

**An exploration of counselling
psychologists' understandings of
domestic violence and abuse:
Implications for theory and practice**

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ABSTRACT

A growing body of knowledge suggests many mental health practitioners will work therapeutically with women who have experienced domestic violence and abuse (DVA). Relatively little research has focused specifically on the felt readiness of counselling psychologists when working with this group of clients. The present study adopts a qualitative approach to explore the private and public experiences of counselling psychologists in their work with women who have experienced DVA. The analytic aim is exploratory and aims to provide insight into the ways counselling psychologists understand DVA and the practices which establish and sustain therapeutic interventions undertaken. Semi-structured in-depth interviews were carried out with six counselling psychologists who had worked with women living with DVA. The narratives produced were mapped using Interpretative Phenomenological Analysis (IPA) highlighting understandings of DVA as well as some of the dilemmas and challenges that the participants engaged in as they negotiated their therapeutic work with their women clients. Four master themes emerged from the IPA analysis – “privately owned and professional/institutional/public ideological tensions”, “disclosure of domestic violence and abuse affects the therapeutic boundaries and goals”, “working with domestic violence and abuse provokes human, humanitarian and humanistic responses” and “hermeneutic repositioning”. These collectively demonstrate the multi-layered private and public conflicts that make up counselling psychologists therapeutic work with women experiencing DVA. The study also discusses the importance of raising awareness of the private and public clashes that working with DVA has the potential to ignite and the need to increase readiness in counselling psychology trainees to engage in the angst potentially triggered by working with DVA. The strategic role in increasing readiness to work with DVA, of therapeutic guidelines for DVA, reflective practice, self-care and supervision are discussed. This study also acknowledges the importance of specialist care for women experiencing DVA and calls for specialist DVA training for practitioners.

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1. Introduction and Literature Review

1.1 Introduction

The aim of the present research is to gain detailed and rich narrative descriptions of the experiences of counselling psychologists who have worked with women experiencing domestic violence and abuse (DVA). As such, the primary analytic aim is phenomenological, in that the study focuses on how counselling psychologist's understand DVA, how it feels for counselling psychologists to carry out clinical work with women experiencing DVA and the interplay between the private and professional challenges and tensions common to working with DVA.

The contribution this thesis makes lies in the specific focus on counselling psychologist's understandings of DVA. Some research has pinpointed the ways mental health practitioners and counsellors work with clients presenting with difficulties associated with DVA (Iliffe & Steed, 2000; Hogan *et al.*, 2011). Nevertheless, there is a paucity of research that highlights the ways counselling psychologists experience and negotiate this type of clinical work. Given the estimate that 50% of women presenting for talking therapy have some experience of DVA (Department of Health, 2002) and that high numbers of counselling psychologists find themselves providing such therapeutic support in many private, public and statutory services, this gap in the research lends itself to further qualitative exploration. Moreover, much of the previous research has looked at the ways professionals are affected by their clinical work through a secondary trauma lens (Steed & Downing, 1998; Sakunanayagam, Tunariu & Tribe, 2010). While the present study does not investigate secondary trauma, it is open to mapping the aspects of working with DVA that are subjectively felt by these counselling psychologists and the impact of this work on their psychosocial worlds.

My belief that counselling psychologists have a responsibility to ask critical questions of taken for granted knowledge (Strawbridge & Woolfe, 1996) has sparked my interest in researching the ways counselling psychologists understand and work with DVA.

In the following chapter I set out to present some of the context of this research, providing empirical accounts of the ways DVA is understood and worked with within the therapeutic community. I attempt to provide enough information to give the reader a feel for differing and at time oppositional views of the nature of DVA, in order to set the context within which clinical work with women experiencing DVA sits. I then go on to examine the ways these professional understandings are negotiated in conjunction with practitioners private beliefs and responses to DVA underpinned by the theoretical philosophies inherent to counselling psychology. Next I introduce the concept of secondary trauma and review some of the relevant research that describes professionals' experiences when working with DVA. I also add to the debate surrounding the way practitioners are trained to work with DVA and state my support for specialised training for counselling psychologists – providing them with relevant and affective skills with which to provide best clinical practice to their women clients.

The present thesis and the research questions it attempts to answer are positioned within a specific ontological and epistemological framework: namely within the relativist paradigm of knowledge and knowledge production. This asks an engagement with the relative, contextual and provisory nature of knowledge produced by a piece of research. The analysis of the narratives generated by the participants in this study will be guided by an interest to plot the phenomenological aspects of working with DVA and the human contradictions and messiness that underpins it.

Thus the present research opens itself up to the multiplicity of different experiences and different realities that counselling psychologists encounter when working with DVA. Its aim is to prioritize the participant's narrated experience and gives space to the participant's voices in detailing their interpretative accounts of their work with women experiencing DVA.

1.2 Literature Review

For the past thirty years DVA has come to be a topic high on the political, legal, social and health care agenda in the UK and across the world (Nicholson, 2010). Changes to laws and the legal position towards DVA, across the globe, have meant DVA is now classified as a crime in many countries, with prosecution for perpetrators. A wide base of research evidence surrounding DVA has led to the creation of guidelines for practitioners and training for professionals working with people involved in violent relationships (Hamberger & Ambuel, 1997; Zerbe Enns, Campbell & Courtons, 1997; Humphreys, 2007).

Given the psychological, moral and professional implications of encountering violence and abuse, it is crucial to establish a shared and accepted definition of what DVA can mean that represents a common point of reference for any professional working with individuals and couples experiencing violence. Clarifying and defining a range of terms and behaviours that could amount to DVA help to characterise what phenomena individuals, researchers, practitioners and organisations class as DVA and will affect how individuals present to services, how services assess and response to DVA and subsequent treatments offered. Several attempts to conceptualise DVA phenomena focus around DVA as a social issue rather than an individual concern localised in individual families (Yllo, 2005). Further conceptualisations frame DVA as a health care problem, with treatment for individuals (Iverson *et al.*, 2011).

The basic elements of what could constitute DVA that are commonly accepted by professionals include a commitment to viewing DVA as involving all forms and acts of aggression and abuse, incorporating physical, verbal, sexual, emotional, psychological and financial, centring on coercion and control (Bograd, 1990). DVA overrides boundaries of class, gender and sexual identity. Therefore DVA can be perpetrated by both genders, can be found in same sex and heterosexual couples regardless of relationship status (www.respect.co.uk).

For the purpose of the present study, to explore the research questions and to give sufficient focus to the analytic aims, DVA is considered to be a mode of relating to oneself and another that includes a range of physical and emotional abusive behaviours both verbal and non-verbal set within the context of a heterosexual relationship perpetrated by a man towards a woman. Research suggests that for more severe forms of DVA sexual abuse can be present (Archer, 2000). Research also suggests that violence can be perpetrated by women towards male partners (Dixon & Graham-Kevan, 2011). These cases are likely to bring up further clinical complexity stretching the beam of the analytical framework contained within this qualitative exploration. For this reason, sexual abuse and female perpetrated violence were not taken into account within the definition of DVA utilised in this study.

1.2.1 Impact of DVA

Despite changes to laws and health care provision, DVA against women continues to be a significant problem that affects millions of women around the world (Boonziaser & Rey, 2004). Estimates suggest that up to 1.3 million women are physically assaulted by a partner in the USA (Sartin, Hansen & Huss, 2006). Within the UK, around 1 in 4 women are likely to experience DVA in their life times (Womens Aid, 2010). The British Crime Survey Inter-Personal Violence self-completion methods found 26,000 women victims of DVA in 2001.

Estimates also suggest that 1 in 6 men will experience DVA in their lifetimes (ManKind, 2012) and that DVA is often reciprocal in nature. For example, National surveys in the US have shown that 12% of the men and women answering questions about the use of violent acts in their relationship, had experienced violence from their partners and 50% of this violence was reciprocal (see Dixon & Graham-Kevan, 2011 for a review). It is likely though that these figures are under representative of the actual numbers of women and men affected as both genders tend to underreport the violence they have been party to (Batsleer *et al.*, 2002, Dixon & Graham-Kevan, 2011).

What is clear is that the experience of DVA can have devastating, long lasting effects on women's physical and mental health. DVA experiences are linked with poor quality of health and life, increased levels of depression, anxiety, low self-esteem, post-traumatic stress disorder, personality disorders, increased risk of suicide and substance abuse (Campbell, 2002; Moracco *et al.*, 2007). The Department of Health's summary, Women's Mental Health: Into the mainstream (2002, p.8) claims that: "one of the most devastating life events that can impact on women's mental health is experience of violence and abuse". The report suggests that 50% or more of women in touch with mental health services have experienced DVA.

The effects of DVA are not just felt by women but extend outwards to have an impact on the children of the victim and/or perpetrator (Nicholson, 2010). DVA has been linked to long lasting negative effects, both emotional and behavioural on children who witness DVA in their home (Jaffe & Sudderman, 1995). Moreover, children living with DVA are more likely to be physically injured themselves (Jaffe, Wolfe & Wilson, 1990). To this extent, the experience of DVA in a child's family life is understood to be a serious child protection issue (Nicholson, 2010).

Literature suggests DVA does not uphold boundaries of class, race or religion yet women from ethnic and religious groups where women are not valued may be most at risk

(Nicholson, 2010). Batsleer *et al.*, (2002) highlight some of the specific problems for minority women (i.e. Afro-Caribbean, Irish, Jewish and South Asian) living in Manchester experiencing DVA. The impact of DVA is exacerbated through socio-economic factors caused by migration and family separation. Cultural ideas of women as obedient and compliant further serve to breed a culture of acceptance of DVA and make contacting DVA services difficult for women who may require specific help. Similar beliefs about women's position as subservient, which may support DVA and make getting help more difficult, have been explored in Chinese women living in Hong Kong (So-Kum Tang, Wand & Mui-Ching Chang, 2002).

The combined physical, mental, human and emotional suffering brought on by an experience of DVA is devastating at the time, enduring and all encompassing. This suffering has a further impact on the financial and economic structure of the country. For example, DVA is estimated to cost the UK £23 billion in health and mental health care costs as well as loss of earnings through injury and distress (The Cost of Domestic Violence, 2004). By virtue of the number of women, children and families affected, DVA is a serious human rights issue (Nicholson, 2010). Furthermore, the number of women, children and families presenting to health and mental health care services for support in the UK makes DVA a concern for all professionals working within these fields.

1.2.2 Theoretical frameworks of DVA: origins, maintenance and treatment

The way DVA is understood, constructed and researched within the social sciences field is surrounded by a number of complex, theoretical, ethical, moral and political controversies (Loseke, Gelles & Cavanugh, 2005). Nicholson (2010, p. 33) highlights that these controversies are based on “methodological and ideological disagreements” and that: “navigating this complex area, which is in part about psychology versus sociology, feminism versus traditional psychology and qualitative versus quantitative research and making a

contribution to knowledge and to women's lives poses a major challenge to any discipline". The aims of the following exploration of the literature are twofold. Firstly, to provide a comprehensive appraisal of important and influential theoretical understandings of DVA, drawing attention to the inherent controversies and differing theoretical standpoints. Having clear theoretical structures about DVA support knowledge within counselling psychology and help guide professional practice when encountering DVA. The second aim of the literature review is to appraise research evidence that informs best practice in the therapeutic treatment of DVA.

1.2.3 Gendered theoretical framework: the interplay between gender, culture and experience

An abundance of theoretical writing places DVA as topical within feminist literature. Through this lens DVA is seen to be a gendered act. The most influential risk factor in either perpetrating or experiencing DVA is gender (Respect, 2008). Perhaps the most important element of the feminist understanding is that DVA is a gendered source of control and domination that men wield over women. This control is supported by historical, social, and institutional norms and commonly held beliefs about women and men and the ways women and men should behave (Dobash & Dobash, 1998). Imbalances created and upheld by the institutions of family and marriage that prop up financial, economic and professional male power are thought to be at the heart of female oppression (Bograd, 1990). The claim is that DVA is used by men as a means of controlling women to implicitly hold them under the tyranny of institutions and sustain a male hegemonic patriarchal society.

A feminist perspective is typically embedded within and draws upon world views promoted by social constructionism. Within a social constructionist perspective language is seen to construct realities, what we can know and study about these realities. Moreover, knowledge is thought to be situated within cultural norms and principles, gendered and influenced by

political structures. Knowledge (a set of ideas regarded as true and valued by a community) and the ways in which we can generate knowledge are made possible through the linguistic resources that are available to a community. Some feminist thinkers argue that gender, gendered practices and injunctions are constructed categories and have a direct impact on everyday life (Butler, 1990).

Through the feminist lens, the experience of DVA is understood to be constructed by values and beliefs associated with concepts such as power, womanhood, masculinity and hegemony that are promoted within a community, empowering men and disempowering women (Dobash & Dobash, 1998). Powerfully held beliefs and valued constructions of what it means to be a woman and a man and discourses surrounding romantic relationships generate rights, duties and injunctions for men and inequality for women that allow coercion and abuse to take place. Dominant ways of looking at the world imply women who have experienced DVA ask for violence, bring it on themselves by nagging men, that men have the right to punish women if they do not perform in their role as women and that ultimately women are responsible for men's behaviour (Greenblat, 1983; Bograd, 1990; Dobash & Dobash, 1998). Kelly (1990) outlines the officious belief that women who experience DVA are poor, weak, down trodden, nagging and deserve to be hit. One upshot of living with taken for granted, dominant discourses surrounding traditional gender roles, is that women are unsure of how to define their experiences of violence and the beliefs associated with DVA often prevent them from defining their experience at all (Kelly, 1990).

The feminist framework is centred on discourses and the interpretations discourses allow people to make and live within when doing intimacy and doing marriage. The product of male dominance as a discursive construction sets up a power imbalance and a tyranny for both men and women. Whereby, discourses implicitly guide behaviour within a heterosexual relationship. This set up is not necessarily problematic until one of the partners takes up this

world view, translating it into an entitlement to be abusive and/or coercive. DVA is then a by-product of the mobilised dominant discourses.

Research conducted from a gendered framework, that recruited participants from DVA shelters and A&E departments, reported high rates of male violence against women and non-violent coercive and controlling behaviour used by men alongside actual violence (Dobash & Dobash, 1979, 1998; Tjaden & Thoennes, 2000; Batsleer *et al.*, 2002). These findings tally with the feminist view that when communities include dominant ways of understandings that empower men, women by implication remain at grossly disproportionate risk of violence and coercion. “Violence is used as a means of obtaining an end, as a product of men’s power over women, and is deeply rooted in men’s sense of masculinity” (Dobash & Dobash, 1979, p. 164).

Subsequent research taking into account a wider population suggests only small numbers of men are violent (Straus, 2008) and when surveyed, most men from Western cultures do not think DVA is acceptable (see Dutton & Nicholls, 2005 for a review). Similar disapproving attitudes towards DVA have been explored in males living in Jerusalem (Haj-Yahia & Schiff, 2007).

Approaching the therapeutic side of DVA, the feminist framework also makes contributions. Pivotal to the therapeutic strategies informed by feminist principles is instigating change for men who perpetrate violence. This change entails men developing behavioural control over violence, replacing patriarchal beliefs with more democratic ideas, increasing relationship skills and becoming educated about the socially supported abuse of women (Stith, Rosen & McCollum, 2008). The process of change is facilitated through gender specific group programmes based on feminist, psychoeducational and Cognitive Behavioural Therapy (CBT) principles (see www.respect.net.uk and www.relate.org.uk for programme outlines). Evidence proposes the efficacy of these programmes in reducing male perpetrated DVA

(Sartin, Hansen & Huss, 2006; Stith, Rosen & McCollum, 2008). However, the studies themselves have been heavily critiqued from a methodological perspective and controversy exists over what makes up a reduction of DVA (Dutton, 1995; Dutton & Corvo, 2007).

Agencies and specialist services taking a feminist perspective offer places of refuge and support for women leaving violent relationships, (see www.womensaid.org.uk, www.refuge.org.uk, www.respect.net.uk). Individual therapy focused on non-pathologizing and non-blaming women, empowering through voicing experiences and bolstering confidence and self-esteem (Marecek, 1999) is part of the healing and recovering process. Findings suggest psychoeducation and supportive psychotherapy for women improves their self-esteem, assertiveness and social support, reducing levels of anxiety and depression (Tutty, 1996).

1.2.4 Gender inclusive perspective and diversity

However instrumental and far reaching the gendered perspective may be; its importance has been criticised by a number of researchers who argue that the core assumptions of patriarchy and gender influence are born out of ideological philosophies rather than rigorous scientific evidence (Dutton & Corvo, 2006). Both rates of male perpetrated violence and the influence of discourses on behaviour are thought to be inflated and not in line with typically quantitative research that shows less of a gender influence on DVA (Archer, 2000; Archer, 2002). For example, Straus (2005, p. 56) collected data through the Conflict Tactic Scale (CTS) with a large number of people and reported equal rates of assault by men and women, indicating the operation of the idea that sometimes the: “marriage licence is a hitting licence”.

Other survey results and meta-analysis have also reported equal rates of violence in women as in men (see Dixon, Archer & Graham-Kevan, 2011 for a review). Archer (2006) postulates levels of women’s violence towards men to be slightly higher than men’s towards women in

western societies. The reverse is true in more patriarchal cultures where women have a higher risk of receiving violence rather than perpetrating abuse.

In addition to equal rates of violence amongst both genders, same sex relationships evidence violence (Archer, 2002; 2004; 2009). While rates of DVA in same sex relationships have mostly been weighted towards male perpetrators, Dutton (1994) reviewed research that suggests rates of DVA in lesbian relationships can occur at levels higher than in the heterosexual population.

In defending a gendered perspective, the CTS as a quantitative measure of behaviour is not seen to determine context, meaning or motivation for violence (Renzetti, 1999). Lloyd (1999, p. 93) claims it is: “over simplistic to assert men and women are equally violent without closer examination of context and consequences”. When the context of and motivation for DVA is taken into account, theoretically women are assumed to use violence in self-defence (Lloyd, 1999). When investigated, women’s motivations for using violence are not solely about self-defence, but similarly to men, the use of violence can be motivated by jealousy, control and anger (Graham-Kevan & Archer, 2009).

It is thought that women may be more economically and socially dependent on men which may result in them being exposed to increased levels of violence (Arias, 1994). Nonetheless, authors such as Holtzworth-Munroe, Smutzler and Bates (1997) proclaim violence by women to be just as devastating as male perpetrated violence in terms of psychological distress and level of injury.

Professional and public debate surrounding rates of women’s violence has, for some researchers, the potential for negative and concerning implications for women. The fear being that quoted research statistics are used to financially and socially undermine projects that intervene with violent men and support women (Yllo, 2005). It is important to note that many

gender inclusive researchers have acknowledged the negative potential statistics detailing women's violence have and call for reporting findings on women's violence in an ethical way (Loeske, Gelles & Cavanaugh, 2005). However, to deny women's aggression and potential for perpetrating DVA for fear of badness (Batsleer *et al.*, 2003) would risk standing in the way of furthering psychological understanding and creating a complete, clinically relevant understanding of DVA (Dixon & Graham-Kevan, 2011). A comprehensive understanding of DVA also requires an appreciation of the intersection between meaning making as greatly indebted to cultural discourses and individualised habits of relating to another person.

As with feminist thinking and the emphasis on the role of language in constructing realities, actions and events, the notion of gender inclusivity in DVA also has clear implications for clinical practice and how to best work with men and women living in violent relationships. Couple therapy is one way to approach working with DVA for couples who wish to remain in a partnership (Dixon & Graham-Kevan, 2011). Nevertheless, complexities surrounding partner's goals and wants for therapy make couple work an intricate and multifaceted intervention.

Wathen and MacMillan (2003) state that evidence for the effectiveness of couple interventions for DVA is scarce. Jones and Schechter (1992) accentuate the dangers of someone disclosing DVA in the same space as their abusive partner in terms of their safety when they return home. The therapist may innocently encourage a disclosure of DVA without being aware of the rules imposed by the abuser outside of the therapy room which could jeopardise the abused partner yet more. Furthermore, separate assessments of DVA are thought essential in any couples service to ensure safety of all family members, especially women (Vetere & Cooper, 2003). Some support for conjoint couple's therapy that does not appear to increase the risk of harm to the partner experiencing violence is beginning to develop (Harris, 2006).

The responsive model developed by Relate (Owen *et al.*, 2008) combines individual sessions for men and women with on-going couple work. Using a double parallel approach, safety is established in women's individual sessions and men are linked in with projects that help them change their perspectives. Once safety is ascertained, couple therapy that builds on the individual work is started. Women are encouraged to develop a stronger sense of personal assertiveness, repositioned as survivors and supported in their own personal growth. Men are encouraged to develop ways to manage angry feelings. The model that pays close attention to safety has been welcomed and endorsed by the British Association for Counselling and Psychotherapy (BACP) and is thought to be an effective way of working with DVA.

1.2.5 Modes of relating to self and others

Whilst the feminist perspective draws on the cultural, social and discursive factors that sustain and maintain DVA as a way of relating to another, the psychodynamic perspective focuses on the individual level. This perspective highlights the individual sense making strategies that develop through the conscious and unconscious process of reaching maturation as an individual in a family setting.

Winnicott (1953) coined the phrase "good enough" mothering to refer to his picture of the mother child relationship where the child is sufficiently nurtured, contained and loved. The sense of being loved and contained involves periods of frustration for the child and feelings of rejection, which are held together by the mother, alongside periods of proximity and availability. The end product of this mothering is an adult who can trust sufficiently in themselves, care for themselves in an autonomous way and hold value in their own self-worth. Attributes such as these are seen to be protective factors against choosing a potentially violent partner in spite of early evidence that this could be the case (Nicholson, 2010). When this process of parenting falls short of the child's unconscious needs, uncontained emotions and experiences become overwhelming and the unconscious deals with them in the best way

it can. From the psychodynamic perspective the internal sense of self is often 'damaged' through early uncontainment and left in an insecure state. One upshot is that this insecure sense of self-worth may lead women to select unsuitable and potentially violent partners (Nicholson, 2010).

Bowlby (1969) defined the links between early experience and later relationships in his writings on Attachment theory. He clarified our internal need to develop secure attachment bonds with those around us, mostly our primary care givers: someone viewed as stronger or wiser. Due to a variety of complex factors, abrupt separation from the attachment figure can lead to strong emotional responses and insecurities in future ways of relating to the individual. Through the process of developing a relationship, separation, disruption and re-connection to important figures in early life, internalized models of self, others and attachment styles are laid down. Attachment styles vary according to a continuum ranging from securely attached through to anxious/ambivalent and insecure attachment styles. A securely attached child and/or adult has a sense of confidence in the way they relate to others and has a positive view of themselves and people around them. A secure attachment style has found to be protective of mental health, relationship functioning and general functioning in adult life (Bifulco *et al.*, 2002). Whereas those with more insecure and anxious styles have more negative views of themselves alongside idealised and positive views of others. They may be more inclined to depression, poor social support, difficulties with intimate relationships and low self-esteem (Bifulco *et al.*, 2002). Our early attachment styles include internal working models that govern possible ways of relating to both self and others. In this way, our attachment style and associated working models have been shown to create patterns of relating to others that can shape our adult romantic relationships and affect regulation throughout our life span. If DVA is seen as mode of relating to others, it follows logically that an individual's internal working models may create some susceptibility to repeating

patterns of violence within relationships. Adults with secure attachment styles are less likely to experience DVA (Alexander, 2009). Whereas adults of either gender with both anxious attachment with more anger traits and insecure attachment styles tend to either perpetrate and/or experience DVA (Dutton & Painter, 1993; Babcock et al., 2000). Henderson *et al.*, (2005) point out the relational nature of attachment styles and links to reciprocal DVA between couples. Interacting insecure and anxious attachment styles of both members of the couple in the context of a relationship are thought to increase the likelihood that violence will occur. For example, a preoccupied attachment style was found to be associated with both perpetrating and experiencing DVA regardless of gender (Henderson *et al.*, 2005). A more preoccupied attachment style may mean individuals are in conflict over needing and receiving love and support from others and fearing not having these needs met. This internal conflict may lead adults with a preoccupied attachment style to become more vulnerable to perpetrating violence when their attachment needs aren't met. Furthermore, the same individuals could be more vulnerable to tolerating abuse through excusing and idealising their partners. Feeney (2007) suggests that attachment styles laid down in early life are stable and stay consistent throughout our lives. The stability of the attachment behaviour relates to the power of the early experience and internalised prototypes of relating to ourselves and others.

Early experiences conducive to the development of an insecure attachment style are often linked to encountering DVA in later life. For example, emotional deprivation in early infancy, witnessing DVA as a child and experiencing childhood sexual abuse may increase the likelihood of later DVA experiences (Alexander, 2009). Witnesses of parental violence are equally likely to experience or perpetrator DVA (Dryden, Doherty & Nicholson, 2010). The suggestion is that female witnesses may be more likely to live with abusive partners and male witnesses may be more likely to become abusers. Though this has not been clearly established (Nicholson, 2010). Indeed, some authors dispute the notion that abuse witnessed

by one generation will be necessarily and automatically transmitted to the next. Kelly (2001) asserts the idea that doing and receiving violence, taken up through early experiences of witnessing abuse is too simplistic, does not take into account context, social factors or individual differences. Moreover, the notion of transmitted violence overlooks the protective influence of an earned secure attachment style, formed through positive experiences in teenage years and later adult life, which shapes and alters insecure modes of relating (Feeney, 2007). It may be that abusive, neglectful, early experiences that leave people with low self-esteem, sexual unassertiveness, higher need for approval, limited emotional repertoires to deal with uncertainty, anxiety and fear of abandonment lead to vulnerabilities to selecting potentially abusive partnerships, rather than making it a certainty (Henderson, Bartholomew & Dutton, 1997).

The cyclical nature of DVA serves to strengthen and maintain an insecure attachment bond (Dutton & Painter, 1993). An insecure attachment bond is initially formed through periods of disconnection and re-connection with a powerful other, uncontained anxiety at periods of separation and overwhelming fear of future estrangement. The insecure attachment common in DVA, recreates this previous pattern through intermittent periods of violence, making up and anxiety that violence will occur again. The way of relating that is formed through an insecure attachment style and reinforced in DVA (termed traumatic bonding) is likened to an elastic band which stretches away from the abuser, but with time snaps those experiencing violence back (Dutton & Painter, 1993). This analogy has been used to explain why people stay in violent relationships and why abusers continue to use violence (Nicholson, 2010).

While psychodynamic attachment theories extend the psychological knowledge of DVA; their importance has been disparaged by a number of researchers who argue that attachment relationships are but one potential moderator in DVA. For Babcock *et al.*, (2008) a focus on ways of relating ordained by attachment styles does not take into account the social support

of the person experiencing DVA, an imperative factor that influences risk of DVA. Dysfunctional cognitions and the attributional style of those experiencing DVA are also overlooked in an attachment based explanation of DVA, again considered critical factors in the development of DVA (Elwood & Williams, 2007). Furthermore, concentrating on the attachment and relationship styles of women can be assumed to 'blame victims' of DVA for generating the violence they experience. The implication is that women invite abuse by choosing partners who will abuse them (Henderson, Bartholomew & Dutton, 1997). Though Iverson *et al.*, (2011) argue that 'victim blaming' concerns are valid, locating factors that practitioners and women alike can work with to reduce the risk of future experiences of DVA is essential.

Implications for treatment of DVA from this psychodynamic understanding relate to working with relationship dynamics in session (Weiss & Marmar, 1993). The containing process of developing a relationship and secure attachment in therapy is healing and crucial for women to recover from experiences of DVA (Nicholson, 2010). Herman (1997) describes the primary need to establish safety before work with DVA can begin. The need for safety echoes the secure base provided by the attachment figure that leads to a secure attachment (Jordan, 2010). In order to provide a secure therapeutic base, strong feelings of anxiety, fear and anger brought on by DVA are given freedom and room to be explored within the therapeutic alliance (Levy & Lemma, 2004). The therapist becomes an "empathic container" for strong feelings, holding and moderating them before women are able to reintegrate the altered internal states back into their own experience. This nurturing process of holding and reforming strong feelings provides a genuinely different relational experience from early detrimental patterns (Levy & Lemma, 2004). Through a valued relationship and secure attachment with the therapist, built on genuine connection and empathic discussion, new relational patterns are taken in, laid down and extended beyond the therapy room (Weiss &

Marmar, 1993). Alongside cultivating interpersonal blueprints, a fragile and ‘damaged’ sense of self is ‘repaired’. A stronger sense of autonomy develops as anxiety, fear and anger reduce. With a greater sense of trust, value and regard restored women have greater internal resources that reduce the risk of developing future violent relationships (Nicholson, 2010).

1.2.6 Psychological theories of ‘victimhood’

The cycle of violence was first postulated by Walker (1979). Through her work with women in DVA shelter and refuge settings, Walker came to consider DVA to be an intermittent punishment/indulgence pattern made up of three stages that continue in a circular repetition. Firstly, angry tension builds in a relationship, followed by a period of violence. The cycle continues with a calm, loving period of reconciliation and re-connection. For example, women experiencing DVA report to undergo a particular psychological reaction to this cycle which came to be known as “the battered woman syndrome” (Walker, 1979). In an attempt to gain control of the cycle and stop violence women live at heightened levels of alertness. This alertness includes: women looking out for small signs that violence may occur, minimising the impact DVA has on them and justifying reasons for DVA occurring in the first instance (Walker, 1979). Exposure to prior uncontrollable shock or violence interferes with the ability to learn later that such violence or shock is avoidable. What is learned is a sense of helplessness, powerlessness and hopelessness: that there is no way to control violence, rewards or punishments in life (Seligman, 1975).

Along with this learned sense of powerlessness, the intricate dynamics of forced control, betrayal of trust and traumatic bonding (Dutton & Painter, 1993) involved in DVA have a substantial and distinctive psychological impact. For Herman (1997), prolonged ‘victimisation’ leads to an insidious destruction of the unified self. Whereby, the person loses

a lucid sense of themselves at the hands of someone using the power of actual coercion or perceived powerlessness in a detrimental way.

The trepidation resulting from coercion inherent in DVA captivates the woman and bolsters the power and control of the perpetrator. This leads to considerable anguish in which women fear for their safety, survival and in some cases their life. To manage this torment, as well as fearing reprisals if DVA were named, women become silent and voiceless (Scarf, 2005) and withdraw from social contact. This serves to increase the sense of dependency on the perpetrator. Alongside this pattern of control and withdrawal the perpetrator enforces a change of identity on the woman. This identity encompasses the negative judgements of the perpetrator. The woman's internalised negative perception of self leads to self-blame and assumption of full responsibility of difficulties in relationships, impaired judgement of safety, self-doubt, failure to distinguish abuse and idealisation of their partner (Sanderson, 2008). To protect the inner world, defence mechanisms such as dissociation and compartmentalisation are employed to block out the abuse. Due to the betrayal of trust and disruption of safety in DVA, ideas about the self, world and others as safe and trust worthy are fragmented. This leads to a lack of trust in others and loss of meaning in life. Moreover, this process also disrupts mentalisation where women are unable to reflect on life encounters or emotions and understand them. The inner ability to think is shaken, further rupturing inner reserves and strength, leading to an increased sense of imprisonment and unconscious submission to the status quo (Sanderson, 2008).

A growing body of research knowledge recognises the impact of DVA as a personal trauma. The psychology of trauma is such that destructive and vicious experiences from the external world force through and pierce the protective shield of the internal psyche (Freud, 1920). External events considered to be individually traumatic involve actual or perceived death, or serious injury. Along with this perception is an intense and overwhelming feeling of terror,

powerlessness, horror and distress (Hemsley, 2010). After a violent or traumatic experience that is prolonged, excessive and/or repetitive permanent emotional and affective damage can be done to body and mind. The pattern of psychopathology and symptomatology, common in DVA, are diagnosed as a defined and identifiable psychiatric disorder, namely post-traumatic stress disorder (PTSD). Research has confirmed the prevalence of PTSD in samples of women experiencing DVA (Cascardi, O'Leray & Schlee, 1999) and PTSD has been linked to an increasing likelihood that women will experience future DVA (Johnson & Zlotnick, 2009). Through the process of emotional numbing, women's ability to assess risk is impeded and the potential to engage in future violent relationships is increased (Krause *et al.*, 2006).

Routing DVA in a specific psychiatric, medical framework has drawn critique by some researchers who state that this medical approach does not recognise cultural, religious and economic factors surrounding a conceptualisation of trauma (Rosen, Spitzer & McHugh, 2008). Furthermore, a diagnosis of PTSD does not take into account the subjective and unique meaning making processes of women (Lavis *et al.*, 2005). It also recreates a power dynamic that places the therapist in a position of medical expert (Parker *et al.*, 1999) that may be particularly detrimental to women with DVA experiences. Yllo (2005) claims the psychiatric perspective medicalises women's world experience, deflecting attention away from DVA's social causes and leads to individualising the problem and the solution. Individualised perspectives may be more popular as an explanation for DVA as individuals can be fixed and social structures upholding DVA are left unchallenged (Loseke, Gelles & Cavanaugh, 2005).

1.3 Approaching working with DVA: guidelines, personal impact and professional readiness

A conceptualisation of DVA as a public health care problem has led to a research focus on the health care system and the way women who have experienced DVA are treated within it. Given the link between DVA and enduring and debilitating mental health difficulties, one of the primary supports for women who experience DVA, in western countries, is the mental health system (Campbell, Raja & Grining, 1999). As such, the way women present to mental health services and their experiences within the mental health system have come under research scrutiny. Moreover, mental health practitioner's personal, professional and psychotherapeutic approach to the treatment of DVA has been explored by researchers in multiple ways. A summary of this research literature will be presented and discussed.

1.3.1 Towards the development of guidelines for working with DVA

Drawing on research commissioned by Women's Aid, Humprheys and Thiara (2003) explored women's experiences within the mental health care system. The researchers established women tended not to disclose DVA in an initial assessment with a mental health practitioner, but presented with behavioural symptoms of depression, anxiety or general inability to cope with life. For many of the women, practitioners failed to ask directly about DVA which led to their abuse experiences staying hidden. Increasingly, disclosure of DVA could be encouraged by practitioners asking direct questions about DVA and helping women to name the abuse. Women reported wanting their immediate safety to be protected, to feel listened to, believed and have their DVA experiences validated. The study also found it was important for women to not feel judged for staying in violent relationships, have DVA explained to them and advice of specialist services offered.

In an attempt to support practitioners to develop best practice with DVA, i.e. to assess, respond and work with DVA in a safe and active way, a number of organisations have developed their own specific guidelines and protocols. For example, The Relate Institute in the UK (www.relate.org.uk) commissioned a project to trial and evaluate ways of working with DVA in a couple setting (Owen *et al.*, 2008). Using a combination of quantitative and qualitative measures, the researchers assessed the use of Relate's therapeutic model when working with DVA over a period of two years. The model incorporated a structured interview that contained a number of questions designed to help practitioners focus the conversation on safety and discuss DVA in a coherent and systematic way. The authors concluded that Relate's model of working with DVA and the structured interview promoted safe, effective and best practice treatment for DVA. Furthermore, recommendations to roll the trialled protocol out to all Relate centres (80+) means practitioners have a well evaluated, clinically relevant and comprehensive resource to increase the quality, safety and efficacy of their clinical work with DVA. Similar guidelines exist in specialist services for those experiencing and perpetrating DVA (www.womensaid.org.uk; www.respect.uk.net).

The National Institute for Health and Clinical Excellence (NICE - www.nice.org.uk) provide recommendations and guidelines for clinical practice with specific difficulties that assist both clients and practitioners to make decisions about treatment plans. As an agency, they provide the most clinically relevant guidelines to counselling psychologists in all mental health settings. The guidelines are derived from and evaluated against available research. At present, no distinct guidelines for specifically working with DVA exist. Yet NICE are in the process of completing a set of DVA guidelines and recommendations aimed at all health and mental health workers in public, private and statutory settings. These are due to be completed and available in 2014. The guidelines are designed to support best practice and foster clinically effective interventions with DVA by promoting early identification of violence to reduce the

impact on those concerned. The ultimate aim, as stated by NICE, is to support people experiencing DVA to feel safe, in control and improve their psychological, physical and relational health.

1.3.2 Encountering DVA: Personal and professional responses

While previous research has focused on the centrality and sensitivity involved in disclosing DVA from the perspective of those involved in DVA, subsequent research focuses on tackling DVA from the perspective of practitioners working with it.

McCann and Pearlman (1990) have noted that practitioners are beginning to become aware of the personal effect of working with women traumatised by DVA. Regular exposure to emotionally distressing stories of DVA can lead practitioners to experience feelings akin to burnout, vicarious traumatisation and countertransference effects (Sexton, 1999). This set of consequences, subjectively experienced, reflects the work that has looked into secondary trauma in mental health practitioners working with traumatised populations.

Burnout refers to a sense of anger, ineffectiveness and incapacity to reach therapeutic goals that can lead to physical symptoms such as disturbed sleep, headaches, aggression and exhaustion (Valent, 2002).

Secondary trauma or vicarious trauma is thought to be a natural result of working with traumatised individuals (McCann & Pearlman, 1990). The impact of secondary trauma on practitioners is thought to be at the cognitive level, disrupting practitioner's beliefs, ideas, values and schemas about themselves, the world and others in a way that is individual to each practitioner (McCann & Pearlman, 1990). Furthermore, practitioners can experience flashbacks, nightmares and intrusive thoughts surrounding clients verbalised trauma, may lose a sense of goodness in others and the ability to be compassionate and empathic (Sanderson, 2008).

Countertransference refers to effects influencing practitioner's feelings in and out of session. Common feelings as a result of working with trauma stories are helplessness, frustration, vulnerability, fear and ambivalence towards the positive influence of therapy (Sanderson, 2008).

Countertransference is seen to occur in the context of therapeutic work, while secondary trauma is thought to be the result of working in a therapeutic way with a person who has trauma experiences. Countertransference effects may surround the practitioner's emotional being during and after session, while secondary trauma effects can be longer lasting, affecting practitioner's world view and disrupting their everyday functioning. To this extent, research has documented the ways mental health practitioners mediate self-care when working with secondary trauma.

Iliffe and Steed (2000) documented the effects of working with DVA to include phenomena such as vicarious trauma, burn out and countertransference effects coupled with disruptions to world views of safety and justice. In conjunction with the personal effects described, counsellors interviewed by the authors depicted a number of complex, demanding and challenging tensions associated with working with DVA. These included: having to break confidentiality, fearing the impact on the therapeutic relationship and increasing risk to women once confidentiality had been broken. The counsellors talked about the ways DVA impacted on their clinical practice; often doing more than therapy by offering practical support, outside service contact numbers and extending sessions to allow greater discussion of the practical ways to support their clients. Furthermore, the counsellor's connected with feelings of horror when encountering DVA, powerful feelings of anger and a need to distance themselves from DVA stories as a way to protect their own internal equilibrium. As their work continued, the counsellors recognised their growing sense of confidence with working

with DVA and the way they worked at coping with the stories they heard through their own levels of self-care, using peer support and recognising client's strengths.

For Hogan *et al.*, (2011) counsellors working with men experiencing DVA, talked of tensions and struggles surrounding their clinical work, as well as the personal effects relating to vicarious trauma as outlined above. One tension surrounded men's sense of shame and embarrassment at living with DVA that impinged on their ability to name and openly discuss their experiences in therapy. Feelings of frustration and fear for client's safety were complex and challenging for the counsellors. In order to gain confidence in their clinical work, the counsellors drew on their past clinical experience and described the usefulness of having received specific training for working with men experiencing DVA. Distinct to working with these male clients, the counsellor's perceptions of the goodness of women changed as a result of their therapeutic work.

Two studies by Harway, Hansen and Cervantes (1997) question mental health practitioner's level of ability to assess and react to DVA. American family therapists, clinical psychologists and psychotherapists were presented with a DVA vignette, asked to establish the presenting problem and propose an appropriate treatment plan. Most practitioners did not recognise DVA as a major concern or see its significance. As such, treatment focused more on discussion rather than interventions aimed at DVA. Harway, Hansen and Cervantes (1997, p. 39) stated the findings revealed that: "many of the therapists were unprepared to assess for dangerousness in violent families and indicated they would not be able to protect their clients from harm".

A more recent study by Hamel *et al.*, (2009) sheds further light on the way legal and mental health professionals understand and assess DVA in a family context where children are likely to be affected. Child custody mediators, family law professionals, domestic violence workers, mental health practitioners and students completed a questionnaire designed to

gauge philosophies surrounding DVA. When asked questions about the frequency, context and consequences of violence, professionals and students responses were thought to show support for a patriarchal understanding of DVA that positions men as the predominate perpetrators. Viewing DVA through this patriarchal lens potentially overlooks women's aggression and mutual couple violence that may place children who live in violent families at increased risk of physical and emotional harm. Hamel *et al.*, (2009) propose the findings illustrate that professionals involved in child custody do not have a thorough and empirically supported understanding of what constitutes DVA and conclude that "if child custody mediators and evaluators are making their decisions and recommendations based on erroneous beliefs associated with a faulty paradigm, family courts may not be acting in the best interests of the children" (p. 37).

1.3.3 Counselling psychology: nature, framework and role when working with DVA

Theoretical principles, professional values and curriculum of training typical to counselling psychology come together to provide a backdrop against which working with DVA will occur. To this extent, some of the core underpinnings of counselling psychology will be briefly outlined.

The principles of counselling psychology are often associated with a humanistic stance towards clinical work. The humanness of an other is valued and nurtured in a respectful way (Cooper, 2009). Relating to the humanness of each client includes: a commitment to recognising clients as unique, with their own specific subjective experience, a focus on personal growth, actualisation and empowerment through a democratic and collaborative relationship (Cooper, 2009). Connection to the unique human experience of another requires counselling psychologists see beyond a label, diagnosis or even psychological framework. Instead of fixing symptoms, counselling psychologists attend to the complex and intimate

experience, well-being, needs, wants and goals of each client as is consistent with a humanistic idea of humanness, human problems and human suffering (Strawbridge & Wolfe, 2010).

By placing the client and their individual uniqueness at the heart of the therapeutic encounter, counselling psychologist's position clients as experts on themselves. Clients make their own discoveries of who they are and how they wish to live their lives. Part of elucidating the client as expert often entails using language in the same way as the client and following the client's therapeutic agenda. Specific to DVA, adherence to not imposing your own agenda as a practitioner may be problematic; as many women do not name DVA unless asked direct questions (Read & Fraser, 1998). Likewise, it can be argued that using clients own frame of reference for describing experiences may limit the scope of possible exploration (Kaye, 1999).

It is the role of the counselling psychologist to come alongside their clients in a process of joint discovery. Rather than doing in the therapeutic space, the emphasis is on being with the client, wherever they are in the here and now of the therapeutic space. The vehicle for this collaborative and emotional being is the therapeutic relationship itself, which is nurtured and attended to at all times. An active process of reflection on the therapeutic relationship, as well as feelings emerging in session, aids this being stance and ensures best psychological practice. Despite the pull towards reflective practice, Hegarty (2008) reminds us that therapists are ordinary people, situated within culture and susceptible to voicing the same prejudices as lay people. Evidence suggests that psychologists remain susceptible to using dominant ideological views that exist in the cultural milieu in their therapeutic work, may not question these or how they position their clients (Hare-Mustin, 1994).

While evidence based clinical practices are necessary to establish the effectiveness of interventions (Murray, 2009), research evidence of clinical practice is poorly taken up by practitioners (Proctor, 2004). Due to this, a gap between research and practice occurs in many mental health care fields including counselling psychology (Proctor *et al.*, 2009). To some extent practitioners report uncertainty about ways to incorporate research into practice (Owenz & Hall, 2011).

1.4 The benefits of increased preparedness for counselling psychologists in encountering DVA: an empirical proposal

Despite the support the mental health system can offer those experiencing DVA, reports suggest that these clients can be treated in insensitive ways by practitioners (Humphreys & Thiara, 2003). It has been proposed that practitioner's responses to working with DVA can be improved through participation in training specifically aimed at understanding DVA and the complexities inherent to clients presenting with this problem (Campbell, Raja & Grining, 1999).

Ways to enhance best practice with DVA become more pertinent in the light of the national delivery plan to reduce domestic violence, UK Government, Home Office Tackling Domestic Violence: effective interventions and approaches (2005). This imperative compels professionals working with anyone experiencing DVA to provide an environment conducive to safe disclosure of violence and to provide individuals with suitable and effective clinical interventions. Furthermore, The Taskforce on the Health Aspects of Violence against Women and Children published a report in 2010 that called for: "standardised training in domestic violence" (p. 45) to be provided for all professionals working within the NHS at all levels of training. This recommendation for specialist training for all practitioners working with members of the public likely to have experienced of DVA is echoed in the Home office report – Tackling Domestic Violence: The Role of Health Professionals (2004). The call for

specialised training for DVA is also contextualised in the current climate of change, development and production of guidelines specifically for working with DVA i.e. NICE and Relate.

Research shows DVA has a negative personal impact on practitioners to the extent that it can cause burn out and feeling unsafe. In some cases, this has lead practitioners to create their own support systems and change their clinical practice (Iliffe & Steed, 2000). Little research has focused on counselling psychologist's experience of working with DVA. It would seem logical to imagine that this specific issue, with its complex and intricate nature, would have a powerful impact both personally and professionally on counselling psychologists working with cases of DVA.

Recent research has also shown that counsellors benefit from receiving specific training in DVA, which may help them feel more prepared to deal with some of the personal and professional conflicts and impacts e.g. Hogan *et al.*, (2011).

The notion of specialised training for DVA does not appear to be a systematically adopted position within counselling psychology. Currently, the curriculum at doctorate level in counselling psychology does not include specific theoretical and psychological knowledge of DVA, leaving graduates somewhat unprepared to deal with this wide spread phenomena. Current research and calls for specific training within other related mental health care fields as outlined above, point towards the benefits of including specialised lectures about the nature and aetiology of DVA and theoretical frameworks that offer explanation for DVA within counselling psychology courses; to raise awareness of DVA and prepare trainees to work effectively with DVA in their future careers.

The common theoretical conceptualisations of DVA outlined previously (see page 6 for theoretical frameworks of DVA) all offer important knowledge about the origins and maintenance of violence, along with associated principles for best treatment approaches and

are reliably supported by empirical evidence. No one theory provides the sole understanding that can fully account for DVA in the context of a relationship, as relationships by their very nature are made up of complex, human, social and context specific factors which impact on the individuals living within them and their experience of DVA. Therefore, the DVA theories presented here provide a repertoire of ideas that counselling psychology trainees can have at hand and integrate into their clinical practice to use in specific situations with specific clients. This style of integrating theories to create individual and specific formulations sits comfortably within the philosophy of counselling psychology. It is proposed that offering counselling psychologist trainees a through over view of the influential theories summarised earlier, which combine to provide an extensive understanding of the complex interplay between the collective and individual nature of DVA is the most effective way to increase trainees preparedness and readiness to work with DVA.

Given the paucity of research surrounding the way DVA is understood and worked with, inside a counselling psychology framework, the present study aims to go some way to filling the gap in this area of interest based on the qualitative methodological principles of Interpretative Phenomenological Analysis (IPA). This approach is phenomenological in that it delves into descriptions of personal understandings and individual subjective experiences of working with DVA in a clinical setting from a counselling psychology perspective. In this way, the research does not attempt to offer an explanation of DVA itself. But offers descriptions of counselling psychologist's notions of DVA when detailing the way they work therapeutically with their women clients and their lived sense of preparedness for this type of clinical work.

Research in this area is also pertinent to counselling psychology in terms of the implications for theoretical and clinical training and improving the quality of clinical work with DVA. As the British Psychological Society Division of Counselling Psychology Professional Practice

Guidelines state, practitioners have an obligation to be practice led, grounding professional practice in research, offer their best practice and take steps to continually develop and maintain theoretical knowledge and clinical skills.

1.5 Aims and research questions

The research aims to delve into counselling psychologist's narrative conceptions of DVA in their work with women clients and their preparedness to work with women bringing DVA experiences. Phenomenology takes the diverse experience of being human and meanings attributed to human lived experience in all its various aspects as its focus (Smith, Flowers & Larkin, 2009). IPA represents one form of phenomenological enquiry that attempts to understand the quality and texture of lived experience and the individual sense making process. However, IPA acknowledges the inability for exact connection with participants lived experience (Willig, 2001). Only through a process of active interpretation of participant's narratives and talk, by the researcher, can any knowledge of the participant's life world be gained (Smith, Flowers & Larkin, 2009). The focus on distinct life experience, knowledge and sense making, coupled with examples of the specific analytic steps required has meant IPA has become a useful method of qualitative inquiry for psychologists (Willig, 2001).

The main analytic focus of this research is to map out the key phenomenological factors of counselling psychologist's knowledge and understandings of DVA. The particular analytic lens will lock into the struggles, dilemmas and tensions associated with this clinical work and ways counselling psychologists attempt to both solve the tension and create clinical interventions for their women clients. Further exploration surrounds the practitioner's perceived level of readiness and preparedness for this work.

The specific research questions that guide the analysis and interpretative conclusions are:

1. What are some of the prevalent definitions and understandings of DVA that counselling psychologists working in private practice draw on?
2. What does it feel like to work with women who have experienced DVA? What are some of the tensions and dilemmas involved in this work and how are these predicaments negotiated?
3. How prepared do counselling psychologists feel they are to work with this population and what are some of the common forms of support employed?

2. Methods

2.1 Design

A qualitative method of analysis is adopted to explore the research questions as it enables detailed interpretation of participant's subjective experience. Qualitative research takes a bottom up approach, allowing participant's meanings to develop in their context, while emphasising the researcher's active relationship with these descriptions (Ponterotto, 2005). A methodological choice of data collection via one to one semi structured interviews that generates idiosyncratic descriptions replicates this ideology. The contextual nature of these accounts is acknowledged in the adoption of a relativist approach to knowledge and knowledge production that underpins the data collection and analysis process. IPA was employed to create a phenomenological and interpretative map of participant defined meanings and understandings in relation to DVA.

2.2 Participants

Six women counselling psychologists who had worked with women experiencing DVA were recruited to the study. All were chartered psychologists with at least two years post qualification clinical experience, some gained in a private non specialist mental health care setting. Ages ranged from 30 to 60. The criteria used to recruit participants included a focus on homogeneity across a number of contextual features, allowing for diversity and depth of data to emerge. The research aims were not systematic gender differences and women counselling psychologists were recruited as they represent the majority gender in this field. Incorporated into the selection criteria were a training background in psychological and integrative counselling psychology and having practiced therapy for two years. These standards encouraged descriptions of common clinical barriers and solutions associated with working with DVA. Additionally, exposure to a variety of clinical cases in two years of post-

qualification practice would add to the diversity of data. There are many services available for DVA. Most of these are situated outside of the NHS within specialist statutory agencies. Practitioners who have worked in a private practice settings, outside of these services, may be assumed to have little access to specialist training and support. Counselling psychologists with this experience were recruited to draw out narratives that highlight the common support networks and systems employed and devoid in this context.

Participants were recruited via an invitation to participate poster placed on the premises of a private hospital in the London area (see appendix A). As well as introducing the main research area, the poster asked interested individuals to contact the researcher with any queries and to discuss the logistics of participation. If appropriate, an email was sent to the participant with an invitation to participate letter attached that further detailed the specific research topic (see appendix B). In order to facilitate analysis sufficient in scope and depth, the following account of what DVA can mean was outlined in the invitation letter that prompted participants to self-select. Violence was defined as any physical act or emotional act of abuse carried out by a man towards a woman partner in the context of a heterosexual relationship. It is important to note that other forms of violence exist, both within heterosexual and same sex relationships, perpetrated by both women and men that are outside of the scope of this thesis. After participants had opted in to the research process, the interview location was discussed via email or telephone, which in most cases was a room in the hospital. On meeting with the participant, they had chance to ask any questions before signing the consent form (see appendix C).

2.3 Mode of data collection

Data was collected via semi-structured interviews. An interview schedule was prepared (see appendix D) to guide the interviews and was created through comprehensive deliberation of

the current DVA literature with specific emphasis on the research aims. The interview schedule was a list of open ended questions with some prompts, divided into three sections as recommended by Smith, Flowers and Larkin (2009). Part A included questions inviting participants to detail their understandings and experiences of working with DVA, attending to the common challenges faced and clinical solutions engaged with. Part B covered aspects of preparedness to work with DVA and support required for this work. Part C comprised summing up and recommendations for training institutes and governing bodies.

The interview schedule was constructed to facilitate conversation, but not direct or steer narratives. It assisted the development of rapport between interviewer and interviewee giving participants space to offer their own reflections. Consequently, the interview style was open and facilitative, offering sufficient interaction when necessary though avoiding interruptions. The open ended structure and style in unison enabled themes to emerge by generating long, in depth narratives that contained deliberations deemed important to the participants. For these interviewees, the questions prepared and interview style was sufficient, as only a few questions were needed to foster the emergence of participant's voices. The final question was repeated across all interviews to sum up focal common elements across all participants and firm up aspects of the research questions. The interviews were expected to take 60 minutes. Interviews lasted between 55 minutes and 111 minutes, were audio recorded verbatim with participants permission and all identifying information removed.

A research journal was maintained throughout the data collection and analysis. The main purpose of this log was to be a reflective space for noting down hunches and thoughts to be returned to and to ensure bracketing off (Husserl, 1931). At the end of each interview notes were made that captured the experience and thoughts the interview elicited.

2.4 Procedure and Ethics

Once ethical approval was gained from the University of East London (UEL) a call for participant's poster was advertised on the premises of a private hospital in the London area (see appendix A). The poster had prior approval from the hospital management. No additional ethical approval was needed as UEL approval was sufficient. The poster contained details of the research topic and contact details for registering interest or gaining further information. After initiating contact, interested participants were sent an invitation to participate letter via email (see appendix B). This letter described the purpose of the research, indicated some of the research questions and outlined the inclusion criteria. Once the criterion was confirmed, interviews were arranged over the telephone or email to take place within the private hospital or UEL. At the initial meeting, participants were made aware of the exact nature of the research and what volunteering would entail, through an information form (see appendix C). This indicated the procedure and re-iterated the rights of the participants. Only after reading the document, verbalising their understanding of their rights and asking any questions, were the participants asked to give their informed consent. Once participants indicated their acceptance to proceed, the opening interview question was posed. Participant's well-being was monitored throughout the interview. Visible signs of discomfort or distress would have initiated a style switch from researcher to empathic supportive listener and the interview terminated. Time was built in at the end of the meeting for participants to raise questions and discuss their experience of the interview process. This was important to monitor any associated adverse effects. The option to be de-briefed was also offered. Material containing information of where to find on-going support if distressed by the interview was provided to each participant. This document further outlined how to get in touch with me following participation if any stress or distress should arise (see appendix E). Participants

were moreover encouraged to seek the support of supervisors or personal therapists if this was deemed appropriate.

2.5 Mode of data analysis

The process of analysis followed Smith, Flowers and Larkin's (2009) guidelines for IPA. IPA was proposed as an approach to qualitative analysis by Smith (1996). Smith developed a method of analysis that considers the way people gain knowledge about their worlds and experiences in specific situations, contexts and at specific points in time.

IPA is a phenomenological method. Phenomenology places peoples lived experience at its heart. The exploration is of people's collective lived experience and common understandings, alongside a consideration of subjective individual differences. The result is a mapping out of both common meanings within and deviation across peoples accounts. Alongside recognition of people's subjective experience, IPA appreciates that the connotations people ascribe to experiences are the result of exchanges between people in the social world (Willig, 2001). It is further an interpretative method. While IPA tends to participants meanings and aims to get close to these, direct access to individual's understandings is thought to be impossible (Willig, 2001). Experiences can only be made sense of through the interpretations of the researcher. So meaning is co-constructed through the interaction with the researcher and filtered through the researcher's internal world. This outlines the double hermeneutic stance or double interpretation that occurs whereby the researcher aims to make sense of the participant's sense making process (Smith, Flowers & Larkin, 2009). In this way, the phenomenological accounts are seen to be interpretations. As part of this system and to create transparency, the process of interpretation is reflected upon and made visible.

One way to capture the interpretive aspect of IPA is to locate it within a relativist paradigm (Willig, 2001). This model makes the relative nature of knowledge and knowledge

production explicit. What we come to know as our reality is produced through our own representations and accounts of that reality (Burr, 2003). There is no one, final or true reality outside of these perceptions. That is not to say the position of the thesis is one of hard relativism that denies the material world or the real experience of DVA, but takes the ways DVA is understood in the context of a social interaction as its focus. Implicit in this stance is the idea that knowledge and how we produce this understanding of the world is relative to the speaker, the speaker's position and interests and life experience (Willig, 2001). It is further relative to the setting and is contextualised between the two people talking at that moment. In this way, knowledge and what we can know is seen to contain multiple, fluid realities. The inference is that the emerging knowledge produced through the current research process is provisory and temporary; only typical to the group of counselling psychologists located in the context that created it. Across this transitory snap shot of meanings, institutional practices and common group elements such as gender, psychological training and practice maintain elements of consistency and continuity that can be captured. The advantage of taking a relativist approach is that knowledge of DVA is arrived at through the exploration of various understandings. As these are not judged for their accuracy and truthfulness against a perceived external truth, each participant's voice is recognised as being equally important (Smith, Flowers & Larkin, 2009).

This relative and contextual nature of knowledge production stands in opposition to a realist framework (Gergen, 1985). A realist approach to knowledge operates on the reality truth correspondence, asserting that an external world exists separately from our depictions of it. (Ponterotto, 2005). Though separate, our perceptions are underpinned by this external reality so precise knowledge of this reality can be revealed (Burr, 2003). An empirical study adopting a realist position proposes there is one permanent, final truth that can be arrived at and discovered through systematic, scientific, objectifying approaches.

IPA and Discourse Analysis (DA) are both valuable methods of analysing text. On the one hand, DA invites the researcher to map out discourses available to the speaker and points to the social systems and practices that sustains those structures. On the other hand, DA highlights the realities and ways of being that are made possible and not possible for communities living amongst these social structures. In this way, DA focuses on the interplay between culture, society and sense making and serves to thematically map prevalent discourses.

IPA, however, allows the researcher to map key psychosocial and phenomenological dimensions of the human experience. Furthermore, an IPA analysis grapples with and explores the individual and collective patterns of sense making, particular to the participants. Part of this exploration focuses on the messiness of human experience and the human emotional life. This incorporates the struggles, tensions, conflicts and contradictions inherent in the ways people make sense of their own experiences. Coming to understand the multi-layered and multi-faceted meaning making systems that people draw on is especially important for counselling psychologists.

The present study holds an appreciation for the analytic lens of DA and the knowledge created through such an analysis. Nonetheless, the analytic aim of this research moves in an expansive way from a focus on social structures and prevalent discourses, to the narrated phenomenological impact and subjectively felt experience of working with DVA. In order to ensure an engagement with the paradoxes and variances of the participants experience of working with DVA and to best answer the research questions, IPA, rather than DA was selected as a method of analysing the participant's particular and common sense making practices.

2.6 Phases of data analysis

In shaping a qualitative analysis, IPA is not prescriptive. Yet in order to produce a systematic rigorous investigation there are several phases that are recommended as a framework for data analysis (Smith, Flowers & Larkin, 2009). The word phase is used to indicate the multiplicity inherent in the relativist approach that underpins the analysis. The term allows inclusion of analytic overlapping, moments of return to narrative and flip flopping back and forth between description and interpretation in the process of analysis.

The following are the phases that were used to guide the analysis of this study.

Phase one: knowing the data

The process of IPA began with the transcription of the audio recorded interviews. This then lead to a repeated reading and re-reading of the text and listening back to the audio recording. This initial engagement with the text is very important as it creates an in-depth sense of familiarity with the data.

Phase two: noting and witnessing meaning making

As part of the process of noting and witnessing meanings, I noted anything of interest emerging from the participants in the right hand margin as I was reading the text. The process of spending long hours allowing the data to create ideas that I could observe was very fruitful, as important issues began to develop. Possible theme clusters running through the text that related to my research questions and aims were flagged up (see appendix H).

Phase three: creative identification between possible themes and a return to the narrative

The connection between participants own words and my interpretations was secured as theme groupings were headed with participants own words. Towards the end of this process I

gathered together this noting. This culminated in creating a pictorial representation of some of the core patterns that seemed to emerge (see appendix I). I began to wonder at the relationships between the patterns of meanings that presented themselves. A return to the narrative underpinned this phase, as I moved back and forward between the previous analytic phases, for each participant, ensuring the integrity of individual meanings was protected. This culminated in the creation of a list of possible master themes in table form (see appendix J). Theme titles became possible sub themes clustered together in terms of descriptive similarity and named according to the over-riding conceptual quality. One other way of safeguarding the return to the text was taken in the injection of rich, illustrative extracts into the table (see appendix K). The analytic phases of working, reworking and refining understandings and interpretations were applied to each interview producing a table of themes for each participant.

I approached each narrative with an open mind to create a close reading, allowing themes to develop out of the text. Individual nuances and differences were retained to develop a coherent and integrated understanding of the data.

I am aware that IPA unlike grounded theory does not involve a disciplined rigid progressive, identification of themes. What drives IPA in terms of ordering and noting themes is a flip flop between phases and close return to the text. Awareness of such positions and the double hermeneutics at the heart of IPA drove a deliberate attempt to take charge of this process. Interpretations echoed participant's expressions where possible, preserving the integrity of and increasing the intimacy with the narrative.

Phase four: seeing master themes as they emerge

The final phase involved creating a credible and consolidated table of themes and subthemes for the group of participants (see appendix L). This included a focus on the common themes

and meanings adjacent to an emphasis on the specific unique understandings. Some themes that seemed to overlap were merged into others and exclusive themes mentioned by one or two participants were highlighted. A descriptive chronicle of the interplay between interpretations and participants accounts was shaped out of this process.

After the analysis was completed credibility checks were undertaken. The findings from the analysis were shown to the research supervisor and three counselling psychologist colleagues working in private practice. Feedback was gained from two participants who were given the chance to validate their experiences by reading through the analysis.

2.7 Reflexivity

Accepting the co-authorship imperative at the centre of qualitative research implies a specific focus on the practice of reflexivity. Reflexivity is a positioning or a stance towards analysis that involves stepping back from and observing the process of research. The focus is on the particular assumptions and actions of the researcher, developing a sense of accountability for and awareness of the moment by moment practice of research. In this light, reflexivity is seen to be a method for doing research, an important practice in the associated process. Whilst reflexivity is considered to be a core, fundamental practice within any qualitative research, it is especially important in relativist research as it is instructive of the contextual features within which the knowledge has been generated. Paradoxically, in quantitative research, reflexivity would be seen as a confounding variable that needs to be controlled.

One of the earlier places that reflexivity is necessary and useful is in the development of the research questions and in preparation for proceeding interviews. In preparation for the interviews, it is common and good practice in qualitative research, for the researcher to become aware of their own assumptions. So that the natural attitude the researcher has towards the topic of study becomes alive and clear (Husserl, 1931). Becoming aware of this

natural attitude can be achieved through listing the researcher's assumptions, fears, beliefs and ideas about the research process and topic. Once written down the researcher attempts to bracket off (Husserl, 1931) these perceptions. This involves acknowledging and attempting to distance oneself from these attitudes to allow the voice of the participants to truly emerge. My research journal was used as place where my attitudes and ideas about the topic of study were noted (see appendix F)

3. Prevalent themes in counselling psychologist’s narratives of working with DVA: dilemmas, struggles and solutions

The Interpretative Phenomenological Analysis of interviews with six counselling psychologists generated four predominant master themes. These master themes and associated subthemes will be introduced, illustrated and discussed.

Figure 3.1 shows the equal value and contribution of each of the themes to the overall emerging analytic map set within and framed by this specific interview context.

3.1 “Privately owned and Professional/Institutional/Public ideological tensions” master theme

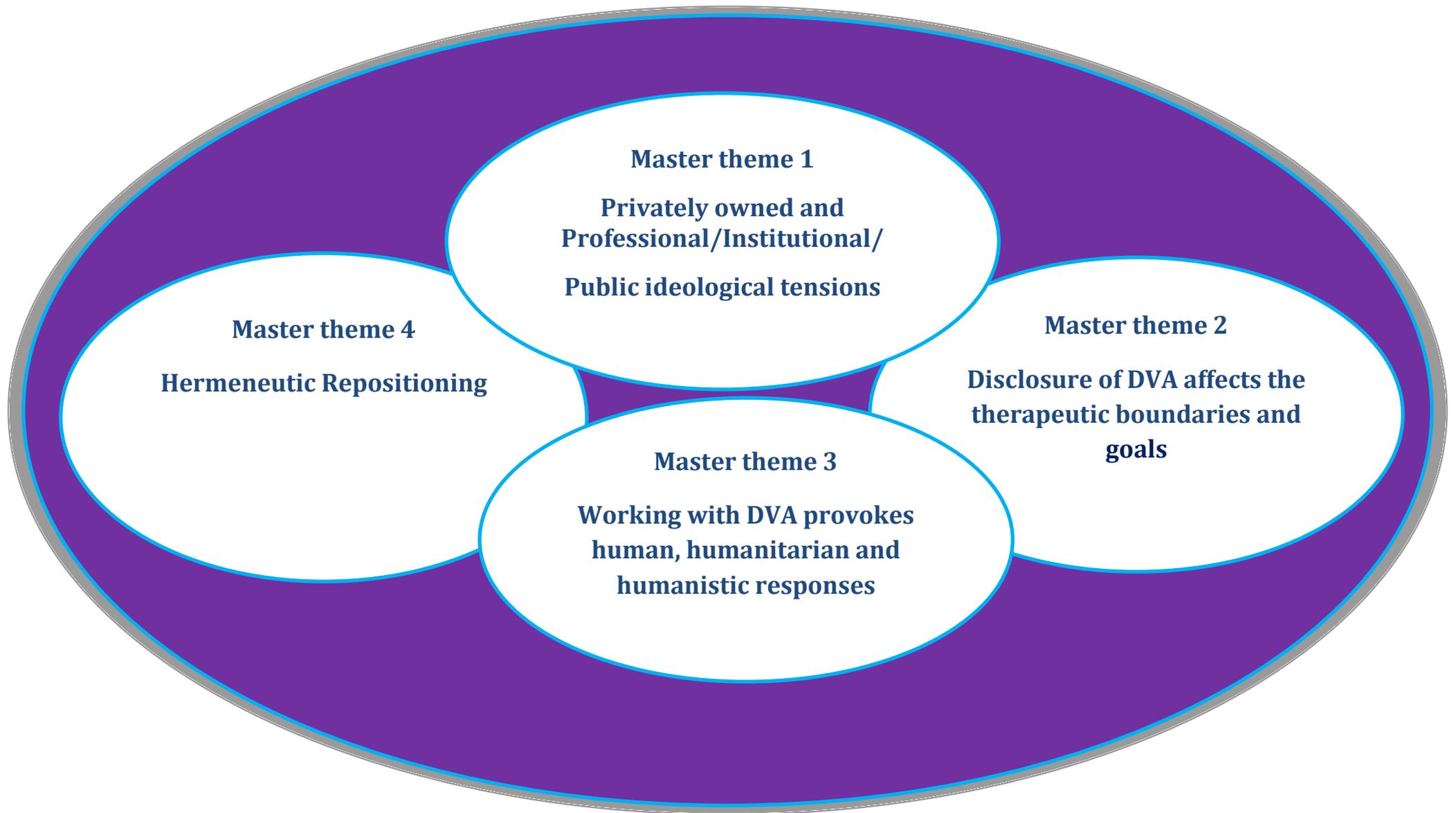
The privately owned and professional/institutional/public ideological tensions master theme rests on two subthemes: privately owned views, professional injunctions and their dilemmas, struggles and solutions and the role of counselling psychologist.

The master theme contains prevalent narratives about the struggles and tensions for these participants arising from the co-existence of privately owned notions of DVA alongside the publicly explicit professional notions, rules and ideologies of counselling psychologist’s role when working with DVA. These notions are created and maintained through the specific training undertaken, ethical codes adhered to, membership of professional bodies and continuing professional development undertaken.

Extract 1

“If you are talking to a friend it would be like, oh go on love just leave him it’ll be alright. But you can’t do that with someone because there are so many other things that can be tied in, that are cultural, that are financial” (Sarah, 490-493).

Figure 3.1- Working with DVA: An interpretative mapping of major themes



Extract one is an illustration of the tension associated with working with DVA. An awareness of this multi-faceted tension is communicated in all of the interviews. The friction associated with the clash between what is privately owned and publicly known encompasses a difficult struggle, much angst and instability for these participants. This extract lays bare the multi-layered aspect of privately owned and professional standpoints of DVA and the ways these ideologies coincide and collide with each other. The following analysis will draw attention to some of these ideologies both private and public and highlight the ways they collide.

3.1.1 Privately owned views, professional injunctions and their dilemmas, struggles and solutions

A pivotal feature of this first master theme is the collision between privately owned views and professional injunctions observed in the participants talk. An outcome of the collision, which is commonly experienced by these participants, is a sense of tension created between an experience of having privately invested notions and ideologies of DVA alongside and often in opposition to publicly expressed rules, norms and philosophies.

The participant's understandings of DVA create a backdrop to view the tension created between these ideologies. While the participants conveyed many different and complex comprehensions of DVA, a common theme was that DVA incorporated elements of physical, sexual, verbal, financial and emotionally abusive behaviour. Essential to all these behaviours was agreement that if coercion is present, towards another in the context of a relationship, these behaviours constitute DVA:

Extract 2

“I made sense of it, let's see, that he was going to get his own way by whatever means he could and if he had to go as far as hitting her he would and he had a good lever because she

didn't want, as soon as she'd had sex with him she had now crossed a line, he had control over her because of that" (Sarah, 182-185)

The notion of control of another person and using coercion over another to gain this control is the sufficient and essential feature of what comprises DVA. This is not seen to be gender specific by these participants as DVA is thought to be perpetrated by both men and women:

Extract 3

"Personally I think as many women are abusive as men" (Jill, 159-160).

A further element of the understanding backdrop relates to DVA's perceived link to early experience. Specific to these participants, DVA is considered to be part of a habitual, on-going pattern of relating to others that was influenced by early childhood experience that draws on attachment theory (Nicholson, 2010). This common professional conception and the way it is used in practice also begins to draw attention to the impact of the conflict and tension contained within this master theme:

Extract 4

"If you're not heard when you're a child, if you're either abused.. then.. all things being equal go onto expect that from other people or find a chemistry with people who treat you in a similar fashion or you behave in such a way that those are the kind of people that you attract" (Sarah, 317-320).

What is commonly professionally known is that DVA is an engrained, repetitive, rigid and habitual cycle. This shapes and pushes forward a common source of tension relating to a sense of hopelessness about change in the therapeutic space. The composition of this backdrop will emerge forcefully in the participant's subsequent talk about working practically with DVA and the ideas surrounding the violent relationship.

As well as containing the essential professional knowledge of what makes up DVA, the backdrop forms and manipulates part of the dilemma between the private and public worlds

visible in the participants accounts. Our internal life world and public life world can be thought of as spheres, consisting of knowledge, beliefs, ideologies and practices. The dilemma between the private and public sphere is a phenomenological quandary through which the overlaps, gaps, collisions and conflicts between the two spheres are laid bare. For the purposes of clarity and in order to assist understanding, the private and public sphere as pictured in this context will be briefly outlined below.

Part of the private sphere is owned and known. Within the privately owned sphere there is an awareness of ideas and personal workings. The awareness leads to an owning of and investment in ideas that are then communicated comfortably, readily and with ease. What is known then impacts on personal practices and behaviours, clinical practice, world views and how tension is solved.

Alongside this is part of the private sphere that is not yet owned or explicitly known. Ideas in the not yet owned sphere are individualised, moral and not yet within awareness. Though as with what is privately owned, there is evidence of implicit investment in ideas which influence clinical and personal practices. The term awareness is not used in a technical psychoanalytic manner to refer to a state of conscious or unconscious knowledge. Instead it is used in a more generic fashion in reference to a mindful ownership of knowledge. So ideas and beliefs contained in the owned and known sphere are accepted and legitimate while those in the not yet owned sphere remain for the time being unaccepted and illegitimate.

Beside the private sphere is the public sphere. Contained within the public sphere are all forms of public, professional and institutional knowledge. Professional philosophies and principles emerge through education, training, professional codes of practice and subscription to ethical codes of conduct. This creates a social, moral and local framework that shapes and

supports what can be known and achieved in clinical practice. A visual representation of these collectively shared understandings is captured in Figure 3.2 and 3.3.

Figure 3.2: Private sphere

Ideas in the private sphere draw on privately owned notions and sit in one of two compartments – not yet owned and owned. Ideas in the not yet owned sphere are not freely known about and this sets up a contradiction, a private split, anxiety and tension between what is and what is not yet known

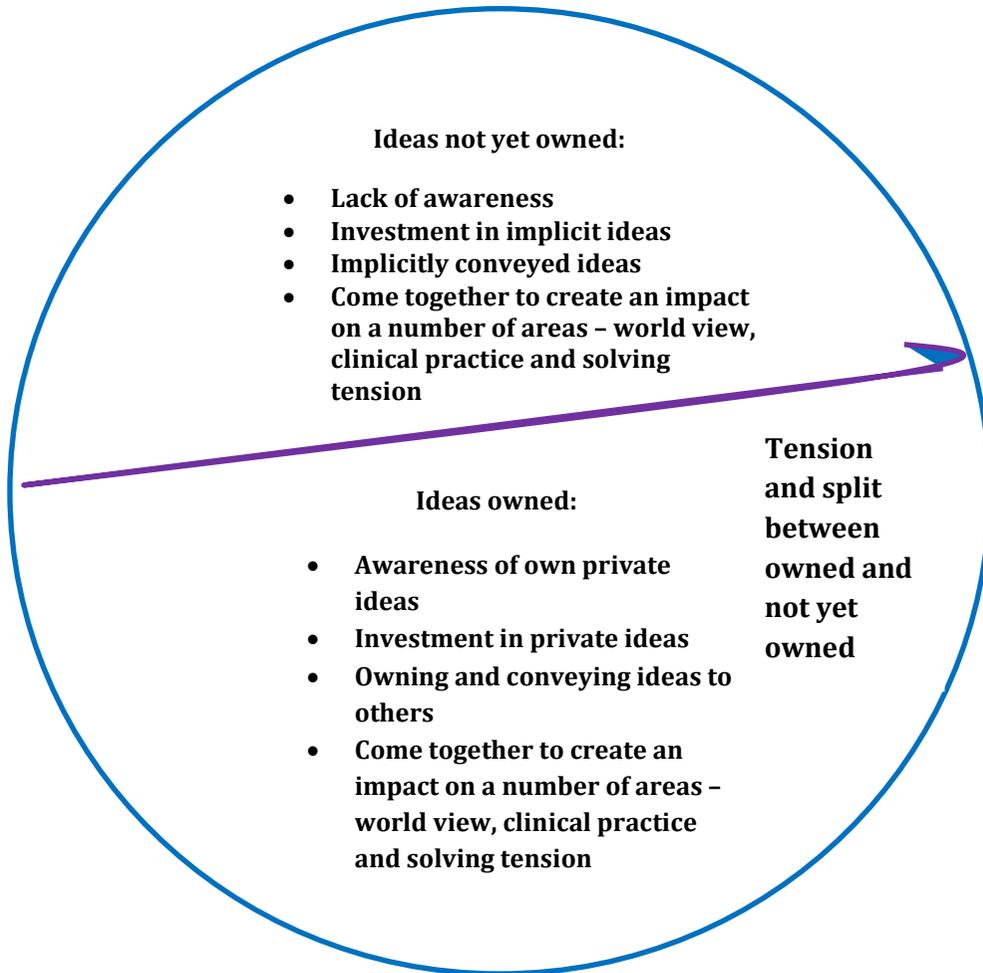


Figure 3.3: Public sphere

Ideas held in the public sphere are ideologies and understandings that are freely known about and communicated, drawing on public, professional and institutional knowledge, local to a community



A social constructionist view invites us to appreciate that however private an experience might feel values, concepts and conventions are already societal. For the purpose of examining the pivotal tension here, the subtheme will focus on what and where the areas of contradictions are between these counselling psychologists' private spheres and professional spheres in relation to DVA and what seems to be involved in these paradoxes.

The following extract represents a good example of the pivotal conflict and tension that is solved in an individualised way:

Extract 5

“What people present in terms of their concerns about their relationship generally would fit into if they're in an abusive, unbalanced relationship and maybe it's fitting into a wider description of what domestic violence is, that it can be quite wide ranging rather than the sometimes limited view that it's only physical or sexual” (Helen, 228-233).

If we look closer at Helen's narrative, the public definition of DVA is examined and found to be limiting in its focus on only physical or sexual acts. Her privately owned sphere contains investment in an ideology of a wider ranging understanding of what constitutes DVA. Based on her commitment to understanding the nuances of her client's individual experience, she expands the privately owned sphere philosophy into the public domain. By adapting the public sphere in this way, Helen is able to pay close attention to her client's needs rather than being guided by a check list of behaviours.

Another illustration that adds to the notion that the professional definition of DVA is limiting is acknowledged by some of the participants. Reported understanding of the professional/institutional/public definition of DVA shifted and often a fresher, wider more encompassing meaning of DVA is embraced. This demonstrates the dynamic nature of working with contradiction and tension. In that awareness of the tension between the private sphere and public sphere results in reframing of the public definition of DVA. According to

the wider, fresher institutional definition, for example, Lisa came to recognise DVA as more common in her case load than she had initially thought:

Extract 6

“As I’m talking to you I’m thinking there are other clients that I’ve worked with who have had some form of, maybe not, yeah some kind of violence in their relationships, I mean some kind of abuse for sure” (Lisa, 149-151).

Extract 7

“and I am now discovering from talking about it today it’s quite rife, maybe more rife than I thought” (Eve, 553-554).

The passage above illuminates further how awareness of the contradiction between private spheres and public spheres of DVA can translate into switching and investing more in one realm than another. The awareness of the privately owned sphere has expanded to incorporate a new understanding of DVA which is comfortable to convey and stand by. In re-thinking what constitutes DVA and the process of owning it, client work is seen in a different way. When looking at client work through the lens of this re-thinking, a new picture emerges of a case load made up of increased number of cases that constitute DVA.

Often the tension expressed by the participants emerged in the conflict between the private and public sphere. Further friction also arose for these counselling psychologists within their private sphere. The discord was borne out of a clash between what is privately owned, known about and readily conveyed and that which is not yet owned, not in awareness and individual. The large majority of beliefs within the privately owned sphere are known about and conscious. However, in the participants talk a number of suspicions that belonged to the privately not yet owned sphere surfaced. These suspicions are ideas about women experiencing DVA that are not yet in awareness, but have a striking impact on ways of working with DVA and subsequent clinical practice.

One clear depiction of the tension within the private sphere and the impact of the suspicions that are out of awareness is detailed below:

Extract 8

“It’s alright for me to say well they’re staying in it because they don’t value themselves enough and I think they often are but it’s not easy to leave is it sometimes but I think there are people who respect themselves who wouldn’t stay who wouldn’t be attracted to these people” (Jill, 183-186).

Extract 9

“So it’s almost in some cases maybe you could argue, that there is an agreement that this is what is going to happen because there is some kind of consent because they are still part of the process and I feel really terrible for saying that it feels like that” (Sarah, 365-366).

In this extract from Sarah’s narrative, we see an example of the discomfort that comes with becoming aware of a not yet owned suspicion. The use of “consent” suggests some prior expectation that the violence will occur. The not yet owned suspicion is that some women sanction violence. At the same time as awareness of the not yet owned suspicion develops, further tension exists between the private and public sphere. Sarah’s description of feeling “really terrible” relates to the conflict occurring between her not yet owned suspicion that women assent to DVA and knowing this is not in accordance with the public spheres politically correct view that women should not be blamed for violence.

Another illustration of the impact of a not yet owned suspicion features in relation to the purpose of the violent relationship highlighted previously as an area of tension. This is vividly demonstrated in a passage from Lisa’s account:

Extract 10

“It’s bringing up for me maybe a belief these women get something out of the relationship and we don’t know what that is and until we know what that is we can’t say you must change because change what, you know” (Lisa, 333-335).

In addition to not yet owned suspicions that relate to provocation, this excerpt represents another common pattern of a not yet owned suspicion that relates to women’s investment in staying in violent relationships.

The privately not yet owned suspicion emerging above is that the violent relationship serves an implicit function or recreates a specific dynamic that prevents women from leaving. This draws on a professional notion that DVA is a habitual, rigid and inflexible pattern created in early experience and maintained in current relationships. Coupled with this is a further professional philosophy that working therapeutically is in essence about transformation and alteration. The struggle for Lisa, within her private sphere, is that she cannot work therapeutically towards change with women experiencing DVA, due to their not yet owned investment in staying in and recreating violent relationships.

As mentioned earlier, the not yet owned suspicions cause within and between private and public sphere conflict and tension, in these participants’ accounts, that then impacts on and shapes clinical practice. The influence of a not yet owned suspicion within the private sphere and the further effect on clinical work with DVA is represented below:

Extract 11

“I think it’s got a lot to do with them putting their children at risk as well, but yeah probably because utter confusion about not being able to identify with that as as a woman myself, why would I, not being able to identify with that, not being able, I guess to, maybe not being able to empathise with it. No I can empathise with it” (Lisa, 379-383).

Another set of not yet owned suspicions from Lisa's internal private sphere surrounds the view of womanhood and women in relationships. Womanhood involves a "good enough" mothering style that is caring and nurturing, making sacrifices for the benefit of others and keeping children safe. What is missed out here is an understanding of the psychology of abuse and being abused, being stripped of agency and self-worth. The impact of such a strong investment in the privately not yet owned notions of womanhood creates an empathic paralysis, distancing Lisa from her clients and congruent consideration of their experiences.

Extract 12

"The relationship serves some kind of function, whether it's maladaptive, it's an unhelpful or unhealthy relationship, fine, like it, I mean that's our perception of it. I guess it's everybody's, well I don't know it's everybody's perception, it's not their perception and until they change their minds about the relationship therapy's not going to be helpful for them I don't think" (Lisa, 338-339)

Lisa unwittingly verbalises the depth to which she is invested in the not yet owned sphere and the impact of an over investment in a not yet owned suspicion. While it may be therapeutically useful to explore existing patterns, relationship styles and dynamics and the different roles that maintain these relationships, a strongly held conviction in the privately not yet owned view can freeze thinking and create stuckness. This stuckness is represented in the sense of powerlessness that leads to hopelessness about the prospect of therapeutic change, coupled with little reflection on or appreciation of how to move forward.

3.1.2 Role of counselling psychologist

A further feature of the tension articulated by these participants, which is at the heart of this master theme, relates to conflict between the privately owned ideologies associated with DVA and the professional/institutional views of the role of a counselling psychologist.

Despite the theoretical orientations to which the participants subscribe in their profession, the role of counselling psychologist across the body of data was generally thought to be one of therapeutic neutrality. That means participants taking a non-directive stance and being careful to allow clients freedom to explore their experience in the context of a non-judgemental therapeutic alliance.

One shared understanding that emerged from the participants talk is fear of the risk of slipping away from therapeutic neutrality. The fear relates to openly challenging clients in accepting and recognising DVA:

Extract 13

“I think you know in challenging that too harshly at least in the beginning of therapy I think would have she would have gone and not come back from there” (Beth, 150-151).

The quotation from Beth’s narrative demonstrates a distinct lack of tension between the two spheres. The privately not yet owned notion is that confronting her clients at the start of therapy could result in the breakdown of the therapeutic relationship. This is in alignment with accepted professional/institutional understandings of therapeutic neutrality. However, this coherence between what is privately not yet owned and what is professionally known is not enduring. In that discussion about DVA is dynamic for these participants and returns to create a conflict between the privately owned notion of its wrongness and unacceptability and a pull towards upholding the professional/institutional ideology of therapeutic neutrality. This dynamic conflict results in rapid switches in and out of therapeutic neutrality where professional/institutional beliefs are thrown out of kilter with privately owned views. This pattern of rapid fluctuation can be observed below:

Extract 14

“But I guess if somebody came because they were being abused perhaps what they want is for someone to say this isn’t right and you know, you don’t have to put up with this. I can’t imagine myself ever saying that though for some reason” (Eve, 229-232).

A robust tension that drives the fluctuation in and out of therapeutic neutrality is related to readiness to work with DVA. The need for clarification that the first priority when working with DVA is not about neutrality or change but is about the safety of the client is highlighted. Eve is engaging with the resulting sense of conflict in her work. While the professional/institutional sphere guides her in the direction of neutrality, her privately owned notions that abuse is wrong lead her to consider the needs of her clients. Eve hints at a sense that a professional position of neutrality may implicitly collude with a quiet acceptance of DVA and the importance of stating the wrongness of abuse.

Extract 15

“Because she is saying that she understands why he did it, but in my mind there is never any excuse for physical abuse, but that’s not my place to say, I think is the moral dilemma, it’s not my place to say I believe there’s never any excuse for physical abuse, so I had, I felt as though I just had to leave it there and take her reality of things and her reality was I wound him up” (Eve, 147-151).

The strength of the tension between the private and professional sphere is apparent in the extract above, through the difficulty to up hold therapeutic neutrality and blurring of boundaries. The use of “moral dilemma” reflects Eve’s privately owned ideas of DVA being wrong. “I believe” shows commitment to the characteristics that make up a privately owned view as previously defined. This statement shows the level of conscious awareness, strong vested ownership and degree of comfort to convey this privately owned view. When in conflict, Eve re-focuses. She draws on her commitment to facilitate some transformational experience for her client and makes this her priority. In doing so, Eve uses her underlying

therapeutic intention to balance out the tension she is encountering and brings her private and professional spheres back into line.

In the professional/institutional sphere, alongside an emphasis on the role of the therapist as neutral observer, is the role of the therapist as empowering agent of change. This means actively supporting and empowering clients to gain clarity and arrive at their own choices. Some participants use this imperative as a way of re-focusing and finding avenues out of the tension between the publicly owned and professional sphere:

Extract 16

“I think more the goal that I work towards is empowering them, so empowering them to either stay in the relationship and be treated in a safer way in a more respectful way or you know if they have the goal of leaving the relationship supporting them in that” (Helen 204-209).

Extract 17

“That in the nature of being the therapist you’re in a powerful position (...) I guess you’re always checking out whether it’s your own opinion that’s being shaped by those values or whether it’s this professional opinion, so therefore it’s not always the right one, it’s just one” (Helen, 310-322).

Rather than a strict adherence to neutrality or a moral investment, for Helen in the above excerpt, the privately owned sphere is expanded into the professional sphere. Through highlighting the power differential in the therapeutic relationship, privately owned beliefs are set aside, allowing greater focus on clients experience and increased ability to enable and empower clients.

3.2 “Disclosure of domestic violence and abuse affects the therapeutic boundaries and goals” master theme

The second master theme is underpinned by two subthemes: safety goal and therapeutic goal become intertwined and difficult to remain neutral. The focus of the master theme is the impact a disclosure of DVA can have on the therapeutic work and the consequent feelings aroused in the participants by this disclosure. The point of disclosure is such a significant and important milestone in what is to follow in the therapeutic work. For these counselling psychologists a disclosure of DVA meant engagement with the horrific stories of violence in their client’s lives for the first and essentially fundamental time. While these participants may come to know similar narratives as therapy progresses, bearing witness to another being harmed for the first time brings with it a distinct phenomenological experience that cannot be repeated. This initial disclosure had a powerful emotional impact on these participants, compelling them to confront their own sense of preparedness to work with DVA and strong feelings aroused after encountering another being abused. This reaction coupled with the overwhelming need to retain client’s safety shape and change the therapy that will follow. In this way, we are offered a snap shot of the journey towards readiness that these counselling psychologists are engaged in.

3.2.1 Safety goal and therapeutic goal become intertwined

One essential facet of this master theme, voiced by the participants, is the pull to retain client safety after a disclosure of DVA. After such a disclosure, the safety of the client becomes paramount and as such intermingles in the therapeutic agenda of moving towards change and empowerment. So that the therapeutic work is put on hold:

Extract 18

“Upon hearing this I really encouraged her to... thought that this wholly changed the nature of our work and changed my plans of ending with her, of her ending therapy” (Helen, 693-695).

Recognising the importance of and ensuring client’s safety by contacting outside services if needed, became the necessary focus of the in session work for the participants. One demonstration of this is seen in an excerpt from Helen’s narrative:

Extract 19

“Because the risk can increase to them, that you’re really transparent about needing to inform the police if you have to and needing to inform social services if you have to” (Helen, 362-364).

Helen is talking about her professional duty of care towards her clients. Her use of “transparent” outlines her frankness and desire to make her clinical code of conduct clear to her clients. The obligation she has to guarantee her clients well-being includes a commitment to shared and multi team care.

While contacting outside services as a result of a disclosure of DVA was seen to be an imperative part of risk assessment and reduction, not all participants positioned contacting outside services in such a way.

3.2.2 Difficult to remain neutral

Again, therapeutic neutrality as a core feature of counselling psychologist’s role becomes part of the conflict and tension raised when working with DVA. In this instance, the conflict verbalised by the participants, lies between the attendance to necessary risk assessment and associated emotional responses. Ensuring and managing risk after encountering DVA and

feelings roused in the participants often results in obstructions to upholding a neutral therapeutic department:

Extract 20

“I think when you have very strong feelings and very strong reactions about how your client’s being abused, having the space to discuss whether you know that defining that area whether you need to legally take action or whether you don’t necessarily legally need to take action but ethically you might feel that you need to take action” (Helen, 585-590).

The impact of powerful emotions and subsequent reactions, often experienced after a disclosure of DVA, leads to a professional dilemma after engagement with these sentiments. The clear implications of legal and ethical codes of practice are core positions in this predicament. The obligation to uphold the laws of the land sit alongside a commitment to agreed or correct moral conduct in clinical practice.

As stated by these participants, an additional obstruction to upholding a neutral therapeutic stance was a pull towards a desire to rescue clients from DVA. The wish to deliver clients to a safe haven often related to a sense of injustice and personal distress at hearing accounts of violence. A good example of this can be seen in the extract below:

Extract 21

“It made me angry and frustrated, I wanted to lead her away into a safe space, there were times in sessions with her when I just wanted to take her away to some sort of island and help her start again really” (Sarah, 192-194).

A specific outcome of the urge to rescue is a strong sense that the therapeutic relationship itself becomes a holding place of shielding and sanctuary after DVA has been disclosed:

Extract 22

“So when someone says they’ve got abuse in their past, I then have to feel like a change in some way... perhaps to notice myself trying to become more containing, more protective, less judgemental, a lot more aware of what they might be experiencing” (Eve, 272-278).

During the conversation about risk and risk management, the impact of the need to ensure safety and a desire to rescue is felt very deeply as can be observed in the above passage from Eve’s account. The thread leading from a readiness to ensure safety and a desire to rescue, to continue on to therapeutic change and empowerment is dropped. Though an active re-turn to a therapeutic focus is picked up generically in later talk of clinical solutions and normalising humanitarian feelings, a sense of suspension in thinking and stuckness about where to go next becomes apparent.

3.3 “Working with domestic violence and abuse provokes human, humanitarian and humanistic responses” master theme

This master theme connects three subthemes: human feelings, humanitarian feelings, and humanistic feelings. Attention is placed on the emotional thread interweaving through these counselling psychologists’ narrated experiences of working with women clients with a history of DVA. The specific focus of the master theme is the emotional impact of the clinical work on the participants and the associated responses.

3.3.1 Human feelings

A pivotal aspect of this master theme is the extent to which hearing accounts of DVA touched on the participants’ own sense of humanness. All of the counselling psychologists recognised that encountering another being harmed and abused had a dispersing emotional and metaphysical impact. The impact was felt beyond gender or professional standing and touched on their core sense of being an empathic human bearing witness to the harm of

another human. Powerful feelings of anxiety and fear were created as a result of being moved at this very human level, as is made distinct in the excerpt from Sarah's dialogue:

Extract 23

“that would make me very anxious that she was with him, this very abusive, manipulative man, ok, who would do anything to get her to do what he wants and I think her life would be shut down once she's with him so that's real fear for her if she does that” (Sarah, 284).

As well as feelings of fear and anxiety, bearing witness to DVA lead to arduous feelings of sadness and dismay:

Extract 24

“I think sometimes it's hard to I think it's hard to hear how someone's been treated sometimes and that can be upsetting to hear how someone's been treated and how someone's been hurt” (Helen, 511-515).

Moreover, a detailed account of violence, abuse and de-humanisation lead to fear for the safety of clients, alongside the participant's personal sense of distress and fear that disturbs and shakes their established internal equilibrium:

Extract 25

“if she had been talking about emotional abuse would it have been different but because her imagery, the imagery that she described of physical abuse was so graphic and quite upsetting to hear, yes, it left me feeling a little bit shaken I guess and quite frightened for her that it was still going on as she was still with this person” (Eve, 156-160).

3.3.2 Humanistic feelings

The impact of DVA on the emotional world is not just at the human level. In conjunction with feelings related to witnessing horrific stories of another human in distress, disarray and confronting violence, participants voiced humanistic feelings. Here, the human connection to clients becomes distorted. An expressed sense of powerlessness in an ability to protect clients

and outrage that those clients had experienced such abuse in the first instance, led to a dominant feeling of frustration on behalf of the client, illuminated in the following example:

Extract 26

“She did a lot of, I think you call it in jargon terms projective identification, she would be telling me something in a very dead pan face and I would be feeling inside furious, frustrated, angry, indignant you know I’d feel all the feelings” (Jill, 83-85).

The internal frustration and sense of powerlessness related to being unable to protect their clients’ mirrors and absorbs some of the powerlessness women clients experience at home. Through the participants’ naming the emotional experience of frustration and anger, the absent voice of powerlessness, anger and rage is taken up and articulated. Often this frustration, if not processed and reflected on, tends to be projected outwardly and displaced onto the client:

Extract 27

“It can be frustrating you know how many times people will come and say oh I’m sure he’s changed or at last they decide to leave him and then you know lo and behold go back again and are totally surprised when the same things happened” (Jill, 27-29).

A further way this feeling is projected externally is toward the perpetrators, as demonstrated in an extract from Sarah’s dialogue:

Extract 28

“Kind of outrage that anyone would hit anyone else, I really have a problem with people using physical violence or any kind of violence against other people and yeah so it’s just kind of angry at him and not being able to get at him, that is sort of telling him off and you can’t do that but not being able to, how dare you, that sort of thing” (Sarah, 443-445).

Variation in the participants talk about the emotional impact of working with DVA can be seen in Eve's narrative. Here, never having experienced domestic violence lead to a personal feeling of relief:

Extract 29

“I have felt frightened for my own safety for sure, if somebody has described a current abusive partner in particular, yes, for my own personal safety, I guess it does make me feel, I don't know if this is a nice thing to say, but it does make me feel lucky that nothing like that has ever happened to me” (Eve, 507).

There is great depth to the metaphysical and human impact and subsequent humanistic response when engaging with stories of DVA. The stories are so horrific and disturbing that an instinctive and guttural response is to feel relieved in and for personal safety and security.

3.3.3 Humanitarian feelings

In addition to feelings of being connected to another at the human level and feelings of a more guttural, instinctive and humanistic nature are feelings encountered after witnessing DVA that touch on these participants humanitarian sense of looking after others.

A powerful and captivating feeling often experienced after encountering DVA is wanting to care for and improve client lives within the context of professional boundaries and practices.

An example of this is visible in an extract from Eve's account:

Extract 30

“and when I find myself feeling very protective about these clients, it's quite a surprising feeling for me, it's quite unusual and I find myself feeling maybe quite pleased that I am able to experience that feeling, even though it's an unusual one to feel protective and to want to kind of yeah to care for them in that way, yeah, that is quite surprising but nice really” (Eve, 516-520).

Personal experience of DVA meant this humanitarian drive became more compelling, fuelling and engendering the desire to help and improve:

Extract 31

“I tell you what really gets me through is that I went into therapy because I needed it, I was attracted to people, so I quite understand, who to relationships that were destined to fail basically and I went into therapy” (Jill, 120-122).

Acutely recognising the deep feelings of humanitarian need and wanting to take away the pain of DVA is an important first step in preventing acting out these feelings by over stepping the therapeutic boundaries. Additionally, great value is placed on supportive self-care as ways to further resist acting upon these feelings to intervene and save as detailed below:

Extract 32

“So I might think about what we as therapists need in order to take care of ourselves when working with women who are incredibly frustrating or who do put their children at risk or who are very scared you know because that can have you know can be traumatising you know listening to those stories” (Lisa, 596-598).

Common practices involved in the self-care protocol relate to a preparation process, coming to understand and be equipped to manage the emotional impact that working with DVA will inevitably have. This is clearly demonstrated in an illustration from Eve’s dialogue:

Extract 33

“Yeah, yeah, I definitely think being frightened. Some reassurance about the fear would be helpful. I think the first time someone hears that somebody’s been abused, if they’ve never experienced abuse themselves it’s going to be quite a shock, I think to prepare for that shock” (Eve, 619-622).

Other illustrations of the participations engaging in a process of recognising, normalising and ventilating human, humanistic and humanitarian feelings make up an important aspect of this master theme. An initial recognising, normalising and voicing process is promoted as a

valuable and essential part of any clinical work. This process is often done in an individualised way in accordance to the counselling psychologists own habits and depth of reflection. One such individualised story that highlights the three way pattern of developing awareness of, normalising and processing feelings can be observed in Helen's narrative:

Extract 34

“Being aware of those feelings and being aware that they were coming from my own values and continuing to be really curious about the woman's feelings and her own values and her own perspectives about the relationship” (Helen, 126-130).

Extract 35

“Checking your own.. what you are bringing to the counselling relationship yourself in terms of your values and in terms of your own decisions about how the situation should be handled” (Helen, 90-92).

Helen's commitment to a bracketing off process is clear. She is endeavouring to make sense of and disentangle the feelings that come from her own internal experience in order to set aside these assumptions to be truly in the here and now therapeutic relationship alongside her client.

As well as deliberating upon her own emotional responses to come to know herself and to work towards acting as a thinking and reflective practitioner, Helen pondered how to use her feeling sense in session in the context of the therapeutic relationship:

Extract 36

“Checking whether it's kind of helpful to show that very natural reaction for it to be very normalising and validating for the woman or whether you feel that kind of you're getting the sense from the woman that she needs you to be strong and to be able to hear what she's describing to you, to be encouraged to talk like a woman” (Helen, 515-520).

Helen is considering being consistent with her emotions. Showing and valuing her very personal response to her client's story may increase her empathic connection with her clients, strengthening the therapeutic relationship and process. The other side of this may be to retain a position of therapeutic neutrality to give her clients space to talk in a relationship that is based on equality.

As well as working through these feelings internally and using them in the therapeutic alliance, supervision was thought to be a useful space for further contemplation of these feelings and consideration of the professional way to manage them:

Extract 37

"I think I would take them to supervision if I didn't, if I felt I needed some some more support for myself in managing those feelings and I would take them to supervision if I felt that was getting in the way of the work that we were doing in me being able to be a support for the woman and to allow her to speak openly and if those feelings were influencing my leading her to particular decisions" (Helen, 529-534).

3.4 "Hermeneutic repositioning" master theme

The chief focal point of this master theme is twofold. Firstly, to delineate key clinical challenges, specific to these counselling psychologists that arise after a disclosure of DVA. Secondly, to detail the hermeneutic activity the participants employ such as transposing, rethinking, reframing and repositioning following an acknowledgment of and engagement in the moral and clinical struggles and tensions that working with DVA put them in touch with. It is through the process of rethinking clinical problems that these participants are able to consider and reflect on possible clinical interventions. When they engage in this rethinking and reframing, what can be observed is an altering and changing of the way in which their client is located both in their own lives, in the therapeutic relationship and dialogue. An upshot of this arising from the participants talk is a process of hermeneutic repositioning. The

hermeneutic repositioning described in this master theme has three layers. Firstly, repositioning can be seen to occur between participants and their clients, whereby participants shift ways the client is engaged with, understood, viewed, imagined and expected to behave. Client's history, abilities, strengths, weaknesses and experiences are hermeneutically repositioned through this process and a number of lenses created through which clients can view their lives and options. Secondly, repositioning of DVA itself can be appreciated. The ways DVA is spoken about within the therapeutic dialogue and the choice of words the participant's use alters the way DVA is viewed. A third layer of hermeneutic repositioning takes place within supervision. Here participants detail the ways they alter their own beliefs, abilities and clinical practice. While the identified dilemmas may not be solved through this multi-layered hermeneutic repositioning, awareness is raised and a space opened up for giving clients a voice. Witnessing this rethinking and reframing process emerge through the participants narrated experience gives a good window to what is actually being done in the therapeutic work with women clients who have experienced DVA.

3.4.1 Knowing what to do challenges

A number of challenges when working with DVA emerged across the body of data. Some of the challenges noticeably overlap with one another and become intertwined. As a result of this interconnection, no one particular challenge transpired to be dominant for the participants. Instead, several challenges arose. The number and range of problematic clinical encounters illustrated within the master theme reflects the individual, unique and particular nature of DVA.

Despite the unique and specific quality of the clinical challenges associated with DVA, some of the participants portrayed the risk of taking on a role that replicated the abusive relationship dynamic as challenging:

Extract 38

“So I think I was worried about re-shaming her, I was worried about scaring her more, So I remember being very softly softly with her (...) I don’t know what that has to do with risk really, like I guess risk of re-offending, you know being the abuser because she’d already had twenty years of abuse” (Lisa, 110-113).

As demonstrated above, the preoccupation with knowing what to do when encountering DVA often lead to an awareness of not wanting to re-enact the abusive relationship. The concern with taking a very directive therapeutic stance seemed to relate to the clients’ ability to understand this as empowerment and the risk of direction being experienced as coercion. Underpinned by this, is an appreciation of the long term effects and psychology of DVA on the depletion of self-esteem (Nicholson, 2010) and a pledge to work in a way that nurtures a sense of self efficacy.

Alongside an awareness of not wanting to replicate coercion within the therapeutic relationship, the participants identified the challenge of how to name, approach and recognise DVA. How to name violence is of particular concern in relation to reflecting on readiness to work with and knowing how to practice interventions with DVA:

Extract 39

“I think that’s probably been the biggest challenge about how to really introduce the idea that what they’re talking about is actually domestic violence and to do it in such a way that is still being respectful of their partner” (Helen, 14-18).

The option to name DVA from the onset can facilitate a ‘language’ for the client to voice and articulate their experience. The challenge, in the above excerpt from Helen’s dialogue, is in retaining a deferential balance in the therapeutic approach towards the perpetrator.

Again, knowing and appreciating the uniqueness and differences that each case of DVA brings with it, alongside knowing the therapeutic needs that may be presented in each case, converged to create a complex challenge, visible in an excerpt from Beth's talk:

Extract 40

"The challenge was sort of (pause) you know trying to yeah, to talk to her about her girls when she was also an individual as a woman who was homeless, you know afraid and depressed and her whole life had fallen apart" (Beth, 254-256).

In considering the complexity involved in women's lives, these participants returned to query the exact professional obligations and clinical procedures when working with on-going DVA:

Extract 41

"I did find myself thinking do I need to report this, she is an adult, he is an adult, the police had been called that night anyway but yes I found myself thinking what responsibility do I actually have, is it wrong for me not to point to her that you know physical abuse is against the law and she doesn't have to take it" (Eve, 167-170).

In this example from Eve's account, we have a sense of an indirect communication about two consenting adults being involved in every aspect of a relationship, including violence. Hinting at this sense of consent between two adults, each with a sense of agency raises a new level of uncertainty about the clinical picture creating ambiguity in the professional commitments and intervention required. Moreover, the participant's readiness to work with DVA often appeared to be overshadowed by a lack of clarity in the particular legal and professional protocols required after a disclosure of DVA.

In addition to knowing what to do when working with male perpetrated violence and understanding the professional requirements for male perpetrated DVA, knowing what to do with women's violence was also identified as a knowing what to challenge:

Extract 42

“I’ve certainly dealt with working with women who when they are talking to me are extremely abusive to their partners which brings up just as many challenges as hearing about, I’m sitting here thinking poor bugger you know god what’s going to happen to you” (Jill, 160-164).

According to these participants, engagement with the specific and challenging nature of DVA meant focusing on the way their client’s cultural backgrounds potentially diverged with DVA as expressed in a passage from Helen’s narration:

Extract 43

“There’s that difficulty there with having to understand the culture from the client’s perspective but also wondering whether her perspective has been influenced by the domestic violence itself” (Helen, 107-110).

Considering the specific nature of DVA for Helen meant an awareness of how to extrapolate cultural factors from a sense of self potentially ‘damaged’ by DVA. The importance of co-constructing an understanding of client’s cultural context seems imperative when considering women who live with cultural systems that de-value their position are more likely to be abused (Nicholson, 2010). When these participants engage in this co-construction, it is likely that they will encounter a discussion surrounding a range of principles, values, prevalent norms and socially valued realities that relate to ways of being ‘healthy’, being a ‘woman’ and ways of doing marriage.

Helen points out, through the extract from her narrative, a complex challenge in relation to culture. What Helen has understood here is that cultural norms and values, as described by clients experiencing DVA, may be filtered through the lens of a depleted sense of self resulting from DVA. The challenge revealed above rests in holding an appreciation of

cultural norms and values that may support DVA with an appreciation of the impact of violence itself on client's world view and sense of self.

In summary, a feature that was striking across this body of data was the participant's awareness of the challenging complexity of working with DVA, which included an engagement with the individual specificity of DVA for their clients and attempts to bring together the most appropriate therapeutic approach. In combination, the juggling of these three tasks was associated with a feeling of being de-skilled. A good example of feeling de-skilled is captured in an illustration from Eve's dialogue:

Extract 44

"I have obviously highlighted that I don't feel maybe equipped to deal with it and I deal with it in the best way I know how but otherwise maybe don't know the best way" (Eve, 538-539).

3.4.2 Seeking solutions to knowing what to do challenges

A pivotal feature of this master theme is the participant's journey of awareness of and engagement with rethinking and reframing of the knowing what to do challenges likely to occur in session, within the therapeutic alliance, between them and their women clients.

One common way for these participants to solve the knowing what to do challenge related to the potential risk of repeating the abusive relationship, wittingly or unwittingly within the therapeutic relationship, is to hermeneutically reposition the client as an agent. Repositioning the client who has experienced DVA in this way builds in the notion that they are able to take control of their lives. In doing so, what also gets transformed is the therapeutic agenda. The result in turn is that clients take charge of the therapeutic flow and exchange. Thus, putting them in charge with clarity, deliberateness and agency; in short re-empowering the clients to dictate and make their own choices:

Extract 45

“What do you do when you have a completely different agenda from what your client has, your clients’ agenda which is it can obviously happen but you, I don’t think that in the same way ever experienced it so explicitly because you obviously need to sort of question your own agenda and you know go along with the client” (Beth, 411-415).

Moreover, the act of hermeneutically repositioning clients as masterful and with choice included the participants representing their role as supporting, encouraging and giving space for clients to voice personal preference, personal values and beliefs in relation to DVA:

Extract 46

“Because her husband had sent and she needed to change and she accepted that yeah, challenge that, really just make her say anything with the word I as the first word, just to formulate any kind of sentence about what she would want, what she would prefer, what she would think about something” (Beth, 222-224).

This journey of hermeneutic repositioning is by no means straight forward. As revealed in the passage above, this repositioning involves a sense of struggle and conflict from moving the clients from passive and agentless, with little perceived ability to affect the world around them to active with a sense of control, choice and preference. However, actively encouraging clients to take up their own voice and state their own preference has the potential to merge into a directive therapeutic stance. A very directive stance towards this way of relocating agency appears to run the risk of recreating the domination common in DVA. Again what we see here is a revisiting of the cautiousness these participants show in not wanting to re-enact the power and domination dynamic that abusive relationships constitute.

Along with hermeneutically repositioning clients in charge of the therapeutic agenda, the therapeutic dialogue itself becomes a vehicle with which to support client’s self-agency and ability to make choices. An example of this is evident in Lisa’s dialogue below:

Extract 47

“I think unless the person uses the language themselves I tend not to create labels so I’m quite careful well I think I’m careful about what I say in sessions. So if I’m reflecting back or you know trying to make an intervention then I’ll try to use as much of their language” (Lisa, 409-413).

Extract 48

“I would put myself in position as you know I know I have the right terms, I know as a therapist what is going on here and your laymen’s terms don’t work in this room or I would be putting myself in a position as knowing better than them about their experiences and that is I think essential in the way I work, not to do that and be true to their words and the language they use” (Beth, 475-481).

This second illustration evidences the hermeneutic repositioning of the client within the therapeutic dialogue as expert in their own experience and the participant as keen learner. In order to uphold this hermeneutic repositioning, taken for granted, label dependent understandings of DVA are examined rather than recycled. Instead, clients own words are prioritised within the therapeutic dialogue as the honourable, rightful terms to converse in, giving important validation to the clients own life world.

Earlier talk from the participants about ways to approach DVA led to an active rethinking of DVA as something to be named by them in session. This was seen as an important step towards choice, empowerment and enablement, for example, in Helen’s narrative:

Extract 49

“I would name domestic violence and I would .. but also respect that they might make the choice to stay with the partner or not want to consider the option of leaving or being quite some way away from considering that option” (Helen, 194-197).

Moreover, through actively naming DVA, a sense of openness and space within which clients can consider future options and possibilities is created. This space itself reframes the client as

being able to make their own choice about the route they wish to take in their own lives. Having space to freely deliberate over alternative ways of being and state preferences often creates an important restorative sense of agency:

Extract 50

“Exploring from their perspective what they considered to be a healthy or unhealthy relationship. Maybe also explore if anyone else had been influencing their ideas about what had happened in the relationship in terms of you know their friends or or their family. And then I might also introduce the Duluth Wheel of violence and non-violent relationships, I might explore like just the different aspects of that wheel, it’s quite helpful” (Helen, 176-182).

The above excerpt further evidences the hermeneutic repositioning that is made possible after naming DVA. Here, the psychosocial life world of the client is utilised as an additional resource and clients are repositioned as members of extended social and cultural support systems that they can draw on to inform their own decisions and choices.

In addition to hermeneutically repositioning clients with agency in the therapeutic alliance and naming DVA as part of an empowering process, an implicit engagement with one particular understanding of DVA arose across the body of data. Adopting the established theoretical position of DVA as something that is best seen as a rigid and habitual pattern, owned by the individual and based in early experience, became apparent in the participants talk. While not explicitly described as problematic, it emerged none the less as a challenge. This well embedded way of theorising and understanding DVA was discussed in relation to client’s ability to break down patterns and dynamics laid down in early life. Through the lens of this theoretical view, the first step to solve the knowing what to do challenges is to raise awareness of the potential for the client to repeat difficult and damaging dynamics:

Extract 51

“I certainly work very hard with the client to try to find out what it is, you know why they are attracted to these particular men, what is it about their childhood etc, what experiences have they had that lead them to feel that men can treat them like s h i t ” (Jill, 7-9).

In attempts to move towards and seek resolution of the knowing what to do challenges, participants also turned to the resource of the therapeutic relationship:

Extract 52

“My natural way of thinking of them is not to think of them in CBT terms if they have come with abuse (...) I guess when they come with abuse I become so much more aware of the psychodynamic issues at play, rather than perhaps the coping skills and the present day stuff which is I guess what I always feel CBT works with most the present day patterns, I always become more involved with what’s happening between them and I in the room and what their early attachments were like” (Eve, 316-323)

As Eve illustrates above, the here and now of the therapeutic alliance is used as a transformative space. This may be beneficial to build up trust with another, allowing the client to practice ways of relating to others without negative consequences in a safe space. In order to use the therapeutic relationship as a transformative resource in this way, it is necessary to see DVA as relational. What seems to be marginalised in this reframing process is a focus on modes of engagement with day to day difficulties. However, while a sole focus on past relationships and ways of relating may be of benefit when working with DVA, not all the participants see their client work in such a way. In the excerpt from Sarah’s account for example, DVA is understood to require an integrative approach that incorporates elements of relational work with a focus on client’s actions and practices:

Extract 53

“Well I did mix the work with her doing some DBT skills and working some schema. We are looking at changing behaviours as well as looking at emotional and patterns of emotional relating” (Sarah, 49-50).

Amalgamating two theoretical frameworks and taking a dual approach of focusing on relational patterns and behavioural aspects allowed for further hermeneutic repositioning of the client as active and empowered agent of change in the therapeutic work. In occupying a dual focus, Sarah is able to hold in mind her client’s relational patterns alongside their present problems and engagement with life. In this way, the client is seen as a holistic and whole person. Rather than present day behaviour being seen as a consequence of past patterns and experience, the client is understood as being able to make active behavioural changes in the here and now that can influence future ways of relating.

While the process of rethinking, reframing and hermeneutically repositioning weaves subtly throughout the participants narratives a missing story makes itself known. The knowing what to do challenges are complex, the knowing what to do solutions are multifaceted and there is tension and anxiety between what is privately owned and not yet owned. It is not surprising then that this submerged story refers to the participants being able to hold on to one clear theoretical philosophy of DVA. On the one hand, this missing aspect may be understandable due to the participant’s engagement with personal, professional and moral conflict. On the other hand, not committing to a thorough theoretical consideration of what DVA is seems to have a less beneficial impact when it comes to understanding the psychology of DVA. What is not captured within the participants’ voiced experiences are descriptions of the psychological impact of DVA on the client’s minds, bodies, world views and sense of humanity. The down side of this state of affairs is that an appreciation of the psychology of DVA is sparse and an opportunity to fully formulate the psychological impact of DVA with

clients is missed. This brings into clear focus the need for specialised training for practitioners working with DVA.

The theme of knowing what to do challenges and solutions to these challenges is consistent and dominant across the body of data. One variation expressed emerged in relation to some participants making an open choice to avoid directly communicating about DVA in session.

Avoidance of communication about DVA appeared to close down space for rethinking and hermeneutic repositioning. The process of closing down therapeutic rethinking often occurred when the position of counselling psychologist is seen to be one of staunchly non-directive, not naming the problem itself or not enquiring further as to what clients are bringing. The upshot of this in the extract below is that opportunities to provide clients with space to be heard and voice their experience of DVA are overlooked and dismissed. As a consequence, DVA and its impact appear to be hidden and minimised:

Extract 54

“I think I just, I just follow their lead. Like if if they want to talk about it then that’s what we’ll talk about. If they don’t want to talk about it then we don’t talk about it. But if I say something like if I make an intervention “oh that sounds pretty, pretty rough, that sounds like a bit of rough handling” and they go “oh that’s not it wasn’t like that” then I’ll follow that lead you know. I wouldn’t want to push because I don’t think it’s my job to disprove their belief” (Lisa, 241-246).

An additional aspect of choosing to avoid open discussion about DVA was reported to lie in the fear of the perceived impact of such a discourse, as highlighted in Eve’s dialogue:

Extract 55

“Maybe I’m avoidant of it in some ways – Maybe I feel like I’m going to shake the person who it is happening with currently, maybe I feel I’m going to shake things up too much for them and it is for them to find that place where it is no longer acceptable” (Eve, 208-211)

The depth to which Eve owns her own avoidance of talking about DVA is clear. This avoidance leads to a lack of client reframing as a valued and active agent. Instead, the client is left to shoulder the sole responsibility to deliberate over how to move forward. Opportunities to arrive at resolutions in terms of knowing what to do challenges are also therefore frozen.

3.4.3 Knowing what to challenges: supervision as a resource

The ways these participants rethink clinical difficulties, reframe client's abilities and experiences and hermeneutically reposition clients as active agents of change within the therapeutic relationship makes up an important layer of this master theme. In combination, sits the use of supervision as a place to reframe and work at hermeneutically repositioning. This process includes a focus on the way the client is understood, but also relates to ways the participants themselves appraise their private beliefs, strengths and abilities to gain greater therapeutic clarity and facilitate higher quality clinical work and in doing so attempt to reach resolutions to some of the knowing what to do challenges.

In order to become reflective practitioners, the participants recognised the importance of having regular supervision as a space to consider the nuts and bolts of the therapeutic work, including emotional responses and subsequent clinical interventions driven by these feelings.

The particular importance of having their own feelings in relation to DVA contained by supervision was paramount in the process of engagement with finding solutions to the knowing what to do challenges:

Extract 56

“It seems as though for my supervisor nothing is too scary, nothing is too much and for these cases where perhaps I have initially been quite shocked and a bit frightened and a bit scared my supervisor has always been good at just kind of calming that down and you know before I

get ahead of myself about what I need to do to just like I said before, he is just able to say you know their coming and that's good enough, just wait and see what happens. Any impatience I might have to make sure that they feel safe is kind of, yes calmed down a bit and that is really helpful" (Eve, 294-296).

The experience of having feelings of fear and trepidation contained within supervision is experienced by all participants as highly beneficial and important when working with DVA.

As well as having a containing space in order to facilitate their own ability to contain client's needs, supervision offered a space for the participants to work at hermeneutically repositioning how they perceive their own work, beliefs and abilities that influence their therapeutic work. The experience of discussing the private sphere and the beliefs and ideas contained within this in supervision is seen to refresh the private understandings, adding the potential for new and creative options to therapeutic work:

Extract 57

"We carry a lot of stuff, the psychologists don't we, we carry a lot of stuff and it's I think unsafe to carry it without having someone else to explore it with because we've got our own subjective experience but we also need some fresh air to come in and sort of put some light on it the things that we miss" (Sarah, 261-264)

Extract 58

"and they've been supervisors women supervisors who are very much into into women's rights and empowering women and so I think that they share quite similar values to me and they're also the ones that were influencing my opinions about not coming into the session with your own agenda about what should happen in this domestically violent relationship. So and that really fitted with my values so and at the time what I was learning and about the power differentials in the therapeutic relationship and always being aware of and respecting those" (Helen, 298-307).

A close and comfortable match between the private sphere and professional/institutional sphere in the supervision relationship is clearly seen in the above illustration from Helen's

account as a rich and supportive resource. In this way, private sphere beliefs are held in suspension in order to create a more equally balanced therapeutic relationship.

The value of supervision as a positive resource whereby hermeneutic repositioning can occur towards the participants themselves is emphasised in its absence. For example below, when that is not possible, the effect of not being heard is visible, as the supervision space becomes one of desecration and rejection that echoes the participant's client's experience of DVA:

Extract 59

“and I remember us, yeah I remember us sort of almost feeling violated after this supervision because he completely dismissed anything that we sort of, yeah that's strange, I'm just remembering this now, also very uncomfortable yeah (...) I just remember us feeling completely you know not listened, just not understood so that supervision wasn't helpful at all” (Beth, 383-397).

4. Discussion

4.1 Key findings

The four master themes that emerged from the participants narrated experience – “privately owned and professional/institutional/public ideological tensions”, “disclosure of domestic violence and abuse affects the therapeutic boundaries and goals”, “working with domestic violence and abuse provokes human, humanitarian and humanistic responses” and “hermeneutic repositioning” outline the complex and intricate nature of the ways working with DVA are made sense of by this specific group of counselling psychologists. By exploring the prevalent understandings of DVA that these counselling psychologists draw on and some of the tensions and dilemmas involved in this type of clinical work, the interpretation offered through the master themes aimed to answer the following research questions. Firstly, what are some of the prevalent definitions and understandings of DVA that counselling psychologists working in private practice draw on? Secondly, what does it feel like to work with women who have experienced DVA? More specifically, what are some of the tensions and dilemmas involved in this work and how are these predicaments negotiated? Finally, how prepared do counselling psychologists feel they are to work with this population and what are some of the common forms of support employed?

As mentioned earlier in the literature review, there is a paucity of research focusing specifically on counselling psychologists’ experience of working with women experiencing DVA. In the analysis proposed there is an attempt to contribute towards this empirical gap by highlighting the ways these counselling psychologists work with DVA. While other fields of health and mental health care are beginning to develop guidelines for ways of working with DVA (NICE, 2014) and calling for specialist training for all practitioners (The Taskforce on the Health Aspects of Violence Against Women and Children, 2010), the Division of

Counselling Psychology and British Psychological Society appear to have yet to develop their professional stance towards DVA in similar ways. A further aim of the study was to reignite and rejuvenate a debate about the need for specialist training and guidelines for working with DVA within the counselling psychology milieu.

4.1.1 Counselling psychologists' understandings of DVA

The interpretations drawn from the participant's dialogue show a strategy of understanding DVA that leans on experiences from their clinical work. There was an active sense that DVA was the result of coercion and control by one partner towards another, exacerbated by previous relational histories and past individual childhood experiences. This shared understanding shaped participant's meaning making of DVA and the clinical interventions undertaken. What appeared to be obscured from the participants' accounts was an understanding that the patterns of behaviours and psychological problems associated with DVA are a specific psychological response to long term control and coercion by an intimate partner. What also appeared to be marginalised was an understanding of the impact of DVA and the shattering of a coherent sense of self, which left the participants somewhat unprepared for undertaking clinical work with their women clients. Furthermore, concealed within the body of data was an understanding of DVA that looked beyond control and coercion. Research suggests that DVA and the likelihood that violence will occur between a couple is multifactorial and complex (Dixon & Graham-Kevan, 2011). According to this understanding, DVA includes elements not only associated with control and coercion but widens the framework to allow consideration of features specific to individuals such as alcohol and drug use, stress levels, psychopathology, possible personality disorders and previous exposure to DVA (see Holtzworth-Munroe *et al.*, 1997 for a review). Alongside these individual factors sit aggressive family dynamics that all come together to provide a holistic understanding of DVA (Dixon & Graham-Kevan, 2011).

In order to increase counselling psychologist trainee's readiness to work DVA, to make effective risk assessments and provide appropriate therapeutic intervention, trainees need to be provided with a comprehensive review of the various factors that account for the aetiology of DVA. Utilising this knowledge, trainees can then assess and appraise the multifaceted features of DVA in the context of their clients experience without bias.

4.1.2 Complexity and tension when working with DVA

One of the dominant themes to emerge from the analysis of these counselling psychologists narratives is the multifaceted nature of clinical work with DVA. All of the participants' spoke of an awareness of complex, challenging and uncomfortable anxiety and tensions associated with their clinical interventions with DVA. This tension appeared to be located in the differences between and within what is privately owned and publicly known in terms of ideologies surrounding DVA and women experiencing DVA. Within this awareness a dynamic is created, whereby the ownership of this tension and conflict shifts in a number of ways. There is expansion of one sphere into the other, a reframing of the investment placed in one sphere over the other and an over investment in one sphere that creates stuckness. This verbalised aspect of these participants' work with women experiencing DVA mirrors the notion that mental health practitioners attitudes, whether known or unknown, can affect their responses in a clinical setting (Jackson, Witte & Petretic-Jackson, 2001). It is clear from the data analysed here that the counselling psychologists not yet owned beliefs about their women clients influenced the clinical decisions they made and affected their practice at times. The impact of these biases was seen to be an empathic paralysis and disruption in the ability to come along side clients. Other researchers have shown that mental health practitioners may harbour beliefs that women do something to deserve the violence they experience (Walker, 1994). A number of factors that lead to the development of these beliefs have been suggested by Jackson, Witte and Petretic-Jackson, 2001). These factors relate to unacknowledged

feelings of hostility toward women experiencing DVA, secondary trauma or personal internal characteristics.

However, talk, as always, is contradictory. Some of these participants visit areas of understanding DVA that moves away from straightforward recycling of beliefs surrounding women being to blame for DVA and move towards seeing their clients as women with agency, able to take action and change situations that are not of benefit to them.

Biases and not yet owned beliefs can emerge from lack of knowledge and sound understanding of DVA. The more knowledge about violence an individual has at their disposal, the more likely they are to own their not yet owned beliefs and reduce the degree to which these biases influence behaviour, practices and subsequent clinical interventions. To this extent the findings of this study supports the call for professionals working with women experiencing DVA to be provided with accurate information about DVA to increase their readiness and preparedness to work with DVA and reduce the professional tensions experienced. This would include providing trainees with a space to acknowledge, reflect on and work through their owned and not yet owned beliefs surrounding their clients in order to aid their clinical stance of empathic understanding (Sanderson, 2008).

4.1.3 Counselling psychology: nature, framework and role when working with DVA

When working with women experiencing DVA, participants experienced tension not only centred on their private spheres of understanding but extended out to include their professional spheres. A Professional stance of therapeutic neutrality and valuing subjective experience related to working in ways consistent with the theoretical underpinnings of counselling psychology can clash with the private notions of DVA and at times the specific needs of the clients themselves.

Kurri and Walhstrom (2001) report that inherent to working with DVA is a professional and personal dilemma. On the one hand, therapeutic work includes signing up to a neutral stance, with a focus on the client taking the lead and making their own decisions about what to do in their relationships. The findings of this study corroborate with this view. Alcock (2001) promotes this notion by suggesting it is essential to support women to take control over their personal recovery process by working at their pace and staying with the women's experience. On the other hand, the therapeutic community condones the notion that violence is always wrong. In this way, individual psychological theories of DVA have been thought to fail to account for moral dilemmas and tensions as they work out in actual interaction (Kurri & Walhstrom, 2001). Likewise, the participants in the present study point to the moral dilemmas and feelings of tension associated with the knowing-what-to-do-challenges in their own work with DVA.

The professional therapeutic interaction occurs within a social context, not devoid of social and publicly held meaning making practices common to a specific community (Strawbridge & Woolfe, 1996). Thatcher and Manktelow (2007) point out that counselling psychology's adherence to focusing on individual experience and personal values has marginalised the social origins of distress. Viewing psychological distress through an individualistic lens suggests that people come to counselling psychologists with problems that are largely of their own making and as such can be treated at an individual level. This focus on individual experience and individual treatment neglects the social aspect of problems like DVA and may be seen to support socially constructed inequality (Strawbridge & Woolfe, 1996). A call has been made for counselling psychologists to extend their interventions from a focus only on individualistic and humanistic values of empathy, that overlook the ways problems are constructed through social meaning making systems, to promote a view of interpersonal problems like DVA as rooted in social categories (Strawbridge & Woolfe, 1996). These

participants celebrate an individual approach in a humanistic kind of way, by supporting women to take up their own sense of agency and leadership in the therapeutic encounter. However, what they do not engage with, which may be of added benefit, is to recognise the social impact on DVA and the influence of social structures on women's lives. Consideration of the social context of DVA when building clinical interventions suggests it is essential for practitioners to understand traditional values that support DVA, self-blame, economic dependency and particular difficulties for women of different races in responding to DVA (Hage, 2000).

4.1.4 Experiencing overwhelming feelings

The phenomenon of affective disturbance through working with trauma is inescapable when talking about work with DVA. All of the participants in the present study spoke of the strength of feeling in response to a disclosure of DVA and being marked at a personal and emotional level by their work with women experiencing DVA. Many of the participants articulated wanting to create a sense of safety for their clients that impacted on their ability to remain in a neutral therapeutic stance, required by the therapeutic field, and led to a pull to rescue clients. This moral imperative was worked through in supervision and acted against through self-care. The desire to keep clients safe has been echoed by McCloskey and Fraser (1997) who remind us that the tension between ensuring safety and empowering women to make their own decisions is challenging to settle and can draw practitioners into a power battle with clients. Likewise, the participants in the present study mirrored this preoccupation in their dialogue, supporting these findings.

The analysis revealed the depths to which stories of DVA and descriptions of abuse and violence impacted on the participant's personal emotional world. Explicit in the participants' dialogue was an acknowledgement of the dilemmatic impact of working with DVA, such as

dominant experiences of fear and anger. These feelings were projected into clients or client's partners or served as a way for participants to distance themselves from their clients.

The impact on affective emotional experience was mirrored in previous research. For example, Steed and Downing (1998) where dominant reports of anger, pain and frustration, shock, horror and distress came from practitioners concerned about their inability to bring about therapeutic change, which culminated in an overwhelming sense of helplessness. Echoed in the present study, participants voiced feeling inexperienced and unconfident in their work with DVA in relation to the knowing-what-to-do-challenges. What seems to be becoming clear in research is that practitioners often experience parallel feelings to those of their clients such as: anger, grief and hopelessness (Steed & Downing, 1998; Iliffe & Steed, 2000). In line with previous research, the present interpretation points to the importance of practitioners engaging in self-care. Specifically, self-care means protecting a personal sense of well-being through supervision, personal care paths such as personal therapy and supportive relationships and monitoring personal beliefs as a way to manage these strong and uncomfortable feelings. Counselling psychologists in the current study saw supervision as a positive resource, giving the opportunity for hermeneutic-repositioning of their own beliefs and view of their work. They called for on-going professional development and training specific to DVA to dissipate some of the emotional experiences they had in their work. This has been echoed by practitioners in previous research from Steed and Downing (1998) and Iliffe and Steed (2000). In these early studies, practitioner's emotional experiences have been linked to secondary trauma, vicarious trauma and burn out, with reports of changes to cognitive schematic world views, physical bodily reactions and changes to perceptions of safety (Steed & Downing, 1998; Iliffe & Steed, 2000). Everall and Paulson (2004) highlighted that practitioners who do not adequately deal with the effects of secondary trauma are more likely to experience disruptions of their essential empathic abilities in

session. Such a disruption when working with DVA may be due to intense emotional countertransference reactions. Countertransference reactions are difficult to locate initially as by essence they develop out of consciousness. However, if left undetected, countertransference responses can lead to avoidance of discussing DVA, wanting to rescue the client and fear of becoming the perpetrator (Sexton, 1999). Empathic withdrawal may also fuel private beliefs that put women in places of responsibility for initiating DVA. Pearlman and Saakvitne (1995) suggest the detrimental effects of such unconscious forces can be lessened if practitioners are taught to spot and monitor them through specific training and professional development. However, the researchers suggest that historically counselling, psychotherapy and psychology courses have not always provided such adequate training.

The experiences of these particular counselling psychologists were not explicitly constructed around the concepts of countertransference, secondary trauma, vicarious trauma or burn out. Nonetheless, implicit in some of the participant's narratives was a rupture in the empathic connection and avoidance of talking about DVA. It may be that practitioners who specialise in working with traumatised clients are more prepared to identify the impact of secondary trauma. However, as the well-being of practitioners of all categories is paramount (Zimering, Munroe & Gulliver, 2003) this study supports the notion that counselling psychologists need to be well armed through adequate and specific DVA training to protect the welfare of their clients. As highlighted by these participants, that training would need to include a focus on self-care through identifying and becoming aware of the impact of working with DVA.

4.1.5 Knowing what to do when encountering DVA

Alongside personal challenges when working with DVA, participant's narration revealed a number of knowing-what-to-do-challenges relating to interventions in session. A preoccupation with knowing what to do when working with DVA was central in the

participant's dialogue. Knowing the complexity, the specificity and uniqueness of DVA and trying to bring together the most appropriate therapeutic approach, while not knowing what to expect, seemed to lead to a feeling of being de-skilled for some of the participants. A central dilemma was how to talk about DVA in session and whether to name DVA directly. Previous research presents the importance of practitioners finding ways to name DVA, as women tend not to disclose DVA due to feelings of fear and shame (Spangaro, Zwi & Poulos, 2011). Furthermore, women have reported wanting to be directly asked about DVA and for this asking to be persistent. Having abuse named has been reported to be helpful for women as they thought they tended not to know or think their experiences were abusive (Spangaro, Zwi & Poulos, 2011). In the present study, the participants recognised the benefits of talking directly to women about DVA, but get muddled and slowed down with a preoccupation with not wanting to repeat a controlling relationship dynamic through naming DVA. This knowing-what-to-do-challenge confuses and disrupts their attempts to communicate openly about DVA with their clients.

A preoccupation with knowing what to do when DVA was disclosed, for these participants, lead to reframing, rethinking and hermeneutic-repositioning after acknowledgement of and engagement in moral and clinical struggles and tensions. Across the body of data there are three distinct objects of the hermeneutic-repositioning. The first object refers to the way the participants see the client. Secondly, is the way the participants see themselves and thirdly how DVA itself is seen within the therapeutic encounter. Hermeneutic-repositioning of the client takes place through ways the participants view their clients as having agency to set the therapeutic agenda. Further hermeneutic-repositioning takes place towards DVA within the therapeutic dialogue in terms of not recycling labels. Finally, repositioning also occurs for the participants within the process of supervision. The counselling psychologists who did not adopt the hermeneutic-repositioning spoke of avoidance and fear instead.

This type of repositioning work was echoed to some extent in the work of Kurri and Walhstrom (2001). The counselling dialogue in this piece of research was used to protect the morality of the client's decision to stay with her partner. The wrongness of DVA was made explicit, though the client was not challenged directly. Instead, new options were offered by expanding client's strengths. When DVA becomes the focus of hermeneutic-repositioning in this way, attention is turned towards the DVA as a phenomenon or act rather than the focus being on the couple involved. So the dialogue shifts and the client is incorporated into the dialogue as an ally against the DVA.

An important and distinguishing feature of the participant's vocalised experience in this study was a missing description of an understanding of the theoretical frameworks supporting DVA and a knowledge of the psychological impact of DVA. The participants were so caught up in the moral dilemmas and challenges of DVA and knowing what to do with these, that a distinct or well established clarity of the psychology of DVA was overlooked. Walker (1996) notes the tendency for DVA to remain undetected by practitioners poorly trained in screening, assessment and therapeutic interventions with people experiencing abuse. All of the participants, in numerous places, emphasised from their own experience their personal need for specialist training to aid their understanding of DVA. This need for specialist training is echoed by Hage (2000) and Sanderson (2008). These researchers suggest practitioners need to have a thorough understanding of the complex nature of DVA. This includes an awareness of the impact of long term coercion and control on the psychology of the self and ability to relate common in DVA. Such awareness would increase practitioners' assessment of manifestations of DVA symptoms and ability to make appropriate referrals. The present research adds to this body of knowledge, calling for specialist training for any practitioner working with DVA to foster confidence, knowledge and ability: ultimately increasing levels of effective client care and nurturing best practice with DVA.

4.2 Implications for practice

4.2.1 Specialist training for DVA

One argument that can be drawn from the current interpretation of these counselling psychologist's narratives is consideration of the need for specialised therapeutic care for those experiencing DVA and specialist training for any practitioners likely to work with DVA. The complex and challenging nature of violence, set within an adult relationship, can undermine clinical confidence and leave practitioners feeling de-skilled and inexperienced, as illustrated through the participants struggle with moral dilemmas and knowing-what-to-do-challenges. This feeling can exacerbate the personal impact of working with DVA in terms of burn out and/or secondary trauma (Iliffe & Steed, 2000) and experiencing overwhelming human, humanistic and humanitarian feelings. Not yet owned personal beliefs about DVA can further generate an idea that cases of DVA are difficult to work with, creating a culture of avoidance as observed in the participant's accounts. Not yet owned ideas about DVA, suggest that clients are the problem rather than the practitioners personal meaning attached to working with women experiencing DVA. It may be a case of fearing the unfamiliar or what is not yet known about that leads to working with DVA becoming a "mysterious speciality" (Sanderson, 2008). Given the number of women and men experiencing DVA and the number of both genders presenting for talking therapy, it would seem that counselling psychologists will inevitably work with DVA either at an individual level and/or couples forum. As these participants have demonstrated, it seems imperative that the 'mystery' of working with DVA is dispelled and counselling psychologists are armed with the skills they need to provide best quality therapeutic care for their clients through a thorough training schedule. As Wandrei and Rupert (2000, p. 280) state: "education of current and future psychologists in the treatment of intimate partner violence must be more than a haphazard accessory to training; it must involve in-depth examination of theoretical and personal views on DVA and

comprehensive presentation of the ethical, empirical and practical issues involved in the treatment of perpetrators and targets of violence”.

For counselling psychologists who are trained to a professional doctorate level this may include some specific and specialist lectures over the course of their training. All of the participants in the present study spoke of the need to have some type of specific DVA module within their curriculum, including space for case conceptualisation and reflective practice.

Following on from the literature, the ideal DVA module may include topics such as the prevalence and definitions of DVA (including physical, emotional, sexual abuse, various tactics of control and coercion). Attention should be given to the impact of DVA on physical and mental health and the particular difficulties of minority groups with DVA (including same sex relationships and cultural differences). Psychological theories of DVA (including feminist perspective, gender inclusive arguments, psychodynamic elements, and links with PTSD) the psychological impact of DVA and long term effects of coercion and control should also be covered. Ways of working with DVA with attention paid to difficulties inherent in this work would be a major part of the ideal curriculum e.g. the importance of establishing safety, making safety plans, issues with confidentiality and ways the dynamics of control and coercion may emerge in the therapeutic relationship. Case examples, group work and role plays could be incorporated to aid reflection. Ways people experiencing DVA may present in clinical situations, feelings aroused and beliefs associated with this type of work should be considered in these reflective spaces.

On the basis of the collective voice of these participants, the following attributes are useful to include in a DVA curriculum. In terms of developing a readiness to work with DVA, trainees should be prepared and supported to reflect on and own their not yet owned beliefs about DVA in a supervisory relationship. This could help trainees to understand and work through

any clashes. If these beliefs are not processed they can impact on the clinical work and cause stuckness. Trainees also need to be ready to move away from a neutral therapeutic stance in order to ensure safety. This may feel uncomfortable but is an essential first step in creating an effective therapeutic encounter. In ensuring safety and talking about DVA, trainees need to be aware that they will feel strong feelings. Some feelings may be related to a desire to rescue and hold clients and some may be angry and frustrated feelings. As part of becoming prepared to work with DVA, it would be essential for trainees to understand that these feelings are inevitable and an important part of their work. They need not be afraid of them, but become mindful of them and take them to supervision to discuss further. An additional aspect of increasing trainee's readiness to work with DVA would be to help trainees to expect there to be a level of complex and demanding moral and clinical challenges associated with this work. Because of the merging of challenges and need to provide clinical intervention, trainees need to understand they may feel de-skilled and inexperienced. It would also be common for trainees to be mindful that they could become preoccupied with knowing what to do. A preoccupation with knowing what to do, may lead trainees to feel torn between wanting to be direct in their communication about DVA and feeling concerned about taking a controlling stance. This conflict is to be expected: though will feel difficult. Other conflicts to expect and prepare for when working with DVA centre on trainees professional and legal obligation to ensure their clients safety. These conflicts are best worked out in supervision and may require specialist advice. In order to facilitate thinking about these conflicts and manage the demanding nature of this type of work, trainees need to be prepared to look after themselves through supervision and personal support systems.

In summary, in order for trainees to work effectively with women experiencing DVA, they must be prepared to feel strong and difficult feelings. Moreover, support is essential to make

trainees ready to engage in demanding personal, moral and clinical challenges through the process of training, supervision and self-care.

4.2.2 Guidelines for DVA

The current culture of creating guidelines for various mental health problems remains a contentious issue for many researchers and practitioners. The creation of therapeutic guidelines has thought to go some way to establishing a ‘one size fits all’ type of therapeutic approach, taking away from the emphasis in counselling psychology of being with clients rather than doing (Strawbridge & Woolfe, 2010). Despite these arguments, there are pragmatic and legal advantages to having guidelines for working with DVA. When faced with moral dilemmas and muddling effects of knowing what to do, these participants would benefit from guidelines to draw upon to raise them out of the muddling quagmire. The benefits of having guidelines for these participants to evaluate their work against and use to develop best practice with DVA outweigh the disadvantages of crossing into prescriptive clinical practice.

For DVA specifically, Sanderson (2008, p. 237) reminds us that practitioners may feel the need to stick to rigid guidelines for fear of engaging with the client and may lose touch with being with the client: “to be consumed with what one should do or should say can override the phenomenological aspects of the work in which two people meet and connect in the therapeutic space”. The task at hand is for practitioners to balance out holding onto the unique and phenomenological aspect of client work, alongside utilising guidelines to steer psychological interventions with DVA and increase best practice.

4.2.3 Reflective practice

The need to develop a reflective stance towards clinical practice is paramount within counselling psychology and is indeed part of what is thought to set counselling psychology apart from other branches of clinical practice. To this extent the Division of Counselling Psychology Professional Practice Guidelines (p. 7) states that: “practitioners will be reflective about their practice and that of Counselling Psychology as a profession”. What emerged from the participants talk emphasises the importance of counselling psychologists developing reflective skills. Many of the participants spoke of the ways they reflected on their own practice. One reflective skill mentioned was to bracket off personal assumptions about what should or shouldn’t happen in an abusive relationship in order to focus on the client’s experience. A further reflective skill expressed was thinking about how to use personal feelings in relation to women clients, whether to bring them into session or hold them in suspension. According to the participants, in the area of DVA, reflective practitioners look back on the struggles that appear and delineate the privately owned sphere from the publicly known, in order to develop awareness of areas of avoidance and resistance and face difficult impasse’s in the therapeutic work. Engaging in such a process of self-reflection serves to propagate and develop an internal understanding that it is not clients that bring us problems. Those problems and dilemmas inherent in clinical work with DVA relate to the conflict and/or gaps between what we privately adhere to and publicly know. What the participant’s narration also points out is that the process of self-reflection does not serve to iron out and solve difficult tension. The overlapping tense movement between humanitarian feelings of needing to rescue, moral and legal dilemmas surrounding DVA combined with privately owned and not yet owned beliefs merge to remain live and necessary in the face of a complex issue such as DVA. Staying with and experiencing tension and a difficult sense of muddling are necessary in order to keep practitioners alert to the complexity of working with DVA. The

impact of such a reflective engagement may be to leave space to hermeneutically-reposition clients as active collaborators in therapeutic change. The participant's message emphasises a notion that this internal process of reflection should be developed in initial training. However, it does not stop there as reflective practice requires an adherence to continuing development and on-going learning. In that reflective practitioners use regular supervision and CPD to reflect on current practice and development of therapeutic interventions.

4.2.4 Importance of self-care for practitioners working with DVA

The concept of self-care for practitioners working in talking therapies is not new. Being a reflective practitioner emphasises recognising that in the interaction between client and practitioner, each will be affected (Shillito-Clarke, 2010). In some instances the effect will be negative, challenging and difficult, resulting in awareness of strong and at times overwhelming emotional responses. As part of managing these feelings and interactions, in line with good self-care, counselling psychologists are encouraged to find personal support outside the work relationship. This may extend to personal therapy (BPS, 2005). Many of the participants spoke of the ways they used their own personal support structures, such as personal therapy, family and friends to mitigate the difficult aspects of their client work. As well as these personal ways to ensure well-being, supervision was discussed by all the participants as a professional way to promote self-care. Part of self-care is attending regular supervision as space to hermeneutically-reposition privately owned notions and abilities. When supervision was not felt to be a safe and containing space, this process of hermeneutic-repositioning was ruptured.

4.2.5 Wider implications: the individual is ‘social’

Within counselling psychology, the debate surrounding the problematic aspects of individualising client's problems continues (Thatcher & Manketlow, 2007). An important opportunity to work at a social, cultural and community level is overlooked by the individualising process (Strawbridge & Woolfe, 1996). It can be argued that it is imperative to consider working at a social level when thinking about DVA. The ways language, community belief systems and the cultural and social temperature of those communities construct and prop up DVA and what is made possible in the context of a relationship have been made clear in previous research. For these participants, the hermeneutic-repositioning took place at an individual level. The notion of the social and cultural impact on their women clients was submerged rather than directly picked out in their discussion. Debate continues as to the implications of positioning DVA as an individual health care problem rather than a social collective problem (Lavis *et al.*, 2005). Similarly to the on-going debate within counselling psychology, positioning DVA as a health care issue overlooks the social and community level of prevention work that could take place. If we accept the social and cultural construction of individual problems and the meaning making systems that increase distress, we as counselling psychologists have a responsibility to work at a community and environmental level. Calls for counselling psychologists to work at a community level, raising awareness of DVA, taking a stance against mobilising dominant and pathologising constructions of violence and its use within relationships and working to dissipate stigmatizing cultural beliefs surrounding DVA have been made (Hage, 2000).

4.3 Evaluating the interpretative story

Qualitative research embraces particular standards of evaluation (Morrow, 2005). These standards entail criteria specific to the epistemological structures of qualitative work and are different from quantitative analysis. The presented discussion draws on the following criteria in order to evaluate the “trustworthiness” (Morrow, 2007) of the study and its knowledge-claims: interpretative commitment, rigour and transparency, transferability and impact and importance (Yardley, 2000).

Qualitative research strives to represent the participant’s voices as closely as possible to the intended message (Marrow, 2005). The need for an accurate, viable representation of the participant’s talk requires a high level of commitment from the researcher (Yardley, 2000). In order to enhance the interpretative imperative of these participant’s accounts, the analysis of the narratives contained within this study was driven by an attention to closeness to the participant’s subjective descriptions of the phenomenological aspects of working with women who have experienced DVA. In this way, the participant’s dialogues were used as a checking point throughout the research process, whereby a constant return was made to reading and re-reading the participants words. The interpretation has tried to illustrate the dominant ways of talking about clinical work with DVA, associated struggles and dilemmas and also more implicit or missing ways the counselling psychologists made sense of their experience of working with DVA.

A further criterion for evaluating qualitative research, in addition to interpretative commitment, is in relation to the level of rigour and transparency made available by the researcher (Yardley, 2000). Rigour relates to the thoroughness, quality and completeness of the analysis. As this was a small and exploratory study, a detailed, intense and rigorous engagement with the participant’s narrated experience was made possible through the process

of transcription of the interviews and constant returning to these transcriptions (Stiles, 1992). Transparency and rigour went hand in hand throughout the phases of analysis as indicated in the appendixes. The aim was to offer an expansive interpretative representation of this group of counselling psychologist's understandings, struggles and negations when working with DVA.

It was possible to check the credibility of the interpretation with two participants. These participants felt the analysis was a credible and viable story, which represented aspects of topics they had emphasised during the interviews. In addition to this, another good practice that was used here to ensure transparency and rigour was to share and discuss earlier drafts of the analysis with my director of studies and counselling psychology colleagues. In both instances, I felt reassured by their feedback that the story created through the analysis is viable and credible, albeit, those others would have created different themes and a different reading of the data.

A further credibility check would have been to conduct an independent audit (Smith, Flowers & Larkin, 2009) of the data paper trail through requesting a colleague to assess the credibility and step by step logic of the final report against the material used to construct the interpretation.

As the interpretation of the participant's talk was an exploratory qualitative reading, the resulting analysis needs to be evaluated in terms of transferability rather than generalizability (Henwood & Pidgeon, 1999). The power to generalise results are a preoccupation of quantitative researchers who are seeking norm like theories that they can derive from a sample and expand to an entire population. Qualitative researchers are not creating law like propositions. Instead, they take the position of looking at the findings generated from their analysis, as a series of inductive conclusions based on the participant's interpretations that are

temporary, provisory and contextual. So it makes no logical sense to have a preoccupation with generalising the findings. However, the usefulness of a qualitative study can be expressed along the lines of transferability. Transferability refers to the extent to which the reading offered here, of this group of counselling psychologist's narratives can be transferred to other similar contexts. The findings from this study can be usefully transferred to enhance the readiness of counselling psychology trainees to work with DVA (see page 93 for recommendations).

The literature review and reading of the narratives outlined in the thesis point towards the benefits of further exploration of the ways counselling psychologists make sense of working with DVA. Further research could expand on the diversity of the sample. Extending research in this way could explore the specific protocols and local guidelines that counselling psychologists utilise in their work in the larger community setting of the NHS and the localised nature of statutory settings. It could also be empirically useful to recruit practitioners who have had experienced specialist training in DVA to explore their specific understandings e.g. Relate practitioners. As the number of men and same sex couples reporting to services for support with DVA seems to be growing, (www.respect.uk.net) another avenue for future research would be to focus on practitioners understandings of DVA when working with diverse client groups. A further focus may be to look at the ways DVA is understood by practitioners working with specific cultural groups, the social and cultural factors that influence the ways counselling psychologists understand DVA and how these dynamics impact on their clinical work.

An important aspect of evaluating a qualitative piece of research relates to the impact and importance of the knowledge produced by the study (Yardley, 2000). This research addresses a topic that remains under researched from a qualitative perspective, ways counselling psychologists work with DVA. The ultimate aim is to raise awareness of the inherent

dilemmas associated with this type of work. Furthermore, the study calls on educational institutions to provide additional and specialised opportunities to develop skills in and enhance readiness of trainee counselling psychologists when working with DVA.

In terms of impact, counselling psychologists and other mental health practitioners can use the reading of these participant's experiences to aid and expand their current clinical practice and develop their own readiness to work with DVA.

4.4 Ownership, accountability and knowledge production

As mentioned in the method section, an IPA analysis takes a double hermeneutic position. This asserts that the researcher is a co-constructor of knowledge and meaning making (Morrow, 2005). In order to manage beliefs and assumptions that come from the researcher's life world, the meaning making process within the research encounter is approached reflexively. Reflexivity, as an inherent part of doing qualitative work, calls for the researcher to make themselves aware of their personal influence on the research process and act with agency towards this influence (Morrow, 2005). This section will outline my reflexive journey which includes a dual focus on both personal and empirical reflexivity. The account of my personal reflexivity details the ways the research process has shaped my own views of myself as a professional, my own ways forward, attitudes, beliefs and practices. Alongside this sits an expression of empirical reflexivity which shows appreciation for the ways I and my own sense making procedures have influenced the research process itself. By reiterating my position in relation to the research, I will explore my own influence on the interpretation produced through a discussion of some of the dilemmas I faced and decisions I made throughout the research process. In this way, I become self-aware and act with agency towards this self-awareness: making myself accountable for the reading, interpretation and conclusions presented.

I am a young, white woman currently training as a counselling psychologist, with an interest in mental health problems and the ways these problems are constructed through language. I work in a private mental health setting and see various clients as they present themselves or are referred to the service. The service is underpinned by a medical and psychiatric model of formulation, with much emphasis placed on the importance of medication and developing coping skills. It may be thought that these are important aspects of my own person which may impact upon my sense of professional identity, my values, beliefs and associated responses made live within the research process.

I have no experience of DVA, either personally or in my circle of friends or family though I have had uncomfortable experiences of professionals attaching labels to my history that did not seem to accurately describe my own experience. It was from this discomfort and developing interest in the therapeutic dialogue, through my training, that I began to become curious about the powerful influence our words as professionals have when working with vulnerable clients. An interest in language and its power of construction drew me to read widely incorporating feminist and post-modern thinking. I became fascinated with the many ways social and cultural truths were thought to be borne out of the language used to describe them and grappled with the possibilities this way of thinking opened up for my clinical practice.

Through informal discussion, many of my colleagues reflected on the high number of women they had worked with who came to them with a presenting symptom that on closer discussion related to on-going DVA. My colleagues began describing their experiences of this type of work. They thoughtfully reflected on the difficulties they encountered and a sense of confusion about how to do this type of work, though it was common in their case load. Many mentioned not having formal training in DVA, but managed cases with their own integrative therapeutic stance. I reflected on my own training and absence of knowledge of DVA and

wondered how I may work with women clients with DVA experiences who would inevitably present to me at some point in my career. It seemed a natural progression to me to steer my research interest towards giving a voice to counselling psychologists who worked with women experiencing DVA.

The process of interviewing was difficult and challenging for me. I became very aware of the power dynamic between myself as a trainee and the participants as qualified professionals. Having not encountered DVA in my clinical practice, I have no shared knowledge of working with DVA, as my participants did. Neither am I qualified or chartered. In this way I felt elements of being an outsider and did not feel comfortable to pose critical questions or prompts in the interview. Whilst aware I could not find my voice in the interview process, I came to realise this was for the benefit of the data. It allowed the participants to narrate openly and freely rather than engage in a conversational, turn taking, challenging dialogue. At the time, I wrote in my research diary how shocked I felt at the responses the participants seemed to be giving. I recall feeling angry feelings on behalf of the women clients and to some extent on behalf of the counselling psychologists, that their educational institutions have not provided them with specialised DVA training to enhance their engagement with their clients. Moreover, I came to realise that this feeling of anger related to my own sense of frustration at not having had any specific DVA training. Through this process of reflection, I connected with my position as a researcher and took up the role of advocate for my participants. It took time to reflect on the interview process and make sense of what I was experiencing.

On reflection of the interpretation phase, I changed my frame of reference relating to what I had 'heard' from the participants. During the interview process, I felt a sense of frustration and powerlessness at what seemed to be rigidity in the participants understanding of and readiness to work with DVA. I wondered if this related to my idea that the participants as

qualified counselling psychologists should know the answers to the types of challenges we were discussing. I noticed a sense of fear and anxiety surrounding the things that were left unknown. I began to find it hard to fully immerse myself in my participant's narratives. I felt a conflict between wanting to stay empathic and close to their words and not wanting to sound critical of the description of the conflicts and struggles they were offering. At times, I felt I was distancing myself from their comments. It seemed this process accompanying my interpretation of the participants narratives echoed the distancing and empathic rupture some of the participants talked about with their clients. I felt a pull to make my participants talk sound clearer or less confused than it had come across to me. For example, in the first draft of my analysis I overlooked the conflicts that were emerging, choosing to select short extracts where the participants made definite statements.

I wondered whether I wanted to clean up and rescue my participants as some had done to their clients. I became curious about the parallel process that was occurring between me and my participants and participants and clients. Through this process, I came to understand the essential nature of this conflict and the importance of not having all the answers known about and held to be true. It seemed to me that actually engaging with a sense of conflict about working with DVA learnt governance to the complex nature of the issue itself. This clarity is reflected in the final mapping of the master themes and how they relate to one another.

I may have prioritized some themes over others, e.g. the "privately owned views, personal injunctions and their dilemmas, struggles and solutions" sub theme. I wanted to illustrate the impact of that which is unknown and the importance of becoming aware of our own assumptions. This prioritising, I see now, paralleled my own reflective process as I used continual self-reflection, journal keeping, supervision and personal therapy to aid this process and help me bracket off my own assumptions.

I have learned much through the research journey. I feel fascinated by qualitative research, though found it hard to reiterate the process in the writing up phase. I felt as if I was learning to walk again, taking small and uncertain steps into the new and unfamiliar world of qualitative thinking. The pull to return to the known and safety of quantitative research was strong and at times irresistible. This extended from the language I habitually choose to describe the research process, to my own internal ways of thinking about research, its position and its value e.g. the way I use the word true and commitment to and valuing rules. My hope is to provide a voice for counselling psychologists and highlight some of the clinical tensions associated with working with DVA from a counselling psychologist's perspective. There were times when I was angry, frightened, anxious, unhappy and powerless during the research process. I have also felt amazed, curious, impatient and empowered. I have learned to be more critical of my own assumptions and to some extent begun a process of owning what is unacknowledged in my own private sphere.

Another thing I have learned is that this piece of research is my way of responding to something I felt unhappy about in terms of the prevalence of DVA. It is also my attempt to gain a better understanding of DVA and how to work with women experiencing this problem. As well as increasing my own personal understanding of the phenomena, one can only assume this process has given me greater clinical skills and confidence in terms of effective ways to work with women experiencing DVA. Through the research process described, I have attempted to give my participants a voice through bearing witness to what it means to work with women experiencing DVA.

If this research helps others to develop a greater professional understanding of DVA and acknowledge problematic tensions within their private sphere rather than thinking problems lie with clients and adds to a debate about becoming aware of these assumptions through training and supervision, my own voice has found its strength and I hope been heard.

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Domestic violence and abuse,,

women - victim or survivor?

What are your views?

Are you a counselling psychologist or psychologist working in a private setting/private practice?

Have you worked with women clients who disclosed domestic violence and abuse?

What are some of the common difficulties encountered in working with DVA?

My research study is looking to explore Counselling psychologists' understandings of domestic violence and abuse (DVA) and examples of good practice as well as barriers commonly encounter in working with DVA. This will help develop recommendations for practice and training.

The interview is part of my doctoral research and should last between 40 to 60 minutes.

The interview will be completely confidential and your anonymity guaranteed.

Please contact me. I would be very willing to talk to you.

THANK YOU.

Dear

Your participation in this research project is being sought as you have valuable experience of working with women who have experienced domestic violence and abuse.

The research aims to explore your experiences of working with women who have experienced domestic violence and abuse, how prepared you are to do this work and what you think would support you in this work. For the purpose of this study domestic violence and abuse is defined as any physical or emotional act of abuse perpetrated by a man to a woman in the context of a heterosexual relationship. Questions will be focused on working with this specific population so volunteering for this study implies that you have experience in this area.

To discover your perspective, face to face interviews will be used which should take about 60 minutes.

Your participation will be greatly valued. In accordance to the UEL code of ethics, your anonymity and confidentiality will be protected at all times and you have the right to withdraw at any point.

Should you wish to take part in this study, I would be very grateful if you could contact me at the above address. Similarly, should you require any further information about the study, please do not hesitate to contact me.

Kind regards

Zoe Knight

Trainee Counselling Psychologist

Consent form

Introduction

You are being invited to participate in a Doctoral research study titled: Counselling Psychologists understandings of domestic violence and abuse. This study is being conducted by Zoe Knight under the supervision of Dr Aneta Tunariu in the School of Psychology at the University of East London.

Volunteer status and confidentiality

Your participation in this study is completely voluntary and confidentiality is assured in all published and written data resulting from the study. You have the right to refuse to answer particular questions. You may elect to withdraw from this study at any time and the information we have collected from you will be destroyed. If you decide to participate the information you provide will be used only for the completion of this study.

Purpose

The research aims to explore Counselling Psychologists understanding of domestic violence and abuse and how they work with domestic violence and abuse when it has been disclosed to them in session. The research also aims to look at how prepared Counselling Psychologists are to do this type of work and what they may need to support them in this area.

Procedure

Face to face, semi structured interviews will take place. The researcher will firstly introduce the research topic to orientate you to the research topic. The researcher will then ask you four to five questions and will use a number of prompts to help you think about and answer the questions. When you have answered the questions as much as you feel able, the interview will stop and there will be time for a de-brief with the researcher. This interview will be recorded and the researcher will then type them verbatim and use these transcripts as part of the analysis. Your confidentiality will be kept at all times and you may choose not to answer any question. You also have the right to withdraw from the research at any time. Your anonymity and confidentiality will be protected at all times.

Time Commitment

Your participation in this study will take approximately 60 minutes.

Risks

Taking part in this study may bring up some thoughts and feelings surrounding difficult client experiences you may have had.

Benefits

There is likely no direct benefit to you for participating in this study, but it will help us and others to raise the issue of male partner violence and how Counselling Psychologists help clients who have experienced domestic violence and abuse. It may also help develop theory and safe practice when working with this client group.

Payment

You will not be paid for participating in this study.

Ethical clearance

This study has received ethical clearance from the School of Psychology ethics committee at the University of East London. You may have access to the data and findings and your anonymity and confidentiality will be protected at all times. Some of the data in this study may be used for a published study.

For further information

Any questions that you may have about this study can be answered by ;

Zoe Knight

Before You Sign This Document

By signing below, you are agreeing to participate in a research study. Be sure that any questions have been answered to your satisfaction and that you have a thorough understanding of the study. If you have any further questions that come up later, please feel free to ask the researcher. If you agree to participate in this study, a copy of this document will be given to you.

Participant's signature:

Date:

Print name:

Researchers Signature:

Date:

Interview schedule v2

Pseudo name:

Age Group:

Gender:

How many years practicing:

Part A: Understanding of working with DV&A

1. Thinking back at cases where domestic violence and abuse was disclosed to you, Can you tell me about the challenges you encountered and how you negotiated these?
Prompts
 - What was it like for you?
 - What do you remember about it?
 - What stayed with you about it?
 - How would you define domestic violence and abuse?

2. How did you work with these cases?
Prompts
 - What did you do about the domestic violence and abuse that was disclosed to you?
 - How did you understand the domestic violence and abuse that was disclosed to you?
 - Supervision – What happened when you took it to supervision?
 - How did that leave you feeling?

3. What are your views on the terminology surrounding domestic violence and abuse?
Prompts
 - What terms do you think are suitable/more suitable?
 - What are your thoughts on the use of the term victim?
 - What are your thoughts on the use of the term survivor?

Part B: Preparedness for working with domestic violence and abuse

4. What additional support is necessary do you think to help be prepared to work with domestic violence and abuse?
Prompts
 - Some of the work suggests that linking with multidisciplinary specialist services is helpful – what do you think?
 - Personal reactions – some of the women participants I have spoken to have mentioned their personal reactions to the violence they heard – what were some of your personal reactions?

Part C: Summary – professionals views regarding future support and needs

5. If we could sum up, what recommendations would you make to
 1. Training institutions
 2. Professional bodies – BPS, UKCP, BACP

Notes:

Debriefing Information

Purpose of research

It is estimated that 1 in 4 women will experience domestic violence and abuse (DVA) in their life times (Women's Aid) and many of these women will present to private practice for talking therapies to help them recover. Counsellors have available guidelines and recommendations for ways of working in this area for specialist and frontline services. However, research has shown that there are many conceptualisations of what constitutes domestic violence and abuse. This leads to a range of clinical principles and recommends a range of provisions to be made to aid counsellors working effectively with DVA cases. Likewise, the debate continues over what terminology is best used to describe as well as engage therapeutically with instances of DVA.

The present study sets out to explore counselling psychologists/counsellors understandings and accounts of working with women who have experienced domestic violence and abuse. The analytic aim is to map out common themes that occur when engaging with DVA as a phenomenon and working with DVA in the therapy session. This may include negotiating tensions and dilemmas, arriving at therapeutic change, as well as developing strategies for good practice.

To protect your confidentiality, pseudonyms will be used throughout and the recordings will be stored in a securely locked cabinet. After writing up the data, the recordings will be destroyed.

Resources

www.womensaid.com

www.wgn.org.uk

www.relate.org.uk

www.counselling.org

www.counselling4london.net

www.talktherapylondon.co.uk

In the event you would like to read more about these and related topics, here are several articles and books that you might find interesting.

Hollander, J. A. (2005). Challenging Despair: Teaching about women's resistance to violence. *Violence Against Women*, 11, (6) 776-791.

Nicholson, P. (2010). *Domestic violence and psychology*. London: Routledge.

Montalbano-Phelps, L. L. (2003). Discourse of Survival: Building families free of unhealthy relationships. *The Journal of Family Communication*, 3,(3) 149-177.

If you have any questions or concerns about this study – you are encouraged to contact me on:

Zoe Knight – 07748085945 or zoe.knight2@blueyonder.co.uk

Thank you very much for your participation.

Extract from Reflective Diary

05.09.2011 – after interview with Eve

Safest thing to do – I move on to the definition quickly – should have explained the safest things to do – what is the safest thing to do – who for? Client? Therapist?

What is policy?

Why doesn't she know what her responsibility is?

Social responsibility? Responsibility of CP?

"a little bit abusive" – if not comfortable with it have wide defo – why not talking about that

CP – I would try to stay safe by keeping this open – everyone has different frame of reference – is this avoidance – avoidant of it – shake things up too much

Women got there in the end – hadn't got anything to do with CP

CP – impact=responsibility – so stays quiet

"I had told them too" – not advice – hope they would do it – avoidant – me agreeing – think you are avoidant

CP – wouldn't say you don't have to put up with it – rule I only see what I want to see – I will only work with what they bring

What other rules does she have for working with abuse?

CP – "I was frightened, he came to sessions – her safety and my safety

Women come with other issues

CP "ask broad questions" – why not be specific and ask questions

CP "reflecting distress" – patronising?? Hold on to own distress??

Refer to it – sexual abuse – leave it if it doesn't come up – I haven't forgotten about it – is that ok??

Somewhat abusive?? – poke at it for them – what does she make of that – I don't know what I am talking about – I'm not experienced enough



Dr Kendra Gilbert
School of Psychology
Stratford

ETH/10/89

25 February 2013

Dear Dr Gilbert,

Application to the Research Ethics Committee: How do counsellors talk to women who have suffered male violence (Z Knight)

I advise that the University Research Ethics Committee has 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

A handwritten signature in blue ink, appearing to read 'L. Knight', is located below the 'Yours sincerely' text.

Emergent themes	Lisa interview 23.07.11	Exploratory comments
	<p>Interviewer</p> <p>1. So if you think back at, umm, cases where domestic violence and abuse has been declared... disclosed to you...</p> <p>Lisa</p> <p>2. Hmm mmm.</p> <p>Interviewer</p> <p>3. „can you tell me about the challenges you encountered...</p> <p>Lisa</p> <p>4. Hmm mmm.</p> <p>Interviewer</p> <p>5. ...and also how you negotiated these?</p> <p>Lisa</p> <p>6. Sorry, when you said disclose, do you mean like I'm the first person that person has told or</p> <p>7. do you just mean that that's part of the...the counselling?</p> <p>Interviewer</p> <p>Interviewer</p> <p>8. Yes, when they disclose it to you in your session, yeah.</p> <p>Lisa</p> <p>9. Yeah, so they're just telling me about it, okay. So the... the challenges?</p> <p>Interviewer</p> <p>10. Yeah.</p> <p>Lisa</p> <p>11. Umm, [pause] I... I think... well, straight away the challenges that... that I think of were...</p> <p>12. were...were risk, umm. I'm</p>	<p>6: CP asks for clarification of term disclose</p> <p>9: CP asks for confirmation of term disclose</p> <p>11: Cp thinks of challenges</p> <p>¶12: CP challenge – risk</p>

	<p>thinking of two quite different people now actually, umm, and</p> <p>13. in... in... in one situation there was risk to her but in the other situation the client had risk</p> <p>14. not only to herself but also she had three under age children, so she had three very very</p> <p>15. young children and this man kept coming back into her life, umm. So... so the... the</p> <p>16. challenges there were for me to create a... a... a therapeutic relationship, umm, umm,</p> <p>17. provide safety, comp... confidentiality, that kind of thing, but also protecting the children's,</p> <p>18. umm, safety. That was.... that was really difficult actually. Umm, I don't know which one</p> <p>19. I should talk about mostly but, umm... does it matter? No. Umm, [pause] I suppose one of</p> <p>20. the challenges I had, umm, apart from risk was with, umm, one woman who... there was...</p> <p>21. there was no... there were no children involved so there was no, umm, there was no fear</p> <p>22. that I... I had that I would have to break confidentiality, umm, it was just risk to her, umm,</p> <p>23. and she, you know, she's a capable adult, umm. But the... the challenge there was it was</p> <p>24. complicated by.... there was a bereavement issue, umm, there was a housing issue, umm, so</p> <p>25. it was quite complex... complex needs, I think that's it. That... that's something that both</p> <p>26. had in common, it was quite complex, umm, needs on... on... in... in dealing with two those</p> <p>27. particular clients. Umm, so it was a challenge in terms of organising therapy, umm, umm... [pause] yeah.</p>	<p>CP brings risk as the first challenge when working with dva</p> <p>¶13: CP challenge – risk The challenge of risk applies to clients</p> <p>¶14: CP challenge – risk to children Challenge of risk applies not just to clients but also to clients under age children</p> <p>¶15: CP challenge – risk to children ¶15: CP challenge – this man kept coming back into her life The risk was also to the clients children as the male partner kept coming back into the clients life</p> <p>¶16: CP challenge – creating a therapeutic relationship Challenge was to create a therapeutic relationship</p> <p>¶17: in dva cases the therapeutic goal and safety goal become intertwined The creating of a therapeutic relationship is challenging as it includes providing safety and confidentiality but also safety for the children</p> <p>¶18: in dva cases the therapeutic goal and safety goal become intertwined ¶18: CP personally marked by a case CP found this process of therapeutic relationship and safety issues mingling together difficult</p> <p>19: CP wonders which case to talk about 20: CP thinks about other challenges she had apart from risk</p> <p>¶21: CP challenge – managing risk to children Risk to children includes fear</p> <p>¶22: CP challenge – managing risk to children Risk to children includes fear that CP would have to break confidentiality to keep the children safe</p> <p>¶23: CP challenge – she's a capable adult Risk to children includes fear of having to break confidentiality but when risk is to women it's a challenge as she is a capable adult and doesn't need safeguarding in the same way</p> <p>¶24: CP challenge – dva complicated by bereavement ¶24: CP challenge – dva complicated by</p>
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	<p>Interviewer</p> <p>28. What was... what was the challenge of the risk that... that you were taking out?</p> <p>Lisa</p> <p>29. Umm, well I... I... I was extremely worried about, umm, this young woman. She was... she</p> <p>30. was in her thirties but she had three young children all under the age of, I think it was six,</p> <p>31. they were all very young kids, and she was allowing this man to keep coming back into her</p> <p>32. life, even though she'd reported him, there was a restraining order, umm. He was extremely</p> <p>33. violent towards her and had been to the children and she'd managed to get out of the</p> <p>34. relationship, umm, I think two or three times actually before she'd actually left, umm. She...</p> <p>35. she'd sort of gone out of it and then gone back and got out of it and then gone back and this</p> <p>36. time, the last time when I was</p>	<p>housing issue</p> <p>¶124: in dva cases the therapeutic goal and safety goal become intertwined CP challenge was in working with dva when other issues needed to be addressed such as where the client lived and bereavement</p> <p>¶125: CP challenge – dva clients have complex needs ¶125: in dva cases the therapeutic goal and safety goal become intertwined DVA clients have complex needs that need to be addressed that make working in therapy very complex</p> <p>¶126: CP challenge – dva clients have complex needs ¶126: in dva cases the therapeutic goal and safety goal become intertwined DVA clients have complex needs that need to be addressed that make working in therapy very complex</p> <p>¶127: CP challenge – dva clients have complex needs ¶127: in dva cases the therapeutic goal and safety goal become intertwined ¶127: dva cases affect the boundaries and goals of therapy CP found it difficult to organise therapy as dva clients had other complex needs</p> <p>¶129: CP challenge – managing risk ¶129: CP personally marked by a case ¶129: working with dva activates humanitarian emotions CP was extremely worried about a case</p> <p>30: CP describes client</p> <p>¶131: CP understanding of dva ¶131: CP views of women experiencing dva – she was allowing this man to keep coming back into her life CP was extremely worried about the safety of her client yet she kept allowing this man to keep coming back into her life</p> <p>¶132: CP understanding of dva ¶132: CP views of women experiencing dva – she was allowing this man to keep coming back into her life even though she had reported him Even though the client had reported the male partner to the police and had</p>
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	<p>seeing her was like the third or fourth time that she'd left him</p> <p>37. and on this third or fourth time she'd moved a significant distance away from this guy, umm,</p> <p>38. she'd been set up in a Council, umm, Council flat or house and then there was a</p> <p>39. neighbourhood around her, she'd made really good friends, it seemed like they were all very</p> <p>40. concerned about her, they were very supportive of her. But this guy found her, she said</p> <p>41. found, I... I don't know exactly, but she said he found her, he found her telephone number</p> <p>42. and then she... she said that he was calling her a lot and actually in one of our sessions this</p> <p>43. guy called her and she interrupted our session to go out and answer the phone. So I was</p> <p>44. really confused, you know, did she want to be with him or did she not want to be with him</p> <p>45. and... and for... for me the risk is... the risk was, if she was going to engage with this man and</p> <p>46. have a... a relationship with him, what did that mean for those children. Because the</p> <p>47. restraining order wasn't just for her, it was also for the children and I felt like it was my... my</p> <p>48. responsibility to contact somebody or let Social Services know. Also, because these kids</p> <p>49. were on the child protection register, umm. So, yeah, I mean, I'm even getting nervous just</p> <p>50. talking about it with you because I remember being extremely anxious in sessions with her</p> <p>51. because this guy kept coming back into her life, umm. So when I say managing risk, I mean</p> <p>52. the risk for those children. You know, she's going to make her own choices at the end of the</p>	<p>obtained a restraining order she kept allowing him to come back</p> <p>¶133: CP understanding of dva ¶133: CP views of women experiencing dva – she was allowing this man to keep coming back into her life even though he was extremely violent towards the children and she had managed to get out</p> <p>Not only had the male partner been violent to CP's client but also to her children and she had managed to get out</p> <p>¶134: CP understanding of dva ¶134: CP views of women experiencing dva – she was allowing this man to keep coming back into her life even though he was extremely violent towards the children and she had managed to get out</p> <p>Client had left the male partner a number of times before she had finally been able to leave him</p> <p>¶135: CP understanding of dva ¶135: CP views of women experiencing dva – she had got out of it and then gone back</p> <p>Client had left the male partner a number of times before she had finally been able to leave him</p> <p>¶136: CP understanding of dva ¶136: CP views of women experiencing dva – the last time she left was when I was seeing her</p> <p>Client had left and gone back to her partner a number of times before presenting for therapy</p> <p>¶137: CP understanding of dva ¶137: CP views of women experiencing dva – she had moved a significant distance from this guy</p> <p>Client had moved away from her partner the last time she had left</p> <p>¶138: CP understanding of dva ¶138: CP views of women experiencing dva – she had been set up in a council house</p> <p>Client had been provided with a council house in new location</p> <p>¶139: CP understanding of dva ¶139: CP views of women experiencing dva – she had a neighbourhood around</p>
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	<p>53. day, I... I didn't feel like it was my job to convince her otherwise, she had Police, she had</p> <p>54. Social Workers, I felt like my job was there to... to listen to her, to help her navigate options,</p> <p>55. to... yeah, to [laughs]... to bring what she wanted to bring, umm, and talk about managing</p> <p>56. stress and ya di ya da but for those children I felt like I had more of a responsibility, umm.</p> <p>57. So, yeah, risk, yeah. Does that... does that make sense because like they were on the child</p> <p>58. protection register and because they were known to the GP to be on the child protection</p> <p>59. register I felt like I had a duty of care to report that this man was back in their lives, even</p> <p>60. though that would have been extremely upsetting for my client, I think, because it would</p> <p>61. have meant that potentially she could have lost her children, umm, because she was letting</p> <p>62. this guy back in their lives, umm. The... the Social Worker would have found out, could have</p> <p>63. taken them out of her custody and... and she would have lost her kids, so.</p>	<p>her</p> <p>Moving to new area Client had a neighbourhood and had made some good friends</p> <p>¶140: CP understanding of dva</p> <p>¶140: CP views of women experiencing dva – she had supportive friends but this guy found her</p> <p>Despite moving to a new location and having supportive friends the clients partner found her</p> <p>¶141: CP understanding of dva</p> <p>¶141: CP views of women experiencing dva – she said he found her</p> <p>Client said her partner found her though CP is not sure about this</p> <p>¶142: CP understanding of dva</p> <p>¶142: CP views of women experiencing dva – she said he was calling a lot</p> <p>Male partner started calling her alot</p> <p>¶143: CP understanding of dva</p> <p>¶143: CP views of women experiencing dva – she answered the phone to him in our session</p> <p>Client answered the phone to her partner in one of the therapy sessions</p> <p>¶144: CP understanding of dva</p> <p>¶144: CP views of women experiencing dva – does she want to be with him or does she not</p> <p>¶144: CP challenge – does she want to be with him or does she not</p> <p>¶144: CP personally marked by case</p> <p>¶144: working with dva activates humanitarian emotions</p> <p>CP felt confused as to whether her client wanted to be with this man as she kept returning to him and then leaving</p> <p>¶145: CP understanding of dva</p> <p>¶145: CP views of women experiencing dva – does she want to be with him or does she not</p> <p>¶145: CP challenge – risk</p> <p>CP thinks there is risk involved if her client wants to engage with her partner</p> <p>¶146: CP understanding of dva</p> <p>¶146: CP views of women experiencing dva – does she want to be with him or does she not</p> <p>¶146: CP challenge – managing risk to children</p>
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	<p>CP thinks the risk involved is to the children if her client engages in a relationship with her partner</p> <p>¶147: CP understanding of dva ¶147: CP views of women experiencing dva – does she want to be with him or does she not ¶147: CP challenge – managing risk to children</p> <p>The risk was also to the children and the restraining order was also for the children</p> <p>¶148: CP challenge – managing risk to children ¶148: its my responsibility to tell social services</p> <p>The challenge is that the CP thinks it is her responsibility to tell social services if the children are at risk</p> <p>¶149: CP challenge – managing risk to children ¶149: the children were on the child protection register ¶149: CP personally marked by case ¶149: working with dva activates humanitarian emotions</p> <p>The CP is aware that these children were on the child protection register and thinks it is her responsibility to tell social services at risk. She begins to get nervous just talking about this case</p> <p>¶150: CP personally marked by case ¶150: working with dva activates humanitarian emotions</p> <p>CP recalls feeling extremely anxious about this client</p> <p>¶151: CP personally marked by case ¶151: working with dva activates humanitarian emotions</p> <p>CP recalls feeling extremely anxious about this client as the partner kept coming back into her life</p> <p>¶152: CP challenge – managing risk to children ¶152: CP views of women experiencing dva – she’s going to make her own choices at the end of the day</p> <p>Because CP thinks the client will make her own choices her sense of risk is aimed at safeguarding the children</p> <p>¶153: role of cp – its not my job to</p>
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	<p>convince her otherwise</p> <p>¶153: CP solution to dva cases the therapeutic goal and safety goal become intertwined – its not my job to convince her otherwise</p> <p>¶153: CP solution to dva cases affect the boundaries and goals of therapy CP thinks it is not her job to convince her client to do anything to ensure her own safety as she has other forms of support for this like the police</p> <p>¶154: role of cp – my role is to listen and help her navigate options</p> <p>¶154: CP solution to dva cases the therapeutic goal and safety goal become intertwined – my role is to listen and help her navigate options</p> <p>¶154: CP solution to dva cases affect the boundaries and goals of therapy CP thinks its her role to listen and help her client navigate options rather than ensure her safety as she has other forms of support for this such as her social worker</p> <p>¶155: role of cp – bring what she wants to bring</p> <p>¶155: CP solution to dva cases the therapeutic goal and safety goal become intertwined – bring what she wants to bring</p> <p>¶155: CP solution to dva cases affect the boundaries and goals of therapy CP sees her role as one of letting the client bring what she wanted to</p> <p>¶156: role of cp – talk about managing stress</p> <p>¶156: CP solution to dva cases the therapeutic goal and safety goal become intertwined – talk about managing stress</p> <p>¶156: CP solution to dva cases affect the boundaries and goals of therapy</p> <p>¶156: CP challenge – managing risk to children CP sees her role as one of taking about managing stress rather than ensuring her clients safety but felt she had more responsibility for the safety of her clients children</p> <p>¶157-58: CP challenge – managing risk to children</p>
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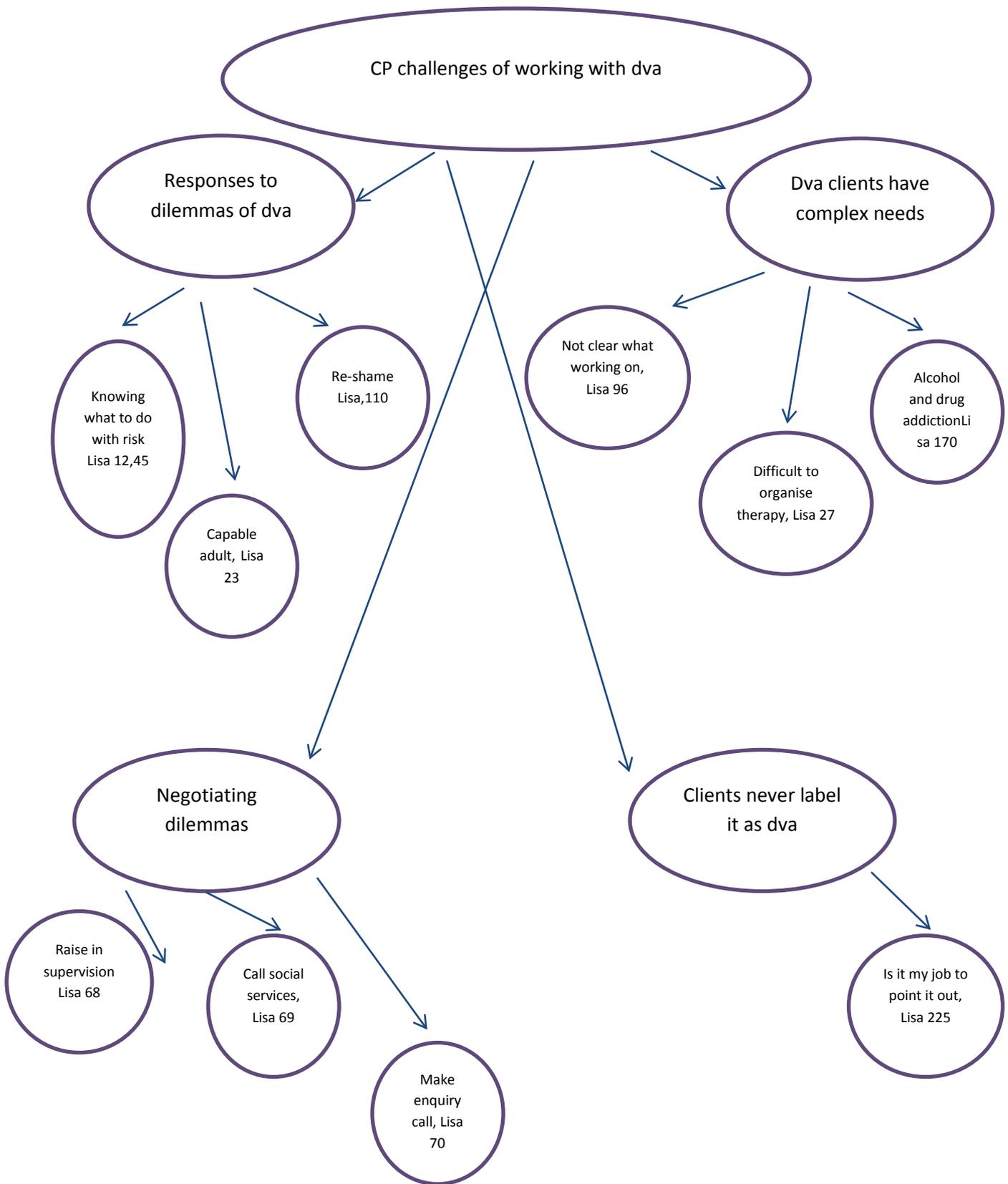
	<p>Interviewer 64. And did you do that?</p>	<p>¶157-58: they are on the child protection register and known to the gp CP thinks she has more responsibility to ensure the safety of the children as they were on the child protection register and the GP knew about this</p> <p>¶159: CP challenge – managing risk to children ¶159: I had a duty of care to report this man Because children were known to be on the child protection register CP thinks she has a duty of care to report that the clients partner was back in their lives as they may be at risk of dva</p> <p>¶160: CP challenge – managing risk to children ¶160: I had a duty of care to report this man though this would be extremely upsetting for my client Even though CP thinks she has a duty of care to report the return of the clients partner to the appropriate services she thinks this would extremely upset her client</p> <p>¶161: CP challenge – managing risk to children ¶161: I had a duty of care to report this man though this could mean potentially she could have lost her children Reporting this could have meant extremely upsetting her client as it could mean she could potentially lose her children</p> <p>¶162: CP challenge – managing risk to children ¶162: I had a duty of care to report this man though this could mean potentially she could have lost her children as the social worker would have found out Reporting this would mean social services would be informed</p> <p>¶163: CP challenge – managing risk to children ¶163: I had a duty of care to report this man though this could mean potentially her children being taken into custody Reporting this would mean potentially the children being taking into the care of social services</p>
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	<p>Lisa</p> <p>65. Umm, I reported it to the GP, umm, I said that, umm, this woman was, umm, talking to the...</p> <p>66. the ex-partner again, umm, and... and was there anything else I had to do and I... I had a</p> <p>67. really supportive GP actually and the GP said let me.... let me take care of that, umm. And I</p> <p>68. raised it in Supervision and my Supervisor said, umm, that I perhaps should have called, or</p> <p>69. call, still could call Social Services, umm. I think I did call Social Services and I spoke to, umm,</p> <p>70. the duty Social Worker just... just as a, umm, umm, an... an enquiry phone call rather than</p> <p>71. 'this is happening', umm, I made like an anonymous information phone call because I figured</p> <p>72. the GP was going to take... take over anyway, umm. So, yeah, I mean, I... I apparently did</p> <p>73. what I was supposed to do, yeah [laughs].</p> <p>Interviewer</p> <p>74. How did you know to do those things?</p> <p>Lisa</p> <p>75. Umm, [pause] doesn't everybody, I don't know [laughs]? Umm, probably because I've</p> <p>76. worked, umm, in.. in Child Services so I... I've worked... before I was, umm, working with</p> <p>77. adults I worked with young people and young people I find are the most at risk, you know,</p> <p>78. they have, umm, they have very</p>	<p>¶165: CP challenge – managing risk to children – reported it to GP CP told GP that her client was talking to her partner</p> <p>¶166: CP challenge – managing risk to children – reported it to GP and ask what else did I have to do As well as informing GP that he client was talking to her ex partner she asked what else did she have to do</p> <p>¶167: CP challenge – managing risk to children – reported it to GP and ask what else did I have to do GP was really supportive and said would take care of that</p> <p>¶168: CP challenge – managing risk to children – raise it in supervision CP also took this case to supervision</p> <p>¶169: CP challenge – managing risk to children – call social services When taking case to supervision CP was advised to call social services which she did</p> <p>¶170: CP challenge – managing risk to children – make an enquiry call to social services CP called social services and made an enquiry call to a duty social worker</p> <p>¶171: CP challenge – managing risk to children – make an anonymous information phone call CP made an anonymous phone call to social services</p> <p>¶172-73: CP challenge – managing risk to children – let the GP take over CP made an anonymous phone call to social services as she thought the GP was taking over and she thought she had done what she was supposed to do</p> <p>¶175: knowledge of professional procedures to manage risk to children CP thinks everyone would know to follow these procedures</p> <p>¶176: knowledge of professional procedures to manage risk to children came from working in children's services CP thinks working in children's services previously helped her know the way to manage risk to children</p> <p>¶177: knowledge of professional</p>
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	<p>little resources for autonomy or, umm, safeguarding, if you</p> <p>79. like, but they...they... they had a very strict protocol. Because I was working in a CAMHS</p> <p>80. service and they had a very strict protocol for how to deal with risk, umm, so... and I had</p> <p>81. a really supportive Manager as well and I just remember one time she said look, if you ever</p> <p>82. have any problems you can always call the Duty Social Worker and just ask, you don't have</p> <p>83. to say your name, you don't have to, umm, yeah... you don't have to disclose any</p> <p>84. confidential information, you can just make enquiries and, umm, they might ask you some</p> <p>85. questions but, umm, [pause]... yeah, I think... I think I just knew because I'd had... I'd worked</p> <p>86. in Social... sort of a Social Service situation with young people so I was always... I've always</p> <p>87. been very attuned to risk with young people anyway and working in... in Services with young</p> <p>88. people you're very aware of what can go wrong.</p>	<p>procedures to manage risk to children came from working in children's services</p> <p>Working in children's services CP found that children are most at risk</p> <p>¶178: knowledge of professional procedures to manage risk to children</p> <p>Children are at most risk because they have little resources or autonomy or safeguarding</p> <p>¶179: knowledge of professional procedures to manage risk to children CAMHS have strict protocols</p> <p>Working in CAMHS meant adhering to a strict protocol</p> <p>¶180: knowledge of professional procedures to manage risk to children CAMHS have strict protocols for dealing with risk</p> <p>Working in CAMHS meant adhering to a strict protocol for dealing with risk</p> <p>¶181: knowledge of professional procedures to manage risk to children – supportive manager</p> <p>CP thinks she had a supportive manager who helped her understand the procedures to manage risk with children</p> <p>¶182: knowledge of professional procedures to manage risk to children – You can always call the duty social worker and just ask</p> <p>CP's supportive manager advised her that she could always call the duty social worker and just ask</p> <p>¶183: knowledge of professional procedures to manage risk to children – You can always call the duty social worker and don't have to disclose</p> <p>CP's supportive manager advised her that she could always call the duty social worker and just ask questions without disclosing</p> <p>¶184: knowledge of professional procedures to manage risk to children – You can always call the duty social worker and don't have to disclose</p> <p>CP's supportive manager advised her that she could always call the duty social worker and just ask questions without disclosing and confidential information</p> <p>¶185-86: knowledge of professional procedures to manage risk to children –</p>
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		<p>Working in CAMHS with young people CP thinks her knowledge of managing risk with children comes from working in CAMHS services</p> <p>¶187-88: knowledge of professional procedures to manage risk to children – Working in CAMHS with young people Because of this working experience CP thinks she is very attuned to risk of young people and what can go wrong when you don't follow these protocols</p>
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Pictorial representations of themes



Possible themes - Lisa

Possible Master theme	Possible theme	Noting	Illustrative extract
<p>Theoretical dilemmas in working with dva – theoretical, philosophical, moral, professional dilemmas.</p> <p>Specificity appears in emotional context of the alliance</p> <p>Supervision needs – skilling and de-skilling</p>	<p>Knowing what to do Moral issues CP knows dilemmas</p>	<p>Knowing what to do when dva is accepted</p>	<p>171-173 173-176 23</p>
		<p>Knowing what to work on when dva is disclosed</p>	<p>191-192 188-191 194-195 195-198</p>
		<p>I could be the abuser</p>	<p>113 116-117 118-119 120 110 249-254</p>
		<p>Knowing what to do with my own beliefs</p>	<p>177-178</p>
	<p>Clinical solutions Cp finds solutions to dilemmas</p>	<p>Name the challenge</p>	<p>202-203</p>
		<p>Talk about specialist services</p>	<p>204-208 208 209-211 211-213 213-215 520-521 524-525 530-535</p>
		<p>Be timid and tentative</p>	<p>111 112 237-240</p>
		<p>Not re-shame</p>	<p>178-180 180-181 157-158</p>
		<p>Fall back on integrated model</p>	<p>255-257</p>

		Follow their lead	241 241-243 243-245 141 141-143 141-145 199-201 201-203 222
	Theoretical issues	Choice of model is repeating patterns	133-135 135-136 137-139 139 145-147
	Issues for supervision Restrictions and prescriptions in supervision associated with inescapable risk assessment	Container	294-296 296 298 298-299 301 302-303 304
		Encouraged to call social services	305-306 68-69 308-310
		Decided on model	300
Specificity of working alliance Emotional context of working alliance makes the decision process more sensitive and specific	Aspects of the client that hinder working with dva	Denial	222
Communicating with clients and language used to name dva	Avoided terms	Labels	227-230 230-231 230 404-405 406-408
		Anything client has not used	409-411 409 413-415
	Used terms	Clients language	411-413 414 413 440-442
	Connotations of victim	Hates it	419 399 399 400 401-402 403

			419 419-421 421 422 423-424 424-429 447-448
	Survivor	Empowered	439 443-448 449 448 449-452 452-453
Working with dva provokes human, humanistic and humanitarian responses Repositioning of the CP at human, humanistic, humanitarian level. Normalising human, humanistic, humanitarian responses as part of working with dva	Human	Anxiety	29 49-51 114 -115 50 328-329 332
		Empathy	390-391 382-384 384-391 370-377
		Sad	348-349 468-474
	Humanistic	Frustration	362- 366 391-392
		No empathy	366-367 379 381-382
		Confusion	41-44 380-381 351-356
		Shock	154 156-157 175-176
	Humanitarian		
Disclosure of dva affects the therapeutic goals and boundaries Impact of dva splinters main goal into two – when therapy	Safety goal and therapeutic goal become intertwined	Complex needs	11-12 13-14 14-15 20-23 23-25 25-27

becomes a holding place – issues for CP as a process			27 30-33 45-46 51-53 95-96 164-165 168-171
	Difficult to remain neutral	Challenge to relationship	16-18 391-394
		Duty of care	46-48 56 310-311 58-60 60-63 65 66-67 69-71 71-72 72-73
	Re-establish focus on therapeutic goals		
Clients difficulties with presenting problem		Got out for others	99-100 102-103 104-105
		Couldn't get on with life	107 108 108 108-109 317-319
		Can't name	167-168 307-308
		Sad	103-104
		Terrible to be in and terrible to leave	319-321 321-322 322-323 325-326 481-484 484- 488 495-501 502-505 506-513
Recommendations for practice	Working with dva	Be open	627-628
		No right or wrong	629-630 630-631 632-633 634
		Be educated to ask questions	489-491
	Training institutions	What you bring to therapeutic	575-580 581-584

		relationship	560-561 570-580 637-639 643-644
		Talk about it	636-637 563 564 641-645 645-649
	Professional bodies	Self-care	592-593 594-595 596-598 599-600 604 604-605 607 607-610 613-614 615 616-617 615
		Use peer support	602-603
	Specialist services	Links would feel supportive	541-542 542 542-543 545-546 546-551
Professional vs Personal dilemmas	Role of cp	Not to convince	53-54 323-325 568-569
		Not to challenge beliefs	246 248-249
		Let clients take the lead	223-224 54-56 340-341 342-343 368-369
	CP understanding of dva	Men are predatory	269 271 272
		More common and not just physical	264-267 149-151 151-152 285-287 267-268 277 278 279 272-273 280

			276-277 279-284
		Not just male perpetrators	270
		Is not sole purpose of therapy	189
		Repeating pattern	383-384
	Cp views on women experiencing dva	Women get something out of the relationship	313-315 333-335 353-354 335-336 96-98 429-432
		Therapy is not helpful for them	338-339 343-349

Possible themes - Lisa

Super theme	Sub theme	Theme	quote
<p>Theoretical dilemmas in working with dva –</p> <p>theoretical, philosophical, moral, professional dilemmas.</p> <p>Specificity appears in emotional context of the alliance</p> <p>Supervision needs – skilling and de-skilling</p>	<p>Knowing what to do</p> <p>Moral issues</p> <p>CP knows dilemmas</p>	<p>Knowing what to do when dva is accepted</p>	<p>This guy used to be, I don't I don't think he beat her but I think he slapped her and that was okay and pushed her and that was okay and you know that to me is not okay (laughs) 171-173</p> <p>The challenge is accepting that these women accept that as part of their normal life and you know for me that's quite shocking because I I would never accept that and I hope my friends or my family wouldn't accept that 173-176</p> <p>She's a capable adult 23</p>
		<p>Knowing what to work on when dva is disclosed</p>	<p>So when she disclosed the dv to me I think I just said that because it's a twelve, it was only a twelve, well actually it was a six session service, because there were so many this we negotiated for twelve 191-192</p> <p>When told me about it, it was just sort of as part of her xenophobia. It was kind of put put almost in there without being a big issue. So it was not her reason for</p>

			<p>coming into therapy, she wanted to deal with her inability to leave the house, she wanted to be able to walk here dog again 188-191</p> <p>So when she disclosed the domestic violence to me there were there were other things like xenophobia later the bereavement that she brought in 194-195</p> <p>She was really concerned about her relationship with her son, so she had she had lots of things that she wanted to focus on and when she disclosed the domestic violence I remember thinking you know, this is a big subject even of itself and probably at the heart of the other stuff 195-198</p>
		I could be the abuser	<p>Risk of reoffending, you know being the abuser because she'd already had twenty years of abuse 113</p> <p>Just worried about getting into that transference relationship where you repeat previous patterns, I mean she was very timid 116-117</p> <p>At the time I was very</p>

			<p>into my CBT and do this, do that and you know I was very aware that I could be repeating something there from her from her history and not wanting to do that 118-119</p> <p>The challenge in this case was the risk of repeating previous unhelpful relationships for her 120</p> <p>I think I was worried about re-shaming her, I was worried about scaring her more 110</p> <p>God, I'm hearing myself talk about it and actually maybe I could do more for these women. Because when when she did go "yeah its not like that" I could have said you know I could have said something more, I could have said "it sounds like that to me" you know. I could have, I could have been more challenging with her but then again I would start to think "am I being abusive" you know 249-254</p>
		<p>Knowing what to do with my own beliefs</p>	<p>I think a challenge working as a working with it is to be aware of myself and my beliefs about it 177-178</p>

	<p>Clinical solutions Cp finds solutions to dilemmas</p>	<p>Name the challenge</p>	<p>I said perhaps one of her challenges would be feeling safe outside of the house and if she didn't feel safe outside of the house it could be because of all the abuse in her history 202-203</p>
		<p>Talk about specialist services</p>	<p>I said because it's a short, probably because it's a short term service we could probably only focus on one or two things but the domestic violence could be a significant thing to address and there were specialist services, was she interested in any of those 204-208</p> <p>I do remember getting the flyers for her 208</p> <p>I have tons of them now. I picked them up from the, there's a local civic centre in x (town) where they have all this, you can go in and get leaflets for pretty much anything 209-211</p> <p>So I picked up on a load of these leaflets on, there's an actual provision for women about, that have experienced domestic violence so there's a specific counselling group 211-213</p>

			<p>I think they even have a safe house in x (town) as well which is quite good. So we talked about that and then I don't know what she did with it to be honest. And then, like I said, she only last another few sessions before she went 213-215</p> <p>this woman who I gave gave the leaflet to but but I've sort of said, you know, this is the information, you have to go forward with it 520-521</p> <p>I mean, I called so many services for that woman actually, I called the Substance Misuse Service, I called the Domestic Violence Service 524-525</p> <p>So when I called this, umm, I can't remember the name of it, whatever, x (town) Domestic Violence Service or something, whatever it is, when I called them to ask about this woman with the with the young children and what was available to support her, umm, they said "oh you need to get her to call us and come in" and</p>
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			and ya di ya. So it puts a lot of, I guess pressure, I mean, it puts a lot of responsibility, it puts the onus on the person to make the the, phone call, make the steps to change 530-535
		Be timid and tentative	<p>I remember being very softy softly with her, very very timid 111</p> <p>Picking up on her timidity 112</p> <p>I've been quite tentative in asking questions with people who have been in domestic violence not because I think they'd make stuff up, because, well maybe I do believe that, I don't know. No, I don't, I don't thinks its because I worry that they would create a new memory, I thinks its because I yeah maybe I don't know. 237-240</p>
		Not re-shame	<p>Maintain a sort of distance so that I'm not reoffending , recreating that abusive relationship that I'm not re-shaming them if you like 178-180</p> <p>Because I mean, I wouldn't like to disclose something to my therapist and for her to go "Oh my god,</p>

			<p>how can you live with that?" 180-181</p> <p>Be a compassionate witness and all that kind of stuff to what she's gone through 157-158</p>
		Fall back on integrated model	<p>I think I don't have a model if you like for working with this kind of client group so I really just fall to my you know fall back model which is sort of a mixture of CBT and psychodynamic and bringing things forward and challenging stuff. So its very complicated isn't it 255-257</p>
		Follow their lead	<p>I think I just follow their lead 241</p> <p>If they want to talk about it then that's what we'll talk about, if they don't want to talk about it then we don't talk about it 241-243</p> <p>But if I say something like if I make an intervention "oh that sounds pretty, pretty rough, that sounds like a bit of rough handling" and they go "oh that's" (laughs) "no it wasn't like that" then I'll follow that lead, you know. I wouldn't want to push 243-245</p> <p>I always ask for an</p>

			<p>agenda anyway 141</p> <p>I always ask at the beginning of where I usually ask at the beginning of the session “what would you like to talk about today, what would you like to focus on today”. 141-143</p> <p>So in that way it was whatever she wanted to to bring and I I felt like if she was deciding what to talk about, if it was her agenda then it was more she was empowered and she was in control of the session rather than me 141-145</p> <p>So I asked her what she wanted to focus on, again I always put it back on on the client, what did she want to focus on and she said “I want to be able to walk my dog again” 199-201</p> <p>So I said that perhaps one of her challenges would be feeling safe outside of the house and if she didn’t feel safe out outside of the house it could be because of all this abuse in her history and she said yeah, she would agree with that 201-203</p>
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			<p>I think just probably denial for myself. She was in denial of it so you know 222</p>
	<p>Theoretical issues</p>	<p>Choice of model is repeating patterns</p>	<p>I sort of got the impression straight away that CBT wouldn't be helpful to her, she was feeling very overwhelmed anyway 133-135</p> <p>But I kind of just decided not to do it, I didn't talk to her about it, I didn't say "CBT is a model that I work with, how would you feel about not working with it." 135-136</p> <p>I just kind of decided not to do CBT so in that way, I guess I was deciding what was best for her really so I guess (laughs) I was repeating the relationship anyway 137-139</p> <p>Rather than letting her tell me what she wanted I made up my mind what was best for her 139</p> <p>So even though I thought, yeah we won't do the CBT worksheets and challenging and all that kind of stuff, we still worked with some collaboration 145-147</p>

	<p>Issues for supervision Restrictions and prescriptions in supervision associated with inescapable risk assessment</p>	<p>Container</p>	<p>The first one I took to supervision quite quickly because she was just so complex, there was, there was just so much and it was quite early on in my training here as well 294-296</p> <p>My supervisor was really supportive 296</p> <p>He used to say all the same thing to me actually, he used to say "containment Lisa" 298</p> <p>What can you do in a six session or twelve session service 298-299</p> <p>He didn't tell me how to manage it he just said what can you do 301</p> <p>he also allowed me to agree an extension of the service so instead of offering her six sessions we were going to offer her twelve. So, yeah, that... that was quite useful 302-303</p> <p>because it helped me just kind of relax a little bit while I was working with her 304</p>
		<p>Encouraged to call social services</p>	<p>In the... in the second one the supervision was really about</p>

			<p>calling the Duty Social Worker and getting more information 305-306</p> <p>My supervisor said that I perhaps should have called or still could call social services 68-69</p> <p>I took that to supervision more because I was worried about the children to be honest, [pause]. 308-310</p>
		Decided on model	<p>I think that's probably why I decided I wasn't going to do CBT with her through a conversation with him 300</p>

Table 1: Working with DVA: Emerging themes

Master themes	Sub themes
Privately owned and Professional/Institutional/Public ideological tensions	<ul style="list-style-type: none"> ● Privately owned views, professional injunctions and their dilemmas, struggles and solutions ● Role of counselling psychologist ● Counselling psychologist understandings of DVA
Disclosure of domestic violence and abuse affects the therapeutic boundaries and goals	<ul style="list-style-type: none"> ● Safety goal and therapeutic goal become intertwined ● Difficult to remain neutral
Working with domestic violence and abuse provokes human, humanitarian and humanistic responses	<ul style="list-style-type: none"> ● Human feelings ● Humanistic feelings ● Humanitarian feelings
Hermeneutic repositioning master theme	<ul style="list-style-type: none"> ● Knowing what to do challenges ● Seeking solutions to knowing what to do challenges ● Knowing what to challenges: supervision as a resource