EMOTIONALLY FOCUSED FAMILY THERAPY IN CASES OF INTIMATE PARTNER VIOLENCE: EXPLORING PSYCHOTHERAPIST VIEWS

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A thesis submitted
in partial fulfilment of the requirements for the degree of

MASTER OF EDUCATION

in

COUNSELLING PSYCHOLOGY

Faculty of Education
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

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Abstract

There is no published data on emotionally focused family therapy (EFFT) for families impacted by intimate partner violence (IPV). In this thesis, 79 psychotherapists were surveyed about whether to use EFFT when parents disclosed violence in the home, including weighing risks and benefits. Descriptive statistics and correlational analysis were used to analyze the data. All responding therapists believed it was important to receive IPV-specific supervision and preferred working with parents motivated to eliminate violence. Participants believed EFFT may promote more responsive caregiving but could also be risky when therapists have limited IPV training. Those with EFFT or IPV training seemed most interested in using EFFT with families impacted by violence. A top priority for future research includes investigating the safety and efficacy of this approach. Future directions for psychotherapists include seeking IPV-specific training and supervision when working with clients impacted by violence. Institutions are encouraged to prioritize IPV training.

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EFT	Emotionally Focused Therapy
EFFT	Emotionally Focused Family Therapy
ICEEFT	International Centre for Excellence in Emotionally Focused Therapy
IPV	Intimate Partner Violence

Chapter 1: Introduction to the Issue

There is great debate within the field of psychotherapy about how best to address intimate partner violence (IPV) from a systemic perspective. Scholars have made arguments for the use of conjoint therapy in cases of IPV—particularly for situational couple violence—but there is an absence of literature on the use of family therapy for such cases. In this thesis, the researcher investigated therapists' views on the use of emotionally focused family therapy (EFFT) in cases involving IPV, with emphasis placed on cases of situational couple violence. Given how little is known about the use of any form of family therapy to address IPV, the researcher was careful to take a neutral stance on the topic.

In this chapter, the reader is introduced to the issue of using EFFT to address IPV. The following areas are briefly explored: the problem this thesis will investigate, the purpose of the study, and the researcher's personal interest and background in this topic. EFFT is discussed throughout this chapter, as that is the framework selected by the researcher to investigate the use of family therapy in cases of IPV.

Statement of the Problem

IPV is a life and death issue with staggeringly high reported rates around the world. Global estimates suggest that one in three women experience IPV in their lifetime (World Health Organization, 2020). In Canada alone, there were nearly 99,000 cases of IPV reported to police by both men and women in 2018 (Conroy et al., 2019). It is even more shocking to consider these statistics from the perspective of the individual; over a five-year period, approximately 432,000 Canadian women and 279,000 men self-reported as victims of spousal violence (Conroy, 2021). IPV is well known to result in devastating

effects for individuals, families, communities, and society as a whole (Conroy, 2021; Conroy et al., 2019; World Health Organization, 2020). The physical and psychological injuries that result from IPV can be significant and long lasting (Conroy, 2021; Conroy et al., 2019). Children are often overlooked as silent witnesses to IPV, yet living with IPV in the home can significantly impede the healthy development of a child (Clements & Fay-Hillier, 2019; Perry, 2001). Sadly, children often end up repeating patterns of violence in future relationships, thereby transmitting IPV intergenerationally (McFarlane et al., 2017). Thus, it is imperative that therapists find a way to work with each member of a family in a way that mitigates these disastrous effects.

The treatment of IPV is a complicated issue within the field of psychotherapy, and there has been extensive debate about what treatment options are best (Brown & James, 2014). Therapeutic treatment options for IPV perpetrators, victims, and child witnesses have been the focus of many scholarly articles within the field of IPV research (e.g., Babcock et al., 2016; Clements & Fay-Hillier, 2019; Hackett et al., 2016). Much of the extant literature focuses on variations of individual, group, and/or conjoint therapy. However, one therapeutic option is conspicuously absent from this body of work: family therapy.

Family therapy holds the potential to address the systemic effects of IPV by giving voice to the experiences of all family members (Flåm & Handegård, 2015). Family therapists are also well positioned to help parents identify and repair attachment injuries with their children (Furrow et al., 2019). However, family therapy may increase safety risks (S. M. Johnson & Lee, 2004). Given the potential for both benefit and risk, it is imperative that therapists be given direction on the use of family therapy in cases of

IPV. Unfortunately, there is a dearth of empirical research on the use of family therapy to address the effects of violence in the home. An exhaustive scan of scholarly work revealed no empirical studies addressing the risks and benefits of working with the entire family to reduce IPV.

Emotionally focused therapy (EFT) has been proposed by several authors as a means to address IPV using conjoint therapy (Rouleau et al., 2019; Slootmaeckers & Migerode, 2018, 2020). This body of work focuses specifically on the use of EFT for couples experiencing situational couple violence. Situational couple violence is one of several typologies of IPV described in the literature (M. P. Johnson & Leone, 2005; Kelly & Johnson, 2008). Situational couple violence arises from the escalation of arguments and conflict between partners rather than from power, control, or coercion, as is the case for other types of IPV, such as coercive controlling violence (Kelly & Johnson, 2008). Another point of distinction lies in the fact that situational couple violence may be bidirectional rather than unidirectional (Kelly & Johnson, 2008).

While there may be great value in working conjointly with carefully screened couples, this approach does not address the needs of children who have witnessed IPV in the home. EFFT seems well suited to addressing the impact of situational couple violence on the family unit. Unfortunately, no studies to date have explored the use of EFFT in cases of situational couple violence. Thus, nothing is known about how an EFT therapist may make a decision about the suitability of EFFT in cases of situational couple violence. Previous studies have highlighted some of the risks and benefits associated with taking a systemic approach to IPV treatment (e.g., Stith et al., 2012), but none have explored what EFT therapists consider to be the risks and benefits of using EFFT in cases of situational

couple violence. Existing literature highlights how a variety of demographic factors could impact a therapist's ability to effectively assess and treat clients impacted by situational couple violence, including, but not limited to, age, confidence with IPV assessments and treatment, knowledge of IPV assessment and treatment, level of IPV training, and level of clinical experience (Clark et al., 2017; Karakurt et al., 2013; Lushin et al., 2019; Stith & McCollum, 2011; Todahl & Walters, 2011). However, no empirical studies have investigated demographic factors that may be associated with the views EFT therapists have about the use of EFFT in cases of situational couple violence. The researcher intended to fill these profound gaps in knowledge by investigating the views of EFT therapists on the use of EFFT in cases of situational couple violence. Special attention was paid to therapist decision-making factors, the risks and benefits of this approach, and the demographic factors associated with these views.

Beginning this thesis, this researcher hoped to provide the information necessary to make initial recommendations for EFT therapists considering the use of EFFT in cases of situational couple violence. However, very little is known about the safety or efficacy of this application of EFFT. As such, the researcher elected to survey EFT therapists about their views on this topic in order to provide EFT therapists with a summary of what their colleagues believe to be most important when considering the use of EFFT in cases of situational couple violence. In this way, the collective voice of EFT therapists can help provide direction to those who are struggling with the question of whether or not to provide EFFT in cases of situational couple violence.

Purpose of the Study

The primary purpose of this study was to investigate the following central research question: What are the views of EFT therapists on the application of EFFT in cases involving situational couple violence? The following three subquestions further elucidates this central question:

1. What contextual factors do EFT therapists believe to be most important when considering the use of emotionally focused family therapy in cases involving situational couple violence?
2. What are the risks and benefits of using emotionally focused family therapy in cases involving situational couple violence?
3. What demographic factors are associated with the views of EFT therapists on the use of emotionally focused family therapy in cases involving situational couple violence?

This thesis contributes to the existing body of literature on therapeutic treatment options for IPV and adds novel information to the applicability of EFFT in cases of situational couple violence. EFFT is well-positioned to address the effects of situational couple violence in the family, given that it is based on the identification and repair of attachment injuries in children and caregivers (S. M. Johnson, 2019). Bowlby (1984) was one of the first authors to describe violence in the family as fundamentally a disorder of the attachment and caregiving systems. He also raised alarms about how children exposed to such broken systems grow up to perpetuate the cycle of violence in later relationships. Within the framework of attachment theory, some forms of family violence can be understood as stemming from, and resulting in, insecure attachment and unmet

attachment needs (Bowlby, 1984; Slootmaeckers & Migerode, 2018). However, IPV is a complex phenomenon, and thus, attachment theory may not be appropriate for all types of IPV. As such, subsequent sections will provide a review of contemporary classifications of IPV, including situational couple violence, in order to highlight which forms of IPV EFFT may be appropriate to treat.

This study has critical implications for research, training, practice, and society. It is the intention of the researcher to use the results from this study to provide the foundation for future research into the use of family therapy to treat IPV, particularly the use of EFFT to treat situational couple violence. It is hoped that EFT trainers and educators use this study to justify the implementation of robust IPV training for EFT trainees. It is expected that further investigation into innovative intervention strategies for IPV will improve EFT therapist practice. This, in turn, will support the recovery of those impacted by violence in the home and enhance the societal response to IPV.

Personal Interest and Background

The researcher has had the privilege of working within the field of IPV since 2014 and has attended over 60 professional trainings related to violence, trauma, and/or crimes against children. The researcher has been honoured to have the opportunity to support individuals impacted by IPV and/or crimes against children in numerous roles at an antiviolence organization in British Columbia, including front-line support worker, prevention and awareness coordinator, child and youth advocacy centre program coordinator, child and youth counsellor, and family therapist. She has also been fortunate enough to work alongside experienced professionals such as police, social workers, and counsellors on committees such as the Violence Against Women in Relationship

Committee and the Sexual Assault Services Committee.

IPV is a complicated issue and the researcher recognizes that a one-size-fits-all approach to service provision is not appropriate. She has seen many of the existing IPV services meet the needs of those impacted by violence, but she has also seen significant gaps in IPV service provision. In her experience, children are often overlooked and underserved by IPV programming. In an effort to combat the intergenerational transmission of violence, the researcher was compelled to explore other means of meeting the needs of children impacted by IPV. Family therapy will not be an appropriate intervention for all families impacted by IPV, but it may serve to meet the needs of a small subset of families. As such, it is the opinion of the researcher that this topic warrants further investigation, if only to advance the discussion on how to meet the needs of a greater number of families impacted by IPV.

In addition to having a passion for work within the field of IPV, the researcher has an interest in EFT. This interest has led her to participate in a 4-day externship training with the founder of EFT, Susan M. Johnson. Furthermore, the researcher has participated in a 2-day training on EFFT: Level 1 as well as a 2-day training on EFFT: Level 2 with Gail Palmer and Jim Furrow, two of the foremost experts on applying EFT to families. The researcher has also completed the 10-day core skills training, cofacilitated by Gail Palmer. Additionally, the researcher has attended 4 days of training (Level 1 and Level 2) on applying EFT to IPV with Lieven Migerode and Jef Slootmaeckers. Lastly, to increase her competence in this area of practice, the researcher has participated in training on the ethical, legal, and relational risks associated with EFT.

The researcher acknowledges a bias toward novel interventions intended to

mitigate the effects of IPV, including family therapy. However, the researcher recognizes the potential risks associated with the use of EFFT in cases of situational couple violence. While this thesis uncovers potential benefits associated with the use of EFFT in cases of situational couple violence, the researcher must stress the importance of exercising caution when considering this approach. This thesis is exploratory in nature, and thus, further empirical research will be needed before generalizations can be made about the practical application of EFFT in cases of situational couple violence.

While the researcher recognizes the personal bias outlined above, great care was taken to ensure the survey and data analysis reflect a neutral position. Furthermore, the results and discussion chapters will reflect a balanced reporting of potential risks and benefits associated with the use of EFFT in cases of situational couple violence.

Summary

The goal of this thesis was to investigate the views of EFT therapists on the application of EFFT in cases of situational couple violence. To achieve this goal, the researcher begins by providing the reader with an overview of pertinent IPV literature in Chapter 2, including the prevalence and impact of IPV, relevant theories, and a detailed description of situational couple violence. In Chapter 3, the researcher reviews the available literature on the use of couple and family therapy in cases of IPV. The focus of Chapter 4 is on reviewing EFT and EFFT, including how EFT can be applied to couples and families impacted by situational couple violence. In Chapter 5, the researcher outlines the methodology of this study. Chapter 6 provides the reader with the results of the online survey within the context of the three research subquestions. This thesis concludes with a discussion of these results in Chapter 5.

Chapter 2: Intimate Partner Violence in the Literature

IPV is a complicated subject within the extant literature. Varied terminology, theoretical differences, and diverse measurement approaches contribute to considerable variability in the body of IPV literature (Eckstein, 2017). The literature review presented within this chapter aims to add clarity by answering questions such as what is the prevalence of IPV, how does IPV impact child witnesses, what theories inform IPV literature, and what violence typologies are used in the literature to describe IPV?

Prevalence

Criteria for measuring IPV prevalence varies within this body of literature. Of the 3,767 IPV studies listed on the World Health Organization's (2017) database, 987 studies explored IPV prevalence. Of these 987 studies, most focused exclusively on physical abuse (342 studies), followed by psychological abuse (246 studies), sexual abuse (206 studies), any form of abuse (188 studies), and financial abuse (five studies). In each category, the vast majority of studies based their prevalence rates on female samples. As such, readers must be aware that prevalence rates reflect a bias toward reporting on physical abuse within female samples.

Data collection methods must also be discussed within the context of IPV prevalence rates. In some cases, prevalence rates may reflect self-reported incidences of IPV, which can capture IPV experiences that were not reported to police. In other cases, prevalence rates may be based on police reported incidence of IPV (e.g., Conroy et al., 2019). However, many incidences of IPV go unreported to police. As an example, a report for Statistics Canada found 76% of male victims of spousal violence and 64% of female victims did not report the violence to police (Burczycka & Ibrahim, 2016). Under

reporting may be due to a variety of reasons, including victims fearing that perpetrators will not be adequately punished, belief that police would not be effective, not wanting to be involved with the court process, and/or having unsatisfactory service from police in the past (Perreault, 2015). Victims may also believe IPV is a personal matter and/or may not want to bring shame to their family (Perreault, 2015). Additionally, victims may not want to get their partner in trouble and/or fear revenge from the perpetrator (Perreault, 2015). Due to the underreported nature of IPV, it must be stressed that data presented in this chapter may grossly underrepresent the actual prevalence of IPV.

The prevalence of IPV varies globally. According to the World Health Organization (2017), the highest median lifetime prevalence of physical abuse related to IPV (36%; *N* = 8,956 across six studies) is found in the Eastern Mediterranean regions (e.g., Jordan [43%], Pakistan [45%] etc.) whereas the lowest (27%; *N* = 74,928 across 15 studies) is found in the Western Pacific regions (e.g., Australia [23%], New Zealand [17%], etc.). The World Health Organization (2017) has estimated the lifetime prevalence of physical abuse related to IPV in the United States to be 26% (*N* = 150,411 across 58 studies).

In Canada, nearly 99,000 cases of IPV were reported to police in 2018, representing a 2% increase from 2017 (Conroy et al., 2019) and a 6.5% increase from 2016 (Burczycka & Conroy, 2018). Of these cases, the highest rates of IPV were reportedly experienced by those between the ages of 25 to 34 (Conroy et al., 2019). A recent report found that the Canadian cities with the highest rates of IPV were Lethbridge (589 victims per 100,000 population), Regina (477 victims), and Moncton (428 victims); in contrast, the lowest were St. Catherines/Niagara (147 victims), Barrie (193 victims),

and Vancouver (195 victims; Conroy et al., 2019). The same report found that women living in rural areas were four times more likely to report being the victim of IPV to police (789 victims per 100,000 population) compared to men living in rural areas (218 victims; Conroy et al., 2019).

Data from Statistics Canada (e.g., Boyce, 2016; Burczycka & Conroy, 2018; Conroy, 2021; Conroy et al., 2019) provided further insight into the prevalence and nature of IPV within the Canadian context. Using data from 2018, Conroy et al. (2019) found 79% of police-reported IPV victims were women. Adding to this examination of gender dynamics, Burczycka and Conroy (2018) found women were four times more likely than men to be the victims of intimate partner homicide. This gender disparity was echoed by Conroy (2021), who found women to be more likely than men to be victims of spousal violence over the span of one year (1.5% compared to 0.8%). Over the span of five years, 4.2% of women reported being the victim of spousal violence in Canada, compared to 2.7% of men (Conroy, 2021). These authors further noted men were more likely to be accused of IPV, compared to women (77% for men compared to 23% for women). According to a report by Boyce (2016), Indigenous women appear to be at greater risk for being the victim of IPV and report higher rates of injury, compared to non-Indigenous women. Similarly, Conroy (2021) found Indigenous people were more than twice as likely to experience violence, when compared to non-Indigenous people (7.5% compared to 3.4%). Data from 2018 and 2016 suggest it is more common for weapons to be used in cases where men were victims of IPV (Burczycka & Conroy, 2018; Conroy et al., 2019).

In a study of 1,581 substantiated cases of IPV-related crimes from police

departments in the Northeastern United States, children were in the home at the time of an IPV event in 43% of cases; of these children, 95% had seen or heard the violence (Fusco & Fantuzzo, 2009). Furthermore, 75% of these children were directly involved in the event, such as being part of precipitating events or by calling for help (Fusco & Fantuzzo, 2009). Earlier research supported these findings, as authors have also found exceptionally high rates of child exposure to IPV (e.g., Fantuzzo & Fusco, 2007; Graham-Bermann et al., 2007; Jaffe & Juodis, 2006). Additionally, researchers have demonstrated children do not need to have witnessed IPV to be negatively impacted; rather, the awareness of IPV and/or the toxicity that accompanies violence in the home is enough to negatively impact a child (MacMillan & Wathen, 2014; Perry, 2001). There has been considerable growth in this area of study since it began to gain traction in the 1990s (Geffner et al., 2000), but there continues to be significant barriers to providing services to children who have witnessed IPV (Reif et al., 2020). Such findings highlight the need for therapeutic interventions aimed at meeting the unique needs of children who have witnessed IPV.

Impact

IPV is a serious and persistent public health issue. There is robust evidence demonstrating the negative physical, mental, emotional, and socioeconomic effects of IPV, both short- and long-term (e.g., Burczycka & Conroy, 2018; Stewart & Vigod, 2019). Exploring the full impact of IPV for each family member is beyond the scope of this thesis. Instead, the researcher elected to highlight the impact IPV has on child witnesses and their families, particularly as it relates to attachment bonds. This area of impact was chosen for two reasons. First, a central focus of this thesis was identifying

factors that EFT therapists believe to be most important as they consider applying EFT to families. Before readers can understand why various factors may be important, they must become familiar with how an EFT therapist is likely to make sense of the impact that IPV has on children and families. EFT therapists are trained to conceptualize presenting problems from an attachment perspective (Furrow et al., 2019; S. M. Johnson, 2019). As such, the reader is introduced to literature that describes the impact of IPV in terms of attachment. Second, this thesis was also focused on identifying potential risks and benefits associated with treating IPV within the family system. Thus, the reader must be familiar with how IPV can impact the family system and what areas of impact may serve as potential targets for systemic interventions. With these two issues in mind, the researcher provides the basis for investigating the use of family therapy in cases of IPV by reviewing: (a) the impact that IPV has on attachment style, (b) the intergenerational transmission of violence, and (c) changes to family structure resulting from IPV.

Impact of IPV on Attachment Style

There is a well-researched relationship between IPV and the styles of attachment. Although a review of attachment theory is provided later in this chapter, it is important to first highlight the impact that IPV can have on attachment, particularly for children who witness violence in the home. Attachment styles begin to develop early on in a child's life and thus, are shaped by experiences within the family of origin. Witnessing physical violence between caregivers may negatively impact the attachment representations of children, in that they are more likely to see their caregivers as an unreliable, and/or inconsistent source of safety and support (Bowlby, 1969/1983; Gustafsson et al., 2017).

Exposure to IPV has been shown to negatively impact a child's ability to form

secure attachments with caregivers in early childhood and adolescence (Gewirtz & Edleson, 2007; Sousa et al., 2011). Gustafsson et al. (2017) emphasized this relationship between IPV exposure and attachment styles (N = 98) and found, for children in the United States, exposure to physical IPV in early childhood was significantly associated with an increased chance of being rated as insecurely attached as they began first grade.

Unfortunately, the negative impact of IPV on attachment styles is not limited to childhood. In their recent study, Pang and Thomas (2019; N = 218) found a significant association between exposure to IPV in adolescents and negative functioning in adulthood, more difficulties with emotional regulation, and higher reported rates of anxiety, depression, and posttraumatic stress disorder. However, when the authors used the primary attachment style questionnaire (Salzman et al., 2013) to explore how attachment style moderated the effect of IPV exposure on negative functioning in adulthood, they found participants who were more securely attached to a primary caregiver during adolescence fared better in adulthood, despite expose of IPV during adolescence, when compared to participants who were not exposed to IPV. Although findings such as these highlight the potential long-term consequences of childhood IPV exposure on future functioning, they also reinforce the need to strengthen child–parent attachment in order to improve long-term outcomes for children.

Intergenerational Transmission of Violence

One of the most alarming impacts of IPV relates to the intergenerational transmission of IPV. There is a substantial body of literature highlighting the association between witnessing IPV as a child and the presence of IPV in later romantic relationships (e.g., Jaffe et al., 2014; Juan et al., 2020; Kimber et al., 2018; Simons et al., 2012; Smith

et al., 2011; Sutton et al., 2014). For example, in their longitudinal study, Smith et al. (2011; N = 1,000) found exposure to severe IPV during adolescence significantly increased the risk of IPV at ages 21–23 years (adjusted OR = 1.66, CI = [1.09, 2.53], p <˜0.05) and severe IPV at ages 21–23 years (adjusted OR = 1.69, CI = [1.09, 2.61], $p < 0.05$). The authors also found an indirect effect of exposure to severe IPV during adolescence on IPV at ages 29–31 years, as mediated by the presence of IPV at ages 21–23 years (adjusted OR = 2.33, CI = [1.66, 3.27], $p < 0.001$) and severe IPV at ages 21–23 years (adjusted OR = 2.20, CI = [1.45, 3.33], $p < 0.001$). Many authors have begun to explore the mechanisms by which violence is transmitted intergenerationally, including looking at the relationship between exposure to IPV in childhood and factors such as aggression (e.g., Holmes, 2013; Holmes et al., 2015; Juan et al., 2020), prosocial skills deficits (e.g., Holmes et al., 2015), antisocial behaviour (e.g., Sousa et al., 2011), and attachment (e.g., Juan et al., 2020; Sousa et al., 2011).

In their recent longitudinal study from the United States, Juan et al. (2020; N = 2,896) found children who were exposed to IPV between ages of 0 to 3 years demonstrated increased aggression at ages 5 years ($\beta = 0.061$, $p < 0.01$) and 9 years ($\beta = 0.044$, $p < 0.05$), as measured by a modified version of the Child Behaviour Checklist (Ainsworth et al., 1978/2015). According to Holmes (2013), who measured aggression using the Aggressive Behavior Problem Scale of the Child Behavior Checklist (Achenbach & Edelbrock, 1981), the likelihood of increased aggression in children following exposure to IPV increases with earlier and more frequent exposure. Although the connection between increased aggression and IPV perpetration may seem straightforward, some authors have attempted to explore this issue in even greater depth,

looking at how the maladaptive behaviour of aggression may be linked to deficits in prosocial skills following IPV exposure (Holmes et al., 2015).

Holmes et al. (2015) used longitudinal data from 1,125 children to explore this relationship between childhood IPV exposure, aggressive behaviour, and prosocial behaviour deficits. The authors found, regardless of gender, IPV exposure at ages 3–4 years predicted aggressive behaviours at that time point through to ages 5–7 years ($\beta = 0.15$, $p < 0.01$ for males; $\beta = 0.09$, $p < 0.01$ for females). For girls in Holmes et al.'s study, exposure to IPV at ages 5–7 years predicted prosocial deficits at that time point ($\beta = -0.10$, $p < 0.01$). For boys in Holmes et al.'s study, there was a cross-domain relationship between aggressive behaviour and prosocial skills deficits, in that aggressive behaviour at ages 3–4 years was associated with prosocial skills deficits at ages 5–7 years ($\beta = -0.03$, $p < 0.05$). Such findings highlight the need for early interventions designed to target aggressive behaviour and prosocial skills deficits for children exposed to IPV (Holmes et al., 2015). The authors also recommended such interventions may need to be sensitive to gender differences in order to meet the needs of each child (Holmes et al., 2015).

In an earlier study, Sousa et al. (2011) analyzed longitudinal data from children exposed to IPV ($n = 96$) and found exposure was associated with increased antisocial behaviour in adolescence. When compared to children who were not exposed to IPV in childhood ($n = 134$), exposure to IPV was associated with increased felony assaults (12% increase), minor assaults (17.8%), status offences (15.9%), and delinquent behaviour (9.8%; Sousa et al., 2011). Adolescent antisocial behaviour measures were self-reported incidences of felony assaults (e.g., sexual assault; attempted sexual assault; hitting

someone other than parents, siblings, or persons at work; having the idea of killing or seriously hurting another person), minor assaults (e.g., hitting or threatening to hit a parent, persons at work, or others), status offences (e.g., absenteeism, suspensions, running away from home, drinking alcohol), and general delinquency (e.g., theft, disorderly conduct; Sousa et al., 2011). Sousa et al. also explored the role that attachment plays in this relationship. According to the authors, building stronger attachments between parents and children may not be enough to completely counter the effects of IPV exposure during adolescents, but it may reduce the risk of antisocial behaviour (Sousa et al., 2011).

Attachment may play a key role in the intergenerational transmission of IPV. According to Godbout et al. (2009; $N = 644$), exposure to psychological IPV as a child was significantly associated with avoidant ($\beta = 0.14$, $p < 0.05$) and anxious ($\beta = 0.09$, $p < 0.05$) attachment strategies within married or cohabiting adult relationships, as measured by a shortened version of the Experiences in Close Relationships Questionnaire (Brennan et al., 1998). This finding is important to consider, given that insecure attachment in adult relationships has been identified as a risk factor for both IPV perpetration (Almeida et al., 2019) and victimization (Sandberg et al., 2019). For male perpetrators of IPV, insecure attachment has been found to be significantly associated with anger and hostility (Almeida et al., 2019). Insecure attachment has been found to be significantly associated with female IPV victimization in terms of physical assault victimization, sexual coercion, and psychological abuse (Bonache et al., 2019; Karakurt et al., 2019; Sandberg et al., 2019). Although there is less research available on attachment and male IPV victimology, Karakurt et al. (2019; $N = 174$) found, among

heterosexual couples, attachment security accounted for 7% of variances in minor physical victimization for males.

It may be that the key to understanding the intergenerational transmission of violence may lie in understanding how violence perpetration and victimization interact with factors such as adult attachment as well as destructive disagreement beliefs. In their study, Sutton et al. (2014) found, among university students (N = 1,148), destructive disagreement beliefs fully mediated the association between violence perpetration and insecure attachment style (0.07, $p < 0.01$ for males; 0.04, $p < 0.01$ for females), as well as violence victimization and insecure attachment style (0.08, $p < 0.01$ for males; 0.03, $p < 0.01$ for females). In Sutton et al.'s study, destructive disagreement beliefs were measured using a modified version of the Disagreement is Destructive Subscale (Cramer, 2001). Sutton et al. noted holding destructive disagreement beliefs may lead an individual to equate arguments with a sign that their relationship is in trouble or that there is a lack of love in their relationship. The authors speculated insecurely attached intimate partners who hold destructive disagreement beliefs may escalate the intensity of disagreements with their partners, moving the argument from a spat to a physically violent confrontation (Sutton et al., 2014).

Given the significant and long-lasting impact that the intergenerational transmission of IPV can have on children, therapists must strive to provide effective therapeutic interventions that are able to decrease the likelihood that patterns of IPV will be repeated. Having a robust understanding of how attachment styles interact with IPV may prove helpful in this regard, but the results presented above highlight the need to consider a variety of mediating variables.

It is important to emphasize that not all children who witness IPV are destined to experience negative long-term outcomes. Protective factors include strong caregiver–child attachment, high levels of emotional support from caregivers, overall family functioning, and having strong friend relationships in adolescence (Fusco, 2017; Genç et al., 2018; Juan et al., 2020; Pang & Thomas, 2019). As such, therapists should remain hopeful that with effective intervention a positive outcome is possible for children exposed to IPV.

Changes to Family Structure

IPV may also impact child witnesses by way of changes to the family structure, including separation and divorce. Even without the presence of violence in the home, parental separation is a stressful life event for children. It is well established that family conflict exacerbates the potential for child maladjustment following parental separation (e.g., Camisasca et al., 2016). Fortunately, the adverse effects of separation on children may be mitigated by quality coparenting, as this is a significant protective factor for the well-being of children impacted by parental separation (Amato, 2000). Although much of the extant literature focused on conflict, rather than IPV specifically, a limited number of studies have explored the unique challenges and stressors associated with the quality of postseparation coparenting following IPV (e.g., Hardesty et al., 2012, 2016, 2017). A study by Hardesty et al. (2016; $N = 154$) found the type of IPV was an important factor in the quality of coparenting following separation; quality of coparenting was found to be significantly lower when relationship violence was based on patterns of coercive control ($M = 2.95$, $SD = 0.62$), compared to nonviolent relationships ($M = 3.37$, $SD = 0.76$). In contrast, no significant differences were found in coparenting quality for participants

reporting a situationally violent relationship (M = 3.15, SD = 0.86) compared to nonviolent relationships (Hardesty et al., 2016). Such findings highlight the need to recognize the heterogeneity of IPV and how this heterogeneity impacts children and families. IPV typologies are reviewed in greater depth in the final section of this chapter.

Theories

In the following section, the researcher provides a brief overview of the theories used to conceptualize IPV within this thesis. The focus of this researcher's thesis was on developing a better understanding of the views of EFT therapists on the application of EFFT in cases involving situational couple violence. However, before this can be fully explored, it is necessary to introduce the reader to the main theories that are likely to inform the views of EFT therapists, particularly those relating to violence within the home.

Three theories are introduced: feminist theory, general systems theory, and attachment theory. It is important to note that these three theories do not represent the breadth of the theoretical literature related to IPV. Rather, the researcher elected to include only those theories that provide the necessary theoretical rationale for the present study, as it links to the study of EFT applied to families with a history of violence.

Feminist Theory

The feminist theory of IPV began to appear in the literature in the 1970s, often referring to *wife abuse* or *battering* to describe patterns of male-perpetrated violence against women (Dobash & Dobash, 1979). In addition to IPV, the term *domestic violence* was often used within this body of literature. Proponents of this theory position IPV as a social issue, founded upon the premise that structures of gender inequality have created a

climate in which men use violence as a means of power and control over women (Dobash & Dobash, 1979; Yodanis, 2004). Feminist theorists propose that ending IPV lies in understanding and advocating against gendered expectations within the family and patriarchal ideological structures that underlie intrapersonal and interpersonal relationships (Gelles, 1993; Yllö, 1993). This theory has traditionally emphasized the unidirectional use of violence against women, most often presented as within the context of heterosexual relationships (George & Stith, 2014).

Feminist theory has helped shape the dominant discourse on IPV and made significant contributions to the collective understanding of violence against women. Feminist theory has influenced the treatment of IPV, due in large part to the development of Domestic Abuse Intervention Programs, commonly referred to as the Duluth model (Bohall et al., 2016; Pence & Paymar, 1993). This intervention program is based on the feminist conceptualization of IPV as stemming from men using violence as a means of power and control. The Duluth model uses tools such as the popularized *power and control wheel* to provide educational and cognitive-behavioural-based programming to men who use violence against their female partners (Bohall et al., 2016; Pence & Paymar, 1993).

Some authors have suggested that in Canada and the United States, the Duluth model is the most commonly used intervention program for men receiving mandated treatment following convictions of IPV-related offenses (Corvo et al., 2009; Stover et al., 2009). Despite strong support for the presence of a power and control-based structures within some violent relationships, the Duluth model continues to be a controversial topic (Burge et al., 2016). Opponents such as Dutton and Corvo (2007) argued the Duluth

model fails to meet the test of evidence-based practice, pointing to a lack of empirical research demonstrating the effectiveness of this intervention. Proponents such as Gondolf (2007) countered by highlighting the methodological challenges inherent in the experimental evaluation of interventions which intersect with the criminal justice system. Indeed, the evidence is mixed. Corvo et al. (2009), Dutton and Corvo (2007), and Herman et al. (2014) found the self-reported aggressive behaviours and attitudes within an intimate relationship can be modified using a 24-week Duluth model batterer intervention program. However, the same study found completion of this program did not have a significant effect of recidivism rates (Herman et al., 2014). These authors concluded current models of IPV treatment are ineffective (Herman et al., 2014). Following a meta-analysis of Duluth model program research, Bohall et al. (2016) came to similar conclusions. The authors called for an updated theoretical framework for IPV, one capable of accounting for the multiple types and/or causes of IPV as well as the variances within participant samples, often resulting from factors such as culture, sexuality, race, and gender.

A strength of feminist theory lies in the fact that it offers both an explanation for IPV as well as a means of ending violence against women (Gelles, 1993). It also highlights the role that society plays in shaping attitudes about relationships, love, communication, connection, and involvement with children, as well as many other factors that influence violence in the home (Yllö, 1993). Feminist theory has been criticized as defining IPV exclusively as gendered and power-based, thereby limiting the exploration of additional contributing factors (Gelles, 1993; Mayer, 2017). However, in recent years, some researchers and practitioners have begun to adopt what George and Stith (2014)

refer to as a both/and feminist approach to IPV. This updated feminist approach seeks to oppose the oppression of women through violence while also supporting couples who describe their violence as bidirectional or as a failed attempt to resolve conflict (George & Stith, 2014). Thus, this approach allows for the existence of power-based, unidirectional violence as well as conflict-based, bidirectional violence. Even so, there continues to be debate about the need to explore the roles that conflict and attachment play in IPV, as discussed in the sections below.

General Systems Theory

According to Straus (1973), general systems theory applies a sociological lens to the understanding of IPV. It is necessary to note that the term *systems theories* may include several theoretical frameworks, and thus, it may be thought of as an umbrella term used to describe the processes and interactions occurring between individuals within any given system. Here, general systems theory explores the processes and interactions occurring between members of a family system that account for the presence of violence (Straus, 1973). Thus, rather than viewing violence as the result of an individual, general systems theory conceptualizes violence as being the product of a larger social system (Gelles, 1993). Theorists suggested conflict, rather than patriarchy, is the underlying cause of violence within intimate relationships (Straus, 1979). Reasoning, verbal aggression, and violence are all understood to be tactics used to deal with conflict (Straus, 1979). Furthermore, researchers operating from this theoretical framework emphasized the presence of bidirectional violence within relationships and the existence of a continuum between the constructs of conflict and control (Carlson & Dayle Jones, 2010).

Like feminist theory, general systems theory has made significant contributions to how IPV is conceptualized within research and practice. The Conflict Tactics Scale, a widely used assessment tool, was developed within the theoretical framework of general systems theory (Straus, 1979). The assessment tool has since been revised (Straus et al., 1996) and continues to be used to assess family violence. However, the researcher recommends readers consider the risks and benefits of using the Conflict Tactic Scale. Furthermore, the researcher does not endorse the use of this, or any assessment tool. Rather, readers are encouraged to review relevant literature on a variety of assessment tools prior to engaging in IPV assessment.

The conceptualization of IPV described above was also influential in the development of IPV typologies, which are discussed at the end of this chapter. IPV typologies distinguish between the contexts in which violence can arise within an intimate relationship, rather than focusing exclusively on victim or perpetrator characteristics (Kelly & Johnson, 2008).

A significant strength of general systems theory is its emphasis on the social forces, including norms and values, which provide context to IPV (Gelles, 1993). It also highlights the unique factors present within a family that help account for the presence of violence (Gelles, 1993). However, such systemic conceptualizations of IPV have been criticized as ignoring the importance of gender, failing to recognize power dynamics within intimate relationships, and even placing responsibility for violence on the victim (Dobash & Dobash, 1979; Yllö, 1993). Furthermore, systemic conceptualizations of IPV may not fully account for the influence of early childhood attachment patterns—as well as adult attachment patterns—for the perpetrators, victims, and witnesses of IPV, which

is emphasized more heavily in attachment-based conceptualizations of IPV (e.g., Schneider & Brimhall, 2014).

Attachment Theory

Attachment theory was relevant to this study for two reasons. First, attachment theory provided another useful conceptualization of IPV. Second, attachment theory forms the theoretical basis of EFFT (Furrow et al., 2019), which was the therapeutic approach investigated in the present study. Attachment theory provides the framework for EFFT therapists seeking to repair attachment injuries between caregivers and their children. Thus, attachment theory is reviewed below within the context of both IPV and EFFT. A more in-depth discussion of EFFT will be presented in Chapter 4.

One strength of attachment theory is its focus on relational processes; connectedness and emotional engagement with caring others are markers of a healthy relationship, rather than something to dismiss or suppress (Knudson-Martin, 2012). It also has the advantage of recognizing the importance of secure attachment across the lifespan. However, this theory has been criticized as not situating attachment within the context of gender, power, or culture (Knudson-Martin, 2012). Additionally, authors have noted attachment theory is based on Western values, thus overlooking caregiving and care-seeking practices in non-Western cultures (Keller, 2018).

Attachment theory, initially developed by Bowlby (1969/1983) and Ainsworth (1963), describes how secure attachment relationships are formed between mother and child and how this relationship leads to healthy development. This attachment bond between mother and child is based on the mother's ability to be accessible, responsive, and emotionally engaged (S. M. Johnson, 2019). According to this theory, children are

biologically hardwired to seek proximity to their principal caregiver as an early survival strategy, and it is this need for closeness that primes an infant to be receptive to a mother's physical and emotional proximity (Ainsworth, 1985; Bowlby, 1969/1983). If the mother is able to meet the attachment needs of the child predictably, she acts as a secure base from which the child can explore (Ainsworth, 1963). If the child feels threatened or fearful, they are able to return to their secure base, both for physical safety and for the regulation of emotions (S. M. Johnson, 2019). Within attachment theory, this marks the beginning of secure attachment.

The benefits of having a secure attachment spread across the lifespan and are necessary for healthy functioning within a family. For instance, secure attachment in childhood has long been thought to be foundational in the development of a child's ability to regulate emotions and cope with stress (Bowlby, 1969/1983). Contemporary empirical research supports this claim (e.g., Brumariu, 2015), and, in fact, goes deeper into identifying specific aspects of emotional regulation that are impacted by attachment. For instance, Brumariu et al. (2012; $N = 87$) found children with secure mother–child attachment had less difficulty identifying emotions and greater emotional awareness. In another study, Brumariu and Kerns (2012; $N = 1{,}097$) found children who were securely attached in infancy had a better ability to manage intense emotions at 4 years of age through to first grade, as rated by their parents. Emotional regulation becomes increasingly important as children move through middle childhood, as this is a time when children begin to become more autonomous and less dependent on the proximity of caregivers to meet their attachment needs.

Secure attachment may also be an important factor in developing positive conflict resolution strategies. In their study, Creasey and Ladd (2005) found secure attachment, as measured by the Adult Attachment Interview (George et al., 1996, as cited in Creasey & Ladd, 2005), to be associated with positive conflict resolution strategies among college students ($N = 130$). Similarly, Tan et al. (2016; $N = 184$) found securely attached adolescents displayed more constructive conflict resolution strategies in later romantic relationships. In Tan et al.'s study, researchers used data from a larger longitudinal study to evaluate the relationship between attachment security at age 14 and dyadic conflict resolution at age 18 or 21. Results indicated that secure attachment was associated with supportive behaviours with romantic partners at 18 years of age (0.40, $p < 0.01$), as well as constructive conflict discussion behaviours with romantic partners at 18 years (0.37, $p < 0.001$) and at 21 years (0.42, $p < 0.001$). The authors noted how couples demonstrating these behaviours are more likely to resolve conflict with more reasoning, confidence, warmth, and affection. As such, it seems that interventions aimed at improving secure attachment in adolescence may serve to strengthen conflict resolution strategies in future romantic relationships.

Secure attachment in adulthood is the foundation for a healthy parent–child relationship. According to Mikulincer and Shaver (2016), secure attachment promotes compassion and altruism, which serves as the foundation for caregiving behaviour. However, Bowlby (1969/1983) noted individuals, including caregivers, alternate between needing protection and security and providing protection and security. The importance of secure adult attachment becomes evident as these two systems interact; caregivers who are securely attached are better able to attend to the needs of others because their

attachment behaviour (i.e., needing protection and security) is less likely to interfere with their caregiving behaviour (i.e., providing protection and security). This relationship between secure attachment and increased compassion and altruism (Mikulincer & Shaver, 2016) is then expressed as a parent's ability to prioritize the attachment needs of their child over their own attachment needs. However, violence within the parent's intimate relationship interferes with this ability to prioritize the needs of their child, as the parent's need for protection, security, and connection increases.

Attachment theory can be used to conceptualize IPV as being rooted in attachment and caregiving behaviour (Bowlby, 1984; Velotti et al., 2018). Proponents of an attachment-based understanding of IPV suggest that the perpetration of violence within intimate relationships may be a result of a dysfunctional bid for connection and proximity with an attachment figure, particularly when these attachment needs are threatened (Park, 2016). As Park (2016) described it, because partners take on the role of primary attachment figures in intimate relationships, the demanding and aggressive behaviours used by violent partners can be conceptualized as a form of protest against attachment needs not being met by their intimate partner.

IPV may also arise from a mispairing of attachment styles between partners. Depending on each partner's attachment style, a need for distance and autonomy by one partner may be perceived as a threat to the relationship by the other partner, whereas a need for proximity and intimacy may be similarly threatening for others (S. M. Johnson, 2019). According to Doumas et al. (2008), the key to addressing IPV may lie in understanding more about discrepancies between this need for intimacy and distance among intimate partners. In a study of 70 heterosexual couples, the authors found the

mispairing of male attachment avoidance and female attachment anxiety was a significant predictor of both male physical violence ($\beta = 0.28$, $p < 0.05$) and female physical violence ($\beta = 0.31$, $p < 0.05$). These results suggest that different attachment styles may create a discrepancy in attachment needs, which may in turn result in violence.

There is a sizable body of literature on the application of attachment theory to IPV, yet no published articles have investigated the suitability of EFFT for families impacted by IPV. Researchers are beginning to apply EFT to couples impacted by violence, noting that attachment theory may help EFT therapists make sense of some types of violence (Rouleau et al., 2019; Slootmaeckers & Migerode, 2018, 2020). Although EFT therapists are heavily influenced by attachment theory, the conceptualizations of violence presented within feminist theory and systems theory are likely to influence the views of EFT therapists on the use of EFFT when there is violence in the home. As such, it may be difficult to ensure that the EFT therapists who participate in the research project conceptualize IPV in the same way. In order to address this potential limitation, the researcher has chosen to focus on situational couple violence as the only type of IPV being considered for EFFT use. IPV typologies are a relatively new area of research within the field of EFT (e.g., Rouleau et al., 2019; Slootmaeckers & Migerode, 2018, 2020). As such, asking EFT therapists to consider EFFT for a specific type of IPV may reduce the variability in IPV conceptualizations that may otherwise arise from asking about EFFT in cases of IPV generally.

Typologies

The term *IPV* can refer to many distinct patterns of violence. Several types of IPV within heterosexual couples have been identified. However, the researcher has elected to

focus exclusively on the application of EFFT to cases of situational couple violence within this thesis (M. P. Johnson & Ferraro, 2000; M. P. Johnson & Leone, 2005). This decision was made for two reasons: (a) as noted previously, focusing on situational couple violence has the potential benefit of reducing variability in the conceptualizations of IPV used by research participants and (b) there is existing literature on the use of EFT in cases of situational couple violence. Researchers such as Slootmaeckers and Migerode (2018) have begun to explore how situational couple violence could be conceptualized and managed using an EFT framework. By contrast, these same authors are clear that other types of IPV, such as coercive controlling violence, are not suitable for EFT. In light of these two reasons for focusing on situational couple violence, the researcher has chosen to use the following section to introduce IPV typologies. A brief summary of coercive controlling violence is provided in advance of the discussion on situational couple violence in order to familiarize the reader with the two forms of violence most often referred to in this body of literature.

It is important to emphasize that the IPV typologies reviewed here describe the patterns of violence between two individuals and are, therefore, separate from perpetrator or victim typologies. Delineating types of IPV serves to clarify the dynamics and contexts in which IPV occurs (Kelly & Johnson, 2008). IPV typologies have been found to be helpful in a variety of contexts, such as by informing the work of family mediators in establishing safe family arrangements with separating couples (Rossi et al., 2019). IPV typologies are also helpful for psychotherapists considering couples therapy with partners who intend to stay together (Stith et al., 2012). However, it is important to note that the types of IPV may not be mutually exclusive, given that they are based on patterns of

violence rather than a single event (Gulliver & Fanslow, 2015; M. P. Johnson & Ferraro, 2000). Authors have also noted that the IPV types initially described by M. P. Johnson and colleagues (M. P. Johnson & Ferraro, 2000; Kelly & Johnson, 2008) fail to capture all patterns of violence (Rossi et al., 2019). Nevertheless, the move toward recognizing the heterogeneity of violence is likely to open the door for innovations in how IPV is approached therapeutically, given that they delineate between couples that may or may not benefit from conjoint or familial therapeutic interventions.

Previous authors have argued that situational couple violence can be conceptualized using an attachment-based perspective (Slootmaeckers & Migerode, 2018). Additionally, some have begun to explore whether EFT may be a suitable form of intervention for couples struggling with situational couple violence (Slootmaeckers & Migerode, 2020). This is based on the idea that insecure attachment, relational fears, and unmet attachment needs are at the heart of situational couple violence (Schneider & Brimhall, 2014; Slootmaeckers & Migerode, 2018, 2020). To date, no published articles have explored whether EFFT may be similarly suitable for families impacted by situational couple violence. Thus, the researcher intended to fill this gap by surveying EFT therapists about their views about this subject.

Although situational couple violence was the focus of this thesis, it is necessary to first describe another type of IPV, coercive controlling violence. Like situational couple violence, this type of violence is commonly referred to in the IPV literature. However, it is critical that the reader is able to differentiate between coercive controlling violence and situational couple violence, as an attachment-based intervention is not appropriate in cases involving coercive controlling violence (Slootmaeckers & Migerode, 2018). As

such, coercive controlling violence will be presented here in order to emphasize the differences between one type of IPV that may be suitable to an attachment-based intervention and another type that is not suitable to an attachment-based intervention.

Coercive Controlling Violence

Coercive controlling violence refers to patterns of violent and nonviolent behaviour indicating a desire to control an intimate partner (M. P. Johnson & Ferraro, 2000). This type of IPV is characterized by the use of the following tactics, in any combination, to gain power and control: physical violence; emotional abuse; economic abuse; coercion and threats; intimidation; manipulation; isolation; minimizing, blaming, and denying; use of children; and asserting male privilege (Ali et al., 2016; Kelly & Johnson, 2008). The power and control wheel (Pence & Paymar, 1993)—often used by women's shelters—provides a visual representation of the tactics used in this IPV type (Kelly & Johnson, 2008). Originally, the term *intimate terrorism* was used to refer to this type of IPV, but this has since been changed to coercive controlling violence (Kelly & Johnson, 2008). Coercive controlling violence typically escalates over time and is more severe and frequent than the other types of IPV (Kelly & Johnson, 2008). This form of IPV may also be distinguished by the fact that victims are fearful of their violent partner (Eckstein, 2017). Researchers have found that within the context of heterosexual relationships, coercive controlling violence is most often perpetrated by the male partner (C. J. A. Beck et al., 2013; Gulliver & Fanslow, 2015). Traditionalist views on gender are thought to be strongly associated with heterosexual power-based IPV perpetration (M. P. Johnson, 2011; Sugarman & Frankel, 1996). Coercive controlling violence is the type of IPV most often seen in the courts and agency settings, including law enforcement and

shelters (Kelly & Johnson, 2008).

Situational Couple Violence

This thesis focused on situational couple violence as one type of IPV that may be appropriate for EFFT. This approach is not suitable in cases of coercive controlling violence, as it is not suited to addressing unilateral power-based forms of IPV (Slootmaeckers & Migerode, 2020). However, therapists must be capable of distinguishing between typologies in order to determine whether EFFT is appropriate. Given the limited research on this topic, little is known about what criteria therapists use to assess which cases involving IPV are suitable for EFFT.

Situational couple violence refers to patterns of violence that result from an escalation of arguments and conflict rather than from power, control, or coercion (M. P. Johnson & Leone, 2005; Kelly & Johnson, 2008). According to Kelly and Johnson (2008), this form of IPV typically involves minor forms of violence, such as pushing, grabbing, and shoving, as well as aggressive verbal behaviour such as cursing, yelling, and name calling. This type of violence and aggressive verbal behaviour may also be present in cases of coercive controlling violence, but in the case of situational couple violence, they do not form an ongoing pattern of control and intimidation.

In cases of situational couple violence, the violence may be mutually perpetrated, or it may involve one violent noncontrolling partner and one nonviolent partner (Kelly & Johnson, 2008). This is thought to be the most common form of IPV amongst cohabiting partners (M. P. Johnson, 2011; Kelly & Johnson, 2008; Simpson et al., 2007). Situational couple violence is not simply a less severe form of coercive controlling violence, but rather a distinctly different type altogether, with different precipitating causes and

resulting consequences (Kelly & Johnson, 2008). Situational couple violence results from the situation rather than from coercive control. Poor ability to manage conflict and control anger have been noted as causes of situational couple violence (Kelly & Johnson, 2008). In cases of situational couple violence it is not common for either men or women to fear their partner, regardless of their role in the violence (Kelly & Johnson, 2008).

Distinguishing Between Typologies

Therapists considering working with a case involving IPV may find it helpful to use four criteria, put forward by Greene and Bogo (2002), to distinguish between situational couple violence and coercive controlling violence. First, the therapist can examine the range of control tactics used. Second, the therapist can assess the motivation for the perpetrator's use of violence within the relationship. Third, the therapist can consider the impact of the physical violence on the partner. Lastly, it may prove helpful to get a sense of the subjective experience of each partner.

Slootmaeckers and Migerode (2018) recently proposed three additional criteria for therapists facing the difficult decision of whether to move forward with treatment for violent couples. First, the therapist should evaluate their own subjective experience of working with cases involving violence. Second, the therapist can consider the joint motivation of the partners to engage in conjoint treatment and their desire to repair the relationship. Third, the therapist should consider their own ability to foster safety within the session.

Distinguishing between situational couple violence and coercive controlling violence is a crucial step for any therapist considering work with IPV (Slootmaeckers & Migerode, 2018). However, determining suitability for conjoint or familial therapeutic

interventions does not stop with an assessment of the above criteria. The following chapter will provide the reader with further insight into the use of two therapeutic interventions: couples and family therapy.

Chapter 3: Systemic Approaches to Treating Intimate Partner Violence

There are a variety of therapeutic approaches with the potential to meet the needs of those impacted by IPV. In this chapter, the researcher reviews available literature on the use of systemic approaches to reduce the occurrence of IPV. Although individual and group therapy have historically been the focus of IPV intervention research, the use of systemic approaches for the treatment of IPV, namely couples therapy, has gained considerable attention within the field over the last 20 years. The focus of this thesis is newer systemic intervention for IPV: family therapy. Family therapy has begun to emerge within the literature as a potential option for the prevention and treatment of IPV, particularly with regard to its ability to address the needs of children.

This chapter reviews the available literature on systemic approaches to the treatment of IPV, with ample attention paid to family therapy. The chapter begins with a discussion on the rationale for approaching IPV from a systemic perspective, including the rationale for using couple and family therapy to treat IPV. The potential risks and challenges associated with this approach are presented next, followed by a review of potential benefits and opportunities. Concluding remarks are presented at the end of this chapter.

Overview of Systemic Approaches

Empirical evidence for the effectiveness of systemic interventions is strong. In a recent review, Carr (2019a) presented evidence from meta-analyses, literature reviews, and controlled trials on the effectiveness of systemic interventions for adult-focused problems. Carr (2019a) concluded that the available literature on systemic interventions provides strong support for the effectiveness of this approach for a wide variety of adult-

focused problems, including IPV, relationship distress, psychosexual problems, mood disorders, anxiety disorders, substance use problems, psychosis, and adjustment problems following chronic illness. Carr (2019b) drew similar conclusions about the effectiveness of systemic interventions for a variety of child-focused problems, noting that there is strong support for the effectiveness of this approach in a variety of circumstances, including children recovering from child abuse and neglect, feeding and attachment problems, sleep problems, conduct problems, emotional problems, somatic problems, eating disorders, as well as psychosis. For either adult- or child-focused problems, systemic interventions were deemed to be effective as both a stand-alone treatment option or as part of a multimodal treatment approach (Carr, 2019a, 2019b). Thus, it would seem that a systemic treatment approach is largely supported within psychotherapy literature.

Treatment options for IPV are continuing to develop as conceptualizations of IPV evolve. Systemic approaches to IPV stem from a recognition of the heterogeneity of violence within intimate relationships (Stith et al., 2012). Proponents of systemic approaches maintain that violence within the home, particularly violence that is not based on coercive control, should be understood within the context of family relationships and that the impact of violence must be addressed relationally (Schneider & Brimhall, 2014; Stith et al., 2012). Thus, a systemic approach may be employed by therapists looking to work with multiple family members. Systemic therapists may utilize a variety of session formats to accomplish this goal, including individual, group, dyadic, triadic, or whole family sessions.

Systemic approaches have been criticized for focusing solely on relationship dynamics to the exclusion of power and control-based dynamics described within

feminist literature (Mayer, 2017; Shaw et al., 1996). Contemporary scholars of systemic approaches appear to be more aware of the limitations and potential dangers of providing systemic therapy to couples and families experiencing violence based on power and control (Stith & McCollum, 2011; Tomsich et al., 2015). They seem to be demonstrating this caution by advocating for therapists to conduct violence assessments with attention to assessing coercive controlling violence (e.g., more severe and frequent physical abuse that escalates over time). One common risk assessment appears to be the Revised Conflict Tactic Scale (Straus et al., 1996).

Overall, it is imperative therapists remain open to the possibility of unilateral power-based violence during all stages of therapy including the initial meet and greet session (George & Stith, 2014). When this type of violence is identified within a relationship, then it seems the consensus in the work reviewed was not to conduct systems therapy to avoid causing harm to nonviolent family members (Stith et al., 2012).

Although there is significant overlap between the rationale for using couples therapy and family therapy, there are also distinctions that must be made. Below are brief descriptions of these two approaches and rationales for their use.

Couples Therapy

Couples therapy involves therapists conducting conjoint sessions with intimate partners. Typically, the focus of this form of psychotherapy is on identifying and resolving conflicts between partners. The goals of couples therapy are often framed around strengthening or improving the relationship, although it may also be used to facilitate more amicable separations. Given that the partner relationship is the focus of

couples therapy, the experiences of other family members (e.g., children) are not typically addressed.

Couples Therapy for IPV. Couples therapy has been established as an effective approach for the treatment of some forms of IPV, particularly for carefully screened couples in which partners are not fearful of increased violence (Maharaj, 2017; Stith et al., 2012). Situationally violent couples have been identified as being best suited to couples therapy for IPV (McCollum & Stith, 2008; Slootmaeckers & Migerode, 2018, 2020; Stith et al., 2012). As noted in the previous chapter, couples experiencing situational couple violence may use violence following an escalation of arguments and conflict rather than for purposes of power, control, or coercion (M. P. Johnson & Leone, 2005; Kelly & Johnson, 2008). Thus, authors such as Slootmaeckers and Migerode (2018) argued the patterns of violence within situationally violent couples can be explored within the bidirectional patterns of their relationship and family system, making them well suited to couples therapy.

Therapists may choose to use couples therapy in cases of situational couple violence when couples are intending to stay together and looking for a way to move forward while maintaining safety and accountability; it may also be used when a couple is looking to separate safely (Mayer, 2017). Several authors have proposed models for couples therapy in cases of situational couple violence. For instance, Stith et al. (2002) has proposed the domestic violence-focused treatment model, which is an 18-week manualized program delivered by two cotherapists. The authors emphasize the need for an effective safety plan for both partners before beginning this program. This approach, which is based on a solution-focused framework, begins with 6 weeks of separate gender

programming. In this phase of treatment, one therapist is assigned to each partner and sessions are designed to help each partner develop a vision for their future relationship and the safety skills necessary for conjoint treatment. The next 12-week phase brings the partners and therapists together in couples therapy. In this phase, risk and safety is monitored on an ongoing basis through the use of brief individual meetings before and after each session in which partners are asked to complete a survey on their current level of safety. According to the authors, this program can be delivered as a multicouple group format or a single couple format. In their study, Stith et al. (2004) found the likelihood of male recidivism was reduced for both the multicouple group format (25% recidivism at 6 months, 13% at 2 years, among 16 couples) and the single-couple format (43% recidivism at 6 months, 0% at 2 years, among 14 couples), compared to the no-treatment group (67% recidivism at 6 months, 50% at 2 years, among 9 couples).

Family Therapy

Family therapy involves therapists working with multiple family members to address issues and make changes within the family system. Family therapy typically focuses on communication within the family and relational processes. Within this model, family members are defined as "persons who are biologically and/or psychologically related, are connected by historical, emotional, or economic bonds, and perceive themselves as part of a household" (Gladding, 2019, p. 29). As such, it is the connection between members that creates a family unit, rather than any specific form of membership. In some cases, all family members will be present in a family therapy session. In other cases, work may take place within a subsystem of the family (e.g., one parent and the eldest child).

Within family therapy, the family is conceptualized as an interconnected system, in which each member is influenced by the others (Gladding, 2019). This is typically referred to as a family system and/or systemic approach to therapy (Bowen, 1978; Gladding, 2019). From this perspective, the health and well-being of a family is tied to the health and well-being of the individual members.

Family Therapy for IPV. The rationale for using family therapy over couples therapy lies in the need to address the impact of IPV with each family member, as well as exploring the impact of IPV on the family system as a whole. An advantage that family therapy may have over couples therapy is that family therapists are accustomed to seeing each family as a unique system. As highlighted in the previous chapter, there are several distinct types of violence, each arising from different contexts, and each having the potential to impact families in different ways. In light of this, a family therapist may be well suited to recognizing how each family's unique patterns of communication and relational processes fit within the type of violence they are experiencing and how those patterns may be restructured.

Risks and Challenges of a Systemic Approach to IPV

As with any therapeutic intervention targeting IPV, there are risks and challenges associated with taking a systemic approach to IPV treatment. The majority of risks and challenges are comparable between couple or family therapy. As such, the researcher has elected to present them together. Differences between the two approaches are highlighted where it becomes relevant.

There appears to be eight central areas related to risks and challenges: (a) likelihood of harm, (b) blame, (c) substance use problems, (d) assessment of fit,

(e) assessment of risk and safety, (f) lack of IPV training, (g) inconsistent and ineffective assessment practices, and (h) therapist factors limiting IPV assessment. The researcher has elected to use these risks to inform the survey discussed in depth in Chapter 5. Each area of risk is described in detail below.

Likelihood of Harm

Therapists considering the use of couple or family therapy to treat IPV must consider the likelihood that their approach may impact the frequency, severity, or nature of violence within a family. Therapists are ethically bound to avoid or minimize harm to clients (American Psychological Association, 2017; Canadian Psychological Association, 2017a). Unfortunately, harm can occur without effective assessment of risk and safety on an ongoing basis. Although assessment will be covered in more depth in subsequent sections, it is important to note that effective assessment is essential to safety.

A systematic review of six experimental studies found couples therapy for IPV was no more dangerous than gender-specific therapies (Stith et al., 2003). A more recent review by Hurless and Cottone (2018) drew similar conclusions, noting existing studies provide no evidence that conjoint treatment models increase the risk to nonviolent family members. Additionally, Lechtenberg et al. (2015) found that attending conjoint therapy for IPV made both men and women feel safer. However, a limitation of the reviews by Stith et al. (2013) as well as Hurless and Cottone (2018) lies in the age of the referenced studies, given that the newest data are now 20 years old (Dunford, 2000). Nevertheless, this is an important finding, given that early work on the use of systemic therapies for IPV warned of the potential for an increased risk of violence, particularly for some types

of severe violence or for those looking to leave the relationship (Jacobson & Gottman, 1998; Jory et al., 1997; O'Leary, 2001).

Blame

In order to avoid emotional or psychological harm, therapists must be careful not to place blame on the nonviolent family members. One of the long-standing arguments against the use of a systemic approach to treat IPV lies in the possibility that blame will be shifted from the violent family members to the nonviolent family members by focusing on violence as a relationship problem (Goldner et al., 1990). In this way, therapy may result in psychological harm if the nonviolent family members are made to take responsibility for the violence (Jory et al., 1997). However, contemporary advocates of systemic therapists highlight the importance of holding the violent family member accountable as they work within a systemic framework (George & Stith, 2014; Stith et al., 2011) while also recognizing that the dysfunction and discord within the family is a systemic issue (Glick et al., 2016). Authors such as Brown and James (2014) have added, while examining relationship patterns between violent partners can be useful, it is important that therapists not rely exclusively on this perspective, as it fails to address power imbalances and may lead to victim blaming.

Substance Use Problems

Substance abuse often cooccurs with IPV and may play a role in the pattern of violence for some couples (Fals-Stewart, 2003; Karakurt et al., 2016). For instance, a study by Fals-Stewart (2003) found, among 104 couples, men are up to 11 times more likely to be physically aggressive toward their intimate partner on days when they reported consuming alcohol. In order to reduce the risk of violence, it is recommended

that family members with a history of substance abuse refrain from using while in therapy; in such cases, the therapist may need to refer to external substance abuse supports while systemic treatment takes place (Glick et al., 2016).

Empirical evidence appears to support the application of a systemic approach to cooccurring substance abuse and IPV. For instance, a study by O'Farrell et al. (2004) found alcohol behavioural couple therapy significantly reduced male-perpetrated IPV in a sample 303 heterosexual couples. Additionally, a study by Schumm et al. (2009) found alcohol behavioural couple therapy was more effective at reducing male- and female-perpetrated violence among a sample of 103 heterosexual couples in cases which the female partner struggled with an alcohol use disorder. In both studies, IPV was measured using the Verbal Aggression and Violence subscales of the Conflict Tactic Scale (Straus, 1979). Thus, when substance use does cooccur with IPV, it is recommended that the therapist focus on supporting sobriety.

Assessment of Fit

A predominant theme within systems literature centres around the need for therapists to assess the fit of a systemic approach before initiating treatment. Early researchers suggested that a basic assessment of fit should explore whether (a) the nonviolent partner is aware of resources (e.g., local shelters), (b) both partners want to remain together, (c) both partners want to participate in therapy together, (d) remediation is reasonable, and (e) the violence can be controlled (Rosenbaum & O'Leary, 1986). Contemporary authors have added to this discussion by noting that an assessment of fit should also include exploring whether the violent family members blame their partner for the violence (Stith & McCollum, 2011).

Glick et al. (2016) emphasized the need to balance assessment between the individuals and the family system when assessing for fit in cases of violence. Individual factors to assess include the presence of psychiatric disorders, the motivation of violent family members to accurately report violent behaviour, as well as the ability for the violent family members to acknowledge their behaviour as problematic. Glick et al. also highlighted the need to assess the factors that are motivating participation in treatment as well as the motivation of the violent family members to stop the violent behaviour. Some have recommended that couples seeking system-based treatment sign a no-harm contract and commit to attending therapy for the full 3- to 6-month course of treatment (Carr, 2019a; Stith et al., 2002). Family therapy is contraindicated when the violent family members are not motivated to stop their violent behaviour or the violence cannot be controlled (Glick et al., 2016).

Assessment of Risk and Safety

Assessment is key to determining the safety and suitability of this approach. Guidelines suggest that couple and family therapists (a) screen each family, regardless of whether violence was disclosed (i.e., universal screening); (b) screen each relevant family member individually in order to ensure an accurate safety assessment; and (c) screen using a variety of assessment strategies, including standardized assessments (Stith et al., 2012). There are over 45 assessment instruments purported to assess IPV within medical and mental health settings (Hays, 2017), including the Revised Conflict Tactic Scale (Straus et al., 1996) and the Danger Assessment Scale (Campbell, 1995). It is beyond the scope of this thesis to make recommendations as to the preferred scales.

Within the context of IPV, the assessment of risk and safety should cover a variety of areas. Therapists are advised to inquire about the frequency, severity, and nature of past and present violence (Glick et al., 2016). Therapists are also advised to assess violent family members' ability to control their violent behaviour and their ability to acknowledge their behaviour as problematic (Glick et al., 2016). Information on the availability of weapons, past threats to use weapons, and willingness to relinquish firearms should also inform treatment decisions (Glick et al., 2016; Stith et al., 2002).

When considering working with the whole family, therapists must assess the family members as individuals and within the context of their family relationships (Hamel & Nicholls, 2007). Family therapists must also evaluate family functioning and examine the impact of violence on family functioning (Hamel & Nicholls, 2007). Hamel (2014) has recommended family therapists assess six key areas in cases involving IPV: (a) the ability of each family member to cope with conflict, stress, and anger; (b) beliefs about violence and anger; (c) family structure, including differentiation and organization, boundaries and hierarchies, as well as adaptability; (d) relationship dynamics, including attachment styles, communication, emotional expression, as well as conflict management; (e) functions of each family member's behaviour, and (f) and the trajectory of violence over time.

Lack of IPV Training

Clinical guidelines from Stith and McCollum (2011) provided recommendations for therapists working with families impacted by IPV. Such guidelines highlight the need for therapists to have advanced training in IPV. However, it remains unclear how therapists should go about receiving advanced training in IPV. Authors have long been

calling for couple and family therapists to have graduate-level training in addressing IPV (e.g., Avis, 1992), yet this continues to be reported as a gap in counsellor training programs (Hurless & Cottone, 2018; Karakurt et al., 2013; Stith et al., 2012).

Frontline service providers are likely to benefit from IPV-related training. Soh et al. (2018) recently conducted a survey of 116 counsellors, psychiatrists, psychologists, doctors, nurses, social workers, and occupational therapists; the majority of participants reported training would be helpful in the areas of (a) screening for IPV (69.6%), (b) supporting patients impacted by IPV (72.5%), and (c) referring patients impacted by IPV (76.5%). A study by McCarthy and Bianchi (2019) found the implementation of an IPV screening protocol in a university health care clinic, which served to provide IPV screening training to service providers, was related to positive changes in IPV screening knowledge, attitudes, and perceived self-efficacy. Although advanced training is not likely to be standardized, readers may benefit from referring to article by Creech et al. (2018), which briefly described a 2-day IPV training delivered by licenced clinical psychologist experienced in treating IPV.

Based on their findings from a systematic review of IPV screening literature, Todahl and Walters (2011) suggested IPV training for therapists include information related to the following 10 areas of practice: (a) IPV prevalence and dynamics; (b) assessing violence on a continuum; (c) informed consent policies and how they relate to IPV (e.g., how a no secrets policy may impact a IPV screening policy); (d) procedures for conducting IPV screening in individual interviews; (e) the danger, imminence, and lethality of IPV; (f) violence disclosure procedures; (g) safety planning for all members; (h) therapist self-efficacy and attitudes related to IPV; (i) working with diverse client

populations and IPV; and (j) IPV screening for adolescents. Alarmingly, there is limited literature available on the nature of existing IPV-related training for couple and family therapists.

Inconsistent and Ineffective Assessment Practices

Unfortunately, inconsistent and ineffective screening protocols by couple and family therapists are a regular theme within the extant literature. Numerous studies have demonstrated consistent underutilization of standardized safety assessment tools by therapists and therapists in training (Flåm & Handegård, 2015; George & Stith, 2014; Schacht et al., 2009; Todahl et al., 2008). In a survey of 620 members of the American Association for Marriage and Family Therapy, only 3.5% of therapists reported adherence to all guidelines related to screening intimate partner violence (Schacht et al., 2009). In a study of 620 respondents, only 53.2% of family therapists reported they screened all families, 37.2% always screened family members separately, and 11.9% used multimodal assessments (Schacht et al., 2009).

Similar conclusions were drawn by Froerer et al. (2012), who found 28 marriage and family therapist interns, at both master's and doctoral levels (25% and 75% of the sample, respectively), consistently underassessed for IPV when conducting couples therapy. Trainees in Froerer et al.'s study did not universally or systematically screen for IPV. Furthermore, the authors found, although IPV assessment was three times more likely to occur when the female partner indicated that violence was a problem on the intake form, this factor did not always result in an IPV assessment. Given the age of Froerer et al.'s study, as well as the study by Schacht et al. (2009), it is hoped that these results would be different if replicated today.

Marriage and family therapists are not alone in their inconsistent IPV screening practices, as this variation has also been found in populations of other healthcare professionals (e.g., Clark et al., 2017). Unfortunately, the consequences of inconsistent and ineffective screening are significant. By not using standardized assessment tools, therapists may miss critical areas of assessment, resulting in an insufficient evaluation of risk (Tomsich et al., 2015).

Inconsistent and ineffective IPV assessment is a significant ethical issue with the field of psychotherapy. One of the core competencies of couple and family therapists is the ability to assess violence (Northey & Gehart, 2020). Additionally, couple and family therapists are required to "take steps to ensure the competence of their work and to protect clients from harm" (American Association for Marriage and Family Therapy, 2015, p. 5). Given that IPV assessment is one way to protect clients from harm, a lack of consistent and effective screening is cause for significant concern. However, increasing therapist competence in this area may serve to combat this alarming trend in IPV assessment. Therapist competence can be understood as the degree to which a therapist has the skill and knowledge required for service delivery that meets expected standards and/or achieves desired effects (Fairburn & Cooper, 2011). IPV training may be the key to increasing the competency of couple and family therapists.

Therapist Factors Limiting IPV Assessment

Several therapist-specific factors may be creating barriers to the effective use of systemic approaches in cases of IPV. A lack of therapist confidence and IPV knowledge are central challenges associated with using a systemic approach in cases involving IPV. In a small (N = 5) qualitative study by Karakurt et al. (2013), couple and family therapists

reported that when faced with IPV, they lack confidence in the area of safety planning and are unsure of how to proceed following the initial violence assessment. These same participants reported a lack of course material as well as clinical experience related to working with IPV.

A variety of therapist demographic factors may be mediating IPV the implementation of effective IPV assessment. Research suggested age may be a mediating factor in the utilization of standardized assessments (Lushin et al., 2019), although this difference may be indirectly influenced by years of experience and/or education. Lack of awareness related to IPV has also been associated with limited IPV assessment, including a limited awareness of community resources and referral options (Clark et al., 2017; Karakurt et al., 2013; Soh et al., 2018; Tomsich et al., 2015).

According to Todahl and Walters (2011), who conducted a systematic review of IPV screening practices, self-efficacy beliefs may also play a role in the implementation of universal IPV screening. The importance of self-efficacy beliefs in IPV screening has more recently been echoed by Meredith et al. (2017). In Meredith et al.'s study, primary care providers (N = 94) were asked about their level of confidence in their ability to provide a variety of services, including IPV screening. The authors found stronger self-efficacy beliefs were associated with reporting regular IPV screening (Meredith et al., 2017). The importance of self-efficacy beliefs are significant given the aim of this thesis, in that the views and beliefs of therapists regarding IPV are likely to impact the services they provide. Future research must continue to analyze the relationship between views and beliefs related to IPV and service provision.

Although one expects lower levels of self-confidence in newer therapists, Karakurt et al. (2013) found among marriage and family therapists ($N = 5$) feelings of uncertainty and worry are also present in experienced family therapists, particularly when working with IPV. However, their study found feelings may be moderated by level of clinical experience (Karakurt et al., 2013). As such, future studies investigating the need for IPV training would do well to account for various demographic factors associated with therapist confidence.

Therapists must also have confidence in their ability to work with high-conflict couples and to create safety (Stith & McCollum, 2011). Although IPV training is likely to provide the foundation for therapist confidence in this area, supervision may also play an important role in making therapists more attentive to IPV-related considerations (Todahl et al., 2008). Supervisors who have a high level of competence in the assessment and treatment of IPV are likely to pass on related knowledge to their supervisees (Todahl et al., 2008). This, in turn, is likely to increase therapists' confidence in their ability to work with IPV.

Benefits and Opportunities of a Systemic Approach to IPV

The body of IPV literature has less to say about the benefits of a systemic approach to IPV, compared to the possible risks. Nevertheless, four key benefits and opportunities emerge: (a) safety planning, (b) creating physical safety, (c) creating emotional safety, and (d) attachment injury repair. The following benefits are used to inform the survey described in Chapter 5.

Safety Planning

Ongoing safety planning plays a critical role in any IPV intervention. When working from a systemic framework, therapists have the advantage of multiple sources of information to inform planning, but they also have more factors to consider. Within the extant literature, safety planning has typically focused on establishing the immediate physical safety for nonviolent family members, particularly for women (e.g., Paterno & Draughon, 2016). While therapists should be adept at preparing such a safety plan, they must also be able to create a safety plan that accounts for both the physical and emotional safety of each family member (Schneider & Brimhall, 2014). Furthermore, therapists must carefully consider the diverse safety needs within the family and how these needs may change over time. When working with both partners, it is necessary to establish a safety plan for the violent family members, which may include teaching skills such as an attachment-based time-out (Schneider & Brimhall, 2014). MacMillan et al. (2013) noted the safety needs of children require special attention, as they may have received mixed messages about safety. For instance, children may have been told by a parent to use a secret code to promote safety in the home while also receiving messages from other adults about never keeping violence a secret (MacMillan et al., 2013). Additionally, children may have been told how to cope with the violence, which may send the message that violence is normal (MacMillan et al., 2013). Thus, working within the family system to safety plan involves many factors, but it also presents the opportunity for enhanced physical and emotional safety for each family member.

Creating Physical Safety

Systemic therapies can promote increased physical safety for individuals impacted by IPV. Physical safety may be increased by systemic therapy, particularly when the couple has not separated and/or wish to remain together, and will be going to the same residence following each session (Goldner, 1998). A systemic approach may also help ease the process of separation, given that the therapist can be seen as a trusted third party working toward positive outcomes for both parties (Goldner, 1998). This ability to increase safety through a systemic approach has more recently been echoed by Stith and McCollum (2011), who argued the safety of partners and children is promoted when therapists can enhance the family's ability to collaboratively resolve conflict without the use of violence. Within the context of couples therapy for IPV, therapists view situational couple violence as a relational problem. Rather than focusing on power and control as the only source of IPV, couples therapists are able to explore the patterns of interaction, which both partners engage in, that promote bidirectional violence within a relationship (Hurless & Cottone, 2018). This may include an exploration of events, stressors, or patterns of behaviour that precede violence or increase its likelihood (Cleary Bradley & Gottman, 2012; McCollum & Stith, 2007; Todahl et al., 2012). Once these dynamics are identified, couples are able to learn and practise new ways of interacting with one another with the support of the therapist (Todahl et al., 2012). In this way, the therapist is able to create a level of physical and emotional safety that may not have been possible within the context of a gendered intervention.

Creating Emotional Safety

Systemic therapies have the potential to create emotional safety for children impacted by IPV by providing space to share their experience. Secret keeping is common within families impacted by violence (Bancroft et al., 2012; Jaffe et al., 2014). Children exposed to IPV are likely to believe they must keep the violence—as well as their feelings about the violence—a secret. This belief about secret keeping may result from parent manipulation or pressure (Jaffe et al., 2014). It may also be learned through observation of parents and other adults. Thus, children do not feel safe to express their feelings, and may even believe that sharing is a family betrayal. Through family therapy, children are offered the opportunity to safely discuss events that are seldom brought up, particularly as they relate to the child's experience of the event and their present responses (Furrow et al., 2019). Although some parents may be hesitant to invite discussions related to IPV, children do indeed benefit by having the opportunity to talk about their experiences; even children who described their experiences of IPV as horrific have been found to experience feelings of relief when given the space to discuss their experiences (Izaguirre & Cater, 2018). However, before this discussion can safely happen, therapists must recognize the child's ability to reflect on the experience of IPV; then, they must actively provide support and space to the child who wishes to share (Callaghan et al., 2017; Flåm & Handegård, 2015).

Inviting children to participate in systemic therapy can also promote emotional safety by affirming the child's sense of being seen, accepted, and valued (Hartzell et al., 2009). Indeed, the need for counsellors to create emotional safety when addressing violence was emphasized by both men and women attending couples therapy for IPV

(Lechtenberg et al., 2015). Family therapists are uniquely suited to recognizing the impact that violence has had on children and other family members; they are also in the position to help caregivers recognize it as well (Flåm & Handegård, 2015). However, before therapists are able to work directly with the child to promote emotional safety, they need to be willing to invite the child into the family therapy process.

The decision of whether to include children in family therapy is likely to be influenced by the therapist's preference for inclusion. When given the option to participate in family therapy sessions, the overwhelming majority of children choose to be involved (Hartzell et al., 2009; Sheinberg & True, 2008). However, practising family therapists have historically been hesitant to include children in the therapeutic process when there is no indication of violence (Hartzell et al., 2009; Rober, 2008; Ruble, 1999) as well as when there is an indication of violence (Flåm & Handegård, 2015; Siegel, 2013). In a recent study by Oed and Gonyea (2019), 73 marriage and family therapy students, as well as recent graduates, completed a questionnaire about their attitudes toward the inclusion of children in family therapy sessions. The authors found, although 90% of participants supported the inclusion of children in the therapy process, the choice of whether to include children in sessions became more varied when presented with a case vignette. For child-focused problems, 28.1%–33% of participants would exclude the child from the first session and 8%–11.6% would exclude the child from subsequent sessions (Oed & Gonyea, 2019). For adult-focused problems, 72.3% of participants would exclude the child from the first session and 38.7% would exclude the child from subsequent sessions (Oed & Gonyea, 2019). Thus, the exclusion of children from family therapy sessions may have more to do with the therapist's assessment of the presenting

problem than the therapist's view about the general inclusion of children in family therapy sessions.

Attachment Injury Repair

Systemic interventions may offer the opportunity to heal attachment injuries that can also be related to healing from IPV. Attachment injuries refer to attachment-related events, such as perceived betrayal or abandonment, that negatively impact the felt sense of safety and security within close relationships (S. M. Johnson et al., 2001). Attachment injuries often result in a loss of intimacy and trust within romantic relationships (S. M. Johnson et al., 2001). In families, attachment injuries may negatively impact a child's ability to seek care and connection from a caregiver and/or impede a caregiver's ability to emotionally present for the child (Furrow et al., 2019). For both couples and families, attachment injuries lead to a sense of vulnerability and fundamentally change the relationship dynamics. Couples and families are likely to experience violence and conflict as attachment injuries, as they represent a violation of trust and reduce safety and security within the relationship. Schneider and Brimhall (2014) argued violence may also be the result of an attachment injury (e.g., an affair), such that it becomes an extension of marital discord or distress.

A major theme within IPV literature is the use of attachment theory to conceptualize IPV. However, most studies focus on exploring associations between attachment styles and IPV perpetration and victimization (e.g., Almeida et al., 2019; Park, 2016) and not on the treatment of IPV. Some within this field have recently begun to examine how attachment theory can also be applied to the treatment of IPV, particularly for couples experiencing situational couple violence (e.g., Rouleau et al.,

2019; Slootmaeckers & Migerode, 2018). Rouleau et al. (2019) suggested this approach works by decreasing violence through the creation of a more secure base within the relationship and by exploring the emotional experience associated with the attachment injuries.

Systemic interventions may also help to repair IPV-related attachment injuries between children and their caregivers. Flåm and Handegård (2015) suggested involving children in IPV-related systemic therapy creates space for dialogue between the child and the adults, which can be beneficial for repairing issues of attachment and trust as a family unit (Rober, 2008). However, at present, there are no empirical studies proposing an attachment-based systemic intervention for families experiencing IPV. The researcher intended to fill this gap by exploring how EFFT may be used as an attachment-based systemic intervention in such cases.

Given the abundance of literature on the negative effects of IPV on children, interventions that promote the repair of attachment injuries between children and their caregivers represent an opportunity for growth within this field and, therefore, warrant further investigation. The researcher hoped to address this gap in the literature by exploring how the EFT model, which is an attachment-based approach, may be applied to cases of situational couple violence.

Outcome Data

The effectiveness of systemic therapies has become the focus for many scholars within the field of IPV research. This section will provide the reader with a brief review of the outcome data associated with the use of systemic therapies to treat IPV. One important limitation of the presented outcome data is that it is largely based on

interventions with couples. It is worth noting that the studies reviewed here utilized systemic interventions with carefully screened participants, most of whom reported violence that would be associated with situational couple violence. A theme throughout this body of literature was the agreement among study authors that severe violence and violence based in power and control was not appropriate for systemic interventions.

The researcher was unable to locate empirical, English language outcome data related to family therapy interventions specifically targeting IPV. However, Danielson and colleagues (2020) recently investigated the use of risk-reduction family therapy for 124 adolescents who experienced interpersonal violence, including child sexual abuse, physical abuse or assault, threat with a weapon, as well as witnessing violence. According to the authors, risk-reduction family therapy in an integrative exposure-based approach incorporating cognitive-behavioural interventions targeting seven domains: psychoeducation and engagement, communication within the family, problematic substance use, coping, posttraumatic stress disorder, healthy decision making, and reducing the risk of revictimization. Results from this clinical trial demonstrated that problematic substance use, as well as posttraumatic stress disorder symptoms were significantly reduced in adolescents following risk-reduction family therapy (Danielson et al., 2020). While this study did not target the effects of witnessing IPV specifically, the results remain relevant to the current topic because it seems to support the safety and suitability of family therapy for presenting problems related to violence.

For cases involving mild to moderate violence consistent with situational couple violence, numerous systematic reviews and meta-analyses have found a systemic approach to be an effective intervention (Carr, 2019a; Karakurt et al., 2016). When

compared to couples receiving no treatment at all, systemic interventions have been found to be more effective in reducing both male and female perpetrated violence (Cleary Bradley et al., 2014; Cleary Bradley et al., 2011; Cleary Bradley & Gottman, 2012). For instance, a study by Cleary Bradley et al. (2014) evaluated the use of the Creating Healthy Relationships Program—a psychoeducational systemic intervention based on the work of Gottman (1994)—with 115 heterosexual, low-income, mutually violent couples. The authors found the treatment group demonstrated significantly fewer violent behaviours at 6–12 months ($t = 2.17$; $p < 0.05$) and 12–18 months ($t = 1.72$; $p < 0.010$) following treatment completion.

Systemic interventions targeting IPV within substance-abusing populations have been found to be more effective than gender-specific individual therapy in reducing both male and female perpetrated violence (Lam et al., 2009). In their study, Lam et al. (2009) explored the use of behavioural couples therapy as well as parents' skills with behavioural couples therapy for 30 married or cohabiting male patients entering outpatient treatment for an alcohol use disorder. At posttreatment, participants in both treatment groups reported clinically meaningful reductions in male-to female and female-to male violence, whereas the control group receiving individual gender-based therapy did not (Lam et al., 2009). In another study, Fals-Stewart and Clinton-Sherrod (2009) found, when compared to gender-specific (male only) group therapy, behavioural couples therapy was more effective in reducing male-to-female violence among 207 married or cohabiting heterosexual couples at the 12-month follow up. In this case, male-to-female violence was measured by the percentage of days with any violence ($M = 1.3$, $SD = 1.7$, $p < 0.05$ for treatment group, $M = 2.0$, $SD = 2.0$, $p < 0.05$ for control group) or severe

violence ($M = 0.3$, $SD = 0.4$, $p < 0.05$ for treatment group, $M = 0.6$, $SD = 0.03$, $p < 0.05$ for control group; Fals-Steward & Clinton-Sherrod, 2009).

In a study by Mendez et al. (2014), the majority of the 14 couples who participated in couples therapy for IPV reported positive change for both female and male partners, as measured by their responses to a semistructured interview on their experience. Couples reported gaining personal insights, particularly about their role in the relationship and about issues related to anger (Mendez et al., 2014). They also reported gaining insights into their relationship, particularly regarding solving conflicts, as well as insights into the pace of change (Mendez et al., 2014). Partners reported being more patient with one another following treatment, feeling calmer, and experiencing overall shifts in attitude (Mendez et al., 2014). Interestingly, several female partners noted the experience left them with feelings of empowerment (Mendez et al., 2014). Couples also noted changes within their relationship, including increased closeness and communication, respect, hopefulness, and ability to manage conflict (Mendez et al., 2014). In this study, seven couples reported severe violence before treatment began and three reported severe violence after the final session (Mendez et al., 2014), indicating that a systemic approach may help reduce more severe forms of IPV.

The absence of family therapy literature may be tied to another limitation within this field of research, a lack of studies reflecting diverse cultural backgrounds within the context of IPV (Stith et al., 2012). Hamel (2014) suggested cultural factors may play an important role in the use of family therapy for IPV. For instance, Lee (2000) described how family therapy may be useful for some Asian families impacted by IPV, particularly when respected family members are invited to participate in sessions. Similarly, Carrillo

and Goubaud-Reyna (1998) explored the utility of family therapy for Latino families looking to address IPV.

Concluding Remarks

There is considerable controversy among researchers and practitioners on the applicability of a systemic approach for IPV. This chapter has outlined various rationales for using either couple or family therapy to address IPV and provided the reader with a summary of the potential risks and challenges associated with this approach as well the potential benefits and opportunities. Outcome data on the effectiveness of a systemic approach to IPV treatment has also been presented.

As noted in the previous section, the vast majority of studies on the systemic treatment of IPV has focused on the use of couples therapy. This focus on conjoint treatment has contributed a great deal to this body of literature, particularly with respect to identifying potential risks and benefits to working with couples experiencing IPV. Unfortunately, this singular focus on couples therapy has meant that the voice of the child, and other important family members, has been neglected. This underestimates the needs of all members for familial support and does little to address the significant impact that violence has on all members of the family (Flåm & Handegård, 2015). Family therapy, on the other hand, is well suited to recognizing and giving voice to the experiences of all family members (Flåm & Handegård, 2015).

It is not a simple task to provide "both a child-focused and a violence-sensitive family treatment service" (Flåm & Handegård, 2015, p. 77). This is particularly true in light of the limited research on the use of family therapy in cases of IPV, in that it places family therapists at a disadvantage as they try to decide on the best course of treatment.

The Canadian Association of Marriage and Family Therapists (2019) stipulated in their *Code of Ethics* that family therapists are "expected to assess the risks and benefits of providing therapy, and to ensure the client is protected" (p. 8). However, without empirical literature on the risks and benefits of working with the whole family to reduce violence in the home, family therapists are handicapped in their decision making. The following chapter will provide the reader with an overview of one systemic intervention that may allow for the use of family therapy in cases of IPV, EFFT.

Chapter 4: Emotionally Focused Therapy

The question of how best to address IPV therapeutically has long been a theme within IPV literature. To answer this important question, several authors have begun proposing an emotionally focused theoretical framework in cases involving violence in the home, particularly for situationally violent couples (Rouleau et al., 2019; Slootmaeckers & Migerode, 2018, 2020). Although further research is needed, EFT has begun to emerge as a promising option for those impacted by situational couple violence.

The researcher was careful to draw attention to the fact that while IPV has been identified as a contraindication for EFT (Furrow et al., 2019; S. M. Johnson, 2004), scholars have recently proposed it is not the presence of violence that is necessarily contraindicated, but rather a context of fear and abuse that accompanies some types of IPV (Slootmaeckers & Migerode, 2020). Thus, several authors suggested EFT may be suitable in cases involving situational couple violence (Rouleau et al., 2019; Slootmaeckers & Migerode, 2018, 2020), given that situational couple violence results from the escalation of arguments and is not typically associated with partners being fearful of one another (Kelly & Johnson, 2008). However, the body of literature on EFT in cases of situational couple violence is focused exclusively on couples. There is currently no literature on the use of EFFT in cases involving situational couple violence and no information exists on the views of EFT therapists about this area of practice. As such, the researcher intended to use this thesis to fill this significant gap in the literature.

It is important to note that while EFT was primarily developed by Canadian, Susan M. Johnson, for use with couples, EFT is being increasingly applied to individuals and families (S. M. Johnson, 2019). These advancements within the field of EFT are

exciting, but scholarly literature within these new areas remains sparse when compared to the literature on EFT for couples. Though the focus of this thesis remains on the use of EFT for families, this chapter will also include a review of EFT for couples, given that EFT for couples has been the focus of extensive scholarly literature. Although the theory and principles of EFT holds true regardless of modality, there are several noteworthy differences in its application to couples versus families (Furrow et al., 2019). The researcher draws attention to such differences throughout the chapter, with an emphasis on EFT applied to families.

The researcher begins this chapter by offering an overview of EFT in order to familiarize the reader with the theory and practice of EFT. Following this, the researcher explores the topic of EFT for families, focusing specifically on what makes EFT for families distinct from EFT for couples. A review of recent EFT research is then presented. The researcher moves on to discuss how the EFT model may be applied to couples and families impacted by situational couple violence.

Emotionally Focused Therapy

In this section, the researcher introduces the reader to EFT, beginning with the theory. Attachment theory is described as the theoretical framework that helps conceptualize adult love and family relationships (Furrow et al., 2019; S. M. Johnson, 2019). Experiential and systemic theory is also discussed, as principles from each approach helps inform the EFT theory of change (Furrow et al., 2019; S. M. Johnson, 2019). Following this, the researcher outlines the five primary assumptions of EFT. Then, the reader is introduced to what EFT looks like in practice, including the three-stage

approach used by EFT therapists: (a) stabilization, (b) restructuring attachment, and (c) consolidation and integration.

A limitation within this chapter is that, since EFT was principally developed for use with couples, its application to families is limited. Hence, in order to establish how EFT works, the research presented in this section primarily focuses on how EFT has been applied to couples. Whenever possible links to family therapy will be applied.

Theory

Attachment Theory. Attachment theory plays a central role in EFT. As noted in Chapter 3, attachment theory began with Bowlby's (1969/1983) and Ainsworth's (1963) work on attachment bonds between mother and child. However, in the late 1980s, S. M. Johnson (1986) began applying this theory to the study of adult attachment bonds in couple relationships, particularly how these bonds are damaged and repaired. This focus on attachment bonds within adult relationships forms the basis of EFT.

Attachment theory prioritizes connection to others and emotional regulation, as these form the basis of secure attachment, and thus, mental health and well-being (S. M. Johnson, 2019). When applied within the context of an EFT session, this prioritization of connection and emotional regulation becomes apparent as the therapist asks questions about the emotional balance within the couple or family. For instance, a therapist using EFFT may explore how parental emotional regulation may be impacting parents' attunement to the needs and emotional responses of their children (Furrow et al., 2019).

Promoting secure attachment confers benefits for both the individual family member as well as for the family as a whole. Securely attached individuals have more capacity to attend, support, and respond to others (S. M. Johnson, 2019; Mikulincer &

Shaver, 2016). Furthermore, securely attached individuals are better able to attend to, engage with, and recover from distressing emotions, which has lifelong benefits (S. M. Johnson, 2019; Sbarra, 2006).

Theory of Change. The EFT theory of change is informed by two theoretical approaches: experiential and systemic. Given that systems theory has been reviewed in the previous chapter, rather than review these two individual theories, the researcher has elected to highlight how they have helped shape the EFT model.

According to S. M. Johnson (2004), these two approaches are complementary in many ways. Both focus on present process and view individuals as dynamic organisms capable of change. Moreover, individuals in distress are not pathologized or deemed deficient; rather, they are described as being stuck. Both approaches also emphasize the need to join with the individuals involved, or otherwise develop a strong working alliance.

Although complementary in many ways, experiential and systemic approaches also contribute unique elements to the EFT theory of change. From the experiential approach, EFT gains a focus on emotions, health, and corrective emotional experiences. Individuals are invited to explore their intrapsychic experiences in order to connect with their needs and goals. This also allows individuals to process their experiences and respond to their environment in new ways. From the systemic approach, EFT gains a focus on patterns or cycles of behaviour within a social context, behaviour—rather than content—as communication, and circular causality within relationships. Here, the goal is to foster flexibility and facilitate new patterns of interaction within the system. Thus,

where the experiential approach highlights intrapsychic processes, the systemic approach emphasizes interpersonal interactions.

Primary Assumptions

There are five primary assumptions of EFT (S. M. Johnson, 2004). First, adult love relationships must be understood first and foremost as an emotional bond. These bonds are reciprocal between adults and meet the human need for security and comfort. Perceived partner accessibility, responsiveness, and emotional engagement creates and strengthens these bonds. Second, emotion organizes attachment behaviour. Emotion is central to EFT because it informs the view of self and the view of others. It also acts as a signaling system between partners, which is particularly salient when attachment needs are threatened. Third, rigid patterns of interaction maintain distress. Such patterns are reciprocal in nature and often deepen insecurity. Fourth, attachment needs are healthy as well as adaptive. Thus, a key process within EFT is helping individuals identify and own underlying attachment needs. Lastly, emotional experiences and emotional expression are key to transforming rigid patterns of interaction. Within the EFT model, change does not occur through insight or catharsis, but rather through new emotional interactions that redefine the attachment bond.

Practice

The question of what EFT looks like in practice is important to consider, particularly for readers new to this approach. The EFT therapist is considered to be a process consultant, rather than a teacher, expert, or coach (S. M. Johnson, 2004). In this role, the therapist works collaboratively with couples and families to process their experiences and restructure their patterns of interaction. EFT therapists are trained to

demonstrate qualities of empathic attunement, acceptance, genuineness, and continuous alliance monitoring (S. M. Johnson et al., 2005). They remain focused on the present process, particularly the present emotional experience (S. M. Johnson, 2004).

EFT is structured into a three-stage process, with the therapist working toward the ultimate goal of creating a secure attachment bond: (a) stabilization, (b) restructuring attachment, and (c) consolidation and integration (S. M. Johnson, 2004). Each stage is broken down into a series of successive steps, as described below.

Stage 1: Stabilization. According to S. M. Johnson (2019), Step 1 begins as the therapist joins with the couple or family to create a working alliance. Furrow et al. (2019) emphasized the importance of this first step, noting how the development of a strong alliance provides a secure base for the safe exploration of emotional experiences in later steps. Assessment can also be conducted at this point in the process. Step 2 involves helping the couple or family identify the negative pattern of interaction, which forms the foundation of their presenting problems (S. M. Johnson, 2004, 2019). In Step 3, the therapist helps identify the emotions that underlie the negative pattern of interaction and any reactive moves that may fuel the pattern (S. M. Johnson, 2004, 2019). In Step 4, the therapist reframes the presenting problem in terms of the negative pattern of interaction as well as emotions and attachment needs (S. M. Johnson, 2004, 2019). This final step acts to join the couple or family in seeing this pattern of interaction as the enemy (S. M. Johnson, 2004, 2019).

In many ways, Stage 1 is implemented similarly regardless of whether the therapist is working with a couple or a family. In both cases, Stage 1 involves creating a working alliance, establishing security and safety, identifying negative pattern of

interaction, accessing underlying emotions and attachment needs, and reframing problems in terms of the negative pattern of interaction, which includes helping the individual, couple, or family see the pattern as an externalized enemy (Furrow et al., 2019; S. M. Johnson, 2004). However, when working with a family, the therapist must prioritize work with the most distressed dyad within the family (Furrow et al., 2019). Therapists must also identify blocks to effective caregiving or care seeking, reframe the blocks as attachment struggles, and work toward moving parents past their blocks to a place of increased openness (Furrow et al., 2019). In this stage, the child is not asked to be vulnerable until caregiving blocks are addressed and parental openness is established (Furrow et al., 2019).

Stage 2: Restructuring Attachment. Step 5 involves promoting the identification of disowned attachment needs, emotions, fears, and aspects of the self (S. M. Johnson, 2004, 2019). This step serves to shift partners or family members to new positions of vulnerability and connection. In Step 6, therapists promote more openness to and acceptance of the experiences of others (S. M. Johnson, 2004, 2019). Step 7 involves inviting partners or family members to risk reaching for one another by expressing attachment needs (S. M. Johnson, 2004, 2019). The act of reaching and responding invites a deeper level of emotional engagement and creates new bonding events.

For couples, Stage 2 is intended to facilitate more engagement from the withdrawing partner and encourage blaming partners to begin asking for their needs to be met in a softer and more evocative way. For families, Stage 2 is intended to help individuals restructure their position within the family and to resolve blocks to both caregiving and care seeking (Furrow et al., 2019). This is accomplished through the child

reaching for the parent and having the parent respond in a way that demonstrates greater accessibility, responsiveness, and emotional engagement (Furrow et al., 2019). In Stage 2, the family therapist deepens the expressions of vulnerability from the child in order to prime the parent's caregiving behaviour (Furrow et al., 2019). This process of reaching and responding lays the foundation for repairing attachment injuries between parents and children (Furrow et al., 2019).

Stage 3: Consolidation and Integration. Step 8 facilitates the emergence of new solutions to old problems (S. M. Johnson, 2004, 2019). Previous stages have helped the couple or family view problems within their negative pattern of interaction. Thus, new solutions emerge as they begin to collaborate to solve a common problem. Furthermore, the safety and trust that was developed in previous stages allows for novel exploration of issues. Less time and effort spent regulating emotions can also fuel the emergence of new solutions. In Step 9, the couple or family consolidates their new positions and new secure cycles (S. M. Johnson, 2004, 2019). The therapist highlights the progress, change, and growth that occurred thus far, particularly as it relates to secure attachment. The couple or family creates a new narrative, one which captures their experience of treatment and new-found understanding of their relationship. Here, the final goal is to have the couple or family be able to maintain their emotional engagement, which will allow them to continually strengthen their bond.

According to Furrow et al. (2019), families in Stage 3 feel a renewed sense of safety and security and "are able to express their concerns and cares directly and are able to articulate the importance of these changes to oneself and the family as a whole" (pp. 73–74). Therapists assist the family in creating new meaning regarding what it

means to be a family and help the family establish new rituals that will continue to strengthen family bonds.

Research

Research has supported the efficacy of EFT (e.g., Beasley & Ager, 2019; N. D. Wood et al. 2005). The bulk of this research focuses on the use of EFT with couples. However, publications on EFFT have begun to emerge within this body of literature. The following section will provide the reader with an overview of research related to the applications and effectiveness of EFT for couples and families. It is beyond the scope of this thesis to focus on the efficacy of EFT for couples; thus, the researcher has elected to only highlight a selection of this research in order to establish that EFT is an empirically driven therapeutic approach. Literature related to the use of EFT in cases of situational couple violence is reviewed in the subsequent section.

EFT has been shown to be an effective model of treatment for couples experiencing relationship distress. In a recent meta-analysis, Beasley and Ager (2019) evaluated the effectiveness of EFT across nine studies. Results indicated that EFT for couples significantly improved marital satisfaction over the course of therapy as well as at follow up. Relationship functioning within Beasley and Ager's meta-analysis was typically measured with the original or a revised version of the Dyadic Adjustment Scale (Spanier, 1976). These findings are supported by earlier meta-analyses. For instance, in their meta-analysis, N. D. Wood et al. (2005) found across 23 studies EFT for couples was more effective than behavioural marital therapy for the treatment of moderate marital distress. In a more recent meta-analysis of 33 studies, Rathgeber et al. (2018) compared EFT and behavioural marital therapy and found that both approaches were effective and

superior to no treatment; however, there was a lack of evidence to support gains past 6 months.

EFT has been recommended for couples experiencing chronic illness, as a strengthened couple relationship can act as a resource for both the patient and the caregiving partner (Fitzgerald & Thomas, 2012). Earlier studies found that EFT was effective at reducing marital distress for couples who have a chronically ill child, with an effect size of 1.27 following treatment and 1.28 at a 5-month follow up, based on a sample size of 32 couples (Walker et al., 1996). The results of a 2-year follow-up study not only indicated this effect can be maintained in the long term, but also EFT may reduce the rate of separation for couples with chronically ill children; 38% of control couples in the study separated in the 2 years following therapy, whereas only 6% of couples in the EFT treatment condition separated (Cloutier et al., 2002). Those who did separate following treatment noted EFT helped them separate harmoniously and avoid antagonism.

Researchers have also found EFT to be effective for couples when one partner is struggling with depression. A recent randomized control trial by Wittenborn et al. (2019) explored the effect of EFT on depressive symptomatology and marital satisfaction. Researchers found, after 15 one-hour EFT sessions, marital satisfaction increased for both partners, as measured by the dyadic satisfaction subscale (Spanier, 1976). For women in this study, depressive symptomatology decreased comparably across EFT and control treatment conditions, as measured by the Beck Depression Inventory-II (A. T. Beck et al., 1996). However, for men in this study, EFT resulted in greater reductions in depressive symptomatology. Such gender differences were not found in a previous study

of 16 couples by Alder et al. (2018), although EFT was found to significantly reduce depressive symptomatology compared to a control group. EFT has also been found to be effective at reducing depressive symptomatology when combined with antidepressant medication as well as being effective at improving relationship satisfaction in couples with at least one partner experiencing depressive symptomatology (Denton et al., 2012; $N = 48$).

Overall, the research findings are definitely supportive of an attachment focus to couple distress. When attachment therapy is applied to families, EFFT is in the early stages of being studied within the context of a variety of presenting problems, including bulimia (S. M. Johnson et al., 1998), nonsuicidal self-injury (Schade, 2013), emotional distress (Stavrianopoulos et al., 2014), as well as marital transitions and family blending (Dankoski, 2001; Faber & Wittenborn, 2010; Furrow & Palmer, 2007; Hirschfeld & Wittenborn, 2016; Palmer & Efron, 2007), and, most recently, teen somatization (Dhariwal et al., 2019, 2020). Researchers are also beginning to adapt EFFT for use with young children by integrating play therapy activities (Willis et al., 2016; Wittenborn et al., 2006).

At this point, only one study was located that evaluated the efficacy of EFT for families (S. M. Johnson et al., 1998; $N = 13$). In their study, S. M. Johnson et al. (1998) used EFFT to include parents in the treatment of female adolescents struggling with bulimia, as defined in the third edition of *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1987). Results indicated that 10 sessions of EFFT were as effective as standardized cognitive-behavioural 10-week group treatment in reducing bulimic symptomatology (S. M. Johnson et al., 1998). Two noteworthy

limitations of S. M. Johnson et al.'s (1998) study were the small number of participants and the lack of follow-up data. Nevertheless, the results are encouraging and point to the need for further empirical data to establish the efficacy of EFFT.

The remainder of published articles on EFFT described frameworks for applying the model to a variety of presenting problems. Schade (2013) used a case example to explore how EFFT could be appropriate for treating nonsuicidal self-injury. The author built on the research of S. M. Johnson et al. (1998), noting how previous work on bulimia could inform this new area of study, given that bulimia is often comorbid with nonsuicidal self-injury (Schade, 2013). Stavrianopoulos et al. (2014) also used a case example to describe how EFFT could be applied to emotional distress and mood-related disorders in children and adolescents. Both studies highlighted the potential of EFFT and called for further research.

Marital transitions and family blending are themes within the available EFFT literature. Early on, Furrow and Palmer (2007) highlighted how EFFT can be used as a road map to facilitate healing for families, particularly for families who have undergone marital transitions and family blending. Faber and Wittenborn (2010) argued EFFT can strengthen the attachment bond between parents and children in order to promote resilience in children as they move through these often difficult transitions. Numerous case examples within this body of work help illustrate how this can be achieved by applying the three stages and nine steps of EFT to separated and blended families (Faber & Wittenborn, 2010; Furrow & Palmer, 2007; Palmer & Efron, 2007). Hirschfeld and Wittenborn (2016) have added to this area of study by focusing on the effect that divorce has on younger children. The authors described how play therapy techniques can be

incorporated into the steps and stages of EFT in order to improve communication and strengthen attachment bonds between parents and children as they navigate divorce. This call for more play-based interventions in EFFT is echoed by Willis et al. (2016), who highlighted the importance of modifying interventions to ensure that young children were not left out of the EFFT process. Although S. J. Wood (2015) cautioned the focus of EFFT may be too narrow to fully address all the challenges related to separation and stepfamily formation, the author noted EFFT may be helpful in the expression of grief and healing attachment injuries within these families.

To conclude this section on EFT research, it is noteworthy to highlight a serious limitation of EFT: the scarcity of research on EFT for couples and families across cultures. Although the argument has been made that the concepts related to attachment theory (e.g., attachment needs and fears) are universal and, therefore, applicable across cultures (Wiebe & Johnson, 2016). Nevertheless, authors are now beginning to explore the use of EFT within a variety of cultural contexts, including applying EFT to couples in South Africa (Lesch et al., 2018), intercultural couples (Linhof & Allan, 2019), and African American couples (Nightingale et al., 2019). However, there continues to be a gap in research on the use of EFT for diverse families. It is hoped that this new area of research will continue to evolve in order to address this current limitation of EFT.

Emotionally Focused Therapy with Families

There are important differences between the application of EFT for couples and EFT for families. However, these differences may not be well known among EFT therapists; in order to become a certified EFT therapist, practitioners must be trained in conducting EFT for couples (International Centre for Excellence in Emotionally Focused

Therapy [ICEEFT], 2020), but no requirements exist to be trained in conducting EFT for families. As such, it is likely that EFT therapists are less familiar with EFFT and what separates it from EFT for couples. The following section provides the reader with an overview of these differences.

According to Furrow et al. (2019), the EFFT therapist will structure family sessions according to the level of distress among the family members, the developmental age of the children, and the relevance of the presenting problem (e.g., whole family sessions, couple sessions, sibling sessions, or individual sessions as the need arises). A typical structure is described below.

In the first session, the therapist typically invites any relevant family members to attend. This whole-family session provides the opportunity for each family member to share their unique experiences of the presenting problem. It also provides the therapist with the opportunity to assess family strengths, distress, and patterns of interaction. The subsequent session involves a conjoint parent session. EFFT parent sessions focus on parent attachment histories, parental availability, parental alliances, as well as caregiving alliances. Sibling-focused sessions or individual sessions may then be used to further assess the presenting problem and assess for safety (Furrow et al., 2019).

Just as in EFT for couples, attachment theory plays a key role in EFFT as it provides the framework for assessment as well as treatment. Furrow et al. (2019) described how two key components of attachment theory with families, care-seeking and caregiving, are viewed as two halves of a complimentary system within EFFT. As parents show accessibility, responsiveness, and emotional engagement, children gain confidence in the availability of their primary attachment figures. This, in turn, encourages children

to communicate attachment needs and seek out attachment resources from their parents. Parents then continue to demonstrate an attuned caregiving response as they attend to the attachment needs of the children. When viewed from an attachment-based perspective, family conflict is conceptualized as a disruption to the secure family base. Furrow et al. (2019) noted how the care-seeking and caregiving system, which forms the foundation of a secure family base, strengthens itself over time when family members are attuned and secure. It can also correct through parent–child feedback. However, these two systems fall out of balance when the system is threatened (e.g., a parent uses violence against the other parent and the children witness this violence). For instance, a parent who is experiencing conflict in the marital relationship may become so focused on meeting their own need for connection (e.g., feeling compelled to sooth or connect with their partner) that the parent becomes less able to attune to the needs of the children. When this happens, children may use care-seeking behaviours (e.g., crying, hitting, rescuing) in an attempt to reorient the parent toward reassuming the caregiving role. If the parent is able to reattune to the needs of the child, the care-seeking and caregiving systems can come into balance once again. However, parents may not always be able to reattune to the needs of the child, such as when violence is occurring within the home. Although it has not been the subject of any empirical research to date, it seems likely that parents who are unable to reattune due to violence may benefit from an attachment-based approach to treatment, such as EFFT.

In order for EFFT therapists to support the caregiving system, they must work with parents to move past blocks to caregiving (Furrow et al., 2019). Caregiving blocks can arise from attachment injuries and/or empathetic failures and may manifest as

anything from over responding (e.g., being demanding, critical, overly protective, overly permissive) to under responding (e.g., frozen disengagement, distant rejection). Supporting the caregiving system also involves focusing on parental intent and reframing their potentially negative action tendencies within the context of their good intentions. Once caregiving blocks are addressed, parents are in a better position to demonstrate accessibility, responsiveness, and emotional engagement, which will be required to restructure family interactions and explore new solutions to past problems. Therapists using EFFT must remember that while parent–child relationships are reciprocal, they are ultimately hierarchical. Thus, parental and caregiving responsibilities rest squarely on the shoulders of the adults in the caregiver role.

It is equally important for EFFT therapists to consider the child's blocks to care-seeking. Such blocks can arise from attachment injuries and/or empathetic failures and may manifest as an intensified reaction (e.g., anxious responses) or minimized reactions (e.g., distancing, withdrawal, minimized attachment emotions). During the EFFT process, the therapist encourages children, when safe to do so, to reach for connection from their parents during times of distress. In order to ensure safety for the child, this process only occurs once the parents are demonstrating greater openness. Supporting the child's attachment systems also involves focusing on care-seeking intent, which helps family members understand how a child's potentially destructive behaviour may be a strategy to manage disconnection from parents. Therapists must also help the child to identify and promote acceptance of disowned attachment needs within this process.

In summary, the EFFT model encourages families to reestablish a responsive and flexible connection. It also helps parents and children redefine their relationship through

new shared experiences of trust and vulnerability. Treatment within the EFFT model is centred around two key processes rooted in attachment theory: (a) supporting the caregiving system by increasing parental attunement and responsiveness to the child's attachment needs and (b) supporting the attachment system by increasing care-seeking in the children (Furrow et al., 2019). In practice, this involves identifying blocks to caregiving and then addressing those blocks in order to facilitate greater parental openness. Then, the EFFT therapist may begin to work through blocks to care-seeking so that children feel safe to reach out to their parents for connection. In the end, the primary purpose of treatment is to restore the family as a secure base and safe haven, "where family members more effectively emotionally respond, and can make repairs with a renewed sense of confidence, cohesion, and belonging" (Furrow et al., 2019, p. xii).

Emotionally Focused Family Therapy for Situational Couple Violence

The following section provides a review of literature related to the use of EFFT in cases involving situational couple violence. The researcher also draws attention to the considerable gaps in knowledge within this subject area in order to highlight the need for further research and to establish a clear rationale for this thesis project.

Violence is identified as a possible contraindication when applying the EFT model to couples or families (Furrow et al., 2019; S. M. Johnson, 2004) "where there is significant risk and ongoing threats of violence or abusive behavior" (Furrow et al., 2019, p. 105). Both S. M. Johnson (2004) and Furrow et al. (2019) have highlighted how the safe expression of vulnerability is central to EFFT and that violence makes this process difficult, if not dysfunctional or harmful.

A challenge noted by S. M. Johnson (2004) is that therapists must make a judgement call when determining if abuse is present. As such, recommendations have been made to use the experience of the nonviolent family member as well as direct observation to aid in determining suitability (S. M. Johnson, 2004). In her book with Brubacher (2016), the founder of EFT, S. M. Johnson, noted EFT has the potential to be useful when there are "low levels of intimidation, remorse from an offending partner and a lack of significant fear on the part of the victimized partner" (S. M. Johnson & Brubacher, 2016, p. 332). Thus, it is the opinion of this researcher that further investigation is warranted into the use of EFT in cases of situational couple violence.

Based on the available literature, it appears that situational couple violence is the most appropriate type of IPV to be addressed using the EFT model (Slootmaeckers & Migerode, 2018). situational couple violence can be conceptualized as a relational problem and, thus, part of a pattern of negative interaction (Slootmaeckers & Migerode, 2020). According to Slootmaeckers and Migerode (2020), the patterns of interactions associated with situational couple violence seem to be connected to relational fears and unanswered attachment needs within a couple relationship.

In the case of situational couple violence, the negative pattern of interaction may involve one partner using violence as an extension of a heightened emotional response, triggering underlying attachment fears in the other and even perpetuating further violence (Slootmaeckers & Migerode, 2020). In applying this scenario to the treatment of distress within the EFT model (S. M. Johnson, 2004), it seems that the heightened emotional responses act as a signalling agent to the other partner and that the rigid patterns of interaction act to maintain the distress. As such, therapists using this model would work

toward transforming these rigid patterns through novel emotional experiences and expressions.

Applying the Stages and Steps of EFT to Situational Couple Violence

Slootmaeckers and Migerode (2020) have provided a detailed description of how Stage 1 of the EFT model (i.e., stabilization) could be applied to situationally violent couples. The authors noted four primary tasks within Stage 1, Step 1 when treating situational couple violence: (a) establishing a safe haven and a secure base so partners are able to take responsibility for their violent behaviour, (b) demonstrating empathetic attunement, (c) establishing goals based on underlying attachment needs, and (d) promoting a sense of hope (Slootmaeckers & Migerode, 2020). In Step 2, the EFT therapist works toward tracking the negative pattern of interaction and identifying how it evolves into violence (Slootmaeckers & Migerode, 2020). In Step 3, the therapist's goal is to help partners gain access to their primary emotions without becoming overwhelmed (Slootmaeckers & Migerode, 2020). Finally, in Step 4, the therapist works toward drawing attention to each partner's underlying attachment needs while helping the couple understand that the negative pattern of interaction, including the pattern of violence, is their common enemy (Slootmaeckers & Migerode, 2020).

It is the opinion of the researcher that the utilization of EFFT in cases of situational couple violence would require the therapist to focus on stabilization between the parents before dyadic or triadic sessions could take place with the children. As such, articles describing the use of EFT for couples experiencing situational couple violence (Rouleau et al., 2019; Slootmaeckers & Migerode, 2018, 2020) may provide a useful framework for stabilization within the context of EFFT. It was the hope of the researcher

that future studies continue to add to this discussion on the application of the EFT model for couples and families impacted by situational couple violence.

Summary

In this section, a case has been made that EFFT seems well positioned to address the unique challenges faced by families impacted by situational couple violence, particularly issues related to parent–child attachment. Despite the cautions about the use of EFT when abuse is present within a family (Furrow et al., 2019; S. M. Johnson, 2004), therapists may need to consider that it may not be the occurrence of violence within relationships that is necessarily contraindicated, but rather an accompanying context or pattern of abuse that is contraindicated (Slootmaeckers & Migerode, 2020).

Violence within the home disrupts a child's sense of safety and security and diminishes a child's confidence in the parent's ability to attend to basic attachment needs (Bowlby, 1969/1983; Gustafsson et al., 2017). As highlighted in previous chapters, witnessing violence also negatively impacts a child's ability to form secure attachments, both in childhood and later in life (Gustafsson et al., 2017; Pang & Thomas, 2019; Sousa et al., 2011). By focusing on strengthening the caregiving and care-seeking systems, EFT therapists can be able to help parents and children heal from the damaging effects of situational couple violence and strengthen patterns of secure reaching and responding within the family system.

However, before beginning this work, EFT therapists need to make a decision about whether a family is suitable for this approach. Unfortunately, nothing is known about which decision-making factors are most important for EFT therapists considering the appropriateness of this approach. Additionally, given the lack of available

information on this subject, the researcher can only speculate about the risks and benefits of using EFFT in cases involving situational couple violence based on the general systems literature presented in Chapter 4. To complicate the matter further, there is no information on which demographic factors might be associated with the views of EFT therapists on the use of EFFT in cases involving situational couple violence. This thesis intended to fill this gap in knowledge by surveying EFT therapists about their views on this important topic.

Concluding Remarks

EFT is an empirically validated approach to restoring and strengthening attachment bonds. Although the bulk of the literature focuses on EFT for couples, EFFT is beginning to gain a foothold within this body of literature. Although it is exciting to see how researchers are beginning to explore the use of EFT to treat situational couple violence within couples, there is an absence of literature on how EFFT may be applied to situational couple violence, including an absence of literature on how EFT therapists may view this novel application. This is regrettable, as it seems that EFFT is well positioned to address the unique needs of families impacted by situational couple violence. It is possible that EFT therapists may consider using EFFT in cases of situational couple violence, but there is no information available on what factors they might use to determine the suitability of this approach. There is also no information on the risks and benefits of this approach, or what demographic factors may be associated with the views of EFT therapist.

Clearly, EFFT has room to grow and has much to offer therapists looking to apply EFT to larger family systems. As such, the researcher is hopeful that EFFT will continue to gain momentum, both in terms of research and practice.

Chapter 5: Methods

The purpose of this chapter is to provide the reader with an outline of the methodology that was used for this exploratory research project. Four primary areas are discussed below: participants, survey instrument, procedures, and data analysis. A quantitative design was used to answer three key questions:

1. What contextual factors do EFT therapists believe to be most important when considering the use of EFFT in cases involving situational couple violence?
2. What are the risks and benefits of using EFFT in cases involving situational couple violence?
3. What demographic factors are associated with the views of EFT therapists on the use of EFFT in cases involving situational couple violence?

Participants

Participants for this study must have practised or be currently practising psychotherapy. Participants must also be regular, lifetime, honorary, or regional members of ICEEFT from anywhere in the world. The study intended to capture the views of EFT therapists; thus, participants were required to be representative of this population.

Inclusion and Exclusion Criteria

In order to be included in this study, participants needed to meet two criteria. First, participants were required to identify as having worked or be currently working as a psychotherapist. Any participant who did not meet this criterion was excluded from the study. Second, participants must have identified as being a regular, lifetime, honorary, or regional member of ICEEFT. Associate and student members of ICEEFT were excluded from the current study. Additionally, participants who do not identify as members of

ICEEFT, or indicate that they were not sure about their membership status, were excluded from the study. Participant data resulting from partially completed surveys were included in data analysis.

Recruitment

Participants were recruited in four ways: (a) through the ICEEFT online forum, (b) through ICEEFT affiliated organizations, centres, and communities, (c) through emails to certified EFT therapists, and (d) through snowball sampling. Participants were also offered an incentive for taking part. Each recruitment method is described after a brief introduction of ICEEFT.

ICEEFT is an international organization with approximately 6,000 members. As of March 2020, approximately 5,600 members were eligible to participate in this study (S. Le, personal communication, March 3, 2020). A total of 79 ICEEFT members were included in this study, amounting to 1.4% of eligible ICEEFT members completing the online survey. Data reflecting how participants were successfully recruited are presented in Chapter 6.

ICEEFT Online Forum Recruitment. The researcher is currently a student member of ICEEFT. The ICEEFT Operations Manager granted permission for the researcher to distribute the survey through the ICEEFT online forum (see Appendix A for ICEEFT approval). An invitation to participate was posted to the online forum on October 5, 2020 (see Appendix B), October 12, 2020 (see Appendix B), and June 25, 2021 (see Appendix C). The survey instrument (see Appendix D) and proof of study approval from the University of Lethbridge Human Participant Research Committee (see Appendix E) were provided to the ICEEFT Operations Manager prior to the survey being

distributed to ICEEFT members.

ICEEFT Affiliated Organizations, Centres, and Communities. The second recruitment strategy involved the researcher sending invitations to participate (see Appendix F) to 59 ICEEFT affiliated organizations, centres, and communities. These organizations, centres, and communities allow therapists interested in EFT to promote their services to their local community as well as communicate with other local therapists regarding training events and opportunities. Although 79 ICEEFT-affiliated organizations, centres, and communities were listed on the ICEEFT website as of October 25, 2020, the researcher elected to contact only those with an email address listed on their associated website. After visiting each of the 79 associated websites, the researcher identified 59 ICEEFT affiliated organizations, centres, and communities that met this criterion. A total of 76 email invitations were sent out to the 59 ICEEFT-affiliated organizations, centres, and communities that met this criterion (10 ICEEFT affiliated organizations, centres, and/or communities listed two or more contact email addresses on their website). Invitations to participate requested that the individual receiving the initial email forward the invitation to the members of their ICEEFT-affiliated organization, centre, or community.

Emails to ICEEFT Certified EFT Therapists. The third recruitment strategy involved emailing invitations to participate (see Appendix B) to a total of 723 ICEEFT certified EFT therapists in a two-stage approach. The first phase involved the researcher sending invitations to participate to a random sampling of ICEEFT certified EFT therapists. As of October 25, 2020, a total of 884 ICEEFT certified EFT therapists were listed on the publicly accessible ICEEFT website. The researcher randomly selected 25%

of this sample by first assigning each of the 884 ICEEFT certified therapists a number. Then, the researcher used a random number generator (Calculator.net, n.d.) to select 221 individuals to contact. The invitation email bounced back due to an invalid email address for six individuals. In these cases, another number was randomly generated, and a different individual was contacted.

Following consultation with the researcher's thesis supervisor, it was determined that the first phase of the above-mentioned recruitment strategy resulted in an insufficient number of participants. Thus, the second phase was required in order to bolster recruitment. The second phase involved sending invitations to participate to the remaining 663 (75%) of ICEEFT certified therapists listed on the publicly accessible ICEEFT website. A total of 496 individuals were sent an invitation email, as 167 individuals did not have an email address listed on the website and/or were no longer listed on the website.

Second and third reminder invitation emails were sent to the 227 individuals identified in the first phase and the 496 individuals identified in the second phase. The final invitation email was sent 1 week prior to the survey closing on July 1, 2021.

Snowball Sampling. The fourth recruitment strategy involved providing participants with the opportunity to recruit additional participants. Regardless of whether they meet the eligibility criteria, participants were provided with the following information on the last page of the survey: "You are invited to forward this survey to other EFT therapists by copying the link below:"

Additionally, one thesis committee member (Gail Palmer) volunteered to distribute the invitation to participate to her contacts within the EFT community. The

offer to distribute the invitation email was made without coercion, and the researcher outlined how the committee member could withdraw the offer without prejudice or penalty. This method of recruitment was used a total of 10 times, including invitations to one EFFT supervision group and nine EFFT training groups (G. Palmer, personal communication, July 6, 2021).

Incentive. Participants were offered the opportunity to enter into an anonymous raffle-type draw with a prize of one signed copy of *Emotionally Focused Family Therapy: Restoring Connection and Promoting Resilience* (valued at approximately $54). This book was supplied by one of the authors (Gail Palmer). Participants were presented with an option to enter their email address as the final item of the online survey.

The following steps were taken to ensure that the researcher, supervisor, or committee members would never know the identity of the winner. To protect the anonymity of participants, the researcher was careful to separate survey responses from participant email addresses. To do this, the question of whether they would like to provide an email address in order to be entered into the draw was designed as a separate survey (see Appendix G). As such, data were separated into two distinct groups: (a) survey response data (which did not involve the collection of identifying information) and (b) draw data (which did involve the collection of identifying information). Once the survey closed, the data were extracted by the statistical consultant (Lisa Halma) directly through Qualtrics (n.d.). The statistical consultant then assigned each email address a number. Once the researcher successfully defended her thesis, a random number generator (Calculator.net, n.d.) was used to select the winning number. The statistical consultant then forwarded the winner's email address to a University of Lethbridge staff

member (Margaret Beintema, Faculty Administration Support), who contacted the winner to arrange delivery of the draw prize. The statistical consultant as well as the University of Lethbridge staff member both signed confidentiality agreements (see Appendix H).

Survey Instrument

This study addressed the stated research questions using an online survey instrument delivered using Qualtrics (n.d.) survey software. The survey instrument was developed by the study author and supervisor. The content of the survey was based on the literature presented in the previous chapters. The survey included 17 items divided into five parts. Participants who move past the screening items in Part 1 were presented with all subsequent items. It was anticipated that completion would take 20 minutes (see Appendix D for a copy of the survey instrument). Parts 2–5 include at least one optional open-ended question, which provided participants with the opportunity to clarify their answers to any part of the survey. Additionally, an operational definition of situational couple violence was provided each time this term is used.

Part 1 of the survey contained two items that serve to screen the eligibility of participants. Participants were asked whether they identify as working as a psychotherapist. This item was presented as a simple dichotomous response question. Participants were also asked to select the option that best describes their current membership status with ICEEFT. In order to proceed to Part 2, each participant needed to answer in the affirmative to the first item and identify as a regular, lifetime, regional, or honorary member of ICEEFT in the second item.

Part 2 gathered relevant demographic information from each participant over the course of five items. Participants were asked to identify the number of years they had

been working as a psychotherapist, not including years as a volunteer or practicum/internship experience. Additionally, each participant was asked to identify having any of the following certifications: Certified EFT Therapist, Certified EFT Supervisor, and/or Certified EFT Trainer. Participants were then asked to indicate their level of completion for seven trainings and to rate their level of experience working within several IPV-related psychotherapy modalities. A final item gathered information on the current age of the participant.

Part 3 collected information on current use of family therapy and EFFT. First, each participant was asked to rate the frequency with which they use: family therapy, EFFT, and EFFT in cases of situational couple violence. These items were presented as a 5-point Likert scale, ranging from *never* to *almost always.* Second, participants were asked to indicate whether they would ever consider using EFFT in cases of situational couple violence. This item was presented as a 5-point Likert scale, ranging from *very unlikely* to *very likely.*

Part 4 of the survey investigated the importance of various decision-making factors for therapists considering the use of EFFT in cases of situational couple violence. This section presented participants with 29 possible decision-making factors, organized into the following categories: therapist factors, parent factors, violent family member factors, and child factors. These items were presented as a 5-point Likert scale measuring how important each factor is to decision making, ranging from *I believe this is not important* to *I believe this is very important*. The individual decision-making factors were drawn from the literature presented in previous chapters.

Part 5 explored the risks and benefits of utilizing EFFT in cases involving

situational couple violence. The first item contained in Part 5 included a list of statements reflecting potential risks associated with the use of EFFT in cases of situational couple violence. The second item included a list of statements reflecting potential benefits. Participants were asked to rate their level of agreement with the statements on a 5-point Likert scale, ranging from *strongly disagree* to *strongly agree*. The potential risks and benefits were based on the research presented in Chapter 3 as well as on the stated goals of EFFT, as presented in Chapter 4.

Participants were also asked to identify the method by which they were recruited and whether they were interested in entering the raffle. These questions were presented as the last items on the survey, and responses were not used to investigate the stated researcher questions.

Procedure

In this section, the researcher outlines the procedures that were undertaken to complete the study. Survey completion, ethical clearance, informal pilot studies, recruitment, consent, and data management will be reviewed.

Survey Completion

Individuals who chose to participate in the survey were directed to visit the link provided in their invitation email. Once they clicked on the link, the individual was taken to the participant consent form (see Appendix D). Participants were advised that by proceeding with the survey they were confirming they understood and agreed to the outlined conditions. Participants were instructed to exit the survey if they did not wish to proceed.

The survey was available to complete from October 5, 2020 to July 1, 2021.

Multiple survey entries from a single computer were prohibited by disabling the multiple response feature on Qualtrics (n.d.). Prior to beginning the survey, each participant was provided with the consent document (explained in depth in the following section; see Appendix D).

Part 1 of the survey determined participant eligibility. Each participant must have answered in the affirmative to Question 1 and identify as being a regular, lifetime, honorary, or regional member of ICEEFT. Once these responses are submitted, the participant was directed to complete subsequent sections of the survey. Individuals who did not meet the eligibility criteria were directed to a section of the survey explaining their ineligibility to participate.

Participants who moved forward through Part 1 navigated through the survey by clicking "Continue" at the bottom of each survey section. Upon completion of the final survey section, participants were directed to a page thanking them for their participation and informing them of how to obtain a copy of the results on the Thesis Supervisor's webpage.

Consent and Ethical Clearance

Participants provided consent for study participation as part of the online survey instrument. The first section of the survey contained all necessary information to obtain consent (see Appendix D). Participants were advised that proceeding to the second section of the survey served as confirmation that they understood and agreed to the outlined conditions. Participants were instructed to exit the survey if they do not agree to the conditions. This document also contained contact information for the researcher as well as the University of Lethbridge Office of Research Ethics, in the event that

participants have questions or concerns about the survey or their participation in the study. As an incentive to participate, participants were offered the opportunity to be entered into an anonymous raffle-type draw, with a prize of one signed copy of *Emotionally Focused Family Therapy: Restoring Connection and Promoting Resilience*. Prior to conducting this study, the researcher received approval to proceed from the University of Lethbridge Human Participant Research Committee (see Appendix E).

Pilot Study

The survey instrument was tested informally prior to participant use. This step ensures maximum readability of questions and was used to provide an accurate estimation of the time required for completion (Coolican, 2009). A group of six graduate master-level students within the Faculty of Education were recruited to participate in an informal pilot test of the survey instrument, including the scenario. No participant data from this pilot study was used in the data analysis process. Participants in this stage of informal testing were asked to provide artificial answers to the survey questions in order to protect their privacy. Completion time and feedback were the only data collected from pilot participants.

Data Collection, Storage, and Destruction

Once the time period for survey completion had elapsed, the data collected through Qualtrics (n.d.) survey software was downloaded to an encrypted external hard drive. Only the researcher, thesis supervisor, committee members, and consultants involved with this study had access to the raw data and the encrypted external hard drive where the data were collected and stored. No specific direct identifying information was collected in this dataset; however, email addresses were collected for the incentive. This

identifying information was not associated with survey responses. The incentive data were extracted by the statistical consultant directly through Qualtrics and was not provided to the researcher, thesis supervisor, or committee members. The winner's email address was sent to a University of Lethbridge staff member who contacted the winner to arrange delivery of the draw prize. This data will be destroyed upon delivery of the draw prize.

When not in use by the researcher, thesis supervisor, committee members, or consultants, the encrypted external hard drive was kept in a locked filing cabinet within a private office. The encrypted external hard drive will be kept for a period of 7 years. After this time, the files will be deleted, and the external hard drive will be cleared of any study data.

Concluding Remarks

In this chapter, the researcher has provided an outline of the methodology for the present study. The aim of the project was to survey practising psychotherapists who were regular, lifetime, honorary, or regional members of ICEEFT about their views on the use of EFFT in cases of situational couple violence. Three questions were investigated:

1. What contextual factors do EFT therapists believe to be most important when considering the use of EFFT in cases involving situational couple violence?
2. What are the risks and benefits of using EFFT in cases involving situational couple violence?
3. What demographic factors are associated with the views of EFT therapists on the use of EFFT in cases involving situational couple violence?

In order to answer these questions, participants were asked to complete an online survey

divided into five parts. Data were analyzed using descriptive statistics as well as correlational analysis.

Chapter 6: Results

To learn more about the views and opinions of therapists on the application of EFFT in cases involving situational couple violence, the researcher invited therapists from around the world to complete an online survey. In this chapter, the reader is provided with an overview of the results of the online survey. It is relevant to note that all percentages reported here represent the valid percentages, with missing data excluded.

Participants

Although 103 participants began the survey, 21 were excluded due to their responses to the screening questions, resulting in 82 therapists meeting the inclusion criteria. An additional three participants were excluded as they did not provide responses to any questions beyond the screening questions. As a result, a total of 79 participants' data were used in this thesis; references to these individuals are noted hereafter as *the participants*.

All of the participants were ICEEFT members. The breakdown of membership included 42 (53.2%) participants identifying as having a regular membership, and 37 (46.8%) shared they were lifetime ICEEFT members.

In the following section, readers are introduced to participants' characteristics. This includes how participants were invited to take part, their age, and years practising as a psychotherapist. This section also provides readers with an overview of which EFT certifications were held by participants as well as their general knowledge of EFT. Lastly, participant training levels are presented, along with IPV and family therapy provision.

Invitation to Participate

Participants were asked to indicate how they had been recruited to participate in this research. Of the 57 participants who responded to this question, the majority of participants indicated they had been recruited through an email from another EFT therapist (n = 20, 35.1%). Table 3 provides a frequency distribution of how participants were invited to take part in this research.

Of the 11 participants who provided a written response, four indicated they had been invited through an EFFT training, three had been invited by the researcher, two had been invited through their EFT community, one had been invited by email but did not specify the source, and one speculated they had been invited through the ICEEFT listserv.

Table 1

Frequency Distribution Outlining how Participants Were Invited to Participate

Participant's response	*f*	%
ICEEFT online forum	6	10.5
A group email through my EFT supervision group	5	8.8
A group email through my EFFT supervision group	1	1.8
A group email through an EFT training	4	7.0
A group email through an EFFT training	11	19.3
An email from another EFT therapist	20	35.1
Prefer not to say	1	1.8
Other	9	15.8
Total	57	100.1

Note. The total percentage does not add to 100% due to rounding. EFFT = emotionally focused family therapy; EFT = emotionally focused therapy; ICEEFT = International Centre for Excellence in Emotionally Focused Therapy.

Age

Participant ages ranged from 27 to 74 years old (n = 77). The mean distribution for participant age was 33 years, with a standard deviation of 12.3. Table 2 provides a frequency distribution of the data.

Table 2

Frequency Distribution for Question 4 – Participants' Age

Age	*f*	%
25–34	10	13.0
35–44	20	26.0
45–54	17	22.1
55–64	22	28.6
65+	8	10.4
Total	77	100.1

Note. The total percentage does not add to 100% due to rounding.

Years Practising as a Psychotherapist

Years practising as a psychotherapist ranged from 0–40 years (n = 76). Here, zero was taken to mean the psychotherapist recently began practising. Participants were asked to exclude years as a volunteer and practicum/internship experience. The mean of this distribution was 12.9 years, with a standard deviation of 9.7 years. Table 3 provides a frequency distribution of the data.

Table 3

Frequency Distribution for Question 4 – Participants' Number of Years Practising as a Psychotherapist

Number of years	*f*	%
0–4	18	23.7
5–9	16	21.1
10–14	13	17.1
15–19	12	15.8
20+	17	22.4
Total	76	100.1

Note. The total percentage does not add to 100% due to rounding.

EFT Certifications

Participants were given the option to select multiple EFT certifications. Thirty-five participants identified as a certified EFT therapist (44.3%), 22 as a certified EFT supervisor (27.8%), and five as a certified EFT trainer (6.3%). Nineteen participants indicated that they held none of the previous three certifications (24.1%). A total of 16 participants provided a written response, with the majority indicating they were either in the process of becoming a Certified EFT Therapist (n = 7) or had completed one or more trainings required to become a Certified EFT Therapist (n = 6; e.g., externship and/or core skills in EFT). Table 4 provides a frequency distribution of the data.

Table 4

Frequency Distribution for Participants' EFT Certifications

EFT certifications	*f*	%
Certified EFT Therapist	35	44.3
Certified EFT Supervisor	22	27.8
Certified EFT Trainer	5	6.3
None of the Above	19	24.1
Prefer not to say	0	0
Prefer to answer with a written comment/explain my answer	10	12.7
Total	91	115.2

Note. The total percentage does not add to 100% due to multiple response option. EFT = emotionally focused therapy.

Knowledge of EFT

The researcher assessed existing familiarity with the theory and practice of EFT, as defined by participants completing two foundational EFT trainings: the EFT externship and the EFT core skills trainings. Of the participants, 75 had completed the EFT externship training, with 57.9% (n = 44) completing this training over 5 years ago and 42.1% (n = 32) within the past 5 years. Likewise, 94.9% (n = 75) of responding participants had completed the EFT core skills with only very few participants (5.3%, n = 4) noting they were in the process of completing this training.

Training

Participants were asked to rate their level of completion for five trainings related to IPV and/or EFT. In order of descending frequency, participants indicated some level of completion for EFFT: Level 1 (n = 45, 61.7%), training focused exclusively on IPV (n = 33, 49.3%), EFT for highly escalated couples (n = 31, 48.5%), EFFT: Level 2

(*n* = 29, 41.9%), and EFT for IPV (*n* = 18, 27.2%). Table 5 presents a frequency distribution for each level of training completion. Seven participants provided a written response, highlighting other trainings taken, including EFT for extramarital affairs, EFT for individuals, and EFT for trauma. Participants also described reading about, discussing, and working with couples experiencing IPV. One participant also noted the EFFT training they attended was not distinguished into two levels.

Table 5

Frequency Distribution for Participants' Level of Completion of Trainings

	EFFT: Level 1		EFFT: Level 2		EFT for highly escalated couples		EFT for IPV		IPV training (regardless of whether it was EFT related)	
Participant's response	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
Not Completed	28	38.4	40	58.0	33	51.6	48	72.7	34	50.7
In the process of being completed	1	1.4	9	13.0	1	1.6	2	3.0	3	4.5
Completed within past 5 years	38	52.1	19	27.5	26	40.6	15	22.7	12	17.9
Completed over 5 years ago	6	8.2	1	1.4	4	6.3	1	1.5	18	26.9
Total	73	100.1	69	99.9	64	100.1	66	99.9	67	100

Note. The total percentages do not add to 100% in some cases due to rounding. EFFT = emotionally focused family therapy; EFT = emotionally focused therapy; IPV = intimate partner violence.

IPV Service Provision

The researcher also assessed existing familiarity with IPV service provision within this sample. Participants were asked to identify how often they provided eight core IPV-related psychotherapeutic services. Table 6 presents a frequency distribution for each level of IPV service provision. In order of descending frequency, participants indicated some level of service provision for those impacted by IPV using couples therapy (*n* = 67, 90.6%), individual therapy for women (*n* = 64, 86.5%), individual therapy for men (*n* = 56, 75.6%), family therapy (*n* = 41, 54.7%), individual therapy for children/adolescents (*n* = 38, 50.6%), group therapy for women (*n* = 14, 19.1%), group therapy for men (*n* = 8, 10.9%), and group therapy for children/adolescents (*n* = 8, 10.9%). Four participants provided a written response. One participant noted how they often work with couples impacted by IPV within a previous relationship. Other participants noted working within other areas of practice (e.g., children under the age of 5 years old, families with teens impacted by drug use).

Table 6

Frequency Distribution for Participants' IPV Service Provision

	Individual therapy for women impacted by IPV		Individual therapy for men impacted by IPV		Individual therapy for children/ adolescents impacted by IPV		Group therapy for women impacted by IPV		Group therapy for men impacted by IPV		Group therapy for children/ adolescents impacted by IPV		Couples therapy for those impacted by IPV		Family therapy for those impacted by IPV	
Participant's response	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
Never	10	13.5	18	24.3	37	49.3	60	81.1	66	89.2	66	89.2	7	9.5	34	45.3
Rarely	22	29.7	28	37.8	16	21.3	9	12.2	4	5.4	6	8.1	17	23.0	20	26.7
Sometimes	29	39.2	24	32.4	18	24.0	3	4.1	3	4.1	0	0	35	47.3	20	26.7
Often	10	13.5	2	2.7	3	4.0	1	1.4	0	0	1	1.4	12	16.2	1	1.3
Almost Always	3	4.1	2	2.7	1	1.3	1	1.4	1	1.4	1	1.4	3	4.1	0	0
Total	74	100	74	99.9	75	99.9	74	100.2	74	100.1	74	100.1	74	100.1	75	100

Note. The total percentages do not add to 100% in some cases due to rounding. IPV = intimate partner violence.

Family Therapy Service Provision

Overall, participants were familiar with family therapy, given that the majority reported providing this service over the last year. In order of descending frequency, participants indicated some level of service provision for EFFT (*n* = 50, 68.5%), any form of family therapy (*n* = 49, 67.1%), and EFFT in cases of situational couple violence (*n* = 28, 38.4%). Table 7 presents a frequency distribution for each level of family therapy service provision. Three participants provided a written response, including two people who highlighted how family therapy is not their primary approach. Another noted how their practice involved working primarily with families impacted by domestic violence.

Table 7

Frequency Distribution for Participants' Family Therapy Provision

	Family therapy		EFFT		EFFT in cases involving situational couple violence	
Participant's response	*f*	%	*f*	%	*f*	%
Never	24	32.9	23	31.5	45	61.6
Rarely	17	23.3	14	19.2	13	17.8
Sometimes	20	27.4	19	26.0	14	19.2
Often	10	13.7	7	9.6	1	1.4
Almost Always	2	2.7	10	13.7	0	0
Total	73	100	73	100	73	100

Note. EFFT = emotionally focused family therapy.

Analysis

This thesis aimed to answer one central research question: What are the views of EFT therapists on the application of EFFT in cases involving situational couple violence?

This question was investigated through the three subquestions:

1. What contextual factors do EFT therapists believe to be most important when considering the use of EFFT in cases involving situational couple violence?
2. What are the risks and benefits of using EFFT in cases involving situational couple violence?
3. What demographic factors are associated with the views of EFT therapists on the use of EFFT in cases involving situational couple violence?

These subquestions guided data analysis. Collected data were uploaded to SPSS Statistics for analysis. The researcher prepared the SPSS coding and had a statistician confirm the analysis process and reporting of the results.

Research Subquestion 1: What Contextual Factors do EFT Therapists Believe to be the Most Important When Considering the use of EFFT in Cases Involving Situational Couple Violence?

The first research subquestion was used to investigate the contextual decision-making factors EFT therapists believe to be most important when considering the use of EFFT in cases involving situational couple violence. The possible 29 contextual factors were identified as being related to the therapist, parents, violent family members, or children. The following descriptive statistics were used to analyze collected data: frequency distributions, measures of central tendency, and measures of variability. Each of these measures was used to summarize the collected data. Ordinal data from Part 4 were used to answer this research subquestion. Frequency distributions are presented below each of the factors in Table 8 (factors related to therapists), Table 9 (factors related

to parents), Table 10 (factors related to violent family members), and Table 11 (factors related to children).

Descriptive Statistics. Participants identified many important decision-making factors when deciding whether to use EFFT in cases involving situational couple violence. Twenty-four written responses were provided regarding these factors, which are presented in Appendix I. The following list presents the top 10 most important decision-making factors, as defined by the highest percentage of reported importance:

1. The therapist will seek supervision from someone with high competency in the treatment of IPV while working with this family (*n* = 65, 100% of the sample rated this as somewhat, quite, or very important).
2. The parents indicate they are highly motivated to eliminate violence in their home (*n* = 62, 100%)
3. The parents indicate that they feel safe being in therapy together (*n* = 61, 98.4%).
4. The violent family members recognize the impact of their violence on the family (*n* = 59, 98.4%).
5. The therapist has taken training exclusively focused on IPV (*n* = 64, 97%).
6. The therapist is not intimidated by the violent family members (*n* = 64, 97%)
7. The therapist will screen each family member for risk/safety on an ongoing basis, including but not limited to severity and frequency of violence (*n* = 63, 96.9%).
8. The parents have been screened separately for risk/safety, including but not limited to severity and frequency of violence (*n* = 60, 96.8%)

9. The parents have detailed safety plans in place (*n* = 60, 96.8%)
10. The parents are confident in their ability to implement their safety plan if needed (*n* = 59, 96.8%)

Table 8

Frequency Distribution for Participants' Views on Contextual Factors Related to the Therapist

	I believe this is not important		I believe this is somewhat important		I believe this is quite important		I believe this is very important		I don't know / No opinion	
Therapist factors	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
Has taken training exclusively focused on IPV	1	1.5	13	19.7	18	27.3	33	50.0	1	1.5
Will seek supervision from someone with high competency in the treatment of IPV while working with this family (n = 65)	0	0	4	6.2	21	32.3	40	61.5	0	0
Has taken training in EFFT: Level 1 (n = 65)	4	6.2	12	18.5	14	21.5	32	49.2	3	4.6
Has taken training in EFFT: Level 2 (n = 65)	5	7.7	15	23.1	17	26.2	25	38.5	3	4.6
Will seek supervision from someone with high competency in the use of EFFT	3	4.5	7	10.6	16	24.2	39	59.1	1	1.5
Is not intimidated by the violent family members	1	1.5	5	7.6	11	16.7	48	72.7	1	1.5
Believes they have the ability to create safety in sessions with violent family members	1	1.5	0	0	2	3.0	61	92.4	2	3.0

Therapist factors	I believe this is not important		I believe this is somewhat important		I believe this is quite important		I believe this is very important		I don't know / No opinion	
	f	%	*f*	%	*f*	%	*f*	%	*f*	%
Has screened each family member separately for risk/safety (including but not limited to severity and frequency of violence)	2	3.0	2	3.0	2	3.0	58	87.9	2	3.0
Will screen each family member for risk/safety on an ongoing basis (including but not limited to severity and frequency of violence; *n* = 65)	1	1.5	3	4.6	10	15.4	50	76.9	1	1.5
Believes there are no safety concerns for any family members following risk/safety screenings (*n* = 64)	6	9.4	9	14.1	8	12.5	40	62.5	1	1.6

Note. *n* = 66 for all therapist factors, unless otherwise specified. IPV = intimate partner violence.

Table 9

Frequency Distribution for Participants' Views on Contextual Factors Related to the Parents

	I believe this is not important		I believe this is somewhat important		I believe this is quite important		I believe this is very important		I don't know / No opinion	
Parent factors	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
Have been screened separately for risk/safety (including but not limited to severity and frequency of violence)	1	1.6	1	1.6	7	11.3	52	83.9	1	1.6
Indicate they want to remain together	10	16.1	15	24.2	15	24.2	19	30.6	3	4.8
Indicate that they feel safe being in therapy together	1	1.6	2	3.2	12	19.4	47	75.8	0	0
Have detailed safety plans in place	1	1.6	4	6.5	11	17.7	45	72.6	1	1.6
Are confident in their ability to implement their safety plan if needed (n = 61)	1	1.6	4	6.6	15	24.6	40	65.6	1	1.6
Indicate they are highly motivated to eliminate violence in their home	0	0	4	6.5	10	16.1	48	77.4	0	0
Plan to share the duties of parenting (if they are separated, or plan to separate)	3	4.8	16	25.8	18	29.0	20	32.3	5	8.1

Note. n = 62 for all parent factors, unless otherwise specified.

Table 10

Frequency Distribution for Participants' Views on Contextual Factors Related to the Violent Family Members

	I believe this is not important		I believe this is somewhat important		I believe this is quite important		I believe this is very important		I don't know / No opinion	
Violent family member factors	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
Agree to a no-harm contract for the duration of therapy	7	11.7	4	6.7	9	15.0	36	60.0	4	6.7
Report that they will be honest with the therapist about the frequency and severity of the violent physical contact	0	0	2	3.3	12	20.0	44	73.3	2	3.3
Take full responsibility for their use of violent physical contact	0	0	7	11.7	7	11.7	43	71.7	3	5.0
Recognize the impact of their violence on the family	0	0	3	5	10	16.7	46	76.7	1	1.7
Exhibits no psychotic behaviour	2	3.3	6	10.0	7	11.7	43	71.7	2	3.3
Reports no history of substance abuse	20	33.3	17	28.3	10	16.7	11	18.3	2	3.3
Reports not being criminally charged with an offence related to IPV	11	18.3	21	35.0	8	13.3	16	26.7	4	6.7
Does not direct violence towards children	2	3.3	2	3.3	8	13.3	43	71.7	5	8.3

Note. $n = 60$ for all violent family member factors. IPV = intimate partner violence.

Table 11

Frequency Distribution for Participants' Views on Contextual Factors Related to the Children

	I believe this is not important		I believe this is somewhat important		I believe this is quite important		I believe this is very important		I don't know / No opinion	
Child factors	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
Have been screened separately for risk/safety	0	0	1	1.7	5	8.3	51	85.0	3	5.0
Indicate that they want to be included in family therapy	2	3.3	6	10.0	13	21.7	38	63.3	1	1.7
Indicate feeling safe being in therapy with both parents	0	0	4	6.7	8	13.3	46	76.7	2	3.3
Saw or heard violent physical contact in their parents' relationship	9	15.0	9	15.0	5	8.3	23	38.3	14	23.3

Note. $n = 60$ for all child factors.

Research Subquestion 2: What are the Risks and Benefits of Using EFFT in Cases Involving Situational Couple Violence?

The second research subquestion was used to investigate the risks and benefits of using EFFT in cases involving situational couple violence. Descriptive statistics were used to address this area of inquiry. The analysis included frequency distributions, measures of central tendency, and measures of variability. Each of these measures were used to summarize the collected data. Ordinal data from Part 5 were used to answer this research subquestion.

Descriptive Statistics. The majority of participants identified the top risk associated with using EFFT in cases involving situational couple violence as EFT therapists with training in EFFT having insufficient training in IPV (*n* = 28, 46.7%). On the other hand, the top benefit associated with using EFFT in cases of situational couple violence was the possibility of promoting more responsive caregiving of children by parents (*n* = 55, 91.7%). The frequency distributions associated with the risks and benefits of this approach are presented in Tables 12 and 13, respectively. Sixteen written responses were provided regarding contextual factors, which are presented in Appendix J.

Table 12

Frequency Distribution for Participants' Views on Risks of Using EFFT in Cases Involving Situational Couple Violence

	Strongly disagree		Disagree		Agree		Strongly agree		I don't know / No opinion	
Risks	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
Certified EFT Therapists with training in EFFT will have an insufficient level of competence	9	15.3	25	42.4	13	22.0	5	8.5	7	11.9
Certified EFT Therapists with training in EFFT will have insufficient training in intimate partner violence (n = 60)	5	8.3	18	30.0	19	31.7	9	15.0	9	15.0
Certified EFT Therapists with training in EFFT will inadequately assess for violence	9	15.3	22	37.3	15	25.4	5	8.5	8	13.6
This approach will increase the likelihood of physical harm to family members	19	32.2	27	45.8	3	5.1	1	1.7	9	15.3
This approach will increase the likelihood of psychological harm to family members	15	25.4	32	54.2	2	3.4	1	1.7	9	15.3

Note. n = 59 for all listed risks, unless otherwise specified. EFFT = emotionally focused family therapy; EFT = emotionally focused therapy.

Table 13

Frequency Distribution for Participants' Views on Benefits of Using EFFT in Cases Involving Situational Couple Violence

	Strongly disagree		Disagree		Agree		Strongly agree		I don't know / No opinion	
Benefits	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
Promote the repair of attachment injuries within the family	1	1.7	0	0	17	28.3	35	58.3	7	11.7
Renew the children's confidence in the emotional availability of their parents	1	1.7	0	0	21	35.0	32	53.3	6	10.0
Promote more responsive caregiving of children by parents	1	1.7	0	0	19	31.7	36	60.0	4	6.7
Increase physical safety within the family	1	1.7	1	1.7	22	36.7	29	48.3	7	11.7
Increase psychological safety within the family	1	1.7	1	1.7	20	33.3	32	53.3	6	10.0

Note. $n = 60$ for all listed benefits.

Research Subquestion 3: Which Demographic Factors are Associated with the Views of EFT Therapists on the use of EFFT in Cases Involving Situational Couple Violence?

In order to address Subquestion 3, the researcher used descriptive statistics as well as a correlational analysis. In this instance, the dependent variable was defined as the degree to which EFT therapists would ever consider using EFFT in cases involving situational couple violence. Eight independent variables were included: (a) age, (b) years

practising as a registered/licenced psychotherapist, (c) EFT certifications, (d) EFFT Level 1 training, (e) EFFT Level 2 training, (f) EFT for highly escalated couples training, (g) EFT for IPV training, and (h) IPV training. Correlational analysis was used to identify the strength and direction of the relationship between each of the independent variables and the likelihood of participants considering the use of EFFT in cases involving situational couple violence. The independent variables were selected for their alignment with three distinct themes: experience as a psychotherapist, knowledge of EFFT, and knowledge of IPV.

First, it was the intention of this researcher to investigate whether age or years of experience as a psychotherapist were associated with likelihood of EFFT use in cases involving situational couple violence. Researchers such as Lushin et al. (2019) and Beidas et al. (2015) suggested age may play a role in the implementation of some therapeutic techniques and evidence-based practices, although they noted clinical experience increases along with age. As such, this researcher elected to include both factors. The researcher ran a correlational analysis to check for redundancy between age and years of experience. After consultation with the statistical consultant, these two variables were determined to be sufficiently distinct to include both in the final analysis.

Second, this researcher chose to investigate the relationship between level of EFFT knowledge with the likelihood of EFFT use in cases involving situational couple violence. In designing this study, the researcher anticipated the sample would include therapists who worked exclusively with couples or individuals. For such therapists, the idea of using EFFT with any population could prove daunting, let alone using it with clients impacted by violence. The researcher included EFFT training in this analysis to

explore what impact, if any, preexisting knowledge of EFFT may have on participant responses. Both levels of EFFT training were included in the analysis, following consultation with thesis commit members. Including both levels serves to differentiate between participants with a basic knowledge of EFFT and those with more advanced training.

The final theme investigated in this analysis was the relationship between levels of IPV training and likelihood of EFFT use in cases involving situational couple violence. This relationship was explored through three distinct independent variables: (a) EFT for highly escalated couples, (b) EFT for IPV, and (c) any IPV training, regardless of whether it was EFT-related. The first training, EFT for highly escalated couples, is not offered as an IPV training. However, it was included in this analysis to capture participants with advanced knowledge in de-escalation and managing clients with more challenging presentations. The second training, EFT for IPV, was included in order to assess whether increased knowledge of how to provide therapeutic services to couples experiencing violence would translate to an increased likelihood of using EFFT for families experiencing violence. The third training category was included to capture all other IPV-related trainings participants may have attended. Researchers such as Stith and McCollum (2011) highlighted the importance of IPV training for therapists; thus, this category was designed to capture a range of knowledge relevant to the provision of IPV-related services.

Descriptive Statistics. Descriptive statistics included frequency distributions, measures of central tendency, and measures of variability. The reported likelihood of

EFFT use in cases of situational couple violence and participant training are outlined in the subsections that follow.

Likelihood of EFFT Use. As noted previously, the majority of participants (n = 44, 62.8%) reported they would consider using EFFT in cases of situational couple violence. A frequency distribution of these results is presented in Table 14. Twelve participants chose to include a written response to this question. Participants highlighted the need for training in EFFT (n = 4) as well as training in EFT for domestic violence and clinical supervision/consultation (n = 1) before considering this approach. Two participants indicated they would need to assess each family on a case-by-case basis. Two other individuals noted they worked exclusively with couples and/or individuals and were not interested in working with families. One participant noted how parents did not present with issues related to situational couple violence, but rather issues related to the child's drug use. Another individual described their likelihood of use as "possible."

Table 14

Frequency Distribution for Likelihood of EFFT use in Cases Involving Situational Couple Violence

	Likelihood of considering the use of EFFT in cases involving situational couple violence	
Participant's response	*f*	%
Very Unlikely	6	8.6
Unlikely	12	17.1
Likely	22	31.4
Very Likely	22	31.4
I don't know/No opinion	8	11.4
Total	70	99.9

Note. The total percentage does not add to 100% due to rounding. EFFT = emotionally focused family therapy.

Correlational Analysis. A correlational analysis was performed to investigate the relationship between the views of EFT therapist on the use of EFFT in cases involving situational couple violence and eight independent variables: (a) age, (b) years practising as a registered/licenced psychotherapist, (c) EFT certifications, (d) EFFT Level 1 training, (e) EFFT Level 2 training, (f) EFT for highly escalated couples training, (g) EFT for IPV training, and (h) IPV training.

The researcher used Spearman's rho to produce a meaningful estimate of the relationship between variables. Spearman's rho is a nonparametric test measuring correlations between ordinal variables (Coolican, 2009). Analysis revealed three statistically significant positive correlations between the views of EFT on the use of EFFT in cases involving situational couple violence and therapist factors: (a) completion of EFFT: Level 1 training ($r = 0.269$, $p < 0.05$), (b) completion of EFFT: Level 2 training ($r = 0.369$, $p < 0.01$), and (c) completion of IPV training ($r = 0.286$, $p < 0.05$). However, the strength of these correlations is weak. In summary, the answer to the third research question is that EFT therapists with training in EFFT or IPV are more likely to consider using EFFT in cases involving situational couple violence. Additionally, more advanced EFFT training strengthens this effect. Table 15 presents the results of the correlational analysis.

Table 15

Spearman's rho Correlation: Relationship Between the Views of EFT Therapists on the use of EFFT in Cases Involving Situational Couple Violence and Therapist Factors

	Likelihood of using EFFT in cases involving situational couple violence		
Therapist factors	*r*	*p*	*n*
Age	-0.107	0.383	69
Years practising as a registered/licenced psychotherapist	0.008	0.950	68
EFT certifications	0.094	0.437	70
Completion of EFFT: Level 1	0.269*	0.029	66
Completion of EFFT: Level 2	0.369**	0.001	63
EFT for Highly Escalated Couples	0.168	0.213	57
EFT for IPV	0.136	0.301	60
IPV training	0.286*	0.026	61

Note. * $p < 0.05$ (2-tailed); ** $p < 0.01$ (2-tailed). EFFT = emotionally focused family therapy; EFT = emotionally focused therapy; IPV = intimate partner violence.

Summary

Statistical analyses were conducted in order to address the three stated research subquestions. First, descriptive statistics suggested surveyed EFT therapists believe the most important decision-making factors to be (a) therapists seeking supervision from someone with high competency in the treatment of IPV, (b) parents indicating they are highly motivated to eliminate violence in their home, (c) parents indicating they feel safe being in therapy together, (d) violent family members recognizing the impact of their violence on the family, (e) therapists taking training exclusively focused on IPV, (f) therapists not being intimidated by the violent family members, (g) therapists screening each family member for risk/safety on an ongoing basis, (h) parents being

screened separately for risk/safety, (i) parents having detailed safety plans in place, and (j) parents being confident in their ability to implement their safety plan if needed.

Second, descriptive statistics suggested that surveyed EFT therapists believe the top risk associated with using EFFT in cases involving situational couple violence was that EFT therapists with training in EFFT would have insufficient training in IPV. The top benefit associated with using EFFT in cases of situational couple violence was the possibility of promoting more responsive caregiving of children by parents.

Third, descriptive statistics and Spearman's rho tests suggested three therapist factors were weakly associated with views on the use of EFFT in cases involving situational couple violence: (a) completion of EFFT: Level 1 training, (b) completion of EFFT: Level 2 training, and (c) completion of IPV training. In Chapter 7, the researcher will discuss these results as well as explore the strengths, limitations, and future directions for this research.

Chapter 7: Discussion

This chapter provides the reader with an overview of the purpose of this thesis as well as an in-depth discussion of the notable research results within the context of the literature presented in Chapters 2–4. The researcher also examines the strengths and limitations of the current study. The chapter concludes with future directions for researchers, psychotherapists, and training organizations and institutions.

Purpose of the Thesis

There is currently no published research on the use of EFFT when violence is indicated. This thesis represents the first attempt to fill this significant gap in the literature. By exploring the views of EFT therapists on the application of EFFT in cases involving situational couple violence, this thesis lays the foundation for an entirely new area of research.

It is exciting to see growing interest in the use of couples therapy, including EFT, in cases involving situational couple violence. Certainly, couples therapy has been shown to be an effective approach for the treatment of situational couple violence (e.g., McCollum & Stith, 2008; Stith et al., 2012), but it stops short in one critical area; couples therapy does not address the significant impact violence has had on the family system, particularly the within parent–child relationships. As highlighted throughout this thesis, witnessing violence within the home can have significant and long-lasting effects for children, families, and society as a whole. Although EFFT may be well suited to addressing the needs of children impacted by violence, there is no literature on the use of EFFT in cases involving situational couple violence. As such, nothing is known about the safety or efficacy of this approach. To overcome this critical gap in knowledge, the

researcher invited EFT therapists from around the world to share their views on the application of EFFT when situational couple violence is identified.

In the next section, the researcher explores participant demographics so that readers can become more familiar with the people who generously chose to assist in this new area of research. The researcher then answers the following three questions:

1. What contextual factors do EFT therapists believe to be most important when considering the use of EFFT in cases involving situational couple violence?
2. What are the risks and benefits of using EFFT in cases involving situational couple violence?
3. What demographic factors are associated with the views of EFT therapists on the use of EFFT in cases involving situational couple violence?

These three questions were chosen following an extensive review of available literature as well as in-depth discussions between the researcher and her thesis supervisor. Throughout this selection process, one question kept coming up: is it ever appropriate to use family therapy when there is violence in the home? Having a background in antiviolence work and feminist theory, this researcher was initially inclined to say no, family therapy would never be appropriate when concerns about violence were present. From a feminist perspective, it seemed violence in relationships was best addressed individually or in groups, with the offender receiving educational and cognitive-behavioural-based programming aimed at eliminating violence toward female partners, as described in articles such as Bohall et al. (2016) and Pence and Paymar (1993). However, the researcher began to question her position after reviewing the literature on typologies of violence as put forward by M. P. Johnson and Ferraro (2000). Afterall, if there could

be different types of IPV, could there also be different treatment options for clients struggling with violence in the home? Indeed, literature on the use of couples therapy in the treatment of IPV suggested there was room to consider other options (e.g., Stith et al., 2012). Having attended extensive EFT trainings, the researcher wondered how attachment theory could be used to meet the needs of individuals, couples, and families impacted by violence. In proposing the use of EFT for couples experiencing situational couple violence, authors such as Rouleau et al. (2019) as well as Slootmaeckers and Migerode (2018, 2020) clarified how attachment theory could be used to conceptualize situational couple violence. In the end, there was still no concrete answer to the question of whether family therapy should ever be used in cases of situational couple violence but, based on her journey through the literature related to this topic, this researcher chose to adopt a tentative and curious stance about the prospect.

Although many questions remain about the use of family therapy in cases of situational couple violence, the researcher, with formal support from her thesis committee, believed strongly that the three chosen researcher questions offered a solid foundation from which additional research could emerge. Each of these questions contributes to the collective understanding of how therapists might make the decision to proceed with EFFT in cases involving situational couple violence. This study is only the beginning of what will hopefully be an ongoing conversation not only about the treatment of IPV, but also the potential uses of EFFT.

Discussion of the Results

Participant Demographics

A total of 79 EFT therapists participated in this study, representing a wide range of experiences and knowledge. On average, respondents were 33 years old and had 12.9 years experience working as a psychotherapist. Although not all participants were certified EFT therapists, all had sufficient knowledge of EFT, given the high completion rates of foundational EFT training. However, specific knowledge of EFFT may have been lacking within this sample, given that nearly 40% reported no training in EFFT. Another gap in existing participant knowledge may lie in IPV service provision. Although many respondents indicated providing some IPV-related services, the majority indicated they did so only sometimes or rarely. Less than half the sample had completed any IPV training. There are also cultural factors to consider when discussing IPV training and experience. As noted by one of the participants in the optional written response, "there are a large number of EFT therapists worldwide, so I imagine the level of knowledge about IPV will vary" (see Appendix J). This researcher recommends future research on this topic to investigate the relationship between culture and IPV knowledge. This perceived lack of knowledge and/or experience in the areas of EFFT and IPV is important to highlight as it gives context to this discussion of results.

EFT practice and research is developing rapidly. For example, although EFT was originally developed for use with couples, today, EFT is increasingly applied to families as well as individuals. Likewise, violence was originally identified as a contraindication for EFT; now, patterns of abuse, rather than the presence of violence, are identified as the more pressing contraindication. Unfortunately, these exciting changes are slow to trickle

down to EFT therapists. EFT therapists may become aware of such progress when they take the time to review recently published books and articles, speak with colleagues, or attend optional professional trainings on IPV or EFFT. However, until these types of training become a requirement for EFT certification, it is likely many EFT therapists will have limited knowledge and/or experience related to EFFT or IPV. Indeed, one participant reflected on this point in their optional written response, saying, "Unless you are taking an EFT IPV training, I don't think you'll get this info from core skills, externship, etc." (see Appendix J). As such, the gaps in knowledge and experience noted above are likely representative of the larger population of EFT therapists. That being said, EFT therapists seem to be an engaged and receptive group of professionals, and so this researcher is optimistic they will continue to engage in EFFT and IPV trainings, thereby narrowing this gap in the years to come.

Research Subquestion 1: What Contextual Factors do EFT Therapists Believe to be Most Important When Considering the use of EFFT in Cases Involving Situational Couple Violence?

Overall, contextual factors related to ensuring client safety were highly important to therapists considering the use of EFFT when violence in the home was indicated. The therapists in this sample left no stone unturned as they grappled with the decision of whether to use EFFT in cases of situational couple violence. Each of the 29 decision-making factors had a strong contingent of therapists rating it as important to consider. In the following section, the researcher provides a brief answer to this first research subquestion, with a more detailed analysis to follow.

It was reassuring to read that, above all, therapists want two things: to have a supervisor with high competency in treating IPV and to work with parents who express a desire to eliminate violence in their home. Participants made it clear that the need for safety was a top priority, such as wanting parents to feel safe being in therapy together and for the therapist to feel confident in their ability to create safety. This focus on safety also included ensuring each family member was screened separately for safety and done so on an ongoing basis. Interestingly, this group of EFT therapists tended to prioritize IPV-related competencies to EFFT-related competencies, which could suggest these therapists are recognizing the inherent risks associated with providing IPV support. A detailed commentary regarding this first subquestion is presented below.

It is encouraging to see such support for therapists seeking supervision from someone with high competence in the treatment of IPV, particularly given the limited IPV training and experience within this group of therapists. All responding therapists (n = 65) reported this type of supervision to be at least somewhat important. Given that less than half of these individuals had completed any IPV training, it is likely that many of these therapists recognized that they may be practising outside the bounds of their competence if they chose to work with a family experiencing IPV. Such strong support for IPV-related clinical supervision is encouraging because supervision can play an important role in maintaining an ethical therapeutic practice, which is highlighted in current professional standards (e.g., Canadian Association for Marriage and Family Therapy, 2019). In this case, receiving supervision from someone with competence to treat IPV would have at least two major ethical implications: it would enhance the supervisee's standard of performance in working with violence and it would allow the

supervisor to monitor the quality of that performance on an ongoing basis (Canadian Psychological Association, 2017b). In both cases, the client impacted by IPV is protected from potential harm because not only are the services they receive improved, but they also have an additional, highly knowledgeable, clinician working behind the scenes of their care team.

The importance placed on seeking supervision when working with violence may also speak to this group of therapists wanting to take care of their own mental health, as supervision can protect against the high cost of helping others. Given the relational nature of EFT, it is likely that the participants in the current study could have seen the benefit of being supported by another caring professional when considering taking on a family impacted by IPV. Supporting clients impacted by violence is an exceptionally taxing experience and ample research points to the fact that this work can take a serious toll on the helper. For example, secondary traumatic stress—or extreme stress as a result of helping a traumatized person—is expected in helping professionals working supporting victims of violence and other traumas (Figley, 1995). Fortunately, clinical supervision can help mitigate the costs of helping. Researchers Slattery and Goodman (2009) found quality clinical supervision often acts as a protective factor against secondary traumatic stress for domestic violence workers. A more recent study conducted by Quinn et al. (2019) found a similar effect within clinical social workers, noting it was the quality of the supervisory relationship that protected helpers against secondary traumatic stress, marked by empathy, congruence, unconditional positive regard, as well as a willingness-to-be-known.

It was also reassuring to find that while participants placed a high value on client safety, there seemed to be a willingness to accept a certain level of risk when helping families who report violence in the home. This statement is based on the written responses that noted some therapists in this study (n = 6) were willing to weigh the importance of safety against the risk of doing nothing. For example, one participant highlighted while they hold safety as a top priority, they believed "a therapist can work with families where there is still some risk . . . there will always be risk but we can continue to assess and treatment will help" (see Appendix I). Another therapist mentioned how clients presenting as high risk is "a sign they need services to enhance safety" (see Appendix I). This same participant went on to suggest the creation of a decision tree with various levels of safety risks, which might suggest family therapy would be discontinued if a certain level of risk becomes known to the therapist. For example, a decision tree may help therapists recognize the need to discontinue EFFT and consider alternative treatment approaches if the violence were to increase in severity and/or frequency.

In the end, it seemed as though the EFT therapists in this sample were not nearly as risk averse as the researcher anticipated, a finding which is echoed in the following section examining the risks and benefits of using EFFT in cases involving situational couple violence.

All of the therapists who responded to this portion of the survey (n = 62) wanted to work with parents who were motivated to eliminate violence in the home. This finding is striking when held up against the relatively low support shown in this study (n = 49)

for implementing a no-harm contract because it suggests these therapists were willing to go ahead with treatment even if the violence had not stopped.

The signing of no-violence contracts as a requirement of treatment has been put forward by some authors as a strategy for increasing safety when engaging in couples therapy (e.g., Carr, 2019a; Stith et al., 2002). However, participants in this study did not show the same support for this factor as for requiring a high motivation to eliminate violence. Perhaps this was because the EFT model emphasizes the importance of exploring the emotional experiences of clients rather than strictly managing the behaviours associated with those emotional experiences, which could include having clients agree to a no-harm contract. It could also be these therapists did not feel as strongly that violence needed to stop before treatment could begin because they have confidence in their ability to reduce violence indirectly by helping partners understand the emotions and unmet attachment needs that drive the violent behaviour. In essence, they may have trusted in their ability to create emotional safety, which was lauded as highly important in a qualitative study by Lechtenberg et al. (2015) exploring the experiences of couples attending couples therapy for IPV. The written answer from one participant provides further insight into how behavioural contracts may potentially reduce the ability for therapists to create emotional safety:

> The clients have to trust the therapist so I don't necessarily think it would be in the clients' best interest to have them make various promises at the beginning of therapy that there is a good chance . . . some of them wouldn't be able to keep. (Appendix I)

Clearly, there is a great deal more to investigate with respect to the views of EFT therapists on no-harm contracts within the context of IPV service provision. The researcher hopes to continue to investigate this fascinating area of study in the future.

This desire to have clients with a high level of motivation to end the violence is echoed in some literature on systemic approaches to IPV. For example, according to authors such as Glick et al. (2016), family therapy should only occur when the violent family members are motivated to stop their violent behaviour. Similarly, in the EFT-based treatment approach suggested by Rouleau et al. (2019), therapists assessing the readiness of a couple for conjoint treatment were encouraged consider a variety of factors, including "a desire for change in the interactional pattern in the relationship with an overall goal of eliminating all violence in the future" (p.154).

One question lingers: what about parents with a lower motivation to eliminate violence? Such a family is certainly at a different stage in their desire to change, but could they still benefit from a systemic approach? The stages of change model (Prochaska & DiClemente, 1983) may prove useful in understanding how different levels of motivation to eliminate violence may impact therapy. This model has been used previously to assess readiness for male batterer intervention programs, as described in Tutty et al. (2020). Within the context of family therapy, parents with lower motivation to eliminate violence are likely to be in either the *precontemplation stage*, where they are not aware that the violence is problematic and thus have no intention to change, or the *contemplation stage*, where they are aware that violence is problematic but not committed to take any action to eliminate it. On the other hand, parents highly motivated to eliminate violence in their home have moved through these first two stages of change,

thus presenting at therapy in the *preparation stage of change*, meaning they are aware violence is a problem and intend to take action to eliminate it. This model has the potential to help us see how parents with lower levels of motivation may simply be at an earlier stage of change and need additional support to build motivation to eliminate violence in the home. In this case, the therapist may work towards building motivation through individual sessions, similar to procedures described in Tutty et al. (2020), or conjoint parent sessions. Once parents are in the preparation stage of change, the therapist may choose to invite other family members or children to attend. Future research will be needed to investigate whether family therapy is appropriate in such situations of lower motivation.

Overall, the vast majority of EFT therapists who participated in this study tended to prioritize IPV-related competencies over EFFT-related competencies when making a decision about providing EFFT in cases involving situational couple violence. For example, 97% of surveyed therapists (n = 64) rated IPV training as being at least somewhat important, echoing similar calls from authors such as Stith and McCollum (2011); they all (n = 65) also highlighted the importance of receiving supervision from an individual with a high level of IPV-related competence. The importance placed on these two factors outweighed the importance placed on receiving supervision from an individual with a high level of EFFT-related competence as well as EFFT-related training. This is an encouraging finding because it seems to speak to the participants not only recognizing the inherent risks associated with IPV-related treatments but also identifying what can be done to mitigate these risks.

This trend toward emphasizing IPV-related competencies over EFFT-related competencies may also speak to the trust these therapists could have in the EFT model. In other words, having a foundational knowledge of EFT may have led these therapists to feel sufficiently confident in their ability to navigate parent–child relationships, even without EFFT training or supervision. This assumption will need to be investigated further in the future.

One startling finding was how unsure these EFT therapists were about the importance of children witnessing violence. In fact, no other decision-making factor came close to these levels of uncertainty. Almost 25% of therapists in this study either did not know or had no opinion about the importance of children witnessing violent physical contact in their parent's relationship. The researcher was shocked by this finding, considering the abundance of research investigating the potential impact of exposure to violence on children (see reviews by Tutty, 2014; Vu et al., 2016). Although not all children will be negatively impacted, research has shown how witnessing physical violence can have a damaging effect on attachment, including the development of insecure attachment styles (Gustafsson et al., 2017). Furthermore, rates of children witnessing IPV have been shown to be as high as 95% in homes where police were called (Fusco & Fantuzzo, 2009). As such, it was disappointing that this group of therapists failed to see the importance of assessing children for witnessing physical violence between their parents.

This finding begs one question: why were these therapists on such shaky ground when it came to weighing the importance of children witnessing violence? The answer may be found in the optional open-ended responses that followed each section of the

survey. This factor was one of the most highly remarked upon in the all the written responses (see Appendix I), with many participants highlighting the need for more information and/or context (e.g., age of child, whether violence is partially contained, degree of violence, frequency of occurrence, etc.). Unlike the other factors, participants seemed to need to place the importance of a child witnessing violence within a larger framework for consideration. If the researcher were to reissue the survey, this question of the importance of witnessing violence would be expanded upon. For example, the researcher would include the three subtypes of children's exposure to IPV, as suggested by Black et al. (2020): (a) direct witness to physical violence (defined as being physically present when physical violence occurs), (b) indirect exposure to physical violence (defined as overhearing violence, seeing the immediate consequences, or is told or overhears conversations about the violence), and (c) exposure to emotional violence (defined as direct or indirect witnessing or overhearing emotional abuse). The researcher would also investigate the impact of child age as well as frequency and intensity of violence, as these were highlighted by participants as being important contextual information.

The researcher wonders whether the EFT therapists in this sample were uncertain about more than simply the importance of witnessing violence. Could there be an underlying uncertainty surrounding the involvement of children in the therapeutic process more generally? After all, the therapists in this sample have a foundation in EFT for couples, and while over 60% were trained in basic EFFT only a small portion provided family therapy on a regular basis. As such, some participants may have never had to consider the issue of when to include children in therapy before being presented with this

case example. As highlighted by researchers Oed and Gonyea, (2019), therapists may generally support the idea of inviting children into family therapy sessions but when presented with a specific case example, these same therapists may prove more hesitant to include children. The case example in the present study may have shaken the convictions of even those therapists with EFFT training. This could explain a hesitancy to include children in session, but particularly a population of children with even higher needs: those who have witnessed violence.

Of the 46 participants who did provide a rating on the importance of children witnessing physical violence, nine rated it as not being an important factor to consider. This is an interesting finding because it may indicate one of two things. These therapists may not see this as an important factor because they do not recognize the impact or high rates of children witnessing violence. Alternatively, they may not see this as an important factor because they would work with the children in the same way regardless of whether the violence was seen or heard by the child because the impact would be the same. This latter option may reflect the work of authors such as MacMillan and Wathen (2014) as well as Perry (2001), who noted children do not need to directly see or hear violence to be negatively impacted. Indeed, terminology has changed within the body of research to reflect this position; in cases in which researchers used to speak of children being a witness to violence, there is now a shift toward describing children being exposed to IPV (Tutty, 2014). While previous studies have demonstrated the incredibly high rates of child exposure to IPV (e.g., Fantuzzo & Fusco, 2007; Fusco & Fantuzzo, 2009; Graham-Bermann et al., 2007; Jaffe & Juodis, 2006), a review of the literature suggests not all children exposed to IPV will be adversely affected (Tutty, 2014). As such, when violence

occurs in the home, therapists may benefit from considering whether exposure to violence, or even the absence of a felt sense of safety, may be sufficient to have had a negative effect on the child.

In concluding this review of the answers to the first research subquestion, it appears the therapists in this sample took great care in weighing the presented contextual decision-making factors. Although they showed strong support for a wide range of factors, participants rated factors related to violence as highly important to consider before making treatment decisions. In particular, they tended to prioritize factors related to establishing and maintaining safety. The EFT therapists in this study were generous enough to provide optional written responses to accompany this data set, which allowed this researcher to recognize that while the therapists placed a high value on safety, a certain amount of risk to safety was accepted. The following section explores this issue of weighing risk and benefit in greater detail.

Research Subquestion 2: What are the Risks and Benefits of Using EFFT in Cases Involving Situational Couple Violence?

In a surprising turn of events, the majority of surveyed therapists showed far more support for the potential benefits of EFFT in cases involving situational couple violence when compared to the potential risks. For example, agreement with the five potential benefits ranged from 85% (n = 51) to over 91% (n = 55) for the most supported benefit. On the other hand, agreement with the five potential risks ranged from 5% (n = 3) to only as high as about 47% (n = 28). This was unanticipated because, as noted previously, it was anticipated that participants would be risk averse and therefore err on the side of caution when asked to consider working within the context of IPV. Afterall, the therapists

in this sample were unlikely to have learned how to work with IPV within their counsellor training program, and this continues to be a gap in education (e.g., Hurless & Cottone, 2018; Karakurt et al., 2013; Stith et al., 2012). Furthermore, literature on EFT for situational couple violence is limited. Each of these points led the researcher to suspect the therapists would note more risks than benefits when considering the use of EFFT to treat situational couple violence. The researcher provides a detailed commentary on these findings below.

Over 90% of responding therapists believed EFFT had the potential to enhance the bond between parent and child, even when situational couple violence was indicated, making that option the highest rated potential benefit. In contrast, the highest rated potential risk was EFT therapists not having sufficient training in IPV, although less than half of the respondents agreed with this being a potential risk. Since the majority of surveyed therapists agreed there were more benefits than risks in using EFFT when violence was present, is it also possible they believe EFT can repair and restore connection within families impacted by violence so these benefits invariably outweigh the risks? Further research will be needed to answer this question.

It is important to note that this finding is flawed for one or more reasons. First, the EFT therapists who chose to participate in this study might have already been biased towards EFT; after all, committing to a 20-minute a survey about EFT would speak to a high level of interest in EFT. Further to this point, over one-third of participants were certified EFT trainers or supervisors, suggesting more than a casual interest in EFT for these therapists. Second, participants were not provided a specific case example to consider. As discussed in the previous section, a desire for more contextual information

when weighing risks and benefits was echoed in the written responses to this set of questions which, if provided, might have changed their responses. For example, one participant noted how their responses to some of the potential risks "are dependent on the therapist and on the family; I don't think those can be answered for everyone" (Appendix J). Future research should investigate whether such support for the potential benefits of EFFT holds true when participants are provided with a case example involving situational couple violence.

One of the most interesting answers to this subquestion was most participants did not believe using EEFT would increase the risk of physical (n = 46) or psychological (n = 47) harm. On one hand, this finding is encouraging because it seems consistent with the review by Hurless and Cottone (2018), who found no evidence to support concerns that conjoint treatment models increased risk of harm to nonviolent family members. Authors such as Stith and McCollum (2011) suggested, rather than increasing the risk of harm, conjoint therapy in some cases of IPV held the potential to increase safety for family members by increasing a couple's ability to resolve conflict nonviolently. On the other hand, this finding could reflect a lack of knowledge and/or experience related to risk assessment when violence is indicated. If this were true, it would be consistent with findings from numerous researchers who warn of inconsistent and ineffective IPV assessment by healthcare professionals (e.g., Clark et al., 2017), including therapists (e.g., Flåm & Handegård, 2015; Froerer et al., 2012; George & Stith, 2014; Schacht et al., 2009; Todahl et al., 2008). More research is needed to examine the possible reasons for the present finding and why participants in this study did not regard physical or

psychological harm as a barrier to using EFFT in families who present with situational couple violence.

When therapists were asked to consider the risks and benefits of using EFFT in cases involving situational couple violence, it seems there was a considerable amount of uncertainty surrounding the answer. This might suggest respondents were not well practised in weighing risks and benefits of therapy in general, or that they were unfamiliar with the task within the context of either EFFT or IPV specifically.

The critical importance of therapists assessing risks and benefits must not be underestimated, as it forms the foundation of two basic moral principles of psychotherapy: nonmaleficence and beneficence. In the case of nonmaleficence, therapists have a duty to avoid actions that may harm clients as well as minimize potential risks to the client and society at large. However, it is not enough to simply avoid harm; therapists must also adhere to the principle of beneficence, or the responsibility to do good by promoting the health and welfare of the client and society (Corey et al., 2019). Conducting family therapy adds additional layers of complexity to this process of weighing risks and benefits. As authors such as Shaw (2015) explored, in balancing multiple agendas for therapy, a family therapist may question the acceptable level of risk to each family member in order to elicit beneficial change within the system. Shaw (2015) even gave the example of a family therapist navigating high parental conflict as being particularly challenging. In light of the fact that nearly 70% of the therapists in this sample reported providing some form of family therapy, including EFFT, it is discouraging to see how unsure participants were when asked to consider such a fundamental aspect of therapy.

The researcher is hopeful that the overall uncertainty of responding therapists could be due to the generality of the question rather than a lack of skill surrounding weighing risks and benefits. Many therapists highlighted the need for more information and/or context (e.g., experience, training, and supervision of the therapist; family factors; psychopathology of the family members, etc.). In particular, responding therapists recognized the possibility of benefit existing but not in all situations. Such responses reinforce the sentiment of bodies such as the Canadian Psychological Association (2017a), who emphasize the need for assessment of risks and benefits on a case-by-case basis, specific to the cultural and social contexts of those involved. Some respondents also strongly supported the need for high levels of competence in both EFFT as well as situational couple violence in order to avoid harm and potentially confer benefits.

The researcher must draw attention to one incredible finding: 38% of responding therapists have used EFFT in cases involving situational couple violence within the last year. This is significant because over one third of this sample have real-world experience weighing the risks and benefits of EFFT when violence was indicated and chose to proceed with treatment. It was beyond the scope of this thesis to inquire as to how the assessment of risk and benefit was conducted for those who had previously used EFFT in cases involving situational couple violence, but it would be fascinating to know more about this process. For instance, what immediate, short- and long-term risks did they identify in their specific case and how did these stack up against the potential benefits? Did these therapists engage in any additional steps as they made the decision to proceed with treatment, such as consulting with a clinical supervisor? In the absence of any existing research on risks and benefits of this application of EFFT, what training and/or

experiences supported their assessment of risks and benefits. Such a novel application of EFFT is compelling and leaves many questions unanswered. The researcher hopes to investigate this topic in greater depth in the future.

In summarizing the findings for the second research question, the researcher must draw attention to one noteworthy conclusion: nearly all the surveyed therapists strongly believed that this approach could confer important benefits. Over 90% of the responding therapists believed using EFFT in cases involving situational couple violence could promote more responsive caregiving of children by parents. However, these therapists also recognized the risks, particularly those associated with limited IPV training; participants noted the most pressing risk was EFT therapists not having sufficient training in IPV to use EFFT in cases involving situational couple violence. Therapists have an ethical duty to minimize harm and maximize benefit when considering treatment (American Psychological Association, 2017; Canadian Psychological Association, 2017a), so the level of uncertainty found in this sample surrounding this very process has the potential to be concerning. According to the Canadian Psychological Association's (2017a) *Code of Ethics*, this process must include the weighing of immediate, short-term as well as long-term risks and benefits, both physical and psychological. As such, it is recommended that future researchers collect qualitative data in order to capture more nuanced risks and benefits of this approach, including potential short-term, ongoing, and long-term risks and benefits of using EFFT when violence is indicated. Additionally, the intersection of clinical supervision, which was identified as an important decision-making factor, and the assessment of risks and benefits may prove useful. For example, future researchers would do well to investigate the role clinical supervision may play in

evaluating and mitigating risks as well as maximizing benefit when an EFT therapist is considering the use of EFFT in cases involving situational couple violence. Future researchers are also advised to investigate the views of therapists who have already used EFFT in cases involving situational couple violence, particularly as those views relate to the weighing of risks and benefits.

Research Subquestion 3: What Demographic Factors are Associated with the Views of EFT Therapists on the use of EFFT in Cases Involving Situational Couple Violence?

The main answer to this last question is that therapists trained in EFFT or IPV were more likely to use EFFT in cases involving situational couple violence. Therapists with advanced training in EFFT were particularly partial to this approach. These findings highlight the critical role training plays in the decision-making process as they struggle with the question of whether to proceed with family therapy when there is situational violence occurring between parents. The following section explores this important finding and the relationship between EFFT use and training.

Likelihood of EFFT Use. Surprisingly, over 62% of the surveyed EFT therapists would consider using EFFT in cases of situational couple violence. The level of support for this approach took the researcher by surprise because this application of EFFT has never been researched before and is not discussed in depth within existing EFFT literature (e.g., Furrow et al., 2019). When violence is discussed, it is identified as a potential contraindication of EFT for couples (S. M. Johnson, 2004) and families (Furrow et al., 2019). Due to this absence of empirical data or published literature on the efficacy of this approach, it was suspected that the majority of surveyed therapists would shy away from considering the use of EFFT in this way. In fact, only about 25% of

participants reported being unlikely to use this approach. As explored in the previous section, the majority of surveyed EFT therapists see the potential benefits of this approach. However, correlational analysis revealed that some forms of training may have a role to play in the likelihood of EFFT use in cases involving situational couple violence. The following two sections outline the positive relationship between the likelihood of therapists using this approach and completion of two main types of trainings: EFFT training and IPV training.

EFFT Training. Readers may not be surprised to find out that participants with more training in EFFT were more likely to use EFFT in cases involving situational couple violence. This relationship was stronger for those who completed the advanced EFFT training. It makes sense that therapists who are more familiar with a particular therapeutic approach would be more likely to use it. However, the researcher wonders if therapists attending advanced training have already had the opportunity to use EFFT in their counselling practice and are ready to dive into more complex case examples. Future research will need to uncover the reasons for this response.

IPV Training. EFT therapists in this study were more likely to support the use of EFFT in cases involving situational couple violence when they had attended IPV training. This result seems to align with findings from McCarthy and Bianchi's (2019) work; these researchers found the implementation of a new IPV screening protocol at a health care clinic, including an IPV education session for clinic employees, significantly improved perceived self-efficacy associated with the detection and treatment of IPV. In this way, participants in the present study who attended IPV training might have gained a greater sense of self-efficacy, translating into an increased likelihood of proceeding with

treatment when violence is indicated. In the future, it may be useful to investigate the content of the IPV trainings attended by EFT therapists and how it is implemented in clinical practice.

Interestingly, attendance of the EFT for IPV trainings did not produce a statistically significant result. This was unanticipated, given the intersection of EFT and IPV would be explicitly addressed in the EFT for IPV training. As a consequence of this, the researcher suspected respondents who attended the EFT for IPV training could more easily see how EFFT could be successfully applied to situational couple violence. However, this was not the case. It would seem, then, that not all IPV trainings are created equal. Unfortunately, without knowing more about the types of trainings attended by these respondents, it is difficult to speculate on the reason one type of IPV training is or is not associated with increased likelihood of EFFT use in cases involving situational couple violence. Clearly, more research is needed to unpack what elements of IPV training are most helpful for participants considering family therapy in cases involving situational couple violence.

In asking about real-world experiences of providing IPV services, the researcher discovered one incredible finding: over 90% of the EFT therapists surveyed reported providing some services to couples impacted by IPV. This is particularly unsettling given the relatively low number of respondents who reported attending any IPV training. This finding has several important implications. First, couples impacted by IPV are clearly seeking support from EFT therapists. Second, it highlights the need to make IPV training a priority for EFT therapists. Third, many EFT therapists in this sample were comfortable providing services to couples impacted by IPV despite having never attended any IPV

training. It is possible that some therapists in this sample gained sufficient skill and experience to be considered competent in working with IPV by means other than IPV training. However, the researcher remains hesitant to rely on this possibility. When considering this finding, it may be important to consider the wording used in this question; a client *impacted* by IPV may be someone who has an adult sibling, friend, or extended family member who is experiencing IPV, and thus, not at risk of harm from a violent partner. The client may have been directly impacted by IPV in a past relationship, but no longer presents as being at risk. Likewise, clients may have been impacted by IPV through the intergenerational trauma and they sought support to maintain healthy adult relationships. In any case, this startling result raises many questions about how therapists gain competence in working with IPV and how IPV may be showing up in the lives of clients seeking couples therapy. Clearly, this is a rich area for future research.

Overall Conclusions

For the EFT therapists who participated in this study, there was a willingness to consider working with families impacted by situational couple violence. The assessment of contextual factors, including assessing the safety of all family members, was critical when considering the use of EFFT in these cases. They also want the support of a clinical supervisor with a high level of IPV-related competency. Additionally, they prefer to work with parents to be highly motivated to eliminate violence in the home. Although participants recognized some risks associated with using EFFT when violence was indicated, the vast majority believed in the potential benefits of this approach, particularly the potential to promote more responsive caregiving. Finally, training in EFFT as well as

IPV seem to be associated with an increased likelihood of using EFFT in cases involving situational couple violence.

Strengths of the Research

This thesis represents a significant contribution to the available literature on both EFFT and situational couple violence. Most importantly, it has given rise to a completely new area of research, as it was the first attempt to integrate these two, seemingly disparate, topics. Although the body of EFFT research grows each year, there continues to be critical gaps in knowledge, including what types of presenting problems are appropriate for EFFT. This thesis represents a significant contribution to this developing body of research, exploring the fascinating intersection of EFFT and violence within the home. Given the complex needs of families impacted by IPV, this is an area of research that needs to continue beyond this thesis.

A central strength of this thesis is the exhaustive literature review. There is an impressive number of articles devoted to the prevalence, impact, and types of IPV. In this thesis, the researcher not only provided a comprehensive overview of these topics, but also a summary of three theories related to IPV: feminist, general systems, and attachment theory. The treatment of IPV was also explored from a systemic perspective, including a detailed examination of the possible risks and benefits of such an approach. An extensive yet concise explanation of EFT was also included. In the end, the reader is provided with a foundational understanding of many complex topics, such that they may draw their own opinion about the use of EFFT in cases involving situational couple violence.

The population selected to participate in this study represents another strength of this research. This study presented EFT therapists with the opportunity to speak to their use of EFFT in cases of situational couple violence. I believe EFT therapists would be the population of therapists to implement this approach if it was found to be safe and effective, and thus, their opinions are critical in any discussion on the use of EFFT. Participants were provided the opportunity to not only provide quantitative data, but also the option to include optional written answers to supplement this data. In this way, the present study collected a rich data set representing the views of EFT therapists.

The survey that was designed and implemented in this thesis represents a significant strength. Given the exploratory nature of this research, it was not possible to use an existing survey. As such, the researcher designed a novel survey to be used in this study. A pilot study was conducted to establish timing, clarity, and face validity, which further increased the refinement of the survey instrument.

Finally, the ethical conduct of the researcher was an additional strength of this thesis. The researcher held the best interest of the participants above all and thus ensured the informed consent procedure was comprehensive. The researcher also consulted extensively with professionals familiar in ethical conduct to ensure everything possible was being done to protect the EFT therapists who chose to participate in this research study.

Limitations of the Research

Despite the significant strengths of this research, the findings must be interpreted with caution in light of several important limitations. Overall, the most important limitation lies in the fact that the findings cannot be generalized to the larger population

of EFT therapists. This was due to the small sample size of this study. Thus, the results are only relevant to those that completed the survey.

Survey

Several study limitations are related to the survey instrument developed and used by this researcher. These limitations include problems with how questions were worded, the time it took for participants to complete the survey, the omission of many important demographic factors, as well as the lack of qualitative data.

Written responses from participants indicated the wording of some survey items could have been improved. Beyond the written responses, there was no way for this researcher to ensure items were understood by participants in the way they were intended. This is particularly true of constructs related to violence, as each therapist's theoretical orientation—as well as their personal and professional experience—is likely to influence how violence within relationships is understood. Furthermore, no statistical analyses were performed to establish the reliability or validity of this instrument. However, this task was beyond the scope of this thesis.

The length of the survey proved to be a limitation of this study. Data from the pilot study suggested participants would require approximately 20 minutes to complete. However, about one fifth of the sample took well over 30 minutes to complete the survey. Unsurprisingly, this difficulty with length seemed to have negatively impacted engagement, as questions posed towards the end of the survey had fewer responses when compared to those at the beginning.

In the interest of limiting the length of the survey, several demographic items were excluded from the survey. Questions exploring gender, ethnicity, nationality, and

educational background would have strengthened the response to subquestion investigating the role demographics factors play in this type of decision making. Additional items inquiring about the presence of IPV and/or situational couple violence within the participant's family of origin may have shed additional light on this subquestion. Qualitative data would have also contributed a great deal to these findings. Unfortunately, this was beyond the scope of the present thesis.

In future research, the researcher will need to make four significant changes. First, the researcher will conduct multiple pilot studies to ensure the questions are clearly worded. Second, the researcher will aim to have a shorter survey completion time. Third, important demographic factors will be included in the survey, including but not limited to gender, ethnicity, nationality, and educational background. Lastly, the need for qualitative data will be considered by this researcher.

Recruitment

The researcher had originally hoped to have had at least 200 participants for this study. Unfortunately, fewer than 80 people completed the survey. The researcher had anticipated some difficulty in gaining access to the intended participants, but additional challenges arose because of changes to the way in which ICEEFT members reach out to one another. The researcher had originally intended on making use of the ICEEFT listserv to distribute invitations. Unfortunately, this method of communication with ICEEFT members was eliminated during the recruitment period due to a new communication system being introduced in the following months. As such, the researcher adjusted the recruitment strategy, such as offering an incentive to participate, posting the invitation to participate on the ICEEFT online forum, and more. Nevertheless, only a

small portion of ICCEFT members accepted the invitation to participate. It is also important to consider how the type of people who did complete the survey may be different from the type of people who did not. Any number of individual and cultural factors were likely to have influenced who completed the survey, which in turn, impacts the survey responses provided. The researcher remains curious about how these factors influenced the results.

Another important limitation to consider is the potential lack of familiarity of this sample with family therapy, particularly EFFT. Participation in this study was open to psychotherapist practising within any modality, regardless of past or present experience providing therapeutic services to families. Although this strategy certainly boosted the sample size, it also limited the conclusions that could be drawn about the use of EFFT in cases involving situational couple violence.

The final limitation is also one of the most critical; this study excluded the voices of families impacted by situational couple violence. Given the exploratory nature of this study and the focus on therapist views, it was not appropriate to recruit families impacted by situational couple violence to this study. However, the researcher feels strongly that the voices of individuals impacted by violence are vital to the development of novel treatment approaches. Future studies should provide these individuals with the opportunity to identify and describe their unique needs in a way that is culturally and developmentally appropriate.

Overall, given the small sample size used in this study, future research should attempt to replicate the results with a larger sample of EFT therapists and continue to explore how the content of specific trainings impact decision making. In addition, the

researcher wants to emphasize the exploratory nature of this study to the reader and to stress caution when drawing conclusions. Further empirical data are required before EFFT should be considered for any cases involving violence in the home.

Future Directions

This thesis represents the first step into an exciting area of research investigating the use of EFFT in cases involving situational couple violence. Given the fact that it was the first of its kind, it was unsurprising that it raised more questions than it answered. The following section provides an overview of directions for future research for three groups of professionals: (a) researchers, (b) psychotherapists, and (c) training organizations/institutions.

Future Directions for Researchers

A top priority for future researchers should be determining the safety and efficacy of using EFFT in cases involving situational couple violence. Results of this study revealed that the surveyed EFT therapists are currently using this approach, despite a clear lack of research on this topic. Although there may be benefit in adopting a novel approach to the treatment of situational couple violence, there are also significant risks to consider, as highlighted in the literature review. Replicable outcome data on the use of EFFT in cases involving situational couple violence is of critical importance, not only so that practitioners have a roadmap for treatment, but also so that research on the use of systemic approaches can move forward. Researchers must consider what recommendations can come from their work, so that the approach can continue to be refined and fully understood. Many questions about this approach need to be investigated further if researchers are willing. For example, if EFFT is found to be safe and effective

through outcome data, what is it that makes it so? What modifications to general EFFT, if any, are required to ensure the safety or effectiveness when used for families impacted by situational couple violence? What is the experience of families attending this tailored EFFT approach? What is the experience of the EFFT practitioner in working with families impacted by situational couple violence?

The present study included several optional open-ended questions in order to better situate the collected quantitative data within the experiences of the surveyed EFT therapists. A logical next step in this line of inquiry would be to collect rich qualitative data from EFT therapists to investigate their views about the utilization of EFFT in cases involving situational couple violence, including how they make the decision to proceed as well as their experiences of risks and benefits. Of particular importance would be collecting data from those therapists currently working with families impacted by IPV. Written responses to this survey indicated that therapists were more comfortable making decisions on a case-by-case basis, rather than responding to hypothetical scenarios or general statements. A qualitative study may overcome such challenges by asking EFT therapists to reflect on their own past experiences with clients rather than hypothetical scenarios.

Another important line of inquiry for future researchers would be investigating the needs and strengths of families impacted by situational couple violence. Having a better understanding of why these families may be seeking support could help practitioners better tailor treatment programs to the unique needs of such families. This focus on the family system, rather than individuals, may also add to the existing knowledge of how violence disrupts secure parent–child attachment.

An additional avenue for future research may be investigating the nature of IPV training for psychotherapists. The EFT therapists who participated in this study recognized the need for IPV training. However, it was beyond the scope of this study to ask these therapists about their specific training needs and how they would come to attend such trainings. More information is needed about the current gaps in IPV knowledge and what topics would be most helpful. Researchers interested in pursuing such areas would do well to refer to the work of Todahl and Walters (2011), who suggested 10 areas of practice to address within IPV training. It would also be helpful to know whether EFT therapists want this training to be part of the ICEEFT certification process or continuing education training.

Given that IPV-specific clinical supervision was rated as one of the most important decision-making factors, this researcher is curious about what makes a desirable or helpful IPV-related supervision. Future research should investigate what qualities, training, or experience levels EFT therapists want in a supervisor when working with clients impacted by IPV. It may also prove useful to investigate how often a therapist may seek such support, and how therapists go about finding a supervisor with a high degree of competence in IPV.

Lastly, future researchers would do well to explore how EFT therapists assess and treat IPV within their current practice. The underutilization of standardized IPV assessment tools is a theme throughout the literature (e.g., Flåm & Handegård, 2015; Froerer et al., 2012; George & Stith, 2014; Schacht et al., 2009; Todahl et al., 2008). With new trainings exploring the intersection of EFT and IPV beginning to gain popularity, it would be highly useful to better understand current practices of addressing

IPV in EFT therapist populations as well as how this new area of training may be changing the way EFT therapists address violence in their practice.

Future Directions for Psychotherapists

The researcher had hoped to use this thesis to further the discussion on how to meet the needs of children impacted by IPV. Although this thesis does not provide a roadmap on how to use EFFT with this population, it does raise important questions for therapists to consider as they make decisions about how to provide the best possible support to families.

Supervision. Therapists struggling to address the unique needs of children impacted by IPV and/or questioning whether to engage in family therapy with persons impacted by IPV are encouraged to seek clinical supervision. As highlighted in this thesis, as well as other articles (e.g., Todahl et al., 2008), supervision from an individual with a high level of competence in the assessment and treatment of IPV may prove particularly important in such cases.

IPV Training. There can be no doubt that IPV is a highly prevalent issue worldwide. The devastating impact of IPV can be felt both within the intimate relationship as well as in parent–child relationships. Regardless of whether IPV is prevalent within an individual therapist's practice, it is the strong recommendation of this researcher that all therapists participate in IPV training. For those therapists not intending to provide services to those impacted by IPV, it may be that training on IPV assessment may be most useful. For those who wish to support these individuals, couples, and families, training that includes both assessment and treatment is recommended. Afterall, a central pillar of ethical practice is working within one's limits of competence

(e.g., American Psychological Association, 2017; Canadian Psychological Association, 2017a); thus, anyone interested in treating IPV must take steps to establish and maintain competence within this area.

It is exciting to see a budding interest in IPV training within the broader community of EFT therapists. The work of authors such as Slootmaekers and Migerode (2018, 2020) have led to the development of training focused exclusively on the use of EFT for couples where violence is the presenting concern. EFT therapists would do well to seek out any such trainings, particularly as part of ongoing IPV training.

EFFT Training. Family therapy is becoming an increasingly popular area of practice, particularly for EFT therapists. Training in EFFT may prove helpful not only for therapists interested in working with families from an attachment-based perspective, but also those therapists providing services to individuals and couples. Ultimately, each client population exists within the context of larger family systems and thus, EFT therapists with a greater awareness of these systems would be well positioned to support a variety of presenting issues.

Future Directions for Training Organizations/Institutions

Organizations and institutions have a critical role to play in shaping both research and practice, particularly surrounding IPV. The lives of children, youth, and adults depend on universities, colleges, and organizations such as ICEEFT taking responsibility for educating their students about IPV. The absence of graduate-level IPV training has been noted by previous authors (e.g., Hurless & Cottone, 2018; Karakurt et al., 2013; Stith et al., 2012) and continues to be a gap in the education of new therapists. In a world in which there can be no doubt about the impact of IPV, there is no excuse for the

absence of IPV training. It is the position of this researcher that regulating bodies and member organizations also take an active role in not only advocating for graduate-level training in IPV, but also include IPV training in registration requirements. These organizations may also choose to incorporate discussions on the assessment and treatment of IPV into continuing education training.

Educational institutions looking to incorporate IPV training would do well to refer to the work of authors such as Todahl and Walters (2011), who suggested that IPV training for therapists should include (a) IPV prevalence and dynamics; (b) assessing violence on a continuum; (c) informed consent policies and how they relate to IPV (e.g., how a no secrets policy may impact a IPV screening policy); (d) procedures for conducting IPV screening in individual interviews; (e) the danger, imminence, and lethality of IPV; (f) violence disclosure procedures; (g) safety planning for all members; (h) therapist self-efficacy and attitudes related to IPV; (i) working with diverse client populations and IPV; and (j) IPV screening for adolescents.

Conclusion

This thesis represents the first step to understanding what part, if any, EFFT can play in a move toward healing after situational couple violence. The researcher was surprised by how many EFT therapists supported the idea of using EFFT with families impacted by IPV, and how many EFT therapists were currently using EFFT in this way, despite no previous research on the topic. It was shocking to discover the number of surveyed therapists working with clients impacted by IPV, despite only half this sample having attended any IPV training. Nevertheless, it was incredibly reassuring to find such strong support for decision-making factors related to safety. This group of EFT therapists

clearly have the client's best interest at heart, which fills this researcher with hope. Overall, this thesis has the potential to show that EFT therapists may be willing to consider EFFT in cases involving situational couple violence, and they may see the potential for benefit, but they do not seem to take this treatment approach lightly.

It is the responsibility of each practitioner and researcher working with IPV to identify areas for growth so the field can continue to evolve. Personal and professional experience tells this researcher that while family therapy will not be appropriate for all, researching this avenue may help address significant gaps in existing IPV service provision. This study clearly highlights the complicated nature of this topic, but also the exciting potential for growth. To conclude, this researcher echoes the words John Bowlby (1984), one of founders of attachment theory:

> Far from refusing to see that parents sometimes engage in horrific behavior, we seek ways to succour the casualties, old as well as young, psychological as well as physical. Above all we seek ways of preventing violent patterns from developing in new families. (p. 10)

It is now the task of practitioners and researchers alike to stop the cycle of violence. Having the courage to act is the first step towards change. This researcher remains committed to action through research as well as in her work with clients and in her personal relationships. The researcher hopes this thesis inspires others to commit to their own plan of action.

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Appendix A: International Centre for Excellence in Emotionally Focused Therapy

Letters of Approval to Distribute Survey

survey request--Rosalie Paquette

Stephen Le <[redacted]>
Mon 3/2/2020 11:36 AM
To: 'Rosalie' [redacted]
Cc: [redacted]
<[redacted]>

Hi Rosalie,

Thanks for reaching out to us. We are glad to hear about your research project! Your request is fine. However, the listserv is only open to ICEEFT members. If you are not an ICEEFT member, you should have an ICEEFT member (your faculty advisor, for example) distribute this survey link on your behalf.

If you have any other questions, just let me know.

Best,

Stephen Le
Operations Manager
ICEEFT
Suite 201, 1869 Carling Avenue K2A 1E6
Ottawa, Ontario
Canada
[redacted]

From: Paquette, Rosalie [redacted]
Sent: February 29, 2020 1:53 AM
To: [redacted]
Subject: Question for Listserv Moderators

Dear Moira,
My name is Rosalie Paquette and I am a student member with ICEEFT. I am contacting you with a question for the listserv moderating team.

Are there any policies/guidelines that pertain to the distribution of EFT-related surveys through the listserv?

I am currently working on my Master's thesis, which concerns the views of EFT therapists. A such, I would like to distribute a survey link to ICEEFT members through the listserv. However, I first wanted to connect with a member of the moderating team to ensure that this would be permissible. I would be happy to send a copy of the survey to the moderating team beforehand, forward proof of my institution's ethical approval, or provide any additional information required by the moderating team.

Please let me know if you would be able to forward my question to the moderating team. Thank you for all your help. I look forward to hearing from you.

Rosalie Paquette
Master of Education (Counselling Psychology) student
University of Lethbridge
Lethbridge, AB
[redacted]

RE: survey request--Rosalie Paquette

Stephen Le <[redacted]>

Mon 9/14/2020 3:35 PM

To: Paquette, Rosalie [redacted]

Cc: [redacted]

Caution: This email was sent from someone outside of the University of Lethbridge. Do not click on links or open attachments unless you know they are safe. Please forward suspicious emails to phishing@uleth.ca.

Hi Rosalie,

Thanks for your kind message. Hope you have also been doing well in these times!

Please post your request to the Forums. We will soon be making an announcement about the Forums to the entire membership list, which should increase the traffic on the Forums considerably. The listservs are no longer usable, and the general membership email list is used for official ICEEFT announcements.

If you have any questions, just let me know.

Best,

Stephen Le
Operations Manager
ICEEFT
Suite 201, 1869 Carling Avenue K2A 1E6
Ottawa, Ontario
Canada
[redacted]

From: Paquette, Rosalie [redacted]
Sent: September 14, 2020 2:01 PM
To: Stephen Le [redacted]
Subject: Re: survey request--Rosalie Paquette

Hello Stephen,

I hope you and your loved ones are doing well despite the challenging times we continue to face with this pandemic. I am writing to inquire about the discontinuation of the ICEEFT listserv and the implementation of the new ICEEFT forum.

As we had discussed previously, I had hoped to distribute a survey through the ICEEFT listserv as part of my thesis research project. I had planned to send you an advanced copy of the survey in the next 2-3 weeks and subsequently invite participants to begin participating in the study through the listserv. However, I see that ICEEFT has transitioned to the forum. I have two questions about this change, as it relates to distributing my survey:

1) Is it still possible to communicate through the listserv at this time? If not, is there another way to send an email/communication out to all ICEEFT members?

2) Do I have your permission to post an invitation to my survey on the ICEFFT forum?

Gail Palmer, who is a member of my thesis committee, has expressed some concerns about getting the necessary number of participants through the forum at this time, due to the fact that many ICEEFT members will not have transitioned to using the forum in place of the listserv. As such, any suggestions on how to reach a wider audience of ICEEFT members is greatly appreciated.

Thank you for your help.

Sincerely,

Rosalie Paquette
Master of Education (Counselling Psychology) student
University of Lethbridge

Appendix B: Survey Invitation (Version 1)

Dear EFT therapists,

You are invited to participate in an anonymous online survey investigating the views of EFT therapists on the application of emotionally focused family therapy for families impacted by violence. The survey will take approximately 20 minutes to complete (from the perspective of a practising psychotherapist).

Participation is anonymous and confidential. You will not be asked to provide any personal identifying information.

For detailed information about the purpose of the study, what is expected of you, how the survey data will be used, and your rights as a participant, please click the link below.

If you are interested in participating, please click on the link below to be taken directly to the survey https://uleth.qualtrics.com/jfe/form/SV_cSzfaerb6rTVOVn

If you have questions about this study or are interested in the findings, please contact me at [redacted].

The survey has been reviewed for ethical acceptability and approved by the University of Lethbridge Human Participant Research Committee. Questions regarding the ethical approval of this research may be addressed to the Office of Research Ethics, University of Lethbridge
(Phone: [redacted] or email at [redacted]).

Thank you for your interest,

Rosalie Paquette
M.Ed. (Counseling Psychology) Thesis Student
Faculty of Education
University of Lethbridge
[redacted]

Appendix C: Survey Invitation (Version 2)

Hello,

You're invited to participate in an online survey investigating the views of EFT therapists on the application of emotionally focused family therapy for families impacted by violence. Couples therapists are welcome to participate (family therapy experience not required). The survey will take approximately 20 minutes to complete (from the perspective of a practising psychotherapist). Participation is anonymous and confidential.

For detailed information about the purpose of the study, what is expected of you, how the survey data will be used, and your rights as a participant, please click the link below.

Interested in participating?
Click this link to be taken directly to the survey:
https://uleth.qualtrics.com/jfe/form/SV_cSzfaerb6rTVOVn

Wondering about compensation?
*By completing this survey, you can enter a draw for a chance to **WIN** a signed copy of **Emotionally Focused Family Therapy: Restoring Connection and Promoting Resilience**. You will be given the choice to enter your email address at the end of this survey for your chance to win (approximate odds of winning is 1 in 200).*

Questions?
If you have questions about this study or are interested in the findings, please contact me at [redacted]). The survey has been reviewed for ethical acceptability and approved by the University of Lethbridge Human Participant Research Committee. Questions regarding the ethical approval of this research may be addressed to the Office of Research Ethics, University of Lethbridge (Phone: [redacted] or email at [redacted]).

Already Participated in this Study?
Thank you for your participation! Please disregard this invitation.

Thank you for your interest,

Rosalie Paquette
M.Ed. (Counseling Psychology) Thesis Student
Faculty of Education
University of Lethbridge
[redacted]

Appendix D: Views of Emotionally Focused Therapists Survey

Note that block titles (e.g., PAGE 1 Consent) were not viewable to participants.

(PAGE 1 Consent)

Views of Emotionally Focused Therapists Survey

Thank you for your interest in completing this survey! Please read the information below to learn about the study and your rights.

CLICK HERE to download a copy of this consent form,
or continue reading below.

What is the study about?

This study will investigate the use of Emotionally Focused Family Therapy (EFFT) for families impacted by situational couple violence.

An invitation to participate is being extended to all currently practising psychotherapists who are regular, lifetime, honorary, or regional members of the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT).

This study has been reviewed for ethical acceptability and approved by the University of Lethbridge Human Participant Research Committee.

What is expected of you?

We request that you fill out a survey that will take approximately 20 minutes to complete (from the perspective of a practising psychotherapist).

If you choose not to answer a question you can skip it by leaving it blank.

Is there compensation for participating?

By completing this survey, you will have the chance to enter a draw for a chance to WIN a signed copy of Emotionally

Focused Family Therapy: Restoring Connection and Promoting Resilience. You will be given the choice to enter your email address at the end of this survey for your chance to win (approximate odds of winning is 1 in 200).

How will the survey data be used?

It is anticipated the data may be used in the following ways:

- a student's thesis;
- articles in journals and professional publications;
- presentations at scholarly meetings, professional conferences, and during counsellor training workshops; and
- data may also be integrated into future studies involving the principal investigator.

Only anonymous aggregated summary data will be used in this manner.

Who is involved in this study?

Principle Investigator

Rosalie Paquette, M.Ed. (Counselling Psychology) Thesis Student, Faculty of Education, University of Lethbridge

Thesis Supervisor

Dawn McBride, Ph.D., Faculty of Education, University of Lethbridge

Thesis Committee Members

Thelma Gunn, Ph.D., Faculty of Education, University of Lethbridge

Nicole Letourneau, Ph.D., Faculty of Nursing, University of Calgary

Gail Palmer, M.S.W., Certified EFT Trainer, Supervisor, and Therapist, ICEEFT Board Member and Education Director, Sessional Lecturer

YOUR RIGHTS

What are the risks and benefits of participating?

There is one anticipated risk associated with participating in this study. The survey topic relates to intimate partner violence, which may cause psychological distress. You are free to skip any questions that you are uncomfortable answering. If you experience psychological distress as a result of completing this survey, please reach out to someone you trust or one of the services in your area that provide support for those impacted by intimate partner violence. For more information on intimate violence support services go to:

https://endingviolencecanada.org/getting-help/

https://www.thehotline.org/

There is no direct benefit to you by participating in this study, but you will be adding to the collective understanding on the use of Emotionally Focused Family Therapy in cases of situation couple violence.

How can a participant withdraw?

You may withdraw from the survey at any time without penalty by simply closing the browser before you submit your responses on each page. **Once the "Continue" button on the bottom of each page is clicked, data on that page cannot be retrieved from the dataset.** Completed responses **on each page** will not be added to the dataset if you exit the survey before clicking the "Continue" button on each page. If you choose to withdraw, you may proceed to the end of the survey (leaving answers blank) in order to enter the prize draw.

How will your confidentiality and anonymity be protected?

Participation is voluntary and your anonymity and confidentiality will be protected.

Only the researcher, supervisor, committee members, and consultants involved with this study will have access to the raw data and the encrypted external hard drive where the data will be collected and stored.

No specific direct identifying information associated with your responses to the survey will be collected; however, as with any online survey, complete protection of privacy cannot be guaranteed due to risk of unauthorized third-party access. Once you complete the survey, you will be given the option to provide your email address in order to be entered in to an anonymous draw. Your response to this optional question is not tied to the responses you provided earlier in the survey. The email address you provide will be used for the sole purpose of contacting you in the event that you are the winner of the raffle. All records containing email addresses will be destroyed once the raffle is complete (on or before September 18, 2021).

When not in use by one of the aforementioned researchers, the encrypted external hard drive will be kept in a locked filing cabinet within a private office. The encrypted external hard drive will be kept for a period of 7 years. After this time, the files will be deleted and the external hard drive will be cleared of any study data.

This survey is being hosted on Qualtrics and their privacy policy can be accessed at https://www.qualtrics.com/privacy-statement/.

Would you like a copy of the results? Have concerns about the study?

If you would like to receive a summary of the survey results (available April 2021), please visit my thesis supervisor's website (https://www.dawn-mcbride.com/) within one year of completing the survey to download a summary of the results.

Questions regarding your rights as a participant in this research may be addressed to the thesis supervisor, Dr. McBride at dawn.mcbride@uleth.ca, or the Office of Research Ethics, University of Lethbridge (Phone: 403-329-2747 or email: research.services@uleth.ca).

By proceeding with this survey, you confirm that you understand and agree to the above conditions. If you do not agree, please exit the survey now.

Submission of your responses will be accepted as implied consent to participate.

(PAGE 2; PART 1 - Screening Information)

Screening Information

Do you identify as working or having worked as a psychotherapist (e.g., psychologist, counsellor, social worker)?

- ◯ Yes
- ◯ No

Which option best describes your current membership status with the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT)?

- ◯ I'm not a current member of ICEEFT
- ◯ Regular member
- ◯ Lifetime member
- ◯ Regional member
- ◯ Student member
- ◯ Honorary member
- ◯ Associate member (those who have not taken an externship)
- ◯ I'm not sure

(PAGE 3; PART 2 - Psychosocial Information)

What is your current age?

How many years have you been practising as a registered/licenced psychotherapist

(this does not include years as a volunteer or practicum/internship experience)?

Which Emotionally Focused Therapy (EFT) certifications do you currently hold?
(check all that apply)

- ☐ Certified EFT Therapist
- ☐ Certified EFT Supervisor
- ☐ Certified EFT Trainer

- [ ] None of the above
- [ ] Prefer not to say
- [ ] Prefer to answer with a written comment and/or explain my answer (please provide your response in the textbox that follows)

(PAGE 4; PART 2 - Psychosocial Information)

What is your level of completion for the following Emotionally Focused Therapy (EFT) trainings?

	I have not completed this training	I am in the process of completing this training	I completed this training within the last 5 years	I completed this training over 5 years ago
Emotionally Focused Family Therapy (EFFT): Level 1	○	○	○	○
Emotionally Focused Family Therapy (EFFT): Level 2	○	○	○	○
Emotionally Focused Therapy (EFT) Externship	○	○	○	○
Emotionally Focused Therapy (EFT) Core Skills	○	○	○	○
Emotionally Focused Therapy (EFT) for Highly Escalated Couples	○	○	○	○
Emotionally Focused Therapy (EFT) for Intimate Partner Violence	○	○	○	○

	I have not completed this training	I am in the process of completing this training	I completed this training within the last 5 years	I completed this training over 5 years ago
Training focused exclusively on intimate partner violence (regardless of whether it was EFT related)	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 5; PART 2 - Psychosocial Information)

Please select the response that best reflects the frequency with which you provide the following services.

	Never	Rarely	Sometimes	Often	Almost Always
INDIVIDUAL therapy for WOMEN impacted by intimate partner violence	○	○	○	○	○
INDIVIDUAL therapy for MEN impacted by intimate partner violence	○	○	○	○	○
INDIVIDUAL therapy for CHILDREN/ADOLESCENTS impacted by intimate partner violence	○	○	○	○	○
GROUP therapy for WOMEN impacted by intimate partner violence	○	○	○	○	○
GROUP therapy for MEN impacted by intimate partner violence	○	○	○	○	○

	Never	Rarely	Sometimes	Often	Almost Always
GROUP therapy for CHILDREN/ADOLESCENTS impacted by intimate partner violence	○	○	○	○	○
COUPLES therapy for those impacted by intimate partner violence	○	○	○	○	○
FAMILY therapy for those impacted by intimate partner violence	○	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 6; PART 3 - Use of Family Therapy and EFFT)

Please select the response that best reflects the frequency with which you provide the following services.

In the last year, how frequently did you provide...

	Never	Rarely	Sometimes	Often	Almost Always
Family Therapy	○	○	○	○	○
Emotionally Focused Family Therapy (EFFT)	○	○	○	○	○

	Never	Rarely	Sometimes	Often	Almost Always
Emotionally Focused Family Therapy (EFFT) for cases involving **SITUATIONAL COUPLE VIOLENCE**	○	○	○	○	○

*(In this survey, **SITUATIONAL COUPLE VIOLENCE** is defined as violence used by one or both intimate partners resulting from escalating arguments or interactions)*

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 7; PART 3 - Use of Family Therapy and EFFT)

Please select the option that best reflects the likelihood of you considering using Emotionally Focused Family Therapy (EFFT) in the following circumstance.

	Very Unlikely	Unlikely	Likely	Very Likely	I don't know / No opinion

	Very Unlikely	Unlikely	Likely	Very Likely	I don't know / No opinion
At this point in time, how likely are you to consider using Emotionally Focused Family Therapy (EFFT) for cases involving **SITUATIONAL COUPLE VIOLENCE**? *(In this survey, **SITUATIONAL COUPLE VIOLENCE** is defined as violence used by one or both intimate partners resulting from escalating arguments or interactions)*	○	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 8; PART 4 - Decision Making Factors)

Please read the following scenario before answering the question below

Scenario:

A coworker has come to you for help as they try to decide whether to use EMOTIONALLY FOCUSED FAMILY THERAPY (EFFT) for a case involving SITUATIONAL COUPLE VIOLENCE between parents. Your coworker is an experienced couple therapist and you have no concerns about their ability to perform their duties ethically and competently.

*(In this survey, **SITUATIONAL COUPLE VIOLENCE** is defined as violence used by one or both intimate partners resulting from escalating arguments or interactions)*

Please select the option that best reflects your belief about the statement below.

As you decide how to respond to the scenario described above, **how important is it to you that THE THERAPIST...**

	I believe this is **not important**	I believe this is **somewhat important**	I believe this is **quite important**	I believe this is **very important**	I don't know / No opinion
Has taken training exclusively focused on intimate partner violence	○	○	○	○	○
Will seek supervision from someone with high competency in the treatment of intimate partner violence while working with this family	○	○	○	○	○
Has taken training in Emotionally Focused Family Therapy (EFFT): Level 1	○	○	○	○	○
Has taken training in Emotionally Focused Family Therapy (EFFT): Level 2	○	○	○	○	○
Will seek supervision from someone with high competency in the use of Emotionally Focused Family Therapy (EFFT)	○	○	○	○	○
Is not intimidated by the violent family member(s)	○	○	○	○	○

	I believe this is not important	I believe this is somewhat important	I believe this is quite important	I believe this is very important	I don't know / No opinion
Believes they have the ability to create safety in sessions with violent family member(s)	○	○	○	○	○
Has screened each family member separately for risk/safety (including but not limited to severity and frequency of violence)	○	○	○	○	○
Will screen each family member for risk/safety on an ongoing basis (including but not limited to severity and frequency of violence)	○	○	○	○	○
Believes there are no safety concerns for any family members following risk/safety screenings	○	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 9; PART 4 - Decision Making Factors)

The next question is based on the scenario presented earlier.

Do you want to read the scenario again?

- ◯ Yes
- ◯ No

Scenario:

A coworker has come to you for help as they try to decide whether to use EMOTIONALLY FOCUSED FAMILY THERAPY (EFFT) for a case involving SITUATIONAL COUPLE VIOLENCE between parents. Your coworker is an experienced couple therapist and you have no concerns about their ability to perform their duties ethically and competently.

(In this survey, **SITUATIONAL COUPLE VIOLENCE** is defined as violence used by one or both intimate partners resulting from escalating arguments or interactions)

Please select the option that best reflects your belief about the statement below.

As you decide how to respond to the scenario described above, **how important is it to you that THE PARENTS...**

	I believe this is **not important**	I believe this is **somewhat important**	I believe this is **quite important**	I believe this is **very important**	I don't know / No opinion
Have been screened separately for risk/safety (including but not limited to severity and frequency of violence)	◯	◯	◯	◯	◯
Indicate they want to remain together	◯	◯	◯	◯	◯
Indicate that they feel safe being in therapy together	◯	◯	◯	◯	◯

	I believe this is not important	I believe this is somewhat important	I believe this is quite important	I believe this is very important	I don't know / No opinion
Have detailed safety plans in place	○	○	○	○	○
Are confident in their ability to implement their safety plan if needed	○	○	○	○	○
Indicate they are highly motivated to eliminate violence in their home	○	○	○	○	○
Plan to share the duties of parenting (if they are separated, or plan to separate)	○	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 10; PART 4 - Decision Making Factors)

The next question is based on the scenario presented earlier.

Do you want to read the scenario again?

○ Yes
○ No

Scenario:

A coworker has come to you for help as they try to decide whether to use EMOTIONALLY FOCUSED FAMILY THERAPY (EFFT) for a case involving SITUATIONAL COUPLE VIOLENCE between parents. Your coworker is an experienced couple therapist and you have no concerns about their ability to perform their duties ethically and competently.

*(In this survey, **SITUATIONAL COUPLE VIOLENCE** is defined as violence used by one or both intimate partners resulting from escalating arguments or interactions)*

Please select the option that best reflects your belief about the statement below.

As you decide how to respond to the scenario described above, **how important is it to you that VIOLENT FAMILY MEMBER(S)...**

	I believe this is **not important**	I believe this is **somewhat important**	I believe this is **quite important**	I believe this is **very important**	I don't know / No opinion
Agree to a no-harm contract for the duration of therapy	○	○	○	○	○
Report that they will be honest with the therapist about the frequency and severity of the violent physical contact	○	○	○	○	○
Take full responsibility for their use of violent physical contact	○	○	○	○	○
Recognize the impact of their violence on the family	○	○	○	○	○
Exhibits no psychotic behaviour	○	○	○	○	○
Reports no history of substance abuse	○	○	○	○	○

	I believe this is not important	I believe this is somewhat important	I believe this is quite important	I believe this is very important	I don't know / No opinion
Reports not being criminally charged with an offence related to intimate partner violence	○	○	○	○	○
Does not direct violence towards children	○	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 11; PART 4 - Decision Making Factors)

The next question is based on the scenario presented earlier.

Do you want to read the scenario again?

○ Yes
○ No

Scenario:

A coworker has come to you for help as they try to decide whether to use EMOTIONALLY FOCUSED FAMILY THERAPY (EFFT) for a case involving SITUATIONAL COUPLE VIOLENCE between parents. Your coworker is an experienced couple therapist and you have no concerns about their ability to perform their duties ethically and competently.

(In this survey, **SITUATIONAL COUPLE VIOLENCE** is defined as violence used by one or both intimate partners resulting from escalating arguments or interactions)

Please select the option that best reflects your belief about the statement below.

As you decide how to respond to the scenario described above, **how important is it to you that the CHILDREN...**

	I believe this is **not important**	I believe this is **somewhat important**	I believe this is **quite important**	I believe this is **very important**	I don't know / No opinion
Have been screened separately for risk/safety	○	○	○	○	○
Indicate that they want to be included in family therapy	○	○	○	○	○
Indicate feeling safe being in therapy with both parents	○	○	○	○	○
Saw or heard violent physical contact in their parents' relationship	○	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 12; PART 5 - Risks and Benefits)

*(In this survey, **SITUATIONAL COUPLE VIOLENCE** is defined as violence used by one or both intimate partners resulting from escalating arguments or interactions)*

As I consider the use of Emotionally Focused Family Therapy (EFFT) in cases of Situational Couple Violence, I am concerned that...

Please select the option that best reflects your level agreement with the statement below.

	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know / No opinion
Certified EFT Therapists with training in Emotionally Focused Family Therapy will have an insufficient level of competence	○	○	○	○	○
Certified EFT Therapists with training in Emotionally Focused Family Therapy will have insufficient training in intimate partner violence	○	○	○	○	○
Certified EFT Therapists with training in Emotionally Focused Family Therapy will inadequately assess for violence	○	○	○	○	○
This approach will increase the likelihood of physical harm to family members	○	○	○	○	○
This approach will increase the likelihood of psychological harm to family members	○	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 13; PART 5 - Risks and Benefits)

*(In this survey, **SITUATIONAL COUPLE VIOLENCE** is defined as violence used by one or both intimate partners resulting from escalating arguments or interactions)*

I believe that using Emotionally Focused Family Therapy (EFFT) in cases of Situational Couple Violence will...

Please select the option that best reflects your level agreement with the statement below.

	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know / No opinion
Promote the repair of attachment injuries within the family	○	○	○	○	○
Renew the children's confidence in the emotional availability of their parents	○	○	○	○	○
Promote more responsive caregiving of children by parents	○	○	○	○	○
Increase physical safety within the family	○	○	○	○	○
Increase psychological safety within the family	○	○	○	○	○

Optional: Please add anything you would like us to know that might clarify your answers.

(PAGE 14; Participant Origin Source)

How were you invited to complete this survey?

- ◯ ICEEFT online forum
- ◯ An email from another EFT therapist
- ◯ A group email through my EFT supervision group
- ◯ A group email through my EFFT supervision group
- ◯ A group email through an EFT training
- ◯ A group email through an EFFT training
- ◯ Prefer not to say
- ◯ Other (please describe in the textbox that follows)

(PAGE 15; Indication of Interest in Raffle)

THANK YOU FOR PARTICIPATING

Would you like to enter the draw to win a signed copy of *Emotionally Focused Family Therapy: Restoring Connection and Promoting Resilience*?

- ◯ Yes
- ◯ No

***If you select 'YES'**: scroll to the bottom of this page and click 'Continue'. **Do not close your browser** until you have been taken to a separate page inviting you to provide your email address. Your email address will be used to contact you if you are the winner of the draw.*

BEFORE YOU GO...

You are invited to forward this survey to other EFT therapists by copying the link below:
https://uleth.qualtrics.com/jfe/form/SV_cSzfaerb6rTVOVn

If you would like to receive a summary of the survey results (available April 2021), please visit my thesis supervisor's website (https://www.dawn-mcbride.com/) within one year of completing the survey to download a summary of the results.

Rosalie Paquette
M.Ed. (Counselling Psychology) Thesis Student, University of Lethbridge
rosalie.paquette@uleth.ca

Please note:
If you experience emotional upset as a result of completing this survey, please reach out to someone you trust or one of the services in your area that provide support for those impacted by intimate partner violence. For more information on intimate violence support services go to:

https://endingviolencecanada.org/getting-help/
https://www.thehotline.org/

Appendix E: Proof of Study Approval from the University of Lethbridge Human Participant Research Committee

Office of Research Ethics
4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4
Phone: (403) 329-2747
Email: research.services@uleth.ca
FWA 00018802 IORG 0006429

Monday, October 05, 2020

Student Investigator:	Rosalie Paquette, Graduate Student
Faculty Supervisor:	Dawn McBride, Faculty of Education
Study Title:	Emotionally Focused Family Therapy in Cases of Family Violence: Exploring Psychotherapist Views
Action:	Approved
HPRC Protocol Number:	2020-090
Approval Date:	October 5, 2020
Term Date:	September 30, 2021

Dear Rosalie,

Your human research ethics application titled "Emotionally Focused Family Therapy in Cases of Family Violence: Exploring Psychotherapist Views" has been reviewed and approved on behalf of the University of Lethbridge Human Participant Research Committee (HPRC), and assigned Protocol #2020-090. The HPRC conducts its reviews in accord with University policy and the Tri- Council Policy Statement: Ethical Conduct for Research Involving Humans (2018).

Please be advised that any changes to the protocol or the informed consent must be submitted for review and approval by the HPRC before they are implemented. A final report will be required and is due to the Office of Research Ethics on or before **September 30, 2021**.

We wish you the best with your graduate research.

Sincerely,

Susan Entz, M.Sc., Ethics Officer
Office of Research Ethics
University of Lethbridge
4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Appendix F: Survey Invitation (Version 3)

My name is Rosalie Paquette and I'm conducting research on the use of emotionally focused family therapy. I'm looking for EFT therapists to complete an online survey. Would it be possible to forward the following invitation to your membership?

Thank you in advance for your help!

Rosalie Paquette
M.Ed. (Counseling Psychology) Thesis Student
Faculty of Education
University of Lethbridge
[redacted]

Hello,

You're invited to participate in an online survey **investigating the views of EFT therapists** on the application of emotionally focused family therapy for families impacted by violence. The survey will take approximately 20 minutes to complete (from the perspective of a practising psychotherapist). Participation is anonymous and confidential.

For detailed information about the purpose of the study, what is expected of you, how the survey data will be used, and your rights as a participant, please click the link below.

Interested in participating?
Click this link to be taken directly to the survey:
https://uleth.qualtrics.com/jfe/form/SV_cSzfaerb6rTVOVn

Wondering about compensation?
By completing this survey, you can enter a draw for a chance to **WIN** a signed copy of **Emotionally Focused Family Therapy: Restoring Connection and Promoting Resilience**. You will be given the choice to enter your email address at the end of this survey for your chance to win (approximate odds of winning is 1 in 200).

Questions?
If you have questions about this study or are interested in the findings, please contact me at rosalie.paquette@uleth.ca. The survey has been reviewed for ethical acceptability and approved by the University of Lethbridge Human Participant Research Committee. Questions regarding the ethical approval of this research may be addressed to the Office of Research Ethics, University of Lethbridge (Phone: [redacted] or email at [redacted]).

Thank you for your interest,

Rosalie Paquette
M.Ed. (Counseling Psychology) Thesis Student
Faculty of Education
University of Lethbridge
[redacted]

Appendix G: Views of Emotionally Focused Therapists Raffle Survey

(PAGE 1 OF SURVEY 2; Raffle Entries)

Please provide your email address to enter the draw to win a signed copy of

Emotionally Focused Family Therapy: Restoring Connection and Promoting Resilience.

Please note:

Your email address is not linked to your previous survey responses.

Only the winner of the draw will be contacted.

Powered by Qualtrics

Appendix H: Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

Project Title: EMOTIONALLY FOCUSED FAMILY THERAPY IN CASES OF FAMILY VIOLENCE: EXPLORING PSYCHOTHERAPIST VIEWS

In my role as _____
(indicate either contracted statistical consultant or University of Lethbridge Administrative Staff Member), I _____, agree to:

1. keep all research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., laptops, USB sticks, transcripts, surveys) with anyone other than the research team members also working on our project.

2. keep all research information in any form or format (e.g., laptops, USB sticks, transcripts, surveys) secure while it is in my possession.

3. after consulting with the Principal Investigator, erase or destroy all research information in any form or format regarding this project.

Contracted Statistical Consultant OR University of Lethbridge Administrative Staff Member:
(circle applicable role)

_____	_____	_____
(print name)	(signature)	(date)

Principal Investigator:

_____	_____	_____
(print name)	(signature)	(date)

Appendix I: Written Responses to Part 4 Survey Items

The following written responses were provided by participants in response to decision-making factors related to the therapist, parents, violent family members, and children. Participant responses are unedited.

Decision-Making Factors Related to the Therapist

- I believe that a person trained in EFFT and seeking supervision re: same will have the tools to navigate situational partner violence. In my understanding and experience, situational verbal/emotional abuse iis comparably hurtful or damaging to children as situational physical violence. As for my last answer, I believe safety is key but a therapist can work with families where there is still some risk. With these families there will always be risk but we can continue to assess and treatment will help.
- I cannot answer the final question because no option fits for me. My answer would be “There are never NO safety concerns in a family that started treatment stating there was situational violence”. Screening does not guarantee safety.
- “NO” safety concerns - would say “Believes safety concerns are within reasonable risk levels and lower with EFFT/EFT treatment than without”
- the given answers don’t seem to map to the last question (“believes there are no ...”). I strongly believe there are ongoing safety concerns. I don’t know the difference between level 1 and 2 trainings re: EFFT so I am not answering those questions. in EFCT for IPV, individual screening is not always indicated -- i’m not sure about EFFT. Ongoing screening with EFCT can also be done with both people in the room so I am assuming that would be OK with EFCT. However if to

you “ongoing screening” only means screening done separately, then I have no opinion.

- The last question is tricky: We have to work with people where they are and we have to work with people who can be worked with where they are. I think this is basically an algorithm of the couple and the willingness of the therapist, divided by the skill and supervision the therapist is getting. It’s quite complicated. I don’t think a 1-5 scale answer comes close to responding to this issue.
- The last statement about believing there are no safety concerns: I have mixed feelings about this. I think it is probably more important how are we going to address safety concerns. Similar to working individually with those who are at high risk for suicide, I don’t want to not give them services because they are high risk. High risk to safety is maybe a sign they need the services to enhance safety. I think it is a case-by-case basis again and having a decision tree for levels of safety risk would be beneficial for therapists.
- the last statement is unclear to answer with the options - there are always safety concerns that are ongoing - it seemed out of place compared to the other questions

Decision-Making Factors Related to the Parents

- If one parent had severe mental health problems such as dysregulated substance abuse, I would not be advocating for shared care, though this does not mean that I would advocate for the parent with the serious problem never seeing the child/children
- This survey is starting to feel like a typical survey--trying to gather aggregate data to extremely individual situations. It is why I don’t like these kinds of surveys.

Decision-Making Factors Related to the Violent Family Members

- for me, past substance use, not a problem, current is a problem. For violence against kids, I am out.
- I would be ok working with families where there was violence toward children only in the context that child protective services are already involved and there is a plan in place for the protection of the children.
- I'm not sure about how some of these might relate to the EFFT/EFT approach to creating alliance/safety with this family member. These methods (e.g. safety planning) appear to be from more traditional models of "anger management" and DV treatment, but I heard (from Jef) EFT may approach DV and the therapeutic alliance differently.
- In regards to my answers regarding these prompts, I believe that some of these things such as "take full responsibility" and "recognize the impact of violence on the family" WILL NOT be present at the beginning of EFFT. This would be part of the therapeutic process. So my answers should have the prefix, "after completing therapy, the violent family member(s) would..."
- "No history of substance abuse" - in this relationship? in their lifetime? when they were a teen/20's but now they are in the 50's and not using for years? - context is everything. "not being criminally charged" - ever? given what context? while safety is paramount (and everything stops until safety is established, which in many cases means therapy never starts - or restarts) refusing to provide optimal treatment suggests there is no belief in the potential for change. "violence towards children" - as above.

- Reporting a history of substance abuse twenty years previously, for example, should not exclude a couple form having couples or family therapy.
- The clients have to trust the therapist so I don't necessarily think it would be in the clients' best interests to have them make various promises at the beginning of therapy that there is a good chance the some of them wouldn't be able to keep. 2. Statistically violence and/or aggression is frequently bidirectional and "taking full responsibility" is a nebulous concept at best. I also an unclear on what you mean by "impact" of violence on the family. I imagine the vast percentage of people know that the impact is "not good" but there is probably not a full sense of the impact. 3. Violence against children is a mandated child abuse report whether they say they have done it or not. 3.
- These questions seem to get to task alliance and characterological issues. Unfortunately, EFT doesn't address characterological issues very adequately. There is a necessary step in this situation that individual therapy is mandated (domestic partner violence treatment) before couple/family therapy is possible. EFT does respond to this sequencing.

Decision-Making Factors Related to the Children

- I don't think the children need to have in anyway witnessed the violence to be included in the therapy. However, it needs to be age appropriate and if they didn't witness the abuse then I want to make sure it doesn't get discussed in details in session so as not to traumatize the children. If they did witness the violence and if it's age appropriate and they feel safe then I think it's important for them to participate.

- I'd prefer to consult regarding this. When I've performed family therapy with families impacted by DV, a social worker has been involved and done this screening.
- I'm not quite sure how to understand the final prompt, "Saw or heard violent physical contact in their parents' relationship." It would be important that they saw it?! I would hope that they never did, but IF they did, it would be VERY important to address.
- "Saw or hear violent physical contact" - I am not sure how this question was intended. Does it mean that if children were exposed to seeing/hearing violent physical contact in the parent's relationship that they cannot participate in EFFT? Or that that is a requirement (exposure) to being able to participate in EFFT? Does the degree of violence matter? Frequency of occurrence? Context? (i.e. only when one parent drinks heavily? Daily) The question is a bit broad.
- Seeing or hearing violence in the family is a reportable offense no matter when it occurred or even if the parents say that it has already been reported. I am unclear on why one would bring the children into therapy until the violence has been at least partially contained.
- The last question is strange!
- These are difficult questions. How young is the youngest child that is being asked to participate in EFFT?

Appendix J: Written Responses to Part 5 Survey Items

The following written responses were provided by participants in response to potentials risks and benefits of using EFFT in cases involving situational couple violence. Participant responses are unedited.

Risks of Using EFFT in Cases Involving Situational Couple Violence

- Due to risk of physical harm, and implications of the same from a variety of standpoints, it does seem important to have an EFFT therapist also trained in intimate partner violence.
- I am not sure if you targeting competence in the model of EFFT or simply the effectiveness of working with the family/couple. I disagree heavily because the statements do not take into account training outside of EFT the person may have that could be extremely valuable. That being said, certainly further training will increase competence. Also, if targeting competence in the EFFT model, then my answers would be different (need for training).
- I believe specialized training AND experience in working with DV and DV-focused EFFT clinical supervision are essential for working competently with families impacted by DV. I believe EFFT can work effectively with DV given the right support and skill/competence of the therapist.
- I think the last two questions are dependent on the therapist and on the family. I don’t think those can be answered for everyone.
- Responses 2-4 cannot be reasonably answered without information regarding what additional training the therapist may have. Perhaps the better questions might be, “Given no additional training in domestic violence, Certified EFT

Therapists with training in EFFT...” and “Given no additional training in domestic violence this approach will increase....”. Having EFFT Certification does not preclude or include any additional training, nor does any therapist work purely and only from one set of knowledge. I can’t take my training and years of experience working with domestic violence couples, individuals, and pre-schoolers out of my head just because I am using EFFT in a specific session.

- The above answers depend on the experience and specific violence training the therapist has taken.
- There are a large number of EFT therapists worldwide so I imagine the level of knowledge about IPV will vary. My main concern would be does the therapist really know how to do effective EFT? Is the therapist being closely supervised by a certified EFT supervisor?
- This set of questions covers a WIDE range of experiences.
- Unless you are taking an EFT IPV training, I don’t think you’ll get this info from core skills, externship etc. You need a training with George Faller or Jef & Leiven.

Benefits of Using EFFT in Cases Involving Situational Couple Violence

- Again, is this theoretical therapist working in vacuum without any formal training/experience/supervision in situational couple violence? Any therapist working without formal training/experience/supervision vacuum around situational domestic violence risks doing harm regardless of the therapeutic model used. The corollary is also that a counsellor trained solely addressing situational couple violence is at risk of creating harm if they do not have a solid, clinical

model such as EFFT or other therapeutic approach from which to work from. I can know all kinds of stuff about 0-5 brain development, but if I don't integrate that with an understanding of attachment, how parental history impacts current parenting, and solid utilization of researched therapeutic approaches (i.e. Circle of Security) I will not be so helpful, and could engender harm. It takes layers of knowledge and training to work with complex situations such as domestic violence.

- I believe it can do all of that if done in a very skillful way and if the family is open to it. But I also believe it can do the opposite. Depends on the family and on the therapist.
- I don't have sufficient knowlege of EFFT to say. My training is with IPV and couples
- I strongly believe the five outcomes listed are possible, but I acknowledge they are not guaranteed.
- Injury repair seems possible, I just am unsure about the family staying in therapy with enough time and support to make that possible.
- Obviously not in all situations, but the model affords the opportunity where other approaches have not.
- yeah...IDK. Seems that "slightly agree" and "slightly disagree" might be important options here. Too much depends on the psychopathology of the abuser and the psychopathology of the victim to say whether EFFT would be effective. Maybe ICEEFT wouldn't like that response but that's what I think.