Practitioner's experiences of working with men who engaged in Intimate Partner Violence: An Interpretative Phenomenological Analysis

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Abstract

Historically, Intimate Partner Violence (IPV) has been a subject to a variety of research, mainly based on the gendered perspective of investigating women who have been victims of male perpetration. However, within the last few decades, research evidence has been suggesting that IPV can be perpetrated by both men and women. To date, these research findings have led to disagreements between feminist activists, psychologists, and other professionals in relation to definition, study, and treatment of IPV. Albeit the present controversy, there is a growing number of men presenting with difficulties around IPV in private, public, and statutory services.

The aim of the current study, thus, is to give voice to practitioners working with male clients of IPV, to learn more about their subjective experiences. Interviews were conducted with 6 participants, 2 men and 4 women. The transcripts were analysed using Interpretative Phenomenological Analysis. A total of three themes were developed; a rich account of how the gendered model of IPV led to the invalidation of male abuse was foregrounded and how this might have affected how men presented their difficulties related to IPV in therapy. Furthermore, challenges arising from personal associations of IPV were discussed, including distortions of male clients' narratives of IPV and preconceived ideas of gender. Finally, all of the participants encouraged integrative treatment models depending on each individual case of IPV, including approaches related to person-centred psychotherapy, attachment theory, and cognitive behaviour therapy (CBT).

The findings highlight the need for practitioners to pay attention to the presentation of IPV in therapy, which is linked to the threat of the stereotypical masculine self-concept in society. Also, the study supports the need for practitioners to be aware of distortions/ assumptions of IPV narratives due to personal associations with IPV. Finally, practitioners recommend integrative approaches in which the therapeutic relationship is considered as central.

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List of Abbreviations

CCV	Common Couple Violence
CTS	Conflicts Tactics Scale
IPA	Interpretative Phenomenological Analysis
IPV	Intimate Partner Violence
IT	Intimate Terrorism
MVC	Mutual Violent Control
PTSD	Post Traumatic Stress Disorder
VR	Violent Resistance

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Chapter 1

Introduction

Despite research suggesting that violence can be initiated by both men and women in intimate partnerships, gender stereotypes continue to influence practitioners working with IPV (McCarrick, 2015). Whereas female perpetrated violence is starting to be acknowledge by some, the predominant concept of IPV in society is that women are the victims and men are the perpetrators (Motz, 2008).

The first clinical encounter I have made with a woman who was violent was when I worked as an Assistant Psychologist in a female prison in Bolivia in 2004. She killed her husband. Also, we found out that she physically abused her three- year -old son in prison. Prior to meeting this woman, I imagined finding a physically big, scary and brutish woman. What I actually saw, however, was a slight, softly spoken and gentle woman, which added to my initial confusion. Her story was disturbing to confront, yet what struck me most was my own judgment of the case. When I was speaking to other professionals about her, I could see the judgment, knowingly or unknowingly echoed in their words and gestures. Therefore, I questioned how adequately we had met her needs when seeing her for psychological therapy. This experience planted a seed for my interest in the current research project, as it never really left my mind.

Years later, I chose to work for a domestic violence and abuse (DVA) team in London as one of my placements on the doctorate course in 2015. There, I worked with men who experienced IPV in heterosexual relationships for the first time. Everyone at the Domestic Violence and Abuse (DVA) team followed the gendered model of IPV and used the power and control model as a primary treatment model. This treatment model is based on men being the default perpetrators and women the

victims within an intimate partner relationship. However, this approach quickly felt limiting when working with men who experienced IPV. In addition, on further investigations, I became frustrated about the lack of research on how to work with men with IPV experiences. When consulting my colleagues, I was often met with an awkward smile, and told to just work with men as I would with a woman who experienced IPV. As much as I agreed with this approach from a humanistic perspective, I couldn’t help but realise how much of what I experienced in the therapy room with a man involved how they viewed themselves as male in society and also how it was viewed by their friends and family. It was this, which finally prompted me to formulate this research topic.

McCarrick (2015) suggested gender stereotypes influence not just the work of practitioners but also the criminal justice officers and society’s perceptions of the severity of IPV. Therefore, the polarised view of men as perpetrators and women as victims not only leaves those who do not fit into these categories with severe internal distress but also puts the safety of partners and children at risk (Motz, 2008). With an increasing number of men presenting with issues that do not fit into the dominant discourse of IPV, the idea that violence can be perpetrated by both genders in intimate relationships needs to become more public to educate both practitioners working with IPV and society as a whole. This research thesis, thus, attempts to investigate the experience of practitioners, who worked with men engaged in IPV to stimulate debate about personal, professional and public gender stereotypes in IPV and a request for further exploration of the complexities of IPV relationships.

Reflective practice is an integral part of the research process within counselling psychology. Therefore, my own assumptions but also my professional and personal experiences of working with men who experienced IPV are discussed

throughout this research project. This process has shaped my insights into the processes of how I personally perceive men who experience IPV and the way they are treated personally, professionally, and in society. Thus, this research not only has professional relevance, but also adds to my personal journey of the subject area of IPV.

Definition of Intimate Partner Violence

Various different definitions have been used to describe violence between intimate partners. However, none of them have been accepted worldwide (Flynn & Graham, 2010). Nonetheless, most definitions incorporate physical, sexual, and psychological damage caused to a partner or spouse. For instance, the UK Home Office (2016) describes IPV as an incidence (or pattern of incidents) of controlling, coercive or threatening behaviour, violence or abuse between intimate partners or family members regardless of gender or sexuality, which comprises but is not limited to psychological, physical, sexual, financial, and emotional aspects.

The different words used to describe IPV can have a metaphorical quality, which often imply the researchers' ideological perspectives (McHugh, Livingston, & Ford, 2005). For instance, "wife battering" or "wife abuse" has been in frequent use historically, which implies men causing physical damage to women within heterosexual relationships and therefore centre on victimisation of women (Azam-Ali & Naylor, 2013). The term "domestic violence and abuse" (DVA) has often been used and acknowledges not only that both men and women are being both capable of causing violence within an intimate relationship, but also incorporates other family relationships, such as between child and parent and siblings, elder abuse, or abuse by any other member of a household (Dutton, 2008).

The term "intimate partner violence" (IPV) has been used for this study as it primarily focuses on the physical, psychological, and/or sexual coercion caused between intimate partners and does not incorporate family relationships, which is why I have chosen this term for my research thesis.

Prevalence of male Intimate Partner Violence

The prevalence of IPV is one of the most controversial topics within the current literature. Results of research findings vary dramatically from each other and depend on different measures and types of samples used (Holtzworth-Munroe, 2005). What seems to be common in all of them, however, is that IPV is under-reported. Different reasons for the under-reporting include fear of retribution by the other partner (Johnson, 2010), being unwilling to admit causing violence towards partners (Henning & Holdford, 2006), different perspectives and interpretations of the violence caused between partners (Evans et al., 2016), and commonly held concepts about gender roles (Brown, 2004). The UK government publishes estimated numbers of IPV incidents on a yearly basis. However, the data are provided by the Crime Survey for England and Wales, which are limited to incidents reported to the police. Herman (2015) has shown that some men are reluctant to report IPV within heterosexual relationships, as it may be perceived as emasculating. Merely 10% of male victims report the abuse to the police (vs. 27% of women), 22 % of men will reveal the abuse to an individual working in an official position (vs. 38% of women) and ultimately only 10% of men will expose their experienced abuse to a health care professional (vs. 15% of women) (ManKind, 2014). Whilst acknowledging IPV is under-reported, one of the latest figures suggest that about 4.8% of women and 2.5% of men had experiences related to IPV in 2018 in the UK, which is equivalent to 1.2

million women and 576,00 men; this equates to a ratio of 2 female victims to every one male victim (ManKind, 2020).

Impact of violence in intimate relationships

Consequences of IPV have been well documented in the literature. Victims of IPV have stated they experience a variety of psychological and physical consequences. The psychological consequences include experiences of post-traumatic stress disorder (PTSD), low self-esteem, depression, anxiety (Bell & Naugle, 2008; Ishida et al., 2010; Straus, 2011, Woods et al., 2008), increased risk of developing difficulties related to suicidal ideation, psychological distress, and feelings of hopelessness (McLaughlin, 2012). The physical consequences of IPV mainly involve difficulties with substance misuse (Caetano et al., 2010; Jejeebhoy et al., 2010), physical injury, death (Coker et al., 2000; Lawrence et al., 2012; Van Wormer and Roberts, 2009) and an increased occurrence of somatic and chronic health difficulties (e.g., Campbell, 2002; Howard et al., 2010; Nicolaidis et al., 2004).

These findings are merely based on female victims of IPV. Hence, more research has focused on female victims and therefore these findings cannot be generalised to male victims of IPV. Although there are serious consequences for women victims of IPV which grant further attention in both research and practice, men can also suffer from serious physical and mental health consequences of IPV (e.g., Archer, 2000; Busch and Rosenberg, 2004; Hines & Dunning, 2007). For example, research which includes male victims of IPV illustrates similar physical and mental health difficulties among female and male victims (Coker et al., 2005; Hines et al., 2007; Prospero, 2007), including physical injuries ranging from burns and gunshot wounds (Duminy & Hudson, 1993) to broken bones and teeth (Cascardi et al., 1992),

suicidal ideation (Mascho & Anderson, 2009), substance misuse (Randle & Graham, 2011), being slapped, pushed, kicked, grabbed, punched, and choked (Drijber, Reijinders, and Ceelen, 2013). Research which deals with exclusively male victims of IPV suggests that men who are involved in IPV relationships can suffer from symptoms of depression, anxiety, shame, fear, anger, an increased abuse of substances, and symptoms of PTSD (Hines and Douglas, 2010a, 2012; Morse, 1995; Simonelli & Ingram, 1998). Furthermore, Drijber et al. (2013) found that male victims of IPV can experience bullying, threats, and blackmail, as well as financial harm in their abusive partner relationships. In addition, Tilbrook, Allan, & Dear (2010) have illustrated that male victims are more vulnerable to fall victim to one partner manipulating the legal and administrative systems than female victims due to the gendered perception and stereotypes of men in society (Hines, Douglas, & Berger, 2015). Thus, although research of male victimisation is still more sparse in comparison to female victimisation of IPV, research indicates that both men and women can perpetrate and suffer from consequences due to IPV. However, various studies have shown that the effects of IPV remain in total more detrimental towards women regarding severity and frequency of injuries (e.g., criminal behaviour, and/ or acts which result in emergency medical care) and the required time off from work (Archer, 2000, 2002; Coker et al., 2002; Ehrensaft, Moffitt, & Caspi, 2006; Moffitt, Robins, & Caspi, 2001; Holtzworth-Munroe, 2005).

IPV can also have devastating consequences for children, who are often referred to as the "invisible victims" of IPV (Holmes, 2013). Various studies have shown the effects of IPV on mothers can also have an influence on the quality of their ability to respond to their child and build a basic sense of security and trust, which is important in regards to how children understand, process, and cope with their own

emotions (e.g., Ahlfs-Dunn & Huth-Bocks, 2016). Furthermore, a recent study has suggested the effects on children's regulatory processes can continue well into adolescence and adulthood (Katz, Stettler, & Gurtovenko, 2016). Thus, IPV seems to be a more far-reaching issue in families and might cause a vicious cycle of generational violence.

In addition to this, IPV has also been shown to have a financial impact on the UK health care services and the criminal justice system (Walby, 2009), making it an important issue and therefore paramount on political, social and healthcare agendas. This has prompted a large amount of IPV studies, leading to different theories to understand the social phenomenon (Nicholson, 2010). However, criminal justice policies are still mainly dominated by the gendered perspective of IPV being a male perpetrated act of violence (Dutton, 2013).

Intimate Partner Violence in the context of non-heterosexual men

There is some evidence in research which shows that IPV in heterosexual and homosexual relationships are similar regarding prevalence rates, types of violence and health difficulties (Finneran & Stephenson, 2014; Seelau, Seelau, & Poorman, 2003). However, when compared to the extensive amount of research on IPV in heterosexual relationships and the methodological challenges in capturing true prevalence within same- sex relationships, little is still known about the difficulties men experience in same sex relationships (Jeffries & Ball, 2008). Therefore, Renzetti (1992) believes that for as long as stigma is attached to same- sex couple relationships, it is highly questionable if a true prevalence study is possible. For instance, in a research study to determine prevalence rates of IPV among 199 Puerto Rican men in same- sex relationships, physical violence was reported by 24 % of these men whereas

emotional violence was reported by 48% (Toro-Alfonso and Rodriguez-Madera, 2004). What was unique about these findings is that although men in this study reported that their partners have been emotionally abusive towards them, very few believed that emotional violence is part of the definition of IPV. Similarly, a few studies of male victims of female abuse also dismissed emotional violence as being part of what constitutes IPV (Levant & Kopecky, 1995; Moore & Stuart, 2005). These findings highlight the impact of both societal and cultural norms of masculinity on the constitution of IPV, which may lead to certain barriers in help- seeking behaviour, which are deemed unique to male victims of IPV in both heterosexual and same -sex relationships (e.g., Huntley, et al., 2019, 2020; McClennen, 2005). In a systematic review on help-seeking experiences for male victims of IPV, Huntley et al. (2019) has shown that one of the main barriers to help- seeking behaviours among men victims of IPV include fear of disclosure due to not wanting to be challenged about the perception of their masculinity together with the fear of being accused as the perpetrator within the IPV relationship. Therefore, Huntley et al. (2020) recommended to enhance the awareness and visibility of IPV services for male victims of IPV in order to support them more effectively (Bates, 2020; Powney & Graham-Kevan, 2019). However, there are other factors contributing to barriers of help-seeking behaviours which are unique to male victims in same- sex relationships. For example, some research studies have demonstrated that particularly gay men are less likely than heterosexual women to report or seek help for IPV (e.g., counselling or law enforcement) due to fear of heterosexism and homophobic violence (Bartholomew et al., 2008; Merrill & Wolfe, 2000). Further research suggests that male victims of IPV in same- sex relationships compensate for the stigma they feel for their sexuality by hiding their abusive relationship difficulties from others

(Renzetti, 1998). Moreover, it has been shown that internalised homophobia and self-hatred could leave male victims of IPV in same- sex relationships feeling unworthy of support from others (e.g., Roch, Morton, & Ritchie., 2010). Also, feelings of shame towards their own sexuality might make male victims of IPV in same- sex relationships avoid seeking for help as it may have to involve 'outing' their sexuality to others (Harvey et al., 2014). Effects of gender role socialisation create a barrier to help- seeking behaviours for male victims of IPV, especially myths such as 'boys will be boys' are specifically harmful as they convey the message that men cannot be victims of IPV (Walsh, 1996). In addition, research has shown that male victims of IPV anticipate similar treatment from IPV service providers as they had before, including rejection, bullying, and discrimination (Finneran & Stephenson, 2013; Harvey et al., 2014). Moreover, male abusers of IPV in same- sex relationships might take advantage and threaten the victim to expose their sexuality in a homophobic cultural environment if they threaten to leave them or report the abuse to the police, which often keeps them further in the vicious cycle of violence and abuse (Balsam & Szymanski, 2005; Harvey et al., 2014; Peterman & Dixon, 2003). Besides both intrapersonal and interpersonal barriers to help-seeking behaviours, further research suggests that IPV services lack resources for the LGBT (lesbian, gay, bisexual, and transgender) community to access their services, such as their information of IPV being mainly designed for female victims in heterosexual relationship (Bornstein et al., 2006). Although IPV has been shown to be a major factor in health-related issues for men in same- sex relationships, there is still a lack of research in this specific area, which is comparable to the lack of research about male victims of female violence. Thus, more research is required to understand the nature of IPV for male victims in same sex relationships.

Chapter 2

Different discourses of IPV: History, Controversies, and Treatment

IPV as a gendered model

Despite the evidence that men can also be victims of IPV in a heterosexual relationship and the emerging interest in research focusing on male victims of IPV, the IPV discourse in every-day life continues to take the dominant stance that IPV is mainly seen as a man gaining control over a woman using violence (Johnson and Ferraro, 2000). Why have these findings of men experiencing IPV been ignored for so long and only relatively recently been acknowledged as worthy of research?

The purpose of this literature, thus, is to explore the development of different discourses of IPV that are embedded in the specific understanding and research of this social issue. Additionally, it aims to explore the many challenges and the controversy that the different discourses have brought to our theoretical understanding of IPV and how it is approached in society, the political and legal domain, and ultimately in research and therapeutic practice. Finally, it provides a more contemporary understanding of IPV, which seeks to incorporate a more multi-dimensional understanding of psychodynamic and attachment theory (Dutton, 2008), gender inclusive treatment options, and new research domains; these provide a context for the development of the current research.

The history of IPV as a gendered model

In the early 1970s, the women's movement campaigned for recognition and reforms of IPV, and by this, aimed at the public and the government to take action against this serious social issue (Dutton, 1995). Erin Pizzey's pioneering work at the

first women's refuge in Chiswick, London, brought this difficult and controversial subject further into the public eye claiming that it is far more prevalent than previously assumed and is neither necessarily related to class nor targeted at those so-called "deserving" of IPV (Pizzey, 1974, 1979). Initial research followed soon after, mainly using the method of interviewing women in shelters and reporting high rates of male violence against women (Dobash and Dobash, 1979). These studies were conducted by the feminist activist community, which argued that the social constructionist idea of gender was the only cause for violence. According to such a worldview, women are victims of an oppressive reality, over which they have neither choice nor control over (Bograd, 1990). Hence, men gain power and control over women through the means of violence in the effort to maintain a patriarchal society (Dobash and Dobash, 1995). The understanding of IPV in research has been majorly influenced by the social constructionist view of gender in the 1970s and 1980s, and through this lens IPV is understood as male violence against female victims, and female violence as a result of defence from the male violence experienced (Dobash and Dobash, 1992). This feminist stance has transformed the public discourse of IPV, shifting from IPV being a private matter with many claiming that "it is none of my business", to a public matter by people arguing that IPV is "wrong and can be stopped or even prevented" (Worden and Carlson, 2005, pp. 45-46). As a result, IPV started to become recognised as a global problem and a violation of women's human rights, with devastating consequences to physical health and community welfare (Steinmetz and Tabenkin, 2008). Since then, it has been considered by political, legal, social, and health care settings in the UK and internationally, which has led to changes of the legal disposition of IPV, which now actively seeks to prosecute perpetrators of this type of crime (Pleck, 1987; Azam-Ali and Naylor, 2013). Furthermore, IPV research

has paved the way to developing theories of IPV and to considering specific guidelines for practitioners working with individuals having experienced IPV (Humphreys, 2007). Specialist services offering refuge and support for women are often guided by feminist ideologies, focusing their therapeutic interventions on non-blaming the female victims, empowering them by encouraging them to share their experiences of violence, and boosting their self-esteem as part of recovery work (Marecek, 1999). Research investigating the effects of follow-up programmes for abused women who have been in women's shelters has shown that this type of intervention benefitted female victims by significantly reducing their depression and anxiety rates significantly and enhancing their self-esteem and assertiveness (Tutty, 1996). Furthermore, gender specific programmes for men who have perpetrated IPV were put in place, psycho-educating them about domestic violence and abuse of women. These aimed to shift patriarchal ideas to more democratic beliefs and to help male clients to manage their sudden outbursts of anger through behavioural control (e.g. Respect, 2008). Research has shown that these interventions for men having perpetrated IPV were effective in reducing men's aggression rates towards their female partners (Stith, Rosen, and McCollum, 2008). Thus, the feminist activist movement boosting awareness of IPV had an indispensable effect on the political and legal domains of society worldwide, leading to advances in research and therapy, which was aimed to be specifically tailored for this social phenomenon (Nicolson, 2010). Therefore, it made a towering contribution to tackling intimate partner violence in society to this day and age.

Controversy in IPV research and The Conflict Tactics Scale

However helpful the feminist activist movement was for reforming IPV in society though, postmodern feminist thinking changed the concept of gender as a biological given and believed instead that gender and heteronormative gender roles are socially and culturally constructed in our language (e.g., Wittig, 1992). Furthermore, Wittig (1992) argued that traditional views of gender are preserved to maintain the concept of a man and a woman as polarised in society, which she called the heterosexual social contract. This heterosexual contract makes any changes in the perception of gender in society impossible (Wittig, 1992).

With this new postmodern feminist thinking also came changes in the way researchers thought of IPV, by criticising the argument that gender is the only cause for IPV by the end of the 1990s (Archer, 2000). At present, more than 200 studies have found that both men and women can be perpetrators of violence in intimate relationships (e.g. Straus, 2011), which has created one of the greatest debates in the history of IPV (Hamberger and Larsen, 2015). Thus, these findings demonstrated that while the feminist research community were right to portray IPV as rampant in its nature, they were asked to start acknowledging the fact that there are many types of violence in intimate relationships and that at times, both men and women can engage in various forms of violence (Kessler, Molnar, Feurer, & Appelbaum, 2001). Furthermore, it was argued that the feminist research community based their arguments of gender on their own ideologies rather than scientific evidence, which shows that both genders are capable of causing IPV in the western world (Dutton and Corvo, 2006).

The Conflict Tactics Scale (CTS) has been the most widely used strategy for studying IPV for the last 30 years (Straus, 1979; Straus, 2008) and consists of 18

items that measure three different ways to handle IPV, including reasoning, verbal aggression/psychological abuse, and physical violence, which are ranked from least severe to most severe. Research applying the CTS has shown that many people reported equal rates of violence caused in intimate relationships by both men and women (Archer, 2000; Dixon, Archer, and Graham-Kevan, 2011). Furthermore, Archer (2000) has found slightly higher rates of women's violence towards men than men's violence towards women in the western world. Conversely, reverse results have been found in more patriarchal societies, in which women are more at risk of receiving male violence. These findings have been criticised by the feminist activist research community by stating that the CTS represents "currently fashionable claims" and, thus, it completely misinterprets IPV (Dobash et al., 1992, p.83). Furthermore, it is argued that feminist researchers struggled with the interpretation of the outcomes, arguing that the categories used in the CTS could contain acts of violence that vary in their severity. Therefore, the criticism was directed at the argument that women and men disagree on the amount of violence used, implying that men usually under-report the violence caused to women.

A study discussing the under-and over-reporting in IPV has shown, however, that men and women both tend to over-report minor instances of violence and under-report more serious acts of violence (Morse, 1995). Thus, according to Dutton and Nicholls (2005), the argument over whether women and men agree on the amount of violence used in intimate relationship could be seen as invalid. Nevertheless, the feminist activist argument that the CTS merely measures the number of incidences of IPV and by this, neglects the context in which IPV takes place (e.g. motives and meanings) for violence, might be valid. In theory, Lloyd (1999) argued that if context and motivation for IPV is taken into account, then women use violence only for the

reason of self-defence. Hence, it would be seen as overly simplistic to assert that both men and women are equally violent without knowing, and more closely examining, the motivation for violence (Renzetti, 1999). In response to this, Johnson and Ferraro (2000) reviewed psychological research of IPV in the 1990s and have suggested that violence in intimate relationships cannot be understood without its social and cultural context.

Psychological research of IPV

Gender aside, Johnson and Ferraro (2000) argued that it is important to make distinctions between different types of IPV and to explore the motives for the violence caused and experienced. They labelled four different types of IPV: *intimate terrorism* (IT), *common couple violence* (CCV), *violent resistance* (VR) and *mutual violent control* (MVC). Whereas IT is based on exerting control over one partner and less likely to be of mutual nature, CCV is not connected to a common pattern of control, but has to be seen in the context of how an argument in an intimate relationship develops, in which either or both partners might use physical force towards the other or each other (Johnson, 1995). Moreover, VR refers to the victims of IPV defending themselves against a violent perpetrator and MVC involves both partners in an intimate relationship exerting control and violence. These distinctions complexify the theoretical and practical understanding of the nature of IPV in both the research world and the public by including the different causes, dynamics, and consequences of the different forms of IPV. Consequently, the researchers attempted to put an end to methodological and ideological disagreements between feminist activists and traditional psychologists (Johnson and Ferraro, 2000). However, due to fear of minimizing the importance of tackling male aggression and treating female victims of

IPV, it is understandable that emerging evidence of research displaying similar rates of female violence towards men (e.g., Archer, 2000; Jaffe, Lemon, and Poisson, 2003) have been dismissed by the feminist research community. Indeed, Yllo (2005) argued that the feminist research community of IPV has feared that with more public and professional awareness of female violence against men, the government might decide to financially cut projects fighting male aggression against women. Thus, although there is presently an increasing acknowledgement of both genders being capable of violence in an intimate partner relationship among the feminist research community, it continues to emphasise the danger of financial cuts for women's shelters. Therefore, it promotes that research of female perpetration in IPV should be conducted in a more ethical manner (Loeseke, Gelles, and Cavanaugh, 2005), with specific acknowledgment that IPV has much more severe effects on women; that IPV for women leads to more fear, more serious physical and psychological injuries and higher death rates (Straus, 2008). Therefore, this important difference still needs to be taken into consideration on the political, legal, social and health care agenda, specifically when providing services for women suffering from IPV. Conversely, dismissing female aggression towards men all together limits the theoretical and practical understanding of IPV. Hence, female aggression should not be concealed in the public debate of IPV, as much as in the political and legal domain, nor ultimately in IPV research and therapy (e.g., World Health Organization, 2006).

Concealment of gender symmetry rates in IPV

Some authors suggest that concealment has taken place to a great extent since the late 1970s and until recently (Dutton and Nicholls, 2005). For instance, Straus (2008) published an article explaining the methods used to deny any form of evidence

regarding both genders being capable of becoming perpetrators in IPV relationships. Beginning with the first method, unacceptable data of wife-to-husband violence has been concealed in surveys, in which equal rates of violence among men and women was found, e.g. in a survey conducted for the Kentucky Commission on Women (Schulman, 1979). Moreover, further denial of gender symmetry rates has taken place by simply deleting the questions about female perpetration on the CTS , such as in The Canadian National Violence against Women Survey (Johnson and Sacco, 1995) and by deliberately citing research in favour of male aggression and female victimization, including The World Health Organization report on violence (Krug, Dahlberg, Mercy, Zwi, and Lozano, 2002). Additionally, another method of denial has been to deliberately come to conclusions completely contradicting the data in research, such as stating that female violence is based on self-defence albeit data showing that merely 6.9% of the women involved in violence acted out of self-defence (De Kesserdy et al., 1997). This concealment has gone as far as researchers harassing and penalising other researchers of IPV who have published evidence of gender symmetry in perpetrating violence against their partners (Straus 2007). Furthermore, tactics were used to prevent researchers from getting funding to conduct research investigating female violence in intimate relationships (Holtzworth-Munroe, 2005).

Media denial of female perpetrated IPV and women's perspective of their own violence

While the research world has attempted to deny any form of female violence, the media also contributes to maintaining the official discourse of IPV being merely about a man beating a woman. For instance, Angelucci (2008) argued that female

abusers and male victims are not only politically incorrect, but they also don't sell well. This statement would explain why the media, or any newspaper magazine paid little attention to celebrity Kelly Bensimon giving her boyfriend a black eye and a bloody gash on the cheek. In contrast to this, exaggerated stories of men torturing and killing women partners in relationships attract huge TV audiences, despite only about 1% of couples are experiencing this form of violence (Straus, 2007). Hence, this biased media coverage further distorts the public opinion of IPV, which can only be understood in the light of cultural and social norms that include men being predominately positioned as the gender exerting violence not only in relationships, but also in crime and war zones (Straus, 2011). Indeed, cultural cognition research has found that individuals tend to reject evidence that would threaten their key values (e.g., current denial of climate change (Kahan, Jenkins-Smith, and Braman, 2011). Given the concealment of evidence that women and men are capable of partner abuse and the distortion of IPV in the media, it became even more important for some researchers to make the shift in IPV discourse (Straus, 2011). Increasingly, these researchers have made the world aware that both women and men could be capable of IPV.

Despite research and media denying female violence, an increasing amount of qualitative research has investigated women's narrative of the violence caused in intimate relationships (Fiebert, 2010). For instance, Flinck and Paavilainen (2010) interviewed 24 women who acted violently/abusively or aggressively in intimate relationship. Their findings included female participants denying their violent behaviour and merely admitting to verbal attacks, which they further minimised and showed no signs of regret. Furthermore, these women found it difficult to admit to their own violence, often justifying it as a self-defensive response to the partner and

attributing greater violence from their partners. Although they reported feeling shocked and guilty by their behaviour towards their partners, they did not identify as individuals in need of help. Therefore, the researchers suggested that the normalisation of their violent behaviour might be connected to abusive childhood relationships. Furthermore, the conclusion of this study was that more research is needed to develop appropriate interventions and professional training.

Recent shift in IPV research investigating in men with experiences of IPV

In addition to more research investigating in women being the perpetrators in IPV relationships, there has also been an increasing interest in to explore the experiences of male victims of IPV.

For instance, Hines, Brown and Dunning (2007) investigated the experiences of 190 callers to the first male help line in America. The men calling these services described similar experiences of IPV to those of women who experienced IPV. However, these men also provided some gender- specific experiences of men, stating feelings of being re-victimised by other services in favour of the gendered model, including being treated with doubt and disbelief of their story and even being accused of being perpetrator of IPV when seeking help. Migliaccio (2001) conducted a narrative study of men having experienced IPV and found that men usually refuse to seek assistance in their situation because they feel challenged in their masculine identity, which often leads them to feel ashamed and embarrassed about their circumstances. Furthermore, Hines and Douglas (2010) studied the experiences of men who have endured severe levels of IPV. The conclusions of this study were that men showed both physical and psychological damage due to the violence experienced by their female partners. The reasons for remaining in the relationship included

having invested heavily in their family, feeling committed to and in love with their partners, and at times not wanting to leave their partners due to their children. Further research has demonstrated that IPV can have devastating consequences for men, including symptoms of PTSD and depression (Hines and Douglas, 2009). In accordance with these findings, practitioners working in the field of IPV are increasingly made aware of these experiences and consequences of IPV for men. However, due to the abundance of research dealing with female victims of IPV, there is a lack of theoretical understanding of the victimization of men in IPV (Cook, 2009). This leads to misunderstandings and over- generalisations among practitioners working in the field of IPV (McCarrick, Davis-McCabe, and Hirst-Winthrop, 2016). For instance, mental health practitioners reported a lack knowledge of or training in, IPV and were unsure of how to ask about IPV (e.g., Valpied and Hegarty, 2015). Hence, professionals often apply prevention treatment for men having experienced IPV, which can have negative effects on clients seeking help (Bradbury- Jones, Taylor, Kroll, and Duncan, 2014). Currently, the most prominent treatment model for IPV is still the Duluth approach, which is based on the feminist model and therefore stresses the importance of including male patriarchy in their treatment model and focuses specifically on anger management, relational skills, and developing more adaptive thinking patterns towards violence in an intimate relationship (Walker et al., 2013). However, when looking at the literature of different understandings of IPV, this approach seems to not only be outdated and ineffective but also not suited to men who experienced IPV (Goldenson, Greaves, and Dutton, 2009). Russell (2012) argued that the gendered perspective based on male patriarchy is reductionist, as it neglects to consider all the other possible underlying factors that might be involved when an

individual is becoming violent. Hence, approaching any complex psychological difficulty merely from ideology is bound to be problematic.

Psychodynamic perspectives and attachment theory as an attempt to understand and work with male client of IPV

While the Duluth approach views IPV exclusively as normal male behaviour within patriarchal societal structures, psychodynamic-based approaches for IPV focus on the individual level in the context of family structures. These approaches, therefore, all emphasize the importance of early childhood relationships on understanding underlying psychological forces to any current human behaviours (e.g., Dutton, 2008; Sonkin, 2013).

For example, Winnicott (1978) emphasized the parental role of the mother-child relationship, in which the mother becomes 'good enough' for her child, as the child can feel sufficiently nurtured, held, and loved by her. However, this experience can be disrupted with periods of frustration and rejection, which is also held by the mother alongside periods of proximity and availability. Consequently, the individual can trust in themselves and develop a consistent sense of self-worth. These attributes have been shown to be protective factors against choosing to be in a IPV relationship (Nicholson, 2010). However, if this approach to parenting fails, uncontained feelings may lead to a damaged sense of self, which may contribute to individuals selecting potentially abusive romantic partners (Nicholson, 2010). Equally, these uncontained feelings which are associated with at times painful early life events may be unconsciously re-enacted in romantic relationships in the form of perpetrating violence (Maroda, 2009). For instance, if one partner in a romantic relationship behaves in a certain way that might trigger memories of an abusive context for the

other partner, the individual might engage in violence and abuse as a mean of acting out overwhelming feelings, such as shame and rage (Yakeley & Meloy, 2012). The individual in this case might not be aware of what their specific triggers are on a conscious level. Understanding these early experiences and the symbolic meaning of the violent act can therefore help practitioners to inform both formulation and treatment of victims and perpetrators of IPV (Yakeley & Meloy, 2012). One example of working with individuals impacted by IPV is adopting Winnicott's theories to therapeutic practice. With this approach in mind, the practitioner becomes the proxy parent that provides a safe space to investigate by 'holding' (Winnicott, 1978) and 'containing' (Bion, 1962) the client's feelings which are associated with not having felt held, contained, nurtured, and loved enough by the parental relationship in early life. This therapeutic space might provide the individuals impacted by IPV with an enhanced sense of self-worth, which in turn might hinder the individual to engage in abusive relationships. Moreover, creating a safe place for individuals who perpetrate violence by experiencing a prolonged, secure attachment to the therapist may facilitate an increased capacity to think and manage their emotions instead of acting out unconscious feelings through violent means (Bateman & Fonagy, 2006; Yakeley & Meloy, 2012).

Another example of therapeutic practice for individuals involved in IPV, which grew out of psychodynamic theories, is called attachment theory developed by Bowlby (1969); it stresses the importance of early childhood attachments in determining how individuals perceive themselves and others. Studies have found Bowlby's attachment theory to be a beneficial framework to interpret the dynamics in IPV relationships (Fonagy, 1999; Karakurt, Silver, and Keiley, 2016). At its core, attachment theory assumes an innate human need to develop relationships with

caregivers to provide proximity and protection in times of stress and to enhance survival. Repeated interactions between primary caretakers and infants manifest as internal working models, which include representations of self and others as well as on the self in relation to others (Bowlby, 1969). These internal working models can be a blueprint for how we form relationships throughout all of our lives. Depending on the quality of these early relationships, various different attachment patterns might develop (Bowlby, 1980). Bowlby suggested that a secure attachment pattern occurs when the infant is able to seek proximity and physical contact to the primary caregiver in moments of perceived threats and the primary caregiver is consistent in reciprocating these attachment behaviours. Consequently, the infant develops a sense of belonging, is increasingly able to tolerate separation and develops a positive sense of self and others. Later in adulthood, a secure attachment style has been demonstrated to be of protective nature towards mental health difficulties as well as good intimate partner relationships (Bifulco *et al*., 2002; Bates, 2020).

However, it has been hypothesised that insecure attachment patterns are developed when primary caregivers are unresponsive, uncaring and/or rejecting towards the needs of an infant or the infant experiences abuse by the primary caregiver. Infants might respond with ambivalent, disorganised or avoidant behaviour and display outbursts of anger to communicate their attachment needs to the primary caregiver with the aim of establishing connection. In this case, infants develop a negative sense of self and others and a negative sense of self in relation to others, which can lead to depression, poor social support, difficulties in intimate partner relationships and low sense of self-worth in adulthood (Bifulco et al., 2002). Later in life, individuals might be in conflict about needing and receiving love and develop a fear of not having their needs met by their romantic partners (Henderson et al., 2005).

The ambivalence together with the fear might make individuals more vulnerable to perpetrating violence and therefore, violence perpetration in IPV could be understood as a form of protest and/ or defence when attachment needs are not being met by the partner (Dutton & Corvo, 2006). Also, research has shown that being a witness to sexual abuse or being a victim of sexual abuse increases the likelihood of perpetrating IPV in adult romantic relationships (Siegel, 2003; Alexander, 2009).

However, some researchers dismiss the direct correlation between early experiences of violence and doing and/or receiving violence in later life as too simplistic, as it is not considering context, individual differences, and social factors (Kelly, 2001). Thus, it has been suggested that early abusive and/ or neglectful experiences may lead to a low self-esteem and limited repertoire to deal with uncertainty, anxiety, and fear of abandonment, which all may contribute to, however, do not necessarily cause an individual perpetrating- and/ or being victim to- IPV in adulthood (Henderson, Bartholomew, & Dutton, 1997).

Recent neuroscience research confirms that there is a relationship between an infant's first attachment patterns and adult attachment in romantic relationships (e.g., Bartholomew and Horowitz, 1991; Lothstein, 2015; Siegel, 2013; Motz, 2014). Furthermore, it has been shown that divergent attachment styles make a romantic relationship more prone to becoming abusive, especially if there is a clash of attachment needs. For instance, research has indicated a combination of a highly anxious individual (preoccupied and/or fearful) and a highly avoidant individual (dismissive) is associated with IPV by both partners (Belanger, Mathieu, Dugal, and Courchesne, 2015). In this instance, IPV could be a consequence of the need for distance and emotional separation in an avoidant individual and the need for reassurance and closeness in a preoccupied and fearful individual (Doumas, Pearson,

Elgin, and McKinley, 2008). Insecure attachment bonds in IPV relationships are maintained by its cyclical nature of periods of disconnection and reconnection with uncontained anxiety of separation and an overwhelming fear of estrangement in the future (Dutton & Painter, 1993). The insecure attachment in IPV relationships recreates this pattern by sudden outbursts of violence followed by reconnecting to make up and the fear that violent acts might happen again in the future. This cyclical nature of the insecure attachment bond in IPV relationship was compared to an elastic band that stretches away from the perpetrator but soon snaps the victims of IPV back into violence and abuse (Nicholson, 2010).

Within this school of thought, therefore, violence in intimate relationships could be understood as a dyadic context in which both individuals in the relationship are considered in relation to each other instead of the gendered unidirectional perspective advocated by the feminist paradigm.

The implication for treatment of this specific attachment-based theory for IPV revolves around working with relationship dynamics (e.g., Weiss and Marmar, 1993). It has been suggested that to create safely in the therapeutic space, the ability to feel safe is linked to the secure base provided by a secure attachment figure (Herman, 2015). Therefore, strong feelings of anger, fear, and anxiety that might stem from IPV experiences, are attempted to be explored and contained by the therapist, whose role is to hold and moderate strong feelings before they are able to be re-integrated into the client's experiences (Levy and Lemma, 2004). Through empathic discussions and genuine connection with the therapist, new relational patterns may be taken in and extended beyond the therapeutic space (Weiss and Marmar, 1993). The idea here is that the individual in therapy develops a stronger sense of autonomy, as anger, fear and anxiety decrease. With a less fragile sense of self, individuals may have built

enough internal resources be less likely to engage in future violent relationships (Nicholson, 2010).

Whereas psychodynamic concepts and attachment theories have added considerable knowledge to IPV, many researchers dismiss attachment patterns as only one potential moderator of IPV (e.g., Babcock, Roseman, Green, and Ross, 2008). The attachment perspective does not take into account the social circumstances of the individuals engaged in IPV, such as the social support available to them, which is an important factor in increasing risk of IPV. Also, it is assumed concentrating merely on the attachment patterns and relational dynamics in the therapeutic relationship can lead to so-called "victim blaming", where individuals feel responsible for developing the violence, they are experiencing in an IPV relationship (Henderson, Bartholomew, and Dutton, 1997). This poses a specific concern to affected male clients of IPV, as the heterosexist bias of a man in society already denies men any feelings of vulnerability to the extent that they always live in fear of not conforming to this perception in society (as seen in McClelland and Dutcher, 2016). Hence, Iverson, Jimenez, Harrington, and Resick (2011) suggested that both therapists and clients are responsible to widen the therapeutic encounter to various other potential factors contributing to IPV.

Recent developments have shown integrative psychotherapeutic approaches can widen the therapeutic encounter with clients related to trauma, including Wachtel's (2014) relational perspective of cyclical psychodynamics and Sensorimotor Psychotherapy (Ogden and Fisher, 2016).

Beginning with Wachtel's (2014) relational perspective called cyclical psychodynamics, this psychotherapeutic approach combines psychodynamic, cognitive-behavioral, systemic and experiential point of views and focuses on

interpersonal vicious and virtuous cycles perpetuating maladaptive patterns in current relationship, which were set in motion through childhood traumas and insecure attachment patterns. This integrative approach to attachment, therefore, focuses more on understanding the dynamics between individuals instead of attachment categories, as advocated by traditional attachment approaches to therapy (Wachtel, 2017). The goal of this psychotherapeutic approach is to attain corrective emotional experiences via the therapeutic relationship and to establish new ways of communicating with others outside the therapeutic sessions by also exploring the sociocultural world of the clients. Although there is no research to date investigating in the effectiveness of cyclical psychodynamics for affected individuals of IPV, ongoing interpersonal dynamics between two individuals in an IPV relationship have been increasingly understood within a dyadic context, in which both individuals are considered in relation to each other (e.g., Bartholomew and Horowitz, 1991).

In addition, the integrative approach called Sensorimotor Psychotherapy has been considered for clients related to trauma. This approach has psychoanalytic theoretical underpinnings in that it views trauma and attachment as central to adult psychopathology. However, it seems to also be a behavioral treatment in relation to changing bodily sensations through behavioral adjustments (Ogden and Fisher, 2016). Therefore, practitioners pay attention to both, narratives of IPV including trauma and attachment and bodily sensations of the traumatic events, such as IPV (Saakvitne, 2002). After signs of unresolved emotional, muscular, and visceral activity are observed, practitioners attempt to reorganize traumatic experiences of IPV from experiences of danger to experiences of sensations and emotions through mindfulness- based practice of dual awareness (Fisher, 2017). The purpose of this approach is to make traumatized individuals aware of their emotional distortions and

biases acquired through the traumatic experiences (Ogden and Fisher, 2016). This is a relatively new therapeutic approach to trauma and although there is no control-group based research evidence yet or any recommendation for affected male clients of IPV given, it has proven to be effective for individuals in single case studies with difficulties related to trauma, resolving symptoms and by this, increasing feelings of mastery and wellbeing (Riley, 2015)

Gender inclusive perspective, couple therapy, and the development of guidelines for working with IPV

As with the Duluth approach and the psychodynamic-based treatment models, the gender inclusive model also has implications for possible therapeutic interventions and how to approach men and women who are engaged in IPV. For instance, couple therapy has been considered for both partners in an IPV relationship (Dixon and Graham-Kevan, 2011), yet it is unclear whether couple therapy is a safe approach due to the sensitive topics that are discussed in front of the partner in sessions (Vetere and Cooper, 2003). Hence, initial assessments usually take place separately to ensure safety for all family members before the start of therapy. Although couple therapy is not recommended to couples who are physically violent towards each other, clinical trials show it works on a systematic level (couple, individual, societal and intergenerational) and is effective when treating dysfunctional relationship patterns (Lam, Fals-Stewart, and Kelly, 2009). Significant improvement have been shown in treating communication difficulties (Baucom, Sevier, Eldridge, Doss and Christensen, 2011), sexual difficulties (Clement & Schmidt, 1983), relationship complications (Cohen, O'Leary, and Foran, 2010), conflict management issues (Davidson and Horvarth, 1997) as well as other diverse concerns in IPV (Monson et al., 2012). These

findings have led to a systematic review and meta-analysis to investigate the effectiveness of couple therapy in IPV, which suggested that couple therapy could be used as an integral tool to treat situational violence in couples who do not wish to separate (Karakurt, Whiting, Van Esch, Bolen, and Calabrese, 2016).

In accordance with this, several organisations providing relationship support in England and Wales have developed their own guidelines to support practitioners working with individuals impacted by IPV. For instance, Relate Institute in the UK ran a project to trial the most safe and effective way to work with couples who are impacted by IPV (Owen et al., 2008). Researchers examined the use of Relate's specific therapeutic model that was tailored to working with IPV for a period of two years. The model included a structured interview in which the practitioners focused on the safety of the victims of IPV combined with on-going couple therapy to treat situational violence. The researchers concluded that Relate's specific therapeutic model showed evidence of safe and effective practice for individuals impacted by IPV. After these findings, all Relate centres in England and Wales adopted these guidelines. Also, other IPV specialist services in the UK adopted similar guidelines for their clients, who are both victims of perpetrators of IPV (e.g., Respect and Women's aid). In addition to this, the National Institute of Health and Clinical Excellence (NICE) designed evidence-based guidelines for health and mental health care workers in England and Wales to support individuals impacted by IPV for the first time in 2014. These guidelines have been designed for those who disclose IPV to have access to appropriate support specialist services that can assist them in process psychological, physical, and sexual harm arising from IPV. Furthermore, those guidelines have been designed with the specific target in mind to spot early

identification of violence to prevent the impact on the victims and therefore, to increase the safety of those impacted by IPV.

Working with IPV: Practitioner's Personal and Professional responses

Whereas previous qualitative research has focused on experiences of individuals impacted by IPV, relatively few research has focused on the experiences of practitioners working with those individuals impacted by IPV.

Beginning with McCann and Pearlman (1990), they suggested that practitioners are beginning to become conscious of the personal effects of working with victims of IPV. Subsequently, Sexton (1999) conceptualised the effects of IPV on professionals by reporting that exposure to emotionally taxing stories of IPV may lead to practitioners experiencing feelings akin to burnout, vicarious trauma, and effects related to countertransference; the effects of burnout include a sense of anger and ineffectiveness when working towards therapeutic goals and might lead to physical symptoms including headaches and disturbed sleep (Valent, 2002). Vicarious trauma is assumed to be a natural response to working with traumatized individuals (e.g., McCann and Pearlman, 1990; Aparicio et al., 2013) and akin to primary trauma, it is often shown in the form of painful changes to an individual's core meaning-making systems, their relationships, and their sense of safety (Barrington & Shakespeare-Finch, 2013). The impact of vicarious trauma on professionals working with trauma- related clients include changes in cognitive schemas, such as intrusive thoughts and images, nightmares, overwhelming emotional responses (Barrington & Shakespeare-Finch, 2013), disrupting personal beliefs, values, and ideas about the world, others, and themselves in a manner which is unique to the professional (McCann and Pearlman, 1990; Iqbal, 2015) and may lead to a loss of ability to

connect with the story of IPV and the emotional state of the client and therefore, causes the loss to emphasize with their clients (Sanderson, 2008; Waegemakers, Schiff, and Lane, 2019).

Finally, effects related to countertransference were referred to the impact the narrative of IPV might have on practitioners' feelings, including helplessness, frustration, vulnerability, fear and ambivalence (Sanderson, 2008). Therefore, Wellin (2007) pointed out that practitioners should explore their own assumptions throughout the therapeutic process in supervision to uncover possible collusions, which might lead to therapeutic impasses. Furthermore, it was suggested that practitioners should be encouraged to explore personal feelings, directly addressing vicarious traumatization and using a collaborative approach to also suggest self-care options (e.g., Mollon, 1989; Sommer & Cox, 2005). The importance of self-reflection for practitioners was further confirmed in relatively recent neuroscientific research, which has shown that countertransference processing helps to understand others in terms of unconscious projections from clients to practitioners (Iacoboni, 2009).

Iliffe and Steed (2000) investigated the experiences of counsellors working with female victims having experienced IPV and confirmed that practitioners working in this specific field were influenced by symptoms of vicarious trauma, burnout, and changes in their cognitive schemas. When it comes to gender, counsellors felt that they experienced changes in regard to their view on men in the world. Furthermore, working with IPV impacted on their therapeutic practice, e.g., by colluding and thus, overstepping therapeutic boundaries by offering practical support and extending sessions to allow greater discussions of practical ways to support their clients.

These findings, however, were solely based on female victims of IPV. Therefore, Hogan, Hegarty, Ward, and Dodd (2011) explored the understanding of

counsellors who had worked with male clients with experiences of IPV. Their findings included new themes such as a distinct lack of male victimization, significance of gender in the therapeutic relationship and changes in their perception of women in a modern society. Moreover, in this study they found that the counsellors discussed tensions in relation to their clinical work as well as personal effects relating to vicarious trauma. One of the main tensions was men's sense of shame and embarrassment regarding their experiences with IPV, which affected their ability to openly explore their experience in a therapeutic context. Furthermore, the counsellors described how they had to suspend their own internalised values and to avoid making assumptions and judgements towards their male clients in order to be more empathic with them, a concept which can also be noticed in more recent quantitative-based research of vicarious trauma (e.g., Adams and Riggs, 2008; Aparicio et al., 2013; Chang, Scott, and Decker, 2013). However, these outcomes are based on counsellors' experiences of working with male victims of IPV and there is a deficit of research investigating in therapists with backgrounds from different modalities and their specific experiences and challenges of working with men who have experienced IPV, to differentiate based on the therapeutic approach practitioners might be using.

For example, a study by Harway, Hansen, and Cervantes (1991) questioned family therapists, clinical psychologists, and psychotherapists about their ability to assess and feel ready to react to individuals with experiences of IPV and found that most of the practitioners felt ill-equipped to appropriately assess IPV in families and did not know how to protect their clients from harm. Also, the study by Hamel, Desmarais, Nicholls, Malley-Morrison, and Aronson (2009) has shown that professionals, such as child custody mediators, family law professionals, IPV workers, and students have a predominately gendered view which positions men as

the default perpetrators of IPV. Thus, they concluded that if child custody mediators only favour the gendered model of IPV, family court may not be acting in the best interest for children.

These research findings are solely based on the view of women as victims of IPV. The current research study, therefore, by giving practitioners a voice, aims to enable more effective treatment processes for men engaged in IPV and questions how equipped practitioners from different therapeutic modalities felt when working with affected male clients of IPV.

Research project: Relevance to Counselling Psychology and aims

Although it has been shown that Counselling Psychology has responded inadequately to difficulties related to IPV (Bell and Goodman, 2006), one of its main emphases is to work with marginalised groups of society and its aims are to contribute to individuals' rights to a fair allocation of resources (Cutts, 2013). An Interpretative Phenomenological methodology was chosen for this research study to capture a full depth and complexity of practitioners' subjective and phenomenological experiences working with affected male clients of IPV, specifically in the light of the controversy about both genders being capable of perpetrating IPV, distortions of IPV in the media, and the lack of inclusion of male victimization in the theoretical understanding of IPV. The aim of this study is to provide a distinctive contribution to the literature of IPV by examining the understanding, experiences, readiness and professional/private challenges faced by practitioners, who had experiences working with men with experiences of IPV. Therefore, the aim of the analytic process intends to map out key phenomenological factors of practitioners' experiences working with men who have experienced IPV. The analytic lens will focus on understanding of IPV, and the

challenges participants experienced in their work with men who experienced IPV and how they attempted to work with them to recommend specialist training and stimulate debate amongst practitioners about their own assumptions.

Personal reflexivity

Throughout the process of reviewing the literature, the impact of my experiences and perspectives were carefully considered and reflected on in my diary and further discussed with my supervisors.

When researching for my literature review, I realized that when it came to the concept of gender, I was driven by my first degree in Social Anthropology. I remembered the day I was finding myself in a lecture about gender study while studying Social Anthropology at the Humboldt University of Berlin in 2004. There, I was introduced to the concept of gender being socially and culturally constructed, in the way we use language, but also how we create our reality as humans, which we colour with our concepts of gender; this included norms, behaviours, and roles we associate with each gender as well as how we relate to each other. What seemed like an epiphany to me, I suddenly seem to have understood how much of my prejudice for the violent woman in prison in Bolivia could be due to the subtleties with which social and cultural concept of gender are embedded in our way we think about each other. Subsequently, I started to ask myself what purpose it serves to have these very opposing concepts of gender and what makes it difficult to see nuances of different attributes of both genders within one individual?

These questions have inspired me to reflect in depth about the divide between a man and a woman and how this might lead to difficulties for individuals who do not feel like they fully belong in one or the other category of gender. Whereas post-

modern feminist studies inspired me to reflect on the question Monique Wittig (1992) was asking herself, which is if we even need the opposing concepts of gender, I did not believe it is necessary to abolish these concepts all together. Instead, I think it is important to become aware of heteronormative concepts in society and the challenges it might bring for individuals who do fit into those categories, such as affected men of IPV. Therefore, I decided to include this social constructionist view of gender in my literature review. Also, this made me aware of how powerful all the cultural and social institutions are (e.g., the media denial of male victims of IPV) in perpetuating the gendered model in IPV and thus, how this might lead to deny men access to help when struggling from difficulties related to IPV. While this might be viewed as a bias, I wanted to illustrate the enormous impact the gendered model has on marginalised groups in society, such as affected men of IPV. This has also made me become more aware and inquisitive of my own assumptions about gender. Throughout this reflective process, I have learnt how to sit with uncertainty of not knowing and to acknowledge what was not even consciously available to me previously, which was that I also have biases based on heteronormative concepts of gender. In hindsight, I believe that this reflective space has shaped my journey of becoming both, a better reflective researcher and practitioner.

Chapter 3

Methodology

Introduction

The following chapter demonstrates my initial understanding of IPV and research interest in the qualitative approach to the research topic, which is followed by data collection, ethics, personal reflexivity and a thorough insight into data analysis.

My initial assumptions

When conducting research, it is paramount to reflect on our own assumptions that might have influenced the research process. Whereas the understandings of working with men experiencing IPV has changed in the process of this study, the initial assumptions in regard to the research topic were as following:

1. Both, men and women can be violent and abusive towards intimate partners, and this is not limited to but might also incorporate acts of self-defence.
2.
3. IPV is not static and limited to a situation but rather is complex and fluid in its nature and process.
4. Members of society tend to accept the predominant discourse of victim and perpetrator in IPV and therefore tend to believe the label perpetrator for men in an IPV context.
5. Many agencies treat men who might have experienced violence and abuse from their partners as the perpetrators in an intimate relationship.

My interest in qualitative research

Personally, I felt more drawn to qualitative research, as it seeks to reveal the complexity and multi-faceted nature of human experience, which is important given the lack of research of men who experienced IPV. Whereas there is an increasing amount of quantitative research in regard to men who experience IPV, there a relatively very few qualitative studies focusing on the depth of information about the experience of working with men who experienced IPV, which limits the understanding of this research area. Qualitative research, thus, offers an opportunity to get more of an in -depth understanding of the nature of working with affected men of IPV and might produce new knowledge regarding how to work with these men. Furthermore, qualitative research may provide therapists with a platform to voice their challenges of working with men who experienced IPV without the fear of being judged or perhaps knowingly or unknowingly silenced in supervision. Thus, this research study, seems to also be of particular importance to the social justice agenda of counselling psychology.

Design

In order to adequately examine an in-depth interpretation of the participants' subjective experiences of having worked with male victims of IPV, a qualitative approach to analysis was chosen (Willig, 2013). The bottom-up approach of qualitative research designs allows the participants' meanings of their experiences to unfold in their specific context of (IPV) while also acknowledging the significance of the researcher's active participation in the description of their lived experiences (Ponterotto, 2005).

Sampling of Participants

Due to IPA's idiographic nature aiming to provide a detailed and in-depth analysis of the data, this type of research method is using a small sample size (Smith, Flowers, and Larkin, 2009). Hence, a total of 4-10 participants was recommended as an adequate sample size for an IPA doctoral thesis, as it was argued that too many participants may diminish the complexity of the analysis needed for IPV and too few participants may lead to insufficient data (Willig, 2013). Hence, no more than 10 participants were considered for this research study.

The sampling for an IPA study is recommended to be purposive, in which participants need to be representative of the wider population and need to have experienced the phenomenon that is being explored (Landridge, 2007). In this research study, therefore, practitioners from all areas of psychotherapy, who have been working in various therapeutic services with a variety of different experiences of IPV were targeted to make the sample more representative of the wider population. The ages of the participants varied between 40 and 50 years old and there were four females and two males. However, all of them needed to have at least 2- years post qualification experiences and working one-on-one therapeutically with male clients impacted by IPV to provide richly textured information and, thus, to add more depth to the data (Willig, 2013). A total of six participants met all of the sampling criteria, which can be seen in Figure A.

Pseudonym	Age	Training	Work Place	Experiences with male client cases
Anna	47,	Counselling Psychologist	NHS-based Personality Disorder Service, Private Hospital, London	Emotional, Sexual, and Physical violence
Mark	56	Integrative Psychotherapist	Private Practice, Specialist Services for	Emotional, false allegations in

			Domestic Violence and Abuse, Devon	court, financial and physical violence
Maya	43	Clinical Psychologist	Male Prison Facility, London	Physical, sexual, and emotional violence and controlling behaviours
Jessica	48,	Integrative Psychotherapist	Domestic Violence and Abuse services, private practice, London	Emotional abuse, and controlling behaviours
Jaqueline	41	Person-centred, Counsellor	Domestic Violence and Abuse services, London	Emotional, physical and sexual violence
Rudi	59	Integrative Psychotherapist	NHS-based Personality Disorder Service, Private hospital, London	Emotional, physical, and sexual violence, controlling behaviours

Figure A- table of participants

Recruitment of Participants

Initially, participants were recruited via a poster of the study proposal being placed on the premises of private hospitals in-and around- London (See Appendix A). On this poster, the main research area was introduced to potential participants together with my contact details if they had any further questions. When potential participants came forward with interest in participating in this study and deemed to be appropriate, an email was sent to this individual with an invitation letter (Appendix D) to participate including further details of the research topic. As a limited number of participants came forward for this study, an opportunity and snowball sampling technique were applied to identify further possible participants (Coolican, 2019). If participants decided to proceed with the research process, they were fully debriefed about the procedure to participate and also had time for any further queries and possible concerns. If they decided to proceed, they were asked to sign a consent form

(Appendix C). After this, the interview location was confirmed with them, which was usually completed on the University of East London premises or when too far away, completed over Skype.

Mode of data collection

A semi-structured interview was chosen as the data collection method of this study to facilitate a flexible and open-minded setting for the participants, in which the uniqueness of their experiences is able to naturally unfold in a non-directive way (Smith, Flowers, and Larkin, 2009). The non-directive manner of the interview process facilitated rapport building between interviewer and interviewee, providing space for rich data collection and analysis. However, in order to ensure participants could speak freely about their experiences, I considered not only the possible effects of the participants' social and cultural identity on me as a researcher but also got acquainted with the participants' cultural milieu, and the status of the "interview" within this milieu (Willig, 2001). An interview schedule was prepared for this study and the interview questions were developed with both current IPV literature and research aims in mind. The list of interview questions included open- ended questions together with some prompts, which were divided into three sections (Smith et al., 2009). The first section of the interview included asking participants to talk about their understanding of IPV. The second section asked participants to reflect on their internal experiences of when men opened up about IPV and the third section asked how participants worked with men engaged in IPV and how equipped they felt professionally to work with men who experienced IPV. The interview questions were designed to facilitate conversation, rather than to direct or steer the interview in a specific direction. Moreover, it was aimed at giving the participants space to reflect

and to develop rapport between me as the interviewer and the participants as the interviewees. Therefore, the interview style was open, attempting to avoid too many disruptions with prompting participants with a lot of prepared questions. Thus, the open- ended structure of the interview enabled themes to emerge by facilitating in-depth reflections to discuss in the interview. The interviews were expected to take one hour for this research study. Interviews lasted between 40-110 minutes. All of the interviews were recorded on a dictaphone and those participants who lived outside of London, were interviewed via Skype while they were in a familiar environment, such as their homes (Levitt, Pomerville, and Surace, 2016.). The recordings were uploaded on my computer in a password protected folder. All of the interviews were subsequently deleted. Additionally, a personal journal was used to note down personal reflections of the data collection and analysis phase.

Ethics overview

Before starting the recruitment phase of this study, the ethical implications of this study were taken into consideration as a pivotal part of the research process. Part of this process was to apply to the University of East London's ethics committee (UREC) for acquiring the approval for conducting the proposed study (Appendix F). Additionally, it was important to check if further ethical clearance was required by an external organisation (e.g. Relate) as potential participants might have been part of this external organisation. Another part of the ethical implications was to sustain reflection and review of the research process in order to avoid any actions that could potentially cause harm (e.g. vicarious trauma) to either the participants or the researcher (Smith et al., 2009). This was achieved by being reflective in each step of the research process, including the recruitment processes and gaining informed

consent by participants, but also in the data collection and analysis period, which led to ethical approval (Appendix G).

Beginning with the recruitment process, a poster for this study was advertised in external organisations, including IPV and domestic violence and abuse services. Once potential participants of the study showed interest via email, an invitation letter to participate was sent to them, detailing the focus of the study, possible inclusion criteria, and research questions. This process was to ensure that potential participants acquired enough knowledge about the purpose and content of the study before the interview process. Thus, an information sheet (Appendix B) was also provided for the potential participants before conducting the semi-structured interview, comprising of information about the content and possible impact of this study, including possible phone numbers of appropriate services to approach in case they feel some levels of discomfort at any point of the research process (Hopf, 2004). Additionally, the consent form (Appendix C) provided them with the information they were allowed to terminate the research process at any time if they so wish so and that all the data would be destroyed in case of termination. Due to the potentially intrusive nature of conducting in-depth and semi-structured interview, I, as a researcher, had to be sensitive and empathic to the participants' needs throughout the research process, monitoring their well-being in the interview process and changing the interview style when needed (Cieurzo and Keitel, 1999). After the interview period, room for reflection was provided for the participants by giving them enough time to ask questions and disclose feedback about the interview process. One potential ethical concern was around gender identity and violence. For instance, some therapists might not want to attend the study due to fear that some of their cultural and social constructs of gender might be revealed to me as the researcher. Hence, in order to

protect their identity, participants were guaranteed confidentiality, with an opportunity to withdraw from the study at any point. Finally, a debriefing sheet (Appendix E) was sent to them via email with further questions to reflect on possible challenges in interview. After the interviews, the title for the current study was changed and approved (Appendix H).

Personal reflexivity

When I was recruiting my participants, I experienced some of the frustrations that many of my participants have come across in their work with male clients engaged in IPV. When I received some of the emails from private organisations, they told me that men are really rarely "the victims of IPV" and I found myself being drawn into the debate of gender symmetry in IPV, which felt frustrating. It also reflected the current reality that both services and practitioners are still holding on to the gendered model of IPV and services who accept men engaged in IPV seem rare. This only helped me to confirm my passion and dedication for this much needed research area. Personal reflections on the data analysis can be found at the end of the data analysis, in chapter 4.

Analytic Strategy

This study seeks to explore practitioners' experiences of working with men engaged in IPV. In order to explore these experiences and make sense of them, the methodology was informed by the phenomenological approach due to its philosophical enquiry of focusing on the individuals' experience of the world and the meanings attributed to these lived experiences (Willig, 2013). Kvale (1996b) states that:

> Phenomenology is interested in elucidating both which appears and the manner in which it appears. It studies the subjects' perspective of their world; attempts to describe in detail the content and structure of the subjects' consciousness, to grasp the qualitative diversity of their experiences and to explicate their essential meanings (p.53).

Based on these specific phenomenological ideas and developed within the field of psychology, the methodological approach of *Interpretative Phenomenological Analysis'*(IPA) has been considered as the most adequate approach to the proposed study (Smith et al., 2009). Especially with regard to the aim of this proposed study, IPA was applied as it intends to grasp the multiplicity of practitioners' experiences of working with male victims of IPV and the process in which they try and make sense of it. As opposed to the Cartesian method of analysis arguing that there is one true reality which is tangible, identifiable, and measurable, IPA sets itself apart from traditional psychological approaches in that it dismisses the possibility of having direct access to the lived experiences of participants in research (Willig, 2013). This epistemological understanding is based on another crucial theoretical underpinning of IPA-hermeneutics- which is the theory of interpretation (Smith et al., 2009). The German philosopher Heidegger argued that the researcher cannot remove themselves from the world in order to understand the experiences of their participants. Therefore, Heidegger proposed the idea that the researcher's subjective point of view should be taken into consideration in the analytical process of research in order to carefully distinguish between the researcher's stance and the participants' stance to the world (Smith et al., 2009). According to this "double hermeneutic" stance, the analytical part of IPA is both inherently interpretative and reflexive in its nature in that it seeks

to interpret the reality of their participants by taking into account the researchers' own perception of the world (Willig, 2001). In its critical stance though, IPA is not trying to establish rules of human behaviour on a population level, but rather focuses on the particular and thus on the concept of idiography on two different levels: one the one hand, it aspires to recognise how a particular experiential phenomenon has been understood by a particular person in a particular context; on the other hand it seeks to be particular in its depth of analysis in the sense of paying careful attention to detail. Therefore, IPA requires a small sample size, which is carefully situated and purposively selected in order to move from specific cases to careful attempts of general ideas.

In summary, the proposed study aims to explore lived experiences through a relative, contextual, and provisory lens of knowledge and knowledge production. Thus, this study is positioned within the epistemological framework of the relativist paradigm of knowledge production. The relativist paradigm dismisses the realist approach to knowledge, that there is an external world separately from our perceptions of it, and thus assumes that experience can only be examined through the individual's perception of this reality. Furthermore, this approach is more precisely akin to Roy Bhasker's theoretical framework of critical realism (Bhaskar and Hartwig, 2010), which argues that the focus of research is on the context, culture, and society of any given research and thus, not dependent on what can be empirically tested (de Souza, 2014).

Transcriptions

All of the interviews were transcribed verbatim by a transcription service. The transcription service confirmed that all information would be kept confidential and

that all of the transcripts would be deleted post transcription. The emails that included the recordings and the transcriptions were deleted once uploaded on the laptop and the transcripts were locked in a password-protected folder. The transcripts were checked by listening to interviews again and comparing with what has been written in the transcripts to ensure accuracy of transcripts, which included adding nuances, which have not been captured by transcriber (Pietkiewicz and Smith, 2014). During the review of the transcript, all of the identifying information was anonymised, and pseudo names and numbers were allocated to each participant, including Anna (1), Mark (2), Maya (3), Jessica (4), Jaqueline (5), and Rudi (6).

Process of Data Analysis

Following transcriptions, the data analysis phase of IPA included the exploration of individual and collective sense- making of the participants' experiences. The nature of IPA analysis is not prescriptive; however, in order to develop a systematic rigorous analysis of the interview data, several phases recommended by Smith et al. (2009) were used to build the framework of the data analysis, and are outlined below:

Phase 1: getting to know the interview data:

Before the process of getting to know the data was able to begin, all audio recorded interviews were listened to repeatedly, which was recommended by Smith et al. (2009) to enable me as a researcher to become immersed in the interview data, to recall the atmosphere of the interview, and remember the setting in which the interview took place. According to Smith et al. (2009), this helps the researcher to slow down and perceive the meaning behind these interviews.

Phase 2: writing notes down and witness meaning making processes

As a researcher, I noted down everything of interest, including language usage and semantic content. The descriptive comments had a phenomenological focus and were therefore intended to be close to the participants' meaning. Also, the interpretative notes aided me in understanding how and why participants had certain opinions. This part of the process requires the participant to reflect on how personal attributes of the participants, such as gender, age, social status, use of language, might have affected the rapport between the researcher and the participant (Smith et al. (2009). The language which was used was partly highlighted, as it might have related to the concepts which were discussed by the participants.

These generated initial theme clusters in relation to my research question started developing. An example of this initial theme cluster is shown below in Table 1, which tentative in nature, developed in relation to my second research questions, which encouraged participants to reflect on their internal experiences when working with male clients engaged in IPV:

Participant 6 (89-104)	Um … I guess, um, obviously, you, you can't avoid then to **relate** to it yourself on a per, when **trying to understand a client's experience**, but to some extent there's a bit of um er **transference** or some association with me	**Relate it back to oneself** when trying to empathise with a client's experience- **transference** or countertransference Brings his personal experiences into his narrative. Is he talking about his fear or awareness of vicarious

	[06:41] how you might in some sort of way **identify** with the client's experience, not necessarily in um er a direct way, but by **association** of um [07:01] think of um sort of rejection or not being fulfilled or made to [07:12] feel um er inadequate in some way or likewise um er …	trauma? Playing with some associations in his mind, giving examples of how he **identified with the client's experience** e.g. some sort of rejection or not being fulfilled or made to feel inadequate. Making it a human problem, which everyone might relate to at some point in their lives. Is he perhaps normalising the experience of the clients?

Figure 1: Example of initial noting.

Phase 3: development of possible themes and return to the narrative

When connecting my own interpretations with the words of the participants, possible patterns were clustered together and named in the participant's own words (Smith et al., 2009). At this stage, another column was added to each transcript to the right of the initial notes (Table 2). Subsequently, the identification of initial key

themes began while also attempting to not lose some of the meaning behind the participants' answers (Smith et al., 2009). I tried to return to the original transcripts after writing down possible a theme cluster to ensure the integrity of each participant and their narrative was maintained.

Participant 6 (89-104)	Um … I guess, um, obviously, you, you can't avoid then to **relate** to it yourself on a per, when **trying to understand a client's experience**, but to some extent there's a bit of um er **transference** or some association with me [06:41] how you might in some sort of way **identify** with the client's experience, not necessarily in um er a direct way, but by **association** of um [07:01] think of um sort of	**Relate it back to oneself** when trying to empathise with a client's experience- transference or association with oneself. Brings his personal experiences into his narrative Is he talking about his fear or awareness of vicarious trauma? Playing with some associations in his mind, giving examples of how he **Identified with client's experience** e.g. some sort of rejection or not being fulfilled or made to feel inadequate.Language CBT. Encouraged	Practitioners: 'can't avoid to relate it to it' Transference and countertransference and the risk of vicarious trauma

	rejection or not being fulfilled or made to [07:12] feel um er inadequate in some way or likewise um er …	practitioners to reflect if they cannot directly relate.	

Figure 2: Example of emerging theme.

Phase 4: Connections across emerging themes

In this phase, I developed a visual representation of possible themes on a piece of paper. In the process of clustering possible themes according to their similarity in meaning, lines were drawn to begin connecting possible theme clusters together. Subsequently, some themes were deleted while others were reworded to fit into another related theme cluster. Afterwards, the technique of abstraction was applied, which led to subordinate themes written down on a piece of paper. Each transcript included between 12 and 26 subordinate themes at this point of the analysis.

Phase 5: Patterns across interviews

This last stage of my analysis included developing a table of super- and sub-ordinate themes across the interviews, which were documented on a piece of paper (Smith et al., 2009). At this stage, it seemed that many of the subordinate themes could be relocated under a number of superordinate themes because they linked roughly the same topic together. For instance, *sense of embarrassment and shame,* which represented the way men presented their difficulties related to IPV was moved under the superordinate theme *"the invalidating effect of the gendered model"* and relabelled as *"disclosure of IPV affects therapeutic relationship",* as it best captured what participants in this study reported in their own words. Line numbers were recorded for each participant and put into numerical order to facilitate referring back to how many participants shared similar views.

Superordinate - Theme	Subordinate Theme	Anna (1)	Mark (2)
The invalidating effect of the gendered model	disclosure of IPV affects therapeutic relationship	1.99-1.108, 1.191-1.194, 1.249-1.256, 1.79-1.81	2.196-2.199, 2.177-2.181, 2.151-2.152, 2.104-2.107

Figure 3: Example of a superordinate and a subordinate theme with line numbers.

At this stage, I measured the frequency of my themes and often removed quotations if not shared by a certain number of participants (Smith et al., 2009). However, as this research was based on a critical realist perspective, the aim of this research study was to give every participant a chance to be heard, thus no quotations were overlooked, and notions shared by a minority of the participants are shared in the findings chapter when relevant for super-ordinate and sub-ordinate themes.

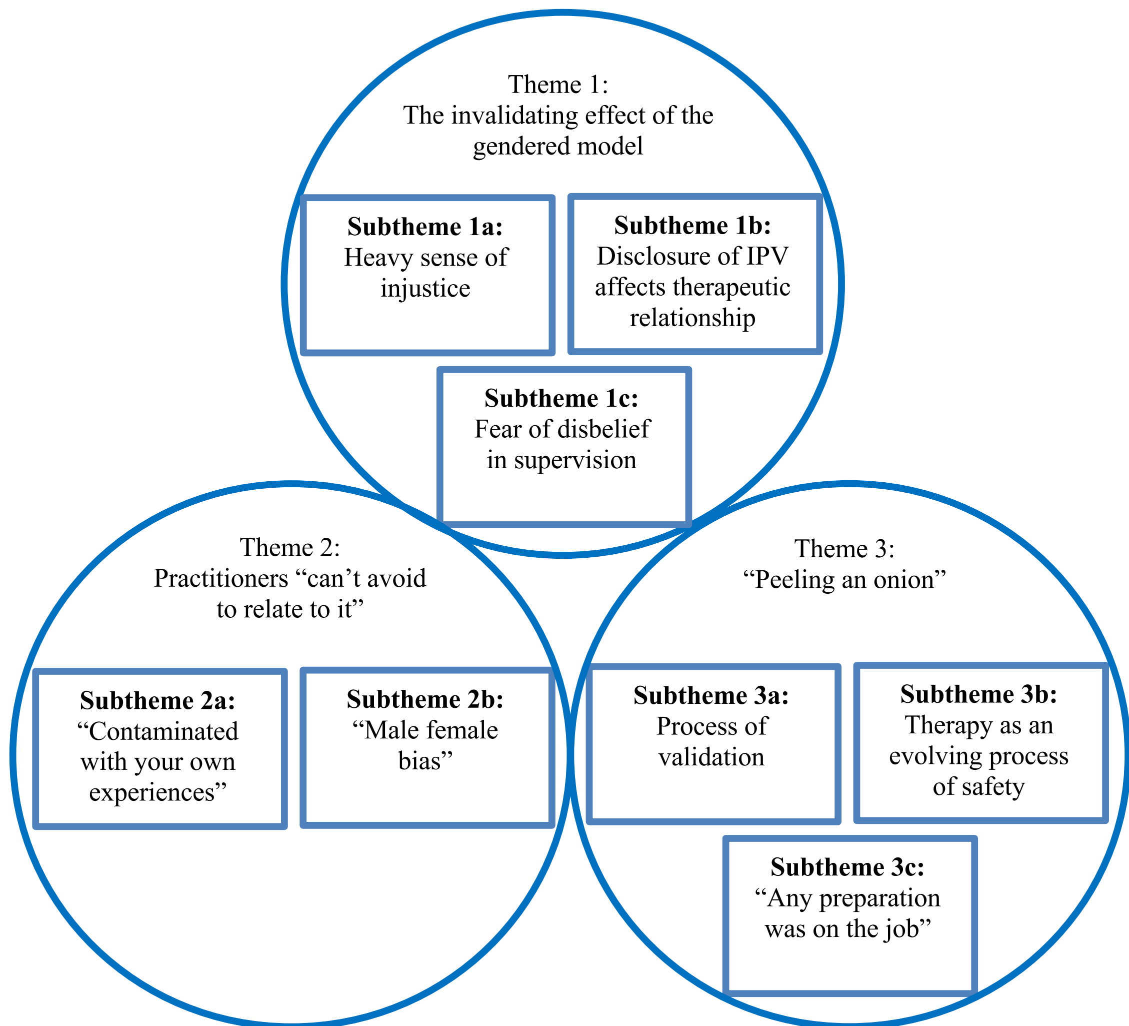
Chapter 4

Data Analysis

This chapter represents how the participants experienced working with men who engaged in IPV, by applying Interpretative Phenomenological Analysis, as outlined in the previous chapter.

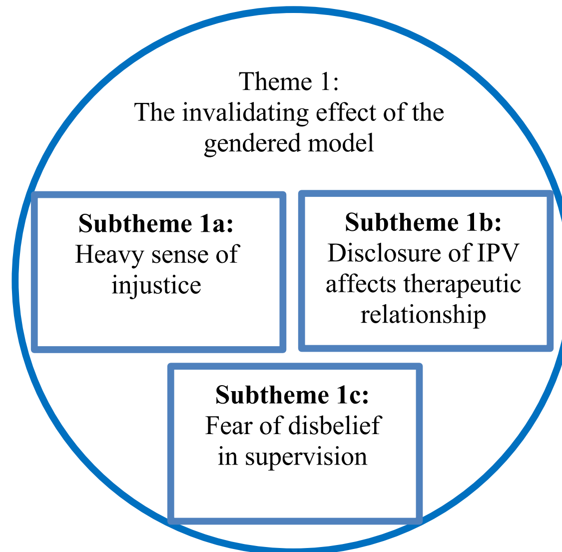
Superordinate theme 1 provides an account of how practitioners felt about the invalidating effect of the gendered model on affected men of IPV, and how this impacted the therapeutic process, and how male clients presented, in therapy, their difficulties related to IPV. In superordinate theme 2, prevalent narratives about the challenges arising from the participants' personal associations/experiences of IPV are discussed (including distortions, values, and preconceived ideas of gender) and how the participants dealt with these challenges as practitioners. Finally, the superordinate theme 3 illustrates how participants worked with men engaged in IPV and how they overcame some of the challenges experienced in the therapeutic process. Themes and subthemes are depicted in Figure 4, and this chapter ends with personal reflections on the analytic process of this research study.

Figure 4: Diagram of themes and subthemes



Superordinate theme 1: The invalidating effects of the gendered model

Figure 5: Diagram of theme 1 and subthemes



Throughout all the participants' accounts was a sense of injustice for affected male clients of IPV. Particularly, the participants highlighted experiences of male clients' expectation of disbelief, including family/friends, therapists, housing services, the police, social services, and the courts. The participants seemed to reiterate the invalidating effect of the gendered model on affected men of IPV throughout their interviews to the extent they seemed frustrated, helpless and astounded with the lack of change of this what they experienced as injustice in society. Furthermore, it seemed some participants confirmed this narrative by how this might have also affected the therapeutic relationship.

The first subtheme "heavy sense of injustice" reflects on how participants felt about the devastating consequences the gendered model had on affected men of IPV in all areas of society. The second subtheme, "disclosure affects therapeutic relationship" reflects on how participants expressed the impact the expectation of disbelief had on the male clients' presentation of their difficulties in therapy,

including being dismissive of and downplaying their IPV experience and presenting their difficulties in a humorous manner. This was linked to male clients' feelings of embarrassment and shame and associated with the threat to their male clients' stereotypical masculine self-concept in society. Some participants described how this presentation led to both male clients and practitioners avoiding talking about difficulties related to IPV. In subtheme 3 "fear of disbelief in supervision", the participants described a parallel process of fearing to be disbelieved in supervision and linked it to feelings of shame and embarrassment, which led to avoidance of reflecting on process issues.

Subordinate theme 1: Heavy sense of injustice

Throughout all the participants' account, each participant first and foremost focused on the sense of injustice they felt for what affected men of IPV face in society and how this might have silenced them, before discussing their own internal experiences of listening to their male clients' experiences of IPV. For instance, Anna explains she thinks male clients *"they are going to be disbelieved",* which is demonstrated in the first excerpt below:

> *... it's a very* ***difficult position for men****, um ... because they certainly nowadays***,** *they seem to be perceived as the ones who are violent and the ones who can do the most harm and yet, when they are the victims of anything, they don't have anybody to turn to because* their **friends laugh, their families can't believe** *that somebody who can be six foot three and fifteen stone could actually be hurt by some woman* and *… I don't know, I suppose it's, I just feel*

that they, ***they think they're going to be disbelieved*** *and* ***I think frequently they might be*** *(1.99-1.108).*

Here, Anna raises her voice when she says that it is a "*very difficult position for men",* as though to make sure her voice is heard. She explains the terrible injustice that men engaged in IPV face in society in relation to the gendered model of IPV, which perceives men as *"perpetrator"* within an IPV relationship by default. Furthermore, she stated that men's typically greater size and strength, compared to women's, leads to stereotypical perceptions about aggression and injury and for male clients to expect "*their friends laugh"* and *"their families can't believe"* their narratives about IPV. Throughout her interview, Anna seems frustrated and helpless about how widespread the gendered model of IPV has become in our society, perhaps to shine a light on the consequences it has on men who are engaged in IPV today. According to Anna and most of the participants, this leaves affected men of IPV silenced and in a vulnerable position with no social support.

In addition, Jaqueline described vividly how her male client did not expect to be believed by agencies and social services, such as housing services (5.19-5.20):

She stabbed him in his head with a dinner fork and he went to Housing and told them that the abuse was going on for some time and the Housing Officer basically made a remark um, ***"Big strapping man like you, can't you defend yourself?"*** *And he was devastated and because of that,* ***he wouldn't report it****. He wouldn't report it to the police (5.25-5.30).*

It appears Jaqueline made use of colloquial language to provide an example of how men get ridiculed and humiliated when speaking up about their devastating IPV

experiences, stating *"Big strapping man like you, can't defend yourself?"* and therefore, how embedded the gendered model of IPV is in the way we communicate with each other in society, which leads to men feeling silenced. Furthermore, Jaqueline emphasises the difficulty men face being silenced by society, by repeating "*wouldn't report it"* twice. Here, it appears her tone of voice becomes higher and louder, which emphasises how astounded and frustrated she was when it comes to the social injustice men face in society. Throughout her whole interview, Jaqueline talks passionately about the changes that need to take place in relation to perceptions towards affected men engaged in IPV. With this, she may have implied an urgency for the changes in perception that need to take place in society and consequently, changes which need to be put in place for affected male clients of IPV in social policies.

Mark reflects on similar experiences working with men engaged in IPV, however, highlights his frustration about the "*authorities*" (2.152) such as the police:

> *And one policeman had been in the police force for many years, I think he said about 30 years. He'd never encountered a male victim of domestic violence. That's because he didn't have his eyes open or his ears open. Because it's* ***not the way police view domestic situations*** *and because the* ***policeman is quite a macho job****, so he would not stand, I didn't ask him any questions, but I suspect he might say something like* ***"Well, if it was up to me, I'd show her whose boss."*** *(*2.167-2.176)

There appears to be great frustration in Mark's voice when he talks about working with one experienced policeman on IPV issues, who he expected to deny any

chance of hearing men who are being violated by women. It is as if he was arguing with this policeman while he was talking to me, repeating the word "*because*" three times, perhaps to portray his anger with the denial of men being subjected to violence and control by women. This suggests that the gendered model stands in the way of acknowledging any mistreatment of men in IPV relationships in the police force today. Moreover, Mark calls the job of a police officer a "*macho job"*, and by this, implies an attitude based on hetero normative gender roles of a men being strong and aggressive. Due to this attitude, Mark has expected the police officer he was working with to judge any men involved in IPV with *"well, if it was up to me, I'd show her whose boss".* In his interview, Mark repeatedly argues the gendered model is not only prevalent in the police environment but also in the media and child services (Children and Family Court Advisory and Support Services (CAFCAS)), which is one of the reasons he decided to become a McKenzie friend in court for his male clients affected by IPV, assisting them in their rights to see their children. It may, therefore, be the lack of belief from "*authorities*" is what drove Mark to overstep his boundaries as a therapist and become someone who takes on the role of saving the client, which is considered as unethical. This poses a concern for therapeutic treatment to both practitioners and clients alike. Mark's frustration with authorities was palpable throughout the whole interview, which repeats that men get re-abused not being believed by as he called it the "*system and the attitude he is confronted with"* (2.196-2.199). Therefore, Mark urges for a change to a more gender inclusive model of IPV in all areas of society.

Subordinate theme 1b: disclosure affects therapeutic relationship

Due to the expectation of disbelief, the majority of the participants seem to describe the many different attributes and feelings with which affected male clients of IPV present in therapy. This presentation affected the therapeutic relationship in a way that some participants felt they fall into traps of either being drawn into their clients' narrative of IPV or avoiding talking about their difficulties related to IPV all together.

For instance, Maya explains her male clients' presentation of IPV and possible reasons as to why they have presented in this particular manner:

> *Um, I suppose, typically, the people I've worked with, they have,* ***they haven't had a sense of expecting people to believe them,*** *so it's often been kind of the first venture into talking about that and, I guess, to start off with, their disclosures have been what … been quite* ***dismissive,*** *I think, perhaps as they test out the waters to whether they will be taken seriously or not, so* ***there can be a downplaying of events or a sense of embarrassment and a bit of a laugh*** *(3.67-3.74).*

Due to her extensive experience of working with men in prison for 20 years, Maya seems to speak confidently when recalling that men have not had a "*sense of expecting people to believe them"*. By making use of words such as "*dismissive*" and "*downplaying",* it appears that this presentation might be enhanced by her work environment in a male prison and perhaps relates to what is known in gender studies as the heterosexual social contract. It argues that heterosexual individuals would follow a similar thinking process of assessing whether what they are experiencing is

going to be valued, accepted, and respected by other like- minded heterosexual individuals in relation to popular beliefs, values, and ideas on IPV. This excerpt, thus, also implies how important it is for practitioners to pay careful attention to how male clients are presenting their difficulties in therapy sessions. This includes becoming aware about their dismissive behaviour towards their narrative about IPV and the way in which they are possibly downplaying violent incidences, such as presenting them as "*a bit of a laugh"*. Also, Maya describes men feeling a sense of "*embarrassment*" when presenting their IPV narratives. This implies a fear of becoming vulnerable in front of therapists and indicates the importance to pay careful attention to feelings associated with male clients' IPV stories, as it may impact on the therapeutic relationship. Throughout her interview, Maya seems to focus on the importance of defence mechanisms to protect themselves from getting in touch with overwhelming feelings of shame and embarrassment, which might have been projected onto the practitioner. Paying attention to these psychodynamic concepts might, therefore, provide a greater insight into male clients' internal worlds and help to avoid colluding with the client throughout the therapeutic process, including preventing practitioners from being drawn into being "*dismissive, downplaying or laughing alongside"* (Maya, 3.76-3.77). However, in the excerpt below, Maya discusses how "*easily"* practitioner may fall into the trap of not paying attention to male clients' stories of IPV:

> *but I can see quite easily how people could get drawn into* ***not noticing and glossing over*** *and* ***not really giving airtime to those kind of stories****, because um I think often the way the information is presented is, it's almost … presented as something that's* ***incidental*** *to other things, not, not something that needs to be explored (3.83-3.89).*

Here, it seems Maya attempts to normalise the experience of practitioners' avoidance of listening to men's experiences of IPV. It may be that this '*incidental*' presentation creates difficulty for practitioners to engage in work with male clients due to being left to believe their IPV stories may be secondary to what they have come and seek help for in in the first place. Also, when practitioners are not providing space to air their narrative of IPV, it might confirm to affected male clients of IPV that it is something which is either not important enough to consider further or should be avoided all together. It appears this avoidance by practitioners relates to the heterosexual social contract in which difficulties related to men engaged in IPV are expected to be culturally dismissed in order to preserve the traditional view of men and women as being very polarised. This, in turn, could lead to male clients avoiding opening up about their IPV experiences and a less effective therapeutic relationship with a high drop-out rate in therapy, a phenomenon which has been discussed by some of the participants in this study.

Thus, there seems to be a parallel process between how society deals with affected men of IPV, how the affected men of IPV deal with it themselves and how practitioners might respond to this. This might have to do with unconscious projections of overwhelming feelings from affected male clients of IPV onto the practitioners, which might have led to practitioners unconsciously colluding with their clients.

Furthermore, Jessica also discussed her experiences of how men present their difficulties related to IPV in therapy:

Um, with my male clients, it tends to be later and I think in terms of a ***minimisation****, there may be issues around embarrassment um…* ***or… some shame around disclosure****. So er and I think that's possibly why it may take a little bit longer for them (4.116-4.120).*

In this excerpt, Jessica hesitated and paused before she mentioned the feeling of shame as a potential social barrier for affected male clients of to open up about IPV experiences. There is a parallel between her hesitation and pause of saying shame and the delay for affected male clients of IPV to openly discuss their difficulties related to IPV. The delayed disclosure of IPV might be linked to the defence mechanism of male clients who might not even be conscious of not wanting to get in touch with overwhelming feelings of shame. Therefore, it might become paramount for practitioners to adequately discern and process feelings of shame in therapy and supervision, as it may otherwise lead to collusion between the client and the practitioners, and thus, to therapeutic impasses. Furthermore, it seems that shame might imply a sensitivity to negative social evaluation and social rejection around disclosure and might relate to the heterosexual social contract of responding to these difficult experiences. Therefore, Jessica states *"it tends to be later"* for male clients to open up about IPV experiences in comparison to women, perhaps due to the debilitating consequences it may have on the affected male clients of IPV, which may be linked to a threat to the stereotypical masculine self-concept.

In relation to this, Mark further discusses the threat to a stereotypical masculine self-concept in the excerpt below:

So, um, the ***men are reluctant to say anything*** *because of the,* ***the response they fear they will get.*** *It's also* **the image of um what it is to be a man***.*

> *There's a lot of expressions, aren't there? If a man cries in a stressful situation, you may hear comments such as **"man up", "be a man", "pull yourself together"** (*2.136-2.142).

Along the same lines as Maya's and Jessica's accounts, Mark added the notion that men are socialised to present themselves as a stereotypical image of a man in society. This usually includes being strong, stoic, and self-reliant, which is also embedded in the way people communicate towards men who seem to be defying against this image, which usually includes phrases such as *"man up"*, *"be a man"*, and *"pull yourself together"*. It appears that Mark intends to highlight how embedded this stereotypical image of a man is in our language. It seems, therefore, that Mark and the majority of the participants in this study urge for a change in the perception of IPV in the way people communicate with each other in relation to gender stereotypes. It seems, thus, that participants argue to incorporate a more gender inclusive model of gender and IPV in our everyday language.

Subordinate theme 1c: fear of disbelief in supervision

Although the majority of the participants reported the importance of supervision when working with affected male clients of IPV, some of them reported that there was a fear of disbelief in supervision. Due to the fear of disbelief, practitioners reported to avoid addressing process issues in their supervision, which was linked to feelings of shame and inadequacy.

To begin with, Anna described how unhelpful her supervision was when working with men engaged in IPV:

Yeah. Um, interestingly, because of the way my supervision was set up, I didn't find supervision very helpful for this kind of work*. Um, so I tended to actually use a colleague who did a lot of forensic work, so we could just run things past and,* ***so just sort of stepped outside my usual supervision thing****. Um,* ***it's hard to explain why it didn't feel right****, um … I think it was because, usually my supervision was very analytic and … the model I used to use mainly … It's very hard to explain now why it didn't seem to work. I'm not really sure, but it didn't, um, and* ***I think it was just a conflict of models*** *where I didn't feel it was appropriate to be pure analytic and … um … yeah, there's no reason why an understand, an analytic understanding wouldn't have helped so I actually****, I can't really put my finger on why I opted to do it the way I did,*** *but I went to somebody who had forensic experience and we worked together on it (1.323-1.342).*

Here, Anna repeatedly stated that it was "*hard to explain why it didn't feel right",* perhaps just realising the limitations of working in an environment with a single psychoanalytic approach. Instead of raising this with her supervisor, she opted instead to make an alternative supervisory arrangement with a colleague instead, who worked within a forensic setting, again stating "*I can't really put my finger on why I opted to do it the way I did".* This implies that her decision to work with an alternative supervisor was not based on conscious reasoning. However, when I prompted her further about her experience of working with her colleague as an alternative supervisor, she reported she did not think her supervisor at work would have believed her:

> *I think, because I felt, interestingly* ***because I felt this person could believe that a woman could do this, these things, and that men could be victims****, and*

> *I think it comes … interestingly a little bit, it was like it was a parallel process,* ***that I didn't think that my supervisor would believe what I was saying sometimes****, so … that's probably what it was and it, you know, it was looking* ***for somebody who was going to actually agree with what I was seeing and hearing****. I didn't want to be particularly challenged on that, that, you know, I didn't want arguments over whether I was getting it wrong or not because I knew that what I'd got. It sounds a bit arrogant now, but … um and then that just developed a pattern over the years (1.346-1.359).*

While reflecting on what was helpful about her work with the alternative supervisor, she seems to have realised it was his belief "*a woman could do this, these things, and that men could be victims"*. Here, Anna repeated "*think*" twice perhaps referring to the level of reflection she used to understand why she found her female supervisor at work unhelpful. It appears that not only did the male clients not expect to be believed, neither did the therapist who took this to supervision. This suggests there might be an unconscious projection of disbelief from her male clients on to the supervisory relationship towards her female supervisor. Furthermore, it appears that the client and also the practitioner's own ability to trust their own experiences with their clients might have been projected into the other, who then becomes unavailable to help with that. This parallel process, thus, might have created a barrier to maintaining a trusting supervisory relationship, which may in this instance have led to Anna's disengagement with her supervisor to finding an alternative supervisor instead, who was going to believe her. Moreover, she reported she felt her supervisor at work would have challenged her on presenting men who were violated by women whether she was "*getting it wrong or not"*. Furthermore, she believed her supervisor at work would have had an "*argument*" over whether she "*was getting it wrong or*

not", which suggests Anna might have unconsciously feared the same violence/retaliation from her affected male clients of IPV and therefore, not allowed to be challenged to deal with intense emotional distress she might have felt when working with male clients engaged in IPV. Moreover, it appears Anna might have misinterpreted her supervisor's questions in regard to "*if she was getting it wrong or not"* and perhaps experienced them as personal judgements on her competence as a practitioner, which she intended to withdraw from by seeking an alternative supervisor. When asked what was helpful in her experience with the alternative supervisor, Anna states in the excerpt below:

> *Um because they* ***had quite a lot of experience, um, of violence*** *and of that kind of behaviour because I think for either of us, um, for both of us, we'd worked a lot with violence, um … I don't know really what was so helpful. I think it's thinking* ***sometimes getting a man's perspective on how a man might, you know, reaction of a man****. That's probably the main bit of it and just sort of running past what I was doing and thinking about whether there was anything, what else could I do or things like that. Um … I guess, yeah' (1.366-1.382).*

Here, Anna repeats "*violence*" twice, perhaps highlighting the violence of the initial supervisor's feared disbelief. Also, Anna found that getting a man's perspective on how *"a man might, you know, reaction of a man"* helpful, which suggests she believes the male gender played an important role in their supervisory relationship, as she might have unconsciously feared the retaliation by her female supervisor. In addition, she reported "*running past"* what she was "*doing*" and asking the supervisor "*whether there was anything else I can do"* was also helpful. Here, Anna repeated

"do/doing" twice in relation to her practice, which suggests she was insecure about her therapeutic approach towards her male clients and wanted to improve her skills in '*doing*' to the client as opposed to being with the client/ staying present with the client's feelings. Her focus on "*doing*" to the client, therefore, might be a defensive mechanism to focus on what she does well as opposed to what she does not do well, which may trigger feelings of inadequacy. During her interview, Anna reveals her thought processes of a protective caregiver, who wants to rescue her male clients engaged in IPV from *"getting thinner and thinner"* and further argues that she lost track of being a therapist by becoming *"nosy"* and asking him what he was eating. Additionally, Anna has felt a *"helplessness and hopelessness"* (2:301-2: 302) between her and the client and by this might be alluding to the lack of resources or help from either the NHS or other services. It appears these feelings of "*helplessness and hopelessness"* might be connected to feelings of inadequacy, which she has therefore attempted to withdraw from by focusing on more tangible issues instead, such as addressing her client's eating difficulties. Also, it is assumed that she might have avoided to explore her feelings in supervision, causing collusions between her and her male client by wanting to know more about his story of *'getting thinner and thinner',* which might have led to the therapeutic impasse of avoiding her supervisor and getting advice from another supervisor instead.

Rudi had also not found supervision helpful. However, he seems to have reflected differently on the dynamics within the supervisory relationship:

> *Um, but, of course, in truth, um, although I'm saying those are the things we should do, um, often* ***there's a degree of embarrassment er if not shame*** *attached to acknowledging that, so often they may not be spoken about. I*

wouldn't say all this, you wouldn't take it to supervision. I mean, I happen to have definitely on one or two occasions I can think of, but um I can also acknowledge sometimes ***probably I wouldn't talk about it in certain supervision settings*** *(6.254-6.264).*

Here, Rudi describes feelings of "*embarrassment er if not shame"* attached to issues related to working with men engaged in IPV, which might lead to practitioners' reluctance to talking about these in supervision. In his career as an integrative psychotherapist and a supervisor to practitioners for over 25 years, Rudi reported he came across a lot of professionals in the field of trauma. These professionals seemed to be in a dilemma about what they should be taking to supervision and what happens in reality, which is often an avoidance of talking about difficult feelings, including shame around sexuality. Here, it appears that there is a parallel process between the affected male clients of IPV feelings of shame and avoidance of talking about it in therapy, and the practitioners' feelings of shame and the avoidance of talking about it in supervision.

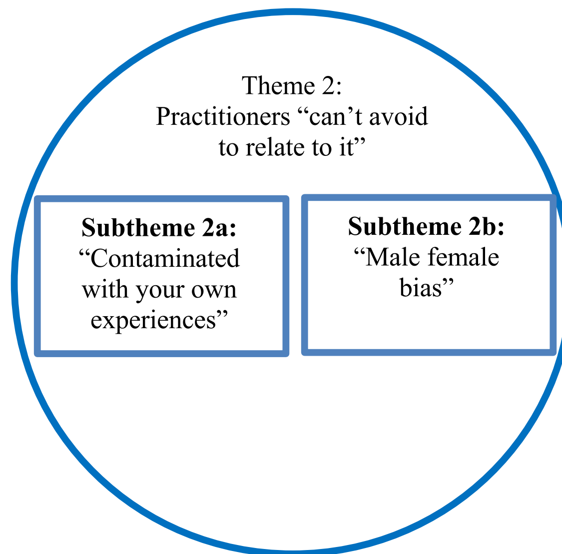
However, I was left wondering what he meant by "*certain supervisory settings"* and prompted him to further explain in the excerpt below:

Um … I think … I think I had the sup… er experience of ***the supervisor sort of shutting it down*** *maybe a bit more that I would, I would have been prepared to talk more, but I think my supervisor was sort of shut it down as being oh well,* ***that's understandable, um, you know, let's move on sort of thing****. (6.277-6.282).*

In this excerpt, Rudi talks about his experience of one of his supervisors "*shutting it down"* when wanting to talk about his difficulties around feelings of shame, which suggests Rudi criticises the supervisor for not providing a space in which feelings of shame could be identified, acknowledged, and processed. This indicates that his supervisor might have struggled in identifying his own shame, thereby allowing Rudi to carry the burden of shame by himself. This demonstrates that both practitioners and supervisors might be experiencing a desire to feel competent as they attempting to balance their many positions as mentor, teacher, and evaluator. In relation to that, Rudi states in a raised voice that his supervisor failed to connect emotionally to him, by stating *"the supervisor shut it down as being oh well, that is understandable, um, you know, let's move on sort of thing"*. Here, it appears that supervisee and supervisor failed to connect emotionally and therefore, it is suggested Rudi and some of the other participants in this study might have not felt ready to reflect on personal associations/ experiences and value judgements in supervision as something more integral to their professional learning and personal growth as reflective practitioners.

Superordinate theme 2: Practitioners "can't avoid to relate to it"

Figure 6: Diagram of theme 2 and subthemes



All the participants alluded to personal associations/experiences with male clients' experiences of IPV. However, the way in which they experienced and reflected on these personal associations/experiences varied, including using transference and countertransference and/or reflecting on relationship dynamics in their personal lives. Furthermore, many participants discussed challenges arising from their personal associations/experiences of IPV, including distortions, values, and preconceived ideas of gender and how they dealt with these challenges as practitioners.

To begin with, Rudi describes his process of relating to his male clients' experiences of IPV "*not necessarily in a direct way, but by association*".

> *Um…I guess, um, obviously,* ***you can't avoid then to relate to it yourself*** *on a per, when trying to understand a client's experience, but to some extent there is a bit of um er* ***transference or some association with me****, how you might in*

some sort of way identify with the client's experience, not necessarily in a direct way, ***but by association*** *of um think of um sort of rejection or not being fulfilled or made to feel um er inadequate or likewise um er…er being used in some way'*

(6.89-6.98).

Here, Rudi displays his internal process of listening to men engaged in IPV to clarify his awareness of possible redirection of feelings from clients on to the practitioner or possible associative feelings of the practitioner when listening to client engaged in IPV, which seems to relate to the psychodynamic concepts of transference and countertransference. This excerpt, therefore, suggests the importance of the practitioner taking a step back while doing the therapeutic work with affected male clients and reflecting on the use of self while remaining in the experience itself. Afterwards, Rudi pauses and hesitates at first, but then shares a specific example of how he was able to "*identify"* with the clients' narrative of IPV in an associative manner. It appears that Rudi provided an insight into his reflective thought processes as if he was playing with some of these associations in his mind. With this process, it is suggested Rudi might have attempted to normalise the associations with IPV; such a process might create more space for practitioners to relate to their clients' experiences of IPV and might develop more empathy for their male clients. Throughout his entire interview, Rudi repeatedly highlighted the importance of perceiving yourself "*in terms of self-identity and trying to associate that with what is being described*" (6.142-144) by clients, as it may impact on the self and the therapeutic relationship. Perhaps Rudi's reflections may be a useful guide, as according to almost all of the participants in this study, self-reflective practice was

described as a specifically powerful tool to understand male clients engaged in IPV and to deepen therapeutic relationships.

Similarly, throughout her interview, Jessica also explains the importance of self-reflective practice when working with male clients; she describes how in most of her male cases of IPV, the clients displayed difficulties around emotional abuse and control, which led her to reflect on her own behaviour in her own personal relationships:

> *Well, well, it is interesting um…not many have actually disclosed physical abuse. It tends to be more emotional um or issues around control. So, and I think that has made,* ***that has made me really look at myself*** *and I think, you know, with most guys sometimes the issues that come up,* ***you do reflect on your own behaviour*** *as well and I think that had made me look at my own behaviour and sometimes, I, I have seen how this can happen um. So…you know, where you have um a relationship and I think where, where your partner might be…not quite, you know, willing to be able to, in terms of some of the* ***power dynamics*** *um, will, will* ***give over a certain amount of control to the other partner*** *um and how that can actually be* ***abused*** *sometimes. So it's, it's… I think because of the complexities and sometimes it can be very subtle (4.125-4.138).*

Here, Jessica seems to have associated the experience of men engaged in IPV with her own difficulties in her intimate relationships. It appears this might be related to female-to-male heterosexual power dynamics; this implied her belief in the concept of one being the dominant and the other being the subordinate partner. When talking

about "*power dynamics"* in relationships, therefore, Jessica may have alluded to how women might abuse the common myth all women are meant to remain as the only default victim of violence. Hence, this suggests Jessica associated herself with women who learned to abuse this privileged victim role common in many societies worldwide to the extent that men perhaps end up discrediting their own experiences of being violated by women. In her interview, Jessica states she was working in an environment in which it is believed women are the victims and men are the perpetrators in a patriarchal society. However, working with men who experienced IPV within a heterosexual relationship seems to have made her more "*objective*" (4.35) and opened her eyes to "*complexities"* (4.48) of relationship difficulties. Throughout the interview, Jessica questions her own gendered beliefs through this experience by stating it is *"too simplistic and I think also we need to look at issues around dynamics in relationships"* (Jessica, 4.63-4.65). It appears that her reflections on her own relationship dynamics contributed to her shift of focus in therapy, away from victimising women and towards investigating relationship dynamics.

However, from this excerpt and my personal reflections in my journal, it seems the majority of the participants believe in the positivist concept of an "*objective*" reality, in which their own personal reality "*contaminates*" the objectivity of the practitioners' omnipotent stance towards their clients and practitioners become "*biased*" by their own concepts of gender. This will be further demonstrated in two subordinate themes, *"the contact being contaminated with own experiences"* and *"male female bias"*.

Subordinate theme 2a: "contaminated with your own experiences"

All of the participants recalled how their personal associations/ experiences of IPV when listening to men engaged in IPV might have led them to distort/assume and judge what was being explored in the therapeutic space by what one of the participants called " *contaminated with your own experiences"*; this implies something potentially hazardous impacting on the therapeutic relationship and alluded to the risk of vicarious trauma. Also, some of the participants reflect on possible challenges it brought to therapy and provided suggestions of how to deal with these challenges.

To begin with, Mark discusses his personal experience with IPV and with it, voices his frustration at the lack of support services available for men engaged in IPV. During his interview, he speaks passionately about supporting men, who go through IPV. When asked about what his experience of listening to men engaged in IPV was like for him, he highlights the importance of empathy:

> *So, coming back to answer your question, it does, I do find it, um…I do find it er…it is very familiar story.* ***I do empathise, realising that it is not my problem****. My problem was a few years ago now, well years ago now. So my problem is in the past.* ***What I am listening to is a similar situation, not my situation****. And I often think, 'Oh I have heard this before. Same story'. So as well as my experiences coming in, it is the stories I have heard from previous callers as well. Oh, here we go again. Same story again.* ***This poor bloke****. I know what he is going to, I know what he is going to be up against (2.309-2.312).*

Here, Mark seems to hesitate to answer first by repeating himself, saying "*I do find"*. This suggests he needed to confirm to himself the importance of distinguishing between his personal experience with IPV and the experiences of his male clients engaged in IPV: understanding the feelings of the clients engaged in IPV without directly sharing their feelings, by stating "*realising it is not my problem"*. Furthermore, Mark seems to have reflected on his personal experiences of IPV, which are in his "*past*", as if to suggest he processed his difficulties by stating *"What I am listening to is a similar situation, not my situation"*. Subsequently, he illustrates how his personal experiences of IPV are not unique to him but actually common to lots of other men engaged in IPV, by stating "*Oh here we go again. Same story again*". This suggests he seems to relate to the familiarity of such issues for so many men and by repeating "*same story"*, he may have wanted to highlight to similar frustration these "*poor*" men are "*going to be up against"*. Furthermore, it is suggested that Mark might have aligned with his clients' experiences by stating "same story". Therefore, it is suggested that Mark was not able to provide his affected male clients of IPV with the space to explore their own subjective experiences. In his interview, Mark appears frustrated and at times, angry with the help he received from a local priest when he had difficulties related to IPV, who not only judged him with "*what? You are a man and you can't take care of yourself"* (Mark, 2.302-2.303) but seemed to have no professional training to work pastorally. It appears from Mark's narrative he has felt judged and perhaps not sufficiently contained in his personal experience of IPV and due to his negative feelings of not being sufficiently contained, it seems questionable if he was able to fully contain his affected male clients of IPV. Furthermore, it appears that Mark might have struggled with difficulties related to vicarious trauma,

as it seems he had difficulties managing boundaries with his clients, e.g. by helping them in court.

Similarly, Rudi describes in his interview how his personal experiences with IPV impacted on him and reflects on this further by stating how this might have led him to "*overvaluing*" the clients' experiences of IPV in the excerpt below:

> *And I guess from my own experience um that feeling of um how that* ***can impact on your self-esteem and self- worth, er… can be quite powerful****, so I, I, that's what I am aware of myself, I think. In terms of sort of experience, so, um…yeah, er, er, and the risk of* ***overvaluing*** *it in terms of um you, you know,* ***the contact being contaminated with your own experiences*** *(188-6.195).*

It appears Rudi believes in personal reflection as a critical tool for practitioners to understand the self within the human context and through this, gain a greater self-understanding. However, Rudi uses the word "*contaminated*" with personal experiences when he was talking about "*contact*" with clients engaged in IPV, which implies the presence of something potentially hazardous spoiling the communication within the therapeutic relationship. Also, it appears by the use of the word "*contamination*", he might have alluded to the risk of vicarious trauma for practitioners by "*overvaluing the clients"* experiences. This implies a vulnerability for practitioners to be *"contaminated"* with the cognitive and affective aspects of the clients' traumatic experiences.

In relation to this, Rudi also talks about the importance of being aware of the possibility to *"distort information or make assumptions"*" about what is being said by

clients in therapy, to further become aware of contact contamination with clients engaged in IPV.

> *Yeah and um because of that, because you have to writ…be aware of how um you know you can* ***distort information or make assumptions,*** *um about what is being said or, or, the* ***meaning that a client is attaching to what is being said*** *because again, the paradox there is some* **paradox** *where um whereas you may say by the nature of it that this is a negative experience, there will be examples where um it could be interpreted as being um feisty or something more um, in some ways um something about the interaction being um, I guess it's in, in terms of the fight in a way of, of, of again sexualising um so maybe, maybe we need to* ***be a bit specific about what the nature of, of the behaviour is really' (****6.146-6.159).*

In this excerpt, Rudi alludes to the complexity of relationship dynamics within an IPV relationship and how this might be misinterpreted by practitioners, which might have an impact on the therapeutic relationship. This might block the practitioner from being open and curious towards their affected male clients' difficult experiences, which might be due to the fear of vicarious trauma. Throughout his interview, Rudi is open about his personal experience with IPV, which mainly revolves around difficulties with sexual intimacy and control. Here, he calls the process of listening and interpreting clients' narrative a "*paradox*", in which the experience described by a client could be interpreted as negative, however, it may also be interpreted in a different light, such as *"feisty"* and *"sexualising"* the experience of the client. It seems Rudi points to the contradictory nature of

interpreting the clients' narratives depending on the context and therefore alludes to the importance of bringing awareness to this as a practitioner. Furthermore, he suggests becoming open- minded and curious by further exploring the behaviour of two individuals who are engaged in IPV, and therefore to *"be a bit specific about what the nature of, of the behaviour is really"*.

Rudi also shares an experience in which he highlights the importance of reflecting on practitioners' own *"value judgements"* when extracting meaning from clients' narratives:

> *And even taking a different meaning, other than or, or checking out* ***how the meaning you are taking away from your own value judgements*** *about things or, or, or, own value judgements about um say, even sexual behaviours and things, you know because that sort of bias to it. Um, but, of course, in truth, um, although I am stating those are the things we should do, um, often there is* ***a degree of embarrassment*** *er… if not shame attached to acknowledging that, so often they might not be spoken about' (6.249-6.258).*

Here, it appears Rudi believes practitioners' individual value system may impact on the therapeutic relationship by stating the risk of applying *"value judgments"* when listening to a client engaged in IPV. Therefore, he suggests practitioners should reflect on their own personal *"meaning you are taking away from your own value judgments"*. More specifically, he points towards the prejudice practitioners might feel towards sexual behaviours described by clients engaged in IPV and perhaps alluded to potential "*contact contamination"* with the client due to a judgment which practitioners might pose towards sexual behaviours of either one or

both individuals within an IPV relationship. Here, it appears Rudi's way of viewing the work with male clients engaged in IPV is congruent with positivist concept of vicarious trauma, which is based on quantitative research and suggests that practitioners who work with trauma-related clients need to suspend their personal values and judgments to become receptive and empathic to disclosures of clients. This is opposed to the social constructionist idea of practitioners integrating their personal experiences and values as part of the psychotherapeutic process. Therefore, Rudi and some of the other participants in this study, talk about the importance to be open to reflecting on their own experiences and value systems, which might assist them in becoming more empathic to their clients' traumatic experiences. For Rudi, this has been the catalyst for training initiatives and support for practitioners working with individuals engaged in IPV.

Subordinate theme 2b: "male female bias"

Some of the participants in this study reflected on their preconceived ideas of gender and how this might affect the therapeutic relationship when working with male clients engaged in IPV.

Below, Maya explains that her preconceived idea about her own female gender might have caused her difficulty when working with men who were violated by women:

I think it's hard for ***women*** *to think about the* ***role*** *that they play as* ***potentially evoking stuff around possibly representing the perpetrator****, so I think men, male therapists are perhaps more used to the idea that they have to make adjustments*

around um whether the…whether that um the person in therapy might see them as being the perpetrator (3.31-3.38).

Here, Maya's language is very tentative of what the experience for a female therapist might be like, giving the impression she is cautious around making assumptions for all female practitioners based on her personal experiences. However, she seems to possibly highlight her personal difficulty with this, by not only repeating it several times throughout the interview but also comparing it to male therapists, who are apparently more accustomed. She elaborates on this further by reflecting it back onto personal hetero-normative concepts of gender in the excerpt below:

> *As a* ***woman you expect to be seen as safe, nurturing, and kind****. Being faced with a man who is physically much bigger and stronger talking about being abused by a woman can be odd, because it doesn't seem logical but* ***of course when people are violent or controlling it's not just about physical size or strength*** *but some of the other tactics people might use to gain control over the situation (3.38-3.48).*

In this excerpt, Maya suggests women have a personal expectation of themselves to be viewed with mere positive attributes such as *"safe, nurturing, and kind"*. Within this context she believes, it becomes an *'odd'* and *'not logical'* experience to hear *"physically much bigger and stronger"* men talking about being abused by women. Here, she is giving the impression that there might be an inconsistency between what she personally believes of herself as a woman and what she is presented with in therapy by men, which suggests an internalised hetero

normative concept of her female gender. Furthermore, when she acknowledges that *"physical size and strength"* are not the only attributes of violent or controlling behaviours by stating *"of course"*", she alludes to an internal dilemma of her own internalised heteronormative gender norms. Although she is questioning normative gender concepts, she seems to still be influenced by the same positivist values and rhetoric on gender biases also presented in quantitative research of IPV.

Moreover, Maya suggests difficult feelings that female practitioners might develop when confronted with this dilemma:

> *Er… well I guess there's a sense of it, it's almost a* ***guilt*** *by association, if you, if you know what I mean. So, the er…it is not very nice to be in connection with anybody doing um committing um acts of violence against another, but I suppose when it is a woman, their sense of kind of like* ***shame of um my gender*** *that they behaved in that kind of way um…and that is why I mean I suppose that it is not really guilt, it is a* ***sense of shame that my gender is capable of, capable of that (***3.57-3.65).

Here, Maya repeats *"shame"* twice whilst also mentioning *"gender"* and referring to me as another female practitioner with *"if you know what I mean",* which might imply that female practitioners may experience difficulty with the thought of being associated with someone who is potentially causing violence to men. Throughout the interview, Maya has repeated this phenomenon many times and displayed great frustration with this difficulty also in the context with other female colleagues, who have apparently failed to confront this challenging thought of becoming the *"perpetrator"* when working with men.

Rudi also stated in his interview that there might be a particular bias towards gender when working with men engaged in IPV:

But in terms of answering your questions directly, to myself, um, I think there is, there is obviously some, um, pack, I don't know if the right word is ***pack mentality****, but there's a certain awareness of an association of, of er…* ***male female bias*** (6.99-6.103).

Rudi makes use of the word *"pack mentality"*, which implies a tendency of each gender to pose a judgment or make decisions based upon the actions of the other gender. He elaborated on this thought stating that he had *"certain awareness of an association of, of er… male female bias"*, giving the impression there is a certain discrimination of gender in a practitioner's mind. It may be that *"male female bias"* impacts on the therapeutic relationship, which according to Rudi, should be considered as a subject for reflection in supervision.

Within this context, Jaqueline, who had over 15 years of experience working with individuals engaged in IPV in a domestic violence and abuse team, states that she initially found it hard to imagine working with affected male clients of IPV:

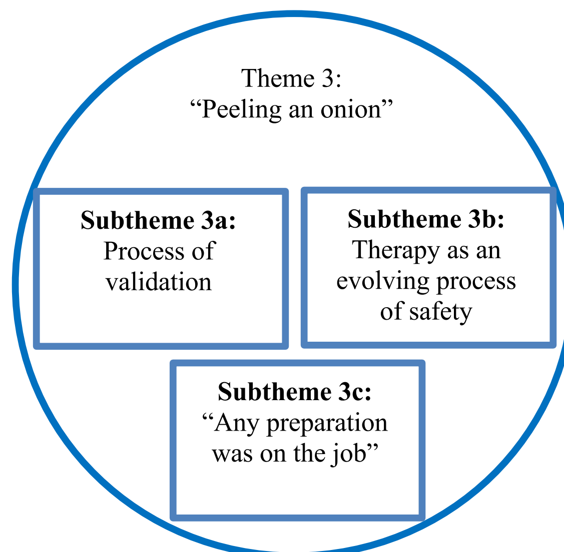
> *I didn't know if I could work with men,* ***I didn't know if I would feel comfortable working with men*** *and I realised at that point that was because of issues I had with my own father that I needed to address (5.193-5.198).*

When prompted to talk about her experiences of listening to men being violated by women, Jacqueline speaks in a soft voice, revealing her initial doubt of

being able to work with men due to her own "*issues*". It seems that her personal history of witnessing IPV as a child has brought out her vulnerable side in the interview. Jaqueline reports growing up with a father who engaged in painful and recurrent emotional abuse with her mother throughout her childhood, and that she needed to work through the difficulties she experienced with this by deliberately choosing a male therapist. Furthermore, she stated she felt more confident to work with men who were violated by women after her personal therapy experience, and by this, alluded to the importance of personal therapy when working with men who engaged in IPV.

Superordinate theme 3: "Peeling and Onion"

Figure 7: Diagram of theme 3 and subthemes



Participants described their therapeutic approach and the process of how they overcame some of the challenges presented when working with men engaged in IPV

as “peeling an onion”. These include the importance of validating their clients’ experiences and slowly building a therapeutic relationship to develop a safe place from which they are enabled to explore hidden meanings of their IPV experiences. In some cases, participants promoted the concept of becoming emotionally authentic with male clients to make them aware of, and to help them reflect on certain dynamics within the therapeutic relationship and to move away from blaming one individual within an IPV relationship, by using terminologies such as victim and perpetrator, for example. Furthermore, the majority of the participants explored the reasons as to why male clients decided to remain in their IPV relationships by exploring both, childhood and adulthood attachment patterns. Although all participants agreed that the choice of treatment model depends on the unique case of IPV, they encouraged integrative treatment models, including approaches related to person-centred, attachment theory, and CBT. Finally, there was a divided opinion on how equipped practitioners felt personally when working with men engaged in IPV. However, all agreed that they had learned how to work with them through their work experiences.

Subordinate theme 3a: process of validation

For the beginning of therapy, all participants highlighted the importance of validating male clients’ narratives of their experiences with IPV.

Mark described the rewarding part of his work as a therapist when clients feel believed, as demonstrated in the excerpt below:

*Very difficult to get them to stay focused. So, but fortunately that’s not many. **Most of the men I’ve worked with,*** **they are so relieved to be heard and to**

be believed *and, um, that's, um, it sounds* ***strange*** *to say it,* ***that's the lovely part of working with men****, actually, and women. I've worked with, with women victims as well. But the* ***lovely part*** *about this work is that the person you're working with is* ***being believed****.* ***They feel believed and they feel as if they are really being supported*** *and, and I like, that's the part of the work that, that, um,* ***keeps me going really****. Um, that you can see that that person, um,* ***"Ah, at last!" they go. It's, that's nice (****2.660-2.672).*

Here, Mark repeats the word *"lovely"* twice, perhaps to highlight the pleasant part of working with men engaged in IPV, which is when they are feeling relieved to be listened to. Also, he repeats "*believed*" three times in this excerpt together with providing an example of how his clients verbalised a sigh of relief by stating "*ah, at last!*" to emphasise how powerful it is for men to experience being believed by their therapists, as if that alone could make them feel "*supported*". Furthermore, he stated this '*keeps him going'* in his job, which could reflect the practitioner's own desire to feel good about himself rather than how to be potentially more useful. Additionally, this implies that there might be less "*lovely*" parts of the therapeutic work with men engaged in IPV, which can be more challenging for practitioners. Here, it appears to me through my voice memos that resources providing help with issues around IPV in society are sparse, and it seems Mark and the majority of the participants felt mental health practitioners seem to be one of the more helpful of the formal resources in terms of listening to them and supporting them by validating their experiences.

Subordinate theme 3b: therapy as an evolving process of safety

All of the participants in this study described the ways in which they were able to overcome some of the challenges presented in therapy with men engaged in IPV. Each participant focused on the individual aspects of their own therapeutic approaches that seemed most helpful. These included building a therapeutic relationship, being emotionally authentic, and moving away from therapeutic approaches that allocated blame, and discussing integrative therapeutic practices which hold both parties responsible. Regardless of the difference between the approaches, there is a common thread about exploration, shining a light on client's unique experiences.

For example, Rudi recognised that one challenge in therapy was that his affected male clients of IPV tended to take more time to open up about their experiences related to IPV, and he felt that the key to overcoming this challenge was in building a therapeutic relationship with his clients first:

> *… there's this **process** of, the way I describe it is um **peeling an onion, really**. That's, you know, there's different layers you have to work through with a client and then, and part of that, um, is a **mystical** possible **process**. I don't mean a religious one, **but some process of connection between the therapist and the client**, where you develop some sort of **safety** um and, and way of communicating which doesn't necessarily happen um it's, it's an **evolving process**, which I know that's obvious to a point, but, but you often hear people make very er **quick judgments** about, **assessments** because of a person says something, that is a **truth in its own right (***6.361-6.373).

Here, Rudi describes therapy with men engaged in IPV as a *"process"*, by which he is "*peeling an onion"*. Furthermore, Rudi repeats the word "*process*" four times and even calls it a '*mystical process'* when he describes "*the process of connection between therapist and the client"*. This illustrates how meaningful it is to build a therapeutic relationship, and to make the male clients feel safe to explore hidden meanings of their experiences with IPV, one layer at a time. Throughout his interview, Rudi and the majority of the participants have talked about men taking longer to open up about their experiences related to IPV. Also, Rudi discussed that one of the challenges some practitioners might fall into is to judge a male client by what has been explored in assessments and by this, miss the opportunity to give space and time to exploring what is happening within an individual, and to get a thorough picture of their experiences with IPV. Thus, it may be that slowly building a connection between therapist and client might help male clients engaged in IPV feel safe to open up about their IPV experiences in therapeutic sessions, rather than pushing them to enter into uncomfortable IPV territory before rapport has been established.

Similarly, Maya also discussed the importance of building a therapeutic relationship with men engaged in IPV by making them feel safe. However, she uses herself differently in the therapeutic process:

> *but I suppose the, the things that are really important for me and for within our service are being* ***emotionally authentic****, so being able to talk … I'm trained in sensorimotor psychotherapy,* ***so really attentive to what I'm experiencing in my body in relation to the individual****, that* ***kind of sense of***

***impulse or motive**, um, that's there and trying to look at that and it's, I suppose it's much harder to, to sit and think about wanting to push somebody away when, as a therapist, your job should be about really wanting **to bring somebody in and invite somebody in and make them feel safe, um.** (3.170-3.182).*

Maya encourages practitioners to use their own emotions and body during sessions by experiencing "*that kind of sense of impulse or motive"* and being open to male clients about what she is feeling in her body, which she called being *"emotionally authentic"* and exploring these feelings together with clients. Also, Maya acknowledges there is a dilemma of feeling like *"wanting to push somebody away"* and the role of a therapist which should be *"to bring somebody in and to invite somebody in and make them feel safe"*. She discusses how important it has been to explore this dilemma and her difficult feelings with clients:

*So, actually he, we were able to have conversations about um there was **a sense of, I felt quite irritated** by his constantly criticising or constantly comparing, monitoring what other people got from me, but actually, I didn't want to feel irritated by him and what I had of a sense of there was **somebody who was frightened of losing something, so I empathising with the, the vulnerable part**, which he wasn't, he wasn't bringing up so easily, um, that there was **a sense of this vulnerable part and really I wanted to have a connection with the vulnerable part and make the vulnerable part feel safe**. (3.295-3.307).*

Here, Maya gives an example of being emotionally authentic with her male client by exploring her own feelings *"* and empathised with the possible motive behind these feelings, including *"somebody who is frightened of losing something",* therefore, bringing male clients into a space wherein they may feel safe in the therapeutic relationship and connect with their more *"vulnerable part"*. Therefore, in contrast to Rudi, Maya has not attempted to suspend her opinions towards her male clients but rather used them as a vehicle for understanding the dynamics between two parties in a relationship and learned how to safely explore them within a therapeutic environment. It appears, Maya has adopted the sensorimotor approach, which combines attachment theories with behavioural treatments, to recreate and reorganise maladaptive patterns of relating to others and make affected male clients of IPV feel safe to explore their vulnerabilities.

In addition, Maya shares how important it is to explore the reasons as to why her male clients decided to remain in an IPV relationship in therapy sessions, as shown in the excerpt below:

> *You know and then and also choosing to stay in that, in that* ***situation****, um, sometimes that that would have been* ***out of fear and anxiety****, but I think the men that I've worked with, it's been more about a sense of um* ***them trying to avoid um feelings of abandonment and not being lovable*** *and all those sorts of, those sorts of things,* ***rather than a fear that of being hunted down by the woman*** *and what would, what would happen (3.208-3.216).*

According to her professional experience, Maya's clients' choices to stay in relationships were not based on anxiety of *"being hunted down by a woman and what*

would, what would happen", but rather on *"them trying to avoid um feelings of abandonment and not being lovable".* This is a phenomenon mentioned by Maya and the majority of participants in this study, which may have roots in experiences with first attachment figures in childhood, such as a parent or another primary caregiver. In her work experience as a clinical psychologist working within a male prison facility for 20 years, Maya reported confidently that her male clients had multiple experiences of being abused by either parent or other caregivers throughout their childhood and also often into adulthood. Therefore, it appears that attachment patterns of individuals engaged in IPV seem to be important to understanding, reflection, and process in therapy to question maladaptive patterns in relationships, which may have their origins in childhood.

Similarly, throughout her interview, Jessica appears to encourage practitioners to reflect with their male clients on early attachment patterns. When asked about her experiences of working with men engaged in IPV, she describes in-depth questions about attachment patterns that she has found particularly helpful:

> *Maybe just their experiences around um relationships with their parents.* ***Who was the primary carer****?* ***What kind of relationship they had with their mother? What's their view of women, sisters****, what kind of relationship, where do they come in, you know, are they the eldest or where did they come down in terms of their siblings. Um, kind of* ***role models*** *they may have had, other,* ***other important figures*** *in their, in their childhood, their growing up,* ***aunties, uncles****. What kind of experience did they have of relationships?* ***Were they positive or not or fractious?*** *That kind of thing um and I suppose a bit about* ***previous relationships if*** *they had any* ***long- term previous***

relationships. *Um, so yeah and, and also in terms of the* ***male role models as well, you know, I think that's also just as important*** *(4.440-4.455).*

Jessica seems confident when she recalls her questions. She asked about both, male clients' first attachment figures in childhood and any other long-term relationships in adulthood, trying to gain an in-depth knowledge of their attachment patterns, to understand if they were *"positive or not or fractious"*. It appears, therefore, that Jessica encourages curiosity and believes these questions could provide practitioners with clues on how male clients engaged in IPV attach to their partners. Throughout her interview, Jessica encourages practitioners to *"shine a light"* on the complexities within IPV relationships, by making use of attachment theory (4.377-4.382) and also by avoiding language which implies blaming one individual over another:

> ***I think um, I probably don't use those terms because I don't find I, I need to, as such.*** *I think there's other ways of being able to um highlight what's going on without being so definitive in that way and I think also because relationships are so complex, I think* ***sometimes issues around victim and perpetrator can be entwined,*** *so that's probably why I don't tend to use those terms.* ***I use them obviously in my um day job, when I'm writing policies*** *and stuff because it's, you need to be quite clear and you know what you're talking about here,* ***but it's not like that in a therapeutic relationship.*** *I think sometimes its um things are a lot more, can be a bit* ***more opaque****, so* (4.343-4.355).

When asked about the victim and perpetrator terminology, there appears to be a conflict between Jessica's work as a therapist, her writing policies as a manager of a domestic violence and abuse team for a local council. In her therapeutic work, she views relationships as *"complex"* and therefore she finds the terminology *"victim and perpetrator can be entwined"* and further too *"definitive"* which implies an opposition to making an authoritative decision to label their clients. Furthermore, she uses the word *'opaque'* when describing the therapeutic relationship with clients who engaged in IPV, which implies it is not as transparent and stands in opposition to when she needs to be clear and know what she is talking about. Here, it appears there still is a discrepancy between the terminology of victim and perpetrator used in policies and in therapy. Furthermore, she uses the word "*knowing*" that she privileges outside the consulting room, yet actively avoids inside the consulting room. Therefore, it seems that although Jessica seems to understand the complexities in relationships and takes the stance of the not knowing, she still has to follow guidelines to carry out policies for the safety of her participants and their family members, which according to her, is only possible by taking the position of "*knowing*". It might be, therefore, that a new language of IPV needs to change in all areas of society and not just in the therapeutic setting, this could help close the gap between the understanding of IPV in therapy and wider policies.

In addition to this, Jessica encouraged not only moving away from blaming one individual over another in therapy, but also to avoid making use of one single therapeutic approach. Instead, she encourages considering different approaches depending on each individual case:

> ***Hmm, that's, it varied, it varied with all clients****. So, um, you know, there was one client who, I think they were* ***both****,* ***they both can be quite destructive****,* ***both*** *him and his female partner, er, and um … with, he was my client, even though I did see both of them sometimes as well, as a couple. So, so that was interesting, but I started seeing him first and um and we used CBT, Person Centred, um, stuff around Attachment and um, in terms of the CBT, it was very much understanding um, you know, the* ***hot cross bun*** *thing around the* ***triggers*** *and knowing what's going on and um and just being aware um, trying to link in to what's actually happening at that time bef… and, and being* ***able to walk out of the situation to defuse it****,* ***rather than stay there*** *(4.178-4.192).*

After being asked to elaborate on the approaches she used when working with male clients engaged in IPV, Jessica repeats *"it varied"* twice, highlighting that she had chosen therapeutic approaches according to each client's specific needs, a phenomenon which has been echoing through all of the interviews in this study. It appears there seems to be a need for flexibility of the therapeutic approach depending on the unique needs of the affected male clients of IPV. Also, she repeats the word *'both'* four times in this excerpt, whilst also mentioning *"destructive",* emphasising the idea that both partners within an intimate relationship have the capacity to be destructive. This might imply an encouragement to move away from blaming one individual over another in an IPV relationship, which has been an approach promoted by the gendered model for many decades. Furthermore, she describes applying integrative approaches to therapy and by using words such as *"triggers"* and to *"defuse"* when applying CBT-based approaches, such as the *"hot cross bun",* she appears to believe that these approaches help two individuals to break dysfunctional

relational cycles in the here and now. Thus, she assumes exploring the narratives of individuals who are displaying present difficulties related to IPV is also relevant in her therapeutic work.

Similarly, Rudi explains how he integrated approaches based on person-centred therapy, attachment theory, and CBT, akin to integrative approaches of cyclical psychodynamics. In his interview, Rudi repeats the importance of exploring attachment patterns with his male clients, which may be carried on repetitively into another relationship and also into adulthood relationship.

Below, Rudi describes how he integrated approaches exploring attachment patterns with CBT- based approaches, by attempting to *"restructure"* thoughts that male clients may have acquired throughout their attachment history:

> *just the point is that if someone has* ***certain beliefs of women****, it's trying to, again it's* ***cognitively based****, I guess, it's trying to help them develop a consciousness of what, you know, what is, um, what the norms of behaviour and what er, how they fit, because they often have quite um, you know, they may have quite* ***negative beliefs about women full stop****, which have sort of* ***become exaggerated because they find some evidence to support something, you know it develops****. So, to answer your question, um, most recent I would say I was, I wasn't doing a great deal, other than providing the situa****… process to restructure the thinking and to model****, I wouldn't say challenge, but, yeah,* ***technically I suppose you would be challenging some of their thoughts too, a, and modelling****, so the more, what I would* ***consider norms*** *really or, or asking them to, to um, have* ***more balanced thinking*** *(6.478-6. 494).*

Here, Rudi brings the cognitive aspects into his narrative about treatment approaches for male clients engaged in IPV. By making use of words, such as *"negative"* and *"exaggerated"*, this excerpt suggests there is something like a common normal perception of gender and through IPV, male clients develop thoughts that deviate from these "*norms*". Furthermore, Rudi seems to repeat the word *"norms"* twice to emphasise this positivist concept of a reality which he seems to want to model to his clients by *"challenging"* their thoughts to achieve a *"more balanced thinking"* about women. Throughout his interview, it appears Rudi adopted mainly a positivist view on his therapeutic work with male clients, trying to extricate his own opinions towards IPV to avoid *"contaminating"* the therapeutic relationship with his own experiences of IPV. Here, it is a though Rudi attempts to "*restructure"* his clients' judgments on women, which his male clients seem to have acquired throughout their experiences with IPV relationships.

Subordinate theme 3c: any preparation was on the job

Although the majority of the participants believed that there was a lack of specialist training for working with affected male clients engaged in IPV, they differed in how equipped they felt to work with this client group. In addition, all of the participants reported having learned how to work with male clients engaged in IPV through experiences on the job.

Below, Anna recalls how she felt equipped to work with men engaged in IPV through her experiences of working in secondary mental health care services. However, she stated that mental health services in general are not equipped for men engaged in IPV:

Um, I felt ***fine****, um … it's, you know, I was experienced in working in secondary mental health services, I'd done a lot of work with* ***personality disorders*** *and* ***forensic work, so in a way it wasn't any different****, but, um, yet there's no guidelines, but* ***there aren't different disorders, but, you know, they are only guidelines. They don't actually tell you moment by moment how to be with somebody, um, so I just drew on everything I'd got****.* ***Um, so I felt equipped to do it****. I didn't feel,* ***I still don't, that services are designed to deal with such matters****, unless, you know, there's um a dis… um, a depression or an anxiety or another illness. That's when it ca… you know, that's what you're treating. Um, and this is just a bit of it, er, unless again you're in a forensic service or working doing something like an anger or aggression programme.* ***Um, so personally I felt equipped to do it. Services aren't*** ***(****1.427-1.444).*

This excerpt illustrates Anna's view that diagnoses are "*only guidelines"* and do not provide practitioners with the knowledge of how to work with any difficulties related to mental health "*moment by moment*". Anna states that her work experience and training prepared her enough to feel *"equipped to do it"*.

However, she argues that services work with diagnoses and, therefore, are not equipped to work with men engaged in IPV, as they do not fall into one specific disorder. Throughout her interview, Anna has appeared to fight against the gendered model in mental health services in the UK. Here, it is as though there is a conflict between her as a counselling psychologist who fights against the gendered model of IPV, and services who advocate the gendered model of IPV. It might be that if services advocate a more gender inclusive model to IPV, there might be less difficulty

in feeling equipped to working with men engaged in IPV, which about half of the participants in this study agreed with.

In contrast to this, Maya did not feel personally equipped to working with men engaged in IPV through her training. However, she learned how to work with this client group through her work experience in forensics:

> ***Not, not all. Not at all***. *We had um quite a lot of training around working with people. When I trained, I qualified in '97, so 20 years ago, quite a lot of training around sexual abuse during childhood, but even then, the assumption was mainly that the victims would be female. I worked for Sexual Assault Care Centre before I trained as a clinical psychologist, for a period and all of the language was about men as bad guy and that men, men hurt women. Um … so, I suppose really …* ***any preparation I've had for working with men as victims of women, has been on the job through reflection (***3.442-3.464).

Here, Maya repeated *"not at all"* twice to emphasise the lack of preparation she felt when working with men engaged in IPV, especially when recalling her training in a sexual assault care centre and as a clinical psychologist. The language in her training as a clinical psychologist and in the sexual assault care centre was based on the unidirectional gendered model of women are *'victims'* and men are the *"bad guy"* who *"hurt women"*. Throughout her interview, Maya seems to have been aware of her shortcomings in working with affected male clients of IPV and was able to reflect on her own personal relationships and how they might have impacted on her being prepared to work with this client group. This phenomenon was present for half of the participants, who believed personally they had not felt equipped to work with

men engaged in IPV, but had to learn how to do so by working with men, such as in a male prison where Maya *"never met a man in prison who's not been abused and neglected during childhood"* (3.459-3.461).

Personal reflexivity

Throughout the whole analytic process, the impact of my experiences and my perspective was documented in my personal journals and further reflected upon in my research supervision. This reflection included the degree to which I felt engaged with my research data and immersed in my participants' life worlds and narratives. These factors may have had an influence on my interpretation of the data.

During the phase of my analysis, I found myself experiencing contrasting feelings. I felt empathy for the participants who discussed the challenges they faced around vicarious trauma as practitioners. At times I also felt overwhelmed by frustration and anger when some of the participants talked about their experiences of how society viewed and managed affected men of IPV, including social services and the courts (Appendix I). Although intellectually I understood and also believed the terrible injustice men engaged in IPV face in society, I was surprised at how easily I got drawn into avoiding some of the participants' narratives of how society still seemed to favor the gendered model of IPV. I felt frustration and a heaviness towards some of the narrative of the social injustice affected men of IPV have to face, and I found myself consciously disconnecting from the interview transcripts. It was as if I was not allowing myself to become immersed in my participants' internal worlds sufficiently for an IPA research study. This seemed to be delaying the analytic process and concentrating on other parts of the research study instead. I noticed through reflection of some of my personal journaling that the way in which I avoided

my interview transcripts was similar to how the body of research avoided affected male clients of IPV, as well as the avoidance of changing the view of affected male clients of IPV in society. At this stage, I wondered whether my avoidance had to do with the overwhelming feelings of frustration, anger, and helplessness that these clients might evoke in me due to the injustice in society and not being able to change this for them. My research supervisor, however, helped me to refocus my attention on the participants' phenomenological experiences and encouraged me to implement my avoidant behavior in my data analysis. I focused on allowing all of my participants' voices to be heard, aiming to find a balance between interpretative and self-reflective stance towards the data. Taking a relational approach to this research study, I became aware that in order to understand my participants' internal worlds I would need to link them with my personal understanding of these worlds. Furthermore, I sometimes found it difficult to move on from one interview extract to the next; at times feeling stuck and unable to fully digest the information in a coherent manner. After reflecting on this with a fellow doctorate student, I noticed that this could mirror how my participants might have felt and their difficulty to digest and feeling stuck when working with affected male clients of IPV. Here, I was thinking of how that might have led some practitioners to the unethical practice, including the attempt to save the client, such as Anna overstepping the boundaries of a therapist to safe the client and Mark becoming a McKenzie friend in court to help his affected male clients of IPV receive the right to see their children. Only when I was able to step back and reflect, however, was I able to seek meaning beyond what was presented by the participants. I understood then that not only male clients but also practitioners are complex and multifaceted beings and, thus, I needed to incorporate their ambivalence in the analysi

Chapter 5

Discussion

Introduction

This chapter consists of a summary of the current study's findings, which will be considered in relation to current research on affected male clients of IPV. Also, the implications of the findings will be discussed in relation to specialist training for practitioners working with male clients affected by IPV. Also, limitations and future research are considered together with relevance to counselling psychology and conclusions.

Research aims and questions

The research study aimed to learn about the subjective and phenomenological experiences of practitioners working with male clients engaged in IPV. It also examined the many challenges that the participants experienced when working with their male clients, as well as how they have overcome some of these challenges when considering implications for treatment. In addition, the study explored participants' recommendation for practice with this client group. Also, participants' readiness of working with men engaged in IPV was explored, to make possible recommendations for specialist training and to stimulate debate amongst practitioners in terms of their own perception of gender.

Summary

The findings of this study highlighted how practitioners felt about the invalidating effect of the gendered model and how this impacted on the therapeutic process, including the way affected men of IPCV presented their difficulties in

therapy. There appears to be a sense of frustration amongst all the participants for the terrible injustice men affected by IPV face in society, and how they often find themselves helpless and hopeless in changing this for them.

The findings also illuminate challenges arising from the participants' personal associations/experiences of IPV, including distortions/assumptions, preconceived ideas of gender and how some of the practitioners dealt with these challenges.

Finally, regardless of the difference between the therapeutic approaches considered, there seems to be a common thread about exploration, shining a light on client's unique experiences. This process included validating the male clients' experiences and slowly building a therapeutic relationship to make them feel safe, by being emotionally authentic, moving away from therapeutic approaches that allocate blame, and discussing integrative therapeutic practices, which hold both parties responsible. In the following sections, these findings and the implications for practice are discussed in further detail.

Main findings and implications for practice

The invalidating effect of the gendered model

The first theme was comprised of the narratives of all participants in this study, who discussed the invalidating effect of the gendered model on affected men of IPV. Participants suggested that their clients had not been believed in various situations, for example when interacting with practitioners, agencies, social services, the police, or when in court. The way participants talked about these experiences so vigorously suggested that there was a lot of injustice for men affected by IPV in society. For example, some participants described how isolated, alone and ashamed

these men can feel due to the disbelief they encountered in society and other participants appeared to demonstrate how men affected by IPV can be humiliated by hetero-normative stereotypes embedded in our language.

The invalidating effect of the gendered model in the current study appeared to be consistent with previous research findings. For example, the studies by Hogan et al (2011) and Migliaccio (2001) found that affected male clients of IPV were afraid that they would not be believed because of their male gender. The researchers related the threat to the stereotypical masculine self-concept in society and their feelings of shame attached to this. Also, Hines et al. (2007) demonstrated that men's narratives of IPV were not believed by professionals, which left these men feeling isolated and without social support, which increased their difficulties related to PTSD. Furthermore, Douglas and Hines (2011) found that men who sought help experienced limited support and/or received gender stereotyped treatment, based on the assumption that men are perpetrators of IPV. This led to feelings of disbelief, suspicion, and even being ridiculed. Finally, Vogel et al. (2011) suggest that men who associate themselves with ideal masculine characteristics are more likely to have negative views towards disclosure and help-seeking in regards to their difficulties related to IPV. Consistent with previous research, thus, these findings suggest that both practitioners and health care services should take the gendered identity into account when addressing and engaging with male clients' needs (Hine, 2017; Liddon et al., 2017; Liddon et al., 2019; Seager & Barry, 2019). Moreover, it is proposed that practitioners could incorporate and emphasize positive concepts of masculinity when in therapy with male clients to rebuild an alternative male identity (Englar & Kiselica, 2013; Krumm et al., 2017; Liddon et al., 2019; Seager, 2019; Seager & Barry, 2019a). This process might lead to a decreased sense of shame for men suffering from

consequences of IPV (e.g., Enlgar & Kiselica, 2013). Also, this process could encourage affected men of IPV to reach out to health care services and to build social support networks to feel less isolated and lonely (Krumm et al., 2017). Finally, it is suggested that more health care services and practitioners expand their view/ stance of IPV from being an individual problem to also incorporating the social and cultural aspects of this highly complex issue, which might lead to working with IPV on a community level. According to Hage (2000), attempts have been made for counselling psychologists to take a stance against pathologizing IPV and instead, to work against the stigma of cultural beliefs of IPV on a community level. Thus, the current research study was not unique in lending support to these findings and implications for practice.

However, as opposed to previous research, the current study seems unique regarding how male clients apparently presented their difficulties in therapy. This included being dismissive of, and downplaying IPV events or presenting them in a humorous manner to test practitioners whether they would be taken seriously by practitioners. Based on postmodern feminist studies, the concept of the heterosexual contract could provide an explanation for this male behaviour in the therapy room, as it argues that heterosexual individuals would assess whether what they are experiencing is going to be taken valued, accepted, and respected by other like-minded heterosexual individuals in relation to popular beliefs, values, and ideas of IPV (e.g., Wittig, 1992). Therefore, it might be due to an underlying understanding of the conventional positioning of gender roles within heterosexuality and IPV relationships, which is responsible for the male behaviour of being dismissive and downplaying of their own suffering (Seager & Barry, 2019a).

Furthermore, most of the participants in this study discussed how male clients

often presented their IPV experiences as incidental, which participants experienced as being related to feelings of embarrassment and shame. In relation to this, the participants highlighted the ease with which they might avoid clients' narratives of IPV. Again, the concept of the heterosexual social contract could provide an understanding of practitioners' avoidance towards difficulties related to IPV, as it argues that the difficulties related to men's experiences of IPV are expected to be culturally dismissed in order to preserve the traditional view of men and women as being polarized (Wittig, 1992). This mindset could also obscure attempts by practitioners to engage in a more gender critical perception of their clients, and therefore, prevent them from applying a more male gender inclusive model for treatment.

Based on previous research and current findings, thus, it is proposed that an awareness of the heterosexual social contract could be helpful for practitioners to the extent that they learn to reflect on their own perception of a man and a woman and how this might impact on how they view their male clients in therapy and perceive different treatment options for affected male clients of IPV (e.g., Zverina, Stam, Babins-Wagner, 2011; Barry, 2017; Barry & Seager, 2019a). This could be achieved by applying case examples and role plays in specialist IPV training to both, inspire and encourage further personal reflection on gender amongst practitioners.

Another explanation for male clients being dismissive and downplaying of IPV experiences is based on the psychoanalytic concept of projection, which has been mentioned by a few participants in this study. This concept could be understood as a psychological defense mechanism in which a client is attributing unwanted and often overwhelming feelings, such as shame, to the practitioner (Casement, 1985). This reflection could not only help practitioners become aware of the possibility of being

drawn into being downplaying, ridiculing, or being dismissive of their male clients, but also provide practitioners with the skills to uncover collusion that might lead to therapeutic impasses (Wallin, 2007).

Hence, these findings are important in encouraging practitioners to pay careful attention of how the presence of shame in the narrative of the male clients may impact on the way they present their difficulties related to IPV and how this might bring challenges for the practitioners to reflect on in supervision, which in turn, may create a more effective therapeutic process with male clients of IPV (Tsui, 2014).

In addition, what seems to be also unique in the current study, and therefore a unique contribution to research in IPV, is that although the majority of the participants alluded to the importance of supervision while working with male clients engaged in IPV, they found their experience of supervision mainly unhelpful. For instance, one of the participants described how she avoided her supervisor at work, as she did not expect to be believed. Instead, she found another supervisor to help her to know what to do, perhaps avoiding feelings of helplessness and hopelessness for her male clients affected by IPV. The positivist approach to therapy might provide an understanding for this, which suggests practitioners feel a strong desire to be competent and therefore fear the objective anxieties about acknowledging personal foibles, thus revealing personal difficulties which may interfere with effective practice (Hahn and Molnar, 1991). Further to this, Mollon (1989) argues that the process of therapy with traumatized individuals involves narcissistic dangers, which include injuries to practitioners' self-esteem. This is not surprising, since the challenging, complex and multi-layered nature of IPV may leave any professional feeling incompetent and de-skilled at times (Wandrei & Rupert, 2000). Therefore, Mollon (1989) suggests that it is helpful to understand these interactional processes by

creating a “space for thinking”, which is more akin to maternal reverie than problem solving. Thus, participant’s feelings, including helplessness, hopelessness and shame, could be identified, processed, and integrated into the therapeutic process without anxiety of criticism, humiliation, or intimidation (Mollon, 1989). It may be that this, in turn, could also help practitioners to provide affected male clients of IPV with space to reflect on difficult feelings related to their IPV narratives, which may lead to more empathy and a better therapeutic process between practitioners and male clients (Sanderson, 2008). Hence, it is suggested that supervisory role plays could be applied in specialist training for working with male clients of IPV to help normalize the reflective processes that may take place during supervisory meeting at work (Sommer & Cox, 2005). Furthermore, it is recommended that health care services encourage supervisory meetings, in which practitioners are enabled to explore their own feelings of IPV and allowed to uncover process collusions which might impact on therapeutic progress (Wandrei & Rupert, 2000; Wallin, 2007).

Practitioners “can’t avoid to relate to it”

When asked to reflect on their personal experiences of working with male clients engaged in IPV, all of the participants alluded to personal associations/experiences with IPV. It seems that participants may have been driven to work in this area by their own psychological wound of IPV. This relates to the concept of Carl Jung’s “wounded healer”, which suggested that those individuals with adverse childhood histories often enter helping professions (Barr, 2006). In relation to this, all participants in this study described self-reflective practice as an effective tool for understanding their male clients affected by IPV; for instance, by making use of transference and countertransference and/or reflecting on the relationship dynamics in

their personal lives. The use of transference and countertransference has also been discussed in previous research as a powerful tool in working with trauma-based clients in psychodynamic therapy and therefore should be strongly recommended for effective practice in specialist training for IPV (e.g., Davies and Frawley, 1992a). One example of this included how one of the participants reflected on her own associations with women who have learned to abuse the privileged victim role common in many societies, to the extent perhaps that many men discredit their own experiences of being violated by women. What seemed to be an epiphany for this participant, it has contributed to her shift in her therapeutic approach from blaming one individual over another, to questioning relationship dynamics of both partners in therapy; this is a phenomenon which seemed to have resonated throughout many interviews of this study. This shift is also present in practitioners' approaches to working with difficulties related to IPV today, which is moving away from approaches based on the gendered model towards therapeutic approaches that are based on a more evidence-based, gender inclusive, and case specific models of IPV; this includes couple therapy for situational partner violence (e.g., Baucon, Sevier, Eldridge, Doss and Christensen, 2011; Karakurt, Whiting, Van Esch, Bolen, and Calabrese, 2016; Lam, Fals-Stewart and Kelley, 2009). Therefore, applying self-reflective practices and learning about gender-inclusive models of IPV could further assist practitioners to feel more skilled and, thus, to work more effectively with affected male clients of IPV.

Despite reporting that self- reflective tools were helpful, however, some of the participants expressed concerns around having potentially unresolved emotional difficulties from their own IPV experiences. One of the participants called the concern "the contact being contaminated with your own experiences", which may imply that the therapeutic encounter is spoiled by something potentially hazardous. According to

this participant, this contamination might also lead to therapists overvaluing the client's experiences of IPV and by this, he might have alluded to the risk of vicarious trauma. This seems consistent with findings of the study by Iliffe and Steed (2000), who investigated the impact of IPV on therapists and found symptoms of vicarious trauma, burnout, and changes in cognitive schemas. In relation to this, vicarious trauma is a common factor found in quantitative trauma-based research (e.g., Waegemakers Schiff and Lane, 2019). Within this positivist school of thought, it is assumed the level of therapeutic intimacy with affected clients of IPV might create a vulnerability to be contaminated with cognitive and affective aspects of the client's traumatic experiences (Aparicio, Michalopous, and Unick, 2013). Therefore, some research suggests that vicarious trauma may be a natural response to the therapeutic relationship in trauma- related work (Barrington and Shakespeare-Finch, 2013; Sansbury, Graves, and Scott, 2015) and thus, it should be considered as something hazardous to the practitioner's work (Shannon et al., 2014). Therefore, it appears that the positivist stance in trauma-based research is congruent with the positivist stance of therapy for participants in this study, who appeared to believe in an objective reality, in which their own personal reality contaminated the objectivity of the practitioner's omnipotent stance towards their clients. This had implications on how participants highlighted the importance to not "distort" information, or "value judgements" when extracting meaning from what male clients discussed in therapy, instead of paying attention to how the preconceived idea of gender might have impacted on the therapeutic relationship. This is congruent with findings by Hogan et al. (2011) who described how therapists need to be aware of their own internalized values, as they might influence their perception of what the client is saying. According to the researchers, therapists need to avoid making assumptions and judgements about their

clients and strive to listen to their clients' stories with no influence from their own background. Thus, it seems that although participants made use of psychodynamic tools of transference and countertransference, they did not apply these tools to integrate their distortions and value judgments into their therapeutic processes but merely used them to then suspend their own personal values and judgements to become both, receptive and empathic to disclosures by their male clients (Aparicio et al., 2013; Chang, Scott and Decker, 2013). It seems that for participants in this study, this approach led to some dilemmas, including one of the participants questioning her own internalized gender norms on the one hand but still being influenced by the same positivist values and rhetoric on gender biases on the other hand. Therefore, it is suggested that it might be beneficial for practitioners to integrate possible distortions and value judgements into their therapeutic processes both in supervision and when working with male clients in therapy. For instance, Iacoboni (2009) has demonstrated in recent neuroscientific research that countertransference processing can be found in the activity of the mirror neuron system in the prefrontal cortex of the brain to better understand others in terms of unconscious emotions. These findings have been applied in further IPV research to highlight the importance of the practitioner's use of self in the reflective process (Dutton & Sonkin, 2013). Thus, it has been recommended for practitioners to make use of countertransferential feelings to not only understand the client's perspective, but also to open up the dialogue about this in the therapeutic process. With these findings in mind, specialist training for IPV should include a section about the importance of reflecting on internalized values and gender biases, including using stories to encourage meaning making and self-reflections as practitioners working with trauma-related individuals (Sommer & Cox, 2005). This might support practitioners in not only being able to stay with their own

tensions when working with male clients impacted by IPV but also help them to stay alert to the tensions that might arise between them and their clients in therapy. This reflexive practice, thus, might assist practitioners to also become more aware of the risk of vicarious trauma and to find support networks and develop and adhere to self-care wellness plans, e.g., by assessing self-care goals during supervision sessions (Williams et al., 2012).

"Peeling and Onion"

When asking about how they worked with affected men engaged in IPV, all the participants highlighted the importance of validating their clients' experiences of IPV. This is consistent with the study by Hogan et al. (2011), in which practitioners felt that the sense of being believed by somebody was beneficial to their affected male clients of IPV. Moreover, in the current study there was a sense of responsibility in the narratives of most participants, who described the lack of support services for affected male clients of IPV. By this, it is suggested that participants alluded to mental health care practitioners being one of the more helpful formal resources for men affected by IPV and therefore, supporting them by validating their experiences became rewarding for the practitioners, which is also seen in Hogan et al., (2011). The validation of male clients' experiences of IPV has also shown to lead to lower levels of abusing alcohol for affected male clients of IPV, as it might assist men to feel more able to express and process their difficulties in therapy (Douglas and Hines, 2011). Therefore, highlighting the importance of validating affected male client's experiences of IPV could become a part of specialist training for practitioners, perhaps in a way training practitioners discuss the invalidating effect the gendered model has on men affected by IPV and therefore, the reasons as to how it is

paramount to help them being acknowledged in their IPV experiences during therapy (Krumm et al., 2017).

What seems to be a unique contribution to IPV research of male clients affected by IPV is that all the participants described ways in which they were able to overcome some of the challenges presented in therapy. Each participant focused on the unique aspects of their own therapeutic approaches that appeared to be most helpful. For instance, one of the participants explained how important it is to build rapport with their affected male clients beforehand. This prevented the practitioner from pushing the client to talk about their painful experiences of IPV too early, and helped the client feel safe to explore the hidden meanings of their experiences, one layer at a time. Thus, it may be helpful for practitioners to become aware of the importance of slowly building a therapeutic relationship with affected male clients of IPV.

Another example included one of the participants discussing the importance of building a therapeutic relationship with affected men of IPV. However, she integrated her feelings and bodily sensations within the therapeutic process in what she called becoming "emotionally authentic" with her male clients. She openly explored her own feelings and bodily sensations with her clients, which often led her to connect with her male clients' vulnerable parts. Therefore, in contrast to the other participants, she did not attempt to suspend her opinions towards her male clients but rather used them as a vehicle for understanding the dynamics between the two parties within a relationship. Hence, she learned how to safely explore feelings and bodily sensations associated with experiences of IPV within a therapeutic context. This approach directly relates to more recent integrative psychotherapeutic treatments for trauma, including sensorimotor psychotherapy, which has psychoanalytic/ psychodynamic

theoretical underpinnings in the sense it views trauma and attachment as central to adult psychopathology (Ogden and Fisher, 2016). However, sensorimotor psychotherapy can also be seen as a behavioural treatment, with regards to the focus on changing bodily sensations through behavioural adjustments. This is a relatively new therapeutic approach that has neither been tested in a randomized controlled group trial for effectiveness nor been recommended for affected male clients of IPV. However, research has shown that individuals suffering from repeated traumatic experiences, such as IPV (Saakvitne, 2002) show maladaptive behavioral patterns (e.g. hypervigilance, hyperactive fight/flight responses, etc.) which can be observed and reorganized in Sensorimotor psychotherapy and increase feelings of mastery and wellbeing (Riley, 2015).

Furthermore, most of the participants recommended to explore the reasons as to why affected male clients of IPV decide to remain in an IPV relationship, which mainly included an avoidance of feeling unlovable and abandoned. This is a unique finding, as it is different to reasons discussed in previous research of IPV for male clients, including staying out of love, having concerns for their children (Hines and Douglas, 2010a), and remaining in an IPV relationship due to the hope that their situation will change for the better (Hendy et al., 2003). According to some of the participants, the reasons why their male clients remained in IPV relationships are rooted in attachment patterns. Therefore, these participants recommended an in-depth and extensive analysis of both early and current attachment patterns, together with approaches related to CBT, to break dysfunctional relational cycles. This integrative approach seems to be consistent with Wachtel's (2014) relational perspective approach of cyclical psychodynamics, which also combines psychodynamic, CBT, systemic and experiential point of views. It focuses on interpersonal vicious circles

that perpetuate maladaptive patterns in current relationships, having been set in motion through childhood traumas. Due to the highly complex nature of IPV, integrative approaches for IPV treatment were discussed and recommended by most participants in this research study. Therefore, it could be argued that practitioners should be encouraged to remain alert to recent developments of evidence-based integrative therapeutic approaches for trauma-related difficulties, (e.g., sensorimotor psychotherapy and Wachtel's cyclical psychodynamics) which emphasise exploring early and present attachment patterns, as it might assist them further with understanding how to approach difficulties presented in therapy when working with affected male clients of IPV.

Finally, all participants agreed that they learned through their work experience with individuals who had difficulties related to IPV. However, there was a divide in terms of how equipped they felt personally and professionally to working with men affected by IPV. Half of the participants felt professionally and personally prepared to work with affected male clients of IPV, as they viewed IPV not as a gender issue but more as a human issue that needed to be approached according to the unique difficulties the clients presented. Therefore, it appears that for these participants, IPV is a reciprocal and complex process, which mental health services need to be more equipped to work with, by acknowledging and incorporating a more gender-inclusive model of IPV. This stands in contrast to previous research, where most of the professionals made use of a more gendered model of IPV and did not feel prepared to assess affected male clients of IPV (Hamel et al., 2009). They also indicated they would not know how to protect clients from harm (Harway, Hansen, and Cervantes, 1991). This is more consistent with the beliefs of the other half of the participants, who stated that they were not equipped to work with affected male clients of IPV due

to their training, which had been based on the gendered model of IPV. However, they had learned how to work with affected male clients of IPV through their work experience. Also, they expressed that they would have valued the opportunity for specialist training on working with affected male clients of IPV. This aligns with recent research findings, which have shown that treatments which are based on male gender informed models to be more effective for practitioners, as it enables them to engage in more male specific difficulties presented in therapy (Barry, 2017; Hamel et al., 2007; Seager & Barry, 2019a). Thus, it is suggested that acknowledging more male gender specific difficulties related to IPV may also assist both practitioners and mental health services with their approach to working with affected male clients of IPV.

Limitations and Future research

Although these findings offer tentative understanding of practitioner's experiences of working with affected male clients of IPV and may be beneficial in recommending possible ways of how to therapeutically approach and support them, these findings have to be seen in relation to the limitations of this study.

All of the participants alluded to personal associations/ experiences with IPV, which might have affected the findings and therefore, it could have been helpful if some of the participants also had no personal associations/experiences with IPV to recognise any differences in the way they understood and worked with affected male clients of IPV.

Additionally, there appeared to be an issue around the uneven gender divide of the participants, meaning that they were 2 male participants and 4 female participants. Although this might be a more realistic representation of the gender divide in the

psychotherapeutic world, it would have been interesting to have attempted to recruit three from each gender to possibly recognise differences within and between genders and how this might have had an impact on the therapeutic relationship with a male or female therapist when working with affected male clients of IPV. Perhaps, this is a limitation in itself as it did not consider differences between gender of the participants.

Furthermore, it seems that delving deeper into the findings of this research study may be useful. To begin with, future research studies could further examine the experiences of practitioners when being made aware of how their own perception of a man and a woman might shape the way they think and therapeutically approach their male clients impacted by IPV. Furthermore, it could be helpful to investigate the experiences of affected male clients of IPV after being presented with more positive concepts of masculinity in therapy, as it may also assist practitioners with understanding how to help affected men of IPV to get in touch with difficult emotions, such as shame and embarrassment.

Also, more research could be done to further explore how affected male clients of IPV presented their difficulties, including being dismissive and downplaying of IPV events and presenting them in a humorous way to test whether they will be taken seriously or not. Understanding the deeper motivations of their behaviour may lead practitioners to a better understanding of how to approach treatment. The need for enhanced understanding of affected male client's experiences of IPV is well documented in previous research (e.g., Hines, Brown, and Dunning, 2007; Migliaccio, 2001; Randle and Graham, 2011; Tsui, 2014)) as it is still at the beginning (Douglas and Hines, 2011) regarding understanding theory and therapeutic approach. Further research, therefore, could provide important implications for

understanding affected male clients of IPV, which might not only lead to more specific treatment options for male clients of IPV but also help to develop further support services put in place for this specific and well under-researched client group (Merrill and Wolfe, 2000).

Secondly, as validating affected male client's experiences and building a therapeutic relationship has been shown to be vital to therapeutic work, future research can investigate into how to best build and maintain these therapeutic relationships, as previously outlined by (Hogan et al., 2011).

Thirdly, it may be important to further investigate the integrative approaches that some of the participants alluded to in this current research study (e.g. Sensorimotor Psychotherapy) to help understand how effective they might be for affected male clients of IPV and from this, to consider approaches for specialist training when working with affected male clients of IPV.

Finally, future research can investigate into not only how practitioners from different disciplines were able to assess and feel equipped to work with affected male clients of IPV, such as in previous research by Harway, Hansen, and Cervantes (1991) and by Hamel et al. (2009), as this might help an integrative approach of professionals from all areas of society of how to approach this specific client group of affected male clients of IPV. Further to this, it could be helpful to further investigate what male specific difficulties are and how to approach more male gender specific difficulties therapeutically, as it might not only help health care professionals but also help inform IPV agencies, social services, and the courts when working with affected men of IPV.

Relevance to Counselling Psychology and Conclusions

The proposed study has many relevance points to the field of counselling psychology research and practice. Beginning with fact that the controversial debate of both men and women being capable of perpetrating IPV has not been resolved, this study shed more light into how practitioners were influenced by this debate and how that might have affected their approach to affected male clients of IPV in therapy. Due to the increasing number of male clients looking for psychological treatment in the UK, the findings are also relevant in terms of how to understand some of the practitioner's challenges faced when working with this specific client group. Additionally, researching the professionals' point of view of working with men having experienced IPV deepened the understanding of the readiness of this type of work professionally and personally.

As a result, the findings might shed some light to the importance of developing specialist training for professionals working with men who experienced IPV. Regarding the distortion of IPV in the media, the at times ambiguous view of the public in regard to IPV, and the risk of vicarious trauma, the findings have shown that it is important for practitioners to understand their own distortions/assumptions when working with men who have experienced IPV. Thus, the present study contributes to the field of counselling psychology by practitioners understanding the importance of becoming reflective about their own prejudices and preconceptions of men having experienced IPV and what consequences that might have on both the therapist, the therapeutic relationship, and the process of therapy. Also, the findings of this research study display relevance to the field of counselling psychology in terms of its theoretical approach. The basic principle of counselling psychology is the humanistic approach to therapy, which includes a commitment to viewing the client as unique

and in regards to their subjective reality above notions of diagnosis, assessment, and treatment (Lane and Corrie, 2006). Congruent with this, the phenomenological hermeneutic approach to this current study focused on making sense of the subjective experiences of the participants in their meaning making processes in a specific context of IPV. Ultimately, the proposed study has relevance to the maintenance of the uniqueness of counselling psychology in that it emphasizes the humanistic stance to research and practice in a time when it moves further and further into the NHS and its medical model- oriented philosophy.

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Appendix A
Recruitment Poster

A woman abusing a man, is that even possible?

Are you a practitioner with an understanding of working with men who experienced Intimate Partner Violence?

What are the challenges (if any) you were facing in relation to approaching this specific client group in a therapeutic context?

My research study mainly revolves around exploring experiences of practitioners, who have been working with male clients engaged in Intimate Partner Violence. This study aims to inform further understanding for practitioners working with men who have been experiencing Intimate Partner Violence. The interview will take about 60 minutes. Please contact me if interested on my mobile number xxxxxxxxxxx or email u1323853@uel.ac.uk

UNIVERSITY OF EAST LONDON

Appendix B
Information sheet

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)
SILVIA RUSU-TIBREANU
Contact details: u1323853@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my Professional Doctorate in Counselling Psychology degree at the University of East London.

Project Title

Practitioner's experiences of working with men who engaged in Intimate Partner Violence: An Interpretative Phenomenological Analysis

Project Description

Although prior research has investigated some of the challenges faced by professionals working with the specific client group of men having experienced IPV, there is few research studies, which looked specifically into practitioner's understanding of IPV. Hence the present research aims to explore the specific experiences of practitioners, who have worked with men with experiences of IPV; by this, it aims to raise awareness for more recognition of this controversial topic and with it, the limitations it sets to the understanding, research, and therapeutic approach of this social phenomenon. Hence, participants are being asked to reflect on personal understanding of IPV and possible challenges faced in therapeutic process. In case participants experience any form of discomfort in relation to the research topic, they are encouraged to attend a supervision session.

Confidentiality of the Data

To inform the participants of the anonymity of their data, an information sheet is emailed to participants describing the nature of the study in further depth and additionally participants will be asked to sign a consent form prior to interview. In case participants decide to take part in research, they are all provided with the right to withdraw within the period of two weeks without any disadvantages to themselves or any obligations to provide a viable reason as to why they have decided to withdraw from the study. In case of termination from study, all collected data of participants will be destroyed. However, after the two- week period, the researcher has the right to use the anonymized transcript collected in the interview phase. Confidentiality of the data includes protecting the identity of the participants by keeping names and contact details in a locked filing cabinet (including all paper documents, such as consent forms), ensuring that only the researcher is able to access the data. In addition, names of participants are altered as well as any other identifying reference in the transcription phase of the study. All recordings will be erased by the end of the

research project and all the anonymized data and consent forms will be erased within the time frame of 5 years. Finally, participants will be also informed that the Director of Studies and examiners will have access to extracts of anonymized data.

Location

Interviews will be carried out within the work premises of participants and if required, in a room based on the University of East London campus or over Skype

Remuneration

Unfortunately, there will be no financial reward for taking part in this research.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. [Include if relevant to you: Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [Name, School of Psychology, University of East London, Water Lane, London E15 4LZ. Telephone. Email address]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,
Silvia Rusu-Tibreanu

Appendix C
Consent Form to participate in a research study

Practitioner's experiences of working with men who engaged in Intimate Partner Violence: An Interpretative Phenomenological Analysis

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher will also seek your consent to use your anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

………………………………………………………………………………………

Participant's Signature

………………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher's Signature

…………………………………………………………………………………………

Date: ……………………..………………………………………………………….

Appendix D
Invitation letter

Dear Participant,

The present study aims to explore your understanding of working with men who have experienced Intimate Partner Violence, how (if) it differed in your work with women who have experienced Intimate Partner Violence, and how prepared you felt working with this specific client group. In this context, Intimate Partner Violence refers to both physical and psychological violence inflicted by a woman on a man within the context of a heterosexual relationship. If you are eager to take part in this study, experience working in this field with this specific client group is implied.

Face-to-Face interviews will last approximately 60 minutes and serve the purpose to explore your understanding of working with men having experienced Intimate Partner Violence. This might lead to interesting new insights in this research area. Based on the UEL code of ethics, your anonymity and confidentiality will be protected at all times and you have the right to withdraw at any stage of research.

If you would like to participate in this study, please contact me on my email u1323853@uel.ac.uk or call me on my mobile number [redacted]. In case you have any further questions in regards to this study or otherwise, please do not hesitate to contact either me or my supervisor Dr Jane Lawrence, j.lawrence@uel.ac.uk.

With the Kindest Regards,

Silvia Rusu-Tibreanu

Trainee Counselling Psychologist

Appendix E
DEBRIEFING SHEET

Research Title:

Practitioner's experiences of working with men who engaged in Intimate Partner Violence: An Interpretative Phenomenological Analysis

Researcher: Silvia Rusu-Tibreanu, u1323853.

Thank you for participating in this study. The purpose of this study is to explore professional's perception of IPV in relation to both their therapeutic work with men and their preparedness for working with this specific client group in the light of the relative lack of research in this area and the controversial attitude towards it in society. Following this interview your data will be transcribed and anonymised, with all your identifying data omitted. The data will be kept on an encrypted memory stick and stored in a locked draw which only the researcher has access to.

The purpose of the following questions is to allow you as a participant to reflect on the interview process, raise any issues you may have and offer valuable feedback:

1. How did you feel after completing the interview?
2. Were there any questions you found particularly difficult to answer?
3. Did you feel the I influenced your answers in any way?
4. Did you get a chance to discuss all the things you wished to?
5. Were there any questions you wish I had asked?
6. Do you have any comments or observations about the interview process which would improve interviews in the future?
7. Are there any questions you would like to ask or concerns you'd like to raise?

Once again, thank you for contributing to this research.

Should you wish to receive a copy of the research once it is completed or have any questions, please contact me at : u1323853@uel.ac.uk

Should you feel in any emotional distress after the interview and feel that you need to talk to someone, please consider the list of agencies provided: New.mankind.org.uk

Appendix F

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

BSc LEVEL 6 PROJECTS

MSc/MA DISSERTATIONS

PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY*

*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to: http://www.uel.ac.uk/gradschool/ethics/

Before completing this application students should familiarise themselves with the latest *Code of Ethics and Conduct* published by the British Psychological Society (BPS) in 2009. This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website http://www.bps.org.uk/what-we-do/ethics-standards/ethics-standards

For BPS guidelines on Internet mediated research see http://www.bps.org.uk/system/files/Public%20files/inf206-guidelines-for-internet-mediated-research.pdf

UEL's code of practice in research is a useful brief outline of good ethics conduct - see http://www.uel.ac.uk/gradschool/ethics/

Note that researchers conducting research that solely involves animal observation or analysis of existing data (secondary analysis) should complete separate forms. These can also be found in the Ethics folder in the Psychology Noticeboard on Moodle.

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.

2. Type your name in the 'student's signature' section (5.1).
3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc** (See page 2)
4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identity its content. Your supervisor will then look over your application.
5. When your application demonstrates good ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review. You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.
6. Your supervisor will let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

MANDATORY ATTACHMENTS

1. A copy of the invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original tests and questionnaire(s) and test(s) that you intend to use. Please note that copies of copyrighted (or pre-validated) questionnaires and tests do NOT need to be attached to this application. Only provide copies of questionnaires, tests and other stimuli that are original (i.e. ones you have written or made yourself). If you are using pre-validated questionnaires and tests and other copyrighted stimuli (e.g. visual material) make sure that these are suitable for the age group of your intended participants.
- Example of the kinds of interview questions you intend to ask participants.
- A copy of ethical clearance from an external organisation if you need one, and have one (e.g. the NHS, schools etc). Note that your UEL ethics application can be submitted and approved before ethical approval is obtained from

another organisation (see 4.1). If you need it, but don't yet have ethical clearance from an external organisation, please let your supervisor know when you have received it.

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than 6 months. This is necessary if your research involves young people (anyone under 18 years of age) or vulnerable adults (see section 4.2 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable, as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the School of Psychology and the School will pay the cost.

  If you need to submit a DBS certificate with your ethics application but would like to keep it confidential, please email a scanned copy of the certificate directly to Dr Mark Finn (Chair of the School Research Ethics Committee) at m.finn@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 18 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is enough (even if older than 6 months) and you will not have to apply for another in order to conduct research with vulnerable populations.

1. Your details

1.1. Title of your course:

Professional Doctorate in Counselling Psychology

1.2. Title of your proposed research:

Selective perception? Exploring Counselling psychologists' understanding of working with men who have experienced Intimate Partner Violence.

1.3. Submission date:

1.4. Please tick if your application includes a copy of a DBS certificate x

1.5. Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mark Finn (Chair of the School Research Ethics Committee) (m.finn@uel.ac.uk) for confidentiality reasons x

1.6. Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2009). See link on page 1 x

2. About the research

2.1. Research question(s):

The main aim of present research is to enquire Counselling Psychologist's perception of IPV in regards to both their therapeutic work with men and their preparedness for working with this specific client group in the light of the relative lack of research in this area and the controversial attitude towards it in society.

2.2. Likely duration of the data collection from intended starting to finish date:

October 2015 – October 2016

Methods

2.3. Design of the research:

The study will use the qualitative methodology of Interpretative Phenomenological Analysis (IPA). This approach involves making use of a semi-structured in the interview, asking participants of the study open-ended questions regarding their personal concepts of IPV. In general, interviews will last about 50-60 minutes in duration.

2.4. Data Sources or Participants:

Due to IPA's idiographic nature aiming to provide a detailed and in-depth analysis of the data, a total of 4-10 participants were recommended as an adequate sample size

for a professional doctorate thesis. Furthermore, a similar amount of both men and women are going to be recruited as potential participants to ensure homogeneity of data. Additionally, participants should demonstrate at least a two years post-qualification status of clinical experience to ensure some form of similarities in terms of possible challenges they have faced working with this client group. Also, they should have been exposed to a broad range of different cases of male victims of IPV in the two years post-qualification period, as it would add more depth to the data. Specialist services dealing with both men and women who have experienced some form of IPV are contacted and in addition, posters are distributed in secondary mental health services and private practice.

2.5. Measures, Materials or Equipment:

Interview Schedule

Applying an audio recorder device, the specific questions guiding my analysis and interpretative conclusions will most presumably be:

1. **What is your personal understanding of IPV as practising Counselling Psychologist?**
2. **What is your experience working with men who have experienced IPV?**
3. **What are the differences in terms of therapeutic work when working with men who experienced IPV in comparison to women with experiences of IPV?**
4. **What (if any) challenges have you have faced working with men who experienced IPV?**
5. **Give me an example of a challenging situation in therapy with a male client with experiences of IPV (if any) and how you have attempted to overcome the challenge with that client**
6. **How prepared did you feel professionally when working with men having experienced IPV?**
7. **What resources did you draw on to help you with (if any) therapeutic challenges?**
8. **Could you tell me more about how you think both Counselling Psychology training and mental health care services could enhance the training for IPV to enhance awareness and preparedness of working with men having experienced IPV?**

2.6. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

YES / NO / NA

2.6. Outline of procedure, giving sufficient detail about what is involved in the research:

Procedure might involve:

- **Providing participants of the study with an invitation letter as a first stage, outlining the main purpose of the study and their right to**

withdraw at any stage of the study. In addition, the participants are given time to both digest and think about the possibility of taking part in the study.

- **In case the potential participants of the study are willing to take part in the study, a consent form is given to them to be signed before commencing the interview phase.**
- **Each Interview will be approximately 50-60 minutes in duration, interviews are planned to be audio recorded and subsequently transcribed for analysis purposes.**
- **Interviews will take place on University of East London campus, in a private room and asked to answer a series of questions revolving around their experience of the nature of Intimate Partner Violence and working with men having experienced Intimate Partner Violence. In case I will be intending to conduct the interview at their workplace, I will make sure to contact supervisor where and when the interview will take place.**

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed. See the BPS guidelines for reference, particularly pages 10 & 18, and other support material in the Ethics folder in the Psychology Noticeboard on Moodle.

3.1. Obtaining fully informed consent:

Obtaining fully informed consent will be done by firstly informing potential participants about the nature of the study, which is followed by providing participants, consent forms to be signed before commencing the interview phase of the study.

3.2. Engaging in deception, if relevant:

The proposed research has no intention to involve any form of deception.

3.3. Right of withdrawal:

The right to withdrawal consists of making participants aware of their right to retrieve from the research study at any given time of the research phase without it affecting them in any way and without needing to give an explanation as to why they have decided to withdraw from the study. This information will be made clear both verbally and in written form on the information sheet. The collected data will be anonymised when transcribed and made sure to be kept safe in an electronic folder with a password access only.

3.4. Anonymity & confidentiality: (Please answer the following questions)

3.4.1. Will the data be gathered anonymously (i.e. this is where you will not know the names and contact details of your participants? In qualitative research, data is usually not collected anonymously because you will know the names and contact details of your participants)

YES / NO

NO

3.4.2. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

In order to ensure confidentiality and protect the identity of participants, names and contact details of participants will be kept in a secure environment, ensuring that only the researcher has access to this type of information. In addition, data is treated confidentially by altering names and identities of participants and other identifying references in the transcription phase of the study. In the invitation letter, participants will be informed that both supervisor and examiners are able to read extracts from anonymised transcriptions of the interview.

3.5. Protection of participants:

Protection of participants in this study includes becoming aware of any signs of emotional distress or upset, which might be caused by the nature of the questions in the interview process and accordingly, advising them to making use of supervision.

3.6. Protection of the researcher:

By informing supervisor of the study before and after an interview about location and time interview takes place, protection of the researcher will be ensured.

3.7. Debriefing:

The debriefing form will involve providing participants with the opportunity to ask questions after the interview phase, reassuring them that the interview material will be kept safe and anonymised, thus confirming that participants are comfortable with their participation in the study.

3.8. Will participants be paid? YES / NO

If YES how much will participants be paid and in what form (e.g. cash or vouchers?) Why is payment being made and why this amount?

3.9. Other:
(Is there anything else the reviewer of this application needs to know to make a properly informed assessment?)

N/A

4. Other permissions and clearances

4.1. Is ethical clearance required from any other ethics committee? YES / NO
(E.g. NHS REC*, Charities, Schools)

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? YES / NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation is acceptable if this is what you have received.

***If you need to apply to another Research Ethics Committee (e.g. NRES, HRA through IRIS) please see details on www.uel.ac.uk/gradschool/ethics/external-committees. Among other things, this site will tell you about UEL sponsorship**

PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary. Also note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised. Speak to your supervisor if in doubt.

4.2. Will your research involve working with children or vulnerable adults?* YES / NO

If YES have you obtained and attached a DBS certificate? YES / NO

If your research involves young people between the ages of 16 and 18 will

parental/guardian consent be obtained. YES / NO

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves children and young people who are younger than 18 years of age. You should speak to your supervisor about seeking consent from parents/guardians if your participants are between the ages of 16 and 18. 'Vulnerable' adult groups includes people aged 18 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see www.uel.ac.uk/gradschool/ethics/involving-children/

SEE PAGE 3 FOR FURTHER INSTRUCTIONS ABOUT ATTACHING A DBS CERTIFICATE IF YOUR RESEARCH INVOLVES VULNERABLE PARTICIPANTS AS OUTLINED ABOVE.

4.3. Will you be collecting data overseas? YES / NO

This includes collecting data/conducting fieldwork while you are away from the UK on holiday or visiting your home country.

* If YES in what country or countries will you be collecting data?

Please note that ALL students wanting to collect data while overseas (even when going home or away on holiday) MUST have their travel approved by the Pro-Vice Chancellor International (not the School of Psychology) BEFORE travelling overseas.

Please refer to the following link for the Approval to Travel form and the Fieldwork Risk Assessment form that should accompany an application.

http://www.uel.ac.uk/gradschool/ethics/fieldwork/

Basically, you must:

1. Complete the Approval to Travel form AND the Fieldwork Risk Assessment form (both found through the above link).
2. When completed, pass the forms to your project supervisor who will give your

application to the Deputy Dean of the School of Psychology for signing.
3. The School will then forward your application to the Pro-Vice Chancellor International on your behalf. Applications must be received by the Pro-Vice Chancellor International at least **two weeks prior to travel**. Details about where to send an application can also be found through the above link.

5. Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

5.1. **Declaration by student**:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Silvia Rusu-Tibreanu

Student's number: u1323853 Date: 12/11/15

5.2. Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor’s name: Jane Lawrence Date: 12/11/`15

Appendix G

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Jane Lawrence **REVIEWER: Nicholas Wood**

STUDENT: Silvia Rusu-Tibreanu

Title of proposed study: Selective perception? Exploring Counselling psychologists' understanding of working with men who have experienced Intimate Partner Violence.

Course: Professional Doctorate in Counselling Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

2. APPROVED but consider amendments before commencing

Minor amendments required *(for reviewer)*:

It is not clear where the interview recordings will be kept – they will need to be on a password protected device at the least.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

[ ] HIGH

[ ] MEDIUM

[X] LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *Dr. Nicholas Wood*

Date: 23rd November 2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

Appendix H
Application for change of title form

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

University of East London Psychology

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the ‘student’s signature’ section (page 2).
9. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
10. Your request form will be returned to you via your UEL email address with reviewer’s response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

3. A copy of the approval of your initial ethics application.

Name of applicant:	Silvia Rusu-Tibreanu
Programme of study:	Professional Doctorate of Counselling Psychology
Name of supervisor:	Dr Luis Jimenez, Dr Meredith Terlecki

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: Selective Perception? Exploring Counselling Psychologists' understanding of working with men who have experience Intimate Partner Violence	The rationale for the change of title is to better reflect the wider inclusion criteria of my study sample, which both my supervisor and me agreed on. In the wider inclusion criteria not only Counselling Psychologists are included but also psychotherapists and counsellors from various different training backgrounds.
New Title: Practitioner's experiences of working with men who engaged in Intimate Partner Violence: An Interpretative Phenomenological Analysis.	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student's signature (please type your name): Silvia Rusu-Tibreanu Jason Poole

Date: 13/03/2020

TO BE COMPLETED BY REVIEWER		
Title changes approved	APPROVED	

Comments

Reviewer: Glen Rooney

Date: 30/04/2020

Appendix I

Extract from my personal journal and voice memo recordings

After Interview with Mark:

So much frustration and anger in his voice, terrible injustice for men not just in terms of therapy but also in society, e.g. courts. It seems like he wanted to be heard and listened to and gave very long answers without really going into my questions. It felt intrusive to me to ask him the question again and clarify, as if he was arguing with me, as a woman?

What is CAFCASS?

How did I question him, he did not directly answer my questions. It felt overwhelming to me how much information he gave me. I felt really out of my depth as to how to steer the interview back to my original questions. I am not experienced enough to be interviewing him.

He was a counsellor for men engaged in IPV but also a McKenzie Friend in court? Unethical? Boundaries blurred due to possible helplessness for his male client and attempting to save the client, I was not sure what was his personal experiences of IPV and what was his client' experiences of IPV, did he know the difference?

Why did I not prompt him back to interview questions? Did I try and contain what has not been able to be contained before?

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