentions to be miscommunicated and misread and so a therapist would need to unpack what happened by asking who did what and why. In the following extract, one participant elaborates on her own intention in taking this approach in practice:

Extract 42

> *36. JL: How does it work where in the example you gave earlier you're you're thinking I'm sitting with a victim but it sounds as though she or he might also be committing violent acts. How how do you do that how do you work with that?*
>
> *37-39. Eva: Um well what I do is to um try to steer away from blame and and guilt and so on and I try to gain a holistic picture of the relationship and usually what happens is er the victim herself says, Well actually I did this and and she could have done that as a way of resisting the violence so this is not about putting blame onto someone or another it's it's just trying to understand the dynamics of the relationship and see what purpose they're serving and so on and so so the relationship is very much in the room and er and sometimes I work*

systemically as well and try try to get the other person symbolically in the room as well and try to get the person to um try to get the client to understand the other person's perspective as well

Here we see how one participant speaks about not only trying to keep the partner in mind, but also bringing the relationship, metaphorically, into the room in order to understand the relationship dynamics and the purpose of the behaviour. In this approach, rather than taking up an educative stance, as we saw described in Themes 1 and 2, a therapist might unpack an example of the behavioural exchange, inviting the client to notice who did what to whom, so gaining a clearer understanding of intention. In the following extract from the same participant the controversial idea of provocation is taken up again. This was discussed and illustrated in Sub-theme 3 where participants spoke about how they might address the issue when a client speaks of 'winding' someone up and here we can see how this might be tackled in practice from the other side with a client who says they have been provoked.

Extract 43

> *24. JL: Mm I wonder if you could give me an example of of that and how you might work with it?*
>
> *26- 27. Eva: well I haven't worked with couples um but the way I would work with the individual is to try to understand their own um responses and even if if someone might come and say, Well actually she provoked me. If she hadn't have provoked me I wouldn't have hit back um then the response he adopted was a chosen response so we'd work with that and and what made him choose that response rather than another and er why he chose that response with his partner and not with another person um so we'd still work with responsibility*

We see how a therapist might try to understand a client's behaviour in context, unpacking what happened and thereby enabling the client to understand and take responsibility for choosing a particular response to what was construed as provocation. When therapists work towards reaching a shared understanding that attempts to take into account both of the partners' perspectives, holding in mind and managing the potential contradictions and tensions this may elicit can be challenging. It seems, for example, in the following extract that getting to an understanding of the different sides of a problem can raise issues for therapists as to what is the truth:

Extract 44

> *70. JL: Some therapists say they get quite caught up in trying to work out the truth of of what's happened. What do you think about that?*
>
> *71-75. Eva: Um yeah I I do I do tend to fall into that and struggle as well and sometimes I catch myself feeling suspicious and trying to understand is that really true? And I wonder if the other side was here what would they say and so on. I used to get caught up more towards the beginning than now um and possibly let's see I'm thinking that possibly I was trying to see the truth because I was more insecure about people saying what I wanted to hear or not and my own ability of helping clients um yeah. The way I see it now I guess is that what we're*

working with is the client in the room so what we're concerned about is what his truth is or her truth is and obviously some some things he or she might say might jar with my understanding of the relationship and if if appropriate I might say, Oh I thought this was what was happening but you're saying this so I wonder what's happening and so it happens sometimes and I guess it happens with some clients certain clients more than others. For example if a client I have at the moment is extremely blaming of the other person I would question that and I would be more likely to think ah but I wonder what the other person would say whereas if the client in the room owned responsibility I would be more likely to think ah so maybe um he is putting his feet into the other person's shoes, although I acknowledge that might not be the truth as well.

When therapists focus on locating responsibility and constructing blame, they can get caught up in trying to work out what is the truth, we saw in Theme 1, 2 and this might result in the scapegoating of one person, as we saw in Theme 3. Whilst for some participants it seemed that truth-seeking was implicit in their approach, this participant was the only one who spoke about her difficulties with this concept, suggesting that confidence and experience might enable therapists to move away from such concerns. There is an explicit positioning of the self as being in a relationship with another person with whom 'truth' is constructed and in which the therapist's needs and motivations will also impact.

Similarly, clients may be understood as in relationship and hence, influencing and being influenced by their partner. Where one person in a couple has become dominated by the other or over-invested in pleasing them, rather than there being different sides to hold in tension, there may be issues of self-differentiation to address. Only one participant spoke about this, referring to the impact on a person's ability to think when they feel disempowered, and the importance then of enabling that person to develop a clearer sense of themselves, separating their identity from the other, as the following extract illustrates:

Extract 45

51. JL: And it sounds complex and very nuanced to negotiate that

52. Dede: Yes it is um because the what happens with the work is that there is a real disparity in the balances of power and these are old words but they're never the less very important because they're so subtle. What that does to the survivor is it wears them down. Their thinking becomes encapsulated by the person who's got the power, so they stop thinking for themselves and they disengage to a lesser degree of finding ways that they can possibly do other things, they get taken away from it and it's very very important to start to separate that out so as the two are not one

Here we see how an understanding of the relationship dynamic can enable a therapist to work with the impact of gender inequality, where there is a disparity of power between partners. A few participants expanded the picture further to put the therapeutic work itself into a relational context and they considered the impact they might have as therapists on their clients in a context where there was also a disparity of power balance, referred to in the extract above. Whilst in principle these issues may apply in any therapeutic relationship,

some participants spoke about both the importance and particular difficulties of building a relationship with someone who had been in receipt of intimate partner abuse, where issues of mistrust, for example, may become apparent between them. The extract below highlights some of the difficulties this can pose to a therapist:

Extract 46

> *52. JL: What kind of difficulties come up because you know I used the word 'tricky' and you you laughed but what what difficulties would you say come up in doing the work?*
>
> *53-55. Lyn: Um I suppose I mean no more no different from somebody who hasn't suffered from DV um um that may be I don't know constantly gets into relationships where they feel they don't get what they want or you know we're talking about a continuum in in a way um you know what's what's going on here you know what's and it's building a relationship with a client building a therapeutic relationship at the same time as you know having to be challenging sometimes and saying well actually you know what was going on there that sort of thing which is part and parcel of of any therapeutic work I suppose um but is you know obviously more tricky um and being aware of of the dynamics you know there are obviously um dynamics in the room, the relationship and what might be going on there and you being aware of what's being what might be projected into me and you know not acting it out.*

As we saw in Theme 1, clients who have been victimised may have lost trust in others, and, as is implied here they can feel rejected and resentful about not getting what they want, bringing these needs and disappointments to the therapeutic relationship and projecting them onto the therapist. In order to work with relational dynamics, a therapist needs to be skilled in using both empathy and challenge, and will need to develop a high level of self-awareness to recognise when they might be responding to projections from a client. In the following extracts, two participants speak about the relationship between the client and therapist and the way in which a power dynamic, to do with differences in status and knowledge rather than gender, can affect the balance of this relationship. One participant questions whether she might be '*another one of those*' people who exercise power over clients in different contexts and how cultural differences can impact on expectations and understanding of how relationships work.

Extract 47

> *113. JL: And those are the kind of issues you said you take to supervision? (…)*
>
> *117. Anita: I do see it as a 2 way relationship because I learn so much from clients and that's invaluable and you know and I always take that away that I've learned something from someone as well I think that's really important especially for the balance in a relationship you know for me it has to be although I question that equality in the relationship I own a position I'm the counsellor there's always going to be that dynamic when that person may possibly feel that I'm in some way a more powerful figure in the room. I don't think you can ever eliminate that totally*

When taking a relational perspective, the therapeutic relationship is also conceptualised as transactional. Whilst a power imbalance exists, and a therapist takes up a position as the more powerful because of their expertise and the status this lends in that context, they can also learn from the client. The need for therapists to be aware of social and cultural differences between therapist and client, and its potential impact on the relationship, is a further point illustrated in the next extract:

Extract 48

> *39. JL: What kind of demands does this place on you?*
>
> *40-41. Dana: I think I'm constantly having to think, there's 2 things, have I communicated have I understood, that's pretty crucial. What am I doing here? Am I talking down? Am I patronising the sort of stuff I wouldn't normally see in my work? I'm constantly having to look at that, the cultural impact what's their understanding? What's their power relationship here? They've been used to professionals who hold power, housing, social services, so all of their interactions are people have power over them. Am I another one of those? How do they see me? So actually establishing a therapeutic relationship you have to be aware of that*

Implicit in this extract is the idea that the therapeutic relationship can repeat a client's experiences of others having, and perhaps misusing, power over them, or it can model a different experience. A couple of participants spoke about how therapists might deliberately use the therapeutic relationship as a vehicle to demonstrate how relationships work and to influence clients:

Extract 49

> *63. Jay: but I think you know we would say that it's the quality of the relationship of the facilitator that's the main thing that's important*
>
> *64. JL: It's more important?*
>
> *65. Jay: Because that's what it's all about if you believe in therapy then it's about the relationship and the relationship is what you're using to model and to influence people and so if you're a very unskilled facilitator then you're not going to be as effective as if you are a skilled facilitator no matter what your model is*

Understanding and working with relational dynamics in the therapy room may be considered a key aspect of therapy for any client group and is commonly understood to be an essential skill for therapists. With this client group, therapists might deliberately model desired behaviours, such as taking responsibility for their response to a client and naming this:

Extract 50

> *40. JL: A number of people I've spoken to have commented on the complexity and difficulty of working with um around this issue of blaming and not being blaming. What how do you think you negotiate that? (...)*

43. Eva: and I guess what what I try to do in sessions is to try and model the the behaviour when you take on responsibility and our our responses and so on and I might sometimes even say when when you say that I feel this response and I wonder how it is for you and do you think this might be happening with your partner and so it's very experiential as well

Rather than taking an explicitly educative stance, a therapist might, as we see illustrated here, deliberately speak about his/her own behaviour/feelings to invite a client to reflect on the impact of their behaviour on the therapist, which might then be generalised to the client's relationship with their partner.

7.3.3.3 Engaging with the whole person

Jay: None of us is perfect we all have the capacity to be abusive (53)

Jay: Well people are multi-faceted they're not just one thing, none of us are just one thing or another and that there's elements of us that can be strengthened or encouraged or allowed to run out of control, the bad bits you know if you don't handle them right that would be the side that's encouraged to flourish (165)

Dede: the other side of him would be I seek to protect and the other side of her might be well I seek to do my best, I want to do my best for this relationship, I want it to work, I want to mediate, I want to make things work out again(69)

In this section of the sub-theme, we see how the principle of seeing people as multi-faceted could be put into practice. It is premised on the notion that people have different sides and are capable of good and bad behaviour and is reflected in approaches to practice that attempt to separate out behaviours from the person, and/or, to help them to recognise and integrate them. In the first extract, separating out the behaviours provides a way of valuing the person who has been abusive, whilst being challenging of the abuse:

Extract 51

147. JL: So what do you find most challenging about the work. (...)

150. Sue: For us the core is they know they separate out their behaviour, attitudes and beliefs from who they are so we can value and respect that individual while being very challenging about how they behave.

It is implicit here that the therapist holds in mind both what is seen as essentially good about a person, alluding perhaps to innate qualities, and the abusive aspects of their behaviour, valuing one and challenging the other. Another take on separating out behaviours might be that this serves to maintain denial, usually attributed to male 'perpetrators', as we saw in Themes 1 and 2, when they might seek to minimise or 'forget' their abusive behaviour. When women separate out men's abusive behaviours, this can be perceived as unhelpful, as is illustrated here, by the same participant:

Extract 52

> *194. JL: I was just wondering if you felt it was something that can't be said?(...)*
>
> *197-98. Sue: So I would ideally want all women in future to know that if it's happened once – all women and men in abusive relationships, if they've assaulted you more than once there is a problem that can only get worse, it will not get better. This is the time to take action. It's about learning to respect yourself and say I I don't deserve this, because what often happens, they feel it's about they they love this man so they separate out his behaviour*

Separating out a person's behaviours may also be understood as a helpful first step in raising awareness of having ambivalent feelings/beliefs, manifest in good and bad behaviours. The next step might be to bring these aspects/behaviours together, as illustrated in this extract:

Extract 53

> *49. Jenny: If someone is um abused then there has to be an abuser (laughs) I'd assume so people can feel very torn about having feelings of love for their partner and not you know so separating out the different parts of their behaviour*
>
> *50. JL: How do you do that?*
>
> *51. Jenny: I use some Gestalt techniques as as a humanistic therapist it's quite an eclectic approach so quite often I might do some chair work and literally put the parts of that person that you like on this chair and the parts and the behaviours that you don't like on that chair and really start to um to kind of have a different chair and also they'll bring it together and appreciate these are behaviours in the same person so it's um I find especially if if somebody seems to need to do some anger work that you know the feeling of oh I love you can kind of get in the way of them just having a release about the awful things have happened to them so that's quite a useful way of working*

As we see here, this approach might enable someone who has been victimised, for example, to acknowledge the '*awful*' things that have been done to them by someone they are maintaining a positive view of. Implicit here is the intention to facilitate a client's awareness that they are in a relationship that is not healthy, so they might leave it, rather than more explicitly naming this, as we saw in the practices spoken about in Themes 1 and 2. Whilst this approach might be taken with victimised clients to enable them to reflect on the behaviour of a partner, 'perpetrators' might also be helped to recognise their good and bad parts, with the therapeutic intention of strengthening the good parts whilst making clear that the abusive parts are not acceptable, as is illustrated in the next extract:

Extract 54

> *72. Jay: And one of the things we have to do in this work is build empathy because a lot of these men have lack empathy for people and I don't think you get to that on an intellectual level so I think you need to have the skills to to be able to communicate about empathy and to explain that and to find places to reach people so that they understand that and help them to relate to other people there's a lot of skill involved in that*

73. JL: Um and that links with one of the questions I've been asking people is about how they approach what you might call the moral issue of the wrongness of DV as a therapist and they talk about the sensitivity required to hold on the one hand the boundary of it's wrong and then do what you just said

74-76. Jay: Yes that's right that is the essence that is the absolute kernel of the work. It's holding the accountability, holding the absolute knowledge that their behaviour is wrong, inexcusable no excuse but also being able to relate to the person the whole person. It isn't all just an abuser, it isn't all just a bad man or a you know that there's a person in there who's got some good parts and some bad parts and that you respect them as a human being and you try to strengthen the parts that are non-abusive while being very clear that their abusive parts are not acceptable. I think it's entirely possible to do that um it is not therapy in that you go wherever the client goes, it is not client led therapy in that sense it's a new a new mixture of of holding people to account and holding a very firm moral line that your behaviour's unacceptable and what you're doing to other people's unacceptable but that there's things in you that are worth developing and strengthening, that you can change and giving them the hope that they don't have to behave like that

The essence of a relational approach is encapsulated in the intention of holding the person to account for the abusive behaviour whilst being able to see other aspects of them that make it possible to communicate respect and empathy to develop a therapeutic relationship. This provides a justification for structured approaches to working with clients who behave abusively that are not '*client-led*', a view illustrated above. However, the approach differs from the more prescriptive approaches spoken about in Themes 1 and 2, and problematised in Theme 3 as ineffective. Whilst those approaches tended to foreground practices that were challenging and focused mainly on the negative aspects of a person, the '*new mixture*' referred to above juxtaposes the use of empathy and recognition of a person's 'good' side, with a clear moral stance on the wrongness of DVA and the therapist has an agenda that is made explicit. However, the participant implies that the person being held to account is male.

The re-positioning of the therapist as understanding but not condoning of DVA by men is further illustrated in the next extract:

Extract 55

141. JL: Um when you were talking what struck me was somebody that I've been talking to here was saying to me about how just looking at acts themselves is not enough and that you need the context you need the relationship and you need to be open to that (...)

152-155. Jay: there are a lot of people are in distress in their relationships and really just don't know how to do them and they've learned something they've had experiences as children themselves, that they've got their own emotional deficits, they've got all sorts of problems and a lot of these men are just very sad and confused me who really don't know and that they really are grateful for some support and help I mean they said when we've asked them you know they all it's wonderful that somebody actually listened to me and actually understood that you know I actually am a person inside this and I need some help and I'm

depressed about my behaviour and I'm sad and you know we haven't found that the men are just you know coming in and swaggering and macho and you know we get her to do what we want you know get our dinner on the table by smacking her that's not kind of the attitude that we find um (...) and that when you can start to recognise that those are people, they're not abusers or perpetrators, they're people who have good sides, bad sides, they have reasons that they're like that and you can start to actually relate to that and start to work with it (...) I mean I don't know if you how you feel about just being accused of being bad, or I told you that you're wrong I mean I shut down a lot of the time and I don't really listen anymore and I think that one of the things that we try to do is not do that because we're trying to work with the whole person and that's what you can work with, you can work with the side of them that recognises themselves as a person and that they're capable of growing and changing. If you don't appeal to that side of them I don't think it's going to work very well cos nobody likes just being told, you're a bad boy, does that make sense?

Men may be understood as behaving in ways that are rational but conflicted, often motivated by wanting to do their best and make the relationship work, but lacking the emotional understanding and skills to change their behaviour. From this perspective people can get caught up in a vicious cycle of behaving badly and being told they are behaving badly that perpetuates the problem. Whilst males who behave abusively may be stereotyped as '*swaggering and macho*', therapists might experience them as hurt, sad, frightened and confused people who need help from someone who is prepared to listen.

This notion that there are different parts to a person and that these may be in conflict and more or less open to awareness, can also be applied to a therapist. In the following two extracts, two participants speak about their different responses to their clients when the material they are listening to elicits strong feelings in them, or they might start to identify with the client's experience. This extract refers to work with victimised clients:

Extract 56

> *90. JL: What enables you to take that position do you think? What do you draw on to enable you to do that?*

> *92-93. Anita: so they've been in that situation such a long time they've probably got their own ways of coping their own mechanisms. It's not taking for granted that they're in any way weaker because of the situation they're in, they're probably stronger because they've got the coping strategies so and you know it's tough it's tough work to walk away sometimes you know if that person's going back that night yet I can, I have the ability to separate that off in a way that's healthy for me, more than anything it's about me I guess for me there's no point working with a client group where I'm constantly taking it home and it becomes unhealthy for me, so it's getting it into perspective,*

This extract refers to work with male 'perpetrators:

Extract 57

> *58. Beth for myself that's always something I have to watch that I don't get too aligned with the wounded child in there I have to really watch that (pause) You*

know if I were writing what what is it you you know what's the part of the work you have to watch that's definitely true for me

59. JL: Ok. So that's um a kind of balance you're trying to strike there

60-62. Beth: Yeah and that the flipside of that cos there's always 2 sides of a coin I guess is I that I have to watch I don't react to the men either as I can either be you know they're 2 sides of the same coin I can either find myself being too empathic if you can be as a therapist ever? Too empathic or too reactive like you know if I feel if I've got a really strong hunch that someone's lying and they're minimising and they're talking about a woman as if she's a real object you know I have to watch that I as a woman particularly although you know my co-facilitator could get angry too for the same reason but you know certainly as a woman it can be tough listening to how some of the men talk about women um I am a woman (laughs) you know I can't completely divorce myself from that

These extracts highlight the sometimes similar challenges therapists face when they engage empathically with either clients who are in receipt of abuse or behaving abusively, seeking to understand what it is like to be in the other's shoes, so-to-speak, whilst maintaining a sense of the self as separate. In the first extract, the participant speaks about having the ability to separate off her concerns for a client and not take this home, echoing approaches taken with clients, spoken about earlier in this section in terms of how helpful separating out feelings/behaviours might be. Striking a balance between being empathic and reactive and 'divorcing' the self emotionally may be particularly challenging when the gender of the therapist is different from the client's, as illustrated here, though it is also implicit that a therapist's ability to reflect on this can give insight into the client's difficulties and offer an opportunity for modelling more adaptive behaviours, as discussed in the previous section.

The use of the self as a therapist might have particular salience when therapist have themselves experienced abuse or witnessed DVA. A few participants said that their own experiences of abuse had informed their decisions to do this work and spoke about how this experience could enhance their empathy for clients, whilst for others, not having such experience might be considered helpful:

Extract 58

99. JL: How important do you think that is in helping you understand the clients' lives?

100-102. Anita: I think it's been essential actually to understand the difficulties of being in in relationships that are possibly violent, abusive um gives me a better understanding of why people stay and what they struggle with um the more I think empathy because I have experience. At the very beginning of my training going into um a placement the level of empathy that I offered that you kind of knew that obviously there was some history there for me without me saying and that was quite but them um then me developing that working on that in the room that if it did hit on something to be open and honest about that so so yeah I find the work I think having the ability to do the work is and remain separate not over involved is such because I can work more effectively with

people as well so I think yeah it definitely has some bearance on the work in the room having the experience of the experience

Extract 59

> *68. JL: It sounds like you've thought a lot about what would be a really helpful approach I was just wondering what you think enables you to work with this client group. What do you think helps you to do it? (...)*
>
> *71-72. Jenny: I know I have the capacity to hear some of the more painful traumatic things without necessarily you know I can I can really hear it but that at some degree and I'm really touched by it cos otherwise you're going to be an ineffective therapist but there is a way in which I can certainly separate that from my I don't take it home with me um you know very occasionally something stays around and I make very sure I make use of SV but what helps me is that I handle these situations in that way and I think for some for some counsellors thinking it may have been their former experience that would have helped I think you know at least I know none of my own stuff is being triggered…*

Two different views are represented in these extracts: personal experience of abuse is valued as increasing a therapist's insight; not having this is seen as enabling some detachment, as it could be argued, that when a therapist has had similar experiences to their clients, this may lead to over-identification. From either standpoint, therapists would want to be able to separate the client's issues from their own, whilst being touched by the issues.

The extent to which therapists might bring the self to their encounter with a client was explicitly mentioned by a few participants in relation to what they might take to supervision, illustrated here:

Extract 60

> *142. JL: And it sounds like you chose carefully with criteria in mind (supervisor) (...)*
>
> *144. Anita: I'm growing in myself as a person I'm not only a counsellor. That's a part of me um and my practice in person-centred is is throughout my life which is something I really believe in too I don't think it's something I pull on as a hat and then I become this person, it may be I just pull up different skills that are part of me for this particular you know 1-1 session*

Therapists, like clients, may be understood as having different aspects to their selves and as making more or less conscious decisions about what aspect of the self they bring to their interactions with others. The extent to which therapists take on a role and in effect put on a hat, or whether they are essentially the same person but draw on different skills, reflects fundamental questions as to the relevance of context in shaping behaviour and in effect opening up particular ways of interacting in a particular context, or limiting the available options.

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7.3.3.4 *Summary of sub-theme 5*

When moving away from 'either/or' ways of understanding abusive relationships to embrace the complexity of the transactions between intimate partners, therapists are likely to encounter behaviours and beliefs that may seem inconsistent or ambivalent. This invites therapists to hold in mind that there could be different sides to a person or different aspects to their behaviour that could be contradictory. In so doing, therapists move away from conceptualising people as either abusers or victims to an alternative formulation of DVA, encompassing the notion that both men and women are capable of a range of behaviours and sometimes have conflicting motivations, that might be both 'good' and 'bad'. The essence of a relational approach is encapsulated in the intention of holding the person to account for the abusive behaviour whilst being able to see other 'good' aspects of them that make it possible to communicate respect and use empathy to develop a therapeutic relationship. When clients are enabled to become more accepting of their own ambivalence this can enhance self-awareness, facilitating a more integrated self, able to reflect on, and take responsibility for actions that may be consciously chosen, or done impulsively.

When taking a relational approach, therapists might also notice the different aspects of the self they bring to the therapeutic encounter with clients and use this awareness to help understand ways in which they might, like clients, separate off their feelings and behaviours. As with their clients, therapists' own personal history and their gender influence their motivation and choices in their interactions with clients.

7.4   Relational Positioning

As we saw in Theme 2, when therapists talk about their approach to working with DVA they may tend to take up different relational positions depending on whether they are working with victimised clients or 'perpetrators'. When victimised clients are perceived as powerless, vulnerable and lacking self-awareness and the capacity to make choices, therapists tend to offer support and empathy. Conversely, when 'perpetrators' are perceived as powerful and consciously choosing to behave in abusive ways in order to control their female partner, therapists tend to take a more explicitly educative, challenging stance. The way in which a person positions themselves can determine the positioning of others as we have seen across the 4 Themes, though these might be challenged or subverted.

When taking a relational approach to therapy, therapists acknowledge the multi-faceted aspects of their clients and themselves. Exchanges between client and therapist are seen as transactional, and therapists are interested in understanding the client's take on their experiences, their own emotional response to this, as well as the personal and professional understandings which influence the meanings co-constructed in this particular context.

7.5   Summary of Theme 4

In this theme, the principles and related practices of a relational approach to working with DVA are mapped out. These ideas were voiced by only a few participants, though many of the principles fundamental to this approach, and any therapeutic endeavour, were shared, and implicit in all participants' concerns to understand and work both ethically and safely with their clients. Whilst not eschewing gendered understandings of DVA, this approach offers an alternative conceptualisation of DVA that challenges approaches informed solely by this single explanation. It proposes instead a more nuanced perspective that integrates both individual and social levels of understanding.

As we saw in Theme 3, therapists adopting approaches based mainly on a gendered understanding could experience dilemmas, when contradictory information brought into question the initial naming of the problem, the location of responsibility and decoding of what was relevant to focus on, though dissonance might be reduced or eliminated when adopting prescriptive practices. Therapists' concerns about being construed as blaming of 'victims', or excusing of 'perpetrators'' behaviour might mean that they became caught up in constructing blame, re-affirming simplistic 'either/or' understandings that reinforce stereotypical representations of men as 'bad' people who are always the 'perpetrator' and of all women as weak and blameless 'victims'. Just as clients might seek to locate blame in themselves, or the partner, so therapists might scapegoat the person designated the 'perpetrator'. Whilst scapegoating 'perpetrators' might seem to resolve these dilemmas, some participants spoke about the ineffectiveness of practices that were focused on challenging 'perpetrators', but did not acknowledge past hurts and their current frustrations, or were undermining of females who had been victimised when they reinforced unhelpful connotations of victimhood.

In this theme, we see how a conceptualisation of DVA in relationships as potentially multi-directional, and people as multi-faceted, can invite more nuanced understandings and approaches characterised by therapists acknowledging and holding contradictory ideas in mind and seeking to integrate oppositions rather than take up 'either/or' positions. From this perspective, men and women are capable of behaving abusively and may be victimised, and abuse can be both unidirectional and mutual. However, whilst this was explicitly acknowledged by some participants, in the main, it remained implicit in the talk of many participants that it was men who would more commonly initiate abuse.

When putting these principles into practice, therapists might deliberately expand the picture to explore the relational dynamics in the client's relationship and the therapeutic relationship, and understand the different aspects of a client that influence their motivation and choices. Whilst *people find it difficult to get their head around'* the complexity,

because '*they appear to be things that are opposite and they exist together*', in this extract (24) we see how therapists might empathise and make judgments without condemning people. They might move away from blaming or excusing, by exploring the meaning of the abuse in the context of the intimate relationship and the risk issues, unpacking abusive incidents to help clients to understand their own and their partner's motivation and responsibility, letting go of the assumption that the behaviour was necessarily intended to cause harm. When not closing down the opportunity to explore the meaning of the abuse for both partners, by precipitately locating responsibility or constructing blame, therapists may expand their own, and, their clients' understanding of the problem and not *'miss out on a lot of that subtlety and nuance'* (Extract 13). In conclusion, it was apparent that practising in this way required skills in working relationally and in using the therapeutic relationship as a model of non-abusive ways of relating.

CHAPTER 8 DISCUSSION AND CONCLUSIONS

8.1   Introduction

In this chapter, the findings of the study will be summarised and considered in relation to debates in the research literature about theoretical understandings of the phenomenon of intimate partner violence/abuse, and what constitutes best practice when intervening therapeutically.

A number of these debates were reviewed in Chapters 2 and 3:

How the phenomena are defined, and whether these generally involve 'male perpetrators and female victims' (Johnson, 1995; 2006; Girard, 2009; Kimmel, 2002), and whether female acts of violence are instrumental, or defensive, are contested matters in the research domain (Archer, 2000; 2006; Dobash & Dobash, 2004; 2011; Dobash *et al.* 1992; Dutton & Corvo, 2006; Graham-Kevan & Archer, 2003; 2005; 2008; 2009; Graham-Kevan, 2009; Próspero & Kim, 2009; Straus, 2009; Swan & Snow, 2003). Furthermore, it was noted that consistent with findings more generally in the fields of psychology and psychotherapy (Owenz & Hall, 2011), some researchers suggest that a gap has developed between research and clinical practice with intimate partner violence (Murray, 2009; Ehrensaft, 2008; Gadd, 2004; Proctor, 2004). This may be reflected in the common usage by services and practitioners of the term, 'domestic', which is associated with violence/abuse towards women, particularly non-lethal violence, according to Dobash *et al.*, (2007), whereas, researchers use a range of other terms, including, 'intimate abuse', 'interpersonal violence' and 'intimate partner violence' (IPV).

It was also shown in Chapters 2 and 3 that disagreements amongst researchers are manifested in sometimes acrimonious and hermetic debates between pro-feminist and gender symmetry perspectives, whilst others argue for a more integrative approach (Hines, 2008; McHugh & Frieze, 2006; McHugh *et al.*, 2005; O'Leary *et al.*, 2007). These theoretical explanations of intimate partner violence/abuse are underpinned by broadly differing assumptions as to whether the problem is primarily a gender issue, or caused by individual psychological disturbance, or whether it can best be understood in the context of the couple's mode of relating with one another (Allison *et al.*, 2008; Dutton, 1999; 2007a; 2008; 2010; Hamel, 2007; 2009; Brown, 2004; Próspero & Kim, 2009). Flynn & Graham (2010, p. 241) suggest that the lack of a shared conceptual model means that research may not distinguish between different kinds of violence, or recognise that 'individuals in bi-directionally-violent relationships simultaneously occupy the roles of 'victim' and 'perpetrator'. The authors propose that different explanations of violence may be associated with differences in self-partner attributions when individuals speak about their own, or their partner's, violence.

It may be argued that intimate partner violence should not be regarded as a special case, rather that it should be understood as having a purpose, and as no different from other aggressive or violent behaviour that is instrumental in aiming to control others, right a perceived wrong, or appear powerful (Felson, 2010). Nevertheless, conceptualisations of IPV as a gender issue tend to predominate in research, policy and practice (Dutton, 2010; Ehrensaft, 2008; Kelly & Johnson, 2008). In the UK, feminist thinking continues to dominate both policy and practice, reflected in the organisation of services designed mainly for providing support for female 'survivors/victims', and bringing male 'perpetrators' to account, despite evidence of violence and abuse in homosexual relationships and the ineffectiveness of approaches to working with 'perpetrators' based on the Deluth model (Renzetti, 1988; Rivett, 2006; Babcock *et al.*, 2004).

In summary, this qualitative study explored practitioners' perspectives, since those who work therapeutically with clients where violence or abuse against an intimate partner is the presenting problem, may play a role in reproducing existing understandings, or in questioning the effectiveness of current practices (Lloyd & Emery, 2000). The intention was to explicate predominant ways of understanding and approaching intimate partner violence in practice, theory/practice tensions, and alternative, more marginalised conceptualisations. The findings will now be considered in relation to the implications for practitioners, and Counselling Psychologists in particular, when therapeutic practices are informed by a single explanation of intimate partner violence or abuse as a gender issue, or more integrative approaches.

Note: The terms Domestic Abuse (DA), Domestic Violence (DV), and Domestic Violence and Abuse (DVA) were used in the conduct of this research in recognition of the predominance of this terminology in UK practice.

8.1.1   Research aims and questions

The aims of this study were:

1. To learn more about ways of working with DVA that move away from 'either/or' paradigms
2. To consider the implications for supervision when moving away from 'either/or' paradigms.
3. To make recommendations for practice development in working with DVA, and for further research.

Research questions:

1. How do practitioners/therapists working with DVA talk about the phenomena and their approach with their clients?
2. What challenges do therapists face in working with DVA?
3. What other potentialities are opened up when therapists take a relational approach?

The term, intimate partner violence (IPV) will be used later in this Discussion, in recognition of the gendered assumptions associated with the term DVA, with the exception of references to the study data, where the terms DV, DA or DVA were commonly used.

8.1.2   Summary of the analytic aims

The analytic intention of the study was to map out the predominant ways in which violence and abuse in intimate relationships was defined and understood by 17 therapists and 3 practitioners/managers, all of whom were experienced in working with clients presenting with these issues, and how they explicated their approach and needs for support, when these understandings were put into practice. Another key aim of the study was to explore both the tensions that could arise when negotiating sensitive, potentially dilemmatic issues, and the implications of moving away from 'either/or' paradigms and approaches to resolving these, when taking a relational approach.

A thematic analysis, informed by discourse theory and positioning theory, was used to interrogate the data and, more particularly, to examine ways in which participants spoke about negotiating their clients' and their own ambivalence, and how understandings of intimate violence and abuse might influence the relational positioning of client and therapist, in the therapeutic relationship. Themes 1, and 2, mapped out the understandings and approaches to practice spoken about by participants, when DVA was conceptualised as a gender issue. Theme 3 set out some of the main challenges and dilemmas that could arise when working with either 'perpetrators', or, 'survivors/victims', and the potential ways of resolving these when 'either/or' paradigms prevailed. The analytic intention of Theme 4, was to illustrate a less commonly spoken about approach to intimate violence, examining some of the principles and different approaches to working with individuals or couples when violence or abuse between intimates was conceptualised from a perspective that takes account of the relational context, as articulated by a few of the participants.

The overall structure of the themes addressed the first research aim and the 3 research questions. The second and third research aims are addressed later in this chapter.

The structure of each of the 4 themes illustrated the complexity of the phenomena spoken about by the 20 participants, who all had experience as practitioners in specialist domestic violence services, or organisations which provide specialist services within their remit. Many of the participants spoke with passion about their therapeutic work and all were deeply committed to working ethically and professionally with their clients. The analytic intention was to capture both this integrity and the nuances of participants' views in an analysis rich with extracts, which gave voice to the dedication of all participants and to the particular striving of some to question their understandings and seek more effective practices.

8.2   Summary of Findings

8.2.1   Diagrammatic summary

The following diagram (Figure 8.1) represents the ways in which gender, and the location of responsibility, are played out, when looking through the lens of Themes 1 and 2. It illustrates a static, uni-directional understanding of intimate partner violence, conceptualised in terms of roles (Harre & van Langenhove, 1999): the male partner behaving violently and abusively to a passive, disempowered female partner.
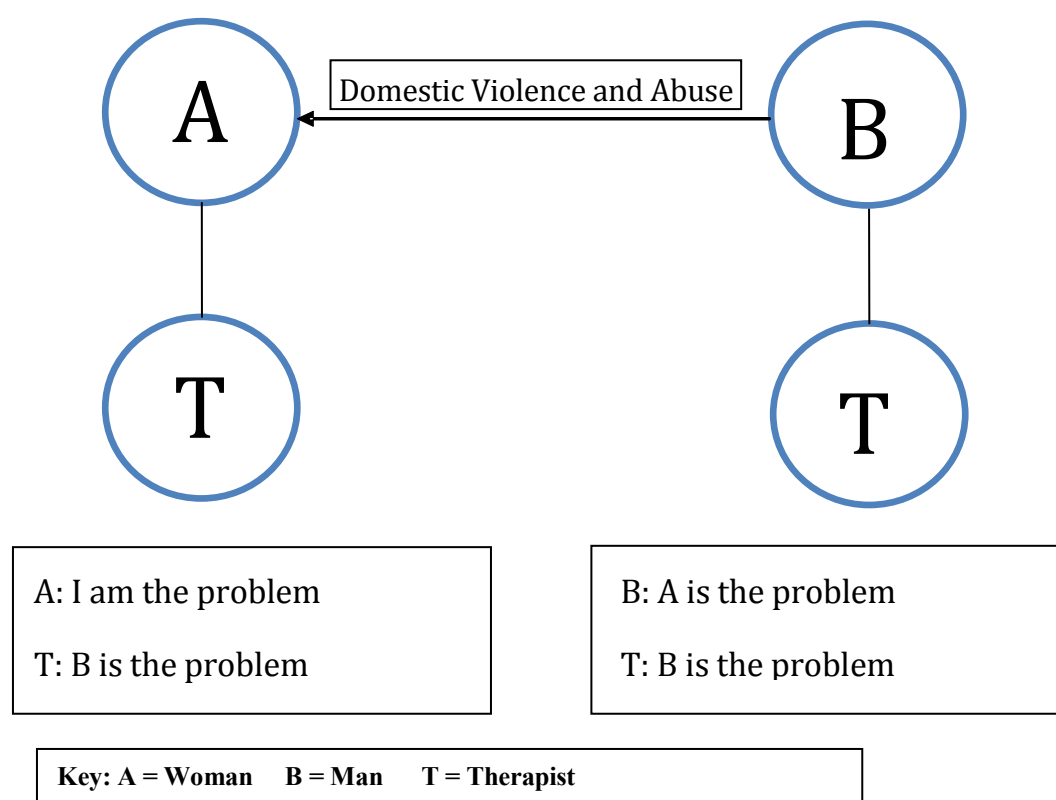
Figure 8.1: Themes 1 and 2: Naming the Problem and Decoding What is Relevant

Theme 3 takes the same interest in gender, the location of responsibility and constructing blame as in Themes 1 and 2, but goes on to identify and explicate the dilemmas and tensions that can arise, and how these are dealt with when using the practices mapped out in those themes. Figure 8.2 sets out how practitioners can begin to get stuck when their own, and clients' attempts, to explain behaviours that hurt others, elicit contradictory information, and also raise questions, for example, as to whether the behaviour was deliberately chosen, done in anger, or self-defence.

A: I am the problem

T: A has a problem with B.

T: Whose problem is this?

B: A is the problem

T: B has a problem with A.

T: Whose problem is this?

Key: A = Woman   B = Man   T = Therapist
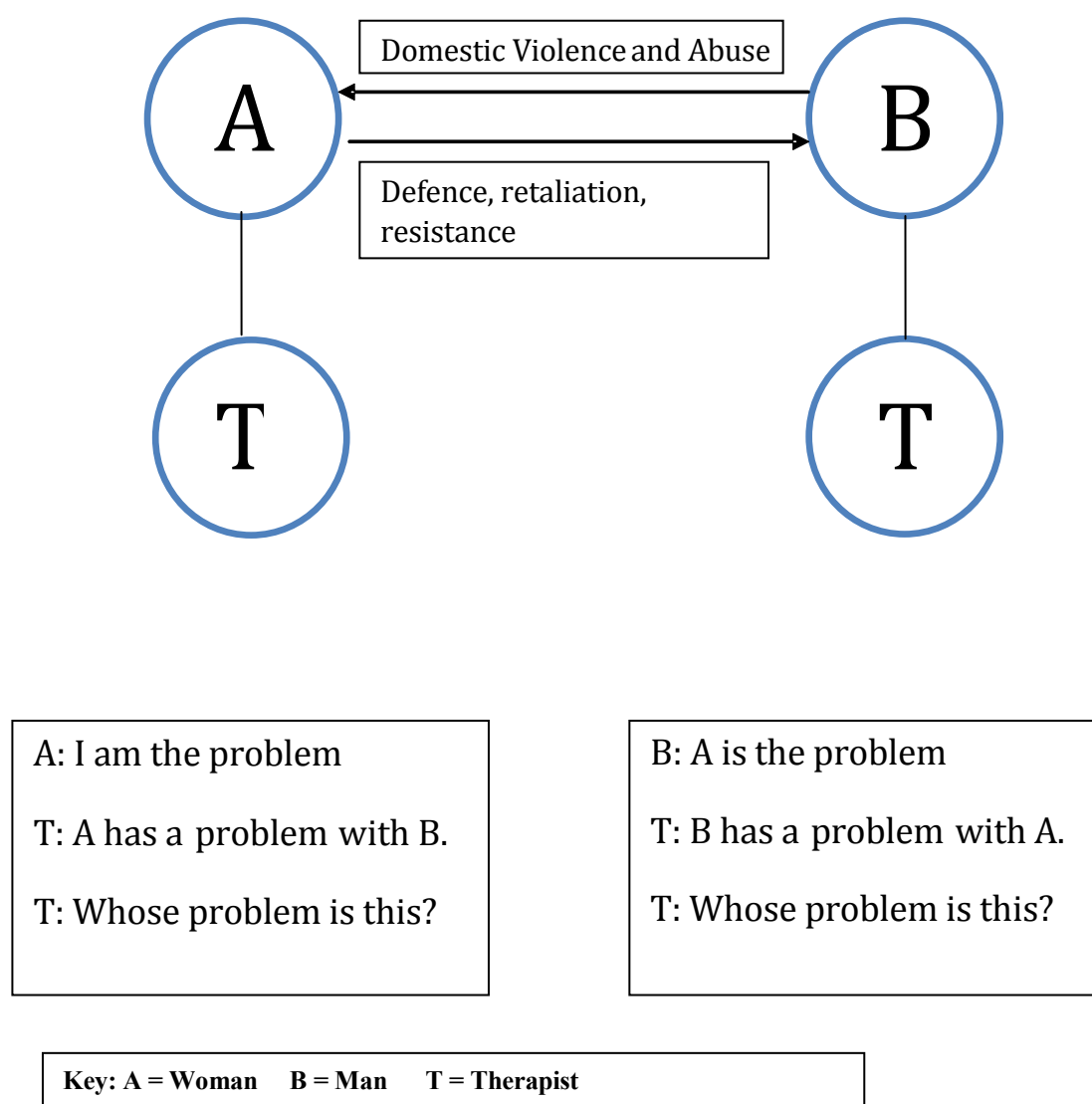
Figure 8.2: Theme 3 How do Therapists Get Stuck? Dilemmas and Missing Narratives

In Theme 4, some participants took a relational perspective whilst in the main retaining a gendered approach. Figure 8.3 represents violence and abuse between intimate partners as gender-related, but potentially multi-directional, and people as multi-faceted, inviting therapists to hold in mind conflictual information and risk issues, whilst focusing on the couple's mode of relating.

ABUSE

A

Conflict, fear of intimacy and abandonment

B

Retaliation
Resistance
Defence

C

T

A: I am the problem/B is the problem

B: A is the problem/I am the problem

T: They have a problem (C). Both are responsible for their behaviour

Key: A = Woman   B = Man   T = Therapist
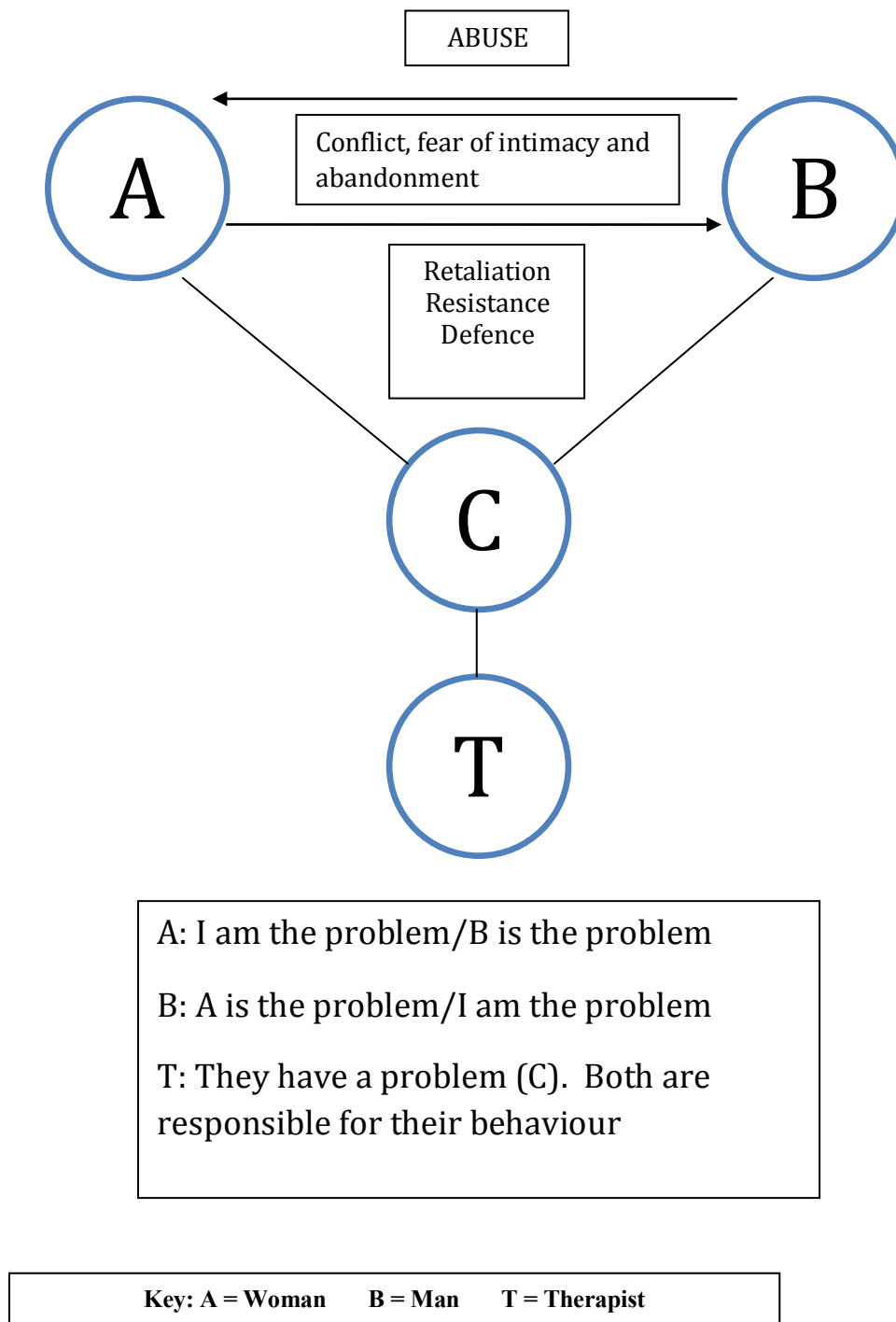
Figure 8.3: Taking a Relational Approach

8.2.2 Table of Results

Themes	Extracts from Participants' Interviews
Theme 1: Naming the Problem	All participants except Dee
Constructions of DVA	Sara , Jas, Dana, Ian, Sam, Dede, Sarah, Anita, Ken, Ann, Jenny, Helen, Beth.
Initial conversational tasks	Sara , Jas, Dana, Ian, Sam, Dede, Sarah, Anita, Ken, Ann, Jenny, Helen, Beth, Eva, Sue, Lyn, Ruth, Jay, Tim.
Theme 2: Decoding what is relevant	All participants except Dee and Jay
Validating 'survivors'/ 'victims' stories	Sara, Jas, Dana, Dede, Anita, Ken, Ann, Jenny, Helen, Lyn
Re-educating 'perpetrators'	Ian, Sam, Sarah, Anita, Beth, Eva, Sue, Tim
Theme 3: How do therapists get stuck? Dilemmas and missing narratives	All participants
Examples of participants' explicit talk about practice dilemmas	Ian, Dede, Anita, Ken, Ann, Helen, Eva, Lyn, Ruth, Jay, Tim, Dee.
Examples of participants' talk revealing dilemmas (outside their awareness) manifest in contradictions	Sara, Dana, Ian, Sam, Dede, Sarah, Jenny, Helen, Beth, Sue, Jay.
Missing narratives: participants who did not demonstrate awareness of experiencing tensions/dilemmas regarding their beliefs about DVA in relation to practice	Sara, Jas, Dana, Sam, Sarah, Jenny, Beth, Sue (Sue also in Theme 4, Extracts 51 and 52) (Jenny also in Theme 4, Extract 53 and 59)
Resolution of dilemmas, or potential dilemmas through 'scapegoating'	Sara, Jas, Dana, Sam, Dede, Sarah, Ann, Jenny, Helen, Sue, Tim Beth's resolution comes through identification with 'perpetrators'(Theme 3, Extract 86; Theme 4, Extract 35, 40, 57) Dana, Dede, Ann, Jenny, Sue and Tim achieve resolution through excusing female 'perpetrators'.
Theme 4:Taking a relational perspective	Dana, Ian, Dede, Anita, Ken, Ann, Helen, Beth, Eva, Lyn, Jay, Dee.
Relational constructions of DVA	Ian, Dede, Anita, Ann, Beth, Eva, Lyn, Jay, Dee (Sam arguing against)
Conversational tasks (including explicit and implicit engagement with a relational perspective)	Dana, Ian, Dede, Anita, Ken, Ann, Helen, Beth, Eva, Lyn, Jay, Dee.

Table 8.1: Table of Results Showing Participants' Extracts Used in Themes 1-4

Table 8.1 shows which participants' interviews were drawn from to illustrate the four themes and sets out differences in the participants' expressed understandings of DVA.

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Across the themes, some participants drew explicitly, and mainly, on gendered constructions of DVA: Jas, Sam, Ian, Sara, Sarah, Dede, Dana and Tim, with Jay, Dede, Ian, Ruth and Lyn offering a critical take, mainly from a feminist-relational perspective. Other participants' expressed views were inconsistent, or reflected some ambivalence, and some of their extracts exemplified an implicit assumption that DVA was a consequence of patriarchy, rather than a consciously articulated construction: Ann, Helen, Sue, Jenny, Beth. Some participants spoke explicitly about facing dilemmas in their practice, precipitated sometimes by client material that did not 'fit' with either their theoretical understanding or personal experience, whilst at other times they seemed unaware of contradictions in their talk i.e. Ian, Dede and Jay, who took a feminist-relational view of DVA which recognised women's capacity for aggression and controlling behaviour, and their responsibility and choices, but still positioned women as 'victims'. Alternatively, Tim, Sue, Ann and Jenny acknowledged women's capacity for aggression, but assumed female 'perpetrators' had been 'victims' and thereby justified women's abusive behaviour as reactive.

Some participants, however, did not speak about experiencing dilemmas, or there were tensions and contradictions implicit in their talk, suggesting these were occurring outside their awareness: Sara, Jas, Dana, Sam, Sarah, Jenny, Beth, Sue. The results suggest that when participants were, like some clients, unaware of, or, they dismissed, information that conflicted with their professional or personal world-view, they could maintain and justify a cognitive bias by scapegoating the 'perpetrator': Sara, Jas, Dana, Sam, Dede, Sarah, Jenny, Helen, Sue, Tim. However, Ann and Beth, who at times acknowledged dilemmas explicitly, while at other times these were implicit in their talk, did not resolve this in their dialogue by scapegoating 'perpetrators'. Instead they both seemed to draw on their personal experience of having behaved aggressively in the past, identifying with, and expressing empathy for, 'perpetrators'.

The views articulated by Ken, Eva, Anita and Dee were those most closely aligned to a gender-inclusive perspective, though they differed in the extent to which they expanded on their views or located them in a particular theoretical position; Eva was the only one of these participants who articulated both her theoretical understanding and practice dilemmas, and also went on to explain how she responded to these.

8.2.3   Overview of study findings

The findings suggest that when IPV is conceptualised as a gender issue, reflecting the idea that patriarchal social relations 'legitimate' the use of violence by men to gain power and control over women, this invites prescriptive approaches to working with IPV delivered in segregated services for clients labelled as female 'survivors/victims', and male 'perpetrators'. The main aims of these approaches, in line with best practice guidelines, and

as articulated by some participants, is to provide validation for women's experiences and support their empowerment, characterised by what Tharpar-Bjorkert & Morgan (2010), refer to as consciousness-raising; and to challenge and change the beliefs and behaviours of men, discouraging discussion of men's personal histories as this is seen as justifying the abusive behaviour (Taft & Murphy, 2007; Milner, 2004; Respect, 2008; Langlands *et al.*, 2009). These aims do not appear to be related to choice of therapeutic model, as a range of different orientations were represented in the data. Tensions and cognitive dissonance can arise in practice, particularly when clients' presenting problems do not fit 'either/or' formulations (Festinger, 1957; Idisis *et al.*, 2007), manifest, for example, when practitioners resist psychoanalytic discourses that position women as choosing abusive relationships (Jackson, 2001; Reavey & Gough, 2000). The analyses indicated that participants might resolve resulting dissonance, or avoid this altogether, when scapegoating men as 'perpetrators', constructing 'villains' in an attempt to avoid victim-blaming, echoing Goldner *et al.* (1990).

The findings also suggest that understandings and ways of working with women who behave abusively and men who are victimised, whether in heterosexual, or homosexual relationships, may be marginalised. Theme 3 provided illustrations of participants disputing, or re-framing female aggression as defence, or retaliation, and conceptualising men's victimisation as a manipulative attempt to shift the locus of responsibility (Dobash & Dobash 1978). In so doing, it was apparent that other ways of understanding clients' motivation, responsibility and choices when they engage in IPV could be closed down, inviting a relational positioning for clients as, either 'perpetrator', or 'victim', commonly influenced by gender. As many participants indicated, however, both positionings may be perceived as carrying pejorative connotations which some practitioners dislike and clients might occupy collusively, or resist (Harre & van Langenhove, 1999).

Expectations that men are always 'perpetrators', and women always 'victims, were spoken about by some participants, in particular, those who worked with male victims, or women who had behaved abusively, as potentially misrepresentative, and subversive to the therapeutic intention to be non-judgmental (Theme 3, Extracts 21-23). Evidence that both men and women might initiate IPV has invited a challenge to existing understandings, strongly contested by some researchers (Kimmel, 2002), but, nevertheless, tending to invite non-gendered re-descriptions that continue to be framed in 'either/or' paradigms in which people are either 'victims' or 'perpetrators'. However, the findings in Themes 3 and 4 (E.g. Theme 3, Extracts 9 and 13; Theme 4, Extracts 12-14) suggest that, in some participants' clinical experience, and as some researchers have proposed, women and men's behaviour can fit either category, and, in some cases, both categories, where there is a propensity in some relationships for a 'switch' to occur due to attachment insecurity (Bartholomew *et al.*, 2001; Henderson *et al.*, 2005; Frieze, 2008; McHugh & Frieze, 2006; Próspero & Kim, 2009; Rhodes *et al.*, 2009).

Difficulties in defining abuse in practice, both implicit and explicit in some participants' talk (Theme 3, Extracts 15-20), call into question the effectiveness of employing prescriptive definitions of IPV and assessments based on identifying the frequency of specific acts of abuse (Murray & Powell, 2009). Some participants suggested, too, that the salience of clients' past and current attachment behaviour was a relevant factor in understanding the meaning, context and motivation to behave abusively. However, when confronted with clients who hurt someone they claimed to love, or stayed with someone who hurt them, some participants spoke of this as confusing or baffling (Theme 3, Extracts 71 and 73), as discussed in Henderson *et al.* (2005). Some participants questioned what love meant to their clients, though said they were cautious about addressing this (Theme 3, Extract 54); on the other hand, those who worked with 'survivor'/'victims' commonly engaged in practices that sought to teach clients about healthy relationships (Theme 2, Extracts 16, 17 and 18).

In the view of some participants, therapeutic practices based on prescriptive definitions and assessments were insufficient to address salient relationship issues and could even, inadvertently, reinforce some women's sense of victimhood (Theme 3, Extracts 39-41) (Tharpar-Bjorkert & Morgan, 2010; Chornesky, 2000; Tower, 2007; Lehrner & Allen, 2009; Girard, 2009; McDermott & Garofalo, 2004); and increase 'perpetrators'' potential to behave abusively (Theme 3, Extract 48), when therapists impose their agenda and clients feel disempowered, victimised and not listened to (Theme 3, Extract 46) (Taft & Murphy, 2007; Milner, 2004; Dutton & Corvo, 2006; Scalia 1994). Indeed, dissonance theory supports the notion of a 'boomerang' effect, or attitude change that is the opposite of what a practitioner intended, or increasingly discrepant, if they make comments perceived as highly divergent from what a client thinks and feels (Staines, 1969).

When moving away from 'either/or' conceptualisations of IPV, some participants spoke about moving away from constructions that either blame or excuse behaviours (Theme 4, Extract 28). Therapists might instead open up the possibility of exploring the different aspects of a person and their history, seeking to understand the meaning of IPV from the point of view of each partner, in the context of transactions that take place in the intimate relationship. The findings suggest that when IPV is conceptualised as a problem in relating, this invites approaches that hold in mind the ambivalence clients, or practitioners, might experience, thereby facilitating a fuller understanding of the issues, potential risks and clients' motivations when they engage in intimate relationships, especially when experiences have been repeatedly abusive (Theme 4, Extracts 24-25). The finding that acknowledging tensions may enable therapists to experience empathy for clients who behave abusively or, for those who seem to tolerate abuse from a partner, when they are emotionally invested in maintaining a relationship, is consistent with studies investigating ways to reduce cognitive bias (Pyszczynski *et al.,* 1993). Letting go of assumptions about

gender-appropriate behaviour may also enable therapists make more nuanced judgments that recognise the few who deliberately choose to harm others, rather than pathologising the majority of clients who may behave in what one participant described as '*unthought*' ways (Theme 4, Extract 40) (Zosky, 1999). These findings in particular have implications for supervision and its role in enabling practitioners to hold in mind, rather than defensively avoid, the contradictory material and intense feelings that are common in this work.

When therapists deliberately move away from constructing blame, and instead position all clients as responsible for their behaviour and able to make choices, they take up a position, spoken about by some participants, that is open to understanding individual differences but does not condone abusive behaviour, whether initiated, done in resistance, or retaliation, or to provoke (Theme 4, Extracts 29; 31-34). From this perspective, the therapeutic intention is to facilitate clients' self-awareness and understanding of their motivation, responsibility and choices, so the therapist role is multi-faceted, rather than prescriptive. This invites more flexible practices, informed by integrative therapeutic models, positioning therapists as responsible for, and choosing adaptive approaches that shift the focus onto an individual when risk issues arise, whilst holding in mind the relational context (Theme 4, Extract 11).

Participants working at the intersection of social and individual levels of understanding in this way, reflected on the dynamic quality of the therapeutic process and the impact of their own and the clients' social and cultural beliefs on the therapeutic relationship, and spoke about their engagement with clients as providing the potential to model ways of relating (Theme 4, Extracts 7; 49-50). From this relational perspective, the therapy process was described as a learning opportunity for both client and therapist, in which meanings were co-constructed in a particular context (Theme 4, Extracts 47; 57-58). Though a partially articulated, and as yet un-developed perspective, some participants spoke about the potential of more integrated approaches for fostering clients' self-awareness and greater capacity for both differentiation and intimacy (Theme 4, Extracts 23; 28; 35).

8.3   The Implications for Practice of Understanding IPV as a Gender Issue

Table 8.2 sets out some of the gendered assumptions commonly articulated by participants, whether or not they spoke explicitly about IPV as a gender issue.

MALE	FEMALE
Men are more violent than women (Theme 1, Extracts 4, 10, 11)	Women's violence is defensive, resistant, or retaliatory (Theme 3, Extract 5, 92, 94)
Men actively choose to use violence and abuse to gain power and control over women (Theme 1, Extracts 7, 8, 14. Theme 2, Extract 20, 43, Theme 3, Extract 100)	Men's control over women is normalised, even by women (Theme 1, Extracts 1, 3, 16, 17, 19, 36. Theme 3, Extract 69) Women do not seek power and control (Theme 3, Extracts 11, 29)
Men are responsible for their own behaviour and for the partner's response (Theme 2, Extract 3. Theme 3, Extract 98)	Women lack choice and are not responsible when they resist, defend, retaliate or stay (Theme 3, Extract 91, 102, 103, 104, 106, 107, 109)
Men lie and minimise, and are in denial of their responsibility (Theme 1, Extract 43. Theme 2, Extract 35, 45. Theme 3, Extract 89, 90, 96, 101)	Women share openly and need to offload (Theme 1, Extract 13. Theme 3, Extract 74, 76)
Men blame the partner: 'You made me do it' Theme 2, Extract 37, 38. Theme 3, Extract 46, 99)	Women blame themselves: 'It's all my fault' (Theme 1, Extract 42. Theme 2, Extract 21. Theme 3, Extract 68, 87)
Men wrongly believe they are 'victims' (Theme 1, Extracts 43. Theme 3, Extract 88, 97)	Women are 'survivors' (Theme 1, Extracts 29, 30)
Men's accounts should be challenged (Theme 1, Extract 37. Theme 2, Extract 33, 38, 39)	Women's accounts should be believed (Theme 2, Extract 8)
Men have low self-esteem and become angry (Theme 2, Extract 31, 32)	Women have low self-esteem and become depressed (Theme 1, Extract 23. Theme 2, Extract 23, 25)
Men must be brought to account/held responsible (Theme 1, Extract 29. Theme 2, Extract 41. Theme 3, Extract 46)	Women require empathy, support and empowerment (Theme 1, Extract 54. Theme 2, Extract 4, 14, 22, 26)
Showing men empathy excuses their behaviour (Theme 3, Extract 62)	Addressing women's choices and responsibility is 'victim-blaming' (Theme 1, Extracts 39, 66, 67. Theme 3, Extract 95)

Table 8.2: Gendered Assumptions About Clients Where DVA is the Presenting Problem, Illustrated in Some Participants' Talk in Themes 1, 2 and 3

8.3.1 Problematising 'either/or' explanations

There is a risk of polarisation through using an 'either/or' framework, which militates against the explication of similarities, as well as of differences, between the genders and

individuals, and any acknowledgement of uncertainty. In other words, each pole is mutually exclusive and excludes everything else e.g. the impact of mental health issues and use of substances (McMurran & Gilchrist, 2008). This is counter to research showing that 'feminine and masculine subjectivities are far from being fixed, stable and unambiguous' and that both men and women construct themselves as, at times, victimised and, at others, acknowledge their agency, and see themselves as powerful (Boonzaier, 2008, p. 202).

Themes 1 and 2 reflected the dominance of feminist ideas in IPV practices and an oppositional dichotomy in participants' understandings, manifest in the way clients tended to be referred to as 'victims / survivors', or perpetrators', although some expressed concerns that the terms over-simplified and over-generalised clients' experiences (Theme 1, Extracts 29-36; Theme 3, Extracts 27, 29). Contrary to the research evidence, assumptions that IPV was commonly, and deliberately, perpetrated by men on women were implicit in the talk of most participants, and expressed explicitly by a few (Theme 1, Jas. 48, Ian. 26, Extracts 2, 8, 11; Theme 2, Extracts 20, 43; Theme 4, Extracts 3, 14, 27, 39). Consistent with Thapar-Bjorkert & Morgan's (2010) findings, however, the data also suggested that practitioners' theoretical understandings and practice might be influenced by implicit counter theories, informed by beliefs and assumption arising from their personal or clinical experience e.g. sympathising with male 'perpetrators' *pent-up ... energy'*, or, puzzling over some women's beliefs that 'victim' is *'written across my forehead'* (Theme 3, Extracts 85, 86; 73).

Nevertheless, the data suggested that participants might strive for consistency and dismiss or avoid acknowledging material that was counter to their personal or professional understanding of IPV, rather than recognise the discrepancy and change their view (Pyszczynski *et al.,* 1993; Staines, 1969). For some participants their own personal experience could also affect their capacity to empathise or take the perspective of the other, meaning that they over-identified with either 'victims' or 'perpetrators' and experienced both empathy and intense feelings other than empathy (Takaku, 2001). Identification with either 'perpetrators' or 'victims' by participants was sometimes made explicit, but could also be implicit in expressions of anger or empathy towards 'perpetrators', or mention of their own experiences and a need, like clients, to offload (Theme 3, Extracts 11, 77, 82, 83, 85; Theme 4, Extract 57). For example, 'perpetrators' might be understood as deliberately manipulative (Theme 1, Extract 8), or behaving in '*unthought*' ways (Theme 4, Extracts 39, 40), whilst empathy towards 'victims' might be expressed in perceptions of them as lacking awareness of their victimisation, or their behaviour, as when their *'internalised rage process somehow gets acted out in violence'* (Theme 1, Extracts 16, 17; Theme 3, Extract 107). Consistent also with Illife & Steed (2000) some participants spoke about becoming over-involved, or, the risk of burn-out (Theme 3, Extracts 78, 79, 80). The data suggested that, as discussed in Morran (2008), practitioners working with intimate partner violence might be at risk of endorsing stereotypical ideas that all men are potential 'perpetrators', illustrated in

some participants voiced concerns that the work was starting to alter the way they thought (Theme 3, Extracts 78, 79).

When practitioners/therapists identify with, or feel impassioned about trying to help victimised clients, they might get caught up in the dynamics of responsibility. For some participants this was a straightforward matter of attributing all the blame to the named 'perpetrator': *I guess in terms of blaming the to me there's one person to blame and that's the person that's um being abusive...'* (Theme 1, Sub-theme 5. 103, Helen). Some participants were expressly motivated by a personal desire to put right perceived injustices, whilst many spoke about the importance of being seen to be taking a clear moral stand that IPV was wrong, captured by one participant: *'what people want is clarity when they've come from domestic abuse. It's about being clear black and white not about the greys cos they've had I'll hit you but I love you. With those kind of mixed messages they don't need that from me'* (Theme 1, Extract 25). This provides a rationale for structured approaches and those that provide education and moral teaching to victimised clients. However, when victimised clients have *'so much to offload'*, and therapists have to deal with clients' *'almost uncontainable'* feelings and their own reactions to clients projections, as we saw in Theme 2, practitioners/therapists might themselves experience confusion and uncertainty, like their clients, whichever client group they work with (Theme 3, Extracts 74, 75, 76; Theme 2, Extract 15). The apparent clarity and certainty of an approach which is predicated on the notion that fault resides either with one or the other partner, and that notions of right and wrong are straightforward, may represent a way of dealing with practitioners' own anxiety, dissonance and discomfort elicited by ambiguous material (Idisis *et al.,* 2007; Safran & Muran, 2000).

Whilst identifying the 'perpetrator' and what is *'obviously abusive'* (Theme 1, 172. Ann), may in some cases be straightforward, in Theme 3 participants' talk about deciding what was *'normal'* (Theme 3, Extract 16) and how, *'what may feel abusive to one person may not feel abusive to another'* (Theme 3, Extract 18), suggested that in practice, making judgements about what counts as abuse, and who is at fault, was a complex process, particularly when this takes the form of psychological abuse. As we saw in Extract 15 (Theme 3), therapists might draw on their own personal experience when deciding what counts as a *'pattern of abuse'*: *'I could have an argument with my husband and he calls me lots of different names, but that wouldn't be classed as domestic violence, it needs to be um a pattern and it's about wanting to have power and control over me... if two people argue that isn't necessarily an abusive situation...'.* However, recognising differences in couple relationships further invites us to question practices premised on reductionist categories. When clients and behaviours are categorised out of context, labels may serve to over-generalise risk, such that all 'survivors' of IPV are perceived to be at risk of death, and arguing, or slapping someone, may not be differentiated from 'battering'. The idea that there

are *'degrees of abusiveness'*, and that*: 'a man who slaps his wife in a jealous fit is not as bad as a man who batters'* remains, nevertheless, highly controversial as it might be perceived as minimising the impact of abuse, or excusing it (Theme 3, Extracts 20 and 32).

Also, contrary to recent research by Graham-Kevan & Archer, (2009), finding that men and women do not differ in their controlling behaviour, it appeared that participants commonly attributed motivation to control to men, and when women behaved aggressively, this was understood as expressive and a reaction to violence perpetrated against them (Theme 3, Extracts 13, 38, 76, 92). Participants also commonly made generalisations about 'victims' as lacking agency and behaving without thought, representing women as not responsible for their behaviour (Theme 1, Extract 3; Theme 3, Extracts 5, 107, 108, 109; Theme 4, Extract 45), and there was little recognition of women's capacity for abusing power themselves (Fitzroy, 2001). The data suggested that, contrary to research indicating that 'a substantial number of women seeking services for victimisation may also be 'perpetrators' of IPV', participants commonly understood female 'survivors/victims' behaviour as self-defence, resistance or retaliation (Theme 3, Extracts 18, 108) (Williams *et al.*, 2008, p. 245). Practices based on this assumption, as illustrated in Themes 1-3, may re-produce stereotypical notions of femininity, and close down the possibility of exploring women's intentions and understanding the meaning of their aggressive behaviour, which might, as one participant proposed, be a way for some of exercising agency or resistance (Theme 3, Extract 96).

Nevertheless, across the data, violence and abuse was commonly explained as the exercise of power and control over the partner, whether or not IPV was seen as a gender issue, so there were some contradictions in the views expressed. It was perhaps indicative of an implicit belief in patriarchal explanations, that participants were commonly more accepting of the term 'perpetrator' for men, and that those who worked in services that provided interventions for female 'perpetrators' spoke of it as an inaccurate descriptor for women (Theme 3, Extract 29). The tendency to see the problem in oppositional terms appeared to be deeply embedded in the organisational structure of services, reflected in the tendency for most therapists to work with either, but not both, client group(s). Female participants commonly worked with female 'survivors'/'victims' in segregated settings, whilst both male and female participants worked with 'perpetrators' of the opposite sex, though it was more common for men to work with men. This segregation of services meant that not only did most participants hear only one side of an account of IPV, they heard only one gender's perspective. Some participants spoke about an organisational culture which reflected a particular take on partner violence and might make accessing services problematic for those who were not either male 'perpetrators' or female 'victims' (Theme 3, Extracts 22-25; 81). In this way, services both reflected and might promulgate a de-contextualised view of IPV.

8.3.2 Problematising 'either/or' constructions of blame and responsibility

48-50. Dede: while you say women are victims it places women in a holding bay. It says you're always victims, you're the lesser, you tap in to that historic psychology. You reinforce the fact that they are victims. What we're suggesting that they do is actually look at this and take responsibility for themselves in it (Theme 4).

22. Eva: ... I can't ever say that a violent act is not a violent act and that responsibility has to be owned either way whether it had whether it had been provoked um or not (Theme 4)

Seeking to understand the origins of violent behaviour has been considered dangerous for 'victims', as it might seem to excuse 'perpetrators'' behaviour (Bograd & Mederos, 1999; Brown, 2004), and blame 'victims' for an event they did not cause (Shaver & Drown, 1986). Consistent with a patriarchal view, many participants spoke about locating responsibility with 'perpetrators' as the main aim of the therapeutic work, and, in particular, for those working with 'perpetrators', there were expressed concerns that practitioners should not get diverted by male 'perpetrator' accounts that sought to minimise their culpability and shift blame onto their female partners (Theme 1, Extracts 37-38; Theme 2, Extracts 3, 29, 35, 37, 41-43, 46; Theme 3, Extract 63, 87, 89, 96) (Anderson *et al.*, 2003; Dobash & Dobash, 2004). When speaking about violence by females this was referred to by some participants as different from male violence e.g. *'females find themselves being angry and aggressive in their relationships'* (Theme 3, Extract 29) or *'this internalised rage process somehow gets acted out in violence' (*Theme 3, Extract 107), and as a response to male violence (Theme 3, Extracts 92, 108). Correspondingly, as Themes 1-3 illustrate, therapeutic approaches taking a gendered perspective would commonly aim to validate women's experiences, whether they were attending services for 'survivors'/'victims' or 'perpetrator' programmes. Participants commonly spoke about assuring 'survivors'/'victims' that their accounts were believed and that they were not to blame (Theme 1, Extract 42; Theme 2, Extracts 8, 9, 11, 20); and this might involve overtly reframing their responses as resistance (Theme 2, Extract 21), and expressions of rage as a '*healthy*' means of creating a '*level playing field*' (Theme 3, Extract 5).

It could be argued that practitioners should challenge societal discourses of 'patriarchal resistance', which suggest women invite abuse, for example, when they dress or behave 'provocatively' (Thapar-Bjorkert & Morgan, 2010). From this perspective, addressing questions of individual responsibility with 'victims' may be understood as transforming public problems into personal ones, obscuring structural disadvantages, and inducing shame (Reavey & Gough, 2000; Wright, 2008). It was explicit in the talk of all participants that victims were not blameworthy, whilst questions of responsibility were contentious, rejected as blaming by some, and approached with caution by others, concerned, for example, that

victimised women who do not leave abusive partners might be misrepresented as getting what they '*deserve*' (Theme 3, Extracts 67, 68, 73).

It may be suggested, nevertheless, that skilled therapists manage the moral dilemmas that arise when negotiating these potentially contentious issues, by fostering moral agency in the client and not becoming either prescriptive about what is right and wrong, or avoidant of addressing issues of responsibility. The study data was consistent with Kurri & Wahlstrom's (2001) findings, that counsellors working with domestic violence 'victims' tend to be guided by the following 3 rules: respect the client's decision; violence is always wrong; help the client in their situation. However, assumptions about 'victims' having no power or choice and so not being responsible for what had occurred, or their responses to the violence or abuse, meant that addressing issues of responsibility was most commonly spoken about as fundamental only to the work with 'perpetrators'. The data suggested that approaches to fostering moral awareness could, nevertheless, be prescriptive with both client groups: expressly linked to 'perpetrators' taking responsibility and learning what is '*wrong and right*' (Theme 2, Extract 36); and '*shifting*' the thinking of 'survivors'/'victims' (Theme 2, Extracts 16-20).

The findings indicated that although the constructs of causality, blame and responsibility, are different, these can tend to become conflated (Shaver & Drown, 1986). It was common across the data that participants spoke about victimised clients as self-blaming and 'perpetrators' as blaming of their partners, thereby subverting what participants believed to be the 'true' relational positioning. Some spoke about having to resist attempts by 'perpetrators' to subvert a repositioning of them as wholly to blame for their own behaviour, and their partner's, particularly when they might claim that a partner had 'wound' them up (Theme 3, Extract 99) (Jukes, 1999). Participants' own motivation and sense of moral responsibility were apparent in their concerns not to collude with what they saw as inaccurate attributions of blame, and this was commonly illustrated throughout the themes. However, although all participants working with 'perpetrators' spoke explicitly about seeking to engender responsibility-taking by clients, it was implicit in the talk of many that 'perpetrators' were assumed to be to blame i.e. intent to harm was taken-for–granted (Theme 2, Extract 43). This provided justification for taking the position that a focus on male 'perpetrators'' experience of past abuse, mental health problems, or difficulties in functioning, would represent a diversion from the main aim of making them take responsibility for their behaviour, and might even be used manipulatively to excuse this (Theme 2, Extract 35, 63), as has been found in other studies (Taft & Murphy, 2007; Scalia 1994).

However, when making judgments about responsibility and blameworthiness, we might question whether someone has to intend harm in order to be morally responsible for the

action, and, indeed, whether men's actions always have a control motive, or whether women are always motivated by self-defence (Felson, 2010; Lamb, 1996) e.g. *'It's not saying that what he does is right whether he's in control there and he should be in control, it's saying you won't be able to help him gain control if you cannot understand that he does not feel that he is in control.'* (Theme 4, Extract 41). Nevertheless, the data suggested that, commonly, a client's motivation and behaviour would be understood in the context of their naming as 'victim' or 'perpetrator'. So, when assessing responsibility, self-awareness and control, appreciation of right and wrong behaviours, and the perceived intent, were considerations more likely to influence judgments as to a 'victim's' responsibility when they engaged in abusive behaviours, than a 'perpetrator's' (Theme 3, Extract 13; 97-8;104-107). Similarly, the data suggested that experience of past abuse was more likely to be considered a mitigating factor for female 'victims'', or female 'perpetrators'' behaviour, than it was for 'male 'perpetrators'', or male 'victims'' (Theme 3 Extracts 4-5).

Where the presence of potential risk alerts therapists to others' vulnerability, triggering anxiety and a sense of moral responsibility to take a firm stand on the wrongness of violence and abuse, this may pose a particular challenge to the therapeutic intention to be non-judgmental when naming the problem and who is responsible. The consequence of the tension created may be a decisive prioritising of risk over other factors, in effect a defensive manoeuvre, reducing the apparent complexity of the problem, but in so doing, as Goldner *et al.* (1990) proposed, creating villains and victims. From this perspective, the person named as 'perpetrator' may be construed as entirely responsible for the victimisation of the other, so justifying the 'victim's' response as having an intent to defend or resist for their own protection. However, these behaviours might otherwise be perceived as contributing to the escalation of violence or abuse and the potential risks to both parties, as in, *'that particular resistance would um perpetrate further violence'* (Theme 3, Extract 32).

Nevertheless, some participants spoke about their own ambivalence when hearing a client talk about deliberately provoking a partner, or when females in a 'perpetrator' group might regard abuse towards a man as a cause for celebration, if they *'got one back'* for having been victimised (Theme 4, Extract 34; Theme 3, Extract 89). This might be understood as tension between institutional discourses and individual perceptions, which, on the one hand, promulgate homogenous constructs of women as 'survivors', or victims', and not to blame for abuse perpetrated against them, and on the other, offer individual stories of a reality that is more complex (Jackson, 2001; Thapar-Bjorkert & Morgan, 2010). The authors suggest that those who work with victimised clients may, unintentionally, convey judgmental attitudes suggesting women are to blame for men's abuse when there is implicit collusion with 'commonsense' understandings that women may provoke or 'wind men up'.

Nevertheless, it was apparent that when participants tried to avoid victim-blaming, or excusing 'perpetrators', they could get caught up in scapegoating 'perpetrators' and excusing 'victims' (Theme 3, Sub-themes 5 and 6). Whilst men were commonly referred to as in denial, claiming, 'She made me do it', when victimised clients make similar justifications for retaliating, it was implicit in some participants' talk and explicit in others' that this posed a dilemma. For some participants, retaliatory behaviours by clients might be reframed as standing their ground (Theme 3, Extract 18), or justified as *'healthy'* (Theme 3, Extract 5). However, the potential consequence of not exploring the reasons for both partners' behaviour, as we saw illustrated across Theme 3 and in Theme 4, may be that treatment decisions are based on partial understandings and risk issues are not fully assessed. If risk issues are not addressed, some abuse might remain hidden: *'there's no excuse for hurting anyone or abusing in any way yeah you know sometimes it can be both of the the behaviours that you know inevitably bring about more abuse so it can hide the abuse so you know that person if someone isn't prepared to walk away and they're still having a go at the person and maybe they should just give them the space you know then then who's at fault then?'* (Theme 3, Extract 52).

Flynn & Graham's (2010) review of common reasons for interpersonal violence suggests that the construct, provocation, was associated with self-defence and retaliation by both men and women. However, they found that constructs tended to be used differently in studies, so reported understandings of how men and women used them were inconclusive. Furthermore, they identified disconnects in experience that mean one partner may perceive the other's behaviour as a threat, and so perpetrate violence or abuse with the intention of protecting the self, whilst the other construes this as an unprovoked attack. The study also found that women were more likely to endorse using retaliation when they felt emotionally hurt, and that whilst women might retaliate to 'get attention', men were found to retaliate to 'get the partner's attention'. Overall, however, they concluded that self-partner differences were more prominent than gender differences, and that there are a number of different factors associated with both men's and women's reasons for behaving aggressively in intimate relationships.

Consistent with this gender-inclusive perspective, some participants took the view that, in their experience, prescriptive, one-size-fits-all therapeutic approaches could result in ineffective outcomes, facilitating only temporary change in 'perpetrators'' behaviour, as research suggests (Babcock *et al.*, 2004; Gadd, 2004; Rivett, 2006; Langlands *et al.*, 2009) e.g. *'you know even from a just a purely effectiveness point of view I just don't think people listen to you when you're just treating them like a bad person'* (Theme 3, 168. Jay). When men's feelings and claims of being abused by a partner are discounted, or dismissed, therapists may, paradoxically, be taking up a position as overtly having power and control over their clients, re-producing, in reverse, the alleged 'perpetrator/victim' dichotomy and

relational positioning in the client's relationship. Some participants expressed concerns about the consequences of confronting 'perpetrators' and not taking account of 'who did what to whom' (Theme 2, Extract 29; Theme 3, Extracts 35, 42, 43, 44, 46, 47, 48, 52, 53). One participant said: *some people actually in our project think you can make people more dangerous by only working with the thought levels because you're not addressing the actual triggers and you're actually not really they talk the talk but they don't walk the walk (*Theme 4, Extract 48). This was consistent with research suggesting that using confrontational strategies with male 'perpetrators', which are controlling and dismissive of their feelings, encourages stereotypical behaviour and may even increase their abusiveness (Taft & Murphy, 2007; Milner, 2004; Dutton & Corvo, 2006; Dutton, 2008; Corvo *et al.*, 2009; Scalia, 1994).

Similarly, the findings in the study suggested that when practitioners perceived addressing issues of motivation, responsibility and choice with females who have been victimised as tantamount to 'victim-blaming, or they feared that it would be construed as such, they might avoid exploring the repeated victimisation of women who return to an abusive partner, or enter into other abusive relationships. As we saw in Theme 2, practitioners might work with an agenda that includes raising awareness and teaching victimised clients about right and wrong. However, in seeking to establish their blamelessness, or lack of awareness (Theme 1, Extracts 16, 18, Sub-theme 2, Sara. 21), practitioners might, unintentionally, reinforce stereotypical constructions of 'victims' as passive and needing to be told by others how to lead healthier lives (Chornesky, 2000; Tower, 2007; Lehrner & Allen, 2009; Girard, 2009**;** McDermott & Garofalo, 2004; Reavey & Gough, 2000; Wright, 2008).

Furthermore, use of the term 'survivor', in preference to 'victim', could also impose a particular generalised take on an individual's experience, a positioning with which clients might not identify. As some participants said, the term 'survivor' could be used to denote a stage in recovery, when they leave an abuser, which some might not achieve, or to emphasise the qualities of strength and endurance, with which some might not identify (Thapar-Bjorkert & Morgan, 2010). Some participants spoke about addressing what are contentious issues regarding women's decisions to stay in, or leave, abusive relationships, drawing on psychoanalytic explanations, attachment or, individual pathology, whilst a minority were strongly opposed to any such approach that might represent victimised clients as engaging in a '*pattern*' of complicit behaviour, and shift the focus away from holding the 'perpetrator' responsible (Theme 3, Extracts 59, 61, 66, 67, 72, 73; Theme 4, Extracts 2, 3, 6, 27).

So, the data provides an account of therapeutic interventions for named 'perpetrators' and 'victims' that differ in their explicit focus and intention, with regard to engendering the taking of responsibility and the construction of blame (Lamb, 1996). It seems that when

therapists use the power lent by their status and knowledge to legitimise practices that confront 'perpetrators' and support 'survivors'/'victims', they may, unintentionally, re-position male 'perpetrators' as 'victims' in the therapeutic relationship, and re-produce women's experience of victimhood, disempowering both. In effect, clients may receive mixed messages, when practices are explicitly supportive but implicitly blaming (Thapar-Bjorkert & Morgan, 2010), or, exercise practitioners' power to judge and even humiliate (Dutton & Corvo, 2006; Corvo *et al.*, 2009). The further consequence of not addressing contentious issues such as provocation and retaliation may be that factors that contribute to maintaining the problem are not elucidated (Flynn & Graham, 2010).

The resolution of dilemmas posed in allocating and owning responsibility for abusive outcomes may, alternatively, be understood as an attempt to manage the paradox represented by actions that hurt someone you love. Clients might justify, excuse or blame, positioning the self in their relationship in a way that renders their behaviours explicable, in an attempt to preserve the relationship and the integrity of the self (Zosky, 1999; Henderson *et al.*, 2005). Men who are dependent on their female partners may experience themselves as both powerful and powerless (Gadd, 2002; 2003). These paradoxes may remain implicit in therapy, however, when the foregrounding of issues of ethics and morality both legitimate the imperative to make someone accountable and keep the vulnerable safe, and close down the possibility of understanding the relational context. The outcome may be that practitioners collude with 'either/or' attributions of blame, and more importantly, some couples' desire to preserve their relationship and make it healthier may remain unaddressed (Theme 4, Extracts 1, 26).

8.3.2.1 *Relational positioning of blaming/taking responsibility*

Participants' talk about male 'perpetrators' blaming their partners, and female 'victims' claiming to have acted in self-defence, represented a construction of IPV that has achieved the status of truth-telling (Gergen, 1999). These may be seen as justificatory manoeuvres by clients to explicitly disown their behaviour and their responsibility, implicitly representing their position as powerless, precipitated by the other's blameworthy behaviour and hence, not their fault. Therapists may challenge or take up these narratives, as was illustrated in Theme 2, Sub-theme 1, and set out in Harre & van Langenhove (1999). Also, when a person takes all the responsibility, both for their own behaviour and the actions of the other, summed up by, 'It's my fault', which implicitly seeks to excuse the other's behaviour as provoked and/or impulsive, it may be seen as a justificatory manoeuvre sometimes used by those being victimised to preserve the 'good' of the other, thereby implicitly representing their own position as powerful and yet potentially blameworthy. The data suggests this is a forced positioning therapists might seek to impose on 'perpetrators', when they are deemed to be wholly to blame for the abuse (Theme 2, Sub-theme 1). In this way, therapists position

themselves as experts, sanctioning a particular representation of the problem (Neimayer, 1998; Peled *et al.*, 2000).

8.3.3 Problematising choice

> *148. Jay: ...I don't actually think that all people walk around consciously going I'm going to hurt her now and not him there. I don't think that's how it works (Theme 4).*

Evidence that those who are victimised would choose to remain in an abusive relationship, and that someone might deliberately harm a loved one, seems paradoxical, and potentially shaming. One approach to managing this, as described in the data, may be for practitioners to take up constructions of 'victims' as not having choices (Theme 3, Extracts 102, 104). From this perspective, suggesting otherwise could be perceived as victim-blaming when, for example, 'victims' might have to stay in an abusive relationship for a range of reasons (Theme 3, Extracts 66-67) (Anderson *et al.*, 2003; Murray, 2008). However, 'perpetrators'' violence was commonly spoken about as instrumental and deliberate (Theme 1, Extracts 7, 8, 11). This approach to understanding choice was illustrated in Theme 3, when, for example, 'perpetrators' had also been 'victims', or when 'victims' seemed to repeatedly 'choose' violent partners: *I think perpetrators or those who use violence are very clever at picking up you know it was my childhood, I didn't know any better, my father used to beat me and my mother, so they are very clever at psychologising their motivations for violence er giving explanations for violence (*Theme 3, Extract 63*); One difficulty for me with er women who are victimised that I work with is when they endorse the idea that they have er repetitive compulsion pattern and that um because I I don't buy into that idea at all (*Theme 3, Extract 59*).*

However, research suggests that patriarchal explanations assuming male violence and abuse to be consciously chosen and directed at complicit female 'victims', represent an over-simplified account (Hamel, 2010). Professional practice provides evidence that motivation in intimate relationships is complex and choices may be driven by emotional attachment: behaviour may be influenced by both love and hate for a partner and people in dysfunctional relationships can be strongly bonded (Borochowitz & Eisikovits, 2002; Gadd, 2003; Lloyd & Emery, 2000; Godbut *et al.*, 2009; Henderson *et al.*, 2005; Zosky, 1999). Indeed, research evidence supports the view that dysfunctional relationships may be the most stable (Bartholomew *et al.*, 2001). However, some participants' talk did not reflect recent research identifying other factors, in addition to gender, as being associated with partner aggression (O'Leary *et al.*, 2007; Hamel, 2009). Whilst one participant spoke about '*co-dependency*' (Theme 4, Extract 3), it was apparent that other participants might reject the idea that love and hate could co-exist (Theme 3, Extract 54, 73).

Participants commonly expressed the view that 'perpetrators' were lying, manipulative, or in denial of their chosen behaviour (Theme 1, Extract 43; Theme 2, Extract 35). However, at the same time, some participants positioned abusive clients as not having been taught about right and wrong behaviour, so preserving their worthiness to some extent (Theme 2, Extract 36) (Harre & van Langenhove, 1999). Similarly, when clients claim to love, and be loved by, someone who is abusing them, this represents a challenge to feminist theory and defies 'common-sense' understandings of what constitutes a loving relationship and a 'healthy' choice of partner. Therapists may therefore find themselves both puzzled and caught in a similar double-bind (Safran & Muran, 2000). The findings suggested participants might extricate themselves and victimised clients by both blaming the 'perpetrator' for destroying a 'victim's' capacity to think rationally, and positioning 'victims' as not knowing about healthy relationships, so preserving their worthiness to some extent (Theme 2, Extract s 18 and 22, Theme 3, Extracts 3 and 104).

As we saw in Theme 3, when the culpability of men, and the innocence of women is assumed, practitioners might tend to scapegoat male 'perpetrators', as not only choosing their behaviour, but also as being responsible for their partner's response. Conversely, the blamelessness of female 'victims' might be preserved through recognition of their traumatisation, rendering any apparent complicity in their victimisation understandable and excusable, and protecting them from accusations of making irresponsible choices, particularly when they had children who were witnessing IPV (Theme 1, Extract 3; Theme 3, Extracts 67, 69). This provided a rationale for the relational positioning in therapy, by most participants, of 'victims' as not knowing and in need of support and educative counselling, whilst 'perpetrators' were similarly positioned as not knowing, but in need of clear instruction on how to think morally (Theme 2, Extract 12; Theme 1, Extract 26). However, whilst the aim to re-educate was explicit in most participants' talk about their approach with 'perpetrators', this was more often implicit in the approach with victimised clients to 'shift their thinking', particularly where a person-centred model was espoused (Theme 2, Extracts 16, 17, 19, 20).

Supporting clients to make choices is, thus, far from straightforward in practice, particularly when participants might hold views as to what were 'healthy choices' and morally acceptable behaviour and might explicitly, or implicitly, promote their own agenda, albeit in a client's best interests e.g. *going in without an agenda but I suppose my agenda at the end would be that they choose healthier relationships for themselves' (*Theme 2, Extract 19). One participant offered an alternative approach, explicitly linking consciousness–raising with the owning of choices: '*make the women more conscious, more conscious of themselves'* in order that they might *'say, I've got a choice I know where this is coming from um I could perhaps do this differently'* (Theme 4, Extract 36).

8.3.3.1 Relational positioning of choosing/not choosing

When 'perpetrators' are construed by practitioners as choosing to abuse a partner, they might be expected to acknowledge their behaviour as being wrong/unhealthy, and deliberate, as was illustrated in Theme 1, Extract 8 and Theme 3, Extracts 96, 98. In the case of someone repeatedly experiencing victimisation, they may see themselves, or be seen, as unwittingly complicit in putting themselves in the way of harm and not having choices, or not knowing they have choices (Theme 3, Extracts 96, 101 and 102). As when implicitly denying responsibility, clients may adopt a position of helplessness, and being deserving of special treatment, by 'offering an excuse by way of an explanation' in order to 'resist an accusation of guilt' (Harre & Luk van Langenhove, 1999, p. 26).

The 'choosing' position may be resisted by those categorised as 'perpetrators', and therapists may be reluctant to position female 'victims' as choosing to stay with abusive partners, as was illustrated in Theme 3. It may be understood as intended to move someone out of experiencing the self as powerless and diminished by the outcome of their behaviour, but it potentially risks shaming, pointing out a moral failure (Kurri & Wahlstrom, 2001). Both victimised clients and 'perpetrators' may believe they find themselves in a position they have not chosen and are unable to change; they may believe that they must accommodate others' wishes, or are being diminished and controlled. Implicit in this position is likely to be an imperative to justify and/or minimise the abusive behaviour whether this is their own or the other's. So, this may not be perceived by the self per se as a choice to be abusive, or a choice to be victimised; clients may see themselves as misunderstood and powerless. Not making choices may be perceived as an overtly powerless position by self and others, and may be experienced and explained by the self as because, 'I'm not good enough', 'I'm worthless', 'I need others to tell me what to do'. However, there is also the potential to be experienced as controlling by others, when behaving in ways that are experienced as deliberately provocative or intended to 'wind up', or belittle the partner.

Practitioners also take up a position in therapy: everything they say represents a decision, whether or not this is consciously made. In this respect, to the extent that they are able to own their own decision-making processes, reflect on their impact and be transparent about this with their clients, they may model ethical decision-making in practice.

8.3.4 Problematising a focus on one partner's perspective

> 'sometimes I would I would sit with the so-called victim and think, 'Mmm but who is doing what to whom? '' (Theme 3, Sub-theme 2. Eva. 21)

When therapists focus only on one person in a relationship, this invites a deterministic, or one- person perspective of relating in which one person is seen as acting on another, or being acted upon without taking account of the impact of the other person's intentions or behaviour (Wachtel, 2008). This may re-produce clients' tendency to focus on self or other, legitimating explanations that may not take account of the relational context in which violence or abuse has occurred. Object relations theory, offers an explanation of how these polarised constructions of reality can arise and are maintained at a micro level, identifying the emotional saliency of a dichotomous relationship for both partners, when each needs the other in order to sustain their own and the couple's integrity (Zosky, 1999). Additionally, attachment theory offers explanations of why individuals in relationships characterised by abuse can be strongly bonded, why they might attract partners with whom they play out early unresolved difficulties in relating, and why violence can serve a function in preserving the relationship (Bowlby, 1988; Bartholomew *et al.*, 2001; Borochowitz & Eisikovits, 2002; Henderson *et al.*, 2005; Schore, 2012). Understanding based on one person's perspective, ignoring the relational context within which thoughts, feelings and behaviours are constructed, may generate explanations that over-generalise and do not take account of the broad range of potential factors: individual, interpersonal and social, that may contribute to partner aggression (O'Leary *et al.*, 2007).

When the culpability of men is assumed, and it is regarded as unacceptable to make judgments as to degrees of abusiveness (Theme 3, Extract 20), what counts as an abusive behaviour may appear deceptively straightforward (Theme 1, Sub-theme 3). However, as was illustrated in Theme 3, Extracts 52, 57, participants could find this more difficult to assess in practice, for example, when information about a partner was introduced. For some participants, however, questions about who did what to whom would not be considered relevant. Talk about the behaviour of a 'perpetrator's' partner was commonly not mentioned by some participants, except in relation to it being used to confirm the 'perpetrator's' culpability, or, as a ploy by 'perpetrators' to blame their partner. When participants were faced with contradictory information, however, some questioned whether the labelling of a client as 'perpetrator' or 'victim' was accurate or useful, *'one person can encompass a whole gamut actually'* (Theme 3, Extract 33), and this could elicit ambivalence and a sense of confusion as to the appropriate focus of the work (Theme 3, Extracts 12, 13).

In the main, however, most participants did not deliberately expand the picture to include the partner, and questions as to why a client might think they had 'victim' written on their forehead, or return to abusive partners, or why someone might switch from being victimised to behaving abusively, could remain puzzling, or unspoken and unexplored (Theme 3, Extracts 13 and 73). Whilst the use of diagnostic categories can be appealing because they '....appear as objective truths, minimising diversity and contradiction', Parker *et al.* (1995, p. 47 and 38) argue that 'the experience of practitioners is often of someone who seems both

anxious and depressed, of people whose problems seem ambiguous and messy, not at all scientific.' As the findings illustrate, when naming the problem involves categorising clients and their behaviour, this invites prescriptive approaches to resolving contradictions, rather than recognising that experiences are 'always contradictory' and people are all 'multiply positioned' in terms of 'different characteristics' (Parker *et al.*, 1995, p.39).

The way in which a person positions the self, or is positioned, in relationships, opens up, or closes down, the options for both, so when a person takes up a position on one side of an opposition this invites the other person to take up the complementary position. It seemed that participants' status and knowledge gave them more power to make moral judgments, influencing or subverting the clients' position in the therapeutic relationship, by deliberately positioning or forcing a position (Harre & van Langenhove, 1999). Practitioners might, therefore, take up a position in opposition or collusion with a client, rather than inviting reflection on the utility of the client's positioning and the multi-faceted aspects of the self they bring to their relationships. Alternatively, a move towards a more dialectical approach, understanding experience in relation to context and the other's perspective, could facilitate the exploration of issues of choice and responsibility in both the client's and the therapeutic relationship, opening up different 'potentialities' for future actions (Willig, 1999, p. 40).

8.3.5 Summary of the practice dilemmas identified in Theme 3

The study findings supported the view that a 'one-size-fits-all' approach may not deliver appropriate and effective treatments (Briere & Jordan, 2004; Fenton & Rathus, 2010; Holtzworth-Munroe & Stuart, 1994; McHugh *et al.*, 2005 Rivett, 2006; Stith *et al.*, 2004), particularly given the evidence that much relationship abuse is reciprocal, or bi-directional (Follingstad & Edmundson, 2010), and it can be, 'hard to distinguish the role of abuser from that of victim', (Bartholomew *et al.*, 2001, p. 50). Also, talk about the impact of factors to do with individual differences in motivation and mental health, for example, was minimal in the data.

It appeared that the prescriptive nature of initial assessments meant that, for example, men who have been victimised and women who have behaved abusively might be inadequately assessed and sent to the wrong service (Theme 3, Extract 21). When therapists are guided by assumptions about gender appropriate behaviour, male victims might not be believed (Lawrence, 2003; Barber, 2008; Platt & Busby, 2009), and females might not be asked about their own abusive behaviours (Theme 3, Extracts 22-23). However, adopting a 'gender symmetry' approach, putting people into either one or the other category regardless of gender, may still not provide an adequate response to the potential complexity of the issues. 'Either/or' approaches to assessment and treatment are revealed as problematic and over-simplistic, when female 'perpetrators' also speak about having been victimised (Theme

3, Extract 13), and male victims have also behaved abusively (Theme 3, Sub-theme 2. 288. Ken).

Intimate partner violence is a complex problem. As illustrated in Theme 3, participants were prone to being caught in a therapeutic impasse when complex or confusing material challenged their assumptions or theoretical understanding, but they differed in their awareness of this process, some talk evidencing cognitive bias, some sounding muddled, whilst a few spoke of holding in mind competing perspectives (Safran & Muran, 2000). Some seemed to unintentionally position themselves as experts, knowing what counts as abuse and who is to blame (Neimayer, 1998). The findings suggested that attempts to avoid or resolve ambivalence might result in prescriptive practices that scapegoat the designated 'perpetrator', and may not fully explicate other contributory factors that could be maintaining the problem.

This common tendency for participants, male and female, to take up a default position of blaming men, begs the question, why? It seemed that participants were commonly unaware of research evidence regarding female perpetration of abuse and the prevalence of mutual abuse. Furthermore, work with female 'victims, and male 'perpetrators' is commonly gender-matched and, the findings of this study suggested, it may be commonly carried out by those with personal experience influencing their beliefs and approach. There was some support also for Morran's (2008) finding that female therapists may tend to identify with victimised females, or the partners of 'perpetrators' and Idisis *et al.,*'s (2007) finding that therapists might be prone to overstate the risks to women. It was perhaps relevant that those female participants, Beth, Eva, Ann and Anita, and also Ken, who spoke about personal experience of their own, or women's aggression, were apparently more able to empathise with those who behaved abusively, perhaps this awareness of their own transgressions reminding them of how easy it can be to blame others (situational factors) rather than take personal responsibility (dispositional factors) (Takaku, 2001). Takaku (2001) suggests that people experience dissonance if they see themselves as hypocritical for blaming others for behaving as they might or have done, and, to reduce this and become more forgiving of self and others, would need to be able to acknowledge this discomfort and recognise the tendency to overestimate personal variables and underestimate situational variables when judging others.

The findings suggest that practitioners working with IPV need to address the following questions:

1. How can we explain why people remain with partners who behave abusively, or harm those they love? (Allison *et al.*, 2008; Borochowitz & Eisikovits, 2002; Goldner *et al.*, 1990; Henderson *et al.*, 2005; Zosky, 1999)

2. What counts as abuse, how might we understand this, including attempts to provoke or wind up a partner? (Flynn & Graham, 2010; O'Leary *et al.*, 2007)

3. How might we understand issues of responsibility and choice, moving away from blame? (Lamb, 1996)

8.4   Implications for Counselling Psychology Practice

> 'To say that violence, domination, subordination and victimisation are psychological, does not mean they are not also material, moral or legal. In other words, 'to develop a psychological explanation of violence is not to explain it away' (Goldner *et al.*, 1990).

The reported views of practitioners in this study suggest IPV is regarded as a special category of problem, requiring specialist knowledge and practices. However, current approaches, informed by feminist perspectives, have been found ineffective in reducing the incidence of IPV and researchers have been calling for more integrative models that take account of the many factors found to be implicated in its perpetration by both men and women (Dixon & Kevan-Graham, 2011; Hamel, 2009; O'Leary *et al.*, 2007; McHugh *et al.*, 2005). Research suggests that, necessary and integral to a resolution of the problem of violence and abuse is an understanding of both male and female aggression, but that there is also a need to understand 'the complex interrelationship and dyadic interactional process between female and male violence within a relationship' (Holzworth-Munroe, 2005, p. 258). Schore (2012) also provides compelling evidence from a neuropsychological perspective of the enduring impact of relational attachment trauma in early life, and the potential for relational psychotherapeutic approaches to change brain function and structure, fostering the capacity to empathise, regulate emotions and develop relational skills.

Engagement in these more integrative therapeutic practices may be predicated on a move away from dichotomous understandings of responsibility and choice and more explicit recognition of the dilemmatic nature of the issues therapist must negotiate. The findings of this study were consistent with Lamb (1996), who argued, that 'perpetrators' and 'victims' are blamed either too much or not enough. In Lamb's (1996) view, similar to the 'both-and' position (see Table 8.3) taken by Goldner *et al.* (1990), those who have fought against the blaming of female victims may be going too far in the other direction, denying 'victims' any responsibility for their own behaviour or reactions to abuse, including depression, anxiety and returning to abusive relationships. On the other hand, those who vilify male 'perpetrators', do so on the basis that abusive behaviour is deliberately chosen, denying the impact of past abuse, mental health issues or provocation. It might be argued instead, that

anyone who behaves in ways that are abusive or elicit abuse does so for a reason that is personally meaningful, and is making choices, for which they are responsible.

IPV is an emotive topic, so, in the search for someone to punish when interpersonal abuse happens, intuition may influence decisions as to who is to blame, and moral judgments of responsibility made about outcomes can become more easily confused with causality (Shaver & Drown, 1986). For example, if someone stumbles and causes another person to fall and break their leg, we might agree they were the cause of the fall, but we would not blame them for this, although they might feel morally responsible. With IPV, it may be unclear as to who started the conflict, and this may be confused by claims and counter-claims about provocation or previous victimisation, for example, when a person who claims to have been victimised, sets fire to their partner after a row, as in Theme 1, Extract 2. Thus, judgments may involve post hoc justifications, based on 'gut feelings' of what is right and wrong, rather than rational argument, especially when outcomes are unintended (Pizarro *et al.*, 2003).

We might question, moreover, what motivates some people to behave abusively and not others. There is no universal agreed definition of abuse, there is diversity in its perpetration, and also in the risk factors and reasons people give for their behaviour (Flynn & Graham, 2010). Furthermore, as reported by Horwitz *et al.* (2009) the most common form of IPV is mild-to-moderate. So, attempts to identify a 'true' victim, or 'perpetrator', risk over-generalising and extrapolating the perpetration of extreme physical violence to what might not be life-threatening incidents. Similarly, attempts to define abuse demonstrate only too clearly, that this is an elusive concept, open to different interpretation by those involved (DeHart *et al.*, 2010; Shafer *et al.* 2002; McHugh *et al.*, 2005). As the findings illustrated, practitioners might agree in principle that IPV is always wrong and should be punished, but in practice, what counts depends on context and is determined by subjective moral judgments informed by personal experience (Theme 3, Extracts 15-18, 20).

Furthermore, research indicates that most IPV is mutual (Hamel, 2009; Stith *et al.*, 2003; 2004), suggesting that responsibility is best understood in a relational context. Nevertheless, when 'victims' defend, resist, or retaliate, therapists might regard them as disabled by their victimisation, and, therefore, not responsible for this behaviour, or, as we saw in Theme 3, it may even be applauded (Theme 3, Extract 91). However, it could be argued that if previous victimisation justifies acts of violence or abuse by 'victims', then this must apply to 'perpetrators' who have been victimised. Similarly, when 'victims' are excused for behaving impulsively or when dissociated, we might question why this does not also apply to 'perpetrators' who claim they 'didn't mean to do it'. As discussed, different arguments may be applied to 'victims' and 'perpetrators' with regard to the extent to which behaviours are

chosen, implying that some abusive behaviours are more excusable than others, in some circumstances, and contradicting the idea that abusive behaviour is morally wrong.

The findings suggested that a common approach to working with 'victims' was to challenge self-blame and excuse retaliation (Theme 3, Extract 107). This implies a straightforward and deterministic view of behaviour, predicated on a one-person psychology, assuming passivity and lack of agency, which may be implicitly disempowering, and pathologising (Theme 3, Extracts 39, 40) (Chornesky, 2000; Tower, 2007; Lehrner & Allen, 2009; Girard, 2009; McDermott & Garofalo, 2004; Thapar-Bjorkert & Morgan, 2010). It may be particularly unhelpful in facilitating change for those who return to abusive relationships or engage in consecutive abusive relationships. Similarly, pointing the finger at a 'perpetrator', saying instead, 'it's all your fault', is likely to induce shame and be counter-productive in motivating them to change (Theme 4, Extract 55) (Lamb, 1996). In both cases, therapists might be accused of not listening and, in maintaining a position as expert, modelling attitudes and behaviours that are unhelpful.

Furthermore, whilst a cognitive coping style of self-blame is associated with poor mental health, so an understandable target for intervention, Garnefski *et al.* (2002) report that certain forms of self-blame ('behavioural self-blame') may be associated with positive outcomes. Therapists might, for example, pay attention to the meaning for the client when they blame themselves and encourage self-reflection and the owning of behaviours that they may regret, or of mistakes made. Other-blame, commonly attributed to 'perpetrators', has also been found to be an obstacle to adapting to negative life events (Garnefski *et al.*, 2002). More adaptive cognitive coping styles might be encouraged, including positive reappraisal, reflecting on what can be learnt and used to create more adaptive responses in future. In both cases, therapists might acknowledge their clients' intention to regain some control through post hoc rationalisation, identifying a reason for the abuse.

Finding a reason or reasons to explain why abuse happens need not justify or excuse it, nor does it mean we have to subscribe to a 'just-world' belief, that people get what they deserve (Lamb, 1996). We might argue, instead, that since it is the intimate nature of the context that makes IPV so personally meaningful, the reasons people give for hurting others, and perhaps repeatedly doing so, whether they see themselves as initiating this or defending themselves, are key to helping them understand their motivation and behaviour, and so make different choices. Also, given the more recent research evidence that both men and women are similarly motivated to control their partners and that perpetration is not limited to men, a gender-inclusive approach is necessary (Graham-Kevan & Archer, 2005; 2009). Unless therapists acknowledge the capacity for agency of both men and women involved in abusive relationships, attempts to create change are premised on an imposed agenda, which may repeat the dynamics of power experienced by either or both clients in their relationship.

When IPV is conceptualised as potentially multi-directional, this invites practices that deliberately expand the picture to include the partner, as was illustrated in Theme 4. An integrative, multi-faceted approach to formulating individual's difficulties in relating, would focus on the meaning of a person's experience in a relational context, in which behaviours are understood as transactional i.e. both individuals' behaviour have a reciprocal effect, as each responds in accordance with how they understand the intentions and behaviours of the other (Wachtel, 2008). It also invites a move away from deterministic views of individual behaviour as being shaped entirely by social and cultural norms in ways that deny their own motivation. Instead of beginning from a position of certainty, as to what has happened and who is to blame, such an exploration creates the possibility of holding in mind different aspects of someone's history and experience, enabling them to make choices from a position in which both their own and the other's vulnerability and the taking of responsibility for their own thinking and behaviour are recognised.

Taking this approach, the therapist's role is to find a way to provide a reflective space within which different and sometimes conflicting elements of a person's behaviour and different aspects of the self are explored, contained and held in mind, though they must first be open to recognising that these competing elements occur. In order not to cause harm to self or others, adults in intimate relationships must validate and hold in mind the other as a separate being whilst being robust enough to retain a sense of the self (Zosky, 1999). For those who experienced, and continue to experience, a lack of attunement in their relationships, whether through loss or disruptions in early parent/child relationships, this can affect the self-representation and cause massive disruption to relationships, with regard to the capacity to manage separation and closeness. Therapists taking a psychodynamic approach, for example, would aim to provide a containing reflective space that promotes self-awareness, differentiation and validation of the other, and enables the integration of affect and cognitions (Fonagy *et al.*, 2004). This may facilitate exploration of difficulties free from the need to defend the self, or to attribute blame, and begin to provide the possibility of tolerating intimacy with the therapist, which could be generalised to other relationships.

From this perspective, gendered understandings are not eschewed but seen as one of many factors that might contribute to the ways in which people construct their experiences (Flynn & Graham, 2010). Indeed, researchers who suggest there is a place for couple therapy in treating couple conflict and aggression, nevertheless advise careful screening to ensure that both partners feel safe (Stith *et al.*, 2002; 2003, p. 407; 2004). They conclude, however, that, 'despite its controversy, carefully conceptualised and delivered couples treatment appears to be at least as effective as traditional treatment for domestic violence, and preliminary data suggest that it does not place women at greater risk'. Other research has proposed integrative models working with couples, promoting understanding of their behaviours

individually in the context of the dyad and focusing on the relational needs behind behaviours (Caplan, 2008).

Whether working with individuals or couples, the therapeutic relationship needs to be experienced as safe and the therapist as trustworthy. The quality of a therapeutic relationship is understood as a key indicator of therapeutic outcomes, and research indicates, as all participants acknowledged, that therapists play a leading role in facilitating this (Norcross, 2002; Safran & Muran, 2000). Whilst therapists' reflective skills, personal qualities and theoretical knowledge may be considered fundamental to building and maintaining a therapeutic alliance, research suggests that it is their skills in facilitating the therapeutic process and, in particular, their ability to handle challenging encounters that contribute to clinical outcomes (Anderson *et al.*, 2003). From a CBT perspective, Bennett-Levy & Thwaites (2007) suggest that the development of interpersonal relational skills and the capacity for self-reflection could be an important focus for supervision and training. When working with clients engaged in or affected by, IPV, who tend to blame the self or other, the therapists' skills in facilitating self-reflection and ownership of the problem may be a key element in enabling change. As the data suggested, clients may lack self-awareness, be fearful of intimacy and lack trust in others, so these skills and the therapist's capacity for the use of self to explicate process issues and model adaptive behaviours, are likely to be even more critical to enabling engagement and delivering effective treatment outcomes.

What therapists understand, and communicate to clients about IPV in initial meetings will position both client and therapist in the relationship and create the potential to open up particular ways of thinking about the client's problems, closing down others (Zavos, 2005; Lavis *et al.*, 2005; Girard, 2009). As was illustrated across the data, and consistent with Willig (1999), practitioners' constructed understandings are informed by their personal experience, wider societal and institutional norms, training and theoretical knowledge. This was reflected in the articulation of some broadly different approaches to practice, foregrounding the impact of gender, or individual experiences, or more integrative approaches taking account of relational dynamics.

Theory/practice dilemmas highlighted in Theme 3 suggest that practitioners working in this field would benefit from having up-to-date knowledge of recent research developments and recommended directions for practice. Research from a neuropsychological perspective, for example, has identified neural mechanisms in the right brain that are implicated in the development and maintenance of 'internal working models' of attachment, and the enduring impact of relational trauma in childhood, affecting the capacity for empathy and processing emotions (Schore, 2012). In recognising the importance of the right brain, Schore (2012) re-conceptualises attachment theory as a theory of affect regulation, suggesting that psychotherapy should incorporate psychodynamic concepts and focus on stress regulation

and the expansion of relational skills. Furthermore, research looking more generally at cognitive dissonance and choice-induced preference has potential relevance for understanding therapists' management of the dilemmas they may face in practice. Izuma *et al.,* (2010) found that the mere act of making a choice can itself create, as well as reflect, self-reported preferences and that these are observable in changes in brain activity. This suggests that a cognitive bias may be self-perpetuating and strengthen without a capacity for self-reflection and ability to identify the underlying dilemma.

Continued reliance by some on prescriptive out-dated practices might explain why participants differed also in the extent to which they explicitly took up a role as expert, or were aware of dissonance, and how they negotiated the unequal power relations inherent in the therapeutic relationship. This inequality is particularly salient when abuse is a presenting issue, and the therapist has the authority of their status and knowledge to diagnose the problem (Neimayer, 1998). There were evident contradictions in some participants' expressed desire to empower clients, and the implicit positioning of them as 'victims', requiring educative counselling, for example, in Theme 2. Inconsistencies, in some participants' explicit and implicit intentions, with regard to attributions of responsibility, when personal 'commonsense' views perhaps came into conflict with professional understandings, as identified by Thapar-Bjorkert & Morgan (2010), also suggest that therapists' awareness of their use of self will affect their capacity to tolerate ambivalence and the degree to which the therapeutic process is collaborative.

If practitioners are to develop consistent and effective practices, that help them to guard against burn-out and the risk of re-producing power dynamics in the therapeutic relationship, they also require support (Iliffe & Steed, 2000; Morran, 2008). Whilst personal therapy may help to address the potential impact on practitioners of disturbing material, supervision can facilitate self-reflection and practices that promote the autonomy of clients and the owning of the process of change, and an understanding of relational dynamics. The reconciliation of ethical dilemmas concerning their own and the client's ideas about what counts as abusive and what constitutes the 'truth' with regard to what happened and who is responsible are challenging issues. Remaining open to acknowledging the discomfort, misunderstanding and contradictions that might emerge, when understandings are co-constructed and negotiated is an approach consistent with perspectives interested in the therapeutic process, whether these are interpretive, or CBT-focused therapies (Gilbert & Leahy, 2007). Counselling Psychologists are particularly well-placed to offer training and supervision that focus on the development of skills in reflective practice, use of self, and being-in-relation, as these are practices fundamental to Counselling Psychology training programmes and practice, whichever therapeutic models are taken up (Strawbridge & Woolfe, 2009).

8.4.1 Ethical practice: implications for training

It is reported that health professionals may not recognise domestic violence (Department of Health, 2002), may not raise the issue, or may rate violence that is not male to female as less serious (Brown & Groscup, 2009). However, research indicates that mental health issues and substance abuse commonly co-occur with interpersonal violence in relationships and that both men and women who have been victimised may suffer depression (Rhodes *et al.*, 2009; Dutton & Corvo, 2007). Indeed, Corvo *et al.*, (2009) argued that treatments for 'perpetrators' that did not take account of the mental health and substance abuse problems, or past trauma, might violate codes of ethics. This highlights the need for practitioners who work therapeutically (regardless of orientation) to be trained to recognise and enable disclosure of abuse, particularly where psychological aggression might be normalised as a 'normal' part of couple conflict, but have negative effects (Capezza & Arriaga, 2008); and, conversely, to assess for mental health and substance use when IPV is the presenting issue.

Whilst all participants expressed concern about ensuring the safety of female clients who had been victimised, some quoted outdated statistics suggesting they lacked awareness of the potential for male clients to be abused by partners, for female 'victims' to also behave abusively, and for mutual abuse in relationships (McHugh *et al.*, 2005). Paradoxically, whilst the expressed aim of all participants was to prioritise safety and assess risk with this in mind, it seemed that 'perpetrators' were not routinely asked questions about having been victimised, nor were 'victims' routinely asked questions about perpetration. Sullivan *et al.* (2005) suggest that these questions should be included at assessment and moreover, McHugh *et al.* (2005) suggest that 'women's status as both victim and perpetrator' should be considered when developing interventions, a point taken up by one participant:

> *'...We don't come in assuming we know all about what's happened so I think that's an extremely important starting point so that you can actually have your mind open to what's going on for that couple because we do have mutually violent couples. We do have couples where the woman is actually the dominant abuser. We do have couples where they switch and I think that you know if you have a model that's very fixed that says this man is this and this woman is this and this is how we're going to deal with it you will miss out on a lot of that subtlety and nuance '(Theme 4, Extract 13)*

8.5 Summary of Proposed 'and/and' Approach (Figure 8.4 and Table 8.3)

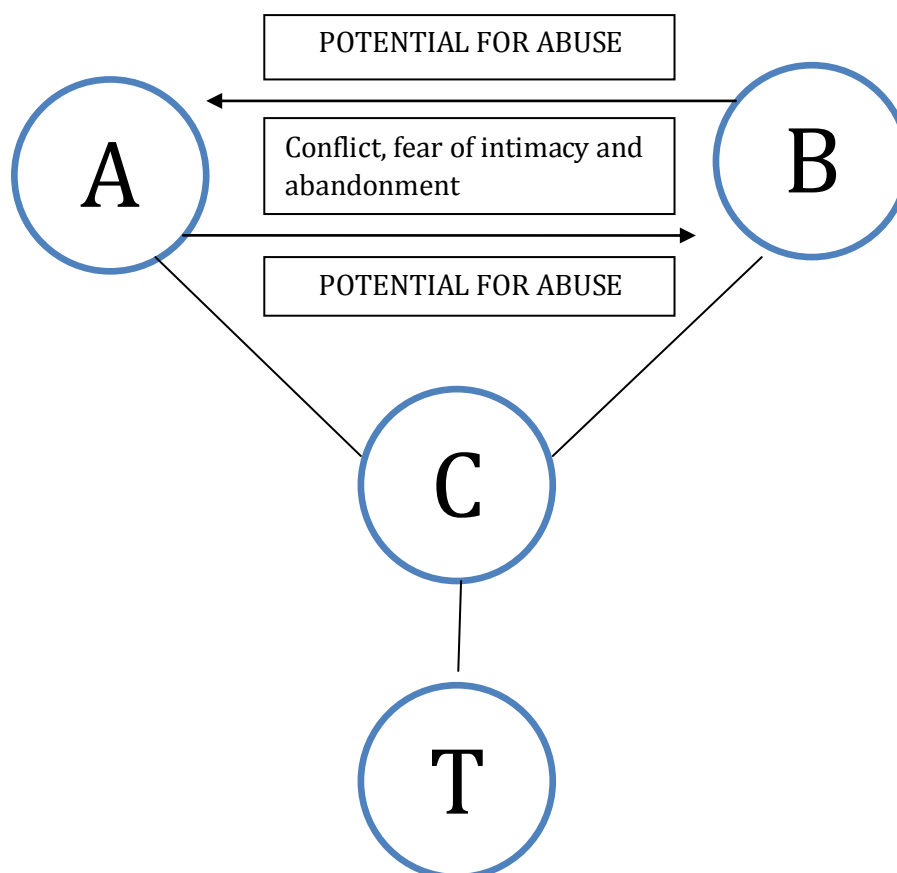> *'...it's a new a new mixture of of holding people to account and holding a very firm moral line that your behaviour's unacceptable and what you're doing to other people's unacceptable but that there's things in you that are worth developing and strengthening, that you can change and giving them the hope that they don't have to behave like that' (Theme 4, Extract 74-76)*

Goldner *et al.* (1990) proposed a 'both-and' stance to male perpetrated violence, in which the therapist remains open to listening to the couple's subjective experience of their relationship and does not conflate understanding with excusing. Research evidence, that women and men behave abusively and most IPV is mutual, points to a need for more nuanced approaches (Hamel, 2009; Bartholomew *et al.*, 2001). Furthermore, developments in attachment theory from a neuropsychological perspective would suggest that people in abusive relationships, as a consequence of early relational trauma, will be most enabled by approaches that focus on the development of relational skills and affect regulation i.e. an integration of interpersonal and intrapersonal approaches (Schore, 2010). This invites an 'and/and' approach to therapy practice, in which issues of responsibility and choice are addressed with the person who abuses, whether male or female, and with the person being abused, whilst holding in mind the possibility that the abuse may be mutual. From this perspective, both partners are considered as appropriate for psychological help and support in order to facilitate understanding of how they engage in their intimate relationships.

A key component of an 'and-and' approach would be a working assumption that both partners in an abusive relationship are responsible for their own behaviour and choices, enabling clients to become more resilient and in charge of the therapy process (Caplan, 2008). This would require therapists to enable clients to manage their own anxiety and cognitive dissonance, rather than blaming self or others, and to hold in tension the potential complexity of the relationship issues whilst assessing risk: eschewing 'either/or' ways of understanding the problem that construe violence and abuse as necessarily uni-directional and measurable in terms of objectively defined acts.

An 'and-and' approach would, therefore, entail not only holding those to account who cause criminal harm, and protecting those at risk, but also understanding the problem from both partners' perspectives and raising awareness of the responsibility of each to take steps to protect the self and their children. So, the naming and decoding process would not be driven by a need to categorise people and behaviours, but instead an openness to exploring and understanding the meaning of the abuse in the context of current and past relationships, and the fears and hopes intimacy generates. Where conjoint therapy is considered unsafe or inappropriate if one partner has left, individual therapy can still take a relational perspective. This need not be done from a position of blaming or excusing, but instead can open up possibilities for insight, personal development, greater differentiation and new ways of behaving in relationships. The process of exploration requires starting without assumptions as to what is, or can be, known, and unpacking the relationship history and abusive sequences to reach a shared understanding of what has happened and how this came about. This requires therapists to have insight as to their own assumptions and the impact of their own personal history, well-developed interpersonal skills and an ability to critically reflect on the use of self (BPS, 2006). It also requires them to recognise that 'our understanding of

other people is always infused with and mediated by our own subjectivity'(Wachtel, 2008, p.19)

Figure 8.4: And/And Approach to IPV

	Either/or	Both-and	And-and
Relational positioning: what's the problem and how do we explain it?	Gendered understanding of men's violence and abuse towards women: constructing a villain	Feminist-relational understanding of how men abuse power and women collude with their victimisation in intimate relationships	Working at the intersection of the individual and social: Understanding violence and abuse in a relational context as a problem with intimacy
	Men are 'perpetrators' of IPV against women	Men are perpetrators' of IPV against women; women are unknowingly complicit	Men and women may behave abusively/violently and/or be victimised
Moral position	Explaining individual violence risks excusing it.	Violence is explicable but not excusable.	Violence is explicable but not excusable.
Conceptualising cause	Unidirectional. Male violence as instrumental.	Unidirectional. Male violence as expressive and instrumental.	Multi-directional and multi-faceted.
Responsibility	Holding the man accountable – answers the question, Who is responsible?	Holding the man accountable - answers the question, Who is responsible?	Holding each person morally responsible for what they do - answers the question, Who did what to whom?
Raising awareness	Of her victimhood and his perpetration of abuse.	Of the way that gender roles are socially constructed and re- enacted in intimate relationships.	Of the way that gender roles and personhood/subjectivity are socially constructed and re-enacted in intimate relationships.
Risk/safety	Keeping women and children safe.	Keeping women and children safe.	Keeping all parties safe.
Agency	Empowering women to make choices; making men own their choice to behave abusively.	Empowering men and women to own their behaviour and make choices.	Empowering men and women to own their behaviour and make choices.
Change	Challenging men's patriarchal beliefs; helping women to leave abusive relationships	Challenging gender assumptions and deconstructing abusive transactions; understanding how women can become stuck in abusive relationships.	Deconstructing abusive transactions in the context of an individual's current and past relationships.
Differentiation			Regulating own emotions, developing ability to self-soothe and manage own anxiety, not reactive to others' anxiety. Developing a sense of self as separate, whilst being able to tolerate closeness.
Integration			Acknowledging ambivalence. Accepting and valuing different aspects of self and partner.

Table 8.3: Different Approaches to Understanding and Intervening With IPV Derived From This Study

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8.5.1   Implications for supervision

Supervisors play a key role in supporting therapists emotionally, modelling ethical, safe practice, and, promoting effective practice interventions informed by evidence-based theory and research (BPS, 2007). Whilst there are many generic models of supervision that provide this guidance, the findings of this study suggest that there are particular aspects to IPV practice which present a challenge to both therapists and supervisors. First, supervisors would need to be aware of recent research and current debates about best practice, and be open to fostering more integrative approaches. The table above sets out some of the practice implications of taking 'either/or', feminist-relational, or more integrative relational approaches.

The findings indicated that the participants were all satisfied with their supervision and also that they tended to seek out supervisors whose views and approach matched their own, suggesting that supervision could play a role in validating therapists' approaches. Given that some participants' talk was illustrative of defensive manoeuvres that functioned to reduce or avoid cognitive dissonance, and that many seemed unaware of the potential bias in their views and practice, it would seem that, for some, supervision may not have been providing a reflective space in which awareness of tensions was raised. Whilst therapists may commonly subscribe to the view that talking about feelings and difficulties reduces defensive reactions, it is paramount that they apply this maxim to their own practice and that supervisors are aware of the tendency for practitioners working with abuse to take up and defend 'either/or' positions. The findings indicated that those participants who experienced cognitive and emotional dissonance and were able to reflect on this were most likely to engage in questioning their views and seemed most open to assimilating new information. So, this highlights the crucial role supervisors can play in inducing dissonance when therapists take up a defensive position of being certain, closing down other ways of conceptualising a problem.

Supervisors would need to be able to contain and work with issues of ambivalence, recognising that therapists might struggle with negotiating issues of responsibility and choice. Crockett (2007) suggests that supervision which understands responsibility as constructed in relationships would re-conceive responsibility as multi-directional rather than held by one person. However, the findings of this study suggest that when concerned about risk issues, therapists may narrow their focus and adopt more prescriptive approaches, closing down exploration and hence reducing the possibility of seeing the whole picture. This may be counter-productive in assessing risk, particularly when abuse could be reciprocal. Supervision taking a relational perspective would focus on enabling therapists to hold in mind client behaviours or beliefs that are contradictory, inviting reflection on the meaning of abuse in the context of the relationship and where possible, the partner's

perspective (Figure 8.5). Furthermore, it would include an awareness to, and deliberate focus on, the supervisory relationship and the potential for parallel processes arising that could provide insight into both a client's and the therapeutic relationship.

Perceived threat or loss

Incident

Interpretation of causality, blame and responsibility

| Current relationship

Mental health issues

Emotional regulation | → | **Meaning of incident in the context of the relationship** | ← | Past experience of abuse

Attachment style

Ability to tolerate separation and closeness |

Taking responsibility and owning choice (client and therapist)

Integration of ambivalence (client and therapist)
Re-establishing control

Figure 8.5: Taking a Relational And/And Perspective to IPV in Supervision

When taking an integrative relational approach, therapists and their supervisors would be curious about who did what to whom, neither colluding with the idea that abuse is excusable nor imposing a view on what counts as abuse. They would encourage a focus on issues of causality, blame and responsibility in relation to past experiences of abuse, attachment style, current abuse and the client's capacity for emotional regulation. More specifically, supervision might provide a reflective space to consider those issues that are tricky to negotiate, seeming to invite blame or excuses: when behaviours provoke, retaliate or defend; when a client stays in an abusive relationship, or hurts someone they love; and when power

dynamics are manifest in the therapeutic relationship. They might facilitate a move away from either blaming or excusing by looking at the meaning for the client of their responsibility and choices, with the aim of helping clients to move to a position of owning these (Figure 8.6).

8.6   Limitations of the Study

Whilst on the one hand interviewing 17 therapists and 3 practitioners with related training, provided a snapshot of views across different services, on the other hand, the lack of homogeneity means that the findings cannot be considered typical of any particular organisation, though they may be representative of different approaches, including couple therapy. It is also not unusual, for example, for practitioners without therapy training to work on 'perpetrator' programmes. The decision to interview participants from a range of agencies and location was nevertheless advantageous in maintaining the anonymity of participants and provided an opportunity for a number of controversial practice issues to be talked about.

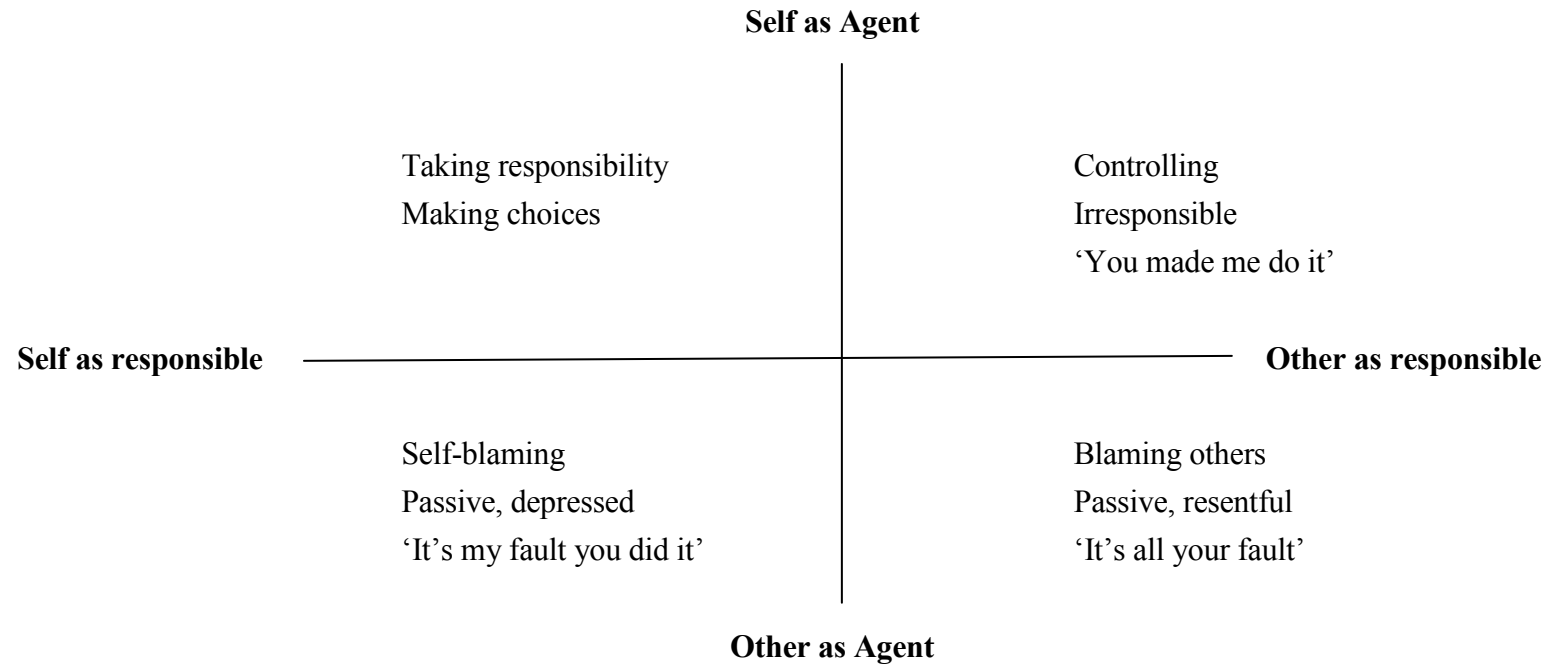Approaches were made to over 20 organisations and services, some of which did not respond, or said they did not have time to participate. It is likely then that the participants from the 12 organisations who did respond were self-selecting in some way and may have been keen to talk about their practice for particular reasons. This could suggest that the participants might be over-represented by practitioners who experienced dilemmas. However, not all participants spoke about experiencing dilemmas even though these were sometimes implicit in the contradictions in their talk, or interpreted as being reflected in their particular understandings and expressed approaches to practice. Similarly, participants might have been over-represented by those keen to make changes to practice. This may well have impacted on the data, as some participants expressed a keen interest in developing a new model, and 2 others worked in an organisation where a new model had been introduced which they considered to be too prescriptive.

Figure 8.6: Hypothesised Two-dimensional, Four-category Model of Responsibility and Choice in Intimate Relationships

Self as Agent

Taking responsibility

Making choices

Controlling

Irresponsible

'You made me do it'

Self as responsible ——————————————————————— **Other as responsible**

Self-blaming

Passive, depressed

'It's my fault you did it'

Blaming others

Passive, resentful

'It's all your fault'

Other as Agent

The data is derived from interviews which may also be understood as generating meaning within a particular relational context, mirroring the unequal power relations inherent in therapeutic and supervisory relationships. The different knowledge and status the researcher and participants brought to the relationship are likely to have impacted on the relational positioning of each and contributed to the construction of meaning and the particular focus of each interview. To some extent, therefore, the interpersonal skills and capacity of both researcher and participants for self-reflection, were reflected in the level of engagement and contributed to the richness of the data. However, the desire to fit into expected roles may have facilitated some collusion on the part of both, and the researcher's desire not to offend practitioners did invite caution and sensitivity when raising controversial issues. Arguably, conflictual issues were held in mind sufficiently in the interviews to enable the expressing of views that might otherwise have been closed down. This reflected the researcher's intention to model a relational approach, opening up the possibility for participants to provide detailed descriptions of their understandings. Nevertheless, the analysis of the interview data and the extrapolation from the analysis of different understandings and therapeutic approaches to practice, were constructions, generated in a particular relational context, and informed by the researcher's theoretical ideas, professional and personal experience (Lyons, 2007). Research focusing on participants' talk about their practice does not provide direct access to the social reality that participants are constructing and cannot be assumed to reflect actual practice (Walton, 2007), so it is important not to extrapolate from 'performance to competence' (Potter & Wetherell, 1987, p. 73).

8.7   Personal Reflexivity

As much of the focus of this discussion had been about managing and integrating conflictual ideas, it is perhaps fitting that I am aware of having mixed feelings as I reflect on the research process, and consider the implications of the findings. I need to reconcile my appreciation of the dedication and professionalism of all the participants with my conclusion that some of the practices some participants talked about were based on outdated theories. The experience of engaging in discussion with them about theory and practice, albeit in a somewhat scripted manner, was one I nevertheless found stimulating and, at times, surprising. I am grateful for the thoughtful way in which all the participants approached the questions and particularly to those who risked expressing controversial ideas, or acknowledging the impact of their own experiences of abuse, entrusting me with their ideas. Even though I have challenged some of the views expressed, I recognise that some participants struggled with contradictory ideas and hope that the analysis, particularly Theme 3, does justice to the multi-faceted nature of each participant's views. The experience has confirmed my own belief that relating is a two-way process which has reciprocal effects, opening up the possibility for constructing new ways of understanding and resolving problems, as long as we are willing to reflect on why we might disagree rather

than blame or dismiss the other view. As a Counselling Psychologist, I endorse Safran & Muran's (2000) view that premature formulation of a problem may be a way of avoiding complexity and confusion, so I conclude that the tensions between theory and practice that I identified in participants' talk may be understood as indicators of the potential for new ideas to emerge.

Nevertheless, the process of conducting this research on the topic of intimate partner violence, whilst both stimulating and surprising, was also frustrating at times, and this was reflected in my experience of supervision. Research supervision has some similarities to clinical supervision, in that it is a two-way process in which difficulties or blocks can be acknowledged and tolerated, creating opportunities for developing new understandings. However, the supervisory relationship itself may re-produce the relational dynamics which a supervisee is reflecting on (Nelson *et al.,* 2008). Supervision can, therefore, become a useful vehicle for raising awareness of a supervisee's blind spots or unconscious contribution to a conflictual or stuck process, but it can also become a source of further tensions that may be difficult to resolve because of the power dynamics that are played out, especially when a supervisee is a relative novice in relation to their supervisor (Jacobssen & Tanggaard, 2009). 'Good enough' supervision therefore, must recognise the needs of a supervisee and that these can vary (Hawkins & Shohet, 2006).

I experienced both of my supervisors as supportive of my intentions. Nevertheless, my Director of Studies was very busy, so often cancelled supervision sessions and did not find time to read two early drafts of a section of the thesis and part of the analysis sent to her over a year before I submitted. In attachment terms, our relationship was insecure, characterised by brief and irregular, but intense and lengthy sessions. Furthermore, I often felt that I was walking on eggshells and had to justify and defend my approach, leaving supervision sessions feeling intimidated and unconfident, more conscious of my novice status as a researcher. I reflected, elsewhere, on my sense sometimes of 'being told' and not having a voice. In the early stages, my supervisor asked me whether she was imposing her views, and initially, this led to a more collaborative discussion, recognising that she had research skills and experience that I lacked, whilst I had clinical and supervisory experience that she lacked. However, the dynamic did not shift, so I began recording supervision sessions to gain some insight into how I contributed to this. This led me to bring my agenda with more assertion and to work harder at presenting a coherent argument. Looking back, however, I question why there was ongoing tension that became 'something that could not be spoken about', just as similar tensions were themes in my research data.

Some of the difficulties that arose in the process of my research, and in the supervision process, in particular, mirrored some of the dilemmas the participants faced, and the dissonance which some grappled with, and some avoided. Questions about the 'right' way

to approach this topic, the 'right' methodology and the 'right' way to analyse the data were matters that both created fruitful discussion and at times were an additional source of tension in supervision, paralleling the control issues the participants were caught up in. There were a number of constraints affecting, as I thought at the time, my ability to raise these issues and name my own dissonance: on the one hand, not wanting to cause a rupture that might prejudice my position in the psychology department at the University (echoing Pack's (2009) findings about trainees' experience of clinical supervision) and my supervisor's commitment to supervising other students on our course, whilst on the other, feeling judgemental about the level of support I was receiving. When I discovered that other supervisees of my supervisor had complained about her availability, and one had recently asked to be reassigned, I decided to find additional support from my clinical supervisor and my second supervisor, whilst continuing to keep in touch with my Director of Studies occasionally to share procedural information e.g. I had her support to apply to do a PhD rather than a Professional Doctorate. This decision was consistent with Staines' (1969) notion of seeking group support to reduce dissonance, whilst also trying to understand my supervisor's perspective and take personal responsibility for the conduct of my research (Takaku, 2001).

My experience leads me to conclude that those conducting, or supervising, research on this emotive and contested topic would be advised to expect that tensions will arise and be played out in the supervisory relationship. Supervision can then be used more effectively as a reflective space to name and consider the impact of the tensions arising, rather than reproduce conflicts over responsibility and choice and asymmetric power dynamics, which may otherwise unconsciously, and unintentionally, create villains and victims (Goldner, *et al*., 1990).

8.7.1   Relational positioning

As a therapist with experience of supervision and training, it would be easy to assume I might share understandings with the participants, so the relationship would be collaborative, rather than unequal. However, the interactions were shaped primarily by the purpose of the interview and the different roles we took up as researcher and participant. Understandings of IPV tend to be framed around issues of power and control, so these were salient to the research interviews and the dynamics of the relationship. In setting the agenda, the researcher's role was the more powerful in influencing the process and focus, though there were occasions when this was inverted when participants asked questions themselves, or challenged the premise of the question. The aim was to convey respect for differing views and tease out the complexity of the issues rather than seek to impose an expert take on what might be best practice, or engage in reductionist debates. The richness of the data suggests

that the relative inequality in the relationship was negotiated in a way that did not close down exploration of sensitive issues.

8.8   Recommendations for Future Research

The potentially paradoxical impact of prescriptive approaches illustrated in this study highlights the need for the development of models that take account of the complexity of IPV. Some research has begun to identify specific factors implicated in the origin and maintenance of conflict from the perspective of those engaged in abusive relationships, including attributions of responsibility, the role of provocation, coercion and control, jealousy, and marital adjustment (O'Leary *et al.*, 2007; Flynn & Graham, 2010). The findings of this study suggest that we need to increase our understanding of the design and effectiveness of therapists' interventions, identifying practices that enable both men and women in abusive relationships to manage conflict in ways that are not destructive, and do not reproduce stereotypical ideas about male and female roles. New integrative approaches would need to be trialled and compared with the current practices designed for 'perpetrators' and 'victims'. In addition to researching therapists' views of new approaches, clients could be asked about their experience of therapy, focusing particularly on the way in which they understand issues of responsibility and choice in relationships, what reasons they give for the abuse, and the cognitive coping strategies they use to adjust to a negative relationship experience.

In the light of the findings and given the particular emotional and cognitive demands of working therapeutically with abuse issues, further research might seek to identify therapists' motivation to work in this field. This could help to elucidate factors that impact on a therapist's ability to recognise and tolerate the potential dissonance that these issues can elicit. There was some evidence to suggest, for example, that participants who had had experience of abuse themselves, or expressed a 'passion' to help 'victims', might be prone to identifying with 'victims' and that this might compromise their capacity to be open to assimilating new information into their existing practice, or taking a relational approach. Those participants who spoke about their own capacity for aggression tended to be more empathic towards 'perpetrators', more aware of their own dissonance, and more open to taking a relational approach. Therefore, it would be of importance for training purposes to gain further understanding of the implications of therapists having personal experience of abuse.

Taking an integrative relational approach to understanding IPV has implications for whether interventions are best made with individuals or couples. Further research may provide guidance as to what factors might determine when interventions with couples are most appropriate, and whether, for example, individual therapy should take place first to enable

differentiation, followed by couple work to focus on developing intimacy and the integration of cognitions and affect, and contradictory self/other perceptions.

8.9   Conclusions

'the science has moved well beyond the policy'
(Dutton & Corvo, 2006, p. 478).

Some of the latest research into the phenomenon of IPV proposes that it is a 'human and relational problem, not a gender problem', challenging the efficacy of the gender paradigm that has guided research, policy and practice in IPV over the past 35 years (Hamel, 2009, p.41). Furthermore, modern attachment theory, informed by neuroscience, supports this view, concluding that relationally oriented psychotherapy is the most effective way of expanding a person's capacity for inter-subjective communication, empathy and affect processing (Schore, 2012). However, some researchers have argued that postmodern perspectives, acknowledging the complexity of the issues and the prevalence of IPV across all intimate relationships have been slow to permeate the field (McHugh *et al.*, 2005). Therapists play a key role in the development of practice and the norm-setting process by which some understandings and ways of intervening become accepted as best practice, whilst others are marginalised, and therefore, for change to occur, therapists must have access to these new understandings and be convinced of their relevance, safety and effectiveness (Proctor, 2004; Murray, 2009). The findings of this study, exploring the views and practices of participants who, in the main, worked therapeutically with either 'perpetrators' or 'survivors/victims', offer some insights into why these new ideas might be resisted and ineffective practices are promulgated, legitimated by an often implicit adherence to outdated 'truths' and invalidated arguments: 'new data accumulating from numerous rigorously designed studies challenge existing theories and are largely overlooked or discounted' (Ehrensaft 2008, p.276).

The following research evidence is available: 'Most domestic violence is mutual, men and women emotionally abuse and control one another at approximately equal rates, intimate terrorists are equally likely to be male or female, men suffer one-third of physical injuries, and males and females are equally affected by emotional abuse' (Hamel, 2009, p.41). Whilst the theoretical debate has moved on, the findings of this study suggest that some practitioners, regardless of their therapeutic orientation, may continue to believe that IPV is predominantly about men seeking power and control over women, as, it seems, do the organisations which deliver services mainly for either male abusers or their female 'survivors/victims'. It remains an accepted truth, from this perspective, that inviting women to consider their responsibility and choices is 'victim-blaming' and acknowledging the previous victimisation of male 'perpetrators' is regarded as tantamount to excusing their

current behaviour. Thapar-Bjorkert & Morgan (2010) argue that unresolved tensions between institutional discourses that are non-blaming of victims, and individual commonsense perceptions that blame victims for provoking or winding up their partners, result in mixed messages and ineffective practices.

The findings of this study are consistent with the view that practitioners want to avoid expressing mixed messages, both seeking to convey that IPV is wrong in principle and resisting practices that may be construed as 'victim-blaming'. However, rather than concluding, as does Thapar-Bjorkert & Morgan (2010), that women are nevertheless disempowered by a pervasive culture of blame and responsibility, analyses of participants' talk invited the conclusion that it is the location of blame, and the avoidance of addressing issues of responsibility and choice that may disempower 'victims' and continue to disable those who behave abusively, so they may be more likely to repeat the same behaviours. It seemed that when participants negotiated between the available opposing ideologies of 'perpetrator'/'victim', blame/non-blame, this could result in polarised views of 'victims' as blameless and having no control, whilst 'perpetrators' were controlling and wholly to blame. Arguably, this invited challenge of both 'victims' self-blame and 'perpetrators' claims of mitigating factors, closing down the possibility of developing a full understanding of who did what to whom and why, and recognising the possibility of mutual abuse. We might conclude that when therapists dismiss clients' reasons for the abuse, or their own doubts and 'commonsense' understandings, they may disregard what is meaningful to clients and risk over-simplifying the cause of the problem and what maintains it.

Dividing people into 'perpetrators' and 'victims' both makes possible, and justifies, practices based on over-simplified theories and different, incompatible arguments. When we bring together, as in this study, the understandings and principles of each approach the dichotomy is apparent. Research evidence that the problem is more complex than 'either/or' paradigms calls into question not only the theories, practices and organisation of services for IPV, but also personal understandings, so it is perhaps unsurprising that therapists, like their clients, might resist change. When we separate out 'perpetrators' as evil men who are somehow different to the rest of us, we may disown the 'bad' in ourselves, but we risk demonising men and overplaying the innocence of women. We also deny the possibility that contradictory feelings and thoughts can co-exist, and we do our clients a disservice. Therapists can help their clients tolerate difficulties with intimacy, but not by avoiding the issue themselves. Therapist, like their clients, need to be able to acknowledge, contain and assimilate conflictual understandings, recognising that relationships can be good and bad, people can be abusive and abused, that someone can both love and hate another person (Henderson *et al.*, 2005).

There is a need therefore, for radical change. Like clients who behave abusively, policy makers and therapists need to be accountable. Codes of ethics for practising psychologists require that ethical decision-making be based on up-to-date knowledge and evidence-based practices (HPC, 2009; BPS, 2006; 2007; 2009). The latest research points to a need for the integration of services for interpersonal violence, or their incorporation in more generic services, and an integration of practices that would represent and model a different theoretical understanding of IPV, foregrounding the reasons for relationship conflict, maintaining factors and issues of responsibility and choice. This suggestion is not motivated by an attempt to introduce an alternative that locates gendered approaches as wrong and relational approaches as right, re-producing the existing 'either/or' debates in the literature. Rather it invites therapists, researchers and policy makers to be open to new conceptualisations that integrate relational, gender, and individual perspectives, and to reflect on the values and assumptions that inform their understandings (O'Leary *et al.*, 2007; Hamel, 2009; McHugh *et al.*, 2005).

In accordance with recent research, the findings of this study suggest that practitioners and supervisors working with IPV, would benefit from training which included sharing more up-to-date research findings (Proctor, 2004; Murray, 2009). It is proposed that organisations move away from 'either/or' thinking and introduce gender-inclusive assessment procedures and more flexible therapeutic practices that respond to the needs of both men and women engaged in abusive relationships, and to those who seek couple therapy. In the interests of ethical practice, inequalities in service provision for men and women should be addressed, services should be delivered by practitioners trained to work therapeutically, and the use of reductionist labels, 'perpetrator' and 'survivor/victim' reconsidered.

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APPENDICES

Appendix 1: Definitions of Domestic Violence

World Health Organisation
'Intimate partner violence refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes:

- Acts of physical aggression – such as slapping, hitting, kicking and beating
- Psychological abuse – such as intimidation, constant belittling and humiliating
- Forced intercourse and other forms of sexual coercion
- Various controlling behaviours – such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance
- When abuse occurs repeatedly in the same relationship, the phenomenon is often referred to as ''battering'''(Krug *et al.*, 2002)
-

Home Office definition:

- "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." This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour killings' and forced marriage.
-

[http://www.crimereduction.gov.uk/dv01.htm].

UK Organisations
Respect has developed a Domestic Violence Intervention Programme (DVIP) for perpetrators and victims of DVA based on the Duluth model (Respect, 2004). DVIP defines domestic violence as:

- 'the systematic use of violence and abuse to gain power over and to control a partner or ex-partner. Domestic violence occurs across all cultures, ages, ethnic groups and social classes. As well as covering physical violence – including all forms of aggressive or unwanted physical contact and sexual violence – domestic violence includes non-physical abuse such as verbal, social, racist, psychological or emotional abuse, threats, neglect, harassment and the use of economic, structural, institutional or even spiritual abuse.
- In a patriarchal society like ours, institutional and societal power structures support some groups' use of abuse and violence against others – for example, men's violence towards women and parents' abuse of children. It is because of this institutional support for male dominance that the vast majority of domestic violence is inflicted by men on women.
- Violence within same-sex relationships or violence inflicted by women on men is neither the same as men's violence towards women nor symmetrically opposite to it. This is why DVIP's main focus is on working with male abusers and women who have experienced domestic violence within heterosexual relationships.'
  http://www.dvip.org/dvip/definition.html

Women's Aid
In Women's Aid's view domestic violence is:

- 'physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour. This can include forced marriage and so-called 'honour crimes'. Domestic violence may, and often does, include a range of abusive behaviours, not all of which are, in themselves, inherently "violent". Crime statistics

and research both show that domestic violence is gender specific (i.e. most commonly experienced by women and perpetrated by men) and that any woman can experience domestic violence regardless of race, ethnic or religious group, class, disability or lifestyle. Domestic violence is repetitive, life-threatening, and can destroy the lives of women and children.

- Domestic violence can also take place in lesbian, gay, bisexual and transgender relationships, and can involve other family members, including children.
- All forms of domestic violence – psychological, economic, emotional and physical – come from the abuser's desire for power and control over other family members or intimate partners.'

(Women's Aid Factsheet, 2009)

http://www.womensaid.org.uk/domestic-violence

US Definitions of IPV:
- ...'a pattern of assaultive and coercive behaviours in intimate relationships...' (Rhodes at al, 2009)

The American Psychological Association (2001), defines domestic violence as:
- 'an ongoing pattern of behaviour, attitudes, and beliefs in which a partner in an intimate relationship attempts to maintain power and control over the other through the use of psychological, physical, and/or sexual coercion' (p. 3).

Appendix 2: Ethical Approval from the University of East London

UEL
University of
East London

Aneta Tunariu
Psychology School, Stratford

ETH/11/84

08 February 2010

Dear Aneta,

Application to the Research Ethics Committee: Decconstructing therapist's and understandings of Domestic Violence and Abuse: implications for practice and supervision. (J Lawrence).

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Simiso Jubane
Admission and Ethics Officer
s.jubane@uel.ac.uk
02082232976

Research Ethics Committee: ETH/11/84

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed: .... Date 10/2/10

Please Print Name: JANE ANNE LAWRENCE

Appendix 3: Information Leaflet

Title of research: Deconstructing therapists' understandings of Domestic Violence and Abuse: implications for practice and supervision

You are invited to take part in a research study. To help you decide whether you wish to participate please read the following information explaining the purpose of the study and how it will be conducted.

What is the study about?
Therapists' interest in working with those who experience domestic violence and abuse (DVA) in relationships is longstanding. However, best practice continues to be a matter of debate over how to intervene to protect those at risk, whilst ensuring that those responsible are held accountable. Following Home Office initiatives to find more viable and effective ways to tackle DVA, multi-agency projects have been established and evaluated, resulting in 'Co-ordinated Community Responses' (CCRs) becoming widely recognised as the best way forward. One aspect of this multi-agency approach is the provision of therapeutic services for men and women involved in DVA.
 The present study engages in a qualitative exploration of the ways in which violence in a close intimate relationship is explained and understood by therapists working with those involved in DVA, with a view to looking at the implications for practice and therapists' needs in supervision.

What would taking part in the study involve?
Therapists who have experience of working with men or women involved in DVA are invited to take part in an individual interview of approximately one hour. The interview will be guided by a set of open questions with the aim of exploring therapists' everyday and professional understanding of intimate partner violence and how they talk about this to presenting clients.

The interview will be audio recorded, with participants' permission, a transcript of which will be made available to the participants on request.

There are no right or wrong answers. If you decide to take part, you can refuse to answer a question or withdraw at any point during or after the interview.

Interviews will take place in your place of work at a time convenient to you.

What will happen to the information?
All interviews will be treated confidentially in accordance with the research guidelines set out by the British Psychological Society. Interviews will be transcribed and analysed, to be used as part of a Professional Doctorate in Counselling Psychology thesis, which will be available on request. Any information provided during the interview will be anonymised when presenting extracts from the analysis of the interview data, in order that the speaker's identity cannot be identified. Recorded and transcribed material will be kept in a locked cabinet and destroyed when the research has been completed.

Who is doing the research?
The research is being conducted by Jane Lawrence, part-time lecturer in the Department of Psychology at the University of East London, undertaking a

Professional Doctorate in Counselling Psychology. I am a Chartered Counselling Psychologist with previous training and experience as a Relate counsellor and supervisor. Dr Aneta Tunariu, who was involved with collaborative research that resulted in the development of a new model for working with DVA at Relate, is my director of studies. The research details of the project have been scrutinised and received ethical approval by the University of East London.

Who do you contact for further information?
If you have experience of working with men or women involved in domestic violence and would like to take part, I would be pleased to hear from you.

Jane Lawrence
School Of Psychology
University of East London
Water Lane
Stratford
E15 4LZ
Tel: 07841 977 752
e.mail: j.lawrence@uel.ac.uk

University Research Ethics Committee
If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact the Secretary of the University Research ethics Committee: Ms S. Jubane,
Administrative Officer for Research,
Graduate School,
University of East London,
Docklands Campus,
London E16 2RD (tel 0208 223 2976; e-mail s.jubane@uel.ac.uk)

Appendix 4: Consent Form

<u>**UNIVERSITY OF EAST LONDON**</u>

Consent to Participate in a Research Programme Involving the Use of Human Participants

Title of research: Deconstructing therapists' understandings of Domestic Violence and Abuse: implications for practice and supervision

I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen to the data once the research programme has been completed.

I hereby fully and freely consent to participate in the study which has been fully explained to me.

Having given this consent I understand that I have the right to withdraw from the programme at any time without disadvantage to myself and without being obliged to give any reason.

Participant's name (BLOCK CAPITALS): ....

Participant's signature: ....

Investigator's name: JANE LAWRENCE..

Investigator's signature: ....

Date: ....19...........

Appendix 5: Debriefing Form

Debriefing

Thank you for taking part in my research.

Purpose of the research

There are differing views about whether Domestic Violence and Abuse (DVA) or Intimate Partner Violence (IPV) generally involves male perpetrators and female victims, or is symmetrical (Bograd, & Mederos, 1999; Jacobson *et al.*, 1994; Johnson, 1995; 2006; Archer, 2000; 2004; Kimmel, 2002; Girard, 2009; Fiebert, 2009), and whether female acts of violence are instrumental or defensive (Dobash & Dobash, 2004; Dutton and Corvo, 2006). Explanations of DVA or IPV are similarly underpinned by differing assumptions as to whether the problem is primarily a gender issue, or caused by individual psychological disturbance, or whether it can best be understood in the context of the couple's mode of relating with one another(Allison *et al.*, 2008; Hamel, 2007; 2009; Brown, 2004). So, whilst there is nevertheless consensus that safety considerations are paramount, best practice for working with those who are involved in violent relationships remains a matter of contention.

The purpose of this study is to explore the ways in which violence in a close intimate relationship is explained and understood by therapists and how these understandings in turn will inevitably shape the possible meanings clients come to make of their experience. More particularly, I am interested in deconstructing professional talk about "victimhood" and "relatedness" with regards to DVA with a view to looking at the interplay between current professional practices, social systems and social norms. Implications for practice and supervision will be considered in the light of this exploration.

Procedure

Therapists who have experience of working with clients involved in domestic violence are being invited to talk about their personal and professional understanding of intimate partner violence. The recorded interviews will be transcribed and analysed using discourse analysis. The data will form the basis of a Professional Doctorate in Counselling Psychology thesis, which will be available on request.

If you were upset, disturbed, or distressed, by participation in this study, or found out information about yourself that is upsetting, disturbing, or distressing, you are encouraged to make contact with your supervisor, to reflect on the issues arising and to decide on what further support you need.

In the event you would like to read more about these and related topics, here are several articles that you might find interesting, as referenced above:

Allison, C. J., Bartholomew, K., Mayseless, O. and Dutton, D. G. (2008) Love as a Battlefield: Attachment and Relationship Dynamics in Couples Identified for Male Partner Violence. *Journal of Family Issues,* 29 (1) 125-150

Archer, J. (2000) Sex differences in aggression between heterosexual partners: a meta-analytic review. *Psychological Bulletin*, 126, 651-680.

Archer, J. (2004) Sex differences in aggression in real world settings: a meta-analytic review. *Review of General Psychology,* 8, 291-322.

Bograd, M. and Mederos, F. (1999) Battering and Couples therapy: Universal screening and selection of treatment modality. *Journal of Marital and family Therapy.* 25 (3), 291-312

Brown, J. (2004) Shame and domestic violence: treatment perspectives for perpetrators from self psychology and affect theory. *Sexual and Relationship Therapy.* 19 (1) 39-56

Dobash, R. P., & Dobash, R. E. (2004). Women's violence to men in intimate relationships: Working on a puzzle. *British Journal of Criminology,* 3, 324-349.

Dutton, D. G., & Corvo, K. (2006). Transforming a flawed policy: A call to revive psychology and science in domestic violence research and practice. *Aggression and Violent Behaviour,* 11, 457-483.

Fiebert, M. S. (2009) references examining assaults by women on their spouses or male partners: an annotated bibliography. Retrieved from http://www.csulb.edu/-mfiebert/assault.htm

Girard, A. L. (2009) The influence of Men's and Women's rights Discourses on Domestic Violence Legislation in Ontario. *Violence against Women,* 15 (1) 5-23

Hamel, J. (2007) Toward a Gender-Inclusive Conception of Intimate Partner Violence Research and Theory: Part 1- Traditional Perspectives. *International journal of Men's Health,* 6 (1) 36-53

Hamel, J. (2009) Toward a Gender-Inclusive Conception of Intimate Partner Violence Research and Theory: Part 2 – New Directions. *International journal of Men's Health,* 8 (1), 41-59.

Jacobson, N. S., Gottman, J. M., Waltz, J., Rushe, R., Babcock, J., & Holtzworth-Munroe, A. (1994) Affect, verbal content and psychophysiology in the arguments of couples with a violent husband. *Journal of Consulting and Clinical Psychology,* 62(5), 982-988

Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family, 57,* 283-294.

Johnson, M. P. (2006). Conflict and control: Gender symmetry and asymmetry in domestic violence. *Violence Against Women, 12,* 1003-1018.

Kimmel, M. S. (2002) 'Gender Symmetry' in Domestic Violence: A Substantive and Methodological Research Review. *Violence Against Women,* 8 (11), 1332-1363

Also, if you have any questions or concerns about this study, you are encouraged to contact Jane Lawrence: j.lawrence@uel.ac.uk or call 020 8223 4483; 07841 977 752

Thank you again for your participation.

Appendix 6: Interview Schedule

Interview schedule

Gender:
Age / age group:
Practitioner since:
Training qualification:
Date of the interview:
Pseudonym:

Part 1:   **Personal Information**

1. Tell me something about your role here with regard to DVA referrals
Prompt: how would you describe the referrals?
Prompt: how do people get referred to you?

2. What led you to work with this client group?
Prompt: what kind of training have you had to do this work?

Part 1:   **Understanding DVA**

3. In your understanding what is DVA?
Prompt: what counts as DVA?
Prompt: how did you arrive at that idea?
Prompt: what is your take on terms such as 'victim' and 'abuser'?

Part 2: Working with DVA: in the therapy session

4. In your experience, what tends to enable clients better engage in talking about DVA?
Prompt: would the terminology used make a difference?
Prompt: what might you say to help them verbalise difficult experiences?

5. What tends to enable you to engage with this client group?
Prompt: what tends to enable **you** to make sense of their experience?
Prompt: what difficulties do **you** encounter? (e.g. therapeutic relationship)

6. Some therapists say they get caught up in trying to establish the 'truth' of what happened- what are your thoughts on this?
Prompt: how do you approach moral issues about of the 'wrongness of violence' with this client group?
Prompt: how does this fit with the counselling intention?

Part 3: Working with DVA: after the therapy session

7. What issues might you take to supervision?
Prompt: what do you find most challenging about working with DVA?
Prompt: what would you need from supervision to help you manage these challenges?
Research issues
8. Research and practice in DVA has been developing over 35 years. What changes, if any, would you like to see in practice?
Prompt: Some researchers say we need to understand why abusive relationships persist. What are your thoughts on this?
9. There has been a growing debate in the literature as to whether men and women are equally violent in relationships. What are your thoughts on this?

CAN YOU HELP?

You are invited to take part in a research study about Domestic Violence and Abuse (DVA)

Talking about sensitive experiences with clients can be challenging, especially when talking about the issues may be putting them or others at risk:

> *What is your understanding of why people stay with abusive or violent partners?*

> *What kind of support do you think a practitioner needs when tackling DVA in the therapy sessions?*

> *How do you reconcile notions of intimacy and violence?*

There continues to be debate about how best to work with DVA and about what is best practice in helping those who use DVA to be accountable, whilst meeting the needs of those at risk.

If you work with clients who are in abusive or violent relationships and would like to share your understandings and could spare 30 – 45 minutes of your time please get in touch. The interviews will be confidential.

Please see the information leaflet for further details.

Jane Lawrence, Professional Doctorate scholar at University of East London tel: 07841 977 752 or j.lawrence@uel.ac.uk

Appendix 8: Notification of Transfer for Registration From Professional Doctorate to Ph.D.

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
uel.ac.uk/psychology

University of
East London

Jane Lawrence

9 December 2011

Student number: 9600024

Dear Jane

Notification of Transfer for Registration from Professional Doctorate to PhD

I am pleased to inform you that the Research Degree Subcommittee on behalf of the University Quality and Standards Committee has approved the change in your registration from Professional Doctorate to PhD Direct. All of the registration time spent on the Prof Doc may be transferred to the PhD.

Thesis title: Deconstructing practitioners' understandings of intimate partner violence and abuse: implications for practice and supervision.

Director of Studies: Dr Aneta Tunariu

Supervisor/s: Professor Rachel Tribe

Please contact me if you have any further queries with regards to this matter.

Yours sincerely,

Dr James J Walsh
School Research Degrees Leader
Direct line: 020 8223 4471
Email: j.j.walsh@uel.ac.uk

Cc: Aneta Tunariu

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