

Working Relationally With Clients Who Have Experienced Abuse: Exploring Counselling Psychologists' Experiences Using IPA

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Abstract

Whilst much research has been conducted into the efficacy of and guidelines for technical interventions in the treatment of abuse, it is argued that a relational or process approach to therapeutic work should become more integrated into the use of technical interventions to aid therapeutic outcome. The study aims to explore counselling psychologists' experiences when working with clients who have experienced abuse. Semi-structured interviews were conducted and analysed using Interpretative Phenomenological Analysis (IPA). Six participants were recruited and asked to share their experiences of their therapeutic work with the client group. The research was given ethical approval by the ethics committee of the university. Three superordinate themes emerged from the data: 'The Holding Environment', 'The Personal versus The Professional' and 'Internal Responses, External Communications'. These were supported by various subthemes within the accounts and were generated as a result of a double hermeneutic engagement with each interview transcript. This research contributes towards a deeper understanding of the processes involved in creating a therapeutic space for the work and the relational dynamics involved in providing therapy to clients who have experienced abuse. The dynamic process between empathising and 'detaching' in session, as well as counselling psychologists' use of supervision, are highlighted as areas for further study.

Keywords: counselling psychology, abuse, therapeutic relationship, relational dynamics

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Counselling psychologists are both reflective and scientific practitioners and recognise the importance of marrying the creation of a trusting therapeutic relationship with clinical and technical expertise (Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016). Whilst much research has been conducted into the efficacy of and guidelines for technical interventions in the treatment of abuse (e.g. Weine et al., 2002), Schottenbauer, Glass, Arnkoff, Tendick, and Gray (2008) argue that a relational or process approach to therapeutic work should become more integrated into the use of technical interventions to aid therapeutic outcome. This 'both/and' approach to practicing sits in harmony with the pluralistic values of the counselling psychology discipline (Cooper & McLeod, 2012). For example, whilst empirically supported treatments for PTSD, such as trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR), have been found to be helpful for many clients, these treatments have also been found to have high non-response and drop-out rates, as high as 50 per cent (Schottenbauer et al., 2008). Hubble, Duncan, and Miller (1999) view the quality of the therapeutic relationship as being of central importance to the therapeutic outcome and highlight such positive outcomes of treatment as being associated with the therapists' interpersonal skills as well as the client's engagement in therapy. Integrating a relational approach within the provision of therapy to clients of

this population is of crucial importance since the treatment process for this client group is not always linear; instead, it is a fluid process, warranting responsiveness and reflexivity on the part of the therapist (Edwards, 2010). Furthermore, creating an adequate therapeutic foundation before exploring and processing previous traumatic experiences, is advocated (Chu, 1992).

Fallot and Harris (2009) highlight five principles considered essential for the provision of therapy to clients who have experienced abuse; safety (ensuring physical and emotional safety), trustworthiness (maximising trustworthiness through task clarity, consistency and interpersonal boundaries), choice (maximising client choice and control), collaboration (maximising collaboration and sharing of power) and empowerment (prioritising empowerment and skill-building). It could be argued that these principles, namely safety and trustworthiness, reflect Winnicott's notion of a 'holding environment', which illustrates a need for the metaphorical 'holding' of a client's emotional distress. Such 'holding' is understood in terms of containment, safety and trust (Slochower, 1991). Winnicott (1963) explains that during the holding phase, the individual will acquire the capacity to 'self-hold', or regulate and validate their own emotions, and be in relation with others. The client-therapist relationship is thought to closely resemble that of the child-caregiver relationship (Bowlby, 1973) and it could, therefore, be considered that the relationship between the client and therapist could provide a 'corrective' emotional experience, allowing clients the experience of processing and containing their emotional experiences, being in relation with another and developing a coherent sense of self (Jones, 1983). The principles of choice, collaboration and empowerment, as evidenced by Fallot and Harris (2009) for the provision of therapy to the client group, are reflective of the humanistic value base of the counselling psychology discipline. Indeed, Bugental (1964) indicate that "human beings have some choice and, with that, responsibility" (p. 1). Cooper (2009) identified key principles across counselling psychology literature which map onto the principles of collaboration and empowerment; "a commitment to a democratic, non-hierarchical client – therapist relationship" and "an orientation towards empowering clients" (p. 5). Based on the evidence, it would appear that counselling psychologists are well-placed to provide therapy to this client population.

However, the extent to which therapists can provide such factors or offer a holding environment may be greatly influenced by the dyadic client-therapist relationship and relational process. The therapeutic process for clients within this population has been referred to as a "therapeutic roller coaster" due to the client's difficulty in maintaining relationships and self-destructive behaviours (Chu, 1992, p. 351). Furthermore, backgrounds of abuse, abandonment and betrayal are often re-enacted in therapy (Chu, 1992). Transference can be defined as "projection of a mental representation of previous experience on to the present, whereby others are treated as though they are playing a complimentary role" (Hughes & Kerr, 2000, p. 3), whilst counter-transference can be defined as the responses evoked in the other as a result of these projections (Hughes & Kerr, 2000). Such responses evoked in the therapist may manifest in power struggles or feelings of incompetency when working with clients expressing anger at the therapist, frustrations when working with clients who do not co-operate with treatment and adopting a 'rescuer' stance when working with clients who adopt a 'victim' role in treatment (Karpman, 1968). Such counter-transference reactions may affect counselling psychologists' ability to offer the principles outlined by Fallot and Harris (2009), namely those of choice, collaboration and empowerment. Counter-transference reactions are dependent of the 'self' of the therapist and their own 'patterns' (Earley, 2013) or 'schemas' (McCann & Pearlman, 1990), thus self-awareness and personal reflection are crucial on the part of the therapist to avoid re-enacting unhelpful and potentially damaging relational patterns. The awareness and use of self has been understood as a key component of counselling psychology practice (e.g. Reupert, 2008). The European Federation of Psychologists' Associations (2017) provides standards for training, which include

the “critical self reflection on own practice...” (p. 49) and UK counselling psychologists are required to “be able to critically reflect on the use of self in the therapeutic process” (Health and Care Professions Council [HCPC], 2015, p.12). The ‘use of self’ can be understood bi-dimensionally, in terms of an awareness of the person of the professional and how this may influence clinical practice, for example, the therapist’s own attachment style, schemas, values, etc. as well as understanding the emotional and cognitive experiences of the client through the therapist’s affective attunement (Pagano, 2012). Such affective attunement is not without its difficulties whereby vicarious trauma (VT) and burnout (e.g. Rasmussen, 2005) can occur in the therapist.

Given the need identified by Schottenbauer and colleagues (2008), this study seeks to identify counselling psychologists’ experiences of working relationally with individuals who have experienced abuse. ‘Abuse’ in the current study refers to: childhood sexual abuse; adult sexual, emotional/psychological, physical and spouse/intimate partner abuse (for a clinical definition of these terms, please see Appendix 1). The research questions were derived from the researcher’s clinical practice in this area (e.g. Schon, 1983) and the study is intended to shed light on the processes involved in being in relation with, and providing therapy to, the client group.

The objectives of the study were:

- to explore counselling psychologists’ experiences of the building the therapeutic relationship with clients who have experienced abuse;
- to explore counselling psychologists’ experiences of the relational dynamics, including transference and counter-transference, involved in the provision of therapy to the client group, and;
- to explore counselling psychologists’ understanding of their ‘self’ within the work.

Method

Design

Given the exploratory nature of the research, Interpretative Phenomenological Analysis (IPA), which seeks to study the personal experience of the participant and how they make sense of that experience, was the most appropriate methodology for the study. It sits within the existential-phenomenological research paradigm and thus, is congruent with the humanistic value base of the counselling psychology discipline, concerned with individuals’ unique subjective experiencing and meaning-making process (Cooper, 2009). Rather than seeking one objective truth, the underpinning epistemology of IPA asserts that meaning is constructed through the contextual and dynamic exchanges within the personal and social aspects of experiencing (Smith, Jarman, & Osborn, 1999), thus implying a relativist ontology in which there are as many realities as there are participants (Morrow, 2007). This further echoes the pluralistic philosophy on which counselling psychology rests (Cooper, 2009).

IPA allows the researcher to gain an insight of the participant’s world through analysis of the content and interpretation of the meaning behind their narrative. Indeed, the researcher engages in an “interpretative relationship with the transcript” (Smith & Osborn, 2003, p. 66), thus meanings are co-constructed between participant and researcher. IPA is not prescriptive and each researcher will have their own personal way of working and will interpret the data differently (Silverman, 2006). Furthermore, IPA posits that the tension that exists between

Table 1

Participant Demographic Details

Participant Name	Sex	Years Post Qualification
Christina	Female	1.5
Paul	Male	5.0
Joanne	Female	1.5
Becky	Female	2.0
Neil	Male	6.0
Fiona	Female	14.0

the interpretation and text is something to be embraced rather than resolved if the interpretation is to be meaningful (Smith & Osborn, 2003).

Participants

The sample consisted of six counselling psychologists who self-defined as having had experience of working with clients' who had experienced abuse, both during their training and post-qualification. Participants were recruited via an advertisement displayed in the British Psychological Society (BPS) Division of Counselling Psychology (DCoP) newsletter and an advertisement circulated across independent psychological services. Purposive sampling was also used to acquire a homogenous sample that would meet the inclusion criteria; (a) qualified counselling psychologists registered with the HCPC in the UK and (b) counselling psychologists who had experience in working with clients who had experienced abuse, as previously defined. The extent of experience of such working was not determined via the inclusion criteria, since the intention was not to recruit a cohort of specialists in the specific field: participants determined whether their experience in working with the client group would allow them to contribute meaningfully to the study. Whilst the nationality of participants varied, all were currently practicing within the UK highlighting the socio-cultural context within which the research took place (Yardley, 2000). Their ages ranged between 27 and 53 years (mean = 36) and the number of years they spent practicing post qualification ranged between 1.5 to 14 years (see Table 1. for full demographic details of participants).

Procedure

Participants who responded to the research invitation were provided with a participant information form outlining details of the study and, once consent was obtained, were invited to participate in an interview lasting approximately 60 minutes. Four interviews were conducted in person and two were conducted via Skype due to geographical constraints. A semi-structured interview, consisting of eight open-ended questions, was used during the study. Interjections were made by the interviewer to clarify points or facilitate conversation (Hunt & Smith, 2004) and sensitivity and attentiveness to participants was demonstrated by offering empathic reflections, space and time for thought and breaks were offered should the participant deem it necessary (Yardley, 2000). Consistent with IPA recommendations (Smith, Flowers, & Larkin, 2009), interviews opened with more general questions (e.g. 'what strengths do you think that you bring to your work with this client group?') before moving on to the more specific questions pertaining to the focus of the research (e.g. 'did you experience any strong positive or negative feelings of the client towards you?' and 'did you experience any particular emotional

or physiological responses in your work with the client group? If so, how did you manage these at the time?'). All interviews were recorded, were later transcribed verbatim and were analysed using IPA.

Ethics

This study was conducted in adherence to the [BPS Ethics Committee \(2009\)](#) and the [BPS code of human research ethics \(2010\)](#). Additionally, [Yardley \(2000\)](#) details four concepts to consider when conducting a piece of qualitative research, since establishing validity and reliability in qualitative research differs from that of quantitative research. These are highlighted as sensitivity to context, transparency and coherence, commitment and rigour and impact and importance and were considered in the conduct of this research study. An information sheet was provided to prospective participants detailing the aims of the study and what participation in the study would involve ([Yardley, 2000](#)). Once it was clear that the participant was fully aware of the research study and all that participation in the study would entail, verbal and written consent was obtained. Participants were made aware that they were not obligated to participate in the study, that they could refuse to answer any question should they desire and that they could withdraw their participation, up to the point that the transcripts had been analysed; thus, their autonomy was respected ([BPS Ethics Committee, 2009](#)). Time was taken prior to the interview to build rapport and any questions that participants had were answered ([Yardley, 2000](#)). Upon completion of the interview, a written debrief was provided, detailing the nature of the study and relevant resources that could be accessed in the event of the participant requiring additional support, thus reducing harm to participants ([BPS, 2010](#); [Yardley, 2000](#)). Contact details of the researcher and supervisor were also provided, should participants wish to raise any concerns, which helped to communicate researcher accountability ([BPS, 2010](#)). Lastly, all material, including recordings and transcripts, were stored responsibly and safely and pseudonyms have been used to assure participants' anonymity ([BPS Ethics Committee, 2009](#)). This study was granted ethical approval by the university ethics committee.

Data Analysis

IPA is idiographic in nature ([Smith & Osborn, 2003](#)) and as such, each transcript was analysed individually in the first instance. Notes regarding the initial thoughts about the transcribed quotes were made, aiming at this stage to stay close to the meaning of the text ([Smith & Dunworth, 2003](#)). These notes consisted of summaries of the narrative, links to previous information within the data and comments on quotes or metaphors used. The transcribed data was re-read and key themes summarising each section within the interview transcription were extracted and noted. Following the nature of IPA, beginning with specifics and moving on to more general claims ([Smith, Harre, & Van Langenhove, 1995](#)), themes were pulled together from each data set to identify cluster themes and super-ordinate themes within the full data set. Consistent with Smith and Osborn's recommendation ([Smith & Osborn, 2004](#)) and by way of considering rigour ([Yardley, 2000](#)), the notes and themes were checked against the individual text (e.g. quotes) and the larger text (the interview) to ensure accuracy of analysis. In other words, that the emerging themes remained embedded in the original text and therefore representative of participants' narratives. In addition, emerging themes were brought to the researcher's supervisor to check against the data ([Smith & Osborn, 2004](#)). As the process of interpretation is subjective on the part of the researcher, critical reflection is an important process to ensure that the true experiences of the participants are expressed. As such, a reflexive journal was kept throughout the process to record the progression of the researcher's thoughts and ideas ([Robson, 1993](#); [Silverman, 2000](#)). Furthermore, the researcher's own clinical interest and experience has potential to create bias when interpreting the data. Nevertheless, the researcher

has attempted to acknowledge these biases and attempts to ‘bracket’ existing knowledge and preconceptions were made throughout the analysis (Giorgi, 1985; Yardley, 2000).

Results

Three superordinate themes emerged from the IPA of all six participants’ accounts. These superordinate themes were supported by various subthemes within the accounts and were generated as a result of a double hermeneutic engagement with each interview transcript; that is, where the researcher attempted to make sense of the participants, making sense of their experiencing (Smith, Flowers, & Larkin, 2009). The three superordinate themes include; ‘The Holding Environment’, ‘The Personal versus The Professional’ and ‘Internal Responses, External Communications’ (for a summary of the emergent themes, see Table 2). In the excerpts that follow in the presentation of each theme, ellipsis points within brackets have been used to denote missing text, ellipsis points denote a pause in the participant’s speech and pseudonyms have been used to protect participant anonymity.

Table 2

Summary Table of Superordinate Themes and Subthemes

Superordinate Themes	Subordinate Themes
1. The Holding Environment	a). Building Trust b). Boundaries: Firmness vs. Adaptability
2. The Personal versus The Professional	a). Empathising vs. Detaching b). Meaningfulness and Managing the Challenges of the Work
3. Internal Responses, External Communications	a). Holding vs. Naming Emotional Responses b). Self-care

Superordinate Theme 1: The Holding Environment

The Holding Environment concerned participants’ experiences of the creation of the therapeutic space within which the therapeutic work could take place. Within this superordinate theme were two subthemes; ‘Building Trust’ and ‘Boundaries: Firmness versus Adaptability’. Both of which seemed important to the creation and maintenance of the Holding Environment for this client population.

(a) Building Trust

Participants commented on the factors they used to develop trust in the therapeutic relationship. Consistency in providing the therapists’ core conditions (Rogers, 1957), particularly empathy, was highlighted as helpful:

“regardless of how they are trying to navigate and develop this relationship, [...] I will be consistent with at least empathy if not all the core conditions”. (Becky)

Empathy was further highlighted as a means by which the client could feel supported and ‘held’ within the relationship:

“being able to feel what they're feeling [...] this can create trust very, very quickly with abused clients, they need to feel held and contained, they need to feel heard they need to feel that someone's on their side”. (Neil)

Participants made reference to the therapist staying with the client's emotional pain as helpful in building trust:

“there has to be a process where you really stay with a client's pain and you're really able to hold the client no matter how distressful it is for you”. (Christina)

Disclosing previous experiences of working with clients who have experienced abuse was indicated as a factor in allowing clients to build a sense of trust in the therapist:

“using self-disclosure for example, about the kind of client base you've been working with in the past [...] they tend to respect that and that can sometimes help them with the trust building”. (Neil)

Building trust was also associated with the foundations of the therapeutic work and in assisting clients' engagement in therapy:

“there is something about building a very trusting relationship and in return they keep coming back to the sessions”. (Christina)

(b) Boundaries: Firmness Versus Adaptability

Participants discussed a process of boundary setting within the therapeutic relationship. Some indicated the need for consistency and clarity when setting boundaries for the therapeutic work and in creating the holding environment:

“I try to be very consistent in terms of times [...] when I see them and to be very clear of how many sessions I'm going to see them”. (Christina)

Some also made boundaries explicit from the outset of the therapeutic relationship:

“the ending is named from the beginning because often this particular client group can experience real difficulty with endings, so that's all part of the boundary, it's all out there, nothing's hidden”. (Fiona)

However, many participants made reference to the boundaries becoming blurred during the therapeutic process and highlighted clarity as helpful in re-setting the boundaries:

“I could feel that we were going in the wrong direction here, you know I'm not your friend and I'm not your daughter, I'm a therapist so let's stick to that”. (Christina)

Participants also referenced the usefulness of discussing the blurring of boundaries with clients in session, bringing such issues into the open and making the boundaries explicit:

“they maybe start to think of you as [...] a relationship or start to see you in that light [...], when that really did come up uhm, it was just talking about the in the session and not kind of shying away from it”. (Joanne)

The importance of setting and communicating boundaries, by way of modelling healthy boundaries for clients, was important to some participants. It was also indicated as helpful for the participants themselves:

“having to set boundaries [...] you know, ‘you can't really speak to me that way, you can't shout at me [...] and not expect me to be affected by that’, you know, so it was a very delicate balance of wanting to

be there needing to be emphasising empathy and unconditional positive regard but also standing my ground so they knew that they couldn't just treat me in any which way.” (Becky)

However, the difficulty in participants setting and communicating clear boundaries was evident for some and regarded as a skill that had to be developed:

“I find conflict quite uncomfortable and standing up for myself in that way, [...] I [...] really had to develop assertiveness to really effectively work with this client group”. (Becky)

Whilst setting boundaries seemed important for the creation and maintenance of the holding environment, being adaptable and responsive to clients' needs seemed a particularly important consideration for the client population:

“very often with abuse you know it's a lack of control, you know, they had no control over what was happening”. (Paul)

Participants described adapting the parameters of the relational framework to meet the needs of their clients at particular moments in time:

“she was very risky at the moment, eh we were going to do safety and stabilisation work and I felt that having a solid grounding in the therapeutic relationship would be beneficial and that then we would go to weekly”. (Joanne)

Acknowledging that the client had made progress and now no longer required bi-weekly appointments, Joanne made efforts to prepare her client for returning to weekly meetings, highlighting transparency as useful in doing so and indicating a process of re-setting boundaries:

“we [...] made it very explicit and, kind of, every session then we talked about ‘ok you know, we have four more sessions twice a week and then going down to one a week’, ‘three more sessions and then we're going down to one a week’”.

A 'both/and' element was evident in this subordinate theme. In other words, participants described both 'firmness', in terms of setting boundaries, as well as 'adaptability', in order to best meet perceived client needs.

Superordinate Theme 2: The Personal Versus The Professional

The second superordinate theme concerned a sense of tension experienced by the participants in their work with clients who had experienced abuse. Participants highlighted the impact of hearing clients' narratives on the person of the professional and highlighted the delicate balance between empathising with the client's experiencing and narrative and keeping themselves safe and able to offer an alternative perspective. Participants also recalled the challenges of the work and the importance of reminding themselves of the client's realities and of the rewarding nature of the work. Subthemes within this superordinate theme include; 'Empathising versus Detaching' and 'Meaningfulness and Managing the Challenges of the Work'.

(a) Empathising Versus Detaching

Participants described the emotional impact of the client's narrative on their selves in session. One participant described becoming emotionally affected when the client appeared child-like in session:

“it was really interesting to see how when they would be so distressed they would kind of emotionally and physically regress to these kind of younger ways of coping and that really affected me, watching

these people turn into these really [...] young- I'd never really seen anything like that before and I think that was something that really got to me". (Becky)

Similarly, another participant described becoming emotionally moved by clients' reactions to their input:

"she, you know, broke down completely at that point, you know, was crying and tears were streaming and it was such a strong reaction from her that maybe I hadn't expected, because you know I've told a lot of people that over the years and- [...] that definitely choked me, in the session". (Joanne)

Another participant described feeling shocked upon hearing and empathising with clients' stories:

"I can't stop thinking how much pain these people went through and it strikes me. It's shocking, it's very shocking and sometimes you hear stories that are very shocking and you can't help, you know, you can't help but to be shocked". (Christina)

The risks associated with empathising on the person of the professional were highlighted:

"you can't help to think you are a human being as well so it could happen to you at any time." (Christina)

Such risks resembled symptoms of VT for one client:

"like I woke up one night and I was randomly having nightmares... eh... or panic attacks in the middle of the night and I have no idea where it comes from but you know, talking about suicide prevention, it sounded like vicarious trauma." (Christina)

Due to such risks associated, participants highlighted the need to protect oneself in session in order to be able to function usefully as a professional:

"they come into the session with a lot of hopelessness and helplessness and I think that its sometimes easy to get trapped into that and feel stuck with the client, not knowing what to do with them anymore and I think that it's very important to take a step back and actually start looking at 'OK, what is it here that we really need to do?' and put your professional hat on". (Christina)

Christina further highlighted the longer-term learning process involved in protecting herself via 'detaching' when she described a process of 'teaching' herself:

"that's a huge challenge you know, just to learn and teach yourself how much to keep in the room and draw the line really from empathising with the client, being with him and also separating yourself you know what is going on [...] it's like I've got another level of detaching really".

(b) Meaningfulness and Managing the Challenges of the Work

Participants recalled the challenging nature of the work with the client group. In recalling her sense of frustration with regards to the speed of clients' processes, one participant described a meaning making process which helped her in managing this challenge:

"when I've been thinking of progressing through the work or if they have sort of lapses, to remind myself of the reality of their situation". (Joanne)

Becoming aware of the challenges that she experienced with the client group was helpful for another in offering empathy:

“And then my supervisor, [...] she was wanting me to notice the consistency, but eventually she just pointed out to me that the only clients that I was having problems with were from the organisation of the survivors of sexual abuse [...], so once [...] I realised it was only in that population, I think that's when my empathy held even MORE”. (Becky)

Despite the challenges and difficulties faced, Becky pointed to the therapeutic work as something which is very special, meaningful and difficult to articulate:

“like there's no words really, it is so unbelievable and some of the things for them to be there and trust you with that, it's very precious yeah, it's very unique uhm, so yeah it is a very rewarding group to work with”.

Similarly, another participant highlighted the positive experiences and sense of satisfaction he receives in working with the client group, perhaps in boosting his personal and professional sense of self:

“we all want to do a good job don't we, we want to help our clients to overcome their difficulties and to grow psychologically, spiritually so, it's a very very rewarding client group to work with because you can make an awful lot of difference”. (Neil)

These participants highlighted the meaningful nature of the work, which therefore assists in managing the challenges experienced.

Superordinate Theme 3: Internal Responses, External Communication

This superordinate theme concerned the participants' process of holding their emotional and physiological responses evoked during session, deciphering the origin of the response, either the client's material or the therapist's material, and whether to share these responses with the client. The usefulness of communicating these internal responses to the client and the therapist's commitment to their emotional process, in the form of supervision and self-care activities, is also highlighted. This superordinate theme comprised two subthemes; 'Holding versus Naming Emotional Responses' and 'Self-care'.

(a) Holding Versus Naming Emotional Responses

Participants described a process of holding their responses in order to identify whether the emotions felt are their own or emotions that the client wishes to evoke in them:

“you have to be aware of how you're feeling towards the client because the client can then be evoking that response from you”. (Neil)

Participants highlighted an awareness of the client's transference, their subsequent counter-transference reactions and the usefulness of this awareness in guiding the therapy:

“you're using your emotionality within the room to help steer the therapy because if you're feeling anger, feeling like a protector, that's probably because that's what the client is looking for... She needs [that] in that moment to feel protected and content”. (Neil)

One participant described the difficulty of this in-session reflection and highlighted the process involved in bringing their felt responses to light to aid the client's process:

“it's very difficult. I try and not to automatically [...] act on something that I am feeling unless I am pretty sure that it has something to do with my client, although you can't always be sure about that. So I might

say something like 'oh my god I felt a bit sad when you said that, I'm wondering how that makes you feel'". (Christina)

'Naming' the relational processes apparent in the room was identified as useful in aiding clients' insight and modelling healthy relationships:

"it's almost like naming? Naming the thing that's going on in the therapy, in the therapeutic relationship because if it's going on there it's going on in most relationships in their lives and we use that as a modelling example". (Fiona)

Similarly, transparency was highlighted as useful in modelling healthy relationships and bringing relational dynamics to light to aid change:

"I've found transparency is really important with them because [...] I find that they're doing that to see kind of, where they stand with you, you know, 'what's going on, who is this person, can I trust this person?' 'I'm going to kind of push her around to see what she will and won't do to me, to see if I can really trust her'". (Becky)

Participants also described the complexity in the relational dynamic between client and therapist with the client evoking behavioural responses in the therapist and the therapist being receptive to such attempts at evoking, due to their own established ways of relating:

"there's a... an examination of the space between you which is the counter transference and the transference, how you're experiencing the client in the room. [...] we have to look at our own relationships and roles". (Neil)

Participants further highlighted a process of 'holding' or pulling back from taking up their usual roles, implying that it may not be helpful for the therapy:

"so I then become the protector in the room and the rescuer, that's the role that I tend to play with abused clients em and that sometimes can blind me so I have to understand that it's there and have to reflect and pull myself back". (Neil)

Similarly, Christina highlighted refraining from acting upon her own 'rescuer' stance as helpful in empowering her clients:

"I was very aware of this rescue moment, you know, of wanting to make it better". She further commented; "because if I try to help them I feel I become another person that takes power away from them. You need to empower them to save themselves. It's being aware of that rescue mode again..."

(b) Self-Care

All participants highlighted the importance of the supervisory relationship in supporting the therapist's self. Similar to the therapist 'holding' the client, the supervisor was able to 'hold' the therapist:

"to emotionally explode with somebody you feel really safe with and allow them to hold you because that's a huge relief". (Christina)

Participants discussed supervision as the space to explore personal feelings about the work:

“you can bring that to supervision as well, [...] (laughs) it's for that you know, you can let your inner voice out, how it impacts you, how you feel about it, you know, opinion calls on it, that's the space for that”. (Paul)

One participant highlighted the supervisory relationship as useful for him processing his own material and aiding his development:

“It's very important that you work it through. I had a client very recently [...] 16 year old boy was pushing my buttons in the room and it was difficult and I realised there was stuff there I hadn't dealt with before. Em and I realised that I had to seek supervision and I did. I spent a couple of hours talking it through so it's no longer a blind spot”. (Neil)

Paul made reference to ‘bringing’ something to supervision implying that he contained and carried his thoughts and emotions himself for a time. Participant’s detailed the usefulness of self-care activities in enabling them to hold and contain this material and one participant highlighted self-care activities as becoming fundamental in her day:

“things like exercise or mindfulness meditation became kind of- [...] doing that mindfulness, doing meditation was something that became a staple in my day to day life, just to give myself that space to really take care of myself”. (Becky)

Similarly, Christina highlighted the importance of taking care of herself after her working day and between sessions:

“there were times that I just went straight out and I couldn't- I was just concentrating on trying to listen to music and trying to shake my brain to somewhere you know really nice and you know, really- my safe place. There were times I went and talked to colleagues about it, [...], peer support really and it was very important”.

The importance of self-care activities was highlighted when one participant recalled finding it more difficult to manage clients’ transference over the course of the working day, and subsequently manage her own counter-transference manifestations:

“[it's] more likely that in your 5th and 6th appointment [...] you're feeling a bit more of the transference, it has a bit more of an impact and [...] it can be anything from tiredness but you can have some symptoms of anxiety as well when people are very hostile and ehm, you know very kind of in your face and ehm blaming and criticising, it can be quite draining. (Fiona)

Discussion

The study sought to explore counselling psychologists’ subjective experiences of working with clients who had experienced abuse, including their experiences of building the therapeutic relationship, the relational dynamics involved in the provision of therapy and their understandings of the ‘self’ within their work. Analysis of the data generated three superordinate themes and six subthemes. Superordinate theme 1, ‘The Holding Environment’, arose from participants’ discussion of the factors deemed necessary when working with the client population. Providing the therapist ‘core conditions’ (Rogers, 1957), particularly empathy, was seen as important in ‘Building Trust’ (subtheme 1). Therapist self-disclosure and the emotional ‘holding’ of clients’ material were also re-

garded as important factors associated with the trust-building process. This subtheme was consistent with previous research whereby offering clients emotional safety and developing trustworthiness (Fallot & Harris, 2009) were indicated as necessary factors involved in the provision of therapy to the client group. The second subtheme, 'Boundaries: Firmness versus Adaptability' concerned the 'both/and' approach to boundary setting and maintenance. Participants highlighted both aspects as necessary in providing therapy to the client group with one referring to the lack of control often experienced, or anticipated, by the client group. This subtheme echoed the principles of choice, collaboration and empowerment, as referenced in previous research (Fallot & Harris, 2009), and are further synonymous with the humanistic and pluralistic value base of the counselling psychology discipline (Cooper, 2009).

The second superordinate theme, 'The Personal versus The Professional', highlighted the impact of participants' empathic attunement to their clients and the risks that this creates, both for the professional work, in terms of feeling 'trapped' or unable to offer an alternative perspective in session, as well as for their personal wellbeing. Indeed, one participant suggested she had experienced VT, or traumatic counter-transference (e.g. Smith, Kleijn, Trijsburg, & Hutschemaekers 2007). Walsh and colleagues (2013) define this as "the painful and disruptive effects of trauma work on the clinician, which can be pervasive and cumulative following repeated empathic engagement with traumatic material" (p. 23). At the time of the interview, this participant had been qualified for one and a half years which may have been a contributing factor in the possible development of VT. Indeed, Walsh and colleagues (2013) highlight experience as mediating against VT. Due to the risks associated with empathic engagement, participants highlighted 'detaching' as a useful in-session coping strategy thus constituting the dynamic subtheme 'Empathising versus Detaching'. Participants referenced the challenges involved in work with the client group however, highlighted the meaningful and rewarding nature as enhancing their professional and personal esteem which constituted the subtheme 'Meaningfulness and Managing the Challenges of the Work'. Participants further derived meaning from the work by reminding themselves of their clients' realities and acknowledging the challenges that they experienced in the work. Whilst such 'rewarding' aspects of working with the client population may contribute to therapists' post-traumatic growth, an area receiving increasing clinical interest, such post-traumatic growth has been associated with practitioners' empathic engagement (e.g. Brockhouse, Msetfi, Cohen, & Joseph, 2011). Furthermore, the process of deriving meaning from the work has been identified as mediating against the effects of VT (Park, 2010). If empathic engagement is central for both positive and negative experiences, future research may benefit from further exploring the intricate processes between therapist empathic attunement, the development of VT and the experience of post-traumatic growth.

The final superordinate theme, 'Internal Responses, External Communications', highlighted the dynamic process of 'Holding versus Naming Emotional Responses', thus evidencing 'reflection in action' (Schon, 1983). Participants described the complexity in the dyadic relationship and made reference to their own roles and relational patterns having the potential to impact on the therapy in an unhelpful way. Given the often unconscious relational dynamics at play in therapy, Owen (1999) argues that an exploration of the emotions felt at the edge of the practitioner's consciousness may potentially be helped via discussion around analytic constructs such as transference and counter-transference. However, regardless of the training received or therapeutic models used, the means of engaging in reflexive practice will be a personal endeavour. Participants' commitment to reflexive practice was indicated as beneficial and necessary for the provision of therapy to this client group in the current study. 'Self Care' was identified as a subtheme and participants highlighted a variety of personal endeavours as a way of managing 'internal responses' in the work. In terms of 'external communications', all

indicated the supervisory relationship as a means of self-care and a way to reflect on their self within the work. However, [Webb and Wheeler \(1998\)](#) identified a positive correlation between the quality of the supervisory relationship, as experienced by the supervisee, and the extent of the supervisee's disclosure. Together with practitioners' lack of choice in supervisor, most evident within public health services, and governance concerning improving access to treatment for service users in such contexts ([Edwards et al., 2005](#)), the extent to which counselling psychologists disclose such relational dynamics within supervision could further be brought to light. Whilst, reflection and self-awareness are highlighted as core components of counselling psychology training programmes and personal therapy remains a mandatory requirement ([Douglas et al., 2016](#)), the role of ongoing personal therapy has been identified as helpful in enhancing clinical practice ([Rizq & Target, 2008](#)), not least since this is self-selected and not associated with organizational management structures. Such reflective endeavours will undoubtedly assist the practitioner in meeting core competencies for practice which include in depth self-reflection and consideration of the use of self therapeutically ([EFPA, 2017](#); [HCPC, 2015](#)).

Limitations

There were several limitations to this study. If participant inclusion criterion A, counselling psychologists registered with the HCPC, have been expanded to include colleagues from other professions, a richer data set might have been generated. Furthermore, this would have echoed the pluralistic and inclusive value base of the counselling psychology discipline ([Cooper, 2009](#)). Nevertheless, this inclusion criterion enabled recruitment of a homogenous sample consistent with IPA methodology ([Smith & Osborn, 2003](#)) and adds to the research base of the counselling psychology discipline. Similarly, it is worth noting the small sample size of the study and the UK-centric participant pool, thus generalizability cannot be assumed ([Yardley, 2000](#)). However, emergent themes may have cross-professional and/or cross-cultural applicability and further research could seek to explore this. Regarding 'experience' as an inclusion criterion (B), participants were permitted to self-define in terms of whether their experience in working with the client group would permit them to contribute meaningfully to the study. It could be argued that this decision generated excess potential variability in the data set and including specific requirements in relation to level of experience could have produced a more meaningful analysis. However, many counselling psychologists will have experience in working with abuse due to its prevalence; for example, [Radford and colleagues \(2011\)](#) report that one in 20 children have experienced sexual abuse and it is estimated that one in four women will experience abuse throughout their lifetime ([Greenan, 2004](#)). It was not the intention of the study to recruit only specialists although this would be a significant area for research – i.e. in organisations, where work is focussed on abuse rather than co-morbid issues ([Dodd, Nicholas, Povey, & Walker, 2004](#)). As such, opportunities for further research are clear. Lastly, qualitative methodologies acknowledge that the researcher may bring biases to the analysis, thus limiting the validity of the claims that can be made. However, this study aimed to provide depth rather than breadth of analysis and attempts to 'bracket' were made throughout the course of the analysis ([Giorgi, 1985](#); [Yardley, 2000](#)).

Implications

[Schottenbauer and colleagues \(2008\)](#) argued that a relational or process approach to therapeutic work should become more integrated into the use of technical interventions to aid therapeutic outcome and indicated a gap in the existing literature in providing therapy to clients who have experienced abuse. The study aimed to explore counselling psychologists' subjective experiences of working with clients who had experienced abuse, including their experiences of building the therapeutic relationship, the relational dynamics involved in the provi-

sion of therapy and their understandings of their 'self' within the work with the client group. The research contributes towards a deeper understanding of the processes involved in creating a therapeutic space for the work and the relational dynamics involved in providing therapy to the client population. A number of implications can be inferred from the analysis. First, 'The Holding Environment' offers contributions to existing theory (e.g. Falloot & Harris, 2009) and the humanistic and pluralistic value base of the counselling psychology discipline. As such, it appears that counselling psychologists are well placed in providing support to the client population. 'The Personal versus the Professional' indicated the risks associated for the practitioner in offering empathy to the client population, on both a personal and professional level. This study suggests that training programmes, workplaces and supervisory relationships may benefit from open discussion around the emotional and physiological impact of the work. Greater dialogue around transference and counter-transference reactions would reduce the stigma often associated with VT (e.g. Newell & MacNeil, 2010) and such reduction in stigma would be particularly beneficial to less experienced practitioners, including trainees and those newly qualified. The third superordinate theme, 'Internal Responses, External Communications', concerned the participants' process of holding their emotional and physiological responses before deciding whether to share, with the client during the therapy or in supervision. This study advocates discussion around analytic constructs such as transference and counter-transference to allow for the exploration of the emotions felt at the edge of the practitioner's consciousness, and the usefulness of supervision and personal therapy in doing so. This in turn offers implications for workplaces, training programmes and clinical practice. Lastly, the research suggests that specific training programmes, for example EMDR and TF-CBT, may benefit from the inclusion of a 'relational' component within its' framework. That is, technical training programmes may incorporate discussion of the relational processes involved in providing therapy to the client population to emphasise its' importance. In this way, practitioners may be able to reflect on their emotional and physiological responses (e.g. Schon, 1983) which in turn, can enhance client care and aid therapeutic outcome (Schottenbauer et al., 2008).

Competing Interests

There are no competing interests or funding to report.

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Appendix

The Diagnostic and Statistical Manual – 5 (DSM – 5; American Psychiatric Association) defines childhood sexual abuse as;

‘any sexual act involving a child that is intended to provide sexual gratification to a parent, caregiver, or other individual [...] includes non contact exploitation of a child by a parent or caregiver – for example forcing, tricking, enticing, threatening or pressuring a child to participate in acts of sexual gratification of others without direct physical contact between child and abuser’ (American Psychiatric Association, 2013, p. 718).

Adult physical, sexual and emotional/psychological abuse is defined as;

‘adult abuse includes acts of physical, sexual, or emotional abuse. Examples of adult abuse include; non accidental acts of physical force (e.g., pushing/shoving, scratching, slapping, throwing something that could hurt, punching, biting) that have resulted – or have reasonable potential to result – in physical harm or have caused significant fear; forced or coerced sexual acts; and verbal or symbolic acts with the potential to cause psychological harm’ (e.g., berating or humiliating the person; interrogating the person; restricting the persons ability to come and go freely; obstructing the persons access to assistance; threatening the person; harming or threatening to harm people or things that the person cares about; restricting the persons access to or use of economic resources; isolating the person from family, friends, family, or social support resources; stalking the person; trying to make the person think that he or she is crazy)’ (DSM – 5; American Psychiatric Association, 2013, p. 722).

Spouse/intimate partner violence is defined as acts of physical, sexual or emotional abuse (as above) carried out by one partner to another (DSM – 5; American Psychiatric Association, 2013).