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Chapter 6

WORKING WITH VICTIMS/SURVIVORS OF INTIMATE PARTNER VIOLENCE: THE 'SELF' IN THE THERAPEUTIC RELATIONSHIP

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ABSTRACT

Women most commonly experience violence victimisation by someone close to them. Therapeutic work with victim/survivors of Intimate Partner Violence (IPV) may range from immediate crisis intervention to long-term support. This includes therapists maintaining the ability to listen to their clients' agonising, sometimes unbearable experiences. Various therapeutic perspectives, commencing with psychodynamically informed ones such as Attachment Theory, recognise that the therapists' personal history and their relationships are relevant to therapeutic work.

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Within the therapeutic domain of IPV, awareness of transference and countertransference dynamics, ubiquitous to all relationships, is particularly important as therapists can become drawn into certain positions vis-à-vis the client; a rescuer, a persecutor, or a victim/survivor themselves. Transference and countertransference issues can impact therapy through practices that interfere with the therapeutic process, such as therapist avoidance, misattunement, denial, dismissal or unconscious manifestations of prior interpersonal dynamics. Additionally, vicarious trauma or secondary stress, are typical therapeutic responses experienced as adverse psychological and physical effects of therapists' exposure to clients' trauma. Considerations for individual therapists comprise the need to assume responsibility for their personal histories by attending to their own experiences of pain, trauma or loss, engage in meaning-making activities or relationships, and develop skills in mindfulness and self-care strategies. Organisations can counterbalance implications for therapists by providing appropriate supervision, adequate training and allowing increased time to debrief and discuss cases.

Keywords: IPV; Therapist; transference and countertransference; vicarious trauma; victims/survivors;

INTRODUCTION

This chapter briefly examines the prevalence and the nature of Intimate Partner Violence (IPV) from a feminist perspective and addresses some of the issues in working with victims/survivors of abuse. Following this examination an explanation of Attachment Theory is presented as a way of working with victims/survivors to highlight some of the unconscious issues that may arise in therapy when working with individuals who are experiencing IPV, with a particular focus on couples who both use violence. Finally, the typical responses experienced by therapists when working with this population group are discussed prior to concluding remarks

Violence against women is a global problem and occurs most often within an intimate partner relationship (Guggisberg, 2010). The abuse and violent behaviour is overwhelmingly directed against female intimate partners, while it is

acknowledged that men are also victims of IPV. IPV may include physical and/or sexual violence along with emotional, psychological, verbal, and economic abuse as well as stalking behaviours or wilfully damaging the victim's property and harming the family pet. Victimisation by IPV is a complex phenomenon that affects many victim/survivors from all walks of life.

While men most commonly experience violence at the hands of acquaintances or strangers who are primarily male, women most commonly experience violence victimisation by someone close to them (Guggisberg, 2010). National and international surveys indicate that approximately one in four women experience physical and or sexual violence by a current or former intimate partner at some stage in their life (Australian Institute of Health and Welfare, 2019; Devries et al., 2013). This victimisation is generally accompanied by controlling behaviour, which means that forms of violence are typically not mutually exclusive (Guggisberg, 2010). Many women experience non-physical forms of violence. However, if physical forms are part of the violence, controlling behaviour is almost always part of the victimisation profile. The effects of IPV include short-term and long-term consequences. Women and children are often the ones suffering the most adverse outcomes (Guggisberg, 2010; Stark, 2007).

Some researchers have argued that not all IPV is the same. Johnson (2008), for example, identified four types of IPV: coercive controlling violence, violent resistance, situational couple violence and separation instigated violence. Johnson argued that situational couple violence (SCV) is gender symmetrical IPV with no systematic power and control issues, and that, based on general population surveys, it is by far the most common form of IPV. Johnson (2008) further argued that the core distinction between coercive controlling violence (CCV) and SCV is that coercive controlling violence, being gender asymmetrical, has a clear pattern of power and control which is informed by the perpetrator's sense of male entitlement and his desire to achieve the victim's subordination and compliance. A fear of the perpetrator is a fundamental feature of this type of violence. By contrast, Johnson stipulated that SCV, being gender symmetrical, is the result of poor conflict resolution and communication skills, frustration and the desire to win an argument between two equal partners; a conflict which may be fuelled by alcohol and/or other drugs and involves the reciprocal use of aggression by both partners. Additionally, Johnson (2008; 2011) argued that other factors contributing to violence are the couple's level of education, and a history of IPV in the family of origin.

Unfortunately, Johnson's typology in relation to SCV is particularly attractive to statutory agencies (Meier, 2015) given that it is considered to be the most common type of IPV and 'extremely widespread' (O'Connell and DiFonzo, 2018, 30) in the family court process. In this regard, Meier (2015) observed that the

remarkably quick adoption of Johnson's explanation of SCV has a detrimental effect on victim/survivors of IPV and their children when they are engaged in family court processes. Meier (2015, 8) stated that Johnson's typology of SCV has become "the new mantra in family law practice". Given the assumption that this type of IPV is "not terribly concerning" (Meier, 2015, 12), it is not surprising that most children exposed to IPV continue to remain in contact with the abusive parent (Jeffries et al., 2016). These ongoing issues may negatively impact on the women who are often affected by an everyday struggle to cope with the abuse.

The widespread nature of IPV in Australia and elsewhere means that there is a great demand for various kinds of victim services. While the quality and quantity of different services have improved since the women's movement in the late1960s in most Western nations (Stark, 2007), there is an underutilisation of service responses available to IPV victim/survivors. Similar to other forms of non-stranger violence, IPV is still significantly underreported and the circumstances constituting a barrier to victim/survivors' reporting their experiences vary considerably (Valor-Segura et al., 2018). A range of factors, including victim- and offender-characteristics, family make-up, victim-blaming social attitudes and other situational circumstances can influence the nature of victim/survivors' help-seeking decisions. In addition, factors such as the interplay of emotional attachment, shame, self-blame and the hope for change can also influence how victim/survivors respond to abuse by an intimate partner (Walker, 2017). Furthermore, the literature identified situational factors such as isolation and fear for the children's safety as barriers for reaching out and seeking help.

Victim/survivors' needs are complex and require a range of different services to ensure safety, protection and recovery, and may range from immediate crisis intervention to long-term support. De Lint and colleagues (2018, 23) argued that victim/survivors should be considered "power brokers". Consequently, interventions designed to address the needs of victim/survivors and children should follow a strength-based approach that supports victim/survivors' right to self-determination and informed decision-making without judgment. While the safety of women, and especially dependent children, needs to be assessed and made the number one priority, victim/survivors need to be given the opportunity to make active and informed choices throughout their help-seeking and recovery process (White and Sienkiewicz, 2018). This can be difficult for practitioners at times, especially when there are discrepancies in relation to perceptions regarding desirable outcomes, personal values or expectations. Importantly the ongoing focus should be on placing and examining the responsibility for IPV with the perpetrator and not the victim/survivor.

Unsurprisingly, therapeutic work with victim/survivors of IPV does not follow a straightforward path as therapists are required to negotiate between necessary practical tasks such as safety considerations, court processes, psychoeducation and emotional support. This includes therapists maintaining the ability to listen to their clients' agonising, sometimes unbearable experiences, which subsequently triggers and occasions an awareness of their own personal challenges and tragedies (Tummala-Narra, 2016). Various therapeutic perspectives, commencing with psychodynamically informed ones, have recognised that therapists' personal history, relationships, interests and passions are not only relevant to, but fundamentally guide the work with clients. Within the therapeutic domain of IPV, therapists' attachment styles in intimate relationships, as well as experiences of loss, trauma, and violence can have profound repercussions on the therapeutic relationship, the outcome of therapy and the therapist. Moreover, the work-related risks of providing services to a population that is increasingly traumatised due to violence exposure, is a public health issue which threatens stability in professionals' work life (Molnar et al, 2017). Consequently, this chapter aims to highlight some of the unconscious processes that may underlie the work with individuals experiencing IPV.

A PSYCHODYNAMIC PERSPECTIVE IN THERAPY

The relationship between one's past and present is a complex one; "We are formed through a variety of experiences, then and later, some remembered, some forgotten, some even misinterpreted, some of which makes us who we are now, some of which have left little apparent mark" (Jacobs 2012, 13). Implicit in a psychodynamic therapeutic approach is the notion that mental phenomena, such as thoughts and feelings, and the resultant behaviours, are the result of the interplay between opposing motivational forces; in other words, that a therapist will always listen out for the interaction between the client's conscious and unconscious thoughts and feelings (Auchincloss and Samberg 2012; Frederickson 1999). Consequently, the focus is on the client's movement between the different dynamic qualities of thoughts and feelings; therapists listen out for what the client is consciously aware of and what she/he is not aware of. All of this movement occurs in a mind, or an internal model of 'self and others' that has been shaped by one's past relationship experiences, affecting one's interactions with others, as well as the underlying assumptions that shape those interactions (Holmes and Slade 2018).

Attachments are the inextricable connections one forms with those that care and protect us from the start of life.

Attachment theory: An example of psychodynamic theory

The work of John Bowlby and Mary Ainsworth contributed to the development of a theory of emotional bonding and emotion regulation (the ability to appraise and manage feelings) by combining significant insights from psychoanalysis, developmental and cognitive psychology and ethology; a theory which has been studied and tested in hundreds of ways in the last couple of decades (Shaver and Mikulincer 2005). From an attachment perspective, the basis of social life is underpinned by an affective exchange between individuals so that emotions are relational experiences (Holmes and Slade 2018). Infants are born into a world with countless threats and in seeking safety are motivated by internal, emotional states to seek proximity to a caregiver; thus, the infant-mother bond is conceptualised as crucial to the safety and protection of the infant. Bowlby remained true to his initial psychoanalytical thinking by considering threat as both internally derived, yet primarily arising from the external world (Holmes and Slade 2018; Shaver and Mikulincer 2005). Building on this conceptualisation, Schore (2003, 37) defined attachment theory "…as fundamentally a regulatory theory", as in the first year of life infants seek to create a secure bond or attachment with the primary caregiver. For a multitude of reasons, such as parental physical and mental illness, death, interpersonal violence, prolonged parental separations, or chaotic homes with drug and alcohol misuse, poverty, discrimination, trauma etc., secure bonds are not always formed; instead insecure bonds may be the dominant form of attachment to a caregiver. There are also numerous individual differences in attachment system functioning that are mediated by the supportiveness, availability and responsiveness of the caregiver when infants are in need. Consequently, a three-category typology of attachment styles originating in infancy was developed, namely secure, anxious and, avoidant (both the latter are insecure); where attachment styles are "the systematic pattern of relational expectations, emotions, and behaviours that results from a particular history of attachment experiences" (Shaver and Mikulincer 2005, 27).

By virtue of the supportiveness, availability and responsiveness of the caregiver, individuals develop a set of maps that tell them about the world around them, as well as how they are in relation to the world; what Bowlby termed an 'internal working model' of self and others (Holmes 2010). The fundamental features of the internal working model concern the anticipated availability of the

attachment figure as well as a complementary working model of the self, for example how acceptable or unacceptable the child feels in the eye of the attachment figure (Fonagy 2001, 12-13). Internal working models are considered representations of 'self and other' and this representational system underpins the attachment relationship. Within the secure-insecure typology of attachment styles, a secure attachment suggests an internal representation of the attachment figure as responsive when needed, whilst an insecure one suggests the child needs to adopt approaches to circumvent the unresponsiveness of the attachment figure. As Fonagy exemplified: "A child whose internal working model of the caregiver is focused on rejection is expected to evolve a complementary working model of the self as unlovable, unworthy and flawed" (2001, 12-13).

An additional and vital human capacity that underpins everyday interactions, developed within early attachment relationships, is mentalising: "the ability to understand actions by both other people and oneself in terms of thoughts, feelings, wishes, and desires" (Bateman and Fonagy 2016, 4). Mentalising is a non-conscious and reflexive recognition of others' intentions and is instrumental to our ability to understand others' behaviours, but similar to language acquisition it is modulated by our social environment (Asen and Fonagy 2017). A central concept is that internal states (i.e., thoughts, beliefs, wishes and feelings) are opaque so that individuals make inferences about them (Bateman and Fonagy 2016). A mentalising capacity may be temporarily lost in stress environments or emotionally charged interactions in family settings which may trigger a fight or flight mode (Asen and Fonagy 2017). In turn, an aroused state may inhibit mentalising (reflective assumptions about the self and others) and an automatic process of non-reflective mentalising is activated. Fonagy and Target (cited in Bateman and Fonagy 2016) suggested that mentalising is both an intergenerational and a transactional process, where social interactions, particularly with primary caregivers in early environments, have a direct bearing on the quality of one's capacity to mentalise. The more a parent can mirror a child's affect correctly, the more a child's capacity to emotionally regulate (including attention mechanisms and effortful control), and to mentalise is developed. Whilst psychodynamic observations regarding the mind have historically been speculative, neuroscience has currently been able to present a more realistic picture of how implicit mental processes, emotions, and emotion regulation work (Bateman and Fonagy 2016; Shaver and Mikulincer 2005).

Furthermore, in adult intimate relationships, corresponding attachment styles were conceptualised by Hazan and Shaver (1987, 523) as they noted that "…romantic love is a biological process designed by evolution to facilitate attachment between adult sexual partners who, at the time love evolved, were likely

to become parents of an infant who would need reliable care". The previously discussed adult categories, and later a fourth (disorganised attachment), were derived from research exploring childhood memories of parental relationships and their effect on adult personality as identified by respondents (Feeney 2016). Thereafter, a four-style romantic adult attachment category was conceptualised, namely; secure, preoccupied, dismissing-avoidant, and fearful avoidant. Much research was devoted to establishing a link between the adult attachment categories and corresponding infant attachment styles, particularly through the use of measurement tools such as the Adult Attachment Interview (AAI) and the Strange Situation experimental method as devised by Ainsworth (Hesse 2016).

Contemporary insights into attachment models have recognised that what appears to be useful to understanding individual differences in how individuals attach are two major dimensions identified along the four-styles of attachment; that of 'avoidance' and of 'attachment anxiety' (Feeney 2016). The first dimension reflects the extent to which people distrust others' goodwill and strive to maintain emotional distance and remain independent from a relationship partner, while the second dimension reflects the degree to which people worry that a partner might not be available or act sufficiently supportive in times of need (Bartholomew 1990). In considering attachment insecurity and how it may contribute to relationship dissatisfaction and possibly violence, it is worth noting that research has identified that attachment security is directly correlated with marital satisfaction (Mikulincer, et al., 2004). Brassard and Johnson (2016, 813) stated that attachment theory identified that the "key issue in distressed relationships is the negative cycles that maintain disconnection and limited responsiveness to emotional signals and attachment cues". Thus, any therapeutic psychodynamic approach acknowledges the key role of emotion in human functioning and will consider how one's past traumatic experiences, particularly from attachment figures who were expected to be trustworthy and safe, affect the way current experiences are encoded and integrated, as well as whether this process leads to growth or dysfunction (Johnson 2019).

Working therapeutically from an attachment model

Therapists recognise that individuals, including them, are often troubled by contradictory aspects of themselves which give rise to anxiety, and may be rejected consciously, even though feelings may remain at an unconscious level (Bateman, Brown, and Pedder 2010). Hence, one resorts to defence mechanisms to assist in denying or disowning parts of the self that are unacceptable. For example, from

infancy onwards, any threat to the caregiver bond (attachment) is dangerous. Consequently children, and later as adults, develop strategies that minimise disruptions to the attachment bond, often suppressing their own thoughts, feelings, desires and wishes to maintain the attachment relationship (Holmes and Slade 2018). Children whose early overtures for comfort were rejected by a mother trying to cope with an intimate violent relationship, may learn to conceal their distress and hide it from others, potentially developing an internal model of the self as unworthy and of others as unreliable (Wallin 2007). Given that there is an interdisciplinary consensus that romantic and adult attachment bonds are shaped by the same mechanisms that regulate mother-infant bonds responsible for 'growing' a mind (Goldner 2014), understanding an individual's family of origin relationship dynamics is necessary to working with individuals who experience IPV; as Asen and Fonagy (2017, 6) asserted, "…the family can be thought of as more of a danger zone or "minefield" than a safe haven". As such, the goal of a psychodynamically informed therapy is to enhance awareness of the 'self', through exploring emotions, examining avoidances, identifying recurring patterns, discussing past experiences, focusing on relationships and examining the relationship between client and therapist (Shedler 2010). It is within the client-therapist relationship that transference and countertransference is manifested.

Transference and Countertransference in therapy

Enactments in therapy refer to both the clients' and therapists' behavioural manifestations of "implicit relational knowings" whose origins date back to earlier attachment relationships, whereby unconscious thoughts and feelings are acted upon following the earliest attachment relationships (Wallin 2007, 122). Thus, the idea that one repeats rather than remembers past relationship dynamics is at the heart of transference. Transference denotes the displacement of thoughts, feelings and behaviours, which one experienced with early attachment figures, onto an individual in a current interpersonal relationship (Auchincloss and Samberg 2012). This process of displacement is largely unconscious; however, it is ubiquitous, occurring in a wide range of circumstances, and in a sense, we respond to any new relationship according to patterns from the past (Bateman et al., 2010). While transference has a general meaning in relationships, in a psychotherapeutic relationship it is used to explore the forgotten and suppressed past of attachment patterns. Clients may begin to experience feelings, attitudes and fantasies related to the therapist that do not befit that person, but rather are repetitions of unconscious reactions to earlier attachments. Likewise, rather than the notion that therapists are

neutral, there is a mutual reciprocal influence on therapists, known as countertransference. This means that: either, unresolved past experiences may contaminate the therapy when they are enacted by the therapist; or the therapist's feelings are elicited, often unconsciously, and they become tuned into a client's conscious or unconscious communication, with a capacity to hold and tolerate the feelings a client cannot (Bateman et al. 2010). Wallin (2007) suggested that as early attachment relationships are constructed so too are psychotherapeutic ones (2007). However, the clinical challenge according to Goldner (2014, 409) is to "co-construct a way out while allowing oneself to be pulled in". Jacobs (2012, 18) referred to the connection between the past and present, between relationships within and outside of therapy, and relationships between the external and internal world, as the "triangle of insight", seen in Figure 1.

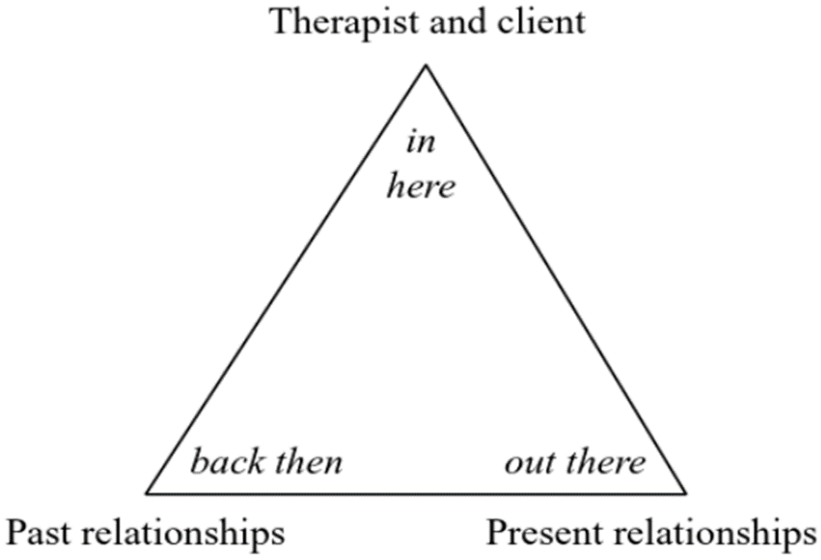

Figure 1 *Triangle of insight*

Accordingly, in working with victims/survivors of IPV, the assumption remains that the client will bring into therapy countless ways of relating to self, others and the world, and that therapists may be pulled into this dynamic. The therapeutic task is to tune in empathically, yet detach sufficiently to be able to reflect on the developing transference relationship; however, as violence can be so destructive, terrifying and shameful, there is a universal temptation to dissociate oneself from it, even as therapists (Goldner 1999). Importantly, therapists need to be able to tolerate uncertainty as well as manage and contain both their own and

their clients' emotions, including anxiety, anger, and fear (Sanderson 2008). Moreover, even if therapists have not been exposed to abuse, they need to be aware of their own experience and understanding of power and control in relationships, including the therapeutic one, the role of shame in interpersonal violence, and their own way of relating to others, i.e., their attachment style and how this may intrude upon the therapeutic space (Sanderson 2009).

VIOLENCE IN RELATIONSHIP: THERAPEUTIC CONSIDERATIONS

In this section, IPV is examined with the case of Alice and Jake to highlight some issues when considering the process of transference and countertransference. Some important caveats to bear in mind: focus of attention is placed on processes that are largely unconscious and particularly related to one's attachment style, thus the discussion is narrowly restricted to these aspects of therapy and does not cover other crucial influences on the development of the self and relationship dynamics, for example, the influences of gender and social norms, trauma and intergenerational abuse, personality disorders, psychopathology, mental health problems, social inequality, culture, political institutions, religion, and media. Accordingly, using a case study based on CCV, where motivations for violence, control tactics, fear of partner, and consequences of violence are important distinctions, would warrant a consideration of all these factors in therapy, both at a conscious and unconscious level, which is beyond the scope of the current chapter. Moreover, psychological modes of thinking, for example systemic or psychodynamic models, have been regarded as having the potential to blame the victim as they do not focus on the power inequality between the couple; meaning, psychological interdependence and individual responsibility become indistinguishable (Goldner 1998). As Goldner (1998, 2) asserted: "To argue that partners mutually participate in an interactional process does not mean they are mutually responsible for it, or for its catastrophic outcome", a point we wish to emphasise when there is unidirectional violence. Finally, conjoint therapy for individuals experiencing IPV remains controversial unless therapists are able to distinguish between types of IPV; accordingly, our discussion does not seek out to satisfy the controversy around assessment and differentiation of IPV for therapy (Karakurt et al., 2013; Karakurt et al., 2016; Slootmaeckers and Migerode 2019). The case study (a composite of clients using pseudonyms) describes a situation of

bidirectional violence, yet it remains focused on the experience of Alice to note some therapeutic considerations.

An attachment perspective: Alice and Jake

> *Alice and Jake have been together for 10 years. Alice is a professional in an allied health field and describes a successful career, despite her misgivings about her competency at times. She recounts that when she first met Jake, he was one of the first men who she felt she could depend on and found him willing to "just be with me". She found Jake was able to "smooth things" for her, especially when she was feeling anxious with work or when she felt hurt by her mother's unpredictable interactions, often when her mother had been drinking. Alice's father left her mother when she was 3-years-old. She recounts that she and Jake "were mad for one another" and "I adored him", relating a satisfying sexual relationship. However, as time went by, Alice felt that Jake's willingness to be with her – to be intimate, loving, and patient - had diminished; her overtures for affection and intimacy, initially being subtle, became more demanding. The more demanding Alice became, the more she felt Jake ignored, dismissed and avoided her, until she would "freak out" and sometimes try to push him in sheer desperation for his attention and affection. Jake's response would be to push back, and he would "become mean", criticising her, laughing at her, infantilising her reactions as "pathetic" and withdrawing into his world, leaving Alice with a deep sense of shame. Through the years, the pushing and shoving had become more common, with Jake using more force, leading to Alice being hurt occasionally. Alice feels helpless to change her behaviour and their situation and decides to seek therapy as despite the conflict, they both want to remain together. Although she does not fear Jake, she does fear that their inability to resolve their issues will lead to further hurt and damage.*

As therapists working with Alice, we commenced by hypothesising that the couple's attachment styles are based on a preoccupied attachment style (Alice) and a dismissing attachment style (Jake), two polar opposites on the dimensions of attachment anxiety and avoidance. This couple attachment pattern, which can be gender specific (i.e., high anxiety-attachment female and high avoidance-attachment male), appears to be supported by research (Belanger et al., 2015; Doumas et al., 2008), although these attachment styles are varied and can be non-

gender specific. While the focus here is on the attachment pattern developed in childhood, others remind us that "relationship-specific attachment" needs to be taken into account too, specifically when considering a case of SCV such as that of Alice and Jake, i.e., when there is bidirectional violence (Slootmaeckers and Migerode 2019, 298).

Many clients in intimate relationships where violence may be a factor unsurprisingly experience fear, anxiety and anger given their interpersonal situation, however Alice's high level of distress, a characteristic that Alice consistently presents with in therapy, needs to be given a deeper and more unconscious consideration. Understood from an attachment perspective, Alice learnt early on that in order to secure attention from a caregiver, she needs to make her distress too obvious to ignore; what Wallin (2007, 225) referred to as "conspicuous insecurity" i.e., the most reliable method of obtaining attention from unreliable others. Research has found associations in victims/survivors of IPV of both elevated levels of attachment anxiety and avoidance, although this is an association and in no way a cause (Mikulincer and Shaver 2014). Alice is experienced by others, for example by Jake as well as the therapist, as 'merger hungry' due to her attempts at wanting to remain close to them (Goldbart and Wallin, cited in Wallin 2007, 225). Alice's biggest fears relate to abandonment, separation and loss and most of her energy is spent on amplifying a defensive strategy of hyperactivating which has prevented her from acquiring an ability to develop self-esteem, trust in self and others, and her own capacity to emotionally regulate. Alice's distress and demands to be responded to can be understood as an exaggerated protest against an unresponsive and unreliable Jake, and insecurity about the future of her relationship (Mikulincer and Shaver 2014).

Alice's style of attachment has given rise to a pattern of helplessness, a willingness to please, a fear of asserting herself and a reliance on the 'other', often experienced as an "other-directed" quality (Wallin 2007, 229). It is likely that at the beginning of the relationship, this pattern led to Alice idealising Jake, a pattern that is also likely to occur in therapy. Some research has indicated that avoidant individuals like Jake, have difficulty with conflict resolution due to hostility, and also have overt and grandiose narcissistic tendencies (Firestone 2017; Mikulincer and Shaver 2012). Jake was drawn in by Alice's idealisation, dependence and doting in the beginning however because he is avoidantly attached, his tendency is to deny attachment needs, avoid closeness and dependence by using deactivating strategies. "These strategies develop in relationships with attachment figures who disapprove of and punish closeness and expressions of need or vulnerability" (Mikulincer and Shaver 2012, 11). Consequently, Jake tends to use evasive communication and withdrawal strategies (Bonache, Gonzalez-Mendez, and Krahé

2019), whether directly or indirectly (for example, passive aggressive behaviour such as sarcasm, criticism, stalling, resisting, lying, contempt or sullen resentment), which can become violent when Jake and Alice get into a push-pull dynamic (demand-withdrawal); that is, the differing needs for closeness and distance between them (Doumas et al., 2008; Mikulincer and Shaver 2014). Although there are differing negative patterns of interactions, for example, pursuer/pursuer and withdrawer/withdrawer, the most common appears to be the push/pull of the pursuer/withdrawer pattern that we are describing (Slootmaeckers and Migerode 2019).

Alice, fearing rejection and hence being constantly concerned with Jake's distant responses to her attempts at proximity and closeness, may attempt to receive reassurance in a number of ways, for example: she may vacillate between escalating her distress (hyperactivating unconscious strategies pulling for intimacy) and being more ready to engage in conflict and becoming controlling (or aggressive, either directly or indirectly), whilst being helplessly unable to reject Jake's coercive or aggressive behaviour (often giving rise to using violence herself in response); in turn, Jake may become controlling, coercive or aggressive as he tries to avoid her intrusive and persistent demands (unconsciously pushing away from intimacy); she may give in to coerced unwanted sexual interactions for complex reasons, including because of her need for intimacy; or, she may interpret Jake's responses more negatively due to high attachment anxiety (Bonache et al., 2019; Mikulincer and Shaver 2014). In the current example, Alice's anger is understood as a consequence of an attachment loss, giving rise to the fear of abandonment, and activating her attachment system in a paradoxical attempt at seeking intimacy and closeness (Slootmaeckers and Migerode 2019). Hence, the partner becomes both the cause and solution to one's attachment need – Alice's need may ignite Jake's unresolved/unsatisfactory attachment trauma and vice versa – a cycle of hurt and hurting continues (Goldner 2014).

Distinctions in therapy when working with IPV

An attachment focused view may also be helpful when considering the attachment patterns of individuals and/or couples who are experiencing coercive controlling violence (CCV); however, it is essential that this type of violence is differentiated and partners are seen for individual and not couple therapy given the risk to escalating violence and unethical consequences with CCV (Karakurt et al., 2013; Karakurt et al., 2016; Slootmaeckers and Migerode 2019). As a unidimensional phenomenon, CCV perpetrators appear to have insecure attachment styles too, and may demonstrate a similar preoccupation with the

relationship, a constant and persistent desire for closeness, which can border on obsession, and exaggerated fears of abandonment and loss (Almeida et al., 2019; Dutton and White 2012). A violent perpetrator with an anxious attachment style facing a similar fear of abandonment and loss to Alice could in protest quickly escalate to rage and violence; or if they had an anxious avoidant attachment style like Jake, could use violence to distance themselves from the partner.

Seen from an attachment view, using inappropriate behaviour such as violence may be regarded as the individual's failure to mentalise. Individuals with emotionally poor or abusive and violent environments, who have not been 'mentalised' by others, in an attempt at communicating overwhelming and unmanageable affective states, appear to not perceive a victim/survivor as a feeling and thinking being; indeed, having had a balanced experience of mentalising by significant others, may make it very hard for an individual to hurt and abuse an 'other' (Asen and Fonagy 2017; Fonagy 1999; Goldner 1998; 1999; 2014; Slootmaeckers and Migerode 2019).

Transference and countertransference

In therapy, Alice's need to be rescued manifested by her helplessness and her eagerness to engage (transference), the therapist's need to rescue or to be idealised as the good and helpful therapist, and the therapist's sense of vulnerability (countertransference) may strike at the core of therapist self-concepts (Sanderson 2009; Wallin 2007). If Alice's therapist remains focused only at the surface level reality, colluding with her defensive hyperactivating by being over-protective, without considering what may lie beneath Alice's defensive style, she may deny Alice "…the opportunity to grapple with the fear and distrust that make her compliance and pleasing feel so necessary" (Wallin 2007, 227). In considering countertransference, a therapist may feel a sense of powerlessness as well as helplessness and so may become invested in a particular outcome for Alice. For example, by constantly reassuring her, the therapist may unconsciously enact power over Alice, ratifying her sense of helplessness, which may be due to the therapist's own history of problematic romantic engagements, IPV victimisation, and/or trauma history, or the activation of a similar attachment style to Alice's. Goldner (2014, 403) suggested that clients or couples can often remind therapists of their own "shameful history of romantic loss and failure", whether conscious or not, and attempts to ward off aspects of selves that identify with this experience all too well. Alternatively, therapists that are preoccupied themselves may respond to Alice's dependency needs by becoming completely dependable, often going beyond the usual remit of their therapeutic practice and assuming full responsibility for Alice's

situation, (for example, out of hours contact) and thwarting possibilities for promoting her autonomy and sense of competency (Slade 2016; Watson, Carthy and Becker 2017). Assuming responsibility for Alice's situation can contribute to a sense of one's therapeutic efficacy and self-belief, which is often the very quality a therapist with a preoccupied attachment style may not have developed. If therapists are not aware of what evokes in them a need for control to assuage their own feelings of helplessness, they are at risk of failing to relinquish control and restore this sense in a victim/survivor (Sanderson 2009).

On the other hand, therapists who have insecure attachment styles, perhaps because of their own experiences of loss and trauma, and past punitive and dismissing caregivers, may feel a lack of empathy for Alice, consequently becoming withdrawn and controlling (for example, being prescriptive), and becoming focused on Alice's defensive interactions rather than on her desire to connect. Alice's dependency needs may evoke a fear-based intolerance to being regarded as too important, leading to rejection, dismissal or anger, a reaction to the feelings of dependent longing that the therapist is unable to tolerate given her own childhood losses (Slade 2016; Wallin 2007). Moreover, Alice's dependency may be experienced as intrusive when the therapists' ability to self-regulate is through distancing (Slootmaeckers and Migerode 2019). Similar to Alice's relationship experience with Jake, the therapist's defences and anxieties may easily be triggered to the point of inability to effectively self-regulate, leaving Alice with the same deep sense of shame at her inability to resolve her romantic crisis (Goldner 2014).

Typical responses when working with violence in relationships

> *"Milton Erickson used to say to his patients, "My voice will go with you." His voice did. What he did not say was that our clients' voices can also go with us. Their stories become part of us – part of our daily lives and our nightly dreams. Not all stories are negative - indeed, a good many are inspiring. The point is that they change us."* (Mahoney, cited in Macnamara, 2019, 4)

As illustrated in Alice's case study, violence in relationships can evoke fear and anxiety, leaving therapists to question their therapeutic ability and competence in the face of what seems a complex and hopeless situation; whether conscious or unconscious, they may doubt their own experience or knowledge base, and feel overwhelmed because they cannot 'fix' the situation (Karakurt et al., 2013; Watson et al., 2017). Therapists' own violent family of origin experiences can

trigger fear and a sense of hopelessness resulting in the avoidance of exploring a client's full experience of feelings, wishes, desires, and expectations; in particular, the therapist's own unresolved and 'unthought of' traumatic attachment material can pose a barrier to confront Alice's past (Briere and Scott 2006; Brosi and Carolan 2006). In their study, Watson et al. (2017, 227) define helplessness as:

> *"…an absence of hope amongst participants in their confidence to work appropriately with women disclosing IPV. This is supported by the therapists' belief that the intervention offered would not have a positive impact on the patient. Therapists defined a positive impact as the patient leaving the abusive relationship. One participant spoke of her wish to "fix" a patient despite stating that she had no idea how to help."*

In the face of such raw and overwhelming emotions, therapists may also attempt to avoid, dissociate, minimise, or resort to the cognitive realm and impose rigid therapeutic models. Alternatively, they may vacillate between the desire to care-give and the desire to abdicate caregiving, as often happens in other relationships (Brosi and Carolan 2006; Goldner 2014).

For therapists working with CCV in particular, where the violence is unidirectional and visited by one person on another, the sense of hopelessness can become 'contagious' and therapists may experience fear of harm to themselves, become hypervigilant, not only at work but also in their personal lives, which may negatively impact their worldview (Beckerman, 2018) and result in them experiencing a number of effects, such as vicarious traumatisation (VT), secondary traumatic stress (STS) or compassion fatigue (CF). All three of these terms refer to the negative impact of clinical work with traumatised clients and even though there are some distinctions in terms of theoretical origin and symptom foci (Bride 2007) the terms recognise that counsellors who are exposed to their clients' trauma material can also be traumatised. In fact, in 2013 traumatisation resulting from secondary or vicarious exposure was formally recognised by the American Psychiatric Association (Brend, Krane, and Saunders, 2019). Morran (2008, 139) asserted that "the term 'vicarious' or 'secondary trauma' has been coined to describe a range of symptoms which impact negatively on professionals' emotions and core beliefs about themselves, their relationships with others and the nature of the world in general". Moreover, Morran (2008, 139) added that this includes "disruptions to feelings of intimacy and trust, self-esteem, safety, autonomy and personal agency, as well as debilitating intrusions such as flashbacks or lingering preoccupations with the painful experiences of others". In their article, Dunkley and Whelan (2006) pointed out that working with traumatised clients can lead some

counsellors to experience anger, sadness and anxiety and even nightmares related to their clients' traumatic material.

Therapist self-care

Therapists working in the area of IPV can protect themselves from the negative impacts of working with traumatic material by ensuring they balance care for other with care for self. Therapist self-care strategies that are restorative, such as good diet and exercise, meditation and mindfulness, reading, monitoring their caseload and identifying clients' resilience and strengths appear to be most helpful in managing the stress resulting from working with clients experiencing IPV (Brend et al., 2019). Organisations on the other hand, are starting to recognise the inevitability of vicarious/secondary trauma and addressing the risk of vicarious traumatisation in their staff by providing appropriate supervision, adequate training and allowing increased time to debrief and discuss cases (Beckerman, 2018).

Moreover, Briere and Scott (2006, 84) propose that an additional intervention is personal therapy:

> *It is an ironic fact that, at least in some environments, clinicians endorse the power of psychological treatment for others yet eschew it for themselves as somehow shameful or unlikely to help. This double standard is unfortunate, since having experienced psychotherapy is usually a good thing for therapists. Therapy is not only likely to reduce the clinician's trauma-related difficulties; it can also increase the richness of his or her appreciation for human complexity, and can dramatically decrease the intrusion of his or her issues into the therapeutic process.*

Although many therapists who have experienced attachment difficulties, loss, trauma and emotional pain may be more familiar and even comfortable with working with this population, unintegrated affect in therapists can negatively impact the work (Slade, 2016). Professional development should include not only supervision, with a focus on transference, countertransference and clinical process, but also separate personal therapy. Despite the risk to therapists of working with this population, a number of studies have also shown that this work could be enriching, with therapists describing a sense of privilege in sharing their clients' struggles or a sense of enjoyment in seeing their growth and change (Hogan et al, 2012; Iliffe & Steed, 2000).

CONCLUSION

This chapter discussed some of the issues that arise in therapeutic work with victims/survivors of IPV. Victimisation by IPV is a complex phenomenon that affects many individuals from every demographic background. While it is acknowledged that men are also victims of IPV, the abuse and violent behaviour is overwhelmingly directed against female intimate partners, and may include physical and/or sexual violence along with emotional, psychological, verbal, and economic abuse. An examination of typologies used to differentiate IPV was presented along with a qualification regarding the potential consequences of relying indiscriminately on these, namely, that certain types of IPV are minimised given that they occur all too commonly and are subsequently regarded as not that concerning. Following this discussion, Attachment Theory was presented as an explanation of how affective exchange between individuals forms the basis of social life, with an emphasis on emotions as relational experiences and therefore fundamental to one's capacity to mentalise, both self and others, in the quest to understand human behaviour. Additionally, working with victims/survivors of IPV and focusing on the conscious and unconscious dynamics in therapy, such as the attachment styles of both therapists and clients, was discussed through the use of a hypothetical case study. Though we acknowledge that IPV is a gendered phenomenon as females are the majority of victims/survivors of IPV, particularly through coercive and controlling tactics by intimate partners, the case study presented an example of a couple where both used violence, given the focus was primarily on highlighting attachment dynamics, rather than all the myriad factors to consider when couples present to therapy with IPV. Finally, the typical responses experienced by therapists when working with this population group were discussed.

The consequences to many victim/survivors of IPV are both extensive and severe, and therapists, like many first responders to traumatised and victimised individuals, are impacted by witnessing and hearing victims/survivors' stories and can be left vulnerable. The importance of self-awareness apropos one's own family and attachment dynamics and how these shape individuals, together with concerted efforts at balancing care for other with care for self, will contribute to the positive influences of working with this population group.

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