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Georgia Louise Banks
Taking the Bait:
Countertransference Among
Female Clinicians Who Work
with Men Who Batter

ABSTRACT

This study was conducted to explore the countertransferential responses in female clinicians who work with men who batter and to determine if the clinicians felt adequately trained and supported in their unique positions within the field of abuser intervention. Participants included nine female clinicians from the mid-Atlantic region of the United States who work or have worked with men who batter. The participants answered and expanded on five open-ended questions (three on clinical experience, and two on recommendations for the field) during an audio-recorded interview that lasted approximately one hour. The clinical questions asked participants to discuss (1) their motivations for working in the field of abuser intervention, (2) their feelings of being a female working with men who batter their female partners, (3) the range of feelings they have felt while working with men who batter.

Some of the major findings of the research showed that all participants had experiences of their clients violating boundaries, generalizing women, and disrespecting the participants because they were female. The above behaviors and transferences of the clients were triggers for the participants and created a variety of countertransferential reactions including but not limited to feelings of being dismissed, offended, and objectified. Also notable was the participants' ability to process these reactions and look at the clients' behaviors from a wider perspective—from a place of understanding of the

whole client and path that brought him into treatment. Once the clients' behaviors were better understood the participants could move the treatment forward.

TAKING THE BAIT:
COUNTERTRANSFERENCE AMONG FEMALE CLINICIANS
WHO WORK WITH MEN WHO BATTER

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION	1
II LITERATURE REVIEW.....	3
III METHODOLOGY	18
IV FINDINGS	22
V DISCUSSION.....	37
REFERENCES	48
APPENDICES	
Appendix A: Initial Email.....	51
Appendix B: Follow-up Email.....	52
Appendix C: Consent Form	53
Appendix D: Interview Questions.....	55
Appendix E: Human Subjects Approval Letter	56

CHAPTER 1

INTRODUCTION

Intimate Partner Violence (IPV) is, what some consider, an epidemic in the United States resulting in thousands of deaths every year and countless bruised bodies, traumatized children, and shattered families (Department of Health and Human Services). IPV is treated in different ways. Historically in the United States, the focus of fixing this problem has been on treatment, resources, and support for the survivors of IPV. This approach—putting a Band-Aid on the survivor to help heal the pain—is helpful, but IPV is still prevalent and causing harm to millions every year (Department of Health and Human Services). Within the past three decades, however, treatment programs for men who batter became increasingly frequent (Roman, 2000). This was a step in the right direction towards treating the problem rather than treating the outcome of the problem.

Treatment programs for men who batter are now offered within many organizations that work to end IPV. A number of treatment modalities have been developed for treating men who abuse their female partner (Pence & Paymar, 1993). The efficacy of these different programs has been researched and consequently multiple views exist on which treatment program is the most effective (Pence & Paymar, 1993). Yet among the differences in treatment modality, the core concept and goal of treatment is agreed upon by all: violence is a learned behavior and therefore has the possibility of being un-learned (Pence & Paymar, 1993).

Most abuser intervention programs require one male and one female clinician to co-facilitate the groups for men who batter. Many of the men who attend abuser intervention programs are struggling with issues of power and control, especially around gender dominance. With that being said, it is a given that transference and countertransference issues come up frequently for the male perpetrators and the female facilitators, respectively. These issues of countertransference in female clinicians who work with men who batter need to be acknowledged and explored as to not impede, but to further, the therapeutic work with the client and/or group.

This study was conducted to explore the countertransferential responses in female clinicians who work with men who batter and to determine if the clinicians felt adequately trained and supported in their unique positions within the field of abuser intervention. It is this researcher's belief that if female clinicians working with men who batter have the support, resources, and training necessary, then the efficacy and authenticity of the relationship and treatment with men who batter will positively increase. In addition, if female clinicians working with men who batter can not only process their countertransference and understand its origins, but also look at the clients' behaviors from a wider perspective—from a place of understanding the whole client and the path that brought him into treatment—then the clinicians can move the treatment forward in a positive way. More support, more understanding, and more effective treatment will equal less violence.

CHAPTER 2

LITERATURE REVIEW

The following is a review of past and present literature that informs the current understanding of countertransference among female clinicians who work with men who batter. There is very little literature and research on this specific topic. Therefore this literature review begins with the development and understanding of countertransference as defined by Freud. The expansion and further development of countertransference over the years, as understood by different groups of thinkers and theorists, will also be briefly examined to better understand this study. The literature review will then move into a broad understanding of gender issues in psychotherapy, and transference and countertransference in cross-gendered psychotherapy (specifically the male client, female clinician dyad). Finally, the philosophy behind abuser intervention programs will be explored along with the common treatment modalities used in the field. The sections that follow are to provide an understanding of the literature on which this study is grounded.

Countertransference

Freud introduced the term countertransference after his introduction of the concept of transference (Freud & Riviere, 1935). Freud first viewed transference as a disruption in the psycho-analytic treatment. However, over time transference was understood as a powerful aspect of psycho-analysis that could enhance and move the treatment forward (Mitchell & Black, 1995). Freud explained transference in two points

of view. The first was the understanding of transference in general and its causes. The second was the understanding of the unique role transference plays in psychoanalytic treatment and how the therapist should deal with it. According to Freud, every person has specific characteristics that form the way s/he lives life. Patterns emerge for dealing with and understanding certain situations. These characteristics and patterns evolve from early life experiences and unfulfilled desires. For Freud, transference is this unconscious and repetitious behavior that is rooted in one's personality (Freud & Riviere, 1935). In psycho-analytic treatment transference is the client's unconscious and repetitious behavior that is projected onto the psycho-analyst. The client unconsciously acts out past or unresolved situations in his/her life and sees the psycho-analyst not as the psycho-analyst but as some other important figure in his/her life.

Freud understood transference in psycho-analytic treatment as resistance to the treatment, and he emphasized the importance of interpreting the transference. Freud wrote about the difficulty and importance in managing transference.

Every beginner in psycho-analysis probably feels alarmed at first at the difficulties in store for him when he comes to interpret the patient's association and to deal with the reproduction of the repressed. When the time comes, however, he soon learns to look upon these difficulties as insignificant, and instead becomes convinced that the only really serious difficulties he has to meet lie in the management of the transference (qtd. In Esman, 1990, p.37).

Similarly to Freud, Klein's stance is that transference operates throughout all of life and influences all human relations (Mitchell & Black, 1995). However, unlike Freud, Klein did not see transference as a form of resistance to treatment. Because Klein viewed the psycho-analytic relationship as a more enmeshed and equally active experience for both the analysand and the analyst, she understood transference within this relationship to

be the analysand's intense hope or dread associated with the analyst's interpretations (Mitchell & Black, 1995).

Anna Freud also wrote about the importance and complexity of interpreting and managing the transference. She stated that "because these impulses are repetitions and not new creations they are of incomparable value as a means of information about the patient's past affective experiences" (Freud & Baines, 1946, p.18). Anna Freud distinguishes between different types of transference and levels of complexity. With different levels of transference's complexities, there are different ways of dealing with and addressing that transference in psycho-analytic treatment (Wolstein, 1988).

Once transference was understood and adopted into psychoanalytic theory it was realized that the psycho-analyst experiences his/her own transference to the client. Freud introduced and established this concept as countertransference, referring to the analyst's unconscious and neurotic reactions to the client's transference. Because Freud believed that the psycho-analyst should be an uninvolved expert and an objective observer it is understandable that the original concept of countertransference and its existence within the psycho-analytic treatment was seen as a certain failure on the part of the analyst and potentially detrimental to the treatment (Mitchell & Black, 1995; Wolstein, 1988). This classical and early stance of Freud and others viewed countertransference as coming from repressed and regressive conflicts within the analyst which implied that the analyst had not undergone sufficient analysis of him or herself (Fauth & Hayes, 2006). Therefore, much like the concept of transference, countertransference was at first seen as an inhibitor to treatment and something to be strongly avoided (Fauth & Hayes, 2006). In the 1950's there was a shift in thinking about countertransference. Countertransference,

like transference, began to be seen as a positive therapeutic aspect of psycho-analysis. Considered by many to be unavoidable, countertransference was being addressed in research, reports, and lectures (Wolstein, 1988).

Over the years theorists have broadened the definition of countertransference (Fauth, 2006). There are differing views on the types of reactions that countertransference encompasses. According to Fauth (2006) there is a “moderate” and “totalistic” view of countertransference. The moderate definition of countertransference includes therapists’ idiosyncratic reactions (broadly defined as sensory, affective, cognitive, and behavioral) to clients that are based primarily in therapists’ own personal conflicts, biases, or difficulties (e.g., cognitive biases, personal narratives, or maladaptive interpersonal patterns)” (Fauth, 2006, p.17). The totalistic definition includes all of a therapist’s reactions to a client. This definition also encompasses subjective and objective countertransference. Subjective countertransference is an experience and reaction that is unique to the therapist. On the other hand, objective countertransference suggests that the feelings that arise within the therapist regarding a particular client are similar to the feelings that arise in most people who interact with that particular client. It is something that the client evokes in every person; it is not a reaction that is unique to the history, personality, and position of the therapist. Therapists who adopt the totalistic definition tend to see countertransference as “normal, inevitable, and potentially facilitative in therapy” (Fauth, 2006, p.17). For the purposes of this study the totalistic definition of countertransference will be adopted because it is this researcher’s assumption that both subjective and objective countertransference will be described by the participants.

Another important development in the theories of countertransference is the Hayes's categorical model (Fauth & Hayes, 2006). Hayes identified origins, triggers, manifestations, management, and effects as the five main components of countertransference (Fauth & Hayes, 2006). The development of this model created an organization for understanding countertransference and was a step towards the measurability of countertransference (Fauth & Hayes, 2006; Hayes & Gelso, 2001). However, there is a lack of research on countertransference because "the complexity and partially unconscious...nature of the construct make it inherently difficult to measure" (Fauth, 2006, p.18). For the purposes of this study (countertransference is not being measured, just explored) it may be useful to keep Hayes's organizational components of countertransference in mind so as to better understand all of the pieces that play a part in the development and workings of countertransference.

Although there are differing views of transference and countertransference, one thing is agreed upon by all: these feelings, experiences, and reactions in treatment are very real and very important. Whichever definition or organizational model one subscribes to, it is universally agreed upon among theorists and therapists alike that an awareness and understanding of transference and countertransference is necessary in order to facilitate an authentic and ultimately positive therapeutic relationship (Tyagi, 2006). It is also necessary that the therapist find support—through supervision and/or co-workers—when dealing with issues of countertransference. If there is a lack of support surrounding these issues there can be a negative impact on the therapist and on the treatment of the individual or group (Tyagi, 2006).

Cross-Gender Psychotherapy and Transference

The social construction of gender-roles has become a topic of recent research and theory development. Because gender-roles are socially constructed, they differ among cultures and countries. Gender-role socialization paradigms “begin with the assumption that men and women learn gendered attitudes and behaviors from cultural values, norms, and ideologies about what it means to be men and women” (Addis & Mahalik, 2003, p.7). Although people from many different cultures inhabit the United States of America, the country continues to be governed mostly by White, Anglo-Saxon, heterosexual men. The culture and values of these men contribute to the culture and values upon which gender-roles are constructed. In order for an individual to thrive in a patriarchal society he or she must be willing to follow most, if not all, of the accepted gender-roles.

Writers and researchers have identified masculinity ideology and masculine gender-role conflict as two important parts of gender-role socialization (Addis & Mahalik, 2003). Masculinity ideology refers to the ideas and beliefs within a social system about what it means to be a man. Researchers look at men’s beliefs and their internalization of the cultural norms and values that construct the masculinity ideologies and male gender-roles (Addis & Mahalik, 2003). These ideologies about masculinity are fluid and of course entrenched in societal expectations and norms. Masculine gender-role conflict looks at the beliefs and characteristics valued within masculine ideology and identifies the potential negative effects it can have on a man who adopts these values. As Addis & Mahalik (2003) write “for example, internalizing the ideological position that men should be tough, competitive and emotionally inexpressive can have detrimental

effects on a man's physical and mental health" (p.7). Other long-valued gender-role characteristics of masculinity in the United States include but are not limited to:

toughness, stoicism, avoidance of all things feminine, self-reliance, success at work (regardless of costs to family relationships), restricted expression of feelings, adoption of non-relational and objectifying attitudes toward sexuality, fear and hate of homosexuality, and belief in never showing weakness" (Deering & Gannon, 2005, p.351).

This gender-role socialization paradigm is directly related to a male's willingness to seek out and/or engage in psychotherapy. Any signs of weakness in the mind or body, and any need to ask for support or help from someone else, is a stark contradiction to the male gender-role, therefore affecting men's ability, or willingness, to recognize a problem or "weakness", and subsequently seek appropriate treatment (Deering & Gannon, 2005).

Several studies have shown that men seek psychiatric services, psychotherapy, and counseling services less often than women (Kessler, Brown, & Broman, 1981; Vessey & Howard, 1993). Other studies have looked at the masculinity ideology and gender-role conflict and have related them to attitudes toward "help-seeking behavior" (Addis & Mahalik, 2003). Robertson and Fitzgerald (1992) found in a sample of male undergraduate students that "success, power, competition, and restrictive-emotionality components of gender-role conflict predicted more negative attitudes toward seeking professional psychological help" (qtd. in Addis & Mahalik, 2003, p.8; Robertson & Fitzgerald, 1992).

Knowing all of the above, when a man does seek out psychotherapy, dynamics of the male gender-role socialization will be brought into the room and should not be ignored (Tyagi, 2006). Recent research and writings on psychotherapy with male clients have regarded the "difference between therapists' ...and male patients' perspectives as a

cultural divide—one that requires the same kind of cultural sensitivity given to racial or ethnic differences” (Deering & Gannon, 2005, p.352).

Pollack (2000) has observed that boys experience a “normative life cycle loss” that occurs in early childhood when cultural norms and expectations push boys away from their mothers in order to begin the development of autonomy. Pollack (2000) argues that the reaction to this “trauma” is the development of compensatory defenses in boys (Deering & Gannon, 2005). Deering (2005) writes that “in the therapeutic setting, this translates into a predictable set of defenses for men: firming of self-other boundaries, conflicts about dependency and overvaluing of autonomy” (Deering & Gannon, 2005, p.358). Therefore the environment of the therapeutic setting needs to be safe and comfortable enough for a man to relax his boundaries. He needs to establish a healthy dependency on the therapist, while at the same time maintaining a sense of masculine identity as to not feel engulfed by the therapeutic relationship (Deering & Gannon, 2005). Similar to Pollack (2000), Levant (2003) explains that through the gender-role identity process a male may learn to be un-emotional, unaware of his feelings and therefore unable to articulate and label these feelings later on in life. This is a process that Levant (2003) has termed “normative male alexithymia”. The therapist can act as a guide for the client to understand and label his feelings. This is a delicate process, however, because a female therapist’s interpretation of a male client’s feelings may be too intrusive and penetrating to that client (Deering & Gannon, 2005; Levant, R, 2003).

For different reasons related to gender-role identity, a male client might prefer to work with either a male or female therapist. The male therapist may appear to the client as holding experience, power, and an ability to fix things, whereas the female therapist

may appear to the client as caring and nurturing like a mother or girlfriend (Deering & Gannon, 2005; Gornick, 1994). A common transference that a male client may have towards a female therapist is the “pre-Oedipal mother transference, in which the male patient longs for holding and nurturing, vacillating between wishes for merger and fears of engulfment by the female therapist/mother” (Deering & Gannon, 2005, p.357).

Reacting to the anxiety and shame he may feel from participating in psychotherapy, a male client may feel eroticized transference to his female therapist, another common unconscious defense (Addis & Mahalik, 2003; Deering & Gannon, 2005; Gornick, 1994; Newirth, 2005). This sexualized transference is a way of objectifying the therapist in an attempt to avoid the intimacy that often comes with self-disclosure. The act of self-disclosure and feelings of intimacy are experienced not only within an authentic therapeutic relationship, but also within close interpersonal relationships. A male in psychotherapy who is struggling with shame, anxiety, and fear of intimacy may have a much easier time sexualizing his female therapist (putting her in the role of girlfriend or lover), thereby seemingly giving himself the comfort of control and power in the relationship (Deering & Gannon, 2005).

So as to not bring personal issues (regarding the men in her own life) into the room, a female therapist also needs to pay close attention to her countertransference. In other words, the therapist must be sure that she is not trying to get her own needs met. “Since women, be they mothers, wives, or daughters, have held the power and responsibility of being the sole confidant of men in their moments of vulnerability, women have had a unique ability to wound men” (Deering & Gannon, 2005, p.358). This distinctive situation requires female therapists to be acutely aware and sensitive in

their interpretations and reactions to male clients while remaining fully aware of their countertransference.

Erotic countertransference is one common experience of female therapists working with male clients. This includes sexual desires and/or fantasies that a therapist may have towards a client. Although this is a normal and frequent countertransferential reaction, a therapist must be aware that it exists and examine the reasons it exists. If for example, a male client's erotic transference is putting the female therapist in the role of lover the therapist may react with feelings of sexual desire in the countertransference. Through the understanding of that countertransference, the therapist can gain more information and understanding about her client's need to seduce or woo her and can therefore move the therapy forward (Newirth, 2005; Russ, 1993).

Fear and disgust in the countertransference is yet another possible experience, perhaps more common in a female therapist/male client dyad. In a study developed to gain information about women treating men, Gornick (1994) found that female therapists who reported fear in the countertransference felt that way due to a client's "account of violent fantasies or actions directed toward women...[or] an identification with the female objects of [his] derogations and a sense that the derogatory remarks were directed toward them—that is, transference displacements" (p.246). Gornick (1994) did not find any discernable differences in the level of experience among the therapists who reported fear of male clients. Of course working with a male client who is in treatment for violent behavior can increase the potential for fear, disgust, or hate in the countertransference.

Although the full range and extent of countertransferential reactions that female clinicians may experience while working with violent men, specifically men who batter

women, is not conclusive, a variety of factors are at play as mentioned in the Countertransference section of this literature review. The therapist's personal history and personality characteristics will affect her countertransferential reactions. Likewise, a male client's history and personality will affect both his transference and the reactions he induces in the therapist. For example, three female therapists (one of whom is a survivor of intimate partner violence, one who witnessed her father abuse her mother, and one who has never been personally involved in physical violence) will each have different countertransferential reactions to a male client convicted of intimate partner violence. Whether it is a role that a client unconsciously gives the therapist, or feelings that the client evokes in the therapist, all countertransference has the ability to be facilitative in therapy if acknowledged, examined, and used in an appropriate, therapeutic way.

Abuser Intervention Program

Due to socially constructed ideologies of masculinity and gender-role behavior—as discussed in the Cross-Gender Psychotherapy and Transference section of this literature review—males are often reluctant to seek out and engage in therapy. However, a male convicted of intimate partner violence who is encouraged to seek treatment may hold all of the socially constructed views of masculinity and may also be unwilling or unable to acknowledge his negative behaviors—behaviors that may have been producing his desired outcomes. If a male is unwilling to voluntarily attend therapy, but a court mandates that he go, this no doubt affects the treatment. It may be more difficult and take longer to fully engage the client in treatment, develop a therapeutic relationship, and move the treatment forward. There will also be added resistance and transference to

work through at the beginning of the relationship, especially in relation to female clinicians. But these men—those unwilling or unable to acknowledge their negative behaviors—will continue to be forced into treatment because of the underlying belief of Abuser Intervention Programs that “within us all is the capacity to change” (Pence & Paymar, 1993, p.xiv).

Abuser Intervention Programs most commonly implement Psycho-educational or Cognitive Behavioral group treatment modalities aimed at supporting a man’s process of change toward nonviolence (Pence & Paymar, 1993). There are a couple of Abuser Intervention models in existence. The models most commonly known and used are “The Duluth Model” and “EMERGE”. These two organizations have printed and online resources available, hold frequent conferences on the subject of intimate partner violence, and offer trainings on the implementation of abuser intervention programs. Many abuser intervention programs use components from one or both of these models and ultimately structure a unique model for their own organization. EMERGE is an organization based in Boston, MA and has a philosophy and model of abuser intervention that is similar to the Duluth Model. Because the programs represented by participants in this study do not adhere strictly to any one model, only the Duluth Model will be briefly discussed to give the reader an understanding of what an abuser intervention program looks like.

The philosophy and structure of The Duluth Model, A Process for Change, came out of the Duluth Domestic Abuse Intervention Project, based in Duluth, Minnesota. The theory that guides practitioners of the Duluth Model is that violence is used to gain power and control over the behaviors of others and that unlearning that violence is possible.

This curriculum is designed to be used within a community using its institutions to diminish the power of batterers over their victims and to explore with each abusive man the intent and source of his violence and the possibilities for change through seeking a different kind of relationship with women. (Pence & Paymar, 1993, p.1).

The curriculum includes eight themes (nonviolence, nonthreatening behavior, respect, support and trust, accountability and honesty, sexual respect, partnership, and negotiation and fairness) that focus on the power and control tactics most often used by men who batter. An assortment of methods are used, such as discussions, handouts, role-plays, videos, and stories. The treatment goals are for the batterer to acknowledge and take responsibility for his violent or abusive behavior, to show understanding of the impact that his abuse has on the victim, to agree to begin the process of change by looking closely at his decisions and attitudes that perpetuate violence, and to adopt non-violent choices and attitudes (Pence & Paymar, 1993).

All abuser intervention programs, ideally, have one male and one female facilitator co-lead the groups. The multiple reasons to have a male and female facilitator is explained below.

(A) a co-gender team will model respectful behaviors and demonstrate equitable power sharing between the two genders (b) seeing the female counselor as being on par with the male counselor will give group members an opportunity to observe women in non-stereotypical positions of power and authority and, (c) as a woman in a male dominated society, the female counselor will bring a different and important perspective to the all male group (Tyagi, 2006, p.4).

The facilitator's job is to encourage reflective and critical thinking about violence, to keep the focus on the perpetrator's violence and ways to change, and to immediately stop any victim-blaming (Pence & Paymar, 1993).

The abuser intervention programs represented in this study use some of the curriculum advice from both the Duluth Model and the EMERGE model. In addition to formal education, some of the participants have been through the training program of the Duluth Model, some of the participants have been through the training program of the EMERGE model, some participants have been through both training programs, and some participants have just received on-site training from the abuser intervention program for which they work. Although components of the two different philosophies are utilized, all of the programs represented in this study adhere to the model of cross-gendered co-facilitators (i.e. a female facilitator and a male facilitator jointly lead groups). All of the programs in this study have also tweaked their program over the years in order to most effectively serve their specific clients and the greater community.

Issues of Diversity

Gender-roles and dynamics in connection with therapy and treatment have been the topic of discussion in this study, but race and ethnicity are also important aspects that inevitably affect the therapy. Just as gender-roles are socially constructed, the concept of race is also socially constructed.

Race plays a part in this research study as there are statistically more minority men attending Abuser Intervention Programs in the United States. Systemic racism and the mere fact that minorities are arrested more frequently increases the number of minorities mandated to treatment. Internal racism cannot be ignored when working with people who are not a mirror image of oneself. This of course plays into the transference

and countertransference that exists in the room. All of this cannot be ignored, but it is beyond the scope of this study.

Summary

Dealing with countertransference is an important and sometimes difficult task that all clinicians face. This task becomes even more difficult when issues of gender, power, control, and violence are the focus of the treatment. These power dynamics are imbedded in our society and immediately brought into the treatment room. In order to establish and sustain a therapeutic alliance, the clinician and client must maintain boundaries, remain aware of the heavy transference and countertransference that is evoked in this type of work, and use that transference and countertransference to move the treatment forward.

Once more is known about the countertransferential experiences of female clinicians who work with men who batter, training programs and resources can be designed and implemented to prepare and support those clinicians. This study is being conducted to gain insight on the experiences of female clinicians who work with men who batter. It is this researcher's hope that this will contribute to the field of abuser intervention.

CHAPTER 3
METHODOLOGY

Formulation

The question that guided this qualitative exploratory study was: what kind of countertransferential reactions are experienced by female clinicians who work with men who batter? In this study countertransference encompasses all feelings and reactions that a clinician may have in response to any aspect of a client's presentation. The primary purpose of this study was to gather information about the clinician's experiences of countertransference. The secondary purpose was to understand from the data the best ways to be aware of, support, and/or deal with the countertransference that arises in this specific dyad—the female clinician and the heterosexual identified male batterer client. There is a substantial amount of knowledge concerning gender and countertransference; however, very little is known specifically about female clinicians' countertransference when working with men who batter. There is also very little research on the most useful ways to acknowledge and work through this type of countertransference (Roman, 2000).

Using a method of exploratory research, individual face-to-face interviews were administered using five open-ended questions to gather narrative data from the participants. This flexible research method was used in order to get a rich narrative detailing the participants' experiences with countertransference when working with men who batter.

Sample

This researcher interviewed nine female clinicians who work or have worked with men who batter. The participants had a variety of educational and employment backgrounds. The requirements for inclusion were that the participant must have been female, English speaking, over the age of 21, and a mental health professional who had worked for at least one year within the past three years in a mental health setting with men who batter. The nature of this work must have been either group or individual treatment. Potential participants were not excluded on the basis of race, religion, or sexual orientation. The potential psychological risks of participation in this study were the potential effects of feelings that could arise when unveiling personal experiences and recalling difficult events or memories. There were two predicted potential benefits of participation in this study. One—participants were contributing to a body of knowledge within social work concerning support and training needed or helpful for females who work with men who batter. And, two—it was also my hope that the knowledge that comes out of self-reflection would be beneficial to participants in similar future situations. There was no economic compensation for participating in this study.

Recruitment efforts took place at Abuser Intervention Programs in urban areas in the Mid-Atlantic region in the United States. This researcher chose to recruit in this region because of professional contacts within the field there which helped in finding an appropriate sample size within the small field of Abuser Intervention. Initially this researcher contacted clinicians through an Abuser Intervention Coalition list serve. The initial email very briefly described the researcher, the research project, and what participation in the study would entail (see Appendix A). If interested, the potential

participants responded by email and at that point a follow-up email was sent to the clinicians with a more detailed description of this research study, the process of participating in the study, and the inclusion criteria for participation (see Appendix B). At that point, if they wanted to participate in the study and if they fit the criteria, initial verbal consent was obtained over the phone and a face-to-face interview was scheduled. All interviews were conducted at participants' place of employment. Before the start of the interview two informed consent forms were signed by the participant (see Appendix C). The participants were expected to engage in an hour long interview. During the interview participants were first asked to provide some demographic information about themselves. Then participants were asked to answer and expand on five prepared open-ended questions (see Appendix D).

Data Collection

The data gathered through this research study was qualitative. This researcher collected narrative data through audio recorded, face-to-face interviews with the participants. Immediately following each interview, this researcher wrote down anything that stood out about the participant's appearance and/or body language. All of the identifying information collected during the interviews was carefully disguised for this study. All of the information collected through the interviews was kept in a locked box while traveling to and from the interviews. Transcriptions were done by the researcher in the privacy of her own home. Once transcribed, a number system was attached to the participants; at that time this researcher's advisor had access to the transcribed information.

Data Analysis

It is possible to code qualitative narrative data in a similar way to the numerical coding that takes place in quantitative research (Anastas, 1999). This is appropriate when looking for a numerical piece in the narrative design. This researcher kept this in mind when going through three parts of the process of data analysis—data reduction, data display, and conclusion drawing (or verification). The data was coded separately for each question; the data was then broken down into the most common categories found in the responses to each question and numbered. Similar responses to the same question that appeared in two or more participants' narratives were recorded as significant. Outliers, or differing responses to the same question among participants, were also recorded as significant. Perhaps the most important piece of the data analysis for this researcher was to efficiently utilize a coding technique that helped with the conceptualization of different poignant categories within the narratives. Anastas (1999) also discusses the importance of self-awareness and skepticism when analyzing data. This researcher was sure to check personal biases as much as possible per usual when interacting with people. Expected findings for this study were that countertransference feelings of fear, anger, and disgust among the participants, and a lack of training and support within participants' unique position would be frequent themes.

CHAPTER 4

FINDINGS

This study was conducted to explore the countertransferential responses in female clinicians who work with men who batter. In order to further understand female clinicians' experiences in the field, each participant was asked to answer and expand on three clinical questions related to their direct experience working with men who batter. The three clinical questions were: 1) What were your motivations for working in the field of abuser intervention? 2) How do you feel being a female working with male clients? 3) Tell me the range of feelings that you have had while working with this particular population (see Appendix D). The secondary purpose guiding this study was to find out the best ways to be aware of, support, and/or deal with the countertransference that arises within this specific dyad—female clinician, self identified heterosexual male batterer. After the participants answered the clinical questions they were asked to respond to two questions regarding recommendations for the field. Those questions were: 1) Do you have any recommendations for support or training that you think may help future clinicians in this field? 2) If your best friend came to you and said, "I want to work in the field of abuser intervention," what would you tell her? (Appendix D).

The sample used in this study included nine female clinicians between the ages of twenty-five and fifty-five. Two of the women were African American while the remaining seven were Caucasian. The education level of the participants broke down into three licensed clinical social workers, three master's in counseling psychology, one

master's in human services, and two bachelor's of arts (one in psychology and the other in sociology). The years of experience in the field of abuser intervention varied among the participants from one year to twenty-three years. The participants worked in urban environments in the mid-Atlantic region. The sample was gathered through professional contacts throughout the mid-Atlantic region. After nine participants were interviewed, data collection stopped due to the limited number of abuser intervention services in the mid-Atlantic region, and therefore the exhaustion of available resources and eligible participants.

The findings of this research study reflect the views of the participants and therefore reflect the experiences of only two races. Race is an important part of who someone is and so it is acknowledged that the majority (7 of 9) of participants in this study are Caucasian with a minority (2 of 9) of African American. As stated previously the abuser intervention programs involved in this study were located in urban areas. The majority of the men who were court-ordered to attend these programs were African American. This point illuminates the systemic racism that continues to operate in our legal system and throughout the United States.

This researcher remained aware of personal biases while analyzing the data. However, race, gender, age, education, experience in the field, and personal beliefs all impact how the data was organized, understood, and reported. Due to the small number of participants and the nature of this research study, these findings can not be generalized to the entire field of abuser intervention.

There were two responses to question one (what were your motivations for working in the field of abuser intervention) that were most prevalent. All participants (9

of 9) said that their motivation came from wanting to affect change and end abuse. They felt that abuser intervention programs had the power to change abusive behaviors, stop the abuse, and protect women. A majority of participants, 66.6% (6 of 9) stated that they began working with survivors of intimate partner violence and felt that the work, while much needed, was one-sided and more focus should be on changing batterers' behavior in order to prevent abuse. A minority of participants, 33.3% (3 of 9) said that they began this work through an internship and felt that it suited them well and stayed in the field. Only 22.2% (2 of 9) of participants disclosed that a personal history of abuse made them understand the pervasiveness of abuse and its affects on extended family and friends.

In response to question two (how do you feel being a female working with male clients), 100% (9 of 9) of the participants said that the batterers made generalizations about females which in turn created a variety of feelings among the participants. Boundary violation was the second most common response—77.7% (7 of 9) of participants stated this as an issue. A majority of participants, 66.6 % (6 of 9) also discussed feeling dismissed into a stereotype of a woman by batterers. A minority of participants, 44.4% (4 of 9) discussed safety as a general issue but stated that it is rare that they are made to feel unsafe through interactions with the batterers. A small number of participants, 33.3% (3 of 9) disclosed that they thought they would encounter more feelings of fear and disgust while working with batterers than they actually did.

Question three asked participants to discuss the range of feelings experienced while working with this particular population. All participants (9 of 9) said they felt compassion and empathy for the batterers. Of the nine participants, seven stated that they felt frustration; 77.7% (7 of 9) also said they felt disappointment. A majority of

participants, 66.6% (6 of 9), also stated that they felt honored to work with the batterers and were proud of their accomplishments. And 55.5% (5 of 9) of participants remarked feeling cautious in their work with batterers. A minority of participants, 44.4% (4 of 9), mentioned feeling disrespected. A minority of participants, 33.3% (3 of 9), mentioned disgust, and 33.3% (3 of 9) mentioned anger. Interestingly 33.3% (3 of 9) of participants said that their negative feelings were connected to their level of fatigue, and only 11.1% (1 of 9) of participants said that they have yet to encounter feelings of fear or intimidation.

In response to question one (what were your motivations for working in the field of abuser intervention), 100% (9 of 9) of participants stated that working in abuser intervention felt like a more powerful place to affect change and end abuse. One participant said, “The thing that interested me about [working in abuser intervention] was that it was the only program that, if you are going to stop the violence it needs to stop with the men that are perpetrating the violence. So while victim services are completely needed and powerful, working with abusers was a really really unique experience because this is where the power of stopping the violence is.” Another participant said, “I sort of like the tag line of changing domestic violence from a women’s issue to a men’s issue. We need to depend on men to make the behavior change.” Another participant said, “I didn’t really know too much about any program like [abuser intervention]. And when I started [working in this field] I kept looking at it like drugs. As long as there are drug dealers on the streets we’re going to keep having addicts. Once I started to work [in abuser intervention] I became much more passionate about working with the batterers and I feel like I’m making more of a difference than if I’m working with survivors.”

Another participant said, “I feel like it feels like a more powerful place to do work than how I felt when working with people who were being abused. You have so little control when you’re working with people who are being abused. Not that I have much control now. But you can help the victim figure out a safety plan, who she should call, where she can go, and legal options. But when you’re working with a guy who’s stalking you can do some work. Whether it’s effective or not, it feels like a place where you can leave some impact.”

Of the nine participants, six responded to question one stating they started working in victim services and felt that the work was one-sided. One participant said, “I worked a lot with women who had been battered and I realized that there weren’t a lot of people doing this kind of work [abuser intervention] so it just felt a little one-sided. It wasn’t a holistic approach to solving the problem of domestic violence; it is pretty much just what we do for the women who are being battered. And although I loved the work [with battered women] and it felt very rewarding I also felt that I wanted to be involved in doing something on the other side.” Another participant said, “Having had to work with so many people who are survivors of domestic violence just made me realize that both sides of the work are really important...I started doing the domestic violence hotline and counseling and I felt like there is all this work with survivors of domestic violence and that’s great but there’s just this small amount of services out there for men who are abusive.”

A minority of participants, 33.3% (3 of 9), said that they began working in this field through an internship and stayed in the field. One participant said, “Once I ended up here [an abuser intervention agency] for my internship it was very interesting because

it was the opposite kind of end of what I wanted to do...part of my desire was to work more with victims rather than with batterers, but I think that working with the batterers of course just gives understanding to both sides and I enjoy the work with the batterers.”

Another participant said, “When I got here [an abuser intervention agency] I was introduced to the domestic violence program as an intern...once I got into it and sat in on the groups it was something that I really did connect with, partially because our main goal is to prevent abuse and protect the victim. Working with these men does give you the opportunity to help an unknown person hopefully.”

In response to question two (how do you feel being a female working with male clients), 100% (9 of 9) of participants said that batterers made generalizations about females which in turn created a variety of feelings among the participants. One participant said, “There is a little static because they [the batterers] are identifying you as a female and so they think you are not going to care...they look at me as just another woman who is not going to understand or be fair because their partner wasn't fair or their parole officer is a woman and she's not fair.” Another participant said, “Sometimes their [the batterers'] comments are so general and they want you to represent all women. You know they are trying to get the women's voice in the group room so they'll be like 'why do y'all do that?' ...I always struggle with limiting my self-disclosure in an attempt to sort of defend myself.” Another participant said, “I would say at the end of the day to people that my job is standing up for myself. It's draining. Especially on days that I ran groups, I heard so many negative stereotypes and beliefs about women. So, as the only woman in a group that is sometimes twenty-three men and having to say wait a minute you know not all women are money hungry whores and lets talk about why, and let's talk about

where you learned that.” And another participant said, “I have a strong personality so I have a lot of guys who if they have issues with women or women in authority they just don’t like me, and I run into that time and time again. They think I pick on them.”

A majority of participants, 77.7% (7 of 9), said that boundary violation was an issue when responding to question two. This included the batterers flirting with and manipulating participants. One participant said, “One of the things that I think all of the women in my program have experienced is the inappropriateness that some of the male clients exhibit, especially when they first come in before we’ve drawn the line, before we tell them that doesn’t fly here. There are the ‘sweetie’ comments, ‘okay baby doll’, ‘honey’...it feels like they are coming in with their assumptions of superiority so it feels like a slight at first, like that’s what they are trying to do. And sometimes it’s just like it’s their culture as men.” Another participant said, “I’m sure the male counselors don’t get the crap ‘oh there is my beautiful social worker,’ ‘oh thank you honey,’ you know, things like that...but it does bother you, the other advances of ‘oh I’m so glad I got a good-looking counselor’ and ‘I work so much better with female counselors because they are so much easier to work with.’ And that just brings you back to this is what he does to women. You know he puts them on the spot and it’s so obviously degrading.” Another participant said, “When you get the guys that hit on you...they might call you baby or something like that and I’m like ‘no, I’m not your baby.’ Then they are like ‘oh sorry I didn’t mean it.’ I think it’s natural. It’s all about manipulation. When it’s my co-facilitator they are like ‘you’re a man, you understand my struggle,’ and when it’s me it’s ‘you know let me try to flirt with you and then maybe I can get what I want.’” Another participant spoke to the change in dynamic that she has experienced over her twenty-

three years in the field. She said, “When I first started working with these guys I was like thirty-two or something. The dynamic was very different because I was a young person working with a different population and I was looking like their girlfriend or their wives and now that I’m fifty-five I can be their mother. When guys want to flirt with you or try to manipulate you in a way that you’re their girlfriend...not that it’s completely gone but it’s a lot easier for me now because they are seeing me as a mother and it gets rid of that sexual dynamic. When guys come at you in that [sexual] way and you put the wall up it creates an additional dynamic that pisses them off and it’s another barrier that you have to get through in order to be able to work with them.”

A majority of participants, 66.6% (6 of 9), discussed feeling dismissed into a stereotyped category of women by batterers in response to question two. One participant said, “What happens is that men will connect with one another about how ‘you know how women like to shop’ or ‘you know how women can get’ and these views become touchstones of knowledge that they have about women and sometimes I’ll feel they are being dismissive of me.” Another participant said, “I think I have a unique position and feel like things have changed for me since I became program manager as far as the way guys speak to me. It has made me aware of the power dynamic change as well as the gender issue and it’s been interesting to see those two dynamics at play because certainly I was dismissed all the time when I was just a group facilitator or just a court monitor, but my title has had a strange effect on things.”

A minority of participants, 44.4% (4 of 9), mentioned general safety as an issue, although they said it was rare that they feel unsafe. In response to question two, one participant said, “There is the issue of basic safety. I spend a lot of time alone with

strange men in a room. Really I'm often alone in the office suite when I do evaluations. And I think that there are ways, and times, and people who have made me feel unsafe, or nervous, or worried, but not typically." Another participant said, "I can recall three clients in my past who the minute they sat down in my office I did not feel safe with them. And that was kind of a gut instinct initially but also because they had very violent pasts with women and I just did not feel safe with them."

Of the nine participants, only three said that they thought that they would have more feelings of fear and disgust while working with batterers. In response to question two, one participant said, "In the beginning, before I actually started doing this work, I thought that I would be very angry and disgusted...but have come to find out that I was more compassionate than I thought I would be." Another participant said, "When I sat in on the group it [working with men who batter] got less scary to me than what I had imagined. I didn't know how it [working with men who batter] would feel, I thought I might even be scared and feel intimidated...so I think at first it was very much not knowing but imagining more fear."

In response to question three (tell me the range of feelings you have had while working with this particular population), 100% (9 of 9) of participants said they felt compassion and empathy for the batterers. One participant said, "It's rare that I really don't like a client and there are definitely clients, one very recently that I have a lot of empathy for because one of the things we do during the psychosocial is talk about their family history, and a lot of these clients' history is pretty traumatic." Another participant said, "I feel compassion for them. They too have to live within this structure that isn't working for them and that makes me feel empathy, it makes me feel compassion."

Another participant said, “I have compassion for these men and the horrible things that have happened to some of them. There is a way of having compassion and saying, ‘I’m sorry that happened to you,’ and at the same time holding them accountable for all of their choices.” Another participant said, “I have compassion for their plights or whatever happened to them that led them to have this kind of behavior. In recognizing that a lot of it was learned behavior based on things that happened in a family of origin and not even necessarily in a family of origin but the way they were raised. So then the compassion came along.”

A majority of participants, 77.7% (7 of 9), said they felt frustration. In response to question three, one participant said, “Frustrated. You know, no matter how many times you work with someone on something and you come out with good solutions and you write them down and you talk about them and how you can use them, and then they still do the same thing. That’s definitely frustrating.” Another participant said, “And it’s frustrating because you have seen strides in this person. Then you hear from the partner about his behavior at home and you think, ‘oh he’s not changing at all.’” Another participant said, “Um, frustration a lot. I’m trying to think of the feelings that I have had the most...frustrated, frustrated, frustrated.”

A majority of participants, 77.7% (7 of 9), said they felt disappointment. One participant responded to question three with, “I actually wonder if there are any feelings that I haven’t had working here. I often feel quite connected to the clients and sometimes I feel disconnected from the clients. I feel sad to hear people’s stories. I feel horrified to hear people’s stories, both the things that people have done to their partners and their kids, and things that have happened to them in their lives. So empathy, disappointment,

and hopelessness about whether or not people are capable of change...I guess the whole gamut.” Another participant said, “Disappointed. It’s not just that you’re disappointed and disgusted but you’re also exhausted.” Another participant said, “Probably the most common feeling I have is disappointment, yeah probably disappointment.”

A majority of participants, 66.6% (6 of 9), said they felt honored to work with batterers and proud of their accomplishments. In response to question three, one participant said, “The work that some of these men do is wow. It is so amazing. There’s this look. It by no means happens everyday. If you get two or three a year, there is a moment when you look at them and something goes behind their eyes and they’re taking that huge risk of letting you in and it blows me away every time I see it because they are so vulnerable and they are so scared that they’ve reached a point where their lives are so painful and so miserable and you can build that trust up in them and I mean that’s our biggest job is to let them know that we are rooting for them, we are there to try to help them, we are not the enemy. That moment when that happens, that is why I keep doing the work. I feel honored to work with a lot of these men.” Another participant said, “My God do some of these men walk around so imprisoned by their own lack of self-acceptance. And it’s always really powerful when there is a breakthrough. So a lot of times group was uplifting and encouraging and I felt honored to do this work.”

Of the nine participants, five mentioned feeling cautious when working with batterers. In response to question three, one participant said, “Cautious always. One thing I hate about this office is that this is how I sit in session, with my back to the door, and there is not really any other way that I can arrange the office. So I’m cautious and I always try to keep people calm. Like I said, I’ve never had to push the panic button but I

have gone out to check my car sometimes after people leave.” Another participant said, “This city is small...and so when I am out and about with friends, at concerts and seeing guys on the street you know...sometimes I do worry about if I did rub somebody the wrong way what would happen in the street. I guess those are the times that maybe fear or discomfort comes into play. I guess it has to affect the work. I mean I think anything that you do affects your work. Maybe I’m more cautious, but if I feel your case is going nowhere or I need to put you out of group, I will.”

Of the nine participants, four said they felt disrespected. In response to question three, one participant said, “You get these guys who when they speak to me it’s very smug and it’s very disrespectful. I have one guy now, he speaks to me like I’m a child and all that stuff but he does it in this air. It’s almost chauvinistic.” Another participant said, “Some guys will target you and bate the female facilitator to get a rise out of her so it’s good to have the male facilitator where you can say he is bating me and I may fall for it and I need you to back me up and you need to address the disrespect to the female facilitator.”

Three of the nine participants mentioned feelings of disgust. In response to question number three, one participant said, “Occasionally disgust and sometimes that depends on my fatigue level, how long it’s been since my last vacation. Often it happens when I’m doing a group by myself...and the guys are all really negative and I just get this feeling of ‘F’ it. You just want to get up and walk out of the room and say, ‘you guys are all pigs, come back when you want to work.’ However, one can’t do that.”

A minority of participants, 33.3% (3 of 9), mentioned feelings of anger. In response to question three, one participant said, “When I am hearing the men report

abuses, or hearing them talk about their partners, can be really hard to hear sometimes so I'll feel things like anger...sometimes I also have these physical reactions and my heart is just pounding when they are telling me stories of abuse and I'm trying to give feedback without talking shaky like my heart is pounding because I'm so furious." Another participant said, "At the beginning I would get angry. I would hear his story and then when I gave the client feedback I would, I think one time what's the worst I think the worst thing I said was that I told a guy he was disgusting. And he never came back to group after that. And I felt so bad. And my supervisor, she said you have got to find ways to not be that angry, and if you are you can't show it like that. So there was this whole transition for me to the point where I am now, which is midway—appropriately hard when I need to be, and also compassionate and consider everything else that makes up the client as an individual because it's not just the abuse that makes that person."

A small number of participants, 22.2% (2 of 9), mentioned feelings of hopelessness. In response to question three, one participant said, "There are times where I walk out of group and I feel particularly hopeless because it's week eight and this person is engaging in the same behaviors. So I have very little hope that they're going to change because they haven't changed in a very high accountability group. Certainly in two weeks when they are out of group and they've satisfied the requirements for the course of attending [an abuser intervention program] and I know that they are not likely to change, something else is probably going to have to happen in order for them to change. So that can be a little scary and hopeless at times."

In response to question three, only one participant expressed never feeling any type of fear or intimidation. This participant said, "I have never been particularly fearful

or intimidated or any of those things. I think maybe a lot of that has to do with me personally. Just my own upbringing and the things I've been through in my life. I'm not very easily intimidated by a man just in my general overall life and that's translated into my work.. I have yet to feel fear or intimidation.”

Two questions were asked regarding recommendations for the field. 1) Do you have any recommendations for support or training that you think may help future clinicians in this field? 2) If your best friend said, “I want to work in the field of abuser intervention,” what would you tell her? In response to question one, 100% (9 of 9) of participants said that supervision is essential and should be required of all staff that do this type of work. One participant said, “I think as you are going through social work school and when you're getting your license you have to go through supervision, and I think one recommendation is that you should always have supervision. Full-time staff get supervision but as part-time staff you don't get the supervision that the full-time staff gets.” Nine of nine participants said that it would be nice to have either formal training or some best practices, and that continued learning and training was essential. One participant said, “I'd like some best practices. Even though everyone puts their own spin on them, I'd really like to have some best practices. I think that would be really helpful. Of course everyone thinks that their agency is doing the best. I feel that way very strongly about us. I think we are great and doing things really well, but I think that would be helpful.”

In response to question two, 100% (9 of 9) of participants also said that it is important to have a female facilitator or colleague around for support because a male facilitator cannot understand the female's experience. If there is no other female

facilitator or colleague to confide in, the participants recommended seeking out support on-line to be connected with other women doing this work. One participant said, “It is important to have the support of other women. I didn’t have that for years. I would go to work, I would run group, and I would go home. It came that I had to find support online.” Another participant said, “I think too that it’s important for females doing this work to have support from other females.”

In response to question two, nine of nine participants said that someone who is considering doing this work must know themselves and their history. It is not beneficial for anyone if someone comes into this field with unresolved histories of abuse. The intense feelings that can arise in this work can be more difficult to deal with if it is triggering past personal experiences that have not been worked through. One participant said, “I think they should be aware of their own trauma history and figure out ways to cope with that and manage that—especially if they are domestic violence survivors and trying to do this work which makes them possibly more vulnerable and possibly much more skilled to do this work.”

CHAPTER 5

DISCUSSION

The primary purpose of this exploratory study was to explore the countertransferential responses in female clinicians who work with men who batter. The secondary purpose was to understand the best ways to support the clinicians, and be aware of and deal with the countertransference that arises within the female clinician and self-identified heterosexual male batterer dyad. This chapter will connect the findings of this study to the available related literature.

Due to the nature of this study, which specifically looked at countertransferential responses in female clinicians who work with men who batter, the findings that relate directly to gender will be discussed. The operational definition of countertransference for this research will be reiterated, and the major findings will be reviewed but delineated by a separation in the findings that are specific to being a female clinician and those that are simply specific to being a clinician regardless of gender will be highlighted. These findings will then be further explored and discussed with relation to the literature. The strengths and limitations of this study will also be examined, along with how this research contributes to the field of social work.

For purposes of this study transference was defined in Chapter 2 as the client's unconscious and repetitious behavior that is projected onto the therapist, meaning, the client is acting out past or unresolved situations in his life and seeing the clinician not as the clinician but as some other important figure in his life. Anna Freud felt that because

transference is a repetitious impulse and not coming from a new creation, it gives invaluable insight and information about the client's "past affective experiences" (Wolstein, 1988). Countertransference can be understood in the same way as transference but as feelings coming from the clinician in reaction to the client. These countertransferential responses are affected and determined by a combination of the client's behavior and transference along with the clinician's own "past affective experiences" (Freud & Baines, 1946, p.18). As mentioned in Chapter 2, a totalistic view of countertransference is used in this research which includes objective countertransference, subjective countertransference—which was expressed by one participant who said, "I might find somebody very, very icky and the other facilitator will say 'Really? I didn't get that from him.' It's very, very personal."—and a belief that countertransference is natural and potentially facilitative within the therapeutic relationship.

In this chapter the data discussed will be separated into two parts: data that is specific to the clinicians' gender and data that is specific to being a clinician regardless of gender. In question one, participants were asked what their motivations were for working in the field of abuser intervention. Seven out of nine participants did not disclose experiences of intimate partner violence in their own lives. One may assume, therefore, that among two-thirds of the participants, the countertransferential reactions that these clinicians experience in response to the batterers were not coming from a place of personal history or trauma. All of the participants said they were motivated to work with men who batter because they felt it was a more powerful place to affect change, end

abuse, and protect victims of intimate partner violence. The responses to question one seem to be gender neutral.

Question two asked the participants how they felt being a female working with male clients. One hundred percent of the respondents said that they felt that the batterers made generalizations about women, which in turn created a variety of countertransferential responses in the participants. Some participants, in response to question two, claimed they felt as if the men had violated their boundaries and that they were being dismissed as clinicians specifically because they were female. Participants also said that only rarely did they feel unsafe, fearful, or disgusted around their clients. Due to the nature of the question all of these responses are considered to be gender specific.

Question three asked participants to discuss the range of feelings they have experienced while working with men who batter. All participants expressed feelings of compassion and empathy. Some of the participants also expressed feelings of frustration, disappointment, anger, hopelessness, and feeling honored to work with the men and proud of their accomplishments. These feelings can be considered to be specific to being a clinician regardless of gender. However, participants also stated that they felt as if they needed to be cautious, and that they felt disrespected at times. Feelings of caution and disrespect may be considered to be gender specific.

The responses to question two—which are specific to the female clinician, male batterer client dyad—will be the focus of this chapter as related to the literature. Participants' reports of the batterers' behaviors and actions will be explored to further understand the clinicians' manifestation and management of their countertransference. If

clinicians can pinpoint, break down, and understand the behavior that triggers countertransference, then that countertransference can be appropriately managed and facilitative in the therapy. The participants most frequently reported that batterers violated personal boundaries (e.g. flirting and manipulation) and that batterers generalized all females. If they had a problem with one woman, they might consider that problem to be universal amongst all women (e.g. if their female parole officer was unfair, all females were unfair). These generalizations were naturally extended towards their female clinicians, oftentimes resulting in dismissive behavior (e.g. resisting a female facilitator's statements, while readily accepting the statements of her male co-facilitator). It was these behaviors that most commonly triggered countertransference within the female clinicians who participated in this study.

Hayes's categorical model identifies origins, triggers, manifestations, management, and effects as the five main components of countertransference (Fauth & Hayes, 2006). This model can further a clinician's understanding of her countertransference, help her to prevent it from negatively affecting the treatment, and allow her to see how that countertransference can be facilitative in the treatment. Positively used, countertransference allows the clinician to further understand herself and her client.

The origins of countertransference—the first component of Hayes's categorical model—are related, obviously, to the batterers' enactment of transference (Fauth & Hayes, 2006). In turn, the origins of that transference among many of the male batterers can be traced back to the influence of a masculine ideology valued in the United States and the batterers' process of gender socialization within that ideology. Some of the most

commonly reported triggers—the second component—were already mentioned (boundary violation and generalization of all females). The third component—manifestations of the countertransference—were the feelings of being disrespected, dismissed, offended, alienated, and hyper aware of every action and reaction in response to the batterers’ behaviors. Some of the different ways the clinicians positively managed the countertransference—the fourth component—were by demanding respect from the batterers, backing up statements with facts and articles, and discussing the countertransference with supervisors, co-facilitators, and colleagues. Due to the subjective nature of countertransference, the effects—the fifth component—varied greatly amongst participants. One clinician told their client that he was “disgusting,” and that client never returned to therapy—an obviously negative effect. But when clinicians identify the origins, triggers, and positively managed their countertransference, the potential effects were an ability to be more compassionate, to see the client as a whole person and not just as a batterer, and to understand the origins of their behaviors. For example, one participant said, “I had completely dehumanized them [the batterers], I thought they were just horrible people beyond help. So the first step was humanizing them. The second part of that was building some compassion for their flights or whatever happened to them that led them to have this kind of behavior. And, recognizing that a lot of it was learned behavior based on things that happened in a family of origin, not even necessarily in a family of origin but the way they were raised. And so then the compassion came along.” Hayes’s categorical model can help a female clinician better understand all aspects of her countertransference. As stated previously, that

countertransference is affected by the client's transference, which in turn is affected by the masculine ideology in the United States.

According to Deering (2005), the components of a masculine ideology include but are not limited to: an objectifying attitude towards women, self-reliance, never showing weakness, and a restricted expression of feelings. Participants' reports of batterers' behaviors are consistent with behaviors outlined in Deering's (2005) masculine ideology. It seems, therefore, that the clients' behaviors are partly related to the gender socialization that these men have experienced. The clients are enacting these socialized behaviors upon their clinicians, which is affecting the clinicians' countertransference. If clinicians can better understand masculine ideology, then they can meet the men where they are coming from, and better understand their own countertransference, which may lead to positive facilitation within treatment. Knowing that some of the batterer's negative behavior is, in part, a result of the gender socialization process, we can therefore see that the culture and values of masculine socialization needs to not only be evaluated but addressed.

Deering (2005) wrote that "adoption of non-relational and objectifying attitudes towards women" (p.351) is a gender-role characteristic of masculinity. The findings of this current study showed that all participants experienced objectifying behavior from their clients. These behaviors included flirting, manipulation, and a general attitude that all women were the same. These non-relational and objectifying behaviors can be seen in one way as an eroticized transference. Eroticized transference is the client's sexual feelings or behaviors displaced onto the clinician. Deering (2005), Addis & Mahalik (2003), and Gornick (1994) all suggest that an eroticized transference to a female

therapist may be a male client's unconscious defense to the anxiety and shame he may feel from participating in therapy. The anxiety and shame surrounding their involvement in therapy can be traced back to their gender-role socialization and to how they understand their role within the masculine ideology. In other words, they feel as if real men do not have problems that they need to "talk out" with a therapist.

Values of self-reliance and a belief in never showing weakness can contribute to the anxiety and transferences batterers may experience upon becoming involved in therapy. Addis & Mahalik (2003) has suggested that masculinity ideology negatively affects male's willingness to seek out and participate in therapy. According to Addis and Mahalik's (2003) study, this masculine ideology can also increase male feelings of shame and weakness once in therapy. Batterers who are court ordered to a treatment program may experience an even greater anxiety and shame. They may feel that their masculinity (in particular their notions of strength and self-reliance) is being threatened. In an attempt to maintain control and a cohesive sense of self, male clients may intensify their gender-biased behaviors towards female clinicians by using sexual comments or dismissive behaviors to gain power.

According to Deering (2005), a "restricted expression of feeling" (p.351) is one component of the masculine ideology. This was illustrated by one participant who said "we have a sheet at our agency that has probably, like, one hundred different faces on it. Because when I ask the men to tell me how they feel they say 'pissed off, angry, or mad.' That is about all of the feelings that we can get from these men so we kind of have to help them label their feelings, and understand their different feelings, and understand that all feelings are okay." Levant (2003) calls this reluctance "normative male alexithymia"—

an aspect of gender socialization wherein males may learn to be un-emotional and therefore unable to define and label different feelings. Perhaps due to normative male alexithymia, the batterers often experienced an inability to articulate and label other feelings, which caused them to resort to anger.

All participants mentioned safety, fear, or disgust as a general issue in their countertransference when working with male batterers. Gornick (1994) researched fear and disgust in the countertransference and found that female therapists who reported fear or disgust in the countertransference when working with male clients did so because of a client's "account of violent fantasies or actions directed toward women...[or] an identification with the female objects of [his] derogations and a sense that the derogatory remarks were directed toward them—that is transference displacements" (p.246). When a batterer makes derogatory remarks about his partner, the female clinician may feel as if those remarks are directed towards her as well, because of the batterer's pre-established attitude that all women are the same. The batterer's generalization of females may increase the clinician's "identification with the female objects" (Gornick, 1994, p.246) simply by virtue of the clinicians' countertransferential feelings of being grouped together with all women. Of course a clinician's personal trauma history would potentially increase the "identification with the female objects of [his] derogations" (Gornick, 1994, p.246) and further impact her countertransference. Understandably, the majority of participants stated that they thought it would be more difficult to work with this population if a female clinician had a history with violent trauma, especially if the resulting wounds had not been acknowledged or processed.

The strength of this study was the ability to retrieve narrative data that highlighted the similar experiences of a small group of female clinicians in the field of abuser intervention. From these narratives this study has explored both female clinicians' countertransferential reactions to men who batter and the role it plays in facilitating an understanding of the origin of clients' behaviors and transferences. This understanding evokes empathy and compassion within the clinicians and therefore further facilitates the therapy by giving the clinician an opportunity to meet the client where they are, while simultaneously still addressing the "issues" that brought them to therapy.

One limitation of this study was that the sample was a small and mostly homogeneous sample size. The participants were mostly Caucasian middle-class women. Another limitation of this study was that the questions for the interview regarding feelings about working with batterers proved somewhat limiting. The open-ended interview questions asked to guide the narratives were less than desirable (see Appendix D). The first question (what were your motivations for working in the field of abuser intervention?) did not lead to as much information as this researcher had hoped. It was a question that could be, and was, answered very quickly without much depth. The second question (how do you feel being a female working with self-identified heterosexual male batterers?) contributed the most relevant information to this study in regards to the goal of this research. The third question (tell me the range of feelings you have had while working with this particular population?) retrieved information about all feelings. Most responses were non-gendered which allowed this researcher to get a broader understanding of all of the feelings involved in the work. However, in hindsight the interview questions would have better contributed to the goal of this study had they been

more gender specific. Also, this researcher made a decision to not mention the term countertransference during the interviews in order to not lead or persuade any responses. This made it difficult to directly address countertransference reactions of the clinicians. Instead, “feelings” were asked to be discussed and explored in depth. This in turn made it difficult to organize the data and specifically label participants’ feelings of countertransference because of the subjective nature of the term. In part this may be why the results of this study were mainly a deeper understanding of the batterers’ behaviors towards female clinicians and speculations on where some of these behaviors had originated.

This study adds to the current knowledge and understanding of the unique role of female clinicians who work with men who batter women. The study explores not only the transference and countertransference that can exist within this specific relationship, but also the origins of the transference and the countertransference reactions. An increased awareness of both masculine ideology and the gender-role conflict will help all clinicians better understand their male clients. For female clinicians who are thinking about entering the field of abuser intervention this study may better prepare them for what to expect within that field. It is this researcher’s understanding that all of these results contribute to the field of social work.

This chapter has looked at the negative affects the masculine ideology has on male batterers in therapy. This ideology has affected their intimate relationships, the way they identify, label, and accept many feelings associated with femininity, their views of women in general, and the ways in which they seek out and participate in therapy. In speaking to the affects that a patriarchal society can have on men, one participant said a

challenge is “helping them [batterers] understand that we’re [clinicians] not just saying things need to change for women’s sake. We are saying things need to change period. And that includes for their benefit, so that they can feel connected with their children, so they can express love, so they can stop feeling like they have to constantly compete. There are all kinds of things in the patriarchal system that are bad for him too.” Another participant spoke to the countertransference that this masculine paradigm can enact: “The way I try to look at it is if we had met these guys when they were six, our little social work hearts would have gone out to them, and we would have done everything we could for them. And, at some point or another they cross over this line and become ‘asshole’ in our minds and in society. But there is something that we have to start doing when they are six; ultimately as a culture we have to start fixing this a whole lot earlier.”

Not only do we need to start fixing the problem sooner, but we need to start thinking of the problem in a more holistic way. We need to move backwards from countertransference to transference to the causes of that transference. As one participant said, “When we talk about the swamp—well it’s that little story that everyone uses now. If you want to work on an issue, like malaria, you can either work on killing the bugs or the people that have malaria, or you can drain the swamp. When you talk about domestic violence you can either work with battered women, or you can work with the mosquito, which is the batterer, or you can work with the swamp, which is the culture that engenders it all.” In other words, we need to think bigger.

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Appendix A

Initial Email

Dear Maryland Coalition of Abuser Intervention,

My name is Georgia Banks and I am in my final year of the Master's program at Smith College School for Social Work. Jane Doe added me to the list serve because she thought some of you may be interested in participating in a research study that I am conducting for my thesis.

My thesis is an exploratory study on the issues facing female clinicians who work with men who batter. To complete this study I need to interview at least twelve different women who have spent at least one year working with men who batter.

The logistics are these: I will come to you, your place of employment, a coffee shop, etc. I will be gathering some demographic information from you and I will also ask you to answer and expand on five open-ended questions about your experiences working with men who batter. The interview will last about an hour.

Please email me at georgia@email.com with any questions you may have. Thank you for your time.

Best,

Georgia Banks

Appendix B

Follow-up Email

Hi _____,

Thank you for your interest in participating in my research study! The purpose of this study is to find the most useful ways to be aware of and deal with the experiences and feelings among female clinicians who work with men who batter. I am looking to find out more about your experiences as a female clinician who works with this population and what is needed to better support you and your work in this field.

As a research participant you would be required to participate in an hour long interview that I will conduct and will be audio recorded. I will ask you questions about your experiences as a female clinician who works with men who batter, and I will also ask you some demographic information.

The criteria for participation in this study are as follows: you must be female, English speaking, over the age of 21, a mental health professional, and have worked for at least one year within the past three years in a mental health setting with men who batter. The nature of this work must be either group or individual treatment.

If you fit the criteria for participation please email me at georgia@email.com, or call (555) 867-5309 with any questions that you may have. If willing, I would also like your phone number so that we can speak and schedule a time to meet. Thanks so much for your interest!

Best,

Georgia Banks

Appendix C

Informed Consent Form

Dear _____,

My name is Georgia Banks and I am an MSW student at Smith College School for Social Work. For partial fulfillment of my degree I will be completing a thesis. I have chosen to do an exploratory research study on the experiences of female clinicians working with men who batter their female partner. The purpose of this study is to find the most useful ways to be aware of and deal with the experiences and feelings among female clinicians who work with men who batter.

The requirements for inclusion as a participant are as follows: you must be female, English speaking, over the age of 21, a mental health professional, and have worked for at least one year within the past three years in a mental health setting with men who batter. The nature of this work must be either group or individual treatment. As a research participant you would be required to participate in an hour long interview that I will conduct. During the interview I will ask you five open-ended questions about your experiences as a female clinician who works with men who batter. I will also ask you for demographic information. I will audio record the interview and later transcribe the information. You have the right to not answer any question that you choose. You have the right to ask any question about the research and your participation at any point before, during, and after the study. Participants will not be excluded on the basis of race, religion, or sexual orientation.

The potential psychological risks of your participation in this study are the effects of potential feelings around unveiling personal experiences and recalling difficult events or memories.

There are a couple of potential benefits of your participation in this study. You are contributing to important implications for social work concerning support and training needed for females who work with men who batter. It is also my hope that the knowledge that comes out of self-reflection will be a benefit to you in similar future situations. There is no economic compensation for participating in this study.

All of the identifying information collected during the interview will be carefully disguised in my thesis. All of the information collected through the interview will be kept in a locked box while I travel to and from the interview. Once at my computer I will transcribe the interviews. Once transcribed, I will attach a number system to the participants, at that time my research advisor will have access to the transcribed and coded information. I will keep the identifying information with the corresponding numbers in the locked box that only I will be able to access. No person other than my thesis advisor will see this information until the submission of my thesis. The uses of the information gained from this study will be used strictly for my MSW thesis at Smith College School for Social Work and other possible publications and professional presentations. All data will be stored and kept secure in a locked box during the process

of my thesis and for three years after as required by Federal regulations; after that time they will be destroyed or continue to be kept secured as long as I need them. When I no longer need the data, the data will be destroyed.

Participation in this study is voluntary. You can withdraw from the study at any time during the data collection process. The final withdrawal date is April 15th 2008, the end of the data collection process. If you choose to withdraw, all materials pertaining to you will be immediately destroyed. You may refuse to answer any question without penalty. If you have any concerns about your rights or any aspect of this study please call me at (555) 555-1234. You may also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (555) 555-6789 with any questions or concerns.

Thank you for your participation in this study. Please keep a copy of the signed consent form for your records.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signed _____ Date _____
Participant

Signed _____ Date _____
Researcher

Appendix D
Interview Questions

Demographic Information

1. age
2. race/ethnicity
3. type of education or training
4. previous work experience
5. years this field
6. current position in this field
7. hours per week spent with clients and in what capacity

Clinical Experience

Because of the nature of an exploratory study I am going to ask you to expand on three questions.

1. Would you mind telling me what were/are your motivations for working in this field?
2. How do you feel being a female working with male clients?
3. Tell me the range of feelings you have had working with this particular population?

Recommendations for the field

1. Do you have any recommendations for support or training that may help future clinicians in this field?
2. If your best friend said, "I want to work in the field of abuser intervention", what would you tell her?

Appendix E

Human Subjects Review Approval Letter

November 15, 2007

Georgia Banks

Dear Georgia,

Your amended materials have been reviewed. You have done an excellent job with their revision and all is now in order. We are therefore happy to give final approval to this very interesting study. I do hope you are successful in recruitment.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your study.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Caroline Hall, Research Advisor