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ECOSYSTEMIC INFLUENCES ON MARRIAGE AND FAMILY THEAPISTS' RESPONSES TO PARTNER ABUSE

presented by

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ECOSYSTEMIC INFLUENCES ON MARRIAGE AND FAMILY THERAPISTS' RESPONSES TO PARTNER ABUSE

By

Matthew W. Brosi

A DISSERTATION

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ABSTRACT

ECOSYSTEMIC INFLUENCES ON MARRIAGE AND FAMILY THERAPISTS' RESPONSES TO PARTNER ABUSE

By

Matthew W. Brosi

Evidence (Hansen, Harway, & Cervantes, 1991; Harway & Hansen, 1990; Howe, Herzberger, & Tennen, 1988) suggests that therapists tend to both minimize cases of partner abuse and provide inadequate or inappropriate assessments and interventions. Not yet known are the factors that guide therapists' ability to address partner abuse or specifically how therapists' belief systems influence the work they do with domestic violence cases. This qualitative study enriches our understanding of how Marriage and Family Therapists understand partner abuse and how ecological factors influence clinical assessment, intervention, and reactions to a partner abuse vignette. Information gained from this study sheds light on the impact that therapists' belief systems may have on treatment approaches within couples' therapy. This research provides supervisors and therapists more insight and knowledge to appropriately and accurately intervene in couples' abuse situations as well as assist in clinical trainees' personal and professional growth.

This dissertation is dedicated to my wife, Whitney,
who has never lost sight of my potential.

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CHAPTER ONE: INTRODUCTION

"I don't know how to define it, but I know it when I see it."
--Supreme Court Justice Potter Stewart, 1964

According to The National Coalition Against Domestic Violence (2003), one-half to two-thirds of all intimate couples engage in partner violence at some point in their relationship. For couples who seek therapy, reports of marital aggression range from fifty to seventy percent of couples presenting (Cascardi, Langhinrichsen, & Vivian, 1992; O'Leary, Vivian, & Malone, 1992). Often, domestic violence or partner abuse is not revealed as the presenting problem. Many times, it is uncovered gradually and may surprise the therapist. Therefore, it is critical to examine the process that therapists go through when addressing stressful issues such as partner abuse. Furthermore, given this alarming statistic, it is important to question the adequacy in which therapists are then able to optimally assess and intervene in couples abuse cases.

Although therapists are presented with a wide range of situations, they may be particularly vulnerable to their own reactions when presented with controversial topics involving victims such as in cases of domestic violence, sexual abuse, abortion, or even HIV/AIDS. These reactions, known as countertransference reactions, are common to therapists at all levels of training or experience, and are especially problematic for clinicians dealing with partner abuse cases (Strawderman, Rosen, & Coleman, 1997).

A limited amount of research exists on topics related to therapeutic treatment involving potentially difficult clinical situations such as domestic violence and the internal emotional experiences or intense reactions a therapist

may experience when working with these populations (e.g., Bograd, 1986; Francis, 1997; Goldner, Penn, Sheinberg & Walker, 1990; Goodwin, 1993; Halperin, 1991; Lantz, 1993; Natterson, 1991; Register, 1993; Taffel, 1993). In cases of abuse, the specifics of the case must be considered in addition to how the therapist reacts to the case.

The created "reality" between the client(s) and the therapist, as well as between the therapist and his or her supervisor, becomes critically important in obtaining a holistic perspective on the therapeutic process. Research (Hansen, Harway, & Cervantes, 1991; Harway & Hansen, 1990; Howe, Herzberger, & Tennen, 1988) suggests that couples therapists tend to minimize cases of partner abuse and provide inappropriate assessments and interventions. In essence, how a therapist may be understanding, making sense of, or reacting to an abusive situation may also affect their ability to appropriately address the presenting or hidden problem as well as their resulting clinical assessment and interventions.

Strawderman, Rosen, and Coleman (1997) note that the clinical field is beginning to recognize that therapists "come to the therapy process with personal values and belief systems and unique life experiences, which in turn affect the therapeutic relationship" (p. 37). Much is also known about the affect that various constructs (i.e., family of origin; therapeutic orientation; gender roles/beliefs; sex; differentiation level; supervision process; etc.) may have on therapist development and their work with domestic violence (Bartle & Sabatelli, 1995; Bartle-Haring, Rosen, & Stith, 2002; Francis, 1997; Goodwin, 1993;

Halperin, 1991; Harway & Hansen, 1993; McGoldrick, 1982; Todd & Storm, 1997). Where the research falls short is in the linking of the therapist's clinical reactions with his or her personal belief and value systems, and just as importantly, with the origins or factors that influence these belief systems. Thus, what is not yet known is specifically how concepts of abuse, belief systems regarding abuse, and reactions to client presentations of abusive situations are governed or driven by personal, professional, and life experiences.

Statement of the Problem

Therapists, like clients, have their own ideas of reality, how individuals should interact, and even what kinds of behaviors might be considered abusive towards others. What is not yet known is the effect that the therapist's schemas regarding abuse as well as their reaction to abusive situations has on the therapeutic process. These issues are critical to consider as the outcomes of therapist's reactions may have a direct impact on the ability to address relevant factors and dynamics related to the personal safety of the clients. In order to better understand this process, it is then important to identify and address the various ecological contributors to how a therapist responds. This study aimed to understand how different components of a therapist's developing self (i.e., developmental level, personal background, and clinical context) affect their reactions to partner abuse cases—which may then further confound the interactions and perhaps the transference or countertransference response between the client and therapist. Furthermore, this helped to identify how a therapist's assessments and interventions are then affected by their personal

realities, beliefs, meanings and reactions to partner abuse. Ultimately, this aided in gaining a better understanding of the process by which therapists then make sense of their client's experiences.

Purpose and Importance of this Study

The purpose of the proposed research project was to qualitatively explore, describe, and analyze the key ecological contributors to how marriage and family therapists respond to partner abuse. Specifically, how the therapists' responses actually vary according to their clinical background, their personal experiences, and their personal developmental level was identified. The components identified helped to explain how these factors affect the therapist's reactions to their client's presentation of partner abuse and ultimately, their ability to optimally assess and intervene in these types of cases.

By having the therapist address his/her own cognitive belief system regarding abuse, an awareness was raised regarding the impact that her own values and belief systems may have on couples therapy in addition to processing the belief systems of each member within the clinical dyad. Furthermore, this process allowed the therapist to gain a deeper understanding of her belief systems related to partner abuse as an ecosystemic product—including their own biases or interpretations, and the practical comprehension of the treatment of abuse from a systemic lens. As a result, therapists are better equipped to handle cases of family and partner abuse having a greater understanding of abuse from multiple perspectives.

Guiding Theoretical Framework for this Research

In order to achieve the basis and rationale for this study, three theories were used—Ecological theory; Social Construction; and Feminist theory—as guiding frameworks. Each one of these theories provides a foundation from which to observe the developing therapist and how behavior is affected. Although these theories are distinct, there are overlaps between some of the concepts within each of these theories. To facilitate the distinctions, a theoretical map laying out relevant aspects from which one can better understand the interpersonal and clinical processes is also provided in Figure 1.1.

Ecological Theory

Primarily, this research project was guided by the theoretical framework of Bronfenbrenner's (1979) Human Ecological Theory. A central assumption of this model is that individuals develop as a result of the influences from and between various systems. Human Ecological Theory focuses on contextual factors or sociological/cultural drives and development, and assumes that the environment has a strong influence at multiple levels on the choices that we make, the lives we live, and as a result, the therapeutic interventions we implement (Arthur, 2001; Booth & Cottone, 2000; Rosin & Knudson, 1986; Whipple, 1996). Bronfenbrenner (1979) promoted the need to pay particular attention to the developing person within several settings and how the settings affect the developing person, thus creating a systemic interplay of influences. The microsystem refers to the pattern of activities and roles in a given physical and material setting (Bronfenbrenner, 1979). For example, familial influences on the

socialization process (a factor that could also be explained by using a clinical transgenerational theory), is included within Bronfenbrenner's microsystem. This variable includes constructs related to value transmission, one's reality/view of normality, viewpoints regarding proper interaction between partners, legacy/loyalty influences, etc. Drawing from Family Ecology Theory, Bubolz & Sontag (1993) support this notion and theorize that the family is the key agent in the transmission of those values and belief systems it deems important. These values then reflect determinations of what is right or moral and are further influenced by society, culture, religion, and other environments (Bubolz & Sontag, 1993). From a countertransference perspective, personal values may be exhibited through a therapist's unacknowledged personal life experiences with partner abuse (both from the family of origin or within his/her own intimate relationships), which then has the ability to affect the particular ways that he/she may react to the client's abusive situation.

Bronfenbrenner's mesosystem refers to the specific interrelations of two or more settings in which the individual participates (Bronfenbrenner, 1979). For this study, it is important to account for the congruency between the value systems of entities such as peer groups, workplace, school, church, and the family. When belief systems of various microsystem constructs are not harmonious, it has the potential to create conflict within the developing individual and may account for potential therapeutic impasse or countertransference reactions within the clinical setting.

The exosystem involves the particular settings that do not directly involve or actively affect the developing person, but yet influences his/her development (Bronfenbrenner, 1979). This level of the human ecosystem includes constructs such as mass media, government agencies, the institution of religion, etc. These factors have the ability to profoundly affect the clinician as higher institutional entities may permeate personal values and belief systems and as a result may promote social behavior through indirect means. For example, the social norms for masculinity or femininity are provided through television programs—which then becomes a construct from which to guide normal behavior. The media may portray the inappropriateness for a woman to be physically mistreated, but a man may be slapped because he is deemed the stronger creature. The church may also promote a philosophy that governs man and wife interaction, such as whom is titled the head of the house, and potentially indirectly, how that title should be maintained.

The macrosystem consists of the consistencies found within the micro-, meso-, and exosystems in various cultures and subcultures (Bronfenbrenner, 1979). They are directly related to the belief systems that the culture(s) hold and thus become an important factor in the transmission of societal values to the individual (Vygotsky, 1978). Factors related to the macrosystem also have the ability to affect the therapist's values or tolerance regarding domestic violence, or even what the dominant society deems "appropriate" social behavior. This is critically important to consider given the social values regarding interpersonal violence and promoted within our legal, governmental, and educational systems.

Finally, Bronfenbrenner's chronosystem addresses a structural developmental factor, which includes the transformations which therapists undergo over time in their professional development, as well as the fundamental shift in one's making sense of the world clinically. As a result, by looking more closely at the ecological factors within a therapist's personal background from multiple levels of the ecosystem, a better understanding of how it affects the therapists' reactions was obtained.

Social Construction Theory

Social construction theory was also utilized for this study to address the concept that abuse, like many other concepts in our social environment, is constructed through the commonalities held in the definitions and meanings assessed throughout society (Cosgrove, 2000). Social constructionism supports Human Ecological Theory in that therapists are exposed to and influenced by their environment at multiple levels. It is through the social environment that the dominant discourse regarding what is considered to be true, normal, or accurate, often permeates one's personal values and belief systems and thus, becomes part of the social construction of many concepts in everyday life.

Robert Kegan's (1982) work also provides a sound framework for understanding basic human development or cognitive evolution. Kegan focuses on the changes in the way people differentiate between their sense of self and their environment—by addressing boundary issues. On a philosophical level, our understanding of our environment or how we make sense of it basically involves determining what constitutes as being truth within our environment and then the

process by which we are influenced by it. Kegan believes that we are in constant movement to make meanings, resolve discrepancies, as well as preserve and enhance our personal integrity. In essence, development is then achieved by our individual responses to the world around us and through the individual construction of our own realities. From a clinical perspective, researchers and clinicians ascribe a particular set of values and beliefs to treating issues surrounding domestic violence that entails taking a certain stand, incorporating specific techniques into therapy, addressing ideals, and way of life. Fruggeri (1992) suggests that it is through the therapist's lens, that meaning of the individual's or family's functioning is constructed. Thus, due to the position that the therapist has within the therapeutic environment, it is critical to consider the process by which he/she has conceptualized what abuse means to them when it comes to the concept of domestic violence. It is only by addressing this concept from a social construction standpoint that the meaning attributed to abuse can begin to be understood and attended to. It is through the process then of deconstructing what "abuse" means to therapists, that one can begin to understand the therapist's point of view and what is important to them—in addition to any personal reactions they may have. Incorporating a social constructivist perspective involves not only identifying what the abuse means to clients, but also the acknowledgment that the therapist has a definition, opens the door to admitting the therapists' reality.

Walsh and Scheinkman (1989) call for an emphasis in family therapy training to assist therapists to be more attentive to the gendered messages found both within our culture and family experiences. A feminist lens was utilized in this study in order to better understand the gendered aspects of the ecological factors influencing therapeutic responses. According to Myers-Avis and Turner (1996), the feminist lens also blends well with the social constructivist model in that gender systems are regarded "…as socially constructed, both determining and determined by social organization" (p. 145).

A feminist lens also aided in addressing the meanings that the therapist has regarding what couple and family abuse is—which ultimately may play a major part in the therapeutic outcome. It is sensitive to the relationship between the therapist and his or her clients. It addresses the notion that neutrality is not a therapeutic option since therapy is not value free and therapists cannot ignore their own personal experiences in therapy. A feminist lens tells us that it is not possible for therapists to not have biases or interpretations of interpersonal dynamics within the world around them (Gale & Long, 1996; Melito, 2003; Prilleltensky, 1997). This principle provides a solid foundation for addressing the various gendered aspects of ecological factors that make up a therapists value and belief system.

A feminist approach also emphasizes tenets that promote the voices of all members of the therapeutic process, including the therapist, to be heard and understood (Walsh & Scheinkman, 1989). This places an emphasis on

collaboration between the clients and the therapist rather than hierarchy. This non-expert approach assists the therapist to acknowledge the multiple realities that exists in the clinical setting. Utilizing a feminist approach also validated the process by which therapists understand how their personal values influence their therapeutic approach as well as their professional positions on controversial and heated issues such as domestic violence, thus also acting as an empowering agent (Whipple, 1996). As a result, the goal is not to try to deal with or resolve the roots of the therapeutic reactions, but to use them as a rich therapeutic resource to better assist the clients with the presentation of partner abuse (Byng-Hall, 1995; Taffel, 1993).

Focus of this study

The primary focus of this research is premised on the idea that the therapist's operational definition of abuse and the therapist's countertransference reaction is an ecosystemic product of society and family interaction. The assumption is that responses to abuse are socially constructed and that each person in a dyad or couple will also have his/her own unique definition. The therapist works with each client's definition of his or her behavior along side of his/her own definition of abuse, which contributes to the overall therapeutic process. As a result, the therapist's own meanings and belief systems may have a dramatic affect on how the process unfolds and subsequently, the questions he/she asks, how he/she interprets client's behaviors, and how he/she intervenes in the therapy session.

Research Questions

In a small clinical study, Strawderman, Rosen, & Coleman (1997) noted the need for research to look at the role of countertransference in cases with couple violence. They (Strawderman, Rosen, & Coleman, 1997) argue that the family therapist needs to understand how his/her reactions influence the work of family therapy. This research delineated the process of countertransference to examine the range of factors that influence therapist reaction. These factors were grouped into three domains—individual, historical, and clinical. Due to the complexity and circularity of the phenomenon under investigation, there were a number of areas of inquiry, each guided by theory. A conceptual map of the theory from which each research question has been derived is provided in Figure 1.2.

Primary Research Question.

The primary research question for this study was: How do ecological factors, including gender and family of origin influence therapist's values, beliefs, and assumptions that in turn, guide therapeutic and personal reactions to partner abuse cases? Since this question is multi-layered, it was divided into seven sub-questions. Table 1.1 illustrates the relationship between questions and theories.

Question 1: How do interactions with various ecological systems from therapist's family of origin influence responses to partner abuse cases?

Question 2: How do interactions with various ecological systems from therapist's clinical background influence responses to partner abuse cases?

Question 3: How do interactions with various ecological systems within therapist's personal/individual background influence responses to partner abuse cases?

Question 4: In what way do therapist's developmental processes influence therapist responses to partner abuse cases?

Question 5: How does the meaning-making process (regarding partner abuse) influence therapist reactions to partner abuse cases?

Question 6: How do internalized messages regarding power and gender influence therapist reactions to partner abuse cases?

Question 7: How do values, beliefs, and assumptions influence therapist reactions to partner abuse cases?

This project was innovative and unique in that an understanding of therapist's personal reactions, informed by human ecological theory as well as systems theory, has not been previously applied to this aspect of domestic violence research. In addition, this project focused on the actual beliefs and attitudes that therapists have regarding the subject of abuse and how such beliefs and attitudes affect their clinical work. This study provided a more complete understanding of how the area of domestic violence is socially constructed and how the therapists internalized understanding of abuse affects the therapeutic process. Such findings were expected to greatly influence the directions that the student/mental health practitioner, educational programs, and supervisors might take.

Figure 1.1: Theoretical Map

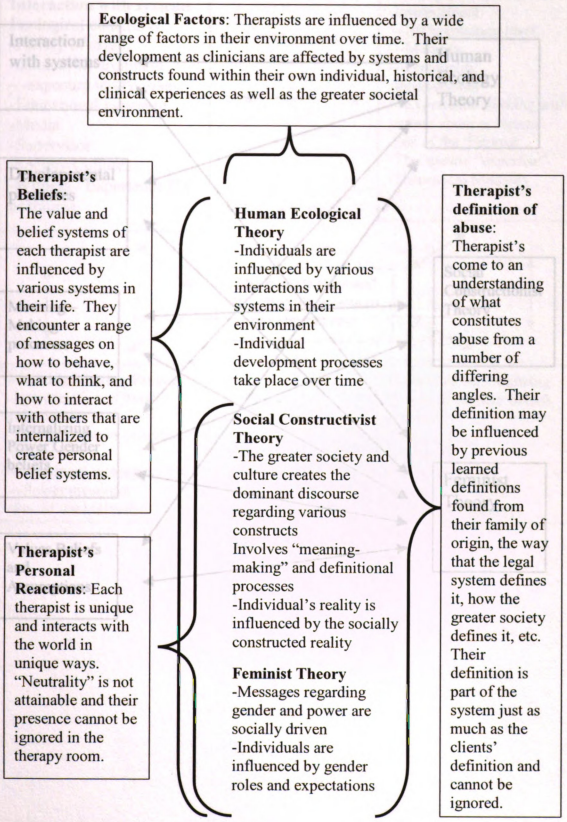


Figure 1.2: Conceptual Map

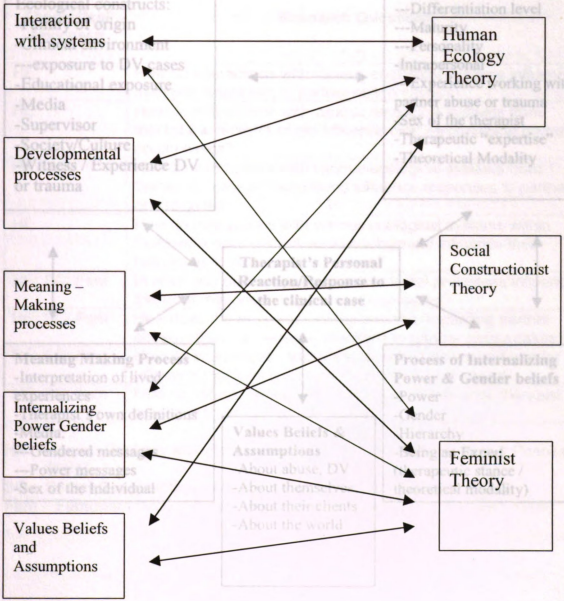


Figure 1.3 Operational Map

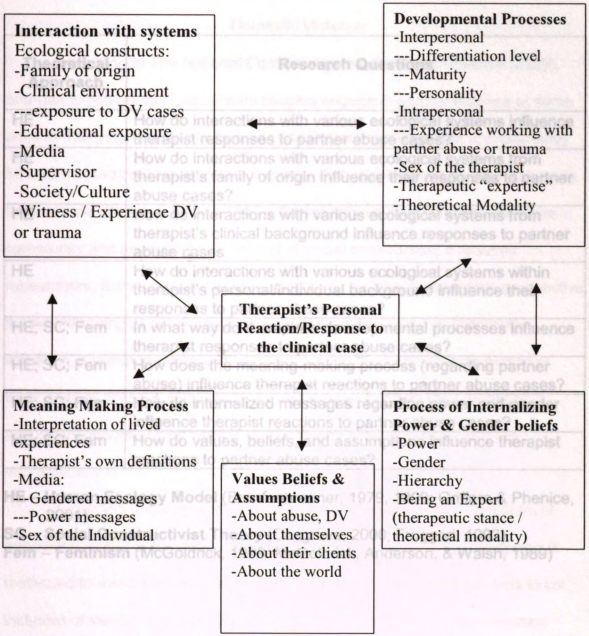


Table 1.1: Relationship Between Guiding Theories & Research Questions

Theoretical Approach	Research Questions
HE	How do interactions with various ecological systems influence therapist responses to partner abuse cases?
HE	How do interactions with various ecological systems from therapist's family of origin influence their responses to partner abuse cases?
HE	How do interactions with various ecological systems from therapist's clinical background influence responses to partner abuse cases
HE	How do interactions with various ecological systems within therapist's personal/individual background influence their responses to partner abuse cases?
HE; SC; Fem	In what way do therapist's developmental processes influence therapist responses to partner abuse cases?
HE; SC; Fem	How does the meaning-making process (regarding partner abuse) influence therapist reactions to partner abuse cases?
HE; SC; Fem	How do internalized messages regarding power and gender influence therapist reactions to partner abuse cases?
HE; SC; Fem	How do values, beliefs, and assumptions influence therapist reactions to partner abuse cases?

HE – Human Ecology Model (Bronfenbrenner, 1979, 1999; Griffore & Phenice, 2001)
SC – Social Constructivist Theory (Cosgrove, 2000; Fruggeri, 1992)
Fem – Feminism (McGoldrick, 1998; McGoldrick, Anderson, & Walsh, 1989)

CHAPTER TWO: REVIEW OF LITERATURE

Domestic Violence

According to The National Coalition Against Domestic Violence (2003), one-half to two-thirds of all intimate couples engage in partner violence at some point in their relationship. In fact, one national survey found that approximately 16% of married couples reported incidents of physical assault by their spouse in the last year (Straus & Gelles, 1990). Partner abuse is an issue for the entire community and because it is a product of social construction, it requires researchers, lawmakers, the general public, etc. to take an outsider's perspective in understanding or redefining the notion of what "violence" is. Practically speaking, it is important for everyone involved to have an accurate picture of what sorts of abuse is involved in families in order to begin the process of accurately understanding what is occurring and what then to do with the information.

According to Baron and Richardson (1994), aggression is "any form of behavior directed at the goal of harming or injuring another living being who is motivated to avoid such treatment" (p. 7). Although this definition seems to be inclusive of various types of abuse, it implies "intention" which may eliminate various abuse experiences from therapy assessment and intervention. Many other theorists and researchers (Follingstad, Laughlin, Ploek, Rutledge, & Hause, 1991; Gondolf, 1993; Holdzworth-Munroe, & Stuart, 1994) have acknowledged the continuum of behaviors that are considered violent as well as the variety of different types of batterers and battering relationships. However, a significant

amount of research demonstrates that partners often do not agree about the incidence or details of intimate partner violence (Arias & Beach, 1987; Bohannon, Dosser, & Lindley, 1995; Browning & Dutton, 1986; Edelson & Brygger, 1986; Heyman & Schlee, 1997; Jouriles & O'Leary, 1985; Moffitt, Caspi, Kruger, Magdol, Margolin, Silva, & Syndey, 1997; O'Leary & Arias, 1988; Schafer, Caetano, & Clark, 2002; Szinovacz, 1983; Szinovacz & Egley, 1995). This implies that there are a number of variables (schemas, beliefs, values, etc.) that contribute to each person's viewpoint. When one considers this phenomenon and adds in others' perspectives including those of the dominant societal discourse, the therapist, a clinical supervisor, peers/colleagues, and each individual's personal and professional backgrounds; the issue becomes increasingly more complex.

Countertransference Reactions

As therapists in all types of clinical programs experience intense training, they bring with them opinions, beliefs, and values regarding life events. Furthermore, therapists frequently operate from or base clinical judgments on interpretations of client's circumstances. The presentation of partner abuse may bring about strong emotional feelings in the therapist such as anger, fear, frustration, and hopelessness (Goldner et al., 1990; Register, 1993). However, just as important to the process of treatment is the therapist's personal conscious, unconscious, immediate, or delayed (Kernberg, 1965) reactions to clients. These types of reactions, also known as countertransference, quickly

become the issue as they affect the ability for the clinician to be an objective member in the therapeutic process.

According to Siegel (1997), countertransference reactions may result from a number of factors. They may involve internalized family relationships and emotionally charged issues from the family of origin. They may be a result of displaced relational interaction from the (couple) clients. They may even stem from dynamics shared by the clients that the therapist is experiencing in his or her own life (Siegel, 1997). Regardless of the origins, it becomes an increasingly complex construct when considering systemic-based therapy—especially surrounding the treatment of emotionally charged areas such as domestic violence.

Countertransference and the Treatment of Partner Abuse

Understanding partner abuse from a treatment lens is a complex phenomenon and involves deconstructing types of batterers, looking at interpersonal relationships, empowering individuals, etc. What it is, how to treat it, and dealing with the content of a partner abuse case is one aspect, but the personal and process aspects of treatment (and clinical training) are not as easily addressed or understood. Unfortunately, many therapists continue to be driven by their own value-based theoretical orientation due to their own unacknowledged values, beliefs, and assumptions. As a result, debates regarding the appropriateness of treating issues such as couples abuse takes away from the ability to engage in constructive dialogue regarding the efficacy of particular therapies (Strawderman, Rosen, & Coleman, 1997).

The specific mechanism of treatment is virtually unimportant if the therapist is not adequately conceptualizing the reported partner abuse or addressing the impact that their personal beliefs has on the therapeutic process. Harway and Hansen (1993) reported on two studies (Hansen, Harway, & Cervantes, 1991) involving therapist's conceptualization of case vignettes in which abuse was relevant. In both studies, a vast majority of therapists either did not recognize the seriousness of violence or minimized the violence by not addressing it at all. What was not addressed was how the therapists specifically felt about the clinical case they reviewed.

In the second study reported by Harway and Hansen (1993), the researchers categorized the therapists into one of three response-type groups based on how they intervened: Contextualists (content driven/action oriented therapists); Communication Interventionists (process oriented/excluded external cues); and Avoiders (no intervention without further information). Furthermore, they reported that a substantial proportion of therapists were unprepared to adequately assess the abusive situation and were unable to provide appropriate intervention plans. Although these studies provide a dramatic descriptor of problems in addressing clinical situations of partner abuse, the real issue surrounds the mechanisms and the reasons behind the inappropriate interventions or minimization of violence by the therapists.

Countertransference responses may vary by clinical situation, by the developmental level of the therapist, and by the multitude of relationships the therapist has in his history. Halperin (1991) points out six countertransference

reactions that developing therapists may experience. They include factors related to power, confidence, incompetence, manipulation, prejudices, unresolved family of origin issues, and pleasing the supervisor. Each are discussed below as ecological factors influencing therapist development.

Strawderman, Rosen, and Colman (1997) looked more closely at the countertransference reactions of a therapist trainee treating a battered woman and outlined the trainee's specific countertransference reactions. They included factors related to the trainee's strong gender beliefs (rooted from the family of origin), feelings of having multiple things in common with the client (identifying personally with the client), and emotional reactions (e.g., fear, frustration, anger, disappointment, guilt, and inadequacy). In addition, the trainee reacted in a victim blaming manner, as well as a need to rescue the client—greatly influencing her therapeutic goal. Furthermore, the trainee reported feeling uncomfortable openly addressing the violence for fear that the client would leave therapy and felt as though she had lost sight of the need to empower her client. Although this case example provides a great account of a buildup of personal reactions, it is also important to consider how these responses might vary for different therapists with differing developmental backgrounds. In addition, their study only looked at the countertransference reactions of a therapist working with one client—a battered woman. It is important to question how this may differ for therapists working with clients presenting as a couple.

Ecology of Therapist Development

As mentioned in Chapter 1, the process of individual development does not occur in a bubble. It is something that is multi-faceted and involves many varying factors that contribute uniquely to the overall process. In fact, Walrond-Skinner & Watson (1987) believe that the therapist contributes to therapeutic process with "his or her personality make-up, his or her own varying emotional needs, knowledge, technical skill and therapeutic experience, all of which contribute to his or her competence, or lack of it, as a therapist" (p. 2). Hines and Hare-Mustin (1981) also point out that therapists' assumptions about families are usually a result of value conflicts—which generally govern therapeutic moves. Utilizing Bronfenbrenner's (1979) Human Ecological model, systems at different levels (e.g., microsystem, mesosystem, exosystem, macrosystem, chronosystem) influence the process of development and the overall make-up of the therapist's belief systems regarding themselves and their abilities. Regarding therapist development, it is important to consider the unique factors that contribute to the process of maturing therapeutically. However, it is also important to consider how the development is influenced by other systems relevant to the therapist's personal history, family of origin, and unique individual life experiences. The following sections contain scholarship relating to the various ecological factors within the therapist's environment and how they relate to the overall development of the therapist and their clinical interaction and reactions with clientele.

Differentiation of Self

Bowen theory (1976, 1978) is a unique clinical and systems theoretical approach that recognizes how the psycho-emotional development of the therapist is related to therapeutic outcomes. There are a variety of constructs that Bowen theory incorporates; however, differentiation of self is the key term that delineates maturity and psychological health (Skowron & Friedlander, 1998). Differentiation of self is defined as the ability to balance both emotional and intellectual functioning as well as intimacy and autonomy in significant relationships with others (Skowron & Friedlander, 1998). To be well differentiated, one must use intrapsychic abilities to separate thoughts from feelings and to tolerate chronic stress found within our everyday lives (Bowen, 1976; 1978).

In general, the degree of one's level of differentiation affects the manner by which individuals interact with one another. Kerr & Bowen (1988) suggest that poorly differentiated individuals avoid conflict, try to please others, and are more likely to be emotionally reactive towards others, thus these individuals often separate themselves from the responsiveness or emotionality of others. In addition, individuals with low differentiation levels may have a harder time separating out intellectual and emotional functioning, and may be vulnerable to emotionality or reactivity (Bowen, 1976; Kerr, 1985). On the other hand, highly differentiated individuals are more able to tolerate conflict and stress and maintain a clear sense of self and shift clearly between their emotional and

rational levels without inappropriately reacting to an emotional situation (Bowen, 1978; Kerr, 1988).

Regarding therapist development, differentiation levels may play a major role in therapeutic outcomes. Bowen (1978) asserts that in the therapeutic environment, the client can only be as differentiated as the therapist. In addition, Bowen (1976; 1978; Kerr & Bowen, 1988) suggests that less differentiated individuals are subjected to greater levels of chronic anxiety and become more dysfunctional under stress. Furthermore, poorly differentiated therapists may be more subject to internalized emotional cutoffs, thus becoming more reactive and emotionally distancing from the situation (Nichols & Schwartz, 1988).

As the therapist engages with client couples, the goal is to establish a higher level of differentiation for both therapist and clients. However, this process fails when both become engulfed by anxiety and are drawn into the family's emotional system. With these outcomes in mind, a poorly differentiated therapist may not be as equipped to deal with couples entangled with serious or extreme differentiation issues—playing out in the form of partner abuse. Instead, they may be confronted with highly anxiety-provoking clinical situations that may be less than ideal for a low differentiated therapist (even perhaps a beginning therapist who has not fully developed or explored these self issues). In addition, this may lead to the therapist's inability to fully address the presented partner abuse issues or to ask questions that may bring out abuse situations that are not being directly presented.

Family of Origin Influences

There are a number of characteristics that therapists may portray—each of them having the potential to influence the therapist in unique ways. The therapist's family of origin is one such system that may affect the therapist both directly and indirectly. Halperin (1991) suggests that the mere training environment sets the therapist trainee to experience a variety of unique dynamics related to their position within the system. Many of these dynamics are related to power, idealization, self-esteem, competency, and inadequacy—all factors, which parallel the parent-child system and may be acted out unconsciously. Thus, at a basic level, the therapist's family may be influencing the learning process, how the therapist interacts with his supervisor, and how he may be interacting with clients.

McGoldrick (1982) notes the influence of the family of origin and how it may influence the therapist and the interactions the therapist has with clientele. She posits that the impasses therapists have with clients are due to the negative emotional reactions rooted within experiences from the family of origin. Framo (1967) also supports this notion by pointing out that therapists may have a much more difficult time detaching from a family than from an individual. As a result, this leaves the therapist with an ideal, unconsciously driven, "opportunity to reconstruct one's own family struggles so that in this family they be worked through and mastered" (Framo, 1965, p. 107). In fact, Titleman (1987) goes so far as to state that "the position the therapist plays in relation to the client family will be similar to the position that is played in the therapist's own family" (p. 4).

As a result, what Bowen (1976; 1978; Kerr & Bowen, 1988) believed regarding the need to work on one's position within their family of origin, becomes the key for the therapist to come to terms with anxiety. It is through this process that therapists are then more able to view the family as an emotional system, thus enhancing their role as less-reactive beings. Furthermore, they are able to stay clear of becoming fused, triangled, or induced into the emotional systems of the client families (Titleman, 1987).

Structured aspects of the family of origin may also play out in the developmental process of the therapist trainee as well as potential countertransference reactions. Single versus two-parent households, being exposed to partner abuse within the family of origin household, varying attitudes and beliefs about gender roles between men and women, number of siblings, or the amount of resources may all play unique roles in therapist development. Lucas (2002) looked specifically at the role that siblings play in buffering the effects of exposure to parental domestic violence. She found that ultimately, sibling relationships serve as a protective factor in which reciprocal caregiving is employed and coping strategies are employed in order to deal with the in-home situations. Thus, even if a therapist was exposed to forms of partner abuse as a child, the sibling support aspect is just one of the varying factors that may affect the degree to which the violence may impact interactions as adults and/or therapists.

Inter- and Intra-Personal Development

Most clinical programs accept the notion that the personal qualities of the therapist may affect the therapeutic process. Gurman (1987) notes that qualities such as honesty, perceptiveness, empathy, open-mindedness, and caring greatly influence the therapy process. Quinn (1996) even suggests that the keys to successful therapy include establishing a good, mutually affirming bond with the client, attending to the client's needs, and promoting a climate of discovery. But how does a developing therapist achieve these outcomes? Keith (1987) suggests that there are several key features that influence the therapist in process—willingness to raise questions, creativity, and the use of the unconscious.

Entering the realm of therapeutic understanding, the developing therapist undergoes a process of re-working what constituted knowledge (White, 1997). From a social constructivist perspective, individuals are subject to the local discourse of a culture, but in the professional arena as therapists, they are given access to a more objective "truth" (i.e., systemic understanding of family dynamics) of interaction (White, 1997). It is a process that greatly involves letting go of the less formalized knowledge that has been co-generated through one's unique personal history and becoming "differently knowledged" (p. 17). At the same time, White posits that upon the entry to the therapeutic profession, trainees also go through a process of becoming extremely accountable and are restricted in their conduct and thinking. Therefore, high expectations are set for

which the therapist must adhere to in order to maintain their eligibility as a broadly defined professional and thinker.

Therapists also develop in their ability to conceptualize problems that clients bring to therapy, and several research studies have looked at the differences between beginning and advanced therapists (Wiedenbeck, 1985; Bereiter & Scardamalia, 1987; Ettenson, Shanteau, & Krogstad, 1987). In a mixed methodology (i.e., qualitative and quantitative) study looking specifically at gender biases and therapists' conceptualization of couple difficulties, Guanipa and Wooley (2000) found that differences exist based on level of training. Their findings indicate that advanced therapists analyze gender more extensively than beginning therapists. At the same time, more experienced therapists tend to use theory more adeptly and spend more time qualitatively analyzing client's problems than beginning therapists (Chi, Feltovich, & Glaser, 1981).

According to Halperin (1991), as developing family therapists, therapist trainees may also experience a number of traps and dangers when working in the clinical arena, thus affecting their countertransference reactions. Power is one such factor that may affect a newer therapist's ability to intervene appropriately in therapeutic situations. Halperin (1991) suggests that this may be due to a lack of confidence leading to an inability to take control when necessary. At the same time, this same feeling of a lack of power may come across as a defense mechanism where the therapist becomes over-controlling and rigid in his boundaries (Halperin, 1991). At another basic level, this factor may be compounded by the needs that trainees may feel to maintain their client contact

hours requirements, which may affect the rigidity of boundaries between the therapist and client, as well as the therapist and supervisor.

The process regarding a therapist's personal and professional development in working with partner abuse should be addressed. It can be assumed that greater amounts of experience with a certain population of clients may affect individuals in different ways (e.g., burnout, vicarious traumatization, etc.). Considering the personal factors related to the experiences of female therapists counseling men who batter women, Roman (2000) found that although the therapists reported being traumatized in their interactions with their clients, they willingly chose to continue working with this population due to their commitment to the field of domestic violence. Furthermore, they did so because of the sense of fulfillment and personal growth they had from their work. However, the women only felt that they were able to maintain their diligent work with this population by supporting one another and openly addressing their mixed feelings when working with this population. This further supports the premise that ecological constructs within the therapist's environment supports and nurtures the development and growth as clinicians.

Gender

A great deal of research exists that addresses therapist's biases and case conceptualization due to aspects of gender, sexual orientation, culture, race, personal history, etc. in addressing a wide range of clinical issues (Currie, 1998; Guanipa & Wooley, 2000; Howe, Herzberger, & Tennen, 1988; Jackson, Witte, Perez & DeBord, 2000; Mwamwenda, 1999; Petretic-Jackson, 2001; Roman,

2000; Shay, 1992; Woods, 1999). According to Guanipa & Wooley (2000), a construct such as gender bias refers to "biases associated with complex characteristics in biological, cultural, social, and political categories" (p. 183). From a feminist lens, Warburton, Newberry, and Alexander (1989) point out the male and female therapist experience from a gender socialization experience—also understood as socially constructed. They suggest that many problems exist during the formation and expression of voice and that women traditionally are socialized to restrict their authority whereas men are socialized to use authority in a more direct manner. As new therapists enter the clinical world, they need to be especially aware of the patterns of socialization that drive the interactions within the therapeutic and supervisor-supervisee relationships.

Regarding domestic violence and the sex of the therapist, Currie (1998) asserts that men and women attribute significantly different "meaning" to violent behavior when responding to the Conflict Tactics Scale (CTS; Gelles & Straus, 1988). Specifically, she suggests that gender stereotypes are very much a part of what behaviors are labeled as violent and that both genders downplay violent behavior for various reasons. When it comes to treating partner abuse, it is also important to consider various "extreme" thinking patterns or reactions such as missing/minimizing abuse due to avoidance versus a hyper vigilance of therapeutic ideals. In either case, both are being driven by emotional reactivity (potentially countertransference issues) and thus, significantly affecting their clinical rationale.

There are also gender differences in the ways that therapists manage their emotions (Kessler, Werner-Wilson, Cook, & Berger, 2000). Women in general, are more likely to tend to emotional work in relationships than men (Tingey, 1993). With this in mind, the degree to which men actually do, or feel comfortable addressing the emotional side of their clients' situations may directly play a role in the therapeutic outcomes. Kessler et. al. (2000) found slight differences between male and female therapist trainees with factors such as marital satisfaction and number of hours worked contributing significantly to the amount of emotional labor spent in their clinical environment. Thus, it should be noted that outside influences continue to impact relationships inside the therapy room.

Process of Supervision

As more individuals are considered within the clinical treatment system, the dynamics become more complex. The inclusion of a supervisor adds another continuum of personal experiences, theoretical paradigms, personality characteristics, unique life experiences, and another relationship to tend to. Many or most of the same factors discussed in the earlier sections may play just as much of a role for the supervisor in working with the supervisee as the trainee with his or her client. This becomes very important to consider, especially given the uniqueness of the relationship between the supervisor (related to power, hierarchy, clinical experience, mentorship status, etc.) and the supervisee. Thus, even in a professionally based relationship between two therapeutically minded

individuals, there is a potential for blockages or even countertransference reactions to occur.

Supervisors carry the responsibility for addressing a range of clinical experiences with training therapists. To preserve appropriate boundaries, the supervisor must not drift into a therapist role (Lee & Emerson, 1999). However, there are a number of techniques that can be implemented in order to address potential transference/countertransference reactions between the trainee and his or her client(s) as well as between the supervisor and trainee. These include becoming increasingly aware and openly discussing power and hierarchy beliefs, and becoming empathically supportive towards the therapist, so as to assist in recognizing growing edges or blind spots for the training therapist. Tending to the hierarchy between the supervisor and supervisee may also play a role in establishing a more open and non-expert relationship (McGoldrick, 1982).

White (1997) believes that the training environment is a place where "co-research" (p. 172) can take place in which the therapist explores his or her belief systems regarding power and gender (as well as sexual identity, class, culture, race, etc.) relations. In this process, specific reflections related to the potentially reinforced power relations within the dominant culture are discussed within the supervisory context or a co-therapy/teaming framework. White (1992) also notes that it is through the supervision process that a supervisee weaves unique outcomes into an evolving narrative about the trainee's "preferred way of being a counselor." They are in essence, developing a sense of doing things that may be

reflective of how the trainee constructs and shapes their reality and how they live their "life as a therapist" (1992, p. 86).

Supervisors also have a unique role in considering the effect of the gendered messages on therapist development and the process of supervision to deal with socialized patterns. In fact, the sex of both the trainee and the supervisor may determine dramatically different types of interactions. For example, Warburton, Newberry, and Alexander (1989) note that because men are traditionally socialized to behave autonomously and females relationally, it may set up varying learning contexts—especially in situations involving opposite sexed supervisor and trainee and the reactions behind the exertion of power and authority. These contexts may require additional emphases related to becoming more aware of the documented gender differences in both the therapeutic and supervisory context.

Clinical Paradigms

Regarding treatment approaches for partner abuse, it is important to consider the controversy surrounding the various philosophical assumptions about the origins and appropriate treatment of the abuse (Saunders, 1981). Each clinical perspective emphasizes unique approaches to working with partner abuse and provides a foundation from which the therapist operates. Yet, each theoretical approach may emphasize ways for the therapist to intervene. As a result, even the theoretical approach may fit with the therapist for various reasons—becoming a potentially unacknowledged factor in the treatment

process. Thus, even the therapist's clinical paradigm may be a contributing variable related to his/her countertransference reactions.

Systemic Family Therapy

In systemic therapy, the emphasis tends to be on the underlying nature of the problem—what function the symptom serves in the relationship (Hansen, 1993). Regarding couple violence, therapists tend to not assign blame for the violence, but at the same time, have been criticized for blaming the victim for his or her participation in the circularity of the problem (Hansen & Goldenberg, 1993). In addition, systems therapy has been criticized from a structural perspective in that it does not challenge the traditional roles of both males and females within families (Hansen, 1993). At the same time, an advantage of systemic therapy is its inclusion of understanding the couple as a unit. From this perspective, systems therapists can begin to look at the dynamics that take place between the couple, how violence arises, how it is maintained, etc. In addition, the meaning behind the couple's interaction can be understood—communication patterns, reasons why they may dismiss violence, etc.

Regarding countertransference, family therapists have begun to view how therapist's personal values and life experiences can act as a resource that may enriches the therapeutic environment (Taffel, 1993; Byng-Hall, 1995). However, this type of "resource" may be the very construct that leads to the potential need for the therapist to blur the boundaries between the batterer and the battered. Furthermore, the therapist may focus on the circularity of the abuse rather than the batterer's (as well as the battered) responsibility in order for the abuse to fit

with their own personal and clinical value system. In addition, due to the general nature of simply working with more than just a battered individual or abusive man, the nature of couple's therapy takes on other meanings. For example, maintaining partiality (i.e., Contextual theory's concept of Multi-Directed Partiality) towards both members of the couple may be taking an inappropriate stance, whereas it may be more important for the therapist to align with the weaker voice. Thus, taking into account the therapist's reasoning for choosing to maintain partiality rather than empowerment becomes the issue.

Feminist Family Therapy

Feminist theory takes a varying perspective to the treatment of domestic violence within couples therapy and requires a significantly different approach by the therapist—to become much more directive and proactive. The basic tenet from feminist treatment perspective is that until the violence has stopped and the victim feels safe, couples therapy should not be attempted. This is primarily due to the belief that power differences will permeate into the therapeutic process. Feminist therapists also suggest that the perpetrator of the abuse is fully responsible and that society has contributed to the problem because of power inequities.

Feminists argue that society has not implemented the needed social structures that might better allow women to overcome violence and other oppressors and that women are inappropriately battling the patriarchal system through a variety of means—all of which require a major overhaul of philosophy and social structure. Salierno (2000) looked more closely at the effect of the

therapist's theoretical orientation and the process and outcome of therapy. When comparing feminist-based with mainstream (cognitive-behavioral) therapy, she suggests that mainstream therapists are more likely to be viewed as more authoritarian and sexist (Salierno, 2002). Furthermore, as a technique for working specifically with male batterers, she noted that feminist therapy might be more beneficial to male clients in helping them to more constructively express their emotions and deal with anger (Salierno, 2002).

Like the systemic critique, however, a rigidly feminist therapist may produce a countertransference reaction that is equally as damaging to the treatment of partner abuse. For example, a rigidly oriented feminist therapist may not be as gender sensitive and may not appropriately address the minority of battered individuals such as battered men, battered persons in same-sex relationships, etc. In addition, the feminist therapist may avoid addressing the battered person's role in the violence for fear of "victim-blaming" (Erickson, 1992; Goldner, Sheinberg, & Walker, 1990) or because it may not fit with the dominant views on treatment of partner abuse.

Postmodernism

Postmodern therapy fits well with the concept of social constructionism in the belief that the therapist's epistemology and ontology is rooted within multiple social, historical, and political contexts (Anderson, 1997; Brown, 1994; Efran & Clarfield, 1992; Freedman & Combs, 1996, Gergen, 1985). From a therapeutic standpoint, postmodernism accepts the multiple realities that clients have regarding actions and beliefs (Weiling, Negretti, & Stokes, 2001). In addition, the

postmodern therapist does not see themselves as the expert or a facilitator and generally provides a setting by which the multiple realities are expressed.

From a postmodern position, therapists may be torn between feminist therapy and systems therapy in dealing with domestic violence. A postmodern therapist may resist the notion of feminism or accepting the title of being a feminist therapist. For example, Miller (2000) points out that feminists tend to promote the fact that they respect diversity and difference, yet they refuse to give up a critical perspective. In other words, problems arise between feminism and postmodernism when multiple perspectives or relativism are taken into account—the way that some families interact (e.g., traditional roles, values where the woman holds a submissive role to her husband) is not the "right" way (Miller, 2000). As a result, therapists may not be comfortable with the degree of direction or influence that feminist therapy often requires them to take. This brings into account the concept of "social change" that feminist therapists are required to implement. As a result, Melito (2003) suggests that "a potential conflict arises between the therapist's inherent moral influence and protecting the client's self determination" (p. 3). Thus, from a countertransference perspective, the therapist may not be comfortable exerting his or her personal influence on the client in order to deal or may be too comfortable with the domestic violence that may exist within the dyad (Dworkin, 1984).

Given the varying perspectives regarding what is considered to be the correct manner in which partner abuse should be treated, the controversy may have an adverse affect on the therapist's ability to deal with countertransference

reactions in an appropriate setting. Due to potential feelings of shame or guilt, a therapist may even avoid discussing "politically incorrect" countertransference issues with their supervisor (Strawderman, Rosen, & Coleman, 1997). As a result, by avoiding personal reactions, this only adds to the disempowerment of the therapist and the potential compromising of optimum treatment of the partner abuse (Strawderman, Rosen, & Coleman, 1997).

Conclusion

McGoldrick (1982) suggests that human beings understand their lives based on their own unconsciously driven cultural values and assumptions. Watzlawick (1976) also stated that when confronted by others who hold differing values, individuals tend to view others through cultural filters. It is inevitably through these lenses that many reactions in the clinical realm occur. Although the treatment of intense clinical issues such as partner abuse may bring about strong emotional feelings in the therapist (Goldner et al., 1990; Register, 1993), little is known about the degree to which specific life experiences or specifically which life experiences, elicit such emotional responses. What is needed is a better understanding of the cognitive and emotional constructs behind therapist's reactions in order to ascertain a truly objective stance with what their clients are experiencing.

Titleman (1987) points out that to train Marriage and Family Therapists, it is necessary to balance and integrate three key factors. These three factors include understanding and implementing family systems theory, exploring the influences of family of origin, and having supervision of clinical work (Titleman,

1987). These components become the foundation for obtaining a more holistic understanding of the systemic and ecological factors influencing the development of the therapist and how these factors play out in the clinical work with partner abuse cases.

CHAPTER THREE: METHODOLOGY

Research Design

This study sought to understand the meaning making experience of marriage and family therapy trainees from both a current and developmental perspective. This research examined the perspectives of therapists, their value and belief systems, as well as the ecological factors that influence their attitudes and beliefs regarding partner abuse. Researchers suggest that qualitative methodology allows for the experiences and valuable contributions of the respondents to be highlighted (Berg-Weger, Rubio, & Tebb, 2001). This study used qualitative methods to focus exclusively on the Marriage and Family Therapy trainee and to expand knowledge about the influences from the ecology and the influence on reactions to client's experiences.

Qualitative research methodology was selected for this research because it also complements and is informed by the feminist perspective (Myers-Avis & Turner, 1996). The researcher chose this as the best method for exploring this new research area and as a way of accessing this population (Marriage and Family Therapy trainees) regarding meaning-making experiences with partner abuse cases. The researcher assumed that personal contact with the researcher (rather than surveys) would increase the participants' comfort with involvement in this study and that face to face interviews would both increase and enhance data collection.

Through this project, the researcher employed the feminist perspective not only to understand therapists' value and belief systems regarding partner abuse

but also to inform the research process. The feminist perspective was essential in necessitating that the researcher be reflexive and acknowledge personal values and ideology in the research process in addition to recognizing power relations between the observer and the observed (Allen & Walker, 1992; Myers-Avis & Turner, 1996). This research project was very much in line with feminist research, in that it was meant to "make the invisible visible" (Myers-Avis & Turner, 1996) regarding the self-of-the-therapist and dealing with partner abuse.

In addition to the feminist perspective, this study included primary components of two types of qualitative methodology—ethnography and phenomenology. This study was ethnographic in that it is inductive; it reflected and was "shaped by theoretical presuppositions and principles that guided the process of data collection and analysis" (Newfield, Sells, Smith, Newfield, & Newfield, 1996). In ethnographic research, culture is variously defined. Thus, this study looked more closely at the nature of the culture of Marriage and Family Therapy trainees' beliefs, values and attitudes and how it structures their behavior patterns. The ethnographic perspective takes into account the process by which theory and the participant's experiences reciprocally inform one another. Furthermore, ethnography utilizes multiple data points in order to better understand a particular cultural construct. Like ethnographic research, phenomenological methods also seek to understand how individuals make meaning of a phenomenon they are experiencing.

Phenomenology is characterized by the idea that individuals have their own reality, eliminating an absolute truth (Boss, Dahl, & Kaplan, 1996). This

approach to qualitative research is characterized by "meaning questions" (Boss, Dahl, & Kaplan, 1996, p. 91) in that it focused on the interpretation of human action. A phenomenological approach assisted in the process of understanding how the participant makes meaning of the phenomenon and his/her lived experience (Seidman, 1991). Regarding this research study, both ethnography and phenomenology guided the underlying principles of the study—that theory and experiences reciprocally inform one another, that reality is socially constructed, and that individuals make various meaning of their experiences. Furthermore, tools utilized within both approaches (interviews, ecomaps, actions, etc.) guided the collection and analysis of data in order to better understand the relationship between therapists' value and belief systems and their reactions to partner abuse situations.

Sample

The sample for the proposed research project was criterion-based in that it only included marriage and family therapy trainees who were currently in a Master's or Doctoral level Marriage and Family Therapy programs. Specifically, seven trainees were sampled from Marriage and Family Therapy training programs in the Midwest region of the U.S. Although a range of 5-8 was the initial target, sampling continued concurrently with data analysis until saturation—the point at which no new information emerged. In addition, the use of fewer participants aided in the ability for the researcher to gather more detailed information on each participant's life history, clinical background, developmental influences, etc.

The rationale for using Marriage and Family Therapy student trainees involved multiple dimensions related to the nature of the study as well as their educational, clinical, and developmental levels. This research study was exploratory in nature and as explained above, conformed well to triangulated study design. It was mostly directed at better understanding the lives and experiences of therapy trainees and attempted to obtain an accurate picture of the unique clinical situations of partner abuse. Furthermore, due to the wide range of influences that may affect therapist development, a fairly diverse sample was recruited in that recruitment was not limited by certain demographic characteristics or clinical background. Ideally, individuals with diverse backgrounds and experiences (i.e., age, ethnicity, sex, sexual orientation, cultural backgrounds, etc.) provided the researcher with a broader range of factors to analyze into the equation of potential influences on therapist responses and added to the richness of each of their stories and life experiences.

Regarding the nature of the therapist's educational, clinical, and developmental levels, trainees were recruited for fixed reasons as well. Specifically, therapy trainees may not be as desensitized to certain clinical experiences—which a high frequency of exposure to domestic violence or partner abuse might provide. As a result, their reactions to clinical situations such as these may have been more raw and unexplored. In addition, due to the likelihood that trainees have not been in the role of being a clinician for an extended period of time, they may have been less likely to have addressed

themselves (i.e., acknowledged the self-of-the-therapist), explored, or incorporated their value and belief systems into their modality of therapy.

Recruitment

Recruitment for this study was conducted at the American Association for Marriage and Family Therapy accredited training programs within a 250 mile radius of the researchers' home institution. These sites were selected due to the convenience of conducting on-site interviews within an adequate travel distance as well as housing pure Marriage and Family Therapy programs (e.g., not dually accredited clinical programs, which may provide increased exposure to non-family systems oriented therapists or instructors). Announcement letters were sent to each of the institutions informing student therapists about the study and recruitment letters were used to obtain contact information from those interested in participating. Those indicating interest in participation were contacted by phone or email and appointments were set for conducting the interviews.

Sample Demographics

The sample of Marriage and Family Therapy trainees came from three universities in two states within the Southern-Midwest region of the U.S. All participants' names have been replaced with pseudonyms and other identifying data have been left out. The total number of participants was seven. Each participant had recently completed their Master's coursework and clinical hours for their degree in Marriage and Family Therapy. Three of them were still working on their Master's thesis work and would be completely done within two

months of the interviews and two of them were currently moving into a doctoral program specializing in Marriage and Family Therapy.

The ages of the participants ranged from 23 to 36 years (mean age of 27 years); all seven participants were female; six participants were Caucasian, one participant was African American; four participants were married, one engaged; and one participant had children. The sample being all female was not surprising given the general trends of the Marriage and Family Therapy field being female driven. Regarding their educational residence, two participants were classified as in-state (Michigan and Indiana), and the remaining five participants were out-of-state with their current residence ranging from three to eight years.

Protection of Participants

This project met or exceeded the standards used by Michigan State University's Human Subjects Review Board. Specifically, in order to ensure protection of the participants, Michigan State University's University Committee for Research Involving Human Subjects (UCRIHS) reviewed the procedures for this study. The collection of data did not begin until full approval was received from UCRIHS.

Participants were given an informed consent form (see Appendix 1), describing the research study and the costs and benefits of participation. In order to ensure that the participant understood and was fully informed about the study, participants were also provided an opportunity to ask questions and obtain additional information about the study. If an interest was expressed, an acknowledgment of the voluntary nature of the project was sought (i.e.,

remuneration was not to be provided) in the proposed research study by providing their signature on the consent form. Furthermore, to protect the participant for any sustained emotional risks, support services or resources in the community was provided. Information and data gathered was kept confidential through the use of identification numbers in place of names on all associated forms and all data was kept secured in a locked filing cabinet.

Procedures

Data Collection

To ensure privacy, the process of gathering information from the participants took place either in a clinical setting, the participants' homes, or another identified setting. After consent for participation in the study was obtained, the interview process began. The primary data collection process involved four main stages: 1) completing a demographic profile; 2) viewing the clinical video vignette; 3) conducting the first interview regarding the therapist's immediate reactions to the vignette; and 4) a second interview regarding the ecological factors affecting reactions. Six separate data points were utilized in the data gathering process. They included the demographic profile, the participant's completion of a differentiation inventory, the researcher's observation (field notes), two semi-structured interviews, and the value system ecomap. Each provided useful information, which was descriptive and expressive of the participant's actual attitudes, beliefs, reactions, and overall developmental processes. In addition, the interview process was both audiotaped and videotaped. The audio recording aided in the transcription

process and the videotaping provided the researcher with a record of the participants' non-verbal responses throughout the interview process. The specific information related to the research questions for this study, or factor that each data point will address, can be seen in Table 3.1.

Individual semi-structured interviews provided detailed information about participants' behaviors, feelings and attitudes. Due to the sensitivity of the nature of the information being gathered, the overall data collection process (e.g., interviews, viewing of the vignette, etc.) was approached in a one-on-one context instead of other techniques such as a focus group. This helped to provide a less threatening atmosphere and to ensure the participants' feelings of safety in sharing personal backgrounds and experiences as well as direct reactions regarding the partner abuse vignette. The individual nature of the process also allowed for more attention to be paid to details such that a large amount of information could be gathered in a short period of time.

Recognizing the sensitivity of this topic, the researcher made special efforts to establish rapport with the participant and to help the participant feel comfortable regarding what to expect throughout the interview process. The researcher invited the participant to ask questions and to express how they were feeling about given topics or lines of questioning. In addition, the researcher probed for clarification of responses when needed, and summarized the interviewee's responses to ensure clarity. In situations where an area of inquiry might have been painful or uncomfortable, the researcher allowed the participant an active part in deciding the depth of information they wished to provide (Patton,

2002). Furthermore, the researcher monitored his non-verbal responses to exemplify neutrality such that the participant's responses would not be tailored or tainted in any way.

Demographic Profile

The demographic profile assisted the researcher in gathering information from the participant regarding their age, sex, ethnicity, sexual orientation, marital status, etc. (see Appendix C). These questions were important in that they became additional factors included in the participant's environmental ecosystem—which were also used as probing questions during the interview. This profile was quite valuable, as it also enabled the researcher to account for factors related to the therapist's residence history, which may also influence value and belief systems. This was also important due to the potential regional or cultural differences (e.g., out of state student versus in state) that may have existed in attitudes towards partner abuse, gender stereotypes, hierarchy within relationships, etc. In addition, it helped to identify the graduate level of the student, their educational background or attainment, family of origin background (i.e., parent's marital status, number and sex of siblings, etc.).

Clinical Presentation

Following the completion of the demographic profile, the participants were then given a mock intake summary including a brief description of a couple that has indicated that they want therapy for "marital issues" and "communication problems" and have scheduled an intake appointment. This process laid the foundation for the concept of the participant being in a role-play exercise in which

the participant acted as a therapist who was seeing a clinical case for the first time. Detailed information was not provided regarding the vignette so as to ascertain an unprocessed response from the therapist regarding the details about what the couple is presenting for. Thus, the therapist was only given the general intake information providing the clients names, phone numbers, and what the primary format of the case was (e.g., couples therapy, communication work, etc.).

A videotaped case vignette in which two actors (a Caucasian man and a biracial (African-American/Caucasian) woman) depicted partner abuse was presented to the participants as a role-play experience in which the therapist was asked to think of the couple as their client and they are conducting the therapy session. The clinical vignette was written as a combination of written vignettes depicting "partner violence" in previous research (Hansen & Harway, 1991) as well as actual clinical events the researcher experienced first hand (see transcripts of the video in Appendix B). This specific interaction was identified as abuse by the researcher due to the inclusion of one person's actions involving direct physical contact in order to control another.

According to Barter & Renold (1999), the use of vignettes fits extremely well with qualitative research in that visual information enable participants to define the situation from their own unique perspectives. The vignette added to the overall data collection process in that it provided a framework for which the research questions for this study could be asked. This technique was key to the study in that the sole use of interviews or observations regarding previous

historical experiences would not be as rich in nature to meet the needs of the research. Specifically, the use of a vignette aided in eliciting "perceptions, opinions, beliefs and attitudes from responses or comments to stories depicting scenarios and situations" (Barter & Renold, 1999, p. 2.).

According to Neale (1999), vignettes can also be useful in order to better understand potentially sensitive topics, that individuals may normally have a hard time discussing. Neale (1999) suggested that having a participant reflect on a story may be less personal and thus, less threatening than them reflecting on their direct experiences. However, the researcher believed that a case (written) vignette would not allow the participant to feel or experience the situation and might only tap the cognitive/thinking component of the participant. Thus, a video was used because of the greater degree of realism and potential for participant interaction and likelihood of evoking an actual emotional reaction than would a written case description/vignette.

The video vignette simulated a first session clinical interview in which the client actors presented their reasons for seeking out and attending therapy. During the vignette, each member of the couple described and explained their experiences in the relationship as well as their participation in and explanation of the partner abuse. After each actor presented his or her perspective regarding the partner abuse, one of them then looked towards the camera and asked the therapist/participant: "What do you think?"

Before, during, and after contact with each participant, the researcher was recording field notes regarding the experience of personal contact with the

participant. As the participant was viewing the vignette, the researcher recorded observational field notes as to the non-verbal (and verbal) responses expressed by the participant. This information served the researcher as potential probes for the first interview to tap into the personal reactions experienced during the vignette. The field notes also allowed the researcher to reflect on the participant's relationship with the researcher as well as overall comfort level with the interview process, their guardedness, etc. This was the end of the second phase of the research process for each participant—each was then asked to respond to the vignette.

Clinical Response Interview

After viewing the video vignette, the participants were then given a semi-structured interview regarding their initial reactions to the case presentation. This interview involved questioning the participants about their feelings toward the clients, their emotional reactions they had as the clients discussed the partner abuse, what questions arose as they listened to the clients, etc. (see Appendix C). This line of questioning provided a foundation for understanding the participant's detailed reactions regarding the case presentation and the final stage of the research process.

Both the clinical response interview and the ecological factors interview (discussed below) were guided by Cowles' (1988) informal guidelines for gathering information on sensitive topics. She suggested considering a number of factors such as the timing of the interview process—the participant's recent experiences, the time allotted for in-depth interviews, the time of day for

interviewing, and the overall process of gathering the information. To this end, maintaining flexibility throughout the process aided in the establishment of more trusting relationships and the enhancement of discussing potentially sensitive topics. Cowles (1988) also discussed techniques to help the participant feel more at ease in sharing personal information such as emphasizing the potential for addressing emotional responses, offering to stop the data collection if they wish, reassuring the participant that their responses are not abnormal, and encouraging the sharing of their thoughts and feelings candidly—reassuring participants that they shouldn't feel embarrassed and will not embarrass the researcher. Finally, Cowles (1988) noted that the following three factors are key for the researcher to elicit information from research participants. These are establishing a trusting relationship, balancing objective and empathetic listening, and maintaining a nonjudgmental stance (Cowles, 1988). Additionally, the researcher should be adequately prepared to deal with the participant directing negative reactions toward them, provide clarification about the information gathered throughout the interview, and provide a debriefing session for dealing with the researcher's own responses to the interview process.

Ecological Factors Interview

The second phase of the interview process asked the participants to complete an ecomap through which ecological factors were identified that influenced their conceptualization and operationalization of partner abuse (see Appendix D). The ecomap was an exercise in which the participant identified the components connected to how they reacted to partner abuse. It also helped to

identify in what ways each identified factor is related to the others or which ones the participant deemed most important to the key construct. The researcher then conducted semi-structured individual interviews with the participants, which included open-ended questions regarding those ecological factors identified by the participant in their ecomap. Ultimately, the ecomap assisted in guiding the conceptualization of the therapist's definition of abuse and served as probing items that were employed as means to garner further details regarding their belief systems. Furthermore, the interviews assisted in obtaining the therapists' personal examples and recollections and additional descriptive information illustrating worldview and belief systems.

An interview guide consisting of a number of open-ended questions as well as sub-questions—based on the researchers pre-determined concepts, the field notes, and the participant's initial responses assisted the interview processes (see Table 3.2). The sub-questions, or probing questions, acted as guides but did not constrain the researcher to a rigid interview format. The primary thrust of this research was to understand how therapist's values, beliefs, and assumptions affected their therapeutic and personal reactions to partner abuse cases. In order to address this research, related research questions were developed. Each question was derived from the operational map (Figure 1.3) found in Chapter 1. Interview questions asked about the participants' reactions to the clinical vignette, their definitions of abuse, what their value and belief systems are regarding partner abuse, gender, and power, and how each of their identified

ecological constructs affect their reactions (i.e., historical, developmental, and clinical).

Triangulated Data

Differentiation of Self Inventory. After the final interview, the participant completed the Differentiation of Self Inventory (DSI, Skowron & Friedlander, 1998). The DSI is a 43-item, six-point Likert-type response scale (see Appendix E) that contains four subscales: Emotional Reactivity, I Position, Emotional Cutoff, and Fusion with Others (see Table 3.3 for each subscale and specific questions). The four subscales reflected the degree to which the participant emotionally responds to environmental stimuli, how one maintains a sense of self in the presence of external stress, feelings of relationship vulnerability, and emotional over-involvement with others. Although an overall DSI score was obtained (ranging from 1, low differentiation, to 6, high differentiation), the individual items also assisted in the triangulation of data collected during the interview process. They also provided more detailed information as to how their inter- and intra-personal dynamics (i.e., thinking-feeling and separateness-togetherness) and the specific relationships in the participant's environment influenced reactions to clinical cases such as partner abuse.

Clarification & Verification. After the data collection and interview process was complete (approximately one week later), the researcher contacted the participants with a follow up letter. This letter thanked the participant for their time and reflected the researcher's enjoyment in learning more about their experiences. At the end of the transcribing process, the researcher then re-

contacted the participants, and asked for additional thoughts or clarification of their responses from the interview process. Upon request from most of the participants, as soon as the data analysis was completed, the researcher then re-contacted the participants via email and shared the outcomes, themes, and conclusions of the study.

Data Analysis

All interviews were both audio and video recorded, and transcribed verbatim. In general, the data analysis addressing each of the research questions involved examining the transcripts for overarching definitions and conceptualizations of definitions of partner abuse, what factors affected reactions to the partner abuse case—specifically how they affected their reactions, and how overall values, beliefs and assumptions were socially constructed. The factors identified from all participants were then categorized into themes, based on the nature and relatedness to each other. In order to maintain credibility and validity of the coding process, the primary researcher and an additional qualified individual coded the data independently. The additional coder agreed to abide by UCRIHS standards by signing a confidentiality agreement. Rather than use a quantitative measure of inter-rater reliability as with quantitative methodology and to maintain the integrity of qualitative methods, the two coders compared codes and reached consensus in order to maintain consistency.

Coding Procedures

The primary key regarding the analysis of phenomenological data is to accurately depict the participant's lived experience, their reality, and meaning

making process. Thus, the constant comparative method outlined by Glasser & Strauss (1967) was the primary modality of analyzing the gathered information. This method involved the simultaneous process of coding and analysis in order to discover emerging theory (Glasser & Strauss, 1967). It involved processes including: 1) comparing incidents applicable to each category (the data was coded into already existing themes or was marked with a newly identified theme); 2) in a reciprocal process, the data was also delineated into categories and was also integrated across categories to support greater findings; 3) the findings were then classified into two primary categories – themes and theory; and 4) the researcher articulated his contribution to existing theory (Glasser & Strauss, 1967).

To facilitate the sorting of data, codes or organizational categories were initially used in the analysis procedures. Miles and Huberman (1994) suggest that even before data are gathered, it is prudent to have an initial broad coding scheme in place, based on conceptual mapping and theorizing. They argue that this makes explicit a process of conscious or unconscious selection of data which is already inherent in data gathering. The initial codes for this study followed the seven research questions and included: 1) Family of origin; 2) Clinical Experience; 3) Personal Background; 4) Developmental processes; 5) Definitional processes; 6) Internalized messages (regarding power and gender); and 7) Values, beliefs, and assumptions.

Trustworthiness and Credibility

A variety of techniques was utilized to ensure trustworthiness and credibility of the data collection, interpretation, etc. This was due to the fact that qualitative research assumes that there are multiple realities within the findings of research. First, method triangulation was ensured by the use of both ecomaps, individual interviews, and the DSI in the collection of data from the participants. Specifically, the use of a step-wise interview process allowed the researcher to check for congruency (i.e., data triangulation) between the participant's initial reactions (following the presentation of the clinical vignette) and the rooted ecological factors influencing their reactions. From a research design perspective, various forms of documentation in the form of five points of data collection (e.g., the demographic profile, the therapist's differentiation score, the researcher's field notes, two semi-structured interviews, and value system ecomap) also aided in the trustworthiness and credibility of the participant's interview responses. As mentioned before, the field notes, taken during the viewing of the clinical vignette as well as after the interviews are complete, also added to the overall trustworthiness and credibility of the research process.

Triangulation of Data. The interviews were audio and videotaped, transcribed, and verified by the researcher. In addition, based on a philosophy that views the participants as experts on their own lives, the data was returned to the participants in order to confirm the researcher's accuracy in interpretation. For the purposes of this research project, each consultant was then contacted by email, asked to supply missing demographic information, and was provided an

opportunity to add any further comments or expand on their responses to the interview. Furthermore, using more than one coder as part of the data analysis ensured that data are accurate and address the concept of credibility (the qualitative equivalent to reliability).

For the purposes of maintaining validity of the concepts under investigation, the term "partner abuse" was used rather than terms such as aggression, violence, or domestic violence. This allowed the participants a greater degree of freedom in identifying and explaining what abuse is to them. As a result, it may have allowed for the inclusion of a wider range of participant responses including both physical and non-physical acts of control (manipulation, emotional abuse, psychological abuse, etc.), which may have accounted for varying reactions by the participants.

As mentioned earlier as another technique for triangulation, following the conclusion of the research findings, peer debriefing was used to increase the credibility of the data gathered and serve as a means to provide the participants and opportunity to add additional thoughts. Ultimately, the process served as a method to enhance the understanding of the participants' meaning-making experiences and to aid in the use of their responses in addressing the research questions.

Reflexivity

The themes and sub-themes obtained from the participants' narratives were subjective, because they are the coder's perceptions of the description or essence of the participants' message. This is affected due to the fact that the

researcher has a unique reality and possesses a view of how therapists define couples abuse, which may be potentially biased. For many therapists, their understanding or definition of abuse is derived from their own lived experiences with abuse, their treatment of abused individuals, or their peers or supervisors' experiences with abuse. In addition, by simply having a particular therapeutic lens to treating individuals, couples, and families may have been a limiting factor to understanding the nature of abuse or why it happens and may aid in the therapist missing out on the meaning that is held behind the actions. Regardless of the perspective, it is important to be aware of the potential influence that the researcher's viewpoint or potential for bias may have on the research process.

As the researcher, I was interested in this research study for a number of reasons. First, I greatly appreciated the personal aspect that is brought to the therapeutic process. Upon completing my own clinical training as part of an accredited MFT program, I have witnessed therapists orienting therapy to both unique perspectives and even to certain personality characteristics. Quinn, (1996) suggests that many factors related to the theoretical approaches therapists identify with, how they interact or build rapport with clients, etc., and that all play a role in therapeutic outcomes. More specifically, from pilot research conducted on ecological factors affecting Marriage and Family Therapists' career choice, family of origin stood out as a significant influence on perception of individual problems in the context of relational dynamics (Brosi & Silverthorn, 2002). Thus, the feminist perspective regarding the inability for a therapist to be

truly neutral seemed to be evidenced. I then became interested in the question of how to best manage therapist's reactions to specific clinical situations.

Limitations

This research study was exploratory, qualitative in nature, and consequently has related limitations. First, the areas of this research were challenging for therapists (of all developmental levels) to identify, address and reflect on. It required willingness, ability, and insight on the part of the participant in order to fully appreciate the complexities that drive their therapeutic interactions. Next, it is important to recognize that in qualitative research, the researcher is an active instrument. Thus, the creation of the research questions, the methods of collecting data, the relationship between the researcher and the participant, etc. is governed by what the researcher deems valuable.

It is also critical to recognize that the relationship between the participants and the researcher may have played a role in obtaining sensitive information such as this. Due to the lack of alliance, there was a great potential for the participant to mistrust or to not feel safe sharing personal information with the researcher. The researcher was not just looking so much at the opinions of the participants, but going to the core of their lived experiences and how they think and feel. Thus, establishing an open, secure environment in which the participant could openly share their experiences was essential. Furthermore, inherent power dynamics in regards to the sex differences between the researcher (male) and the sample (female) may have also affected the relationship.

Finally, there were limitations related to the sample addressed in that this study only addressed how Marriage and Family Therapy trainees react to partner abuse situations. There are wide ranges of professionals who work with partner abuse situations who may react in very similar ways. It is also extremely important to examine whether differences in reactions existed based on other ecological factors such as career, field of study, or length of time as a therapist. Although this study examined the experiences of MFT trainees, it was not inclusive of other mental health professionals.

Table 3.1: Factors Within Each Research Question and the Source of Data

Research Question Factors	Sources of Data				
	Interviews	Observation of particip.	Ecomap	Field Notes	Differentiation Scale
Family of origin	√		√		√
Clinical Environment	√		√		
Educational exposure	√		√		
Media			√		
Supervisory experience	√		√		
Society / Culture	√		√		
Therapist responses		√		√	√
Experiences with abuse	√		√		
Anxiety tolerance	√	√		√	√
Gender/Power msgs.	√				
Partip.'s def. of abuse	√				
Maturity level	√				√
Therapeutic ability	√			√	
Value/Belief system	√		√		

Table 3.2: Relationship Between Research & Interview Questions

Research Question	Interview Questions
RC3	How has the media influenced how you respond to partner conflict?
RC1	What things from your family of origin reminded you of the clinical case that you watched?
RC1; RC5; RC6; RC7	How did your family of origin influence your thinking about partner conflict?
RC2	What things from your clinical experiences may have influenced how you reacted to the clinical case?
RC2; RC5; RC6; RC7	How has your clinical experiences influenced your thinking about partner conflict?
RC2; RC5; RC6; RC7	How do you think your supervision experiences affected how you reacted?
RC2; RC5; RC6; RC7	Tell me about your experience working with cases involving partner conflict. How has that influenced how you react?
RQ3	What things from your unique personal life experiences may have played a part in your reactions?
RC3; RC5; RC6; RC7	How have your personal life experiences influenced your thinking about partner conflict?
RC3; RC5; RC6; RC7	How does your own marital status affect how you react to cases with partner conflict?
RQ4	In what way do you think your developmental level as a clinician might affect your reactions to cases with partner conflict?
RQ2; RQ3	What things in your education do you believe has either helped or hindered your ability to work with a couple experiencing conflict like this?
RQ2	How do you think certain theoretical approaches would assist you in addressing the couple's issues?
RQ4	How do you feel that your own anxiety level contributes to your reactions or ability to interact with clients experiencing partner conflict?
RC3; RC4	How have you been able to deal with your personal reactions when interacting with partners experiencing conflict?
RC4; RC5; RC6; RC7	How have your attitudes about individuals experiencing partner conflict changed over time?
RQ5; RQ6	How do you feel about both individuals in the conflictual clinical vignette?
RQ5; RQ6	How serious do you think the scenario is and why?
RQ5; RQ6	How do you define couples abuse?

Table 3.2 (cont'd)

RQ5; RQ6	What messages, meanings, and beliefs do you have regarding partner abuse?
RQ5; RQ6	How do you make sense of conflict that occurs between partners?
RQ6	What would your primary mode of therapy look like?
RQ6; RQ7	How do your view your role as a therapist in intervening with the partner conflict?
RQ6; RQ7	How has society influenced your attitudes regarding power?
RQ6; RQ7	How has society influenced your attitudes regarding gender?
RQ6; RQ7	Do you believe you, as a therapist should be an agent of social change? Why or why not?
RQ5; RQ6	What stuck out the most to you about the clinical vignette?
RQ5; RQ7	What are your initial reactions about the clinical vignette?
RQ5; RQ6; RQ7	What are your initial instincts regarding the couple?
RQ5; RQ6; RQ7	How do you think the details of the clients reported interaction affected how you reacted?
RQ5; RQ6; RQ7	What are the factors that influence how you define couples conflict? (Use the ecomap as an aid in identifying factors).
RQ7	How do your overall values, beliefs, and assumptions affect your ability to address certain aspects of partner conflict?
RQ2; RQ3; RQ4; RQ5; RQ6	DSI – Emotional Reactivity subscale questions
RQ4	DSI – I Position subscale questions
RQ1	DSI – Emotional Cutoff subscale questions
RQ1; RQ3; RQ4; RQ6	DSI – Fusion With Others subscale questions

Table 3.3: Differentiation of Self Inventory Subscale Questions

Subscale	Questions
Emotional Reactivity	People have remarked that I'm overly emotional.* When someone close to me disappoints me, I withdraw from him or her for a time. I wish that I weren't so emotional.* At times my feelings get the best of me and I have trouble thinking clearly.* At times, I feel as if I'm riding an emotional roller coaster.* I'm overly sensitive to criticism.* If I have had an argument with my spouse or partner, I tend to think about it all day.* If someone is upset with me, I can't seem to let it go easily.* I'm very sensitive to being hurt by others.* I often wonder about the kind of impression I create.* I feel things more intensely than others do.*
I Position	I tend to remain pretty calm even under stress. No matter what happens in my life, I know that I'll never lose my sense of who I am. I usually do not change my behavior simply to please another person. When I am having an argument with someone, I can separate my thoughts about the issue from my feelings about the person. There's no point in getting upset about things I cannot change. I'm fairly self-accepting. I am able to say no to others even when I feel pressured by them. I'm less concerned that others approve of me than I am about doing what I think is right. My self-esteem really depends on how others think of me.* I usually do what I believe is right regardless of what others say. I tend to feel pretty stable under stress.
Emotional Cutoff	I have difficulty expressing my feelings to people I care for.* I often feel inhibited around my family.* I tend to distance myself when people get too close to me. My spouse or partner could not tolerate it if I were to express to him or her my true feelings about some things.* I'm often uncomfortable when people get too close to me.* I'm concerned about losing my independence in intimate relationships.* I often feel that my spouse or partner wants too much from me.* When one of my relationships becomes very intense, I feel the urge to run away from it.* I would never consider turning to any of my family members for emotional support.* When I'm with my spouse or partner, I often feel smothered.* When things go wrong, talking about them usually makes it worse.* Our relationship might be better if my spouse or partner would give me the space I need.
Fusion with Others	I'm likely to smooth over or settle conflicts between two people whom I care about.* It has been said (or could be said) of me that I am still very attached to my parent(s).* Whenever there is a problem in my relationship, I'm anxious to get it settled right away.* It's important for me to keep in touch with my parents regularly.* When my spouse or partner is away for too long, I feel like I am missing a part of me.*

Table 3.3 (cont'd)

Fusion with Others	I try to live up to my parents' expectations.* Arguments with my parent(s) or sibling(s) can still make me feel awful.* I find myself thinking a lot about my relationship with my spouse or partner.* I worry about people close to me getting sick, hurt, or upset.

* Reverse coded

CHAPTER FOUR: RESULTS

This chapter presents the primary findings of this study. First, an overview of the research process will be presented. This will be followed by an overview of the sample demographics. Finally, the findings corresponding with each research question will be demonstrated.

Overview of Process

This study was an attempt to better understand the process by which Marriage and Family Therapy trainees' reactions are influenced by various ecological factors in their lives. This required an emphasis on the meaning-making process relative to how therapists have come to develop an understanding of partner abuse and how it then influences the therapeutic process. However, as all of this is interwoven, it can be a challenging and difficult endeavor. It takes a great amount of introspection on the part of the participant, not to mention a willingness to address these dynamics in the first place and attentiveness of the researcher.

Throughout each of the participant interviews, I found myself absorbed by their stories and how they have come to make sense of their experiences or lack of experiences with partner abuse. Asking the participants to reflect on their own feelings was complicated due to the number of factors that played a unique part in their ability to do so in the first place. Yet, each of their stories was quite unique, and expressive of unique viewpoints. This required a comfort with the researcher and the nature of the research topic. As a result, the interviews

provided insight into the factors and life experiences that influence how they view, react to, and work with clientele experiencing partner abuse.

Overview of Research Questions

The primary research question for this study addressed how various ecological factors influence therapist's values, beliefs, and assumptions that in turn, guide therapeutic and personal reactions to partner abuse cases. As one of the primary guiding theories for this study, Human Ecology theory focuses on the multiple layers of environments and the interaction between the developing individual and the systems within their environment.

As will be shown, the divergent lived experiences of each of the participants indicate the vast influence of the various environmental systems on the reactions toward partner abuse. Information gained from these interviews also revealed how family of origin, clinical experience, and developmental processes have contributed to existing and changing attitudes and belief systems surrounding partner abuse. The other forms of data gathered (e.g., ecomaps, field notes, differentiation scale, and the videotaped reactions to vignette) were utilized and implemented as validation tools for the participant interviews. The following sections address each of the research questions and how the participant therapists have made sense of their interactions with these varying systems. Specifically, the first four research questions address the influence from the participant's ecological environment, including the time/developmental system. Questions five through seven involve a more intrinsic, meaning-making

dimension regarding the values, beliefs, and assumptions the therapist has about partner abuse.

The responses provided by each of the participants grant a certain degree of insight into how their reactions and therapy is affected by the various factors in their lives. Often, the responses fell into broad categories in which every participant had reported similar occurrences. At other times, the participants discussed having similar reactions or feelings that a particular entity held a comparable value or influence in their lives. In these cases, the responses reflect meanings rather than frequencies and the phenomenological, meaning-making experience of the participants and how they make sense of their lives and about partner abuse. In both situations, the shared category was reported as having significance enough to be provided below in addressing each of the research questions (see Table 4.1). Thus, the implications for each of the categories and themes and how they fit together into consolidated stories will be further expanded upon in Chapter 5.

Research Question 1: How do interactions with various ecological systems from therapist's family of origin influence responses to partner abuse cases?

Thematic Content: Direct & Non-direct influences; Making sense of the family influence; Role-playing within the family

The first research question focused primarily on the influence of the participant's family of origin on their responses to dealing with partner abuse. It was assumed that beliefs and values acquired through experiences with the family of origin influence how therapists view couple dynamics involving partner

abuse. Therefore, responses are categorized according to the relationship between the participant's family of origin and the influence that they believe it has on how they respond to abusive couple clients.

Among the respondents, there was a pervasive belief that their family of origin played a significant role in how they viewed partner abuse. This was evident in their responses to the questions, "What things from your family of origin reminded you of the clinical case that you watched?" and "Did it stir up anything you remember from your parent's interaction or with your siblings?" Additional sources of responses validating the influence of the family of origin came from the participant's completed ecomap of influential factors as well as their differentiation of self-score—which specifically addressed relational dynamics with the participant's parents. As a result, the responses from the participants surrounding their family of origin fell into the themes of Direct influences, Indirect influences, Making sense of the influence, and Role-playing. It should be noted however, that all of the participants reported that their family of origin did influence how they reacted to clinical cases of partner abuse. The difference came in the manner by which they reported the influence.

Direct Influences. An initial separation in coding category was established regarding the manner by which the participant believed that their family of origin influenced their reactions. The resulting two thematic categories were direct and indirect family of origin influences. The direct influences pertained to those responses in which the participant felt that being exposed to their parent's or

sibling's type of interaction directly influenced how they viewed or reacted to abusive partners. Mary's words seemed to capture this theme in her statement:

> "I have a fear of violence. I mean, I do. I grew up in high violence and so I have to check that. Sometimes I let that (certain) thought come in, I check it, and that's one way that...that is my anxiety is when I hear the word "violence"—I get anxious. I'm like oh my God, Mary, remain calm, remain calm, cool, you are a therapist, you're not 13."

This passage illustrates Mary's acknowledgment of the connection between her experiences growing up and how it reemerges during her therapy. Dora also provided insight into the direct effects of being exposed to her parent's negative interaction in her statement:

> "...Like I said with my family of origin situation, there was a lot of conflict and a lot of anxiety. Even though I wasn't the victim of the actual abuse, I still kind of felt the aftereffects. And so I can associate some of that, some of my family of origin experiences with what they're possibly going through."

Dora also reported watching her two biological parents slowly learn to interact cordially with one another over a number of years following their bitter divorce. Karen similarly stated that she firmly believes that her therapy with abusive partners and individuals is affected by her experiences surrounding abuse with her family of origin.

> "So when we would go to the farm—that's when we would endure the abuse. And so we were able to keep that secret from mom until we started telling her what was going on. And then as soon as she found out she took us out. But we were in protective custody because he was very violent with us. He came after us with a gun, and literally things like that. So that's going to probably impact me as a therapist---or it actually has now, because I'm very big on safety issues..."

Karen's statement provides evidence that her experiences as a child, not necessarily observing the violence between her parents, but sustaining the

abuse from her father affects her in the attention she gives towards the establishment of safety.

Indirect Influences. About half of the participants reported significant dynamics within their family of origin that played a major role in how they react, view, and work with couples experiencing partner abuse. At the same time, the other half of the participants were addressing a similar observation, but more from what had not occurred in their family of origin. Judy's response specifically seemed to sit on both sides of the fence in that she viewed her parent's non-physically violent interaction in a specific manner—yet still deemed it abusive. As a result, this has a unique outcome on how she then reacts to couples:

> "I think it would push more of my buttons to see a couple... I wouldn't be as worried about my issues coming out in a couple who is being physically abusive because I haven't experienced that, so I wouldn't be as likely to kind of say "you need to get out of the house and leave him" or I think I would just take into account kind of more, all of the presenting factors that are affecting them versus a couple who kind of just distances themselves--like my parents have. I think I would be more kind of worried about what affect that has on their kids. Because that's what my life was. So that's where I would kind of... I would be more tuned to that."

Although Judy is equating a direct influence on her reactions from watching her parents disengage from one another, it seemed to be an opposite type of indirect response on how she reacts. As a result, similar accounts were noted in the indirect notion of family of origin influences. For example, Kim reported having no exposure to partner abuse due to having grown up in a non-argumentative home. She stated that as a result of this type of environment, she reacted differently:

> "I think if this were something that happened in my own family, that I would react differently. Maybe I would be able to...because of more

> transference issues, because this was something that I saw in my own family, because I would be able to put myself better in the place of one of them...Right now that's very outside of me...I can feel for you on the outside, but I've never lived that. So is it a good thing or a bad thing? I think it's probably a good thing that my family is not like theirs, because it stops me from having any further transference problems."

Her response indicates that she deems this specific type of interaction to hinder her ability to fully comprehend exactly what her abusive clients may be experiencing. At the same time, she feels that because her family is different than the ones presenting clinically, it keeps her from potential induction, collusion, or as she stated, any transference problems. However, she does not indicate that her family of origin influences any potential countertransference reactions.

Making Sense of the Family of Origin Influence. Another major theme that emerged involved the participant's ability to make sense of what they had been exposed to within their family of origin regarding partner abuse. In general, the participants seemed quite open in discussing the dynamics that took place between their parents—both positive and negative, as well as how it influences their thinking. But more specifically, most of them described a consolidated viewpoint that they took from their family of origin experiences that helped them to separate their parents interaction from that of others. For example, Mary reflected a great deal on the abuse within her home in that:

> "I think that I have gotten—that I have become more sensitive to it. I think that growing up in it, you don't realize that it is as unacceptable as it is. I don't want to sound like our parents really did love us---they did. I feel like they truly did and to me that makes sense as to how I view this couple."

Sara also discussed ways in which she understood or made sense of the interaction within her family of origin and subsequently how it helps her understand the interaction between the couple in the vignette:

> "We were in a very honest home, which sometimes we fought. But, it was coming from a good place. Sometimes they would scream at each other.... just ridiculous things. Just people speaking openly...this is the way they talk to each other. This is the way that they get it out—yelling. Of course, they could stand to improve a little bit, but...Probably not name calling is the best way, but...But they're a couple that naturally fights and by all means, continue! And that works for them, if that's their style...there are lots of couples that are openly conflictual and are very happy...probably not them (vignette couple), because of their name calling and hitting each other, but that may just be their way."

Sara seems to believe that limiting or drastically changing a couple's way of interacting with one another might affect their innate natural abilities to express themselves. She believes that her parents found a common way to relate to one another and that it provides them that balance in communicating with each other. Judy also discussed some of the dynamics between her withdrawing parents and how she has made sense of it. She noted in her discussion that:

> "My parents showed me that that's not the best way to deal with things...Yeah you might stay married, but it doesn't mean that you're emotionally invested in each other. And that's very important to me."

In this passage, Judy seems to make sense of her parent's interaction by viewing it, as something that may keep them together, but still is not as healthy as she believes it could be. As a result, she has taken this information and incorporated it into her value system and allows it to drive her sense of appropriate couple interaction.

Role-Playing within the Family of Origin. The final theme that emerged within this area addressed the role that the participants held within their family of

origin. This theme did not arise from every participant's discourse, but was significant enough of a theme that it needed to be addressed. Regarding the issue of the influence that the family of origin had on therapist's reactions, it appeared that the participants held unique roles within their family of origin. As a result of these positions, they approached couples interaction in a unique manner. Mary discussed her role as:

> "I was always the quiet and passive—tuck in my room and lost it—I mean lost it one evening and I have never been so afraid of my own actions and had such guilt afterwards---and I saw a therapist."

In this passage, Mary addresses the role that she held as being the good kid. Although Mary openly offered this information, she did not elaborate as to how her role specifically affects how she reacts to couples presenting with partner abuse. However, this dynamic will be further addressed in Chapter 5. Amy also described a great deal of role-playing in her family of origin. She focused much attention on her father's alcoholism and how her mother and the rest of the family dealt with this issue as well as the role that she held in establishing a spiritual base within the family:

> "I think that my family is really rich in strengths, but there have also been challenges too. My dad had a drinking problem when I was growing up, but was never like he spent the money or anything it was just a bad way of coping. And so he quit drinking and we actually worked through a lot of that as a family. So my family is in a pretty good place right now. But I did a lot of taking care of my siblings when I was younger.... I was in a real responsible role pretty early. The story is that when I was little when I was about three, I started asking if we could go to church, and my parents were questioning where she got this from. And so we started going to a lot of different churches, and I kept saying not this church not this church."

Amy's reported role within the family seemed to be as a parentified child in that she was taking on some of the parenting responsibilities due to the established

family dynamics. While in this role, Amy reports having a great deal of influence on the family and the decisions to attend various churches. Similarly to Mary's accounts, Amy openly offers this information; as she understands the link between her own personality and how she fits within her family of origin. Finally, Dora discussed her family of origin experiences and how she served a specific role, which also played a part in the conflict that existed within the family:

> "Now that I'm a therapist I realize that I was always the peacemaker. I was always trying to make them happy, and I would always take focus away from the conflict--let's go play ball, let's go play in the swing set. I was always really close to my mom-- and I moved away from my dad in the fifth grade, and then I became close to him. My stepmother wasn't always there, they were married for the majority of my young life, but they were also separated and getting back together and back-and-forth. And so the time that I moved back in with my dad around the sixth grade, she wasn't there, and so I took over a lot of the household responsibilities as far as cooking dinner, doing chores, going shopping... and when she came back there is a lot of conflict between her and I. Because I took over some of those responsibilities, kind of the parental responsibilities...when she stepped back in, there was a lot of conflict there."

In this passage, Dora discusses the role that she took on in the absence of her stepmother and the conflict that ensued when her stepmother was present again in the family. As a result, not only was there conflict that existed between her father and stepmother, but between Dora and her stepmother due to the role that she had been fulfilling within the family. As expected, Dora did not elaborate on the specifics as to how her role then affected her reactions to partner abuse in her therapeutic realm.

In answering Research Question 1, "How do interactions with various ecological systems from therapist's family of origin influence responses to partner abuse cases" it seems clear that all participants felt that their reactions to partner

abuse cases were affected by the experiences, events, and interactions related to their family of origin. However, given the wide range of experiences, it was less clear that their family of origin had an actual direct influence on how the participants reacted. Thus, the themes that arose focused more on the specific incidences that sparked a response or how the family of origin influenced emotional reactions indirectly. This may have been due to the lack of experience with partner abuse, which still led to reactions related to a degree of "newness" of experiencing partner abuse.

Research Question 2: How do interactions with various ecological systems from therapist's clinical background influence responses to partner abuse cases?

Thematic Content: Clinical activity with partner abuse cases, Clinical case factors, Supervision experiences, and Educational factors

The second research question focused primarily on the influence of the participant's clinical experiences on their responses to dealing with partner abuse. It was assumed that beliefs and values acquired through experiences from working as therapists and therapy trainees would influence how therapists view couple dynamics involving partner abuse. Therefore, responses are categorized according to the relationship between the participant's various clinical experiences and the influence that they believe it has on how they respond to abusive couple clients.

Among the respondents, all of them believed that their experiences while training to become a therapist as well as being clinically active played a

significant role in how they viewed partner abuse. This was evident in their responses to interview questions. Some of these questions were:

> 1) "What things from your clinical experiences may have influenced how you reacted to the clinical case?"
> 2) "How do you think your supervision experiences affected how you reacted?"
> 3) "Tell me about your experience working with partners experiencing conflict. How has that influenced how you react?"
> 4) "In what ways have you been desensitized to traumatic experiences?"
> 5) "How do you view your role as a therapist in intervening with partner conflict?"
> 6) "What things in your education do you believe has either helped or hindered your ability to work with a couple experiencing partner conflict like this?"
> 7) "How do you think certain theoretical approaches would assist you in addressing the couple's issues?"

As a result, the responses from the participants regarding their clinical experience fell into the themes of Clinical activity with partner abuse cases, Supervision experiences, and Educational factors.

Clinical activity with partner abuse cases. The broadest theme dealt with specific clinical experiences with partner abuse cases. The participants reported a variety of clinical experiences with varying reactions to clients. Primarily, the participant felt that being exposed to certain types of client interaction, or a lack thereof, influenced how they viewed or reacted to abusive partners. Furthermore, the concept of knowing what to expect clinically, appeared to have a major influence on how many of the participants would react. One example came from Mary in her statement that:

> "I've had very minimal experience with violence. I've had some parents who are disciplining kids in ways that I would consider violence... I know that on a personal choice, I would never work with strictly domestic violence—any of that. I can't do it. I can't do it as a person, and I don't think I can't do it as a clinician. I think that being desensitized—it sounds

> like it's a negative thing that somehow provides protection for people to get in that mode. And once they get there, they can't be as helpful as they want to be anyway. So they are kind of stuck in a tough spot. I think that does have an influence on my thinking—in that my experience is limited."

Here, Mary discussed her feelings in having a lack of experience and that as a result, she avoids abusive clients as much as possible. She stated that she believes that her strong stance on partner abuse has led to her feeling ineffective in her therapeutic abilities to cope. On the other hand, Sara reported having much more experience working with aggressive, "non-violent" individuals—in that they have not murdered or attempted murder:

> "I work with people who have been to prison, and in that environment, they'll fight fairly openly in front of me about...stupid things... inches away from each other, arms flailing, screaming, swearing, and this is normal. I work with a lot of people who don't know another way to communicate. And to me, I have a much higher tolerance level for overt conflict...because for a while, I let them go---I don't let them get in each other's faces too much, but I let them go because that works for them."

Sara also reported feeling quite comfortable working with couples reporting with partner abuse given her extensive experience in a variety of clinical environments:

> "I have just been exposed to that type of clientele. Having that experience, where there were violent or even volatile couples. I've had a lot of experience is getting people out of immediate crisis situations getting them out a violent relationships in a crisis type of environment."

Sara's two responses seem to indicate her relative comfort in dealing with highly emotionally reactive clients in crisis situations. She stated that it was because of being exposed to these types of cases that has led to her ability to manage her own emotional reactivity while working with them. Somewhat different from

Sara's response, Dora also reports on her experience working with partner abuse and how it affects her reactions:

> "I wouldn't say (my experience working with partner abuse) is extensive by any means... I would definitely say I'm not desensitized and that may be because I'm still pretty new to the field--that of only been practicing for a few years. Definitely once I get more experience, there may be a time that I let it go a little bit further in session, because I know what will happen, and all have more experience with it."

In this passage, Dora really addressed her lack of experience working with partner abuse and discomfort in allowing the clients to present an emotionally intense enactment in session. She speculated that she did not feel comfortable with not knowing what might happen in the session and that with more experience, she would react differently.

Judy also really seemed to capture the essence of not knowing what to expect with abusive couple clients and how it affects how she deals with clientele and her coping, despite having seen many clients who reminded her of the couple in the video vignette:

> "I think the scary thing is the unpredictability of people and when they get angry and what can happen from that. I think over time if I had more experience, I think I feel more comfortable in how I work with the clients, but I still think there's that unpredictability that you can't control. I think what might change is my ability to be comfortable with that. Having the experience to know that nothing is going to happen in the right now, and they probably won't start wailing on each other right there... and experience too, kind of helps..."

Judy also expanded on her feelings of comfort in dealing with partner abuse in response to a hypothetical situation in which a woman was abusing her male partner: "I think you just don't have as much experience with that kind of couple (a man being abused by a woman). And that's something, I don't know if you get

very often. Even though it's out there..." In a very similar account to Judy's first passage, Kim also discussed that even though she works with domestically abused women in very intense situations:

> "I know that there is still the feeling that they are going to throw something at you that you can't handle or that you haven't seen yet and that is just one of my fears...I think that with the very first case I had, my anxiety was straight through the roof. I think that I definitely...wasn't as effective as I could have been and I was probably more content focused too, because I wanted to know what did he do, when did he do it, how many times did it happen, and I'm not quite sure that hearing the stories in the first place took me to another anxiety level anyway—but I'm not sure all of that is necessary to be helpful. I was definitely very anxious in the beginning and I think it drove me to focus heavily on content and probably not be as helpful as I needed to be."

In this passage, Kim really talked about her fears of not knowing what to expect and how early on in her clinical experience, it drove her to react differently than it does now. Similar to the rest of the participants, Karen reports that her experience working with partner abuse has affected how she reacts. However, she discussed how her experience has led her to know what to do more effectively than it once had earlier in her therapeutic practice:

> "I've had a handful of cases probably. I had one case that I lost, where I only had two or three sessions, because it overwhelmed me at first. I didn't know what to do. It was like triage. It was more heated than this video, and I was just starting as a therapist, and I was like oh my gosh, I don't know what to do! I lost them because I didn't act on it. And now, the ones that I have kept, I work with them on where there at, and try to move them through their goals---and that's a big part of it. I guess I'm at that middle point with domestic violence clients where I have learned how to manage my personal issues..."

In another passage, Karen expanded a great deal on her statement above and discussed how she would specifically address the abuse within one of her couple client's relationships. In that passage, she showed her strong clinical skills and

expertise, as well as her maturity in not only knowing what to do, but also in knowing herself.

Clinical Case Factors. Another major theme that very understandably emerged as having an influence on how the participant reacts to partner abuse was the nature of the case itself. The factors involved surrounded many of the demographics of the clients (i.e., sex of the couple, marital status, ethnicity, etc.), the attitudes they portrayed, and the details they reported. The responses provided by the participants generally focused on their reactions to the clinical vignette. On occasion, the participant would reflect on the details of other cases that they have seen in the past. However, the passages presented below are all reflections from the vignette. The predominant clinical case factor reported by most of the participants (Sara, Amy, Dora, Karen, Judy, and Kim) as being influential to how they react involved the presence of children within the family reporting the partner abuse. Furthermore, both Dora and Karen reported that the inclusion of children in the vignette stirred up reactions related to their own family of origin issues and what they had sustained as children. At the same time, many shared other factors that they felt influenced how they reacted. For example, Mary stated:

> "It definitely brought me into the kitchen with them. The details of the situation certainly brought me into the moment so I could understand a little bit more about kind of their affects that they were showing---she showed a little bit of fear, he showed a little bit of uncertainty which was due to insecurity---so the details kind of brought me into the moment. And I think it helped to reiterate their level of concern for the little details..."

Sara reported that the age of the clients, the potential history or pattern of violence, and the lack of resources in the home seriously affected her level of

concern. Amy reported that even the manner in which the couple reported the abuse was a red flag for her in her statement:

> "That's why I'm afraid for her, because they're talking about it so commonly, and this is the milder version, and then I am a little more afraid, because this could be a more serious situation and I'm not sure either way yet." In addition, Amy stated: "the substance use is huge. I worked in a substance abuse facility for a while, and that is huge what comes to domestic violence."

Interestingly, Dora reported that her interests in the details that the couple presented with was quite important in determining how she reacted in her statement, however, it has the ability to sidetrack her clinically:

> "I spent a lot of time trying to get to know them, getting to know what it's all about for them. But that also sucks me in and sometimes I had to be very careful because of the get too involved in the system, I can't be objective."

Judy also provided a unique insight into the connection between the details of the clinical vignette and her reactivity in her statement:

> "I think that I would've had a different perspective of therapy with them if they hadn't mentioned anything about the slapping and that kind of spout and the alcohol use--- this to things were kind of red flags for me. There might be times when they're out of control with each other and that would be worrisome for me, working with clients like that. Just any kind of substance use or violence has always been a real problem for me."

In this passage, Judy acknowledges her concern once the client brought up the alcohol use in that she worries about a person with that type of personality. Specifically, that "...he may be the kind of person who doesn't talk much and withdraws a lot, and when he starts drinking, all the stuff comes out." Finally, Kim expanded a great deal on how a number of the case details affected how she reacted. First, she noted the tone in which the clients discussed their interaction in her statement:

> "...given the way they presented it---the emotion behind what they said...really made me react stronger than if it sounded like they had been able to talk about it and they were on equal terms regarding needing help with the situation, which is not where they sounded to be. His reactions frightens me, his no apologies, no....even understand that what he did was wrong."

In addition, Kim pointed out one detail that none of the other participants noticed or addressed—related to the ethnicity of the couple in the video vignette in her statement: "I was jarred by it being an interracial couple with a white male." Kim expressed her great level of concern and heightened sense of reactivity due to the fact that the woman in the vignette was bi-racial (African-American and Caucasian). Due to her feeling an ethnic connection with her clients, Kim (being African American) reported that she was specifically concerned about the potential for covert power issues to exist and that it is something that she would want to spend time addressing.

Supervision Experiences. The interactions with ecological systems related to the therapist trainee's clinical background often took place within a supervisory context. Many of the participants reported that their supervision experiences have affected how they have been able to deal with the emotional intensity that many of their clients bring to the therapy room. Specifically, characteristics of the supervisor or the nature of the supervision relationship (e.g., between the supervisor and supervisee) were reported as being influential to the reactions they experienced. Factors related to supervision experiences included supervisor availability and approachability, establishment of a safe context or relationship in which the supervisee could discuss limitations, having a

supervisor who shared similar values and beliefs surrounding partner abuse, and the supervisor's level of sensitivity in addressing the supervisee's limitations.

Mary described her experiences working with a feminist supervisor who provided a foundation for her own belief systems surrounding abuse. She described a case in which she was addressing abuse within the family in her statement:

> "I know from my own thing, that I wouldn't have tolerated it. To me that was valuable that I had a supervisor that shared similar beliefs in that. I think I just really respect a lot of my supervisors...rarely do I feel that they kind of look at things with this kind of blinders thing, and I really appreciate that a lot, because I think that when violence comes up, that it's really hard to do that—to not narrow in on that. And I think I've had very good supervision experience with people that are able to take that off."

Mary also described one of her supervisors as being very attuned to family of origin issues—things that she highly valued and appreciated addressing as it related to her clinical cases. Her supervisor would spend time with her asking questions about what other times she has felt herself react certain ways, etc. On the other hand, Sara reported that she did not feel like she had a similar experience with her supervisors in dealing with partner abuse. She stated:

> "I don't have any real big feminists or people who have had a lot of experience working with violence, so I feel like I just trudge a long and try to figure it out for all of us. We have just gone over no violence contracts and things like that."

In Sara's response, she seems to indicate that she is really needing additional support or experience in dealing with partner abuse and violence, but is not receiving it from her supervisors. Amy reported similar feelings, but expanded a little more by addressing her ability to approach her supervisors regarding a reaction she had to a client in her passage:

> "I'm just starting to talk to supervisors about that. I've never talk to them before. (Regarding safety) it depends on the supervisor. I'm very judicious in who I talk with about that. They would have to have a feminist understanding first of all. They would also have to be someone that I knew quite well to understand my context a little bit. And so I would have to have a sense of safety both with him and other faculty."

Amy focused a great deal of attention in her interview on the establishment of safety with her supervisors in order for her to address her therapeutic concerns. She also discussed her own spirituality and how she had only recently discussed her strong beliefs with a supervisor and the demand she has for respect for her beliefs. Karen also discussed how she was able to establish a safety with her supervisors as well as the process she has taken in addressing her self-work surrounding her personal experiences with abuse. She talked about how her ability to work through her personal issues has affected how she now reacts differently to abusive situations by her statement:

> "I've have had some really great professors that have challenged me, and that I feel comfortable with. Like I really really, I have allowed them to...I trust them to take me to those hard places. Because I don't think I would trust just anybody." She also stated: "I've gone through extensive supervision, all of those like, self of the therapist issues, and my background, and like that's left in imprint in me...so I can detect things pretty quickly."

Judy also reflected on the process of establishing safety with her supervisor in order to work through her own personal limitations. She expanded on her feelings of comfort as well as trust with her supervisor and the supervision context—who specifically is in the room (i.e., individual versus group supervision). She believed that her supervisor "knows how to balance kind of prying at some of those issues with providing a supportive environment to get them out." Kim also noted a difference between in her comfort in dealing with her

personal reactions to abusive clients—depending on the context she was in. She described one supervisor from the agency in which she worked with abused women in her statement:

> "The supervisor there has helped me to the fact of calming that superwoman craze that comes out of me, and just really trying to slow me down to let me know what is my role in terms of how to be helpful."

Kim went on to suggest that she felt as though her supervisor at that facility focused more on "rescuing" and "survival", whereas her MFT supervisor focused more on thinking about family systems and to "see beyond the individual in front of me." At the same time, Kim reported feeling a different degree of comfort in working with her two supervisors in her statement:

> "...maybe it's the credentials of the people I work with here, that I feel more intimidated by, like I feel like I have to be on my toes...there it is so much more comfortable that I can say, I really don't know, can you help me? I wouldn't say that here."

In this passage, Kim was really expressing her level of safety in addressing some of her concerns with her clients or regarding her own personal reactions.

Educational Factors. A number of factors related to the participants clinical background emerged thematically—within the realm of their educational environment, as having an influence on how they reacted to partner abuse. Most of the participants reported having spent a great deal of time during their educational training going over the process of establishing client safety, filling out no-violence contracts, etc. They reported that this helped them when it came to knowing what to do regarding the reactions they were having to the abusive clinical situation. Another aspect related to educational factors involved having an exposure to systems thinking or training. This became evident as the

participants talked in length about the key events in their educational history that helped them to define or take a position regarding partner abuse or violence in general.

In her response to what educational factors have influenced her reactions to partner abuse, Mary described having a "monumental moment" in which her education had shaped her understanding about what constituted violence. She also pondered on the question by stating:

> "I had some strong mentors that are very very strong feminists, and very vocal about equity and those kind of things. And just kind of hearing that language a lot and paying attention to that. And then also just my systems training. I mean this idea that everything is interconnected and balance and change and shifting and I don't think you can look at power and imbalance without looking at this too."

Amy also noted how she has always had an instinct for understanding family dynamics a certain way, but never really had the opportunity to process it. She described her educational background as influencing how she now reacts by stating:

> "I think that going to school has helped me find words for it and understand what it's tied to like systemic processes and understanding from a therapeutic lens has been really helpful to me... I would always pick up on stuff and so now sometimes I can just make sense of it or know not to pay attention to it where before I would question how to make sense of it."

Both Dora and Judy also state that their educational background has provided them with a great deal of education surrounding the drives behind battering and why the relationship is in such a negative cycle. They credit much of what they have learned about this topic towards their feminist professors. Many of the other participants also reported that their systemic training has helped them

understand the nature of the relationship as well as understanding the process of arousal and anger within individuals.

In answering Research Question 2, "How do interactions with various ecological systems from therapist's clinical background influence responses to partner abuse cases" it is clear that all participants felt that their reactions to partner abuse were affected by the experiences, events, and interactions related to what they had learned within their clinical background. Based on the participant's responses, it is evident that the degrees of exposure to domestic violence, the amount of practice working with this issue, and proper processing of the intense nature of these cases all have powerful influences on how therapists respond. However, given the range of experiences, it was less clear which specific clinical experiences had a direct influence on how the participants reacted. Thus, the themes that arose focused more on the experiential nature of the clinical experience and the meaning-making process that the participant has taken from their experiences.

Research Question 3: How do interactions with various ecological systems within therapist's personal/individual background influence responses to partner abuse cases?

Thematic Content: Key events, Family of Procreation and Marital Status, and Personal and key demographic characteristics

The third research question focused primarily on the influence of the factors within the participant's personal or individual background on their responses to dealing with partner abuse. These factors might include constructs

that exist outside of their clinical experience or their family of origin experiences. It was assumed that beliefs and values acquired through experiences from these other key constructs in the participant's lives would influence how therapists view couple dynamics involving partner abuse. Therefore, responses are categorized according to the relationship between the participant's various personal or individual experiences and the influence that they believe it has on how they respond to abusive couple clients.

Among the respondents, all of them reported that they had various key events or relationships with others that played a significant role in how they viewed partner abuse. Several questions were asked of the participants to ascertain what stood out for them as influential in shaping attitudes and clinical reactions. This was evident in their responses to questions including: "What things from your unique personal life experiences may have played a part in your reactions?" and "How does your own marital status affect how you react to partner conflict?" As a result, the responses from the participants surrounding their personal and individual backgrounds fell into the themes of Key events, Family of Procreation and Marital Status, and Personal and key demographic characteristics.

Key Events. Many of the participants described some sort of major event in their experiences that helped to shape their belief systems and how they then react to abusive clients. These events encompassed a number of factors including major family of origin events, key clinical experiences, etc. Although some of these responses begin to overlap with themes identified within the

previous research questions, they appeared to hold major significance for the participants in how they storied their lives. Mary described her experience slapping the phone from her sister's hand as being very important:

> "I was old enough to really hurt somebody and so it was one of those moments where I first realized the awesomeness of really getting underneath about what's bothering me. It was like that was THE catalyst of a lot of things."

In this passage, Mary reflected on this situation as being a major milestone in changing her own attitudes and beliefs about violence in her family. She also discussed how it was at this point in her life that she began addressing her own responsibility within relationships, which then affected how she viewed couples. Dora described a key event within her clinical experience as shaping how she has worked with every other client since then. She recalled a specific clinical case in which the couple quickly escalated emotionally and physically in the therapy room. She talked about how she dealt with the immediate situation in her statement:

> "And at the end, they were still very explosive, and took a lot to keep them under control to keep things balanced, to keep them from attacking one another. And so for me that always comes up, like wait a minute, let's make sure that things are under control here, let's make sure that things aren't getting too far out of hand, and no one getting upset, and no one is feeling accused. And because of that couple, I'm always more cautious. I don't let it get too far because I know how hard it is to bring it back."

Karen also described how influential one of her cases was in helping her address some of her more personal experiences as she grew up in an abusive family environment. This key event for her surrounded one particular case in which family abuse was present:

> "The one session...and this is the session that I didn't know that I got that upset about... it taught me a lesson...it taught me so much about me. And so right away, I wanted to protect this kid. But more than just a therapist relationship type of thing. I just freaked out wanting to protect this kid. we realized that part of the reason why I responded that way was because of my---because I had held on, and I didn't realize I'd held onto this guilt that I didn't protect my brothers in the way that I should have....and this kid was the same age that my brothers were, and it all just fit. And so I was like oh my gosh. But everything after that was fine---- it helped me to learn that I'm not responsible for this, but also taught me a good lesson about me, and it was something that I had to let go of and realized that it wasn't my fault. It was almost a blessing in disguise, because I learned that when I feel those things, that I can't ignore them. I have to listen to myself. Not only for my own growth, being ethical in therapy."

In this passage, Karen reflected on her process as a clinician and how this key event helped her process her experiences as a child. It was through this experience that she was able to gain more insight into how she is affected by her clients and how she responds to them as well.

Family of Procreation and Marital Status. Another theme that emerged focused on the significant relationships the participant has outside of their clinical realm and family of origin. Overwhelmingly, each participant discussed how they are influenced by their current marital status or their family of procreation and the affect this relationship or lack thereof, has on how they react to couples presenting with partner abuse. Mary reflected on a significant event during the courtship with her husband in which their interaction was defined and they consciously took a stand against violence in their relationship:

> "...he had moved my hand off of there and I just remember my heart just hitting the floor in that this beautiful man just moved my hand like that? And we made it very clear about four years ago that any type of intent to hurt anybody was unacceptable. And we have just held that to a tee in our house and I truly value that. So we made it a very clear statement and I think that it influences me that, yeah, I've been really hurt in my

> marriage... To exert power in that way is unacceptable and I think one thing that we know is that we trust the other person won't go there. And that there will be an insane amount of guilt if you do. If I buck the system or if I break the contract, I'm sure I will feel like I did when I was 13."

In this passage, Mary was able to acknowledge the influence that her relationship has—not only on how she deals with violence, but also the effect that it might have if she is the one who loses control (e.g., feeling the same way that she did when she was 13 years old regarding the phone incident). Mary, very similarly to Karen and Amy, also reflected on the level of insight that her current relationship has on her ability to understand what couples bring to their relationships—a certain degree of insight. However, Judy seemed to capture the essence of how her relationship has affected how she views abusive couples in her reflection of a personal situation with her husband in her statement:

> "(It) doesn't surprise me that other people can take it one step further. What I'm saying is that sure I've been in a really awful argument with my husband where I thought, man I just want to throw something at him. I think that has changed my perception of how couples can kind of work. It kind of changes how you feel about what's going on, and how you view other people. I don't think that you have to experience violence to understand where couples are coming from. But I think that you need to take a step back and understand that things aren't really that different with your spouse, and you could go to places that you don't think you would ever go. So I think that you had to understand that abuser and victim is not far off from what is to be just a normal person."

In this passage, it seems as though Judy has been able to understand her couple clients and contextualize their experience—almost to the degree of normalizing what they are going through. Finally, Kim gave an example of how her relationship with her husband influences the work she does with abused women in her passage:

> "it does help me to dispute the idea that all men are dogs thing that a lot of women are telling me. I'm like, they're not! I'm married to a good one! I think that it helps keep me sane, that there is really hope. (That the abuse they have encountered is) not the norm, it's not acceptable, it doesn't have to be that way..."

In her statement, Kim believed that her relationship with her husband has helped to contradict the messages that she receives from the abused women she works with in the shelter. Not only does it help her to contextualize their experiences, but it seems to give her a rational frame of reference from which she can understand the possible relationships that her clients can have.

Personal and key demographic characteristics. The final theme that emerged from the participant's personal and individual background involved various components of what they felt was important in their lives. These factors often times included the emotional connections that they felt with their clients, unique personal life experiences, or key demographic characteristics of their own or that they reported about their family. Many of their responses from the demographic profile included what they deemed to be important information related to the fact that their parents were still married or what kind of context they grew up in (e.g., Mary from an urban area, Karen from a farming community, etc.).

Other responses surrounded what they personally bring to the work they do clinically. For example, Mary reports having an intense "fear of violence" and that her anxiety goes up when she "hears the word violence." For her, this would definitely bring into account her individual reactions to partner abuse, but could definitely be connected to her unique life experiences. At the same time, Sara

believes that she was "born with that kind of personality" in which she can deal with intense emotional reactivity quite well. Furthermore, Sara believes that she is different in her final statement during the interview that:

> "I come from an odd family, I guess. Because I don't really...I find it odd that I don't really have a lot of personal reactions. I have little personal reactions, but not big ones that I think really matter..."

In this passage, it seemed as though Sara was connecting much of what was being discussed regarding how she reacted to partner abuse with the influences of many of the other constructs in her life. Amy provided a similar response, however, being quite covert. She reported that the details of the clinical vignette alarmed her—specifically "the substance use (by the male in the vignette) is huge." Amy also reported during the interview that her father was an alcoholic and that through trial and tribulation, her family addressed it, at which point he became sober. She also reported that she came from a Mormon background and that a major illness which almost took her own life had played a major role in the establishment of her belief systems.

Most of the participants also reported that having reflected on their family abuse or their own experience with abuse has helped them to connect with their clients reporting violence within their relationship. Both Mary and Karen discussed in detail how their going through an abusive situation has helped them to understand what their clients experience a little more, relate to them better, and feel more empathy towards them. At the same time, they both reflected on how their personal experiences also influences what they find extremely valuable—being the establishment of safety within the relationship.

Finally, Kim addressed a very specific demographic characteristic that she believed had a direct influence on how she reacted. During the completion of her ecomap in which she identified those factors which she believes influences how she reacts to partner abuse, she stated: "What about the fact that I am an African American therapist and having some sort of more empathy towards her because of that?" Kim also went on to explain that she believes that her own ethnicity is a contributing factor in her statement:

> "There is definitely more transference that I always have to be aware of especially with a lot of the domestic violence clients that I do work with that are black women. It is something that I'm always very aware of..."

In this passage, Kim expresses that she has a heavy degree of identification with the abused women she works with—solely based on sharing a similar ethnic race. As a result, she reports that it raises her awareness of what she is bringing to the therapeutic context and that she monitors her own reactions more consciously.

In answering Research Question 3, "How do interactions with various ecological systems from therapist's personal/individual background influence responses to partner abuse cases" it is clear that all participants felt that their reactions to partner abuse were affected by the unique experiences, events, and interactions within their personal background. However, it was more challenging to directly answer this research question given the participant's responses and often times, the lack of connection made between their individual background and reaction. On the other hand, what was evident is that these key events from their personal and individual backgrounds do play a major part in how the

participant's make sense of partner abuse in general and how their value and belief systems are shaped. This dynamic surrounding the interplay between the participant's attitudes and beliefs and how they react will be further discussed in research question seven as well as Chapter 5.

Research Question 4: In what way do therapist's developmental processes influence therapist responses to partner abuse cases?

Thematic Content: Therapeutic responses, Thinking vs. Feeling, Insecurity and Incompetence, Self-Awareness, The validation of themes (utilization of the Differentiation of Self-Inventory)

The fourth research question focused primarily on the influence of the participant's developmental processes on their responses to dealing with partner abuse. These factors might include constructs related to both interpersonal and intrapersonal dynamics surrounding the individual such as maturity level, confidence level, anxiety tolerance, etc. It was assumed that the varying developmental processes would influence how therapists view couple dynamics involving partner abuse. Therefore, responses are categorized according to the relationship between the participants' reports of their beliefs surrounding their comfort, anxiety, thought processes, and differentiation level and the influence that they believe it has on how they respond to abusive couple clients.

Due to the increased sensitivity of these topics, it was important to maintain an open framework from which this research question would be answered. Thus, several questions were asked of the participants to ascertain what components primarily stood out for them as being influential in shaping their

attitudes and clinical reactions. This became evident in their responses to questions including:

> 1) "In what way do you think your developmental level as a clinician might affect your reactions to cases with conflictual couples?
> 2) "How do you feel that your own anxiety level contributes to your reactions or ability to interact with clients experiencing partner conflict?"
> 3) "How have your attitudes about individuals experiencing partner conflict changed over time?

As a result, the responses from the participants regarding their developmental processes broke down into the themes of Therapeutic responses, Thinking vs. feeling, Insecurity and Incompetence, and Self-awareness. Additional sources of responses validating the influence of the participant's developmental processes came from the participants completed Differentiation of Self-Inventory.

Therapeutic responses. One of the most predominant themes that emerged from the participant's initial reactions following the viewing of the clinical vignette focused on the therapeutic interventions they would employ. The most common response was a desire to slow the therapeutic process down with the clinical couple in the vignette such that they most likely would not have let the clients go on for the entire two minutes (e.g., the length of the video vignette). Mary really seemed to capture this theme in her statement about the reasons she would want to slow the therapeutic process down in her statement:

> "I would have probably slowed them down. Maybe that's my tactic in avoiding that conversation for a little bit. Probably two motives to that—one, that I don't want to go there yet because it's a topic that's hard...hard on me, it's hard for them. And two, to see if there is something else there. I think that affects me---I slow them down and I'll interrupt and I will postpone that conversation for a little bit. It would probably be easier because I am anxious about that."

In this passage, Mary provides the link between her desires to interject with the clients in this particular way with her own anxieties surrounding violence. Dora provided a similar reaction in her statement:

> "My gut impression is to interject and slow them down...Just so that they were not going off in a bad direction so one spouse wasn't feeling attacked, where so they don't get to some point that is beyond bringing them back.. Not too much intervention, but just enough to calm them down and put some words in between their words. So they don't have a chance to kind of run with it."

In this passage, Dora explains the reasons why she would want to step in and slow the clients down, but does not elaborate on where that strong desire is coming from. She simply noted that she wanted to maintain a level of control so that the couple doesn't get out of hand. Amy also gave a similar response, and also frames her response in a way that she really wants to protect the interaction from the intense negativity in the statement:

> "I think I would've interrupted them a lot earlier than let them go on, just interrupt the negativity and not let it get that intense, let them get that negative in my first session. I would want to know some other information..."

Here, Amy provided a brief explanation of her desire to maintain a calm atmosphere given that it is the first session with the clients. She later went on to elaborate on her desire to "want them to work on mutual goals together" and that they couldn't do that if they were so heated. Sara responded with her initial reactions by stating:

> "I would have stopped them a lot earlier. I wouldn't have let them get to this point in the story this early. I think I would have liked to hear the story, but at the beginning they were like talking about losing the job and things like that. I would want to be a lot more clear about exactly what happened. When did they notice things getting worse first? How many

> kids do they have? How old are the kids? We don't know this. Slow them down and get more of this type of information."

Sara explained that she would be more interested in learning about the details of their situation and that this type of interaction would help her to understand where they are coming from. Judy responded with the same desires to slow the couple down, but provided more detailed reasons for wanting to do so from a systemic perspective in her statement"

> "You have to slow it down a lot because these couples are usually so fast and so good and digging at each other that you really have to be conscious in slowing them down in picking through the meanings behind their comments. And you can do that easier if one person is in the room. We've been trained in our program that the more people that you add to the room the more conscious enough to be about the speed of interactions and some of the little things that you might let go and not be able to look at."

Judy notes that it would be prudent to slow the couple down simply for the sake of maintaining a sense of knowing what to address versus what to let go. In essence, Judy's anxiety goes up when the interaction goes too fast during the session. As a result, when the couple becomes emotionally reactive, it leads to her reacting in a certain manner.

Thinking vs. Feeling. Another major theme that emerged from exploring the participant's statements involved the process in which they would have addressed the couple in the vignette—or a clinical couple presenting with partner abuse. In this manner, the participant's reported that, in response to their intervening with the couple in the vignette, that they often times found themselves turning their emotional side off and staying in the thinking realm.

This dynamic was quite evident in Dora's statement that she believes it is necessary in order to be effective as a therapist. She stated:

> "...it's a good skill to have sometimes—to be able to put what I think, what I'm feeling about it out of it as much as possible. Just being present with them and being really into what's going on for them, and not thinking, oh, that lazy bastard! He better get up and get himself a job! You have to be able to turn off that emotional side. You have to be able to otherwise, you're never going to be able to do it. Because that's terrible. It's a terrible situation...you have to be able to separate you from that. You have to be able to shut that off. Otherwise you are going to burnout and a second. Otherwise, you're going to be too emotionally involved. And it's going to be hard."

In this passage, Dora makes it evident that for her, it serves as a protection from caring too much to the degree of burning out as a therapist. In addition, she noted that it also keeps her attuned to not becoming too emotionally involved—potentially keeping her thinking clearly and professionally. Dora points out in her response to whether she felt any emotional reactions—that by her maintaining her thinking side, she is able to ward off her emotional reactions in her statement:

> "Not on a personal level-- I'm thinking purely clinical--- What can I say to them? What can we do next? How can we get through this? How can we pull this out? Make something of the session."

Upon initially viewing the vignette, Sara also provided a glimpse of the process by which she shuts off her emotions and stays in the thinking realm in her statement that:

> "But I definitely think it could get serious. I think it's real close to getting serious. But if you were to grab her wrist and throw her to the ground or throw her up against the wall than that would be serious. But like I said I wasn't paying that much attention to the conflict."

Also in this same passage, Sara acknowledges that she is paying a great deal of attention to the non-verbal communication, and not a lot of attention to what the

couple is saying—specifically, the abuse. In a very similar manner to Sara, Karen responded by immediately questioning her role with the clients and what she needed to do in terms of appropriate intervention. She stated that:

> "I think right away I went into therapist mode, and thinking—what do I need to do, how do I keep them safe, how I help them reach their goals? If I would have had a self of the therapist issue pop up, I would have felt anxious I think. And I would have felt uncomfortable, or maybe try to intervene, or maybe take a side. But I didn't feel that. I felt more of an urgency, and that comes from my background, to put in a safety plan and make sure that we are working towards what needs to be worked on."

In this passage, Karen addressed the number of things that she wanted to accomplish, given the sense of urgency that she felt to intervene. Furthermore, she addressed how she did not feel any particular anxiety-driven factor arise for her, but more of a strong desire to make sure that safety for the clients was achieved and the interaction is under control. Kim also presented a thorough explanation regarding some of the dynamics surrounding her need to shut her feelings off and maintain her thinking realm in her statement:

> "...you shut yourself off so that you don't feel as much anymore. But when my first case like that, I was like struggling to sleep or just know how I can be helpful...you know, this person is going through like something I can't even imagine..."

Kim was reflecting on her extended experience working with abused women and how she has managed to maintain her professionalism despite the strong feelings she has had. Judy seemed to capture the essence of this emergent theme, focusing not so much on the need to maintain her thinking side, but more so, the necessity of doing so for other reasons. Judy stated that:

> "I think that's something important for a therapist to have is that ability to establish boundaries within yourself. That idea of how do I be emotional and present, but not emotionally involved? How can I connect with these

> people, but not be in their world? You just need to find that balance where you can be connected, but not be in it."

Here, Judy notes the need for her to work on her boundaries, not only for the benefit of her clients and establishing a connection with them without being inducted into their emotional system, but also for herself and her own protection.

With this emerging theme, unique characteristics were present throughout each of the participant's individual interviews. The participants openly addressed their tendency to maintain their thinking side while intervening with clients. What was interesting is that this discussion occurred on an overt level in which the participant was able to reflect upon, but also in covert ways in that they did not address openly. These situations involved many of the participants responding to several of the "how did you feel about..." questions in purely thinking terms. Instead of replying that they felt something, they would revert back to statements such as: "I think that they are really frustrated" or "I think I would have asked more questions." This was an indication that the participant was still in the thinking mode or was more focused on the details surrounding their intervention than they were about how they felt.

Insecurity and Incompetence. Several of the participants reported having feelings related to insecurities surrounding their ability to work with partner abuse. They reported confidence issues as therapists, feelings of not knowing what to do or expect in clinical situations, etc. Interestingly, most of the participants reported sharing similar feelings, but two in particular reported quite intense feelings of incompetence. Dora, in particular addressed her beliefs that

she didn't know anything as a beginning therapist as she was working with an abusive couple in her statement:

> "I'm just a one-month therapist thinking what's going on! Because when I was first sitting there... you know how you think that you don't know anything... you just filling at your forms asking general questions, saying um hum. I would say that I'm still more cautious than my supervisors. Because I think that they have more training and I'm not to that point yet-- I don't want things to get too far out of control but I can get control back"

In this passage, Dora is simply noting that even though she has a wealth of knowledge and skills—simply as another person, she doesn't believe that she has anything to offer the couple she is working with. Dora also goes on to report that she doesn't feel as though she could let a couple work through an enactment in session because she feels that: "I don't think I'm to that point yet, where I'm an expert, where I can just let it go. And I think that my being too cocky will get me into trouble." Like Dora's statement, several of the other participants reported similar feelings of not being sure of themselves when it comes to working with partner abuse cases.

Two participants in particular addressed in detail much of their feelings of insecurity in dealing with tough clinical situations. Mary discussed her deep feelings of being incompetent and how it is something that she personally battles. She reported that this dynamic in herself creates quite a bind in her ability to address it with her supervisor—in addition to working through the issues with her clients and focusing on the intellectual side of accomplishing therapeutic goals. She stated that:

> "I have anxiety personally about feeling incompetent. The idea of not being successful makes me extremely anxious. Its not being able to do my job the best I can makes me very anxious. Which is why I think that it

> is very important for me to continue to get the supervision especially when it comes to the pragmatics of the intellectual side of doing those kind of things. Because I haven't done it in a while. And it would be important for me to check that because sometimes I think that oh, I know what to do, I don't need to ask anybody, I'll figure it out. And that's certainly my own anxiety in there of not being good enough, and that comes up for me a lot. I am pretty aware of that, that no, Mary, it's ok if you don't know the answer to that. If you don't know how to help this couple, go ask somebody. And that's really hard for me to do sometimes."

In this passage, Mary really addressed the core of her feeling insecure with herself and her abilities and how these feelings of being incompetent can influence her own judgment. In her interview, Mary went on to describe how it then affected her during a clinical case that she had with one couple, where the abusive man stood over her and challenged her authority:

> "It was just, oh my gosh. I just wanted to cry! Because I mean, somebody was questioning me about whether or not I was competent—it is one of my anxiety things—somebody was exerting power over me in a verbal way, physical way by standing over me. I'm trying to protect the wife who is over here, who has been a victim of him before."

In this passage, she addressed the role that she was attempting to serve as a therapist and how she felt about being in a bind of trying to protect the abused female client, while being verbally attacked by her husband. She brought up several other factors related to power and gender and how they also contribute towards her ability to deal effectively with her clients. At the same time, Kim also reported feeling incompetent in her clinical experience working with abused women, but expanded more upon the developmental process of how her feelings have changed over time. Kim stated:

> "I'm like a novice therapist, it's my internship, I'm just trying to be helpful...and I felt so incompetent honestly, because she's been living with this for 8 years. What am I supposed to do?"

Kim also discussed at length, her feelings of incompetence while working with her two supervisors—one being non-Marriage and Family Therapist at the abuse shelter and the other, her on-site Marriage and Family Therpay supervisor. She stated that she felt a clear difference in her ability to address some of her concerns in her statement:

> "...maybe it's the credentials of the people I work with here, that I feel more intimidated by, like I feel like I have to be on my toes...there it is so much more comfortable that I can say, I really don't know, can you help me? I wouldn't say that here. It's probably me. I don't think that they are exuding anything. It's probably me just feeling this need to be superwoman...or to prove that I know something, where I don't feel that so much there."

In this passage, Kim really expresses her comfort working with her off-site supervisor versus her on-site supervisor and that she owns much of her feelings or degrees of comfort. She also goes on to discuss other realms of her life where she also feels the same kinds of comfort levels or lack thereof—including certain intimate components of her personal life and her preference to not work with clients on this issue.

Self-Awareness. As expected, a theme emerged involving a developmental process related to the participant's becoming increasingly more aware of themselves and their presence with their clients. This theme seemed to speak to the participant's ability to know how she would react to certain situations and a basic level of maturity in dealing with their anxiety. Several of the participants reported feeling that they have "learned" a great deal about themselves by reflecting on their interactions with their clients. Mary addressed her anxiety and recognized that it may be a limitation for her, but she does not let

it go. Instead, she stated: "I manage my anxiety by acknowledging it and saying that, yup, I've been on the phone before; Yup, I've pulled it out." Here, she is not denying that she struggles with knowing what to do, but instead acknowledges it and shows signs of having a mature appreciation for her own experiences. She also reflected on her continual reflection on her reactions in questioning (as stated before) if she is reacting as "Mary the therapist, or Mary at 13." Sara also stated that she noticed a trend in her awareness surrounding what she is in control of in her personal and clinical life:

> "I think that as you develop as a person too, you get better at determining, what do I have control over and what don't I? I think that as you get older, you realize that 98% of the world is out of your control and there is only this tiny little sphere that you can do anything about."

She went on in her description of her growth process in talking about how she would often question if she could have protected her clients any better than she did and that it took some time before she could feel comfortable believing that she really did all she could do. Dora provided an interesting perspective regarding her need to feel in control and how she is aware of this need of hers in her statement: "...And for me gaining control makes me feel safe. When they are out-of-control and then they feel calm, that's whenever I feel safe." Karen also provided an insightful perspective regarding her ability to know herself and what she needs—especially when working with clients where she experiences heightened anxiety:

> "I've learned in my program that I need to end the session when that happens. And that has happened to me twice in my life so far. The first time I didn't know what it was, and the second time I just learned that I should end the session, an ideal with that because that's the most ethical

> thing for me to do at that point. So that's where I'm at with my personal reactions."

In this passage, Karen displays calmness while talking about her experiences even though she knows that the situation was hard for her. She also expressed how she took the opportunity to reflect on her feelings and how she thought through the ramifications of not acting upon her instincts by ending her session. Judy also displayed a great deal of maturity in her description of her experiences with growth and dealing with her anxiety—specifically while working with abusive clients. She did so in this statement:

> "I think over time you learn how to deal with your own anxiety in therapy. I was very anxious whenever I first started therapy. I was always worried, and always overly paying attention to things, and kind of overly sensitive to everything that was going on in the room, and any kind of emotional yucky feelings in the room-- I was like all my gosh, how ideal at this. I think over time you kind of get conditioned, to be calm when things come up. So I think that experience and how you deal anxiety can be a factor."

Judy also further described her upcoming work with abusive adolescents and seemed to encapsulate the same mentality in her reflection about being useful to her clients—even being the same with the couples she works with:

> "...it's not good to be totally desensitized to it, but the same time you kind of have to let go and question how you're going to help somebody else come down if you can't calm yourself down."

In this passage, Judy notes the need to become more self-aware when working with highly intense clients. She believes this is especially necessary because of the potential to not be of assistance and even to do harm.

The validation of themes (Differentiation of Self Inventory). After completing the interview, the participants answered questions related to their differentiation level utilizing the Differentiation of Self-Inventory (Skowron &

Friedman, 1998). The purpose of this instrument was to validate the emerging themes identified within the participants' developmental processes as they relate to the interview statements provided by each of the participant's. The 43-item instrument primarily addressed how the individual feels about themselves and their relationships with others. It provided an overall differentiation score as well as four subscale scores including: emotional reactivity (11 questions), "I" position (11 questions), emotional cutoff (12 questions), and fusion with others (9 questions). Subscale scores are computed by summing item scores and then dividing by the number of items in the subscale—resulting in a range from 1 to 6, with higher scores reflecting greater differentiation. Previous studies conducted by Skowron and Friedlander (1998) indicate that all subscale scores are normally distributed, with subscale means ranging from 2.07 to 4.34 (M = 3.73, SD = .58).

The outcomes from the participants' completed instruments were important for answering this research question because of the implicit nature of what differentiation is meant to measure (i.e., anxiety tolerance, relational dynamics with others, etc.). However, it should be noted that the scores are not valid by themselves and should only be understood in the context of the descriptions of the stories told by each of the participants. For example, during their interviews, both Mary and Kim reported having very intense emotional reactions with some of their previous clients involving partner abuse as well as a great deal of anxiety in working with them. Each of them, relative to the other participants, also appeared very emotionally engaged in their descriptions of their experiences working with partner abuse clients. At the same time, each of them

had relatively lower scores on the Emotional Reactivity subscale (indicating a higher degree of emotional reactivity) and a lower level of differentiation. At the same time, they both reported directly that they felt incompetent as therapists and struggled with this issue. Their responses were also validated by the I-position subscale indicating that they have a lower degree of confidence in who they are or have a solid sense of self.

Interestingly, the lowest score among the four subscales for all of the participants was their fusion with others (FO) subscale score. The lower scores also indicated lower levels of differentiation. This outcome would generally be expected, as all of the participants were women—as previous research and society would suggest, are predominantly the relational or emotional caretakers within families. Thus, situated then by the DSI scale, as being emotionally fused with others—or maintaining the caretaker role. Another example of how the DSI validated some of the participants' responses involved Amy's expression of being very close to her clients and her specific fusion with others (FO) subscale score. Her lower FO subscale score validates her statements regarding her intense caring for her clients:

> "...Sometimes it makes me really tired. Sometimes I get tired when I work with clients, because I feel things more physically and so it makes me tired. I can take on a whole huge caseload of intense cases. I love my clients. I don't think it's the only thing that that is, but I do love my clients, and if I can't love them I can work with them. I mean there hasn't been client that I haven't a little love yet except for one. It's just that I love my clients."

Karen's interview process was also validated by her individual I-position subscale score. Karen was one of the most insightful and mature of the participants

involved with the study and it was evident that she had actually addressed and worked through much of her abusive history. Interestingly, Karen also had the highest "I"-position subscale score of all the participants.

In answering Research Question 4, "In what way do therapist's developmental processes influence therapist responses to partner abuse cases?" it is evident that the actual process is not as clearly identified as originally believed. Instead, a wide range of factors are related to the specific processes, which in turn drive how the therapist then reacts to partner abuse cases. However, the themes that arose provide a great deal of insight into some of the experiences that the therapist might encounter during their developmental process as well as those factors that may need to be addressed as a developing individual and clinician along the way.

Research Question 5: How does the meaning-making process (regarding partner abuse) influence therapist reactions to partner abuse cases?

Thematic Content: Differentiation between physical violence and power/control, Minimization vs. Authentication of the abuse, Interpretation of couple interaction

The fifth research question focused on the meaning-making process and the influence it has on the participant's responses to dealing with partner abuse. It was assumed that beliefs and values acquired through the participant's experiences would color the process in which they understood partner abuse, which would then influence how they react. Therefore, responses are categorized according to the relationship between the participant's definitions,

understanding of abuse, and how they make sense of it, and the influence that they believe it has on how they respond to abusive couple clients.

All of the respondents provided descriptions of how they viewed the couple in the video vignette. This was evident in their responses to specific questions including, "How serious do you think the scenario is and why?" and "How do you define partner abuse?" In addition, the process in which the participant's made sense of their experiences with partner abuse was wrapped within a number of the other interview questions focusing on the participants various ecosystemic constructs as well as their value and belief systems. As a result, the responses from the participants surrounding their meaning-making process led to the themes of Differentiation between physical violence and power/control, Minimization versus maximization of the abuse, and the Interpretation of interaction.

Differentiation between physical violence and power/control. Coding of the transcripts revealed that each of the participants had similar viewpoints as to how they would define partner abuse. They described a range of acts that they would consider violence from throwing dishes or flicking someone to hitting, kicking, or pulling hair. At the same time, a theme that emerged universally from the participants descriptions surrounding partner abuse, involved the acknowledgment of a difference between physical abuse and power or controlling mechanisms. As a result, the participants reported that how they viewed this difference then affected how they categorized or interpreted the

vignette couple's interaction. Sara specifically addressed this dynamic in her statement:

> "I think that what I believe about violence is going to impact how I see them. Pushing, shutting, hitting, any physical contact of a violent nature. I keep that separate from patterns of control—that emotional violence, where there's a pattern of control. And I think in that couple, you don't see a lot of that. You see her being able to hold her own with him. Well, you should have gotten the job. You can get off your lazy bum. I'm the only one who does anything. It's different from a woman, who is in a pattern of control. Who's going to defer to him more? There's a difference between violent acts and a pattern of control and power—that is relationship violence."

In this passage, Sara makes a clear distinction between her feelings of what constitutes physical violence and emotional violence. She takes this one step further and notes that the emotional violence includes acts of manipulation of power and control—which she deems as relationship violence. Karen provided a very similar account of the differentiation of violence and the use of power. She described her beliefs regarding couples' interactions and how power and physical abuse is intertwined in her statement:

> "Well, domestic violence involves a power differential first of all. Whereas physical abuse is a way of gaining power. And so abuse has a lot to do with power. Taking power and displacing power and so forth. Things where you take away power---and the intimidation of the other person... so it's not always that physical abuse, but the emotional abuse that goes along with the physical abuse. I don't think that there can be that physical abuse without their being that power issue or control issue, that leaves a mentally abusive thumb print on that person."

In this statement, Karen did not want to disconnect the two concepts of physical abuse and the use of power or control. She did, however, address the clear difference between the concepts, but kept the link between the two. Amy also addressed her definitions of abuse and included the category of spiritual abuse.

The area of spirituality seemed to be very important to Amy as she believed it has shaped her value and belief systems a great deal. Amy discussed her thoughts about what is included in her definition in her statement:

> "Spiritual abuse to me is whenever you do things to impute shame or guilt or sin when there should be none. That you use guilt or shame in manipulative ways to try to control, when you try to constrict another persons agency to make choices. I think emotional abuse can be very similar in manipulating emotions or shutting down emotions. I think a lot of times it has to do with intent. And usually intent has to do with shutting down one's abilities to choose their agency or disrespecting them as a person, not having a sense of physical or emotional boundaries. I just think the intent is the thing that makes it either abusive or not."

In this passage, Amy is speaking to the use of power and control through the manipulation of guilt and shame surrounding emotions. She also adds the component of intent as the key to her definition of what constitutes abuse. Finally, Judy discussed her attitudes regarding the difference between physical abuse and physical violence as it pertains to power and control or intimidation as she stated:

> "Physical abuse can be small things, it can be kind of depicted as being like very violent hitting, or throwing things at each other, punching each other, things like that. But I think there's physical violence that can happen in terms of physical intimidation, which doesn't even include any hitting or direct contact. It's just that kind of power you have over somebody. And that, is sometimes where I think the aggression can start. A lot of times they can start with that kind of physical intimidation."

Judy even went on with her description by discussing how things even related to how people spend their money can involve a certain degree of psychological intimidation. However, this began to raise many other issues for her to notice the broad range that emerged in what constituted control within relationships.

Minimization versus authentication of the abuse. Another theme focused on the initial descriptions of the seriousness of the abuse. These responses came directly following the viewing of the video vignette when the participants were asked how serious they believed the couples interaction is. This theme provides support for how the meaning-making process affects how these participants then reacted to the partner abuse case. It should be noted that the participants later went on to contextualize their responses with their definitions, their interventions, etc., but these statements were their immediate reactions. Regarding the couple's interaction, Sara responded that:

> "This isn't that bad. But I think part of that is based on the setting in which I work. I work with people who have been to prison, so that's nothing (the vignette). One of those would be a good one---I don't think that they are that bad. The violence, I think, may be a one time thing, but I would really want to check that out."

In this passage, Sara is reflecting on her initial reactions and that she believes the couples' interactions is not on the same level as some of the experiences she has had in her work setting. As a result of this frame of reference, she seems to minimize the couple's abuse and questions the frequency of the abuse occurring. Dora provided a similar response after watching the video vignette in her statement:

> "I would say maybe at this point it's not that serious, just in that two-minute clip, it sounds like there's they're doing a lot of fighting and getting on each others nerves. And I think they're at the edge where they could go over, and it could get really serious."

In this passage, Dora stated that what she observed led her to think that the couple's interaction was not of great concern, but that it had the potential to become more of an issue. She had stated earlier (as reported in the thinking vs.

feeling theme), that she was not paying attention to what was being communicated between the clients, but more on the process of their interaction. What is also of note, is her interpretation of the couple's interaction is that they are just "fighting and getting on each others nerves" instead of initially viewing it as abuse.

Interpretation of interaction. An initial separation in coding category was established regarding the manner by which the participant actually made sense of the interaction between the couple in the video vignette. The resulting thematic category focused on the descriptions that the participant provided in understanding or interpreting their interaction. Mary described how she viewed the interaction between the couple in a unique manner and how she then views her job as a therapist in her statements:

> "It's like they are loving each other more because they are fighting harder and they are losing control and they are getting further and further away from what they are actually looking for. So I think when you look at a couple like that, it's important for me to think about, what is it that they are looking for? What is it that they have lost? What is it that they need to find it?"

In this passage, Mary is really reframing the couple's interaction and looking at their behaviors as an indicator for something much bigger than just victimization and abuse. She is also describing what she then sees as her role in stepping in to help the couple uncover what they once had. Amy also provided this insight into how she interpreted the interaction between the couple in the video vignette:

> "I felt really empathetic towards him because I felt like the sense I had it that the body language is demonstrating that he was really not in alignment with the person he wanted to be. Like there is this frustration, like he was really rageful and angry but I was assuming that he was there, either there was something that she held over him to make him come or

> he felt like in some way he wasn't in line with the person he wanted to be himself."

Similarly, Amy reframes the man's actions to indicate something else other than the obvious anger and rage he is portraying. This view of him specifically seems to assist her in approaching him with a different attitude—especially in attempting to understand what is driving his deep frustration to the point of abusing his wife. Sara also addressed the interaction in an interesting manner, but focused more on the interpretation of the abuse itself and the effect it would have on her level of concern. She stated that:

> "I think that it's a concern, but it's a different concern if it fits into a larger of a pattern of emotional violence or fighting, vocal violence---And this is just the first time of hitting each other. And if it fits into a larger pattern, that's one thing. But if it's an isolated incident and they have been luvy duvy before this, that it really isn't a concern. But I would imagine that this is part of a larger picture."

In this passage, Sara is acknowledging how her level of concern would change based on whether there is an established history of violence or not. She was less concerned if partner abuse was not part of a historical pattern.

In answering Research Question 5, "In what way does the meaning-making process (regarding abuse) influence therapist reactions to partner abuse cases?" it was difficult to ascertain exactly how the participant's meaning-making process actually affects how they react to partner abuse. It was clear that each one of the participants based their reactions on their unique definitions and how they viewed their client's interaction. However, there was often an ambivalence or disconnection between their definition and their level of concern regarding the seriousness of the situation regarding the couple's interaction. This was

especially evident in the involvement of specific components of each of the emerging themes.

Research Question 6: How do internalized messages regarding power and gender influence therapist reactions to partner abuse cases?

Thematic Content: Adherence to feminist values, Viewing therapist's role / therapist position, Entrenched stereotypes

The sixth research question focused primarily on the influence of the participants' internalized belief systems related to power and gender on their responses to partner abuse clients. It was assumed that these beliefs and values acquired through multiple experiences would influence how therapists view couple dynamics involving partner abuse. Therefore, responses are categorized according to the relationship between the participants' reported stance on power and gender issues and the influence that they believe it has (both directly and indirectly) on how they respond to abusive couple clients.

The respondents provided insight regarding their beliefs on power and gender as well as their thoughts regarding the role that they should have as a therapist in working with partner abuse. This was evident in their responses to the questions, "What messages, meanings, and beliefs do you have regarding partner abuse?" and "How do you view your role as a therapist in intervening with the partner conflict?" Additional sources of responses validating the influence of the participants internalized messages regarding power, gender, etc. came from other questions addressing the influence that other external systems has had on their thinking. As a result, the responses coded into the themes of Adherence to

feminist values, Viewing the therapist's role or position, and Entrenched stereotypes.

Adherence to feminist values. The major theme that emerged related to feminism. This included attitudes towards clients in the vignette and strong desires to address the presented imbalance of power, the traditional gender roles, and other equity issues. In fact, the pervasive response focused on addressing the imbalance in power due to traditional gender roles, and a lack of equity within the couple's relationship—even potential unconscious power differentials due to race (i.e., Kim's example regarding the vignette couple being an interracial couple). This was one of the keys to this emerging theme in understanding more about how their internalized messages regarding power and gender influenced their reactions. Both Judy and Kim seemed to directly address how their beliefs surrounding relationships affect how they work with their clients. Judy stated that:

> "I think that one thing that I believe about relationships-- I'm very strong in my beliefs about sharing responsibility and women not having to be the emotional caregivers all the time. And so that would make a part for me to watch another woman going through the difficulty of being stuck in a relationship, and can get out of it's, and you don't have any education, or money... these are all of the things that I think about."

In this passage, Judy specifically addresses her stance on viewing relationships and what she believes equates a balance in power and responsibility. She also described her beliefs surrounding her beliefs if she is a feminist therapist by stating:

> "No, because it kind of has a negative label to it sometimes. And as you read more about it, I think it's hard for me, because I think most of the time you think you have to be an agent for at least recognizing it and seeing

> how it fits with the clinical goals of what your clients are working towards. I think a lot of times you need to help the client to realize that these things are pressing on them, those kind of social things like poverty, or being a woman, or even sometimes being a man-- that they have to be rough and not emotional, and work all of their lives, and not take care of their kids and stuff like that. I guess right off the bat I would say yes I think it would be. At least here in our country I think that sometimes people forget how important it is to stickup for kids or for people who can't stickup for themselves."

In this passage, Judy seems a little torn between her basic instincts to be a feminist and promote the values that she believes in and practices herself. But at the same time, she acknowledges that she feels that there is a negative connotation that goes along with her being a strong woman. On the opposite end of the spectrum, Mary provided insight into some of the reasons that she was uncomfortable addressing issues surrounding power and gender in her statement:

> "There are parts of me that kind of go into some feminist things surrounding power and equity and things like that. But I try to stay out of that because sometimes when you get involved with one person being the mean one and one person being the victim...And although it certainly happens in violence, and I don't want to take that away at all, I know for myself, that it gets me stuck in that bad guy/good guy (mentality). And I don't like to practice therapy in that way."

In this passage, Mary really addressed her strong feelings about wanting to stay away from potentially biasing her perspectives of each of the clients. As a result, she describes her unwillingness to work therapeutically from a traditional feminist standpoint. Sara also provided an interesting perspective towards her ideas about adhering to a therapeutic feminist lens in her statement:

> "I think that there are different degrees of feminism. There are a lot of people out there who write books in feminist family therapy, who talk about changing the world one couple at a time, and defeat this maleness of our culture. And I think that that's crap. It's just the way or culture is..."

In this passage, Sara is really expressive of her opinions regarding what is important for the couple to address in their relationship—outside influences from the dominant society or what is important for them to find relational value in. As a result, she views herself as being "in the moderately feminist camp..." and finding value in having "that balance of power and control in the relationship." Going along this same trajectory, Dora provided another viewpoint regarding how feminist ideals fit with her belief system. She stated that:

> "I'm not a big feminist. I believe everyone should have it equal and fair, but I don't take it should be swayed one way or the other. I would definitely not describe myself as a feminist, and think that maybe because I think that every woman should have the same. I don't know, let's talk about household income--- because I grew up the family were everyone worked. And to me I almost have that feeling that everyone should kind of chip in and should do their part."

In this passage, Dora is really pointing out her position regarding her adherence to feminist values—that she is not connecting various tenets for some reason. She does allude towards women having the same rights, power, responsibilities, but her description seems to address equal rights instead of a balance of power within the relationship per say.

Viewing the therapist's role / Therapist position. This theme focused on the participant's particular views regarding the position that they see themselves in as a therapist working with partner abuse. One of the probing interview questions addressed the participant's feelings toward being an agent of social change and how they felt about their implicit power as a therapist. This question provided direct responses towards their belief systems and how power played a part in their therapy. Another sub-theme also emerged regarding the power that

the therapist has—but focusing on feelings regarding a lack of power. This emergent theme also reflects on the developmental process of the therapist as well as other aspects of their lives, and will be further expanded upon in Chapter 5. For the first theme regarding the participants' opinions as being an agent of social change, Mary reports in her statement that she is feeling like she is an active agent, but in an indirect manner when working with a partner abuse case:

> "Not necessarily in an outward way, I consider myself an agent of social change. Not because I am a therapist or whatnot, but in a way that I participate in society. By the way I react in society. Taking a stand... I chose my words very carefully because people who know who I am--- people sometimes give me more credit than what I need or what I deserve because of what I am (a therapist). I am really careful with that because people will give me that power whether I want them to or not and it will go...but when I can use it, you better believe I do. And if it means that if--- standing up in a conversation...with someone who makes me feel bad or I don't like it—I will walk out. Or in a therapy room and something happens, I am clear to say—"Not in my room."

Here, Mary struggles with the implicit power that she has by being very careful with how she utilizes it. At the same time, she reports that she will become quite active and overt when necessary in order to maintain the balance of power in her therapy room. On the other hand, Sara reports utilizing her implicit power as an agent of social change by defining it a little differently in her statement:

> "I really believe that for therapist to be very active politically is very different from doing therapy. We should really not try to change the world through therapy. We should change the world through being people who know about families and work with families. I don't think we should change the world as therapists. We should change the world as people."

In this passage, Sara seems to be against the idea of utilizing her role as a therapist in order to create change with her clients. She reported that it would be

more appropriate to do so as active advocates within professional organizations and with political policy, but not directly with her clients.

Entrenched stereotypes. Finally, this theme addressed deeply rooted belief systems. Specifically, this theme focused on the responses provided from asking the questions: "How do you make sense of abuse that occurs between partners?" and "How would things be different if a woman abuses a man?" The participant's predominant response involved not only their difficulty in addressing the issue due to a lack of seeing it clinically as well as not knowing what to do with it if it did arise. For example, Mary stated that: "I think that I would have a different emotional reaction only because you are like, oh you don't see that as often. I think that would be my first comment. But I wouldn't treat the case any different." Karen also reflected on her experience with abusive women by stating: "I think it is harder to address. Because...that's one of those entrenched stereotypes within our society---That men don't get abused and only women get abused." She also reported some difficulty treating the situation, especially when:

> "...you bring that up to a man, they often feel embarrassed and they don't want to admit that, or they will devalue it and say it wasn't that big of a deal---or minimize it by saying it's not that big a deal, I can take it I'm a man, she only shoved me, it didn't hurt"

Another aspect of this theme surrounded an aspect of the participant's demographics that was missed altogether except for Dora, who expanded on something that she deemed important to her internalized messages regarding power and gender. Dora reflected on her own sex and how it affects her ability to step in and tend to the issues within partner abuse situations in her statement:

> "I would almost expect...that a man would be quicker to step in where women may pull back and try other methods. I think so...(that a man can exert more control by easily speaking my voice and step in)...And that size with a man traditionally been larger."

In this passage, Dora really described her thinking that male therapist's may have an easier time intervening with abusive clinical situations than female therapists. This is due to her feelings that men are normally larger in stature, but also have traditionally held the commanding presence within society.

In answering Research Question 6, "How do internalized messages regarding power and gender influence therapist reactions to partner abuse cases?" it was evident that the participants adhered to a range of belief systems surrounding power and gender that led to their particular reactions and interventions. These belief systems included their specific attitudes about feminist tenets and even being an agent of social change in helping their clients address the issues that they observed as being relevant (i.e., traditional gender roles, power imbalance, children's exposure to partner abuse, etc.).

Research Question 7: How do values, beliefs, and assumptions influence therapist reactions to partner abuse cases?

Thematic Content: Systemic focus of understanding, Caring for the couple, Changing attitudes over time, and Influences from cultural experiences

The seventh research question focused primarily on the influence of the participant's overarching values, beliefs, and assumptions on their reactions to partner abuse clients. Similar to Research Question 6, it was assumed that the beliefs and values acquired through experiences with the family of origin, with society, from the clinical experiences, etc. would influence how therapists view

couple dynamics involving partner abuse. Therefore, responses are categorized according to the relationship between the participant's various belief systems and the influence that they believe it has (both directly and indirectly) on how they respond to abusive couple clients.

Among the respondents, all provided insight regarding their beliefs related to power and gender as well as their thoughts regarding the role that they should have as a therapist in working with partner abuse. This was evident in their responses to the questions, "How have your attitudes about individuals experiencing partner conflict changed over time?" and "What messages, meanings and beliefs do you have regarding partner abuse—and how do they affect your ability to address certain aspects of partner conflict?" In addition, other sources of responses describing and validating the influence of the value and belief systems came from other questions addressing the influence that other ecological systems has had on their thinking. This section coded into the themes of Systemic focus of understanding, Caring for the couple, Changing attitudes over time, and Influences from cultural experiences.

Systemic focus of understanding. Upon completion of the coding process, a major theme emerged involving a systemic understanding of family interaction and couple's partner abuse. This type of awareness provided a greater appreciation for the hypothetical and intricate dynamics underlying the cycles of abuse between the couple. This theme emerged not only from the participant's understanding of their own lives and development, but also their description of the vignette couple's interaction. Mary:

> "But it is this idea that it's not one person over the other and that I am going to continue to look at these people as striving very hard to maintain something that they have had before. The bottom line is that I feel like I'm very clear in that vignette is that nobody is to blame for what happened—nobody is more responsible than the other person. And I don't mean that in a way that the person that hit the other person is unaccountable—that's not it. But I am very clear as to how they got to where they were—that both of them are equal participants."

In this vignette, Mary addressed her beliefs related to the cycle of abuse and how both partners are ultimately responsible for the interaction. She describes a very traditional systemic perspective of their interaction in that they co-created the relationship. Dora also provided a direct link to her thinking about the couple and the belief in how they are both responsible partners in her statement:

> "I think I've become more neutral and more systemic. I think before I saw as being one-sided. Like there is one person doing something in this relationship and they are responsible for this and I am mad at them. We're now I can kind of see the whole picture and see what going on and see who's affected by it and who's not being affected by... and not so much putting blame on one person, but kind of looking at the whole system. And so tend to balance the responsibility; it's not pointing the finger at one person in asking how could you do that?"

In a very similar fashion, Judy also notes the difference in what the systemic perspective allows her to do as a clinician in understanding the interaction between the partners in the vignette. She stated:

> "It changes it because you don't see the other side, you don't see the other part of the argument. You have to really look at the reasons behind things first, and not just attach a label. It's one thing I learned in my own research, is that you can just attach a label-- that you are an adult child of an alcoholic, or you are an abuser, or you that you are a victim-- because there's always more to it than that."

On the other hand, Kim discussed the difference between her on and off-site practicum's and the appreciation she has for her MFT supervisors approach as opposed to her supervisor's at the domestic violence shelter: "...they still don't

really explore things like intergenerational stuff that much...they don't really talk about stuff like entitlement there." However, she also takes a strong stance in support of the criticisms of systemic thinking in that:

> "I think that a major criticism that I feel is that systemic thinking would say that...it kind of places fault on both people in that relationship...and that he's reacting that way because you reacted this way, and it kind of ends up blaming the wife or the female for the abuse. It makes them have to take equal or at least partial ownership in what happens to them, and I think that's blaming the victim, so I think that it kind of makes you point the finger at both parties and maybe we need to point the finger at the perpetrator here and not blaming the victim!"

In this passage, Kim expresses her opinions about the nature of systemic thinking and understanding cycles of abuse as it relates to the potential for blaming the victim. During her interview, Kim expanded on another example where she is confused—such as the cause and effect process of a "woman who is raped because she wore a short skirt." She believed that by simply looking at the reactions and inquiring about the action that preceded it was not appropriate.

Caring for the couple. Some of the participants even noted that the degree of seriousness of the couple's abusive situation entailed the idea that one of the partners was interested in leaving the relationship. This specific dynamic came up for Mary in her description of her immediate reaction and thought process after viewing the video vignette: "...then the comment that I'm going to leave you—that comes in there and usually means it is serious. Yeah, needs tended to right away." Judy also gave a detailed description of her heightened sense of awareness that the couple's situation needed tended to in her passage:

> "...it's got to the point that they're threatening to leave each other and that's pretty negative... I've seen couples that have gone on in this kind of stage for years, so I don't know how some couples just stay at this kind of

> level with each other for longtime, when some just stay there for a month and they call it quits. It's difficult to tell with that, because every couple is different. But I would judge this is being serious. I think it's serious, but it's difficult to tell what could happen in the future, because every couple is different and some couples go on in that kind of negative way for longtime and some don't.

In her statement above, Judy seems concerned for the couple and the potential for them to continue being in this relational routine for quite some time. Judy had also contextualized this kind of reaction in her as possibly coming from watching her own parent's marriage—consisting of extreme emotional pulling away from one another. In another statement, Judy also brought up the potential for their breaking up the relationship by leaving:

> "And I know the every couple is different .... I feel like if I knew more about their situation... but it is their first session and so I think initially I would be worried because they are both threatening to leave. And that's kind of like a last straw. Some people use that to dig at each other even more... that seems pretty serious to me."

Once again, Judy is pointing out that she believes the situation to be more serious—due to the belief that they might leave one another.

Changing attitudes over time. Another theme that emerged as having an influence on how therapists react to partner abuse was related to their changing attitude and belief systems about abuse over time. This theme is important to consider for the development of value and belief systems in that for the participants, they have been challenged and continue to develop over time. For example, Mary discussed how she has developed as a clinician in reflection of a situation in which she interacted with an abusive couple in her statement:

> "So I was this rookie—I'm still rookie, but I was real rookie at the time and I thought, whoof, can you just tell a person about your personal beliefs on rearing kids or what violence is?"

In this passage, Mary really gets to the heart of what many of the participants reported—in regards to their developmental processes (Research Question 4). However, she questioned her ability to stand up for her own values and belief systems due to her status level, in a session that may have needed it most. Mary also discussed her own reflection on how her phone incident helped to shape her attitudes and beliefs over time in her statement:

> "And I think that in the moment when I was 13 I ever thought that that was gonna shape my idea about violence or interaction or any kind of expression—no way. But somewhere along the line, I decided that this makes sense to me—to interact with families and to understand why it is that we get to the point where we pull things from people's hands."

Mary also captured this theme with her statement regarding her being attuned to certain dynamics related to partner abuse and how that has changed over time:

> "I think that I have gotten—that I have become more sensitive to it. I think that growing up in it, you don't realize that it is as unacceptable as it is. I am very---and maybe part of it is because of my training and my knowledge or my changing philosophy about violence, but I'll notice people in public and I know that they have been hurt—or that they have hurt other people. And if you would ask me 10 years ago if I had felt that, I would have said no, so I think that that changes—my attentiveness to it I think. I think that I am just so much more aware of it and watching parents in grocery stores yanking their kids away from the cereal isle. I think, really? At 13, do you think I knew that? No!"

Dora also noted the change in her belief systems over time and how her mind has opened up to different ways of understanding couple's abusive interaction. She also described how this change in her attitudes and understanding has affected the work she does with other types of clients in her statement:

> "I think I've become more neutral and more systemic. I think before I saw as being one-sided. Like theirs is one person doing something in this relationship and they are responsible for this and I am mad at them. We're now I can kind of see the whole picture and see what going on and

> see who's affected by it and who's not being affected by... and not so much putting blame on one person, but kind of looking at the whole system. So I think for me that definitely changed. I think that's the same thing in regards to my feelings on pedophiles. That was the same thing and that how could you do that? That's so dirty and so wrong, and now I'm taking a little bit more of a systemic perspective of it. And so tend to balance the responsibility, it's not pointing the finger at one person in asking how could you do that?"

In this passage, Dora seems to understand how her systemic lens balances much of the responsibility among the individuals in the system. In a similar way, Karen reflected on how her belief systems changed over time in her statement:

> "Tremendously, since I came here. Because I was constantly being challenged—challenged to define what I believe, and what I thought, and who I was. It wasn't about somebody else. So I had to come to grips with that relationship and heal that, and get to the point where I an at now--- where you let go all the anger you let go to resentment, and I wish him the best, and I have forgiven him of that. And that was a big part of me being able to become a therapist. Because if I didn't let go that, I don't think I could have been a therapist."

In this passage, Karen even went as far as reflecting on her potential inability to work with clients without going through the healing process and dealing with the pain she sustained as a child. Finally, Kim reflected on her growth and changing attitudes and belief systems in regards to her working with domestically abused women in a shelter:

> "I think I work more effectively because I guess I look at them as being stronger. You know, to still be sitting here in front of me. I start seeing the strengths in them. When before, I only saw them as being helpless and so in need of this superwoman that I'm coming in to save the day. And now I feel like, wow, you are a really strong person to be sitting here today."

In this passage, Kim seemed to understand how her thinking that she needed to be a "superwoman" and rescue the abused women had changed. Instead, she

now sees the strengths in the women, which helps her to release that feeling of being completely responsible for her client's wellbeing.

Influence of culture. The last theme that emerged in relation to the vaules, beliefs, and assumptions focused only on a handful of the responses from the participant's. These responses included statements focusing on the participant's various cultural influences and how the participant's felt that they influenced their processing of the couple's interactions in the vignette. Mary indirectly discussed two cultural aspects of her life and how they each influenced her as a therapist. In the first comment, Mary discussed how her religious belief system as well as her feminist beliefs merge, how she makes sense of it, and how it affects how she then views couples:

> "I chose to be a feminist Catholic today—and it brings up all kinds of things—and things come up for me. I think that—I believe the Catholic Church teaches that people are just trying to love each other and be there for each other. That people love each other and that is what they are fighting for. They are fighting for what that felt like—to know that they can feel safe with each other and they can be vulnerable with each other and they are fighting so hard to getting back to that very essence of love—provision, Christianity, and all those types of things. And yeah, they can't find it, they just can't find it."

In other parts of her interview, Mary also talks about the influence of her family's cultural background on how it affects her understanding of couples interaction:

> "And it was coming from a very German background in our house and it gets pretty irate. People don't have any emotions except being 'pissed off'."

At the same time, Amy addressed very similar components of her value and belief system and how she has integrated her strong religious culture into her work and understanding of couple's abuse. She stated:

> "I think that in couple's I've seen, aggression (or dominance, or violence) happens within a religious belief system or context, and unless you are familiar with that religion and religious culture, it is hard to unravel the threads that bind couples in destructive patterns. And, if they know you don't understand -- especially if you don't know enough to at least respect a religious tradition, you pretty much cannot help them. I may be more sensitive to this because of my religiously diverse background -- and being part of a cohesive religious culture (Mormon). And I am also a very strong feminist. So those are the other things as well. I am a Mormon feminist...I don't know if you know very much about the Mormon Church, but there is a huge emphasis on family. So it has but it still something I struggled with within my own religion, how it's articulated and how people live it."

Later in her interview, she also discussed how both she and her husband have worked together to find a healthy balance in their relationship as far as maintaining their religious beliefs, yet being supportive of one another—despite the strong influence of the church and how they define family interaction.

In answering Research Question 7, "How do values, beliefs, and assumptions influence therapist reactions to partner abuse cases?" it was evident that the participants incorporated a number of factors into their belief systems involving power and gender—which then influenced their particular reactions and interventions that they would utilize therapeutically. What was interesting is the clarity of how the participant's understood and processed the couple's dynamics from a systemic perspective, yet maintained what seemed to be an appropriate way of establishing safety for the abused person in the relationship.

Table 4.1: Emerging Themes from Data Analysis by Research Questions

Research Question	Emergent Themes
RQ1	Direct influences Indirect influences Making sense of the family influence Role-playing within the family
RQ2	Clinical activity with partner abuse cases Supervision experiences Educational factors
RQ3	Key events Family of Procreation and Marital Status Personal and key demographic characteristics
RQ4	Therapeutic responses Thinking vs. Feeling Insecurity and Incompetence Self-Awareness The validation of themes (utilization of the Differentiation of Self-Inventory)
RQ5	Differentiation between physical violence and power/control Minimization vs. Maximization of the abuse Interpretation of couple interaction
RQ6	Adherence to feminist values Viewing therapist's role / therapist position Entrenched stereotypes
RQ7	Systemic focus of understanding Caring for the couple Changing attitudes over time Influences from cultural experiences

CHAPTER FIVE: DISCUSSION

The findings in Chapter 4 were based on interviews and collateral information from Marriage and Family Therapy Master's level clinicians. This chapter provides a discussion of the research findings and their implications. It will first address the theoretical implications of Human Ecological, Social Constructivist, and Feminist theories. Specifically, the original theoretical and conceptual maps introduced in the first chapter will be discussed in light of the new findings. This discussion will include the process in which several of the major research question constructs relate to the new models in reflection of the current literature. This will be followed by limitations and suggestions for future research. Clinical implications will then be presented, which will help to provide additional insight into the dimensions of working with partner abuse and how the therapeutic process can be better informed in the future.

Theoretical Implications: Human Ecological, Social Constructivist and Feminist Theories

The purpose of qualitative phenomenological methodology, which guided this study, is to develop substantive theory. This approach to research is characterized by "meaning questions" (Boss, Dahl, & Kaplan, 1996, p. 91) in that it focuses on the interpretation of human action. This is done through a coding process which was previously discussed in Chapter 3. The participant interviews illustrate the depth and breadth of the various factors that influence therapeutic work with partner abuse. As a result, certain themes emerged on a broader scale that was not confined within a particular research question. These broad-

based themes demonstrated the influence of the three theories that informed this study. As a result, a new conceptual/theoretical map was constructed. Figure 5.1 shows the varying influences of each theory that in turn influences the process model described below.

Key Findings: A Process Model of Therapist Response to Partner Abuse

Meaning-Making

In order to represent the key findings of this study, a process model of therapist response to partner abuse was constructed (Figure 5.2). Certain ecosystemic environments were found to be a great influence on the developmental processes of the individual. The systems are the foundation for the components that affect the nurture side of development. However, in interpreting the data, it was clear that therapeutic responses to partner abuse did not occur through the mere exposure to systems experiences, but through the individual's interpretation of these interactions. Thus, meaning-making or how individuals make sense of their experiences appeared to be a centralized theme through which other themes emerged. This finding supports Bronfenbrenner's (1995) more recent person-context-process-time model. This suggests that aspects of the environment beyond the immediate situation containing the subject, may not have a direct effect, but indirectly through how the individual makes sense of that interaction.

During the interview process, the participants were asked directly and indirectly to describe how they had actually made sense of interaction between

Figure 5.1: Revised Conceptual/Theoretical Map

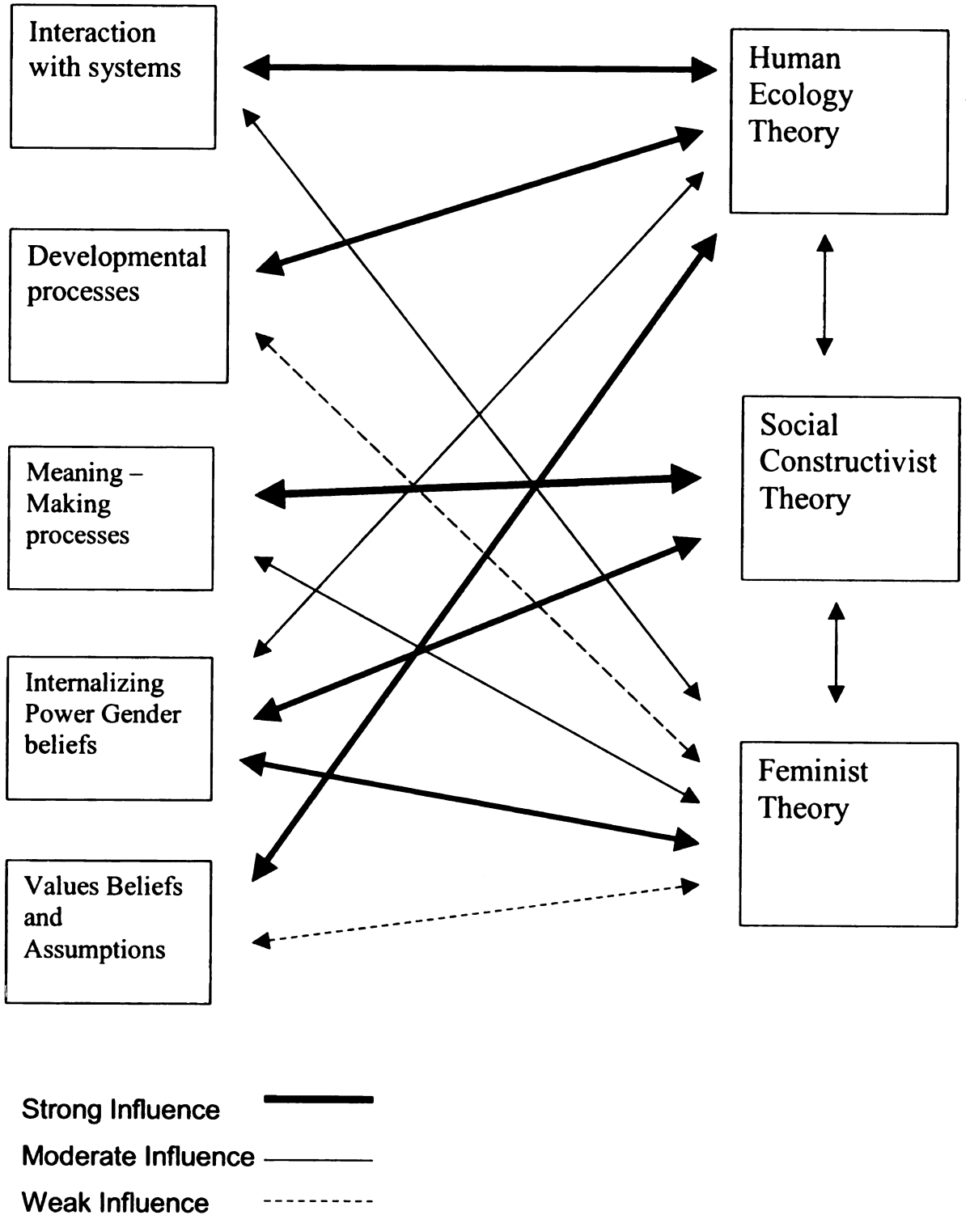
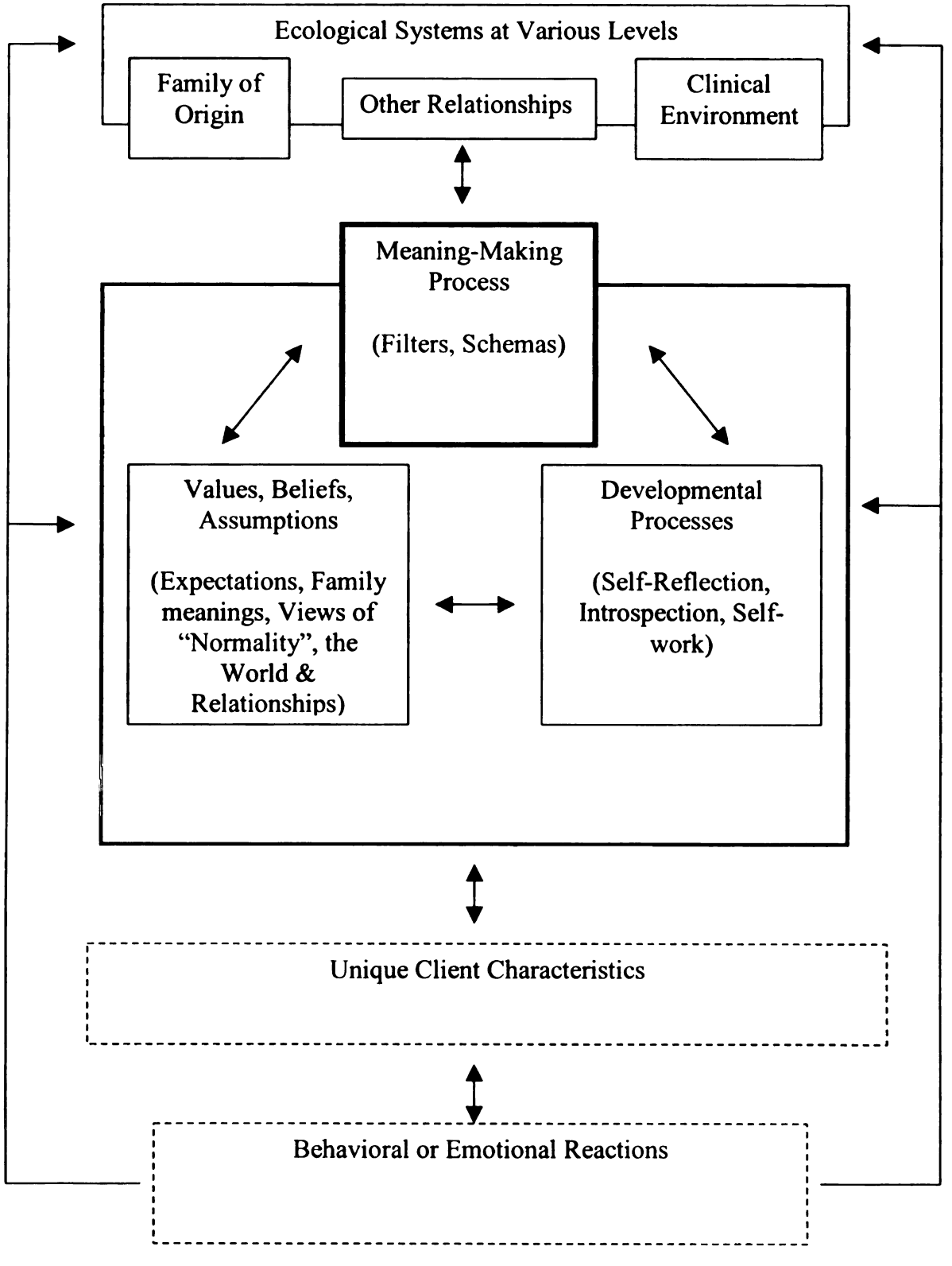


Figure 5.2: Process Model Based on Findings



couples such as partner abuse. Stepping back from the data, this sense-making theme became central in understanding each of their descriptions of their experiences with partner abuse. Throughout the interviews, the participants addressed the process by which each of the ecological factors discussed above influenced their reactions to partner abuse. For these therapists, much of their values, beliefs, assumptions surrounding partner abuse, the reactions they portrayed and discussed, as well as the interventions they deemed appropriate all revolve from within the meaning-making process.

Social Constructivist theory drives this model, understanding the influence of the systems from varying levels on the participant's definitions, beliefs, and assumptions—including not only their family of origin, but their clinical environment, etc. It is the interplay between both Human Ecological and Social Constructivist theories that governs the meaning-making process by which therapist's understand and react to partner abuse. This supports postmodern theorists such as Kegan (1982) and White (1990) who suggest that developmental processes are really embedded and interactive within the context of our social influences. This meaning-making is staged and ongoing such that it is difficult to separate.

Bronfenbrenner also believed that throughout the lifespan, development takes place through processes of progressively more complex reciprocal interaction between the active, evolving individual and different people, objects, and symbols in the immediate environment. This would mean that the meaning-making process and the continuous challenging of belief systems is a recursive

process that does not hold still in time. This would even account for the interplay between the presented clinical situation and the developing individual. Thus, the therapist's reactions would be changing as well as they continue to develop over time. Likewise, a Feminist model would also take this phenomenon into account in that it assumes that the therapist enters the therapy room with evolving and personal values, beliefs, and assumptions. Thus, it would be expected that the therapist would actually be reacting emotionally to situations outside their own belief systems—but as they develop over time and through the process of differentiation and training, would expect to react differently to the same type of situations.

Each of the research questions addressed how the components of the individual's environment, the development of their values and belief systems, and the meaning-making process influence therapeutic interactions with partner abuse clients. The following section will address how the primary constructs, as described by the participants in this study, relate to the new process model. Current literature and guiding theoretical approaches are integrated into these discussions.

Ecological Constructs

Family of Origin Influences. According to Family Ecological theory, the family is the central system from which values and beliefs are primarily transmitted (Bubolz & Sontag, 1993). Given the wide range of experiences of the participants, it was not clear that family of origin had an actual direct influence on reactions. Instead, it is more useful to look closely at what ways or how the

participant has made sense of the interaction within their own family of origin—specifically, what meaning they have taken from it and how it has shaped their value and belief systems. Thus, the coding schemes and the themes that arose focused more on the specific incidences that seemed to bring about a response. Even a lack of exposure to abuse either clinically or personally still provoked intense reactions, which then led to a process of filtering personal family dynamics and how each did or did not fit with a family of origin.

Family of origin influences appeared on two different levels. Initially, the participants were able to discuss how the vignette reminded them of incidents within their family of origin or how their parents and/or siblings interacted. At the same time, they would often respond by saying something similar to the phrase: "...it didn't come up for me in watching it....but now that you mention it...it did remind me of how my parents used to throw things at each other." A first interpretation would imply that there was little reaction from watching the vignette. This would lead to the belief that there is currently no unresolved emotional issue from family of origin (as McGoldrick (1982) suggests), that would influence therapeutic response and would not need attention individually or in a supervision context. Looking again, it is important to consider how family interaction shaped this first response and then the second underlying one—which is subsequently affecting how they may address the clients. This was one of the primary indicators that the meaning-making process became multi-dimensional. This can be seen in Mary's recollection of the phone incident when she was age 13:

> "So there was something very specific in the video that reminded...I mean you probably see this in adults do this and this was just insane sibling rivalry. As kids it is a little different, but it's not...you still have those feelings of mistrust and insecurity and thinking that wow, this person and I could really hurt each other. Wow, this has just gotten to a different level. So there is some family of origin stuff that influences me."

This passage illustrates that for Mary, the meaning that she has regarding the interpersonal dynamics of her family of origin wasn't the direct influence on how she then reacts to clients as a therapist. Instead, her reaction was directly linked to the specific details of the interaction reported by the clients in the vignette (i.e., the phone being slapped from the woman). This would suggest that other factors may be at play in shaping how we then define, understand, make sense of, and ultimately treat partner abuse.

Another way of understanding the influence of the family of origin considers when the participants did not have anything specific to recall. This developed as several of the participants reported that nothing from their family of origin that reminded them of the couple's interaction in the vignette. However, the participants still reported having a number of different reactions—that in fact were based on dynamics from family of origin. This would indicate that the lack of reference to a specific sort of interaction from the family of origin can be just as influential as having one to recall. At the same time, it may point out that there are other factors to consider associated with values and beliefs related to violence.

The theme of playing a role within the family of origin supports the systemic notion that individuals serve as different players in order to maintain the homeostasis within the family system. This dynamic validates previous research

(Brosi & Silverthorn, 2002) that suggests most therapists chose this career in conjunction with having some sort of caretaking role within the family of origin. Furthermore, as mentioned in Chapter 2, Titleman (1987) believes that "the position the therapist plays in relation to the client family will be similar to the position that is played in the therapist's own family" (p. 4). This was evident not only in Mary and Amy's statements in Chapter 4, but also in Karen's description of a case in which she found herself reacting strongly:

> "...we realized that part of the reason why I responded that way was because of my---because I had held on, and I didn't realize I'd held onto this guilt that I didn't protect my brothers in the way that I should have....and this kid was the same age that my brothers were, and it all just fit."

Obviously, this dynamic was important for Karen in linking who she is with how she fits into her family—even when thinking about her family and dynamics involving partner abuse. Interestingly, it is most likely that the participants have come to better understand their family of origin dynamics, have separated themselves enough to recognize the potential family conflict, and specifically, what function they served in maintaining the homeostasis. Thus, the key to understanding the influence of the role playing, may go back once again to the degree of resolution the therapist has had in understanding how they fit into their family of origin and consciously choosing not to replicate that dynamic in therapy with clients.

Clinical Environment. Another important component of the developing individual's microsystem involves the clinical training environment. This part of the system has a unique role in the therapists' world due to the opportunity for

this realm to continue to challenge and shape therapists' value and belief systems. The family of origin is, at this point, not central but more peripheral in the therapists' life, such that the clinical "family" becomes the new primary socializing agent that informs what constitutes good interaction, bad interaction, or partner abuse. As a result, this environment, consisting of peers, supervisors, professors, and clients becomes the intimate setting from which the individual continues to grow and challenge their belief systems.

As expected, the clinical environment appeared to have a great deal of influence on the participant and response to partner abuse. This setting also greatly influenced the value and belief systems of the participant and how they should deal with partner abuse. This was evident in their descriptions of how their programs emphasized safety plans, focusing on gender and power concerns, and general treatment of the couple. This environment also provided a setting in which some of the participants' relationships could be nurtured—where, as reported by the participants, they could share themselves intimately with peers and colleagues.

Developmental Processes. As expected, therapists' reaction to the clinical vignette was highly related to level of differentiation. Developmental processes that emerged influential involved maturity level and overall ability to be able to reflect on background and ongoing development. This process, related to what Bowen (1978) called differentiation, is directly linked with the meaning-making process as well as the establishment of value and belief systems. One example

of an undifferentiated state that emerged from the data involved the participant's desire to slow the therapeutic process down. Mary expanded on this process:

> "I would have probably slowed them down. Maybe that's my tactic in avoiding that conversation for a little bit. Probably two motives to that—one, that I don't want to go there yet because it's a topic that's hard...hard on me, it's hard for them. And two, to see if there is something there. Let's talk about the good things first and then tell me about that."

This passage speaks clearly to Mary's anxiety level and her feelings of being uncomfortable in addressing the abuse. This supports Kerr and Bowen's (1988) notion that poorly differentiated individuals will most likely attempt to avoid conflict.

This dynamic was also interpreted as the participants remained in the thinking mode and reported that it was necessary to "turn off" their emotions. During the interviews, the participant's often responded to the "how did you feel?" interview questions with "I think..." answers. This was interpreted as the participant was still in the thinking mode or was more focused on the details of intervention than feeling states. This could also indicate anxiety-driven reactions and need to remain "clearheaded" so as to avoid being weighed down in the emotional expressiveness of the clients. Again, this supports Kerr and Bowen's (1988) ideas that poorly differentiated individuals often times separate themselves from the responsiveness or emotionality of others. On the other hand, this would support Titleman's (1987) belief that remaining in the thinking realm allows the therapist to stay clear of becoming fused, triangled, or induced into the emotional systems of the client families. Perhaps in general, this (slowing the down of the session) is an appropriate mechanism for traditionally "feeling-

driven" individuals to utilize—given the intense nature of what intervention may need to happen and when. This serves a good purpose in accomplishing the mission of establishing a safe atmosphere and making sure the abused client's needs are appropriately met.

At the same time, the strong desire to slow the therapeutic process down may also speak to the participant's fears of the unknown or their level of confidence in working with this type of clientele. This would support Halperin's (1991) suggestion that developing clinicians are particularly subject to countertransference reactions related to incompetence, confidence levels, and feelings of having a lack of power in therapeutic relationships. This also played out in internalized messages regarding power and gender. This was especially relevant in regards to how participants saw their role as intervening therapists and agents of social change. Lack of feeling powerful affects confidence level, which then affects ability to intervene appropriately. This was the case for several of the participants as they directly discussed the lack of confidence, insecurity, and incompetence they have felt when working with partner abuse clients. This suggests low differentiation levels or inexperience or insecurity about competence and figured in how the participant responds to partner abuse.

This dynamic involving the therapists' fears also supports Nichols & Schwartz (1988) who suggest that poorly differentiated therapists may be more subject to their own emotional cutoffs, thus becoming more reactive and emotionally distancing themselves from the situation. In essence, they may be confronted with highly anxiety-provoking clinical situations that may be less than

"ideal" for a low differentiated therapist—especially for a beginning therapist who has not fully developed or explored these self issues. As a result, it is the lens or definition of self that drives interaction with others. Strawderman, Rosen, and Colman's (1997) findings on therapists' countertransference reactions demonstrate that therapists feared that addressing the violence would result in the client leaving therapy. As a result, a potential developmental impasse may occur—preventing the therapist's from learning to tolerate anxiety and taking a more differentiated stance when dealing with partner abuse.

One participant in particular stood out in regards to the topic of maturity and differentiation. Karen discussed a number of things that she wanted to accomplish therapeutically, given the sense of urgency that she felt to intervene with the vignette couple. Furthermore, she addressed how she did not feel any particular anxiety-driven factor arose for her, but more of a strong desire to make sure that safety for the clients was achieved. From a developmental perspective, it may be the case that she has allowed herself to acknowledge her personal life experiences, and has come to terms with her abuse history. As a result, this allows her to be more in the present with her clients. In regards to the clinical vignette, Karen presented in a highly differentiated manner—she was more able to tolerate the conflict as she shifted clearly between their emotional and rational levels without reacting to the emotional situation (Bowen, 1978; Kerr, 1988).

Other findings stood out in the data in regards to the developmental processes of the participants. In particular, several of the participants discussed a lack of desire to discuss feelings, belief systems, or reactions with their

supervisors. This could also suggest low levels of differentiation in that fears of incompetence loom but could also suggest issues of power and gender that are inherent in training programs. Some even emotionally disengaged from the very situation (i.e., supervision) that is intended to assist in working out these issues. Perhaps the developmental level of a newer therapist, confronted with situations that require a highly differentiated stance is fragile and malleable. However, by not appropriately dealing with anxious states in supervisory situations, the problem could worsen. As a result, the newer therapist who has had limited experience working with this type of clientele may not have the opportunity to address the multitude of emotional reactions that may be typical in these situations.

The developmental process of the therapist is a critical component of clinical work. However, due to a number of factors, it can be daunting to measure—especially in a study addressing dimensions such as this. For example, many of the participants reported that certain factors were not "influential", while others were. Although this may be true, it does not account for any unconsciously driven issues related to avoidance of certain topics, levels of discomfort with topics, or a basic lack of knowledge about other factors outside of experiences and comfort. In other words, the participant may not have been able to address certain dimensions of development simply due to not having addressed it before. This not only is related to maturity level as individuals, but to developmental level clinically.

These responses were triangulated and validated with the use of the Differentiation of Self Inventory (DSI). Those with low "I" position subscale scores appeared to struggle more with value and belief systems and with addressing concerns with their supervisor. These same individuals had the lowest emotional reactivity (ER) subscale scores (indicating low levels of differentiation). This validated interview data in that the researcher noted that these participants seemed the most distracted by their experiences in relation to partner abuse. Another measure on the DSI showed that fusion with others scores (FO) were extremely low in comparison to other subscale scores. This corresponded with the fact that all of the participants were women. Feminist theory (Warburton, Newberry, & Alexander, 1989; Tingey, 1993) suggests that women take on responsibility for relationships and are socialized to take on the caretaker role.

Values, Belief and Assumptions

The themes that emerged in regards to the participant's values and beliefs seemed to overlap a great deal with their developmental processes and personal background. How the participants, as Marriage and Family Therapists, reacted to the couple in the vignette seemed to be a product of how they first defined this couples' interactions, and second, what they then expected from them as outcomes—by their preconceived notions of how they expect couple interaction should be. This is supported by Hines and Hare-Mustin (1981) who point out that therapist's assumptions about families are usually a result of value conflicts—which generally govern therapeutic moves. Each goal that a therapist

established for change is really a product of an ideal or projection of what he or she thinks families should be in the first place. This even has an effect on what clinicians deem as being necessary in their work as therapists regarding the implementation of first vs. second order change. Thus, how therapists have storied their own experiences and have made sense of them will affect how they then even story their clients' experiences. In other words, their story becomes a barometer for how they view client interactions, and how they assess or measure "abuse" or violence".

Collision of Values. An interesting finding involved the cultural influence theme in which some participant's interwove feminist beliefs with personal spiritual or religious beliefs. At the same time, participants seemed to confuse the two areas which seemed to contradict one another. What was evident was that most struggled with these issues and how they fit together and with integration into identity. These two constructs, both being within the mesosystem, refers to the specific interrelations of two or more settings in which the individual participates (Bronfenbrenner, 1979). This finding strongly addresses the potential incongruence between the value systems of the individual's clinical environment (e.g., including their peer groups, workplace, supervisor, coursework) and their church. As expected theoretically, since these belief systems of various microsystem constructs were not harmonious (for the participants), it created conflict within the developing individual and may account for potential therapeutic impasse, or countertransference reactions within their therapeutic setting.

Another specific example of the participant's values and belief systems involved the participant's tendency to want to slow the therapeutic process down—to slow the degree of escalation between the couple. In the developmental processes section above, an explanation was provided that the participant's anxiety may have been rising, fears regarding the unknown of how the couple might react, or they may simply want to establish a safe atmosphere. At the same time, this dynamic was interpreted by the researcher as a representation of a value for preferring that clients stay together and/or to save the marriage by slowing the session down. This was represented as providing an opportunity to build positive interactions between the two negatively driven individuals. In other words, it was viewed that the participant was heavily focused on maintaining the couple's relationship at the potential detriment of establishing safety. However, it is important to identify the potential driving role that the therapist might have in working with the clients—that the clients "hire" us to do couple therapy, not to "save" either one of them from the abusive relationship. This also may involve the overwhelming desire for therapists to work systemically with families in the first place (as discussed in the family of origin section above). Thus, tension exists between the roles of therapist as systems preserver versus sensitivity to power and control or feminist values.

Similar to the struggle between feminist ideals and religious beliefs, the participants also seemed to wrestle with the balance between being an advocate for the weakest voice or the victim of the abuse, yet maintain a focus on the couple and their relationship. Once again, Bronfenbrenner's (1995) model

explains conflict that the participant felt regarding the integration of feminist ideals and maintaining an alliance for the couple.

Finally, the demographic profile actually provided an interesting insight into what the participant found important in shaping who they are—self-governing values and belief systems. After the researcher's primary demographic questions were covered, the question was asked: "Is there anything else you think I should know about you related to your demographics?" Originally, this question was asked in order to make sure the researcher hadn't missed any important characteristics. Responses indicated that each participant had special incidences that helped to shape how they viewed themselves and their lives. Many of them talked about family of origin and mentioned the centrality of an intact family. Others talked about their feminist lens. These descriptions stood out as core aspects of how participants made sense of who they are and how they got here.

Clinical Implications

Self-Work

From this model, it can be implied that understanding of self is critical. Therapists need to understand how they have been influenced by various systems, ways of thinking, and what they believe. Obviously, this is more important if the primary therapeutic modality is working from an insight based systemic lens (i.e., differentiation, anxiety tolerance, etc.). Note this might be different if working from a strategic lens—in which the therapist is expert, and is more concerned with implementing behaviorally-oriented, first order change, etc.

As discussed in Chapter 2, Bowen (1978) would also assert that the client can only be as differentiated as the therapist—that the client's individual growth cannot exceed the level of the therapist, given the anxiety and relational factors that exist. At the same time, feminist scholars (Melito, 2003; Prilleltensky, 1997; Gale & Long, 1996; Whipple, 1996; Byng-Hall, 1995; Taffel, 1993; Walsh & Scheinkman, 1989) emphasize that therapists enter the clinical room with their own set of values and beliefs. For clinical development, optimal training should provide opportunities for the therapist to recognize their own values and beliefs and what they are bringing to the therapeutic relationship.

Supervision

As discussed by many of the participants, supervision is an important component in processing relationships with clients. However, there is also an important relational dimension that, even though is addressed on a practical level, is not so easily established, maintained, and nurtured. This is especially relevant when the supervisor and supervisee have varying belief systems that relate to their client's presenting problems. Given the innate power position that the supervisor is in, this leaves the supervisee in a position themselves, to either challenge their own belief systems, conform, or resist. Unfortunately, sometimes this results in not further addressing the issue and the process becomes lost—with the supervisee blocking any further development of his/her own value and belief systems. Furthermore, this may lead to the therapist's lack of development and ability to become more self-aware. Thus, the problem turns into a new issue involving Halperin's (1991) notation of the therapist "pleasing the supervisor" and

performing as a "professional" versus showing their insecurities. As a result, even though the supervisee should own what they are bringing to the supervision relationship, much of the responsibility falls on the shoulders of the supervisor in establishing a safe environment for which supervisees can share their biases and blind spots openly. In essence, supervisors need to be especially aware of the potential hazards of dealing with their supervisees intense clinical situations as well as how they are affected by them.

This study also has implications for the type of supervision that students receive. Accredited Marriage and Family Therapy programs require a set amount of live, group, and individual types of supervision. However, not all clinical programs share these same standards or may not have the resources to dedicate to live forms of supervision, and inadvertently may miss some of the details of their students' work. Thus, clinical programs should pay even closer attention to building into their coursework, feminist ideals involving the inclusion of therapists' value and belief systems in therapeutic work as well as the nature of having emotional reactions towards their clients.

Potential Blinders

As reported by most of the participants in this study, each had a limited amount of experience with clients presenting with family violence, and/or partner abuse. As a result, the question arises as to whether Marriage and Family Therapists are asking the appropriate questions to address or assess for partner violence with couples. Furthermore, the issue is raised as to whether this is related to training, to not wanting to deal with intense issues on a regular basis,

or to the therapist's propensity to focus heavily on keeping the couple together (as discovered in Chapter 4). Nonetheless, whatever the driving force may be, it is unfortunate that this collusion may be aiding in keeping individuals oppressed and partner abuse behind closed doors. Thus, it is critically important to make these types of potential issues overt by addressing them head on. At the same time, supervisors can discuss the likelihood that countertransference reactions will be occurring, especially with high emotionally intense clients and that addressing these issues is the first key to improving therapeutic outcomes.

Another important clinical implication regarding the potential blinders has to do with feminism and advocating for the oppressed. As discussed in the section above, many of the participants in this study fully accepted the need to address gender and power issues. At the same time, they stated that they either did not consider themselves to be a feminist, or believed that it was a negative term and did not want to associate with even the title. These varying beliefs point out the need for educational programs to clarify for students, just how relevant the underlying tenets of feminism are to the field of Marriage and Family Therapy and how important these ideals be integrated into the programmatic curriculum. In addition, addressing issues outside of the dominant discourse regarding partner abuse (i.e., women abusing men, gay/lesbian violence, etc.) in clinical programs is paramount.

Limitations

As with any study, this research project had limitations—some that could not be controlled, and others that are inherent to the methodology. First, the

participants were self-selected in that they chose to participate because they were interested in doing so. The participants were provided a recruitment letter indicating the purpose of this research. Thus, there may have been inherent differences between this sample versus those who did not choose to participate. Furthermore, the participants were provided an elaborate description of the research topic and the purpose of the study. However, upon personal contact with each of the participant's, it was evident that they had already begun the work of connecting influences to their work with partner abuse. This may have begun with the researcher's recruitment advertisement as well as review of the informed consent form. Each document consisted of the primary goals of the study—which may have also acted as a potential biasing agent for how they responded to the vignette and interview questions.

Another important limitation of this study involves the demographics of the sample. There was very little ethnic, age, and educational diversity in this sample in that most of the participants were also in their middle 20's, and were at the end of their Master's program in Marriage and Family Therapy. As described earlier, the age factor may have also played a part in the elicitation of responses connected to the video vignette. This study may be a snapshot of their development and their attitudes and belief systems regarding partner abuse since development is continuous. Furthermore, this small sample prevents major generalization to the larger population of Marriage and Family Therapists and mental health practitioners in general. However, this qualitative study provided a

rich and deeper understanding of participants' experiences involving partner abuse.

Another limitation involves the demographic characteristics of the actors in the vignette. In the video, they portrayed a younger couple, who has recently married. These specific details may have led to the participants to respond differently than if, for example, the actors were 50 years old and were identified as being similar to their parents. Instead, the actors were young adults—with demographics very similar to the bulk of the participants (age, ethnicity, etc.). As a result, they may have provided responses that reflected how they felt seeing fellow young adults in an abusive relationship. Thus, leading to their enhanced reflection of their current family of procreation relationship instead of a reflection of their parent's interaction.

Another limitation involved the interaction between the researcher and the participant. The participants were asked to reveal personal aspects about their attitudes and beliefs about partner abuse as well as some of the reactions they had towards a clinical case. This may have been more difficult for some participants due to the lack of feelings of safety with the researcher or the abrupt nature of getting straight to the point of the research topic. In addition, the structure of the interview process for this study (being very directive) may have been necessary more so with this sample than with seasoned therapists—who may do better with less structure and more open-ended questions. Furthermore, the nature of the research topic involved the need for the participants to be introspective. As discovered with regards to the developmental processes of the

participant, understanding oneself deeply and insightfully may not come easily for some. In addition, all of the participants were female and the researcher was male. This may have also led to a certain degree of caution on the participant's willingness to open herself up emotionally—especially to a stranger.

Since the researcher is the instrument in qualitative research, it is important to address the interactions between the researcher and the participant as well as the nature of the research topic being addressed. I created the vignette with the approval of my advisor and committee. This means that I too contributed to the meaning-making process by deciding the definition of partner abuse. This limitation is inherent in qualitative process and should be acknowledged as part of the reflexive process given the dynamic interaction that took place between the participants and me. I was very much involved in the meaning-making process as I interacted with the participants and discovered that my own reactions too, were playing a part in the outcomes of this study. However, this study also provided an opportunity for me to reflect on much of what I consider abusive, normal, and some of the value-driven reactions I have when interacting with others.

Research Implications

There are a number of ways in which the findings of this research may serve to support future research regarding therapists' work with partner abuse. In order to better understand the process by which therapists emotionally react to partner abuse, it is critical to first look at how they ascribe meaning to abuse, violence, and basic couple interaction. This study went well beyond simply

looking at "what" ecological factors and attempted to identify "how" these factors influence therapist reactions. Thus, it is useful to continue to conduct qualitative research on this process by which therapists make sense of couple interactions. It would also be beneficial to study other mental health professionals (i.e., social workers, counselors, psychologists, etc.) in order to identify the factors driving their particular belief systems and the influence on their reactions to couples presenting with partner abuse.

In order to better understand the process by which therapists develop their values and belief systems, future research could also focus on the influence of educational programs and supervision relationships on therapeutic outcomes. This information would help to fill the gaps in terms of understanding the therapist's developmental process as well as what types of environments are necessary for establishing safety to discuss difficult issues.

Finally, although qualitative research seems particularly suited for addressing the rich and diverse stories of individuals, quantitative methods may be incorporated to aid in the validity and reliability of the research (Miles & Huberman, 1994). Many of the variables in this study could be addressed from both qualitative and quantitative directions in order to maximize on the richness of the individual's lived experiences. Future research may be appropriate to identify key constructs (i.e., differentiation, anxiety, personality characteristics, relational dynamics, etc.) affecting therapist outcomes with partner abuse cases. This would be especially important for blending qualitative methods with other quantitative measures for triangulation purposes.

Conclusion

In conclusion, the results of this study verified the importance of looking more closely at the varying dimensions of therapeutic work in the field of domestic violence. Based on the factors identified by participants as being influential to their reactions to partner abuse, a process model of therapist-client interactions focusing on meaning-making was proposed. It is with great hope that the results of this study will assist therapists in better understanding what they bring to their therapeutic work; supervisors and the need for their attention on difficult clinical topics such as partner abuse; and clinical programs in the mentoring and education of therapists in order to better serve the clinical population.

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APPENDICES

APPENDIX A: INFORMED CONSENT

Consent Form

Hello. As a part of a research project at Michigan State University, I am asking for your help gathering information about your work as a Marriage and Family Therapist on the area of couple's interaction. If you agree, I plan to ask you a series of questions about the process of your interaction with clients. This process involves two interviews and should take no longer than approximately 45 to 60 minutes.

Please understand that your participation is completely voluntary and you will not be given any form of incentive for participation. Should you decide not to participate in this study or if you wish to withdraw your consent at any time, you may do so without penalty. If you decide to participate, the information you provide during the study will be kept confidential to the maximum extent allowable by law. Further, the results of your participation will be confidential and will not be released in any individually identifiable form without your prior consent.

1) The purpose of this research is to gather information about the experiences that you have as a therapist.
2) The interview process will involve viewing a video vignette, asking several questions about their therapeutic experiences, and is expected to last approximately 45-60 minutes.
3) The results will be confidential and will not be released in any individually identifiable form.
4) My participation is completely voluntary and I may choose to not answer any questions or may withdraw at any time without penalty.
5) Participation entails minimal risk and resources/support will be provided for the participant.
6) The researcher will answer any other questions about the research, either now or at the end of the experimental session.

This study is being done through Michigan State University and is governed by the University Committee for Research Involving Human Subjects. This committee is responsible for ensuring that research participants are treated fairly and ethically. If you have any questions or concerns about this study or your involvement in this study, please contact:

Peter Vasilenko, Ph.D., Chair
University Committee on Research Involving Human Subjects
Michigan State University
202 Olds Hall
East Lansing, MI 48824
(517) 355-2180

This research is also being supervised by a faculty member from Michigan State University. If you have any questions about this project, please contact:

Marsha T. Carolan, Ph.D.
Associate Professor
Department of Family & Child Ecology
13H Human Ecology
East Lansing, MI 48824
(517) 432-3327

Your signature below indicates that you have voluntarily decided to participate in this research project as a participant and that you have read and understand the information above.

_____ _____

Participants Signature **Date**

_____

Participants Printed Name

If you have any questions about the research and/or your rights as a participant, please feel free to contact Matt Brosi at brosimat@msu.edu or by phone at 517-353-3392.

APPENDIX B: DIRECT QUOTE CONSENT FORM

Consent to Use a Direct Quote

This form gives your consent to use direct quotes, from this interview, for the purposes of publishing this study. Your identity will be kept confidential and a false name will be used to protect you. Only the researchers will know the name assigned to you. By signing this form you allow the use of direct quotes in publications of this study and understand that your privacy will be protected to the maximum extent allowable by law.

I voluntarily consent to the use of direct quotes in the publication of this study.

Signature: _____ Date _____

Printed Name: _____

APPENDIX C: CASE VIGNETTE

Initial intake information: Sara called one week ago and is seeking therapy with her husband Mike to work on marital issues, specifically communication problems.

Video Vignette: After the participant has been given the initial intake information and has had a minute to go over the information, the video will begin playing. A young interracial couple (a Caucasian man and a biracial (African American/Caucasian) woman) in their early 20's both enters a room and sit down in two chairs partly directed at one another. The beginning of the vignette will be prompted by the therapist participant asking the clients (Mike and Sara) "what brings you into therapy?"

Mike: Well, we've been together for about four years and have been married for two. For the past several months, she's been really moody and has been bitching a lot--about all sorts of crap and as a result, we end up fighting over stupid things and she thought we should come into therapy to "talk" with someone else about it.

Sara: His fuse has been so short since he was laid off from his job last month...All he does is sit around the house and boss me around—telling me to do this or to get him that. I don't see him even looking for a job at all. It's just getting really old. Now I'm trying to look for a job and manage the household tasks and take care of the kids at the same time.

Mike: Don't blame me for your inability to keep the house clean... You'd think you would have figured it out by now, spending as much time in front of the TV as

you do... I feel like I've been busting my tail for so long, that I need to take some time off. Now I guess I can't even do that without her complaining all the time.

Sara: Well, our fighting has also gotten pretty out of control recently...

Mike: Oh, you would have to bring that up, wouldn't you!

Sara: (getting upset) Well, you're the one who can't control yourself... (She then looks to the therapist somewhat tearfully) He was drinking at home the other day and I was out getting groceries and running a few errands with our baby, Emily...

Mike: It wasn't that much; I only had two or three...

Sara: Either way, when I got home, I could tell that he was already in a foul mood. He started yelling at me about where I had been for so long—something like that... All I know is that we were screaming at each other, the baby was crying, I was crying, and I wasn't backing down! I had enough of his shit!

Mike: Yeah, she was getting all high and mighty in the kitchen and told me that she was going to call her mom and tell her how awful I was treating her...just to be mean.

Sara: Well, he tried to wrestle the phone out of my hands and I screamed for help—I don't know for whom, but I was screaming. He ended up grabbing me by the wrist, slapping me really hard across the face, and then he pushed me down to the ground. He told me if I ever thought about doing that again, he would leave me... At this point, with all this crap that's going on, I'm not sure if we can make it much longer... (Both look to the camera) What do you think?

APPENDIX D: SEMI-STRUCTURED INTERVIEW QUESTIONS

Orientation to Process:

Consent procedures

What questions can I answer for you about this study, your involvement, or what to expect during this process? (Review confidentiality of interview content).

Demographic Profile Questions:

1. Age: _____
2. Sex: Male; Female
3. Graduate level: Masters (indicate number of years); Ph.D. (indicate number of years)
4. Marital Status: Single never married; Single divorced; Single widowed; In committed partnered relationship; Married 1st time; Married 2nd time +
5. Ethnicity: African American, Asian American, Caucasian Hispanic, Native American, Pacific Islander, other (please identify)
6. Educational Residence: In-state; Out-of State student (where originally from?)

Clinical Presentation Interview Questions:

What are your initial reactions to the clinical vignette?

How do you feel about the individuals in the vignette?

How serious do you think the couples' presented interaction is?

What struck you about the clinical vignette?

How do you think the details of the clients reported interaction affected how you reacted?

Regarding this vignette, what would your primary mode of therapy look like?

Ecological Influences Interview Questions:

What are the factors that influence how you define couples conflict? (Use the ecomap as an aid in identifying factors).

> What things from your family of origin reminded you of the clinical case that you watched?
> Did it stir up anything you remember from your parent's interaction or with your siblings?
>
> What things from your clinical experiences may have influenced how you

reacted to the clinical case?

What things from your unique personal life experiences may have played a part in your reactions?

How do you think your supervision experiences affected how you reacted?

How has the media influenced how you respond to partner conflict?

Tell me about your experience working with partner experiencing conflict. How has that influenced how you react?

In what ways have you been desensitized to traumatic experiences?
How do your view your role as a therapist in intervening with partner conflict?

In what way do you think your developmental level as a clinician might affect your reactions to cases with conflictual couples?

What things in your education do you believe has either helped or hindered your ability to work with a couple experiencing partner conflict like this?
How do you think certain theoretical approaches would assist you in addressing the couple's issues?

How does your own marital status affect how you react to partner conflict?

How do you feel that your own anxiety level contributes to your reactions or ability to interact with clients experiencing partner conflict?

How have your attitudes about individuals experiencing partner conflict changed over time?

How do you define partner abuse?

What messages, meanings, and beliefs do you have regarding partner abuse?

How do you make sense of abuse that occurs between partners?

Are things different if a woman abuses a man?
What about abuse within homosexual relationships?

How did each of the ecological factors you identified influence your thinking or worldview or how you understand what partner abuse is?

How has society influenced your attitudes regarding power?

How has society influenced your attitudes regarding gender?

Do you believe you, as a therapist should be an agent of social change? Why or why not?

How have you been able to deal with your personal reactions when interacting with conflictual partners?

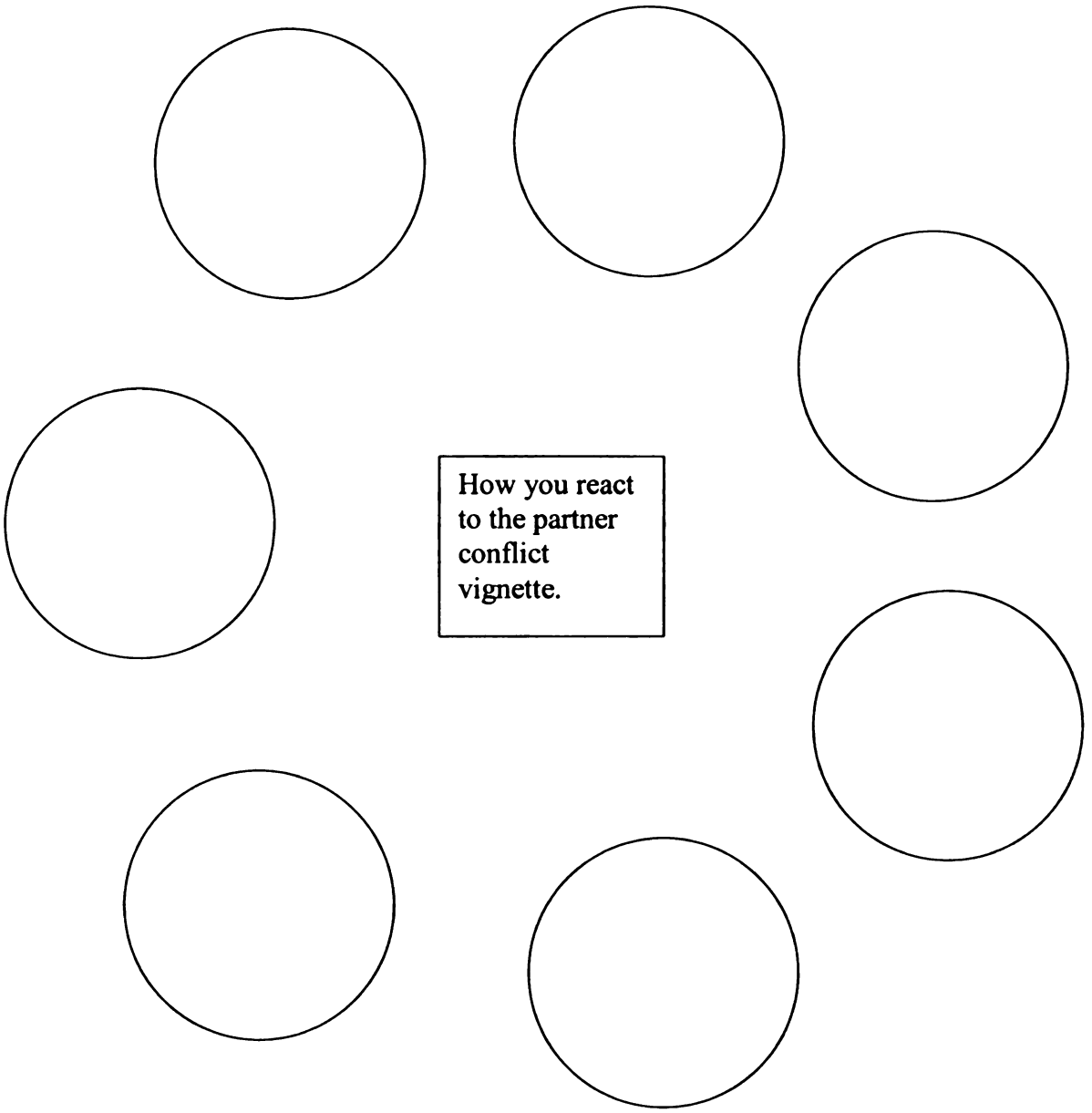
Is this something you feel that you could talk about with your supervisor?

How do your overall values, beliefs, and assumptions affect your ability to address certain aspects of partner abuse?

How do they affect your ability to join with particular clients?

How might your identified ecological factors or your belief systems affect your work with partner abuse cases?

APPENDIX E: ECOLOGICAL FACTORS ECOMAP GUIDE



APPENDIX F: DIFFERENTIATION OF SELF INVENTORY

(SKOWRON & FRIEDLANDER, 1998)

These are questions concerning your thoughts and feelings about yourself and relationships with others. Please read each statement carefully and decide how much the statement is generally true of you on a 1 (not at all) to 6 (very) scale. If you believe that an item does not pertain to you (e.g., you are not currently married or in a committed relationship, or one or both of your parents are deceased), please answer the item according to your best guess about what your thoughts and feelings would be in that situation. Be sure to answer every item and try to be as honest and accurate as possible in your responses.

1. People have remarked that I'm overly emotional.
2. I have difficulty expressing my feelings to people I care for.
3. I often feel inhibited around my family.
4. I tend to remain pretty calm even under stress.
5. I'm likely to smooth over or settle conflicts between two people whom I care about.
6. When someone close to me disappoints me, I withdraw from him or her for a time.
7. No matter what happens in my life, I know that I'll never lose my sense of who I am.
8. I tend to distance myself when people get too close to me.
9. It has been said (or could be said) of me that I am still very attached to my parent(s).
10. I wish that I weren't so emotional.
11. I usually do not change my behavior simply to please another person.
12. My spouse or partner could not tolerate it if I were to express to him or her my true feelings about some things.
13. Whenever there is a problem in my relationship, I'm anxious to get it settled right away.
14. At times my feelings get the best of me and I have trouble thinking clearly.
15. When I am having an argument with someone, I can separate my thoughts about the issue from my feelings about the person.
16. I'm often uncomfortable when people get too close to me.
17. It's important for me to keep in touch with my parents regularly.
18. At times, I feel as if I'm riding an emotional roller coaster.
19. There's no point in getting upset about things I cannot change.
20. I'm concerned about losing my independence in intimate relationships.
21. I'm overly sensitive to criticism.
22. When my spouse or partner is away for too long, I feel like I am missing a part of me.
23. I'm fairly self-accepting.
24. I often feel that my spouse or partner wants too much from me.

25. I try to live up to my parents' expectations.
26. If I have had an argument with my spouse or partner, I tend to think about it all day.
27. I am able to say no to others even when I feel pressured by them.
28. When one of my relationships becomes very intense, I feel the urge to run away from it.
29. Arguments with my parent(s) or sibling(s) can still make me feel awful.
30. If someone is upset with me, I can't seem to let it go easily.
31. I'm less concerned that others approve of me than I am about doing what I think is right.
32. I would never consider turning to any of my family members for emotional support.
33. I find myself thinking a lot about my relationship with my spouse or partner.
34. I'm very sensitive to being hurt by others.
35. My self-esteem really depends on how others think of me.
36. When I'm with my spouse or partner, I often feel smothered.
37. I worry about people close to me getting sick, hurt, or upset.
38. I often wonder about the kind of impression I create.
39. When things go wrong, talking about them usually makes it worse.
40. I feel things more intensely than others do.
41. I usually do what I believe is right regardless of what others say.
42. Our relationship might be better if my spouse or partner would give me the space I need.
43. I tend to feel pretty stable under stress.