DCPsych thesis

A phenomenological enquiry into gay male domestic abuse victims' experience of engaging with psychotherapy

Bruwer, S.

___

A phenomenological enquiry into gay male domestic abuse victims' experience of engaging with psychotherapy

Shaun Bruwer

Middlesex University and Metanoia Institute

Doctor of Counselling Psychology and Psychotherapy

by Professional Studies

2022

ACKNOWLEDGEMENTS

Firstly, I would like to thank my participants, who courageously volunteered to share their deeply moving experiences with me. It was a privilege to be part of their sense-making, and without them this research project would not have been possible.

Thank you to my research supervisor, Professor Adam Bourne, whose pivotal, unwavering patience, support and expertise enabled me to continue to engage with and complete this research project.

Thank you to my psychotherapist, Paul Harris, who helped me to safely navigate, process and work through the painful trauma with which I came into contact during the journey of this research project, as well as my clinical supervisor, Dr Steven Smith, for his steadfast support, encouragement and belief in me.

Thank you to my friends Sue, Natalie, Diana and Emily who consistently supported and motivated me to persist, particularly when it felt impossible to do so. Thank you to Sophie and Sabina, friends from my psychotherapy training who constituted a weekly peer research group, where we supported and challenged one another on our doctoral journeys. Additional thanks to Sabina for her thought-provoking and challenging insights as my critical research friend.

ABSTRACT

Domestic abuse (DA) can have a severe impact on one's mental health and well-being and has been shown to be at least as prevalent within LGBT relationships as heterosexual relationships. However, heteronormative narratives around same-sex DA mean that victims are less likely to name their experience as DA, and less likely to seek professional support, such as psychotherapy. Gay men can face specific help-seeking challenges and there is a seeming absence of qualitative in-depth research into gay men's experiences of engagement with psychotherapy. In this context, this research project used Interpretative Phenomenological Analysis (IPA) to reflexively explore how five gay male victims of DA made sense of their experience of therapeutic engagement, thereby voicing their unique needs and circumstances. The impact of participants' relationships with themselves (Self-with-Self) and others (Self-with-Other) on their sense-making of the abuse emerged as key themes, culminating in often-long journeys to a turning point whereby they knew that something in their abusive relationship had to change. Once in therapy, the therapeutic relationship had reparative potential as it both helped participants to make sense of their abusive experiences and gave them a different relational experience, thus enhancing the potential to break repetitive patterns of abuse. Recommendation for wider society (the macro) down to individual therapists (the micro) were made, in the hope that more gay male victims of DA access and engage with support services such as psychotherapy, thereby not hiding and suffering in silence, and that DA support services and mental health professionals such as therapists are able to respond to them more appropriately and effectively from a more informed position.

CONTENTS

ACKNOWLEDGEMENTS **2**
ABSTRACT **3**
CONTENTS **4**
BLOOD **8**
CHAPTER 1: INTRODUCTION **9**
1.1 Introduction 9
1.2 Background and Rationale 9
1.3 Outline of Methodology 13
CHAPTER 2: LITERATURE REVIEW **15**
2.1 Introduction 15
2.2 Domestic Abuse Definitions and Legal Protection 15
2.3 Incidence and Impact of Same-Sex DA 20
2.4 The Invisibility of Same-Sex DA 21
2.5 Seeking, Accessing and Engaging with Support Services 26
2.6 The Centrality of Relationships in Human Health 30
2.7 Aims, Contributions and Research Questions 35
CHAPTER 3: METHODOLOGY **37**
3.1 Introduction 37
3.2 Methodology 37
3.2.1 Phenomenology 39
3.2.2 Interpretative Phenomenology 40
3.3 Data Collection 42
3.3.1 Recruitment 44
3.3.2 Participant Demographic Characteristics 46
3.4 Interviews 47
3.4.1 Conducting the Interviews 48
3.5 Data Analysis 50
3.6 Ethical Considerations 51
3.6.1 Participants 52
3.6.2 Data 53
3.6.3 Myself 53
3.7 Chapter Summary 54
CHAPTER 4: REFLEXIVITY **55**

4.1 Introduction 55
4.2 Why This Research Topic? 56
4.3 My Philosophical Stance 58
4.4 The Meaning of Reflexivity 59
4.5 Transparency and Trustworthiness 60
4.6 My Role as an Interviewer in Data Collection 62
4.6.1 Interview Preparation 62
4.6.2 Self-disclosure 63
4.6.3 Me as an Insider and Therapist Researcher / Interviewer 64
4.7 Challenges I Experienced Sustaining Engagement with the Data 71
4.7.1 Parallel Processes 71
4.7.1.1 Claustrophobia / Feeling Trapped 71
4.7.1.2 Dissociation / Denial / Paralysis 73
4.7.1.3 Reaching out for Support 75
4.7.2 Further Barriers 77
4.7.2.1 Fear of Success / Failure 77
4.7.2.2 Perfectionism 78
4.7.2.3 Coronavirus 79
4.7.2.4 Sudden Death 79
4.7.2.5 Implications for the Research 80
4.8 My Role as a Researcher in the Analysis and Writing Up 81
4.8.1 Me as a Therapist Researcher / Analyst 84
4.9 Self-Care / Coping Strategies 85
4.10 Chapter Summary 87
CHAPTER 5: RESULTS I: SELF-WITH-SELF AND SELF-WITH-OTHER ORGANISATION 88
5.1 Introduction 88
5.2 Overview of findings 89
5.3 Who Am I and Who Am I in Relation to Others? 90
5.3.1 Self-with-Self 91
5.3.1.1 Self with Gay Self 93
5.3.2 Self-with-Other in Family of Origin 98
5.4 Chapter Summary 103
CHAPTER 6: RESULTS II: THE ABUSED SELF, THE ROAD TO REALISATION, THE TURNING POINT AND THE ROLE OF AN OTHER 105
6.1 Introduction 105
6.2 The Abused Self 105

6.2.1 The Context of Abusive Same-Sex Relationships 106
6.2.2 Types of Abuse 106
6.2.2.1 Psychological / Emotional Abuse and Coercive Control 107
6.2.2.2 Physical Abuse 110
6.2.2.3 Sexual Abuse 112
6.3 Recognising the Harm to Self 113
6.3.1 Leaving the Self 114
6.3.2 Equating the Harm with Domestic Abuse 116
6.4 The Turning Point 118
6.5 The Role of an Other 121
6.5.1 The Role of Parents 122
6.5.2 The Role of a Trusted Other 124
6.5.3 The Role of the Abuser and the Therapist 128
6.5.4 The Role of No Other 129
6.6 Chapter Summary 130
CHAPTER 7: RESULTS III: ACCESSING AND ENGAGING WITH THERAPY AND THE POTENTIALLY REPARATIVE RELATIONSHIP 132
7.1 Introduction 132
7.2 Accessing Therapy 132
7.3 The Role of a Benevolent Other in Engaging with Therapy 134
7.4 The Potentially Retraumatising Other in a Heteronormative World 136
7.5 Characteristics of the Therapist: Making Sense of a Gendered Other 139
7.6 Being Mirrored, the Potentially Reparative Relationship 143
7.7 The End of a Beginning 149
7.8 Chapter Summary 155
CHAPTER 8: DISCUSSION 157
8.1 Introduction 157
8.2 Have I Answered the Research Questions? 157
8.2.1 Reflexivity / Reflections 159
8.3 Summary of Findings 161
8.3.1 Self-with-Self and Self-with-Other Organisation 162
8.3.1.1 Familiarity of Abuse 164
8.3.2 The Public Story of Domestic Abuse: Physical Violence in a Heteronormative World 165
8.3.2.1 The Heteronormative Narrative 166
8.3.2.2 The Physical Violence Narrative 169
8.3.3 The Turning Point 171

8.3.4 Therapy as a Reparative Relational Field 175
8.3.5 Unique Contribution 177
8.4 Limitations 177
8.5 Recommendations 180
8.5.1 Wider Society 180
8.5.1.1 Mass Media Interventions 181
8.5.2 Health Professionals 182
8.5.2.1 Organisations Working with DA 183
8.5.2.2 Therapists 183
8.6 Conclusion 185
REFERENCES 188
APPENDICES 203
Appendix A: Interview Schedule 203
Appendix B: Participant Information Sheet 205
Appendix C: Consent Form 208
Appendix D: Ethical Approval 209
Appendix E: Resource Information Sheet 210
Appendix F: Research Supervisor Confirmation of Consent 211

BLOOD

A blood-splattered shirt.

Did it have to come to this?

Don’t let there be blood.

CHAPTER 1: INTRODUCTION

1.1 Introduction

In this chapter, I introduce my research project, including the background and rationale, and the manner in which I approached it. In doing so, I highlight why this research is a necessary and important contribution to the practice field of counselling psychology and psychotherapy, whilst also briefly outlining my personal interest in this research area. I then move onto a more extensive literature review in the next chapter.

> A phenomenological enquiry into gay male domestic abuse victims' experience of engaging with psychotherapy

1.2 Background and Rationale

According to the website of Victim Support (2022), the national charity that supports victims of crime, domestic abuse (DA) can have a significant impact on your emotional wellbeing, as well as sometimes affecting other relationships and your ability to live your life as you would want to. Whilst everyone reacts differently, some of the effects of DA include depression; fear, anxiety and panic attacks; loneliness or isolation; a lack of confidence or self-esteem; feelings of guilt or self-blame; experiencing difficulties at work or in your other relationships and trouble sleeping.

Holding in mind the myriad of negative impacts that DA can have on one's mental health and quality of life, I now turn to Rolle et al. (2018), who emphasises that the "myth" that DA is an issue only found in heterosexual relationships has been debunked, and its occurrence amongst LGBT couples has been demonstrated to be

comparable to or higher in prevalence than in heterosexual relationships, as seen in several recent studies (Barrett & St. Pierre, 2013; Lewis et al., 2012; Messinger, 2011; Walters et al., 2013). Whilst there is understandably a plethora of research on DA among heterosexual partners, particularly where men are the perpetrators and women are the victims (the most common experience at a population level), very little of the existing literature addresses DA between same-sex partners. The potential problem with having a dominant heteronormative narrative about DA is that it can obfuscate other kinds of DA experiences and realities. I therefore concur with the findings from a review by Rolle et al. (2018) that highlight the lack of studies that address LGBT individuals involved in DA, attributing it to the silence that has historically existed in the LGBT community, due to fears and misconceptions that have impeded a public discussion on the issue. I unpack some of the fears and issues in the literature review in the next chapter. The conclusion of the review (Rolle et al., 2018) was that a space needed to be created where LGBT DA can be discussed and explored, by both heterosexual and LGBT people, and that there is a need for further research on the issue.

Whilst DA is an issue for the LGBT community in general, there is merit and distinct value in researching a specific group, versus broader brush-stroke LGBT DA in general: Deeper and richer insight into the experiences of specific groups of people can perhaps enable us to address their particular needs more effectively. As a gay man, this research project aims to contribute to our understanding of this important subject matter by exploring the non-heteronormative experiences of same-sex victims of abuse, particularly gay men, because a) as a gay man I am well positioned to conduct this research, b) same-sex DA is not part of the dominant heteronormative

DA narrative and c) male victims of DA are also not part of the dominant heteronormative DA narrative, thereby potentially bringing further complexity to what it means to be a victim. Trans men were not excluded from this project (and had any volunteered to be interviewed they would have been most welcome) however I did not make concerted efforts to recruit trans participants given a belief that such research might be most effectively carried out by those within the trans community or, at the very least, those with strong connections into the trans community. Research also indicates that trans people can experience specific challenges in navigating DA (Lusby et al., 2022) and, aligned with my earlier point about the value of focussed study – rather than homogenising all LGBT experience, I would recommend dedicated study of trans men's experiences of DA, help seeking and therapy.

Being a gay man, I am acutely aware of the oppression that has taken place, and continues to take place, for the LGBT community in general, in many aspects of life, from the social to the economic to the legal. More specifically, homosexuality was still a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973, and it was only as recently as December 2012 that the British Psychological Society added an addendum on their website (2021) saying:

> "The British Psychological Society (BPS) opposes any psychological, psychotherapeutic or counselling treatments or interventions (often referred to as 'reparative' or 'conversion' therapies) that view same-sex sexual orientations (including lesbian, gay, bisexual and all other non-heterosexual sexual orientations) as pathological. The Society categorically refutes this position and honours and respects sexual diversity."

A growing body of evidence indicates that conversion therapy may be harmful (Jowett et al., 2021). Considering that conversion therapy can be experienced as homophobic (Williams, 2021), and was not directly or indirectly denounced in the helping professions until relatively recently, and whilst holding the heteronormative societal DA narrative in mind, I wondered (as a psychotherapist myself) what the impact might be on the support-seeking behaviour of gay male victims of DA. This was compounded by that fact that whilst working for Victim Support in 2016, data was not collected for same-sex DA victims, including gay men, partly because they rarely accessed the service. This is in line with studies on health and mental health service utilisation in which men have been found less likely than women to seek help when they have encountered problems that require the attention of helping professionals (McKelley, 2007; Noone & Stephens, 2008). Whilst there is growing literature on the experience of LGBT people (in general) accessing DA services such as crisis housing, case management, and crisis helpline services (Lim et al., 2021), there appears to be a gap in the literature that looks specifically at gay men's experiences of engaging with psychotherapy. Indeed, I was unable to identify any such literature. The implication is that many gay male victims of DA might be suffering in silence, when psychotherapy has great reparative potential to raise self-awareness and help break repetitive patterns of relational abuse, beyond what other forms of support that services such as crisis management might be able to provide. I therefore agree with findings by Sokoloff & Dupont (2005), who espoused that there was a need for research specifically on treatment and, as such, this study set out to explore gay male DA victims' experiences and sense-making of therapeutic engagement. Lastly, part of the rationale for this specific focus is that this is a doctorate in counselling psychology and psychotherapy.

This research project is important to the practice field of counselling psychology and psychotherapy because it represents an attempt to remedy the paucity of psychological research into gay male victims of DA engagement with psychotherapy, in order to enhance our understanding of the challenges they face, shed light on what support or education they might need in order to engage with psychotherapy, and propose recommendations for society in general and therapists in particular, which might decrease the likelihood of them suffering in silence.

I identify with this area of research and have a personal interest in it, not only because I am a gay male, but also because I was a victim of same-sex DA, yet didn't engage with psychotherapy at the time I was experiencing it. This was partly because I did not make sense of, or name, my experience as DA at the time. Having chosen to study a group to which I belong, I recognise my role as one of an "insider researcher" (Breen, 2007). I speak more later about my personal reasons for embarking on this research project, the impact of my insider researcher status on various aspects of this research project, and the importance of reflexivity in Chapter 4.

1.3 Outline of Methodology

Using Interpretative Phenomenological Analysis (IPA) as my methodology, I recruited and interviewed five gay male victims of DA about their experience of engaging with psychotherapy, conducting in-depth qualitative phenomenological enquiries into their sense-making of their experiences. I then analysed the data, establishing themes within and across their experiences, which I then discussed in relation to existing literature in this area. The whole research project was conducted holding the "double hermeneutic" (Heidegger, 1963) of IPA, as well as reflexivity, in mind, both of which I

discuss in detail in Chapter 3 on methodology and Chapter 4 on reflexivity respectively.

Having introduced my research project, briefly outlining the background, rationale and methodology, I now turn to a review of the relevant literature in this area.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Having briefly introduced and outlined the background and rationale for this research project, I now turn to a review of existing literature in this area. I start by examining DA definitions and legal protections, before exploring the incidence and impact of DA, issues surrounding the invisibility of same-sex DA, accessing and engaging with support services and end with my aims, contributions and research questions.

The main search engines I used for my literature search were BPS EBSCOhost, Google Scholar and PubMed, using the following terms: “Gay male domestic violence”; “gay male domestic abuse”; “gay male intimate partner violence (IPV)”; “same-sex domestic violence”; “same-sex domestic abuse”; “same-sex intimate partner violence (IPA)”; “gay male domestic violence and abuse implications for therapy”; “gay male intimate partner violence implications for therapy”; “therapist perceptions of same-sex DA”; “gay male domestic violence and abuse victims’ engagement with therapy”.

2.2 Domestic Abuse Definitions and Legal Protection

Historically, same-sex DA was excluded from the UK government definition of DA with clarity around the inclusion of same-sex relationships only appearing in the form of the word “sexuality” in 2013 when the UK government updated its definition of “domestic violence and abuse”. The implication is that protections of same-sex DA victims has not always been adequate in the UK:

> “Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial emotional.”

The “domestic violence” section of the UK government website (2022) now goes on to say that:

> “We have used a gender-neutral definition of domestic abuse as we want to ensure that all victims and all types of domestic abuse are sufficiently captured, and no victim is excluded from protection or access to services.”

A new document published on the UK government website (2022) in July 2022: “Domestic Abuse: Statutory Guidance” was issued under section 84 (2) of the Domestic Abuse Act 2021, and goes further to specify the breadth of people who can be impacted by DA:

> “Anyone can be affected by domestic abuse – regardless of age, disability, sex, sexual orientation, gender identity, gender reassignment, race, religion or belief. In addition, domestic abuse can manifest itself in different ways within different communities.” (p. 17)

The same document goes on to say that:

> “Domestic abuse most commonly takes place in intimate partner relationships, including same-sex relationships. Intimate relationships can take different forms, partners do not need to be married or in a civil partnership and abuse can occur between non-cohabiting intimate partners. As with all forms of abuse, abuse in intimate relationships can vary in severity and frequency, ranging from a one-off occurrence to a continued pattern of behaviour.” (p. 23)

The definition of DA from the UK government is therefore now more inclusive, recognising that anyone can be a victim of DA, and going further by explicitly stating that DA can also take place in “same-sex” relationships, thereby providing legal protection for people in same-sex relationships. The reason I am emphasising the UK government’s evolution to explicitly recognising / acknowledging legislatively that DA occurs in same-sex relationships is that this legislation can inform service provision to victims of DA in England and Wales and, whilst I recognise that there will be many definitions of DA in circulation in the UK, including those in Scotland and Northern Ireland, as well as various definitions used by non-governmental organisations, I decided to focus on the abovementioned UK government definition because I am conducting my research in England and the Westminster-based UK government has oversight of matters pertaining to DA in England.

From a more macro perspective, the United Nations (UN) definition (2022), similarly to the UK government (2022) includes “any relationship”, specifically stating that anyone can be a victim, regardless of demographic characteristics such as sexual orientation:

> “Domestic abuse, also called ‘domestic violence’ or ‘intimate partner violence’, can be defined as a pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviours that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone. Domestic abuse can happen to anyone of any race, age, sexual orientation, religion, or gender. It can occur within a range of relationships including couples who are married, living together or dating. Domestic violence affects people of all socioeconomic backgrounds and education levels. Anyone can be a victim of domestic violence, regardless of age, race, gender, sexual orientation, faith or class.”

The UN definition highlights the different names that can be used for DA. Indeed, literature and research use the terms “domestic abuse”, “domestic violence”, “domestic violence and abuse” and “intimate partner violence” interchangeably. The use of different terms by different researchers in different countries, and even different researchers in the same country, became apparent whilst immersed in DA literature, and highlights the complexity of ongoing discussion, debate, controversy and disagreement around what terms are best used (Geffner, 2016). For this research project, I decided to utilise the term “domestic abuse” (DA) given its widespread use among professional stakeholders in England, thus helping to ensure the findings of this thesis can be easily understood and integrated in this national context.

Whilst the UK government specifically stipulates legal protections for same-sex DA victims, and the UN definition of DA explicitly includes people of any sexual orientation,

perhaps indicative of growing acceptance and de-stigmatisation of LGBT communities, and the issues they face in some countries and international organisations, new research published by the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) found that 74 countries across the world continue to criminalise same-sex sexual contact, whilst in 13 countries, being gay or bisexual is punishable by death (LGBTQ Institute, 2022). Notably, whilst there has been progress in the UK, it was only as recently as 2004 that the availability of injunctions against domestically violent perpetrators was extended to same-sex couples (Great Britain: *Domestic Violence, Crime and Victims Act of 2004).* In the US, sodomy laws in 14 states were only eliminated by the Supreme Court in 2003, meaning that, as little as 19 years ago, victims of same-sex DA were forced "to confess to a criminal act in order to prove the existence of a domestic relationship" (Jablow, 2000, p. 1116) and therefore the possibility of DA, and support / help, despite the emotional and physical severity of the consequences of same-sex DA. Several states of the US also still specifically excluded gay, lesbian, and bisexual individuals from their DA legislature until 2000 (Jablow, 2000), with it only being as recently as 2021, that LGBT people became eligible for DA protections in all 50 states, with North Carolina being the last state in the country to bar same-sex couples from some of the stronger legal protections from DA, according to the American Civil Liberties Union of North Carolina website (2022).

The main implication of same-sex DA victims being excluded from legal protections until relatively recently in countries like the UK and the US, whilst still to date being criminalised and excluded from protection in many countries in the world, is that same-sex victims of DA may be less likely to make their abusive situations known to

government organisations or agencies, including those such as the police that are supposed to protect people, or reach out to organisations for support, it perhaps being safer to hide, and suffer in silence. I explore literature pertaining to this below.

2.3 Incidence and Impact of Same-Sex DA

It is a misconception that same-sex DA is not an extensive problem, or that it occurs less frequently than heterosexual DA (Burke & Follingstad, 1999), with studies for a number of years consistently indicating that the percentage of same-sex couples experiencing DA was equal to or greater than the percentage of heterosexual couples experiencing DA (Barrett & St. Pierre, 2013; Greenwood et al., 2002; Henderson, 2003; Lewis et al., 2012; Merrill & Wolfe, 2000; Messinger, 2011; Renzetti, 1997; Turrell, 2000; Walters et al., 2013). In one of the earliest studies to examine the prevalence of same-sex DA, Kelly & Warshafsky (1987) found a 47% rate of having been abused among their sample of gay and lesbian participants. In a more recent study, 47.5% of lesbians and 29.7% of gay men reported having been victimised by a same-sex partner (Waldner-Haugrud et al. 1997). Rates of DA among heterosexual couples have been well documented at approximately 33% (Straus & Gelles 1990).

The consequences of DA on mental health and general wellbeing have been outlined in numerous studies (Campbell, 2002; Costa et al., 2015; Johnson et al., 2014; Murray & Mobley, 2009; Reid et al., 2008) and, like heterosexual victims, LGBT victims of DA experience psychological / emotional, physical, and sexual abuse, outcomes being severe, including physical injury, social isolation, property destruction and loss, and disruption to work, education, and career development (Barrett, 2015; Buford et al., 2007; Finneran et al., 2012) and in studies by Ferraro & Johnson (2000) and

McClennen (2005), DA made victims feel trapped, hopeless and isolated I now turn to an exploration of further issues surrounding same-sex DA, problematic because if same-sex DA is just as, if not more, prevalent than heterosexual DA, and the impact of the same-sex DA is just as impactful / harmful as heterosexual DA, then same-sex DA victims would need the same, if not more support to deal with DA.

2.4 The Invisibility of Same-Sex DA

There are several issues surrounding same-sex DA that act as barriers to vulnerable victims accessing and engaging with psychological support services such as psychotherapy. To begin with, same-sex DA is often not recognised as DA at all; many people perceive it to be not as violent, abusive or serious because both individuals are of the same sex (Donovan & Barnes, 2020). This notion is perpetuated by gender role norms, internalised "homonegativity", the predominant (feminist) DA theory, and "heterosexism" (Cruz & Firestone, 1998; Letellier, 1994; Merrill & Wolfe, 2000; Renzetti,1997).

Heterosexist gender norms and heteronormative narratives around DA have led to an array of assumptions regarding same-sex DA, amongst them being that societal norms dictate men's and women's respective gender roles and thus preclude the existence of DA between members of the same sex (Potoczniak et al., 2003). To elaborate, according to Donovan & Hester (2010), the "public story" of DA is "a problem of (presumed cisgender) heterosexual men and (presumed cisgender) heterosexual women, a problem of physical violence and a problem of a particular presentation of gender: The 'big' strong man being physically violent to the small 'weak' woman" (p. 561). The impact is that women are not seen as perpetrators, and men are not seen

as victims, perpetuating potentially dangerous assumptions that DA between women will not be as harmful as that between a man towards a woman, and that in male same-sex relationships, men who are naturally aggressive should be able to defend themselves (Donovan & Barnes, 2020).

In a further study by Sheila & Seelau (2005), male and female undergraduates read one of four DA cases varying by victim and perpetrator sex and sexual orientation. Victim sex, rather than sexual orientation, was the most potent predictor of responses, although male against female DA was considered the most serious and deserving of active intervention, with DA perpetrated by men or against women therefore being judged as more serious than violence perpetrated by women or against men. The perception that male perpetrators were more capable of injuring victims, with female victims being more likely to suffer serious injury were consistent with gender-role stereotypes. According to Donovan & Barnes (2020), the emphasis on female victims and male perpetrators in government strategies to tackle DA confirms the binary in the public story: That DA is a heterosexual issue. The implication of this is that it can be difficult to take alternative DA scenarios seriously, highlighted in a study by Brown & Groscup (2009) which looked at perceptions of same-sex DA among crisis centre staff, one of the few studies to be found that looked at attitudes of people who should be there to support victims. Participants rated same-sex DA scenarios as less serious than opposite-sex DA. Because crisis centres help form the frontline to combating DA and removing victims from harm and, considering the prevalence of same-sex DA, this could have serious consequences, potentially even resulting in fatalities. The other major implication of not being seen in the public story of DA, is that many LGBT victims

do not recognise or name their experience as DA themselves (Donovan & Barnes, 2020).

Linked to gender norms is the concept of “mutual battering”, originally used to describe heterosexual women who defended themselves against a male perpetrator through physical aggression (Marrujo & Kreger, 1996). Since its first use in the 1970s, it is now used to describe only those situations that are created within a self-defence setting (Marrujo & Kreger, 1996). Rohrbaugh (2006), however, suggests that one of the most pervasive and alarming issues is considering violence as a mutual conflict, particularly when the violence occurs in a gay couple, because men “fight equally”, as they are assumed to have comparable physical strength. This notion is sustained by societal attitudes that tolerate violence expressions between men, expressions considered admissible and often normalised as a means of dispute resolution, or because of greater congruence between violence and male roles (Baker et al., 2013). This is highlighted by recent research in Scotland by Maxwell et al. (2022), which found that male-on-male DA assault was perceived societally to be a “normal” way for men to enact masculinity. The concept is particularly relevant to gay male DA because, unlike women, men have been socialised to defend themselves. This societal notion that a man should not be vulnerable and should be able to defend himself, and thus not become a victim, is not only at odds with accumulating evidence of the pervasive and harmful impacts of DA on men’s health (Scott-Storey et al., 2023), but adds to the difficulty in attempting to assist and support a same-sex DA victim, and can complicate gay male DA scenarios because a person such as a police officer trying to assist a victim of same-sex DA may be met with what to them is a confusing or ambiguous situation, in that he or she may perceive both parties to be participating equally in the

violence. Many studies (Barnes, 1998; Burke et al., 2002; Guadalupe-Diaz & Yglesias, 2013; Maxwell et al., 2022; Pattavina et al., 2007) have highlighted how members of the LGBT community have experienced additional victimisation and homophobia when they reported abuse to police with Letellier (1994) finding that the police dismiss the majority of same-sex DA reports as “mutual combat”, a misconception that can prevent potentially stressed and traumatised same-sex DA victims from accessing and receiving appropriate support.

The idea of mutual battering in gay male relationships not only creates obstacles in providing services for same-sex DA victims, but also contributes to an increased tendency to minimise the severity of the abuse (McClennen, 2005), thereby making it more difficult for gay male DA victims to view *themselves* as victims (Potoczniak et al., 2003), perhaps minimising it too, as a reflection of this societal narrative. Additionally, the assumption increases the likelihood of the neglect of the study and recognition of other types of abuse apart from the physical, such as psychological abuse (Finneran & Stephenson, 2013). This is echoed in the abovementioned heteronormative public story of DA as one of physical violence (Donovan & Barnes, 2020), which complicates efforts to understand DA as something much wider and more nuanced that often includes other forms of abuse such as psychological / emotional and coercive control, and sexual abuse. In a recent survey of 895 gay, bisexual and queer men residing in Australia by Salter at al. (2021), participants were asked about the acceptability of ten abusive or controlling behaviours: Whilst there was overwhelming agreement that it was “never” okay to force a partner to have sex (99%); hit a partner with an object (98%); kick or punch a partner (98%); and put a hand around a partner’s throat (94%), approximately a quarter (25%) of the same participants indicated that it was

“sometimes” okay to read a partner’s email / text messages without permission, control a partner’s money (25%), and tell a partner who he can be friends with (22%). This survey therefore appears to confirm the prevailing societal narratives about what behaviour is acceptable or not, and that violence is deemed more serious than other forms of abuse such as psychological / emotional abuse and coercive control. A Canadian study by Gaspar et al., also in 2021, interviewed 24 gay, bisexual, queer, and other men who have sex with men, and found that participants held themselves responsible for needing to be more assertive within sexual encounters to avoid coercion, with many believing unwanted sex to be unavoidable, it simply being something that happens if one is gay. Additionally, research by Maxwell et al. (2022) found that the absence of a rape narrative for men in same-sex relationships made it difficult for most participants to recognise when they had been sexually assaulted. These studies highlight how unwanted sexual experiences, including rape, might be dismissed as normal, or expected, and therefore not seen as problematic or abusive. I concur with Letellier (1994) who suggests that to move beyond these misconceptions and societal narratives, and therefore to help victims of same-sex DA appropriately, it is necessary to examine the abuse within the context of the relationship, as this can shed light on the power dynamic and show which partner has an established physical or psychological power over the other.

“Homonegativity” – negative societal stereotypes and attitudes towards homosexuality – is another obstacle that members of the LGBT community can face (Cruz & Firestone, 1998). Homonegativity can play a large role in same-sex DA in two ways (Letellier, 1994; Murray et al., 2007; Potoczniak et al., 2003; Renzetti, 1997). Firstly, it creates an atmosphere in which someone from the LGBT community may feel

disempowered to seek assistance from traditional DA resources such as the police, lawyers, therapists, and DA shelters, for fear that their sexual identity might be revealed to the community and the legal system (Potoczniak et al., 2003). The result of being outed in a society strongly discoloured by homonegativity could be shame, potential ostracism, and possible loss of income or housing. Secondly, if the same-sex DA victim is already out or does not fear having his or her identity revealed, homonegativity may preclude the victim from receiving adequate treatment from those in a position to protect and support them. This links with findings of a review by Rolle et al. (2018) which suggest that clinicians should be aware that minority stressors are one of the main obstacles for people who have experienced or are involved in same-sex DA and seeking help, and that heterosexism exacerbates difficulties in reporting the abuse to the police, and accessing services (Carvalho et al., 2011). Following the earlier section of this chapter where I explored legal protections for victims of same-sex DA, Balsam (2001) found that they can be reluctant to seek legal assistance, fearing discrimination or adequate legal protection: Over 60% of 100 lesbian women who were interviewed decided not to leave their abusive partner because of lack of resources, and a majority of the sample did not seek help in a women's shelter. In line with Balsam (2001), Buford et al. (2007) found that services and shelters were often unprepared to support victims of same-sex DA. With this in mind, I now turn to an exploration of research into the seeking, accessing and engaging with support services of victims of same-sex DA.

2.5 Seeking, Accessing and Engaging with Support Services

There is much research that illustrates the many barriers that heterosexual populations experience in accessing support services. In particular, there is significant literature

that documents demographic variation in service access. For example, men experiencing trauma are less likely to seek help than women (Pilgrim & Rogers, 2003), language difficulty and a lack of understanding around religious and cultural beliefs may be the reason why smaller proportions of black and minority ethnic communities access services (Clarke et al., 2009), and whilst making up 16% of the population, only 3.2% of primary care mental health referrals are for older adults (Broomfield & Birch, 2009). Whilst holding in the frame that DA help-seeking, access and engagement with services has complexity no matter the demographic of the victim, I now turn specifically to the nuanced challenges experienced by gay men.

A recent systematic literature review documents a range of health services that gay men across the world often struggle to access (Albuquerque et al., 2016). Furthermore, previous research in the UK documents barriers to gay men accessing appropriate health services in the primary care sector due to concerns around disclosing ones' sexual orientation to a general practitioner (Keogh et al., 2004). Despite evidence indicating a higher likelihood of problematic drug and alcohol use, some gay men experience difficulty accessing harm reduction services that understand and adequately address the unique context of their drug use (Bourne and Weatherburn, 2017).

Of particular concern, a 2006 study by Donovan et al. found that very few of the same-sex DA victims they interviewed reported or talked about their experiences with anybody or any agency. This was partly because, as discussed above, DA is largely understood in the UK, including by their respondents, as a problem largely of heterosexual women being physically abused by their male partners. Therefore, most

respondents had not understood their experience at the time as being DA and it had thus not occurred to most of them to report their experiences to any agency or seek help (Donovan et al., 2006). Later research by Donovan & Barnes (2020) indicated that when same-sex victims of DA do seek help, it is mainly from privatised sources such friends and therapists, as they remain largely invisible in DA policy and practice, a trend echoed by the abovementioned survey by Salter et al. (2021), which found that when gay, bisexual and queer men did discuss their relationship problems with others, they preferred informal channels, with 35% turning to friends / neighbours and 17% turning to a family member. Whilst 18% turned to a therapist, one out of every six participants (17%) did not discuss their relational abuse with anyone (Salter et al., 2021), thereby suffering in silence. The same study found that rates of reporting / disclosure of abuse to organisations / agencies was low: 6% to a doctor/hospital representative, 5% to a police officer, 3% to an LGBT service worker, and 1% to a telephone helpline. Notably, the findings of this study (Salter et al., 2021) correspond with a plethora of international research that suggests that same-sex victims of DA are engaging in low levels of formal help-seeking and / or reporting (Guadalupe-Diaz, 2013; McClennen et al., 2002; Merrill & Wolfe, 2000). This makes sense in light of a study by Donovan et al. (2006) which found that because of “homophobia” and “heterosexism”, public agencies are not able to respond appropriately to the needs of those in same-sex relationships by either actively discriminating or stigmatising same-sex relationships or simply being inadequately trained or equipped to respond with knowledge to the circumstances of same-sex relationships (Donovan et al., 2006). Other research conducted in the United States (Giorgio, 2002; Helfrich & Simpson, 2006) showed that same-sex DA victims reported heterosexism, discrimination, stigma, ridicule, disbelief, additional abuse, and hostility from services,

and a study by Cheung et al. (2009) on Asian men accessing services as same-sex DA victims reported that they were not perceived as DA service users unless they were perpetrators. Interestingly and importantly, the study by Donovan et al. (2006) found that even some agencies that people in same-sex relationships might have expected a more sympathetic response from, for example LGBT agencies and counsellors / therapists, had little understanding of DA and thus were also unable to respond effectively and supportively to same-sex DA victims (Donovan et al., 2006). This could be a result of such LGBT agencies being inadequately resourced to meet this particular need among their communities.

Whilst there is increasing research into the experiences of same-sex DA victims' general help-seeking behaviour and engagement with services, and the barriers they face, including with counsellors / therapists (Donovan et al., 2006), mentioned above, none of the studies I found focus specifically on their phenomenological, in-depth sense-making of their experience of accessing and engaging with psychotherapy. Psychotherapy is important because not only can it help people to make sense of their experience, thereby raising self-awareness and increasing the likelihood of breaking repetitive patterns of behaviour / abuse, but the therapeutic relationship itself has "reparative" potential (Casement, 1985). That is, it can give people a different relational experience: By being "mirrored" (Kohut, 1971), and feeling recognised and accepted by another person (in this case the therapist), perhaps in a way that they have not been seen and accepted before, people can develop an enhanced sense of self-worth, and learn to trust themselves and others more, thereby having a different relationship with themselves and the world around them.

Holding the abovementioned reparative potential (Casement, 1985) of the therapeutic relationship in mind, it seems prudent to briefly discuss the centrality of relationships in human health and well-being, before moving onto a discussion of the aims, contributions and research questions at the heart of this research project.

2.6 The Centrality of Relationships in Human Health

At the heart of all DA experiences is a relationship between two individuals, who themselves have been shaped and influenced by relationships they have had, and may continue to have, with a range of others. As such, it is important to explore the nature and role of relationships as a key force in the human condition as a precursor to examining DA in more detail.

As a psychotherapist, the central organising theme that supports me to integrate diverse concepts from across developmental psychoanalysis, relational psychoanalysis and humanist relational perspectives is the notion of how relationships shape and support our development across the life cycle and how equally such relationships can disrupt our maturational trajectory.

In his book, "*Sapiens: A Brief History of Humankind*", Yuval Harari (2014) theorises that through the discovery of fire, early humans were able to cook and therefore process food much quicker than other animals, with the gut using much less energy for digestion and calorie absorption. Harari (2014) believes that this had a large impact on the evolution of the large, complex and unique human brain. If humans had been eating a raw food diet exclusively, they would have had to spend more than 9 hours a day eating in order to get enough energy to support and sustain a large brain (Harari,

2014). As the human brain developed, the head grew larger and, due to the logistics of childbirth, the disproportionate size of the human head meant that the mother would die unless she gave birth when the head could still fit through her birth canal. For this reason, Harari (2014) theorises that the human baby is born prematurely, when it is still very dependent on the mother for its survival. It is this early vulnerability of the human infant that I believe sets the scene for the physical and emotional well-being of the individual for life. As we know though developments in neuroscience, the human infant's brain develops at its greatest rate in its first year, both because being outside of the womb it can now grow without threat to the survival of the mother during childbirth, but perhaps more significantly because of the importance of relationships on the developing human brain. That is, the human infant is born into the world "to be in relationship" (Stern, 1994): Without the relationship with primary caregivers, the helpless infant would die, and therefore "relationship" is a fundamental need that is sought from birth.

From an evolutionary perspective (Darwin, 1968), attachment is therefore an innate biological motivation system that promotes proximity-seeking (Schore, 2003) between the infant and a specific attachment figure, in order to survive to a reproductive age (Bowlby, 1988). In this early interpersonal relationship, the immature infant's brain uses the mature functions of the parent's brain in order to organise its own processes (Siegel, 1999), and the child's experiences form the building blocks of their emotional, social and representational world (Van der Hart et al., 2006). In Sue Gerhardt's words (2004, p. 10):

> “The human baby is the most socially influenced creature on earth, open to learning what his own emotions are and how to manage them.”

Due to this biological instinct, all infants adapt to their environment in whatever way possible in order to feel safe, loved and secure, becoming attached to their caregiver regardless of the quality of the attachment / care. However, the quality of the mother-infant dyad significantly impacts the health and development of the human baby (Schore, 2003) and their pattern of attachment security is pivotal in predicting mental health. For optimal development, the primary caregiver needs to be intersubjectively available to the infant from the offset: infants of caregivers who are generally attuned (Stern, 1985), responsive and show sensitivity to their emotional and physical signals / needs in a “good enough” way (Winnicott, 1965) and are stimulated in a way that evokes a resonance between the two states of minds (Siegel, 1999) tend to manifest patterns of “secure attachment” (Bowlby, 1988). I believe that these bonds provide both emotional resilience and a psychological immune system against psychopathology in both children and adults (Fonagy, 2001), facilitate close, satisfying relationships, support the effective self-regulation of affect (Schore, 2003) and impulses, and enable the developing child to respond to stimuli and make decisions with flexibility and adaptability, as opposed to rigidity. The securely attached child also has a secure base from which to explore and play (Winnicott, 1971), expanding its experience of the world.

At the interpersonal level of subjective relatedness, attunement is thus important as it becomes a powerful tool in social development (Stern, 1985) and the quality, status and consistency of the primary caregiver’s emotional attunement to and psychological

containment of the infant's affective state is vital to the evolution of the child's mature ability to understand and regulate their own feelings, as well as their ability to empathise with others. Many theorists have stressed the importance of reflecting back the infant's inner feeling state for its gradual knowledge of his own affectivity and sense of self (Kohut, 1971; Mahler, 1968). For example, a baby's over-arousal can be soothed by entering their state, perhaps "engaging him with a loud mirroring voice" which can gradually lead towards a point where he feels comfortable again (Gerhardt, 2004, p. 23).

Turning to Kohut (1971), Self Psychology espouses that we are driven by a grandiose sense of self and that the young infant has several needs, known as "self-object" needs. These are, to feel at one with a significant parent (merger), to feel seen, celebrated and enjoyed (mirroring), to look up at a parental figure who one can admire and feel safe and strong in their presence (idealisation) and later as you develop as a young infant and later adult to find people in the world "just like me" that is a source of joy and pleasure and strength (merger transference).

When the infant has not been optimally met intersubjectively, there is impairment in terms of subjectively knowing themselves and unable to intersubjectively meet others in a meaningful way (Stern, 1985). This lack of feeling felt (Stern, 1999) renders the later adult unable to share subjective experiences like love or sadness with significant others. In addition, their affect regulation (Siegel, 1999; Schore, 2003) will either be over-regulated or under-regulated, leading to either isolation or a release of overwhelming feelings that alienates the individual from others.

When the infant has been traumatically frustrated rather than experiencing pockets of bearable disappointment then the infant and later adult will develop an enfeebled sense of self (Kohut, 1971). Such a self will have depleted levels of self-esteem, self-cohesion and self-consistency and be prone to fragmentation and shame when their need for mirroring, idealising and twinship is not reciprocated.

In her book "*The Drama of Being a Child*" (1987), Alice Miller talks about how, when the primary caregiver is less available to attune (Stern, 1985) to the needs of the young child / infant, they will adapt by suppressing or repressing (Freud, 1923) their own needs and instead attune to the needs of the primary caregiver ("mothering the mother"), in order to survive and feel safe, thereby creating an inauthentic "false self" (Miller, 1987). Consequently, the individual's separation / "individuation" (Mahler, 1968) is stunted, and the resulting symbiosis / enmeshment renders them less able to tune into their own emotional needs, engendering a false self-presentation, echoing Winnicott's (1965) notion of the false self as an adaptation. Finding the word "false" to be pejorative, I prefer to see it as the individual hiding their true authentic feelings for fear of rejection.

Turning to Rogers (1961), when the infant's conditions of worth are restricted and prohibitive, forestalling genuine expression of self, then the later adult will develop an external locus of evaluation. The prevalence of this relational stance is accompanied by a compulsion to please others at one's own expense which in turn derails the person's innate actualising tendency to become the fullest person they are meant to be. I see Roger's external locus of evaluation as synonymous with the abovementioned notion of the false self.

Holding some of these early child developmental theories in mind is important because our early relationships with our primary caregivers ultimately inform the nature and quality of our later adult relationships. That is, the adaptations we form in childhood can become “repetitive patterns” (Freud, 1923), which are often so deeply entrenched and reflected in our neurological pathways (Siegel, 1999) that staying with the familiar relational dynamics in our adult relationships, even if painful, and even if no longer fit for purpose, can feel easier and safer than doing something differently or being in the world in a different way.

The brief exploration of the centrality of relationships in human health and well-being in this section is important because DA cannot occur outside of a relationship / relational dynamic. Holding developmental and relational research and theory in mind can therefore help to give insight into some of the challenges that gay male victims of DA experience in their DA relationships, and what might help or hinder their capacity to recognise their experience as DA and reach out for support such as therapy.

I now turn to a discussion of the aims, contributions and research questions of this research project.

2.7 Aims, Contributions and Research Questions

Having reviewed the literature, there seemed to be a clear and critical absence of in-depth qualitative research into the experience of gay male DA victims’ engagement with therapeutic support. One of the main aims of this project was to contribute to this gap by making sense of these vulnerable victims’ sense-making of their experiences, including their thoughts and feelings about what helped them to seek and engage with

therapy, and the institutional, emotional and social barriers that hindered access to services and engagement with therapy.

This aim of this research project was therefore to contribute to the field of counselling psychology and psychotherapy by providing beneficial and valuable insight, understanding, knowledge and guidance for therapists, counselling psychologists, trainers and society at large into what gay male victims of DA might need in order to access and remain engaged with psychological support services such as therapy. By presenting my findings at conferences, becoming involved in the training of practitioners and perhaps even campaigning for change in policy, my hope was for us as practitioners to become more informed and educated, and therefore more effective at supporting a population of people potentially experiencing stress and trauma, thereby decreasing the likelihood of them suffering in silence.

The main question my research aims to answer is:

- What is the experience of engaging with psychotherapy among gay male victims of DA?

Sub-questions are:

- How do gay men make sense of their experience of being a victim of DA?
- What motivated and maintained men's engagement with psychotherapy, or what experiences shaped their decision to end psychotherapy?
- How has psychotherapy shaped, informed or influenced how they reflect on their experience of DA?

CHAPTER 3: METHODOLOGY

3.1 Introduction

In this chapter, I critically reflect on my research methodology from a philosophical standpoint, before discussing the collection and analysis of my data, highlighting the difference between what I intended to do, and what transpired. The rationale for my adaptive decisions will be brought to light. I end with an exploration of ethical considerations I needed to hold in mind for this project, including my position as an insider researcher.

3.2 Methodology

Whilst I considered a range of qualitative methodologies for this project, which I shall return to shortly, my postmodern and phenomenological epistemological and philosophical positioning influenced my research questions, which informed my choice of methodology: Interpretative Phenomenological Analysis (IPA). First proposed by Jonathan Smith (1996), its two primary aims are a) to make sense of (people making sense of) their personal lived experience (a two-stage process) and b) to say something in detail about the perceptions and understandings of a particular group rather than prematurely making more general claims. IPA's focus is therefore on trying to discover the meaning people attribute to their experiences and, as far as possible, to gain what Conrad (1987) refers to as an "insider's perspective".

There were also further considerations that shaped my selection of IPA for this research. Being an insider researcher of such an evocative subject matter, as well as not having used a methodology before, the clear structure and guidelines for

conducting IPA research espoused by Smith et al. (2009) made me feel safe, particularly in relation to the analysis, where IPA offers a step-by-step guide. This distance, and the double hermeneutic (Heidegger, 1963) of IPA, helped to limit my experience from colouring the lived experience of the participants. Despite the safety and distance, however, I believe I was still able to faithfully re-represent the voices of the participants in quotes, so that they were heard, thereby leaning into a narrative stance. Whilst other methodologies such as narrative inquiry (Clandinin, 2006) perhaps have the capacity to give participants a louder / stronger voice than IPA, it is not necessarily all about the loudness of the voice, it also being important that methodology selection is aligned with one's philosophical and psychotherapeutic paradigm. That is, whilst narrative inquiry focuses on how people tell stories to make sense of their lived experiences (Clandinin, 2006), as a person trained in psychotherapy, I particularly value the double hermeneutic of IPA, therefore choosing to employ the latter methodology.

Another methodology I briefly considered was grounded theory (Strauss & Corbin, 1994) but, being a methodology that focuses on social processes more than individual lived experiences rendered it less useful for my study, which is focused on the internal subjectivities of participants. Similarly, discourse analysis (Jørgensen & Phillips, 2002) didn't feel appropriate as it gives primacy to the nature of language and discourse, rather than sense making, which was of most value to me for this study given the research questions I have outlined.

Having explored my reasons for choosing IPA as a methodology, I now turn to deeper exploration of the constituents of IPA, beginning with the philosophy of phenomenology.

3.2.1 Phenomenology

Phenomenology is a philosophical approach to the study of experience which guides us to think about what the experience of being human is like, especially in terms of the things that matter to us and that constitute our lived world (Smith et al., 2009). IPA takes the phenomenological position that the meaning and nature of reality is dependent on our view of it (and our involvement and engagement in it). Therefore, it is concerned with the way in which humans gain knowledge about the world around them, the goal of phenomenology being to explore the lived experience, in line with Husserl's (1927) view of phenomenology as being concerned more with the perception and subjective experience of an object or account, rather than trying to objectively observe and understand it. IPA's interest in the detailed examination of individual lived experience and how individuals make sense of that experience in a particular context and at a particular time (Smith et al., 2009), is what makes phenomenology an ideal perspective from which to explore the situated reality of people's sense-making of engaging with therapy to explore their experiences of DA. IPA was therefore a good choice to answer my research questions as it is idiographic, looking at the lived experience of the individual (Larkin et al., 2006) whilst also looking for patterns across individuals (nomothetic). IPA can help to give a voice to participants, as researchers honour their phenomenological experiences by analysing in detail how participants perceive and make sense of things that have happened to them (Larkin et al., 2006), thereby providing insight into the heart of peoples' lived experience (Biggerstaff &

Thompson, 2008). Being able to give a voice to participants such as those in this study feels particularly important considering the lack of visibility afforded to same-sex DA.

3.2.2 Interpretative Phenomenology

Dissatisfied with the descriptive nature of phenomenology, some people argue that to be more psychological, it must involve interpretation (Langdridge, 2007). Indeed, Heidegger himself contended that in order to understand stories of lived experience there must be a method of interpretation, or hermeneutic (1963). As a result, IPA acknowledged and incorporated "symbolic interactionism" (Smith et al., 2009): People's interactions are not entirely idiosyncratic and free-floating, in that "they are bound up with social interactions and processes that are shared between social actors" (p. 97). Symbolic interactionism was first coined by Blumer (1969) who set out three basic premises of the perspective: Firstly, humans respond to things according to the meaning they ascribe to them; secondly, those meanings arise out of interaction with other people and thirdly, the meanings attributed to things are continuously constructed and reconstructed through interpretation and reflection, dependent on engagement with them. Blumer (1981) contends that symbolic interaction is the primary means "by which human beings are able to form social or joint acts" (p. 153). Symbolic interactionists study the intersections of interaction, biography and social structure.

Gadamer, another noted philosopher, believed that phenomenological understanding is not about trying to produce a-historical and a-cultural truths about the world, but instead he suggests that the production of knowledge is contingent upon both culture and history. In the construction of knowledge, we cannot suspend our knowledge of

what has gone before, or what influences the way we experience the world now. Therefore, IPA can be said to be interpretative in the sense that it acknowledges the impossibility of gaining direct access to the internal world of the research participant and recognises that any exploration of a participant's lived experience must also involve the researcher's own view of the world, as well as the nature of the interaction between the researcher and those being researched. What therefore emerges is an interpretation.

The resultant double hermeneutic (Heidegger, 1963) of IPA means that whilst the participants are trying to make sense of their world the researcher is trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2007). Making sense of the experience of the participant (Larkin et al., 2006) is the overarching goal of the research and also aligns with one of the goals of psychotherapy, which is to facilitate the client's sense-making of their unique phenomenology / lived experience. I return to the concept of the double hermeneutic in the following Chapter 4 on reflexivity.

With the focus on lived experience, attempt to understand meaning associated with experience, and with a primary goal of making sense of that experience, IPA makes the ideal methodology for exploring the experiences of engagement with therapy for gay male victims of domestic abuse. I now turn to the pragmatics of implementing IPA in this research project.

3.3 Data Collection

Sandelowski (1995) recommends qualitative sample sizes that are large enough to allow the unfolding of a new and richly textured understanding of the phenomenon under study, but small enough so that the deep, case-oriented analysis of qualitative data is not precluded. According to Smith et al. (2009) a major influence on IPA is "idiography", which is concerned with the particular, and operates at two levels: Firstly, in the sense of detail, with a thorough and systematic depth of analysis; and secondly, with an understanding of how a particular experiential phenomenon (an event, process or relationship) has been understood from the perspective of particular group, in a particular context (Smith et al., 2009). To achieve this, IPA studies use small, reasonably homogenous, purposively selected and carefully situated samples, even allowing for effective use of a single case analysis (Charlick et al., 2016). Being interested in the deep, rich, lived experience of individuals, my methodology therefore allowed for a small number (4 to 6) of participants to be used for my project. The criteria for participation in this study were:

- Male victims of same-sex DA, including intimate partners and excluding familial DA (NOTE: Trans men were included within this framing, but the resulting sample of participants were all cisgender)
- Participants self-defining as having experienced DA.
- An experience of therapy in which DA was discussed.

Given that having discussed their experience of DA in therapy was a requirement to participate in the study, it was assumed that participants had experienced some form of DA. However, I left it open for participants to self-define this experience, rather than

including a definition in the participant information sheet (Appendix B). This was because not only is there variation in what is understood as DA, highlighted in the literature review chapter, an example being the recent survey findings (Salter et al., 2021) that gay, bisexual and queer men were less likely to identify coercive control as unacceptable, compared to physical abuse, but some LGBT people don't see themselves in mainstream definitions of DA, and can experience LGBT-specific abuse, such as threatening to disclose one's identity, or withholding medication in the case of trans people (Lusby et al., 2022). Using a definition of DA might therefore have ruled out these other experiences of DA, thereby limiting who could participate. Ultimately, I wanted to understand their subjective experiences, regardless of whether they had experienced physical abuse, psychological / emotional abuse and coercive control (the manifestations of which can be extensive and diverse) and / or sexual abuse, as opposed to imposing one, particularly with this group of people.

Longer term therapy was preferable to shorter term, but shorter term was not excluded. A minimum of 4 sessions was preferable, as this is used to indicate the development of the therapeutic "working alliance", described by Horvath et al. (2011) as the quality and strength of the collaborative relationship between the client and the therapist. According to Bordin (1979), not only is the working alliance a requirement for therapeutic work, but it is possibly the main factor in bringing about change. Furthermore, I did not want to preclude people who had not continued to engage with psychotherapy, as an exploration of reasons for disengagement could add depth to the research. It did not matter if a participant was still engaged in therapy or not, or how long ago they attended therapy. However, for any participants still in therapy and

for any participants evoked by the interview, I would follow the ethics outlined in Section 3.6 below.

It did not matter what form of psychotherapy / counselling participants had engaged with and although participants didn't have to be out of the abusive relationship, from a health and safety and risk assessment perspective, they needed to be no longer living with the abusive partner. There were no further restrictions on age, ethnicity and any other demographic characteristics.

3.3.1 Recruitment

Having communicated with two leading same-sex DA researchers in the UK (Damian McCann and Catherine Donovan) whilst writing my research proposal, it became clear that, not only do male victims of same-sex DA rarely engage with psychological support services, but they are also, perhaps in a parallel fashion, notoriously difficult to access for research purposes. In reality, this was indeed my experience: Despite multiple requests for research participants, very few came forward, and it took 7 months to reach my target sample.

The blurb I used for all advertising is below. Whilst I initially intended to include my mobile number, I decided to use my academic email address in order to make it sound official and professional, and potentially safer, considering that the group of people to whom I was reaching out had been in abusive relationships, and might have difficulty trusting others:

> "Are you a gay man who has been in an abusive same-sex relationship for which you attended therapy for at least 4 sessions? If so, and are interested in participating in independent doctoral research, contact Shaun at shaun.bruwer@metanoia.ac.uk"

Below are the actions I took to recruit participants:

- I told friends and ex-colleagues about my research, hoping to recruit participants through word of mouth. I also posted it on my Facebook account, with a number of friends then reposting it.
- In November 2018, the Chief Executive at London Friend, a LGBT mental health and wellbeing charity, agreed to me putting up posters in the foyer of their offices, as well as posting it on Facebook and Twitter in January 2019.
- Stonewall posted it on their social media 3 times over a 2-week period in February 2019, with the blurb retweeted by one of its founders, with a large following.
- The Metanoia LGBT Network posted it on social media.
- In March 2019, the LGBT Foundation tweeted my blurb twice over a two-week period, and also put it in their bulletin.

Despite my research having a very wide reach by this stage, I still only had three interviews completed. A couple of potential participants who reached out at this stage didn't follow through. Stonewall alone has a very large number of followers, yet I didn't

get one query as a result of their tweets. Whilst I reached out to a number of other LGBT charities, I either never heard back from them, or they were unable to help.

Having exhausted London charities, I cast the net wider by contacting Trade Sexual Health in Leicester in May 2019, fortunately getting the last two participants needed for the study. Interestingly, of the 5 participants who took part, and considering the vast number of gay men in London, only two participants came through tweets from London-based organisations. Only when I went beyond London, did I get more interest. Despite having been told by Damian McCann and Catherine Donovan that this group of people are difficult to access for research purposes, I was still very surprised that it took so many months. This I find to be somewhat concerning, and something significant to hold in mind: If this group of people aren't generally good at accessing support, maybe it makes sense that they would not be forthcoming in terms of coming forward to talk about their experiences of accessing support. This phenomenon might therefore be indicative or representative of this group of people suffering in silence.

3.3.2 Participant Demographic Characteristics

A summary of the demographic characteristics of the five participants who took part in this study can be seen below in Table 1: Summary of Demographic Characteristics. All participants were cisgender, no participants identified themselves as having a disability, and only D and E disclosed their religion, both being Muslim. Note that whilst I have used pseudonyms for my participants in the rest of this thesis, I used letters here in order to disconnect their demographic characteristics from their pseudonym, to help maintain anonymity.

Table 1: Summary of Demographic Characteristics

	Age	Ethnicity	Identity	Sex
A	25 - 34	White British	Gay	Male
B	25 - 34	White British	Gay	Male
C	25 - 34	British Asian	Gay	Male
D	35 - 44	British Asian	Gay	Male
E	35 - 44	White American	Gay	Male

3.4 Interviews

In line with IPA guidance on creating a semi-structured interview schedule outlined by Smith et al. (2009), interviews were prepared by devising a small number of open-ended, non-directive questions to ask participants, in order to enter their world and find out about their engagement with therapy. The schedule started with more general descriptive questions to help establish rapport with the participant (Smith et al., 2009), then moving to more specific structural and evaluative questions (Smith et al., 2009) relating directly to my research questions later in the interview. The interview schedule (Appendix A) was broken into four areas: 1) General questions at the beginning, where they were asked how they viewed themselves, and felt about their gay identity, to act as an ice-breaker 2) Questions about the DA, to explore the abuse they had experienced 3) Questions about accessing support, to get a sense of the challenges and barriers they encountered, as well as what was helpful in reaching out and engaging with therapy 4) Questions about therapy, to explore how they made sense of their experience of therapy. The rationale for open-ended questions in a semi-structured interview was to prompt participants to access their phenomenological experience and, by limiting pre-determined questioning, I aimed to allow for more

fluidity and exploration during the interview. This style of questioning also enabled me to pay attention to the words participants used to make sense of their experience, without me putting words in their mouths, something that I will explore further in the following Chapter 4 on reflexivity. Within the interview schedule, I also devised questions that could act as a prompt, should a participant be struggling with any of the questions, and to help ensure a depth and richness of data.

Having devised the interview schedule, I asked my clinical supervisor to interview me. This test run was a very useful exercise that enabled me to experience what it might be like for a participant, and it did not make me change any of the questions. After the first interview, which I had seen as potentially a pilot interview, I reflected again on whether I needed to make any changes / review any of the questions, deciding that it had been largely successful, as the questions had been good enough to yield data that was in turn good enough to be used in the research proper. The first interview is therefore part of my dataset. The first interview helped me to realise the importance of giving participants' space to speak about their experiences of DA, and I took on board feedback from my research supervisor, such as not putting words into the participants mouths, something I explore further in the following Chapter 4 on reflexivity. No further changes were made to the interview schedule for the remainder of the interviews.

3.4.1 Conducting the Interviews

Once contacted by email by a potential participant, I emailed them back with a participant information sheet about the research, asking them to read it and, if they were still interested in taking part, to let me know via email, so that we could arrange a telephone call to a) ascertain whether they met the eligibility criteria and b) arrange

a mutually convenient date, time and location for the interview. Of the five interviews, one was carried out in their home, one was carried out in my home, one was on Zoom, and two were at the Trade Sexual Health offices in Leicester. It was important to hold the health and safety of both myself and the participants in mind, particularly with such a sensitive and complex subject matter, so for the interview carried out in my home, I checked how the participant felt about it, and he said he was fine. Being a psychotherapist in private practice, I am accustomed to having people I have not met before in my home, and can generally get a sense of them from the telephone conversation before we meet in person. For the participant in whose home I conducted the interview, at his suggestion as he lived in Scotland and I would be flying up from London for the interview, I checked that nobody else would be at home, in order to ensure that the interview space was contained and confidential, and told a colleague where I would be going, and what time I expected to finish the interview. I then notified my colleague when I departed the participant's home, good practice I learned whilst working for Victim Support.

Before the interview, informed consent (West, 2002), confidentiality and anonymity procedures were explained, and I asked participants to indicate their acceptance and understanding of these by signing a consent form (Appendix C), including agreement to be audio-recorded, and consent to use their quotes in the write-up. The document also stipulated that the participant could stop the interview or withdraw from the research at any stage, should they wish to do so.

Whilst I originally thought that I might ask participants for a second interview, and had ethics approval to do so, I did not do this because I was struck by the richness and depth of the data in the first interview and had a clear sense that another interview

was not necessary. Indeed, considering the evocative nature of the subject matter, I was conscious that another interview could have been burdensome to participants.

3.5 Data Analysis

Etherington (2004) says that postmodern narrative analysis conveys a sense of the narrator's (participants) experience in its depth, messiness, richness and texture, by using the actual words spoken and that it includes some of researcher's part in that conversation in order to be transparent about the relational nature of the research, and the ways in which these stories are shaped through dialogue and co-construction, as well as providing a reflexive layer with regard to researcher's positioning. The meaning-making for this research project occurred throughout the research process rather than being a separate activity carried out after collecting the data. In line with my philosophical assumptions of the world, I recognised and was mindful and reflexive of the inter-subjective, relational, co-construction of meaning between me and the research participants and the double hermeneutic nature of IPA described above (Smith & Osborn, 2007). Therefore, whilst being involved in, listening to, transcribing and reading the interviews, I took in what was being said and compared it to my personal understandings and phenomenology. In other words, throughout the analysis, I interrogated the data by firstly attending to how they made sense of themselves, before exploring my own sense making of their experience.

The audio taped interviews were transcribed verbatim, with confidentiality achieved by using a pseudonym to anonymise participants. In order to save paper and avoid having to retype notes that I had handwritten, I conducted the analysis electronically, an

analytic option put forward by Smith et al. (2009). Starting from scratch for each transcript, I aimed to follow the below stages:

- Stage 1: Make initial notes
- Stage 2: Transform the initial notes into basic sub-themes
- Stage 3: Connect the sub-themes to make clusters of sub-themes under a superordinate theme

I use the word “aimed” above, as this is not exactly what transpired: Whilst I followed the above steps for the first transcript, employing free association to make initial notes whilst reading the text, paying attention to certain sentences and words used by the participant in their sense making (Smith et al, 2009), and writing down whatever came into my mind, before carrying out the abovementioned in-depth analysis and clustering of themes, I became overwhelmed and evoked whilst doing the analysis of the second transcript, due to my own insider status, which I unpack and discuss in the following Chapter 4 on reflexivity. However, in brief here, it led to a discussion with my research supervisor in which we agreed that I would derive themes from the first two interviews, which I would hold in mind whilst reading and analysing the remaining three transcripts, looking for recurrence of the existing themes, as well as other themes I might not yet have encountered.

3.6 Ethical Considerations

I now turn to an exploration of ethical consideration for participants, and then briefly for myself, particularly as an insider researcher, which I explore further in Chapter 4

on reflexivity. Ethical approval for this research project was obtained from the Middlesex University committee (Appendix D).

3.6.1 Participants

Participants in this research project are from a group of people who often face huge barriers to accessing and engaging with psychological support services, such as therapy, and I was mindful of how much courage it might take for them to take part in my research, which required them to talk about their traumatic experiences. Considering their potential vulnerability, I wanted to do everything to ensure that they were adequately protected from retraumatisation in the interviews. However, as a researcher who is also a therapist, I needed to be mindful and reflexive whilst researching such a potentially evocative subject-matter, so as not to get drawn into a therapy session, rather remaining focused as a researcher, whilst still using my therapeutic skills to enquire about the participant's phenomenology. In the following chapter, I further unpack the tensions that I had to hold whilst interviewing participants. In the interviews I was aware that, should a participant become distressed, it might have been necessary to stop the interview, and remind them of their right to withdraw at any stage. Whilst there were moments in the some of the interviews where I could see that a participant was evoked / emotional, I sensitively paused to check in with them to see how they were doing, and none of the participants chose to withdraw from the interview.

At the end of each interview, I conducted a debriefing with the participant, which involved briefly reflecting on what the interview had been like for them, and checking in with how they were feeling, before they departed. As a therapist knowing too well

that talking about evocative material can manifest in the days afterwards, I gave each participant a resource information sheet (Appendix E) with details of organisations they could turn to for support if they felt they needed it and arranged to contact them four weeks after the interview, through a medium of their choice, to see how they were doing. This was particularly pertinent because a number of the participants hadn't spoken about / revisited their abusive experiences for quite some time. On contacting the participants a few weeks after the interviews, all said that they felt fine, with one having decided to return to therapy to work through some of the material that had arisen in the interview, feeling that there was still more to process. He asked if I could be his therapist, which I said was not possible due to ethical and professional boundaries between my role as a researcher and my role as a therapist, so I shared some websites where he could look for a therapist.

3.6.2 Data

Data was handled and stored in line with Data Protection legislation: My computer was password protected and audio files and transcriptions were only stored for as long as necessary, and only used for the purpose for which they were intended. Once no longer needed, I discarded any paper-based data by shredding it. In terms of anonymity, I was conscious of how much context to include in the write up, in order to ensure that participants were not identifiable, and confidentiality was achieved by using a different name to anonymise the participants.

3.6.3 Myself

As an insider, self-care has been particularly important for the duration of this research project and, without it, I would have been able to complete it. In short, I attended

personal therapy, tried to maintain my reflective journal, and made space for exercise, rest and relaxation. I discuss self-care in greater depth in the following Chapter 4 on reflexivity.

3.7 Chapter Summary

Having explored my choice of methodology, recruitment and interviewing of my participants, data analysis, and ethical consideration for this research project, I now turn to an exploration of reflexivity, and why it is important for a project such as this, particularly as an insider researcher.

CHAPTER 4: REFLEXIVITY

4.1 Introduction

Given that this study makes use of interpretative phenomenology, and because of the magnitude of the impact of being an insider researcher, I decided to have a separate chapter that focuses on issues relating to “reflexivity”. In this chapter, I explore my personal reasons for embarking on this research project, the meaning and importance of reflexivity, particularly as an insider researcher, and issues of transparency and trustworthiness. I then reflect on my role as an interviewer researcher, addressing complex issues pertaining to my status as both an insider researcher and a therapist researcher, before discussing the myriad of challenges I have faced in sustaining engagement with this research project. I then look at my role as a researcher in the analysis and writing up stage of the research and what I did in terms of self-care, before concluding the chapter.

Note that in presenting my reflections in this chapter and beyond, I want to be clear in stating that they are in no means caused by / the fault of the participants in this study. Whilst I wanted to give primacy to participants’ experiences and sense-making, in this chapter I wanted to reflect on their experiences, based on my history, and how I might have taken this forward, consciously and unconsciously, in the analysis that I performed.

4.2 Why This Research Topic?

Whilst I explained the scientific rationale for this research topic earlier in this thesis, I now elaborate on the personal process through which I arrived at the decision to conduct the research, which highlights my position as an insider researcher.

In 2014, whilst working for Victim Support, one of the biggest victims' charities in the world that specialises in the support of victims and witnesses of crime, I noticed that whilst DA constituted a large percentage of the work, the charity didn't record data for same-sex DA. On speaking with DA case workers, it became apparent that very few same-sex DA victims were engaging with support (Note: Since 2019, Victim Support has specialist same-sex DA caseworkers and does record statistics for victims of same-sex DA). Whilst this was something tangible that catalysed this research project, with me wondering how many gay male victims of DA might be suffering in silence, we could say that nothing is a coincidence and, as the project evolved, I became increasingly aware of my position as an insider researcher. That is, I am a gay man who was in an abusive relationship at 21 years of age and, not only did I not conceptualise it as DA at the time, but I didn't seek or engage with psychological support for the abuse at the time. Here is an excerpt from my reflective journal, dated 24th January 2015:

> "In spinning class today, I started getting upset about the fact that Sebastian **[not his real name]** beat me up and I wonder if I ever processed my experience of domestic abuse? Am I attracted to the area of same-sex domestic abuse

because I have never really processed it? I also never sought support! Maybe I could take this to therapy..."

Furthermore, after many conversations with my research supervisor and colleagues, it became apparent that my interest in researching this topic transcended my curiosity about my experience, including why I hadn't sought support whilst in an abusive relationship (therefore my research perhaps being an attempt to answer questions about my own experience), but that it had deeper roots in the abusive dynamics of my "family of origin". According to Dewaele et al. (2011), this term is used in queer communities to distinguish between "intimate partner violence" and "family of origin violence"; the latter typically referring to birth / legally adopted / guardian families in a way that acknowledges that some LGBT people have "families of choice", particularly when they have experienced emotional abuse and rejection by their "families of origin" due to homophobia.

Further impetus for this research was gained when I met with a gay male victim of same-sex DA who had engaged with therapy. The man told me that before accessing and engaging with therapy, he got to such an extreme place that he overdosed on drugs to escape the abuse, and nearly died. The more he spoke about the challenges he faced (including feelings of shame and that he would be judged by the therapist) and what helped him to access and engage with therapy, the more I felt that the research was needed. Not doing the research could potentially result in deaths, I felt.

As a trainee psychotherapist at the time, all the above-mentioned factors came together, making me wonder how therapists and support workers approach and deal

with potentially very vulnerable same-sex DA victims, and how victims might feel about, and make sense of their experiences of accessing and engaging with support services. With the deeply personal reasons for my interest in this research project in mind, I now turn briefly to my philosophical stance, and its relation to reflexivity.

4.3 My Philosophical Stance

As briefly discussed in the previous chapter, my philosophical stance is social constructionist and postmodern in nature. That is, based on my historic experience of oppressive binaries during Apartheid in South Africa, I am sceptical of structuralism and positivism, do not believe that there is one objective reality or truth that can be known or discovered, but rather that we live in a multiple-reality epistemology. From this standpoint, all theory can be seen as a socially constructed attempt to make sense of the world and should be recognised as such. The impact for me as a researcher (and therapist) is that I am most interested in context, and the collaborative, dyadic exploration of the reality, or "phenomenology" (Spinelli, 2005) of the research participant (and client), ultimately trying to make sense of them making sense of their world: That which Heidegger (1963) calls a "double hermeneutic". Therefore, I hold that knowledge and meaning are located within a "co-created" two-person psychology, as opposed to a one-person psychology.

With this philosophical positioning in mind, I now introduce and explore the concept of reflexivity, considering its implications for the qualitative researcher.

4.4 The Meaning of Reflexivity

Whilst reflexivity is an issue for the social sciences in general, it has particular significance for qualitative research (Davies, 2008). In line with my philosophical stance, Alvesson (2003) espouses the belief that the days of being an objective researcher who has no bearing on the data collection is no longer valid, and that the "reflexive" researcher is fundamental to research. This means that the researcher needs to try to be aware of factors that might influence data collection, including their influence on outcomes. In interviewing, for example, there are many ways in which interviewers can affect the responses they receive: The types of questions asked, the relationship between interviewer and interviewee, and the sensitive material being discussed will all affect data collection and cannot be ignored (Lee, 1993). The researcher is therefore not a separate object in relation to the discovery of the phenomenon being explored, but rather a fundamental part of the discovery. This is echoed by Whitaker et al. (2019) who emphasise that central to reflexivity is an awareness that the researcher and the object of study exist in a mutual relationship with one another. Reflexivity therefore calls for attention to how thinking comes to be, how it is shaped by pre-existing knowledge, and how research claims are made. However, there is no single definition of reflexivity, as it has multiple meanings and connotations (Babcock, 1980). According to Pillow (2010), a review of reflexivity in qualitative research shows that researchers can be reflexive about the research process, the participants or topic they are researching, and the world through which they are researching or creating knowledge. Pillow (2010) suggests that self-reflexivity is the most common form of reflexivity, whereby the researcher is required to be critically conscious of how their position and interests influence all stages of the research process. This is generally achieved through self-disclosure, with Van

Maanen (1991) describing reflexive work as a “confessional tale”. In attempting to understand my position as a reflexive researcher for this research project, I came upon Kim Etherington’s (2004) definition of reflexivity (2004):

> “I understand researcher reflexivity as the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry.” (p. 32)

Etherington’s definition of reflexivity resonates with what I believe is the task of a reflexive qualitative researcher attempting to produce high-quality, qualitative research, and I concur with Burman (1998) who see reflexivity as an opportunity for the researcher to lay bare their attitudes and values and examine the impact of these on the research process. Furthermore, the literature on reflexivity stresses the importance of demonstrating that the researcher is a transparent figure who is meaning-making in collaboration with the participants of the interview (Etherington 2004, Hertz 1997). However, as Crotty (1998) states, it is important that the researcher, who is already laden with understandings of the world, is also able to “bracket” these understandings to let the experience of phenomena speak to us first hand.

I now turn to a discussion of issues of transparency and trustworthiness, highlighting how they fit together with reflexivity.

4.5 Transparency and Trustworthiness

Bearing my personal proximity to the research area in mind, one might wonder if it is possible for a researcher to be too close to the material to be able to produce

something with enough distance? This is where trustworthiness comes in. According to Ponterotto (2005), reflexivity, transparency and acknowledging my biases will contribute to the trustworthiness of the research. And in talking about reflexivity, Carla Willig (2013) says that it is important to own our role in the research and that the co-construction of the research must be evident and acknowledged throughout, likening reflexivity in qualitative research to countertransference in psychotherapy. Furthermore, Hertz (1997), says that as a reflexive researcher, I shall not be simply reporting facts or truths but will be actively constructing interpretations of my experiences whilst conducting the research, and questioning how my interpretations came about. Considering my position as an insider researcher, I have aimed to do this as comprehensively as possible throughout the project, partly with the aid of a reflective journal, into which I wrote any thoughts, feelings, observations and revelations. My reflective journal has helped me to both reflect on my impact on the research and monitor the potential impact of the research on me (Ortlipp, 2008).

Being an insider of a such a sensitive subject matter, “peer checking” has been another important way of enhancing the transparency and trustworthiness of my research, alongside my reflective journal. Peer checking involves using an experienced colleague to look at my sense-making and interpretation of the data (Gunawan, 2015), thereby highlighting my blind spots, biases and assumptions. To begin with, my research supervisor is a gay man who has done much research in this area, and part of his role has been to help me think about things from a different angle. In addition to my research supervisor, I have had a female critical research friend with whom I have talked through my thinking at each stage of the research process and who, being a brown lesbian feminist and expert on queer theory, has brought a different perspective

to my work, partly by helping me to interrogate my own heteronormative assumptions.

Having considered various aspects of research reflexivity, transparency and trustworthiness, I now turn to reflections on my role as an interviewer in data collection for this research project, holding reflexivity and my insider researcher status in the frame.

4.6 My Role as an Interviewer in Data Collection

I now look at my role as an interviewer in data collection, beginning with an outline of how I prepared for the interviews, before moving onto an exploration of my decision-making around whether to disclose my insider status to participants or not, the impact of the interviews on me as an insider researcher, and how I navigated the interview process from a position of reflexivity.

4.6.1 Interview Preparation

As mentioned in the previous chapter, my clinical supervisor interviewed me using my draft interview schedule, both to test it out and to help prepare me for the interviews. Not having done research interviews before, this helped me to feel more confident about the interview process, observing how he gently and sensitively moved through all the questions in the schedule, whilst giving me space to express myself. Some of the material that arose in the interview surprised me, the process therefore making it clear that there was some unresolved energy around my own experience of DA, for which I did not engage with support services. This exercise was therefore useful from

both a practical level, and emotional level, as it made me hold in mind how I might respond to the participants' experiences whilst interviewing them.

4.6.2 Self-disclosure

According to Platzer & James (1997), self-disclosure of one's insider status can foster trust, and create a rapport with participants. In thinking about whether to self-disclose my insider status (including my gay identity) to participants, I considered issues of consistency and the potential skewing impact of self-disclosure to some participants and not others. I decided, in parallel with the therapeutic process where I self-disclose to some clients and not others (the decision to do so being based on a number of unique factors), to adopt a similar stance of discretionary self-disclosure with participants in this study.

I ultimately did not disclose my insider status to any of the research participants, feeling that it wasn't necessary in order to create rapport: My sense was that all participants spoke freely and honestly, and I was struck by the level of deeply personal detail they shared with a stranger. Whilst I cannot know for certain what helped to build rapport with the participants, they might have been put at ease by some of the early ice-breaker interview questions about how they perceived themselves and felt about their gay identity. They might also have sensed that I was gay / queer without me having to tell them, which might have put them at ease. Perhaps they felt that someone researching such a specific area would have a personal connection to the subject matter? Whilst this is all speculative, with me not being able to say for certain what helped to build trust in the interview, what I do know is that participants courageously shared their moving and meaningful experiences with me.

Furthermore, none of the participants asked me direct personal questions about myself and my experience. Reflecting on possible reasons for this, I am aware that as a therapist I very rarely explicitly disclose anything personal about myself to clients, only doing so if I feel that it is likely to be of benefit to the client. Clients also rarely ask me direct questions, and I wonder if they unconsciously feel a boundary? Perhaps this manifested in the interview space too.

I also wonder what role, if any, the wording of my advert for participants might have played in instilling trust in research participants, as I mention that the research is “doctoral”. This might have added a sense of gravitas and credibility to the research, thereby helping participants to feel that the research would be boundaried and safe. The participant information sheet I sent to participants was also comprehensive and professional.

I now take a closer look at the impact that interviews had on me, starting with the first interview.

4.6.3 Me as an Insider and Therapist Researcher / Interviewer

Part of the complexity of this project has been for me to have to hold and be aware of my multiple positions in relation to the research: For example, when approaching the interviews, I needed to be mindful of being a researcher, primarily, as well as a researcher who is also an insider, as well as a researcher who is also a psychotherapist. When attempting to structure this chapter on reflexivity, separation of these parts of myself into discrete sections was impossible, so I tackle them

concurrently, thereby illustrating the tensions that I experienced in this research project. I begin with an exploration of my experience of the first interview.

For my first interview, I flew up to Scotland to meet with Charles, the research participant. Whilst I was nervous, I felt as prepared as I could be, considering that the interview had been practiced on me, and I had acquired some practical tips for research interviewing from my clinical supervisor. What I was not prepared for was the degree of pain and suffering that would be disclosed in the interview: I believed that because the focus of my research was on participants' engagement with therapy, I would not be hearing much about the participant's experience of DA itself. Here is an excerpt from the interview:

> Charles: "He smashed the mirror up and got a shard of glass and then went to slash me so I jumped back, and then he dug the glass in his wrist and pulled down..."
>
> Me: "Wow"
>
> Charles: "...and the blood started coming out, and then he jumped out a window."

This was one of a few shocking experiences that Charles disclosed to me in the interview, with me expressing my, perhaps bewilderment, with "Wow". As a psychotherapist, hearing about people's painful experiences is not uncommon, so in the interview, I used a simple technique of "grounding myself" by pressing my heels

into the ground, in order to feel them connecting with the ground. Doing so enabled me to stay present to Charles and his sense-making of his experience.

The other challenge that arose was that, because Charles was sharing a lot about his experience of the DA, I was afraid of not having enough time to explore my research question, which was his engagement with therapy. I tried to sensitively move the questions on, as my clinical supervisor had done with me, but my anxiety can be seen in the below sudden gear change, after which he explicitly says that there is a lot that he has "missed out", possibly because he was not finished reflecting on his experience of DA:

> Charles: "And then he'd just stub the cigarette end onto my hands. He did that a few times. Er…"
>
> Me: "Wow"
>
> Charles: "...so things like that, yeah."
>
> Me: "So, at what stage did you think, "Maybe I need some professional help here?""
>
> Charles: "So, um, there's a lot of things I've missed out. It's quite difficult to lay it all out in one storyline as I haven't spoken about it for a while."

Having shifted the direction of the interview so abruptly, I wonder if I might have shut down some of Charles' sense-making. In addition to my anxiety about time in the

interview, the above exchange involves another example of shocking physical abuse endured by the participant, which was difficult to hear in of itself, that which Clarkson (2004) calls “reactive countertransference” as well as potentially hooking into my own “unresolved” experiences of physical abuse, or “proactive countertransference” (Clarkson, 2004): I could have been inadvertently moving the participant on from continuing to talk about the DA as it was resonating with me at a deeper level, and that I was not always able to stay grounded in the interviews, despite my best efforts. The implication is that my insider status might have curtailed sense-making that another researcher might have been able to elicit. Looking at this scenario from another angle, perhaps moving on helped to avoid retraumatising Charles, thereby facilitating a sense of safety and containment that enabled him to open up in the way that he did when I asked other questions.

A year and half after the first interview (which I shall explain below), I met with my research supervisor, and we unpacked my experience of the first interview. We concluded that a) because the DA is such a large part of the participants’ stories, it is fine to give them space to talk about it, as there is no rush to get to my research question and indeed b) perhaps their sense-making of their abusive experiences would yield deeper insight into how they make sense of their journey to, and engagement with therapy, and therefore add depth to my research question. I went into the subsequent four interview with this in mind.

However, my struggles persisted, and I additionally found it extremely challenging to contain what was sometimes years of abuse into a 1,5-hour research interview, whilst concurrently addressing my research questions, and not going into “therapist” mode,

particularly considering the traumatic nature of the research area. As a therapist, exploration of such material can take years, involving sitting with them in their pain for prolonged periods of time, whilst gently exploring their thoughts and feelings. It therefore felt like there was a clash between my therapist self and researcher / interviewer self, and that I was walking a fine line between giving participants a voice, yet also needing to contain / limit it. I was afraid of coming across as too clinical, or cold in the interviews and of shutting the participant down on such a personal and sensitive topic, by guiding the interview in the direction of what I was looking for in my research questions. That is, I wasn't researching their experience of DA per se, but was more interested in their engagement with therapy. This tension is palpable in the interaction with Charles that I explored above. Furthermore, participants might indeed have lost their voices in their abusive relationships, and I was afraid of "retraumatising" them by "shutting them down". Here are notes I made in my reflective journal, straight after the first interview with Charles:

> "I was so anxious about this interview being too long, yet also didn't want to "retraumatise" him by shutting him down when he was finding his voice, particularly considering that he hadn't revisited his experience for years. I must speak with Adam **[my research supervisor]** about this."

How could I research this topic sensitively, allowing them to tell their story, and also sometimes directing them to other areas that I was interested in, without retraumatising them and indeed, me, considering my insider status? I shall return to this question shortly. The impact of this process was that I sometimes felt quite paralysed in the interviews. In order to address this complexity, I gave participants

space to tell their story, and then would check with them how they felt about changing direction, such as saying, “Would you mind if I ask about your experience of therapy now?” or, “Thanks for sharing your experience. Is it OK if we move on?” Despite this, flavours of “paralysis” persisted in all interviews, to varying degrees.

Other feedback from my research supervisor after he read the first interview transcript was that I sometimes named, re-framed or used my own words to describe the participant’s experience, something not optimal for an IPA study which focuses on the words / language that participants use to describe their own experience. Here is an example:

> Me: “So you felt very guarded, even with, the sort of, the counsellor, there was this sort-of defensiveness, which makes sense...”
>
> Charles: “Definitely, yeah, yeah.”

In this example, I used the words “guarded” and then “defensiveness” when these were not words that Charles had used, thereby potentially taking away his capacity to use words that reflect *his* sense-making of his experience. My research supervisor and I discussed how this was likely to be a manifestation of my therapeutic style of collaboratively helping clients to name and therefore make sense of their experiences. Whilst the small number of participants in my study meant that I was limited in the extent to which I could evolve my interview skills over the period of the interviews, I was mindful of not putting words into the participants mouths in the following interviews, thereby allowing them to describe their experience, and sense making of it, in their own words, which I reflected back to them.

However, my skills as a therapist were of benefit too. Training as a therapist requires years of one's own personal therapy, which has enhanced my self-awareness. This was particularly helpful when conducting such evocative interviews, as I had more of a sense of what is mine and what is theirs, thereby increasing my capacity to bracket my experience and focus on theirs, as well as ground myself when feeling dysregulated (with both reactive and proactive countertransference dynamics in the interview frame). That said, being human precludes flawless self-awareness and groundedness, and I also experienced difficult feelings like paralysis, which I was able to reflect on with curiosity. My self-awareness also meant that I was less likely to feel the compulsion to rescue, or try to make participants feel better, which could be challenging for non-therapist interviewers researching emotive topics. Additionally, my therapeutic stance relies on the Rogerian ingredients of empathy, congruence and unconditional positive regard (Rogers, 1961), and Spinelli's (2005) ideas on phenomenology to honour and explore the client's unique world, which perhaps also enabled me to build a rapport with the participant by creating a safe and non-judgemental exploratory space for the interviews. Therefore, in addition to the challenges that being a therapist brought to the interviews, my qualities as a therapist also had a positive impact on the interviews, partly because my self-awareness and capacity for reflexivity enabled me to decrease the likelihood of retraumatising the participant or myself, or both. Furthermore, despite the challenges of being an insider researcher, I believe that my personal experiences were beneficial too, in that they allowed me to approach participants with enhanced sensitivity and compassion.

Having discussed the impact of phenomena such as my insider status and therapist self on my research, I now share some complex observations about challenges I

experienced whilst trying to engage with this this research project, including “parallel processes”, before moving onto reflections on the analysis.

4.7 Challenges I Experienced Sustaining Engagement with the Data

This research project has been extremely challenging on several levels, some of which I have explored above. However, I now unpack and explore some of the other challenging complex relational processes that I have experienced during this research project, which at times have made it very difficult to continue to engage with the data, and reflect on what my experiences might be telling me about the experiences of the research participants.

4.7.1 Parallel Processes

A “parallel process” in therapy is “a phenomenon that manifest in relationships and interactions, that originates in one setting and is reflected in another” (Jacobson, 2007, p. 26). There are a number of parallel processes that I became aware of in this research project that I felt important to include, as they give insight into the subject matter on several levels.

4.7.1.1 Claustrophobia / Feeling Trapped

Towards the end of all but the first interview (which was somewhat shorter, at 45 minutes), I began to feel claustrophobic: An oppressive pressure on my chest accompanied by panicky, shallow breathing, and a desire to get away, or escape. As described earlier, as a therapist, I am accustomed to the boundaried containment of the therapy hour (50 minutes) where I know when it will end. There is also no pressure to get everything from one meeting, as therapy is generally weekly and ongoing, so

there are further opportunities for exploration. In the interviews, whilst I had told participants that they would generally last for no longer than 1,5 hours, the material was so evocative (due to both reactive and proactive countertransferential phenomena at play) and difficult to contain, that I panicked that I wouldn't be able to end or get away from the interview. Many research participants spoke rapidly and voluminously and, combined with my fear of shutting them down, I sometimes felt overwhelmed and trapped. Significantly, and in a parallel process, this is how I had sometimes felt in my abusive relationship, and, in parallel fashion, I might also have been getting a sense of how participants might have felt in their abusive relationships. This feeling was not only confined to the interviews, with me often feeling trapped and overwhelmed by the whole research project itself, feeling shame and bad about myself for it taking so long, with seemingly no way out, perhaps also reflecting the potential entrapment in an abusive relationship. When I felt claustrophobic in interviews, I tried to employ grounding techniques such as reminding myself to breathe, and to feel my heels firmly on the ground, as discussed above. When I felt trapped by the research, I employed self-care techniques, which I shall discuss further later. Once I became aware of this potential parallel process, I held the possibility that participants might have felt claustrophobic and trapped in their relationships "lightly" in mind whilst analysing the data. The reason I use the word lightly is to highlight the idea of claustrophobia / feeling trapped as a possibility, and not something to *look for* whilst interpreting their sense-making. That is, my experience might be useful information whilst analysing the data, and it might not.

4.7.1.2 Dissociation / Denial / Paralysis

As I type, I notice increased anxiety, and a deep desire to move away from my laptop in order to disengage from the research. This feeling has been an ever-present, large barrier in my ability to engage with the research in a sustained way. At times, I have been more aware of this process and been able to challenge / confront it and at other times, I have dissociated from the research completely, often for months at a time. For example, after the first interview, a year and a half passed before I even listened to the tape. Feeling forced to consider what influenced / contributed to this lengthy hiatus in the research, I was eventually able, through reflection, to see that not only was the content of the interview evocative and difficult to hear in and of itself, due to the aforementioned reactive countertransference (Clarkson 2004) but, unknown to me at the time, it had hooked much deeper than I imagined into my own unresolved experiences of DA, or proactive countertransference (Clarkson, 2004). As a therapist, I need to be mindful of proactive countertransference as it can impact my capacity to stay present to the client's unique experience. As a researcher, the implication of my insider status was that I needed to be mindful of my woundedness, not only in interviews, where I needed to remain curious about the participant's experience, but also in the analysis stage, in my double hermeneutic position as a sense-maker of their sense-making of their experience (Smith & Osborn, 2007). The impact of both reactive and proactive countertransference phenomena at this early stage of the research process was that "I couldn't go there", entering long periods, in some cases many, many months, of dissociation / denial / paralysis. When I was able to engage with my struggles, there was space to wonder if my experience of dissociation / denial and paralysis might also be a parallel process, shedding light on potential experiences

of dissociation / denial and paralysis of research participants in their abusive relationships.

It seems pertinent at this stage to briefly highlight a philosophical tension arising from discussing psychoanalytic ideas such as transference and countertransference in relation to a phenomenological study: At the heart of psychoanalysis is the concept of the unconscious, whereby our behaviour is driven and motivated by unconscious mental processes, as well as repression, a defence mechanism in which people (unconsciously) push down difficult or unacceptable thoughts or traumas that are too difficult to confront, keeping them out of conscious awareness (Freud, 1923). As with any qualitative method, there is an internal challenge for people to recognise their motivation and challenges, thus enabling access to their lived experience / sense-making. How do participants make sense of their lived experience if much of their behaviour is motivated by the unconscious, particularly when the subject matter being investigated is as traumatic as DA? Surely a participant would need to have conscious awareness of their behaviour to articulate their experience, and as a reflexive, insider researcher, I would need to have conscious awareness of my experience to make sense of them making sense of their experience. The answer, I believe, lies in the fact that we can never have access to everything that is unconscious, and as a phenomenological researcher conducting a double hermeneutic study, I am interested in the participants' sense-making by not only paying attention to what they are saying explicitly, but how they are saying it, as well as what they are not saying / omissions. This all, unconscious and conscious, makes up the phenomenological sense-making / reality of both me and the participant at that moment in time and space. This is also the position I take as a psychotherapist when working with clients.

4.7.1.3 Reaching out for Support

Even once I was more aware of the possible reasons for my struggles to sustain engagement with the data, I often felt paralysed. At times, sitting down and even listening to subsequent interviews seemed like an impossible task. Despite having repeatedly explored my paralysis with my research supervisor and agreeing that I would contact him for support when I felt paralysed, I still found it extremely difficult to reach out and ask for help, often due to feelings of shame. This was also despite having other support mechanisms in place, such as my own personal therapy, and a peer support group. This too could be seen to be a parallel process, echoing the fact that I didn't seek support, or ask for help when I felt overwhelmed and paralysed in an abusive relationship, possibly partly due to feelings of shame, perhaps not dissimilarly to the experiences of dissociation, denial and paralysis, and difficulty reaching out for support, experienced by the research participants. Therefore, perhaps my experience was giving me insight into some of the challenges that victims of same-sex DA face in terms of reaching out for support. It might also be interesting to note that in my eight years of personal therapy, I barely talked about my abusive same-sex relationship, perhaps partly being in denial about its significance and dismissing it as something that didn't need talking about. Again, these potential parallel processes were something for me to hold lightly in mind when analysing and interpreting the participants' sense-making of their experience, ensuring to bracket my experience and observations as much as possible, in order to honour their unique experiences.

What helped immensely during these times of paralysis was my research supervisor *reaching out to me.* In June 2020, having collected all of my data, and feeling too paralysed to sit down and start the analysis, my supervisor contacted me, and we had

a meeting during which we once again explored my paralysis. He suggested leaving the data analysis for now, and instead starting with the reflexivity chapter, thereby leaning into my paralysis by writing about it. As a therapist, I know that facing a fear, or challenge, despite it being difficult, can bring some relief / catharsis, so this was an extremely powerful and motivating suggestion. In this instance, leaning into, accepting and acknowledging the paralysis, perhaps paradoxically, allowed for movement, evidenced by me typing this right now.

My research supervisor reaching out to me has been pivotal in helping me to engage with this project. His support has been containing, reparative, even healing. Perhaps feeling seen, empathised with, and held in mind by him enabled me to break the impasse, in a way that I hadn't been empathised with and acknowledged by my parents when they became aware of my abusive relationship. Below is an excerpt from my reflective journal, dated 28th October 2018, which sums up the powerful impact of my supervisor's support:

> "After supervision with Adam, I realised how supportive he is of me. It occurred to me that I am battling to engage with the research (in a way that I didn't engage with therapy when Sebastian beat me up, and I got no support to engage with psychotherapy services from mom). It is almost like I need a shove from Adam to engage with the material, in a way that it might have been useful to get a shove from someone like mom to engage with psychotherapy. Parallel process?"

Having explored some of the complex parallel processes at play during this research project, which have made it challenging to continue to engage with the data and get

to the analysis stage, yet have also borne potentially fruitful insights into the participants' experiences of DA, I now turn to an exploration of further personal contributors to my paralysis that have hindered my progress.

4.7.2 Further Barriers

Throughout my research journey, I have been confronted by a multitude of personal process challenges / barriers, some of which I have already discussed above. However, as I progressed, and the possibility of completing / succeeding became more real, the paralysis became more chronic, a situation partly alleviated when my research supervisor suggested that I lean into the paralysis and write about it.

Before I explore more of the issues that were highlighted in June 2020 when reflecting on my paralysis, it is worth noting that at first, I wasn't sure whether to include these reflections in this project, feeling that it wasn't directly relevant to the research, and being anxious about the research becoming all about me. This makes me wonder if I withhold, or bracket off, parts of myself, because they don't feel relevant, and whether this might have contributed to me not seeking support when I was in an abusive relationship.

4.7.2.1 Fear of Success / Failure

One of the main barriers I identified, beyond what I have explored above in terms of proactive and reactive countertransference, is fear of success and indeed, failure. In June 2020 I wrote:

> "As a child, I always wanted to be a "doctor" when I grew up, a doctorate being the pinnacle of "success" and achievement. I felt that I needed to excel in order

> to be loved. However, whilst striving for academic excellence, I was rebuked by mom for outshining “Johannes” (my far less academically “successful” brother). This was extremely confusing for me as a child, and I (unconsciously) adapted in order to please mom so as to retain her love, and to feel safe. The result was a double-bind, whereby I now walk a tightrope between success and failure, afraid of “shining” / succeeding, yet equally afraid of failing. This often manifests as self-sabotage when I feel that I am succeeding and might “outshine” others.”

Completing this doctorate necessarily involves me challenging my script about not being allowed to succeed, which is no easy task. Indeed, the more I noticed and acknowledged the struggle of my inner child, the more I needed to nurture that part of me, sometimes working with a stuffed toy dog next to my computer, holding a post-it saying, “You are allowed to succeed”.

4.7.2.2 Perfectionism

Whilst writing about my paralysis, I also realised that there were blockages due to my perfectionism: Never having done IPA research and data analysis before, I didn’t know how to do it perfectly and was scared of getting it wrong. Furthermore, in brief data analysis practice exercises in both a lecture and during a research workshop, I had no idea what I was doing when I attempted analysis, which felt scary and confusing. Despite having read *Interpretative Phenomenological Analysis: Theory, Method and Research* (Smith et al., 2009), which clearly outlines the IPA process of analysis, I still felt paralysed. To add to the complexity, I also realised that I was worried that the

interviews weren't perfect, imagining that I would have to do them all again, and so avoided immersing myself in them.

Once I was able to identify my lack of confidence and quest for perfectionism as barriers to progress, and with the aid of my research supervisor and personal therapy, I was increasingly able to remind myself of the Winnicottian notion of only needing to be "good enough" (Winnicott, 1965), and that perfection is an illusion. Furthermore, in qualitative research, everything is information to be analysed, interpreted, made sense of and reflected on, including what went well and what might have been done better.

4.7.2.3 Coronavirus

Yet another barrier that contributed to my paralysis was the emergence of the Coronavirus (Covid-19) pandemic in 2020, as it stoked my existential angst, anxiety and OCD and, combined with working with extremely anxious clients over Zoom, my mental energy levels were at an all-time low. I increasingly needed to practice what I preach around self-care, including regular exercise, and leaving my home for walks and fresh air.

4.7.2.4 Sudden Death

The last major factor (that I can identify) contributing to my paralysis was the sudden accidental death in December 2019 of Sebastian, the boyfriend with whom I had an abusive relationship when I was 21 years old. Not only did his death evoke old, conflicted feelings towards Sebastian, but stirred up questions about the binary, oft polarised societal discourse around the terms "victim" and "abuser". Sebastian's death and the conflicted grief that ensued, make me think of Karpman's "Drama Triangle"

(Karpman, 2014), which talks about the connection between personal responsibility and power in conflicts, and the destructive and shifting roles people play in terms of victim, oppressor and rescuer: Sebastian had been a victim and witness of DA in his childhood, as had my mother, *and* displayed oppressor / abuser behaviour. The implication of this complexity is that I wondered if there was a reluctance to look at the oppressor / abuser within myself, which could be contributing to my paralysis.

As I type, I feel a heaviness in my chest again, and it feels difficult to breathe. Considering the number of factors contributing to my paralysis, perhaps I can be kind to myself and not beat myself up about my paralysis. At the end of my written reflections in June 2020, I wrote:

> "It feels good to be able to write something today, and perhaps getting on with the research will be me being kind to myself. Do I feel less paralysed? Perhaps the mere fact that I am writing this is a positive indicator that the paralysis can shift, albeit not a linear process."

4.7.2.5 Implications for the Research

As a reflexive researcher, I have necessarily had to reflect on the impact of all of these personal challenges, struggles, and delays in engaging with the data, with years passing from the first interview, to the time I sat down to start analysing the transcripts. At some level, it feels that it could not have been any other way, with my therapist saying:

> "We need time and distance to come into contact with our stories, and it can take a long time."

My sense is that the months of disconnect from the participants' data was helpful because in some way, perhaps not consciously, I was processing and working through my own experience of DA. In doing so, I believe that I was more available and present to the unique experience of each participant, without perhaps projecting or getting caught up in my own proactive countertransference. I therefore think that the distance was necessary, and indeed aided the analysis phase of this project. When I returned to the data, which I shall describe shortly, the participants' stories still felt fresh: They were so impactful, that I felt like I was back in the interview room with them, in a positive way. Therefore, I cannot think of any negative impacts of having had so much distance.

Whilst a chapter on reflexivity might ordinarily mainly be focused on the participants, the fact that this section of my reflexivity chapter is so long, and so much about me, can be seen to be indicative and representative of the depth of my struggle as an insider researcher. The size of this chapter could be seen to parallel the gap between the interviews and the analysis. However, having discussed some of the personal barriers I have faced whilst on my research journey, and the impact on this project, I now turn to an exploration of my role as a researcher in analysing the data, with reflexivity in mind.

4.8 My Role as a Researcher in the Analysis and Writing Up

Having explored the plethora of challenges I have had in engaging with this research project, and how I struggled to even start the analysis phase, I now explore issues of reflexivity during the analysis and writing-up phase.

As suggested by my peers in my peer support group, I initially started engaging with and analysing the data by listening to the interviews whilst walking. This literally helped to keep me grounded whilst re-engaging with the material, which was very helpful. At this stage, I jotted down any impactful thoughts, noting any words or sense-making of the participant that stood out due to its energy, or emotional impact. As discussed in Chapter 3 on methodology, I then analysed the first transcript in line with my IPA methodology, sending part of it to my research supervisor in order to a) check that I was doing it correctly in line with IPA, and b) get a different viewpoint, to increase the trustworthiness of this project. My supervisor's response was:

> "If the question here is whether you're on the right tracks in terms of coding and commentary on the data then yes, I think this is looking really solid. I can really see some common themes starting to emerge here, as documented by your comments in the left-hand margin. Most importantly, there's real evidence of analysis of their responses – making sense of them – rather than just taking everything at face value. This component of interpretation is absolutely central to IPA, but is also the aspect that can make it more time consuming. From everything I've seen, it looks like you're doing well."

Considering my insecurity using IPA for the first time, this was very reassuring and encouraging. Analysis of the second and longest transcript, however, was somewhat more difficult, taking four months to analyse. There were a number of factors at play: Firstly, the content of the interview was again difficult to listen to, in and of it itself (reactive countertransference), whilst also evoking my personal experience of DA (proactive countertransference). As a result, I often got caught up in the minutiae, such

as punctuation. Distressed and feeling that I had squandered precious time when my research deadline was coming closer, I reached out to my supervisor, in floods of tears. He compassionately suggested that, as an insider researcher, I was doing the analysis in the *safest* way possible. I was then able to understand my preoccupation with punctuation as a quasi-avoidance coping mechanism, which helped to steer me away from the evocative material, feel more in control, and feel safe.

The meeting with my supervisor was the catalyst for me re-engaging with my personal therapy, in order to process my material, be able to actually analyse the data without dissociating, and to stay as present as possible to the unique sense-making of the participants. We also talked about me engaging with the analysis in a manageable and safe way, which might be just one or two hours, before having a break. However, due to time constraints, it was simply not viable to take so long to analyse each transcript so, honouring my struggle and factoring in self-care, my research supervisor and I agreed that I would derive themes from the first two interviews, and then hold those themes in mind whilst reading the remaining three transcripts, looking for recurrence of the existing themes, as well as other themes that I might not yet have encountered. Whilst this strategy was certainly more manageable, it might be viewed as being at odds with bracketing, and in keeping with the idiographic commitment of IPA (Smith et al., 2009). However, the extent to which true bracketing can ever be fully accomplished is, I believe, doubtful: After analysing a transcript, my “fore-structures” (Smith et al., 2009) would have in any case changed, thereby influencing what I subsequently read and analysed. What was paramount, however, was remaining curious and reflexive, so as to mitigate the impact of this strategy. With this transparency in mind, I believe that the trustworthiness of the study is not at risk.

Another anxiety I felt acutely was about interpreting / making sense of the sense-making of the participants, for fear of taking their voice away from them. However, I was comforted by what Smith et al. (2009) say about this: The resulting analysis in IPA is a product of the collaborative efforts of both the “I” / my interpretation, and the “P” / participants’ phenomenological sense-making of their experience in their own words. These words also helped to put me at ease during the write up, enabling me to go beyond the descriptive, to include my interpretations.

4.8.1 Me as a Therapist Researcher / Analyst

One of the challenges of analysing the data involved my position as a therapist. Because as a therapist, I am always looking for themes and patterns in clients’ experiences, I was concerned that I was not doing IPA correctly. For example, when I was trying to organise the themes, it sometimes felt that I had bypassed emergent themes and gone straight to a superordinate theme.

What I also noticed during the analysis phase was that I would have an exciting thought or observation, or highlight a certain powerful word used by a participant, only to realise that it was the next thing that I had reflected back to the participant during the actual interview. What I take from this is that, as a therapist, I was already analysing participants’ sense-making whilst the interview was taking place. Whilst this realisation felt positive and affirming, in that there was consistency in my thinking, I also wonder if there were other ways of interpreting the data that I might not have been seeing. That said, perhaps that is always going to be the case: The best we can do as researchers is to interpret the sense-making of another from our own frame of

reference, whilst owning and being transparent about that position, which is essentially the point of reflexivity.

Ultimately, self-care has been extremely important for the duration of this project, particularly due to my insider status: I have had to take care of my own mental health because of both reactive and proactive countertransferential phenomena, and very importantly, work through my own experiences of DA in order to stay present to the experiences and sense-making of the participants. As powerfully espoused by Smith et al. (2009):

> "If you start becoming more fascinated by yourself than the participant, then stop, take a break – and try again!" (p. 90)

For this important reason, I now turn to a brief exploration of the self-care and coping strategies that I employed during this project.

4.9 Self-Care / Coping Strategies

Whilst in the early stages of my research journey I anticipated the need for self-care throughout the research project, writing a brief paragraph about it in my research proposal, the reality was somewhat more profound, due to both the evocative nature of this area of research, and my own insider status.

I stopped therapy in December 2019, just as I was about to start analysing the interview data. Ending therapy when I possibly needed it most has flavours of self-

sabotage / self-abandonment, even denial, and proved to be extremely unhelpful, simply aiding my capacity for dissociation and avoidance.

After taking four months to analyse the second transcript, breaking down, and getting support from my supervisor, I re-engaged with therapy, focusing specifically on my experience of DA for what felt like the first time. My therapist and I collaboratively explored how painful it was for me, through the research, to come into contact with my own material, and that the research, whilst being about giving a voice to my research participants, was also about me ultimately working through and processing *my* experiences of DA, the severity of which I had denied for almost two decades, never having sought support to work through and process it. Ironically, I was engaging with therapy about my experience of DA, the exact thing that I had set out to research, *because* of what was coming up in the research.

As already touched on, my relationship with my supervisor, who has been supportive, flexible, containing, and encouraging throughout the project, has been fundamental, even more so at times of paralysis, and I wonder if I would have been able to get to where I did without his pastoral care. In addition to my research supervisor, earlier in the research, I arranged a regular support check-in with a peer, but we were not able to sustain it: We both kept disappearing / dissociating from our deeply personal research projects. In 2020, a renewed attempt to create a peer support structure with two colleagues was much more fruitful and on Monday mornings, the four of us met on Zoom to check-in, thereby providing a structure of accountability whilst being supported, held and motivated.

Other forms of self-care that I have used throughout this project include writing in my reflective journal, which has helped me to lean into and process difficult feelings, some of which I could then take to therapy. I have also exercised regularly, prioritised sleep, rest and relaxation, and made space to socialise with friends. These forms of self-care have been particularly important because I am also a psychotherapist, which can be very emotionally demanding.

4.10 Chapter Summary

In this extensive chapter, I have explored the importance of reflexivity in qualitative research, using examples from my experience as both an insider researcher and therapist researcher to illustrate the complexity of the role of a researcher, both at the interview stage of the research journey, and the analysis and write-up stage of the journey. In between these two stages, I detailed the vast number of challenges that I experienced whilst trying to remain engaged with this research project, some of which I held lightly as potential information about the experience of some of the participants.

Whilst I initially considered inserting reflexivity boxes in the results chapters of this thesis, in order to honour and reflect on my insider status, I decided against it, feeling that this chapter has explored my insider status enough, and not wanting to detract from the voices of the participants in the other chapters of this thesis. With that in mind, I now turn to the first of three results chapters of this research project.

CHAPTER 5: RESULTS I: SELF-WITH-SELF AND SELF-WITH-OTHER ORGANISATION

5.1 Introduction

One of the main challenges of this project has been to maintain focus specifically on my research question, which centres principally around victims' engagement with psychotherapy, as there were so many other areas of interest which came to light on their journeys to psychotherapy, which lend themselves to extensive research in and of themselves. For example, as mentioned in Chapter 4 on reflexivity, it was only after the first interview that I realised the importance of exploring participants' experiences and sense-making of the DA itself, as it helped to shed light on their struggle to *get to* the stage of engaging with therapy. It became clearer as I progressed with the interviews that there were *lots* of questions that I needed to explore before I got to the questions about their engagement with therapy, the importance of which became even more pronounced once I began analysing the data. This explains why the results are not solely focused on participants' engagement with therapy, instead being an exploration of their sense-making of essential stages on their often long and protracted journeys *to* the point at which they engage with therapy, as well as their sense-making of that engagement.

With this in mind, I shall present the findings by outlining and exploring the themes that emerged chronologically / at each stage of participants' journeys to access and engage with psychotherapy, and their experience of therapy itself. Presenting the data in this way felt like the most logical approach as it both parallels the trajectory of their journeys, highlighting the multitude of factors and challenges that impacted them on

their way to getting professional support for their trauma, and reflects the fact that many people make sense of their experiences through the telling of stories, which are largely chronological in nature.

5.2 Overview of findings

Originally, I presented the results in a table, including the three superordinate themes: “Self-with-Self”, “Self-with-Other” and “The Reparative Relationship”, which I shall explain further in the next paragraph. Whilst I had in mind that I would have a separate chapter for each theme, I came to realise that two of the superordinate themes (Self-with-Self and Self-with-Other) were horizontal in nature, in that they permeated all aspects of participants’ experiences on their journeys. Therefore, the approach I took was to weave them through all three results chapters, with the third superordinate theme (The Reparative Relationship) only being explored in the last results chapter.

In this first results chapter, I explore how participants’ relationships with themselves and their sexuality (Self-with-Self) in a heteronormative world (Self-with-Other), and their relationship with their families of origin (Self-with-Other), can predispose them to having lower self-esteem, focusing on the well-being of others before themselves, hiding their true selves, and potentially not turning to others for support / help at points where they may have benefitted from it.

In the second results chapter (Chapter 6), I explore the abuse participants experienced, and build on the superordinate themes by looking at how Self-with-Self and Self-with-Other organisation increases the likelihood of them minimising / dismissing / dissociating from / denying their relational experiences, thereby suffering

in silence. I explore their “road to realisation” that they are experiencing harm, an important “turning point” whereby some participants recognise that something needs to change, and that they might need support to help with that change.

In the third results chapter (Chapter 7), I explore participants’ experiences of accessing and engaging with therapy, continuing to hold the Self-with-Self and Self-with-Other themes in the frame, whilst introducing the third superordinate theme: The Reparative Relationship. That is, the relationship with one’s therapist has reparative potential, in that developing a relationship with a reliable / mirroring / trustworthy other can reconfigure the Self-With-Self and Self-With-Other organisation, thereby enabling participants to view themselves differently, relate to others differently, and be in the world differently.

As espoused by Smith et al. (2009), the data, largely presented in the form of transcript extracts, will be accompanied by my analytic interpretations of the data, whilst explicitly linking my findings to the main and three sub-questions of the research outlined in Chapter 2 Section 2.6.

5.3 Who Am I and Who Am I in Relation to Others?

Whilst two of the superordinate themes are Self-with-Self and Self-with-Other, these are not discrete units, as one’s relationship with oneself is indeed impacted and influenced by one’s relationship with others, and vice versa, in a complex dynamic of mutual influence. For example, one might have low self-esteem, and a poor relationship with oneself because of negative societal and familial narratives about one’s self-worth, and that low self-esteem then has an impact on how one is perceived

and responded to by others. Holding this complexity in mind, I now begin to flesh-out these themes.

5.3.1 Self-with-Self

As mentioned above, our relationship with ourselves (Self-with-Self) determines how we interact with the world and others. When asking participants to describe themselves as a person, four of five participants considered themselves to be empathetic, immediately bringing the other into focus, and highlighting a tendency to think about the well-being of others, at times over themselves:

> Charles: “I’m very loyal, passionate about my work and passionate about the things that I create, um, that I show, um, empathy and consideration for not only my friend and family, but also things like political problems and the environment.”

When asking how Andy would describe himself as a person:

> Andy: “Ok, erm, wow, er, kind, empathetic, um, sensitive, um, I think sometimes I feel I’m a little bit awkward in the world.”

Keith also used the word empathy, going on to highlight the pitfalls of empathy and putting the needs of others before oneself:

> Keith: “I’ve always been quite empathic, but also quite honest with that, so I was trying to put myself and think what it would be like for someone else. I see

> that was a really good trait, but I also see that is a very negative thing as well. because sometimes as part of that. are the things that I've gone through and that might be me possibly through my sexuality, coming out, family, past relationships, what I sometimes fail to do is not actually going with how do I feel about something, and I tend to worry about what it means for other people."

His focus on the well-being of others is emphasised when he talks about the stresses of hosting his birthday party:

> Keith: "I'm more concerned about people who are coming: Are they going to have a good time?"

Whilst Harry did not describe himself as empathetic at the beginning of the interview, whilst describing the abuse that he experienced in his relationship, he said that:

> Harry: "I over-empathise with people, so I was constantly making excuses for him and his psychological make-up."

Andy alludes to the potential danger of being sensitive and concerned about the well-being of the other over himself:

> Andy: "There's that very sensitive, caring part of me, and that part of me is the easier part to be taken advantage of."

Reflecting on the above quotes from Keith, Harry and Andy, it seems that being caring, sensitive and empathetic meant focusing more on the needs and well-being of the

other, than oneself. Such empathy, and the focus on others, is admirable and can be a foundation for loving and caring relationships but, in the context of this study and the criteria for participation, might also reflect a world where they can be manipulated and taken advantage of, or could indeed facilitate a vulnerability and a tendency to explain away another's behaviour, even when the behaviour is abusive. That is, these attributes may predispose one to minimising the harmful behaviour of an abusive partner by not acknowledging the impact of the harmful behaviour on oneself. This is significant as it might translate to staying in an abusive relationship, without seeking support, professional or otherwise.

With this in mind, I now turn to an exploration of participants' relationship with their sexuality, important because it too gives insight into their Self-with-Self (including self-esteem) and Self-With-Other organisation, and can help to explain some of the struggles they experienced in recognising and acknowledging the harm they were experiencing in their abusive relationships, and the challenges in reaching out for support.

5.3.1.1 Self with Gay Self

Understanding how participants made sense of their relationship with their sexuality / "gay self", and the implication for their Self-With-Self and Self-With-Other organisation, including self-esteem, added another layer of complexity to some of the challenges they experienced in their abusive relationships. I asked all participants how they felt about being gay.

Charles described himself as having a largely positive experience of being gay, including when he “came out”:

> Charles: “I really love being gay. I love gay culture. I feel that I’ve been very privileged in that nearly everyone, when I was younger and I came out at 17, nearly everyone was fine with it. I only had a small percentage that was perhaps not as accepting but then over time, they’ve become accepting of it.”

Charles felt “privileged” that “nearly everyone was fine with it” when he “came out”, meaning that some people were not fine with it / accepting of him and his gayness, or he was at least conscious that they might not be. This seems to give a lot of power to others to decide whether we as gay men are acceptable or not. Whilst we shouldn’t have to feel privileged for largely being accepted for who we are**,** the implication of Charles’ comments is that some gay men may start on the back foot with low self-esteem, preoccupied with their acceptability to others, and potentially “hiding” the shameful parts of themselves from others. If I have low self-esteem, I might minimise my experience in an abusive relationship.

Furthermore, not feeling acceptable to others might make us question ourselves. Whilst Harry, for example, never questioned his sexuality *per se*, over time he came to realise that he harboured negative views about homosexuality in general:

> Harry: “I’ve certainly never had any questions about my sexuality, I’ve always been gay. I can tell you the exact moment that I knew there was something different about me, and I was like three years old at a grocery store. I remember that exact moment. And I’ve never been interested in women, I’ve never

> questioned that about myself, and I never really had an official “coming-out” party because of that.”

However, whilst reflecting on his relationship with his sexuality, he said:

> Harry: “In the past, I always thought that I felt fine about it. In the last few years, I’ve come to realise that I was probably, as comfortable as I thought I was, relatively homophobic, to be quite frank. I don’t even know that I was aware I was like that.”

Harry highlights “internalised homophobia”, defined in the literature review as “the direction and societal negative attitudes towards the self” (Meyer, 1995, p. 40), something that happens when we take the biases, prejudices and hatred towards gay men that are reinforced by a heteronormative society and turn them on ourselves (Chard et al., 2015). Internalised homophobia can manifest in self-hatred, shame, fear, anxiety and depression, therefore having a significant impact on gay men's self-esteem and mental health.

The challenges of being gay in a predominantly heterosexual world are more apparent in the words of other participants, a troubling indictment of the struggle to be seen and accepted that many gay men experience. Below, Peter highlights how his positive relationship with his gay self does not translate to his relationship with others, succinctly highlighting the inter-relational / Self-With-Other struggles with his gayness:

> Peter: “I’m really, really comfortable I, I think it’s an amazing thing, and I’m really happy with it, er, yeah, but I think the problems have been with other people, or

> relationships, or everyone else, but it's the best things that's happened to me, or it's the best thing about me, kind of thing. And there's lots of fun parts about being gay, you know like going out, meeting guys, and all those nice things, and lots of positive sides to it of course, so yeah, I'm really comfortable with it. I've known since I was at school, er, and I've not really, er, I mean, I've not really struggled with accepting myself, the struggle has been with other people I think."

Similarly, Andy came out when he was 16, having known he was gay from around the age of 6, and it took him a long time to be comfortable being gay. However, He goes on to describes the ongoing challenge of being gay, both "internally" and from "an external place":

> Andy: "Even now I feel, er, most, most of the time, I feel ok being Andy in the world, um, but there's moments when I catch myself, so if I'm walking down the street and kind of, I'm married, so if I'm holding my husband's hand then I can still feel that kind of homophobia I guess internally but also from an external place as well. So, the world at times can still feel, as a gay person, can still feel quite a scary place, especially when someone like a stranger, shouts some kind of homophobic comment at you. It's a really complex process, so I think, yeah, at the level that I'm comfortable with being gay but then there's a whole external part that I have to or, choose to, navigate in some way that's more challenging than others."

The words "coming out" bring to light the idea of having to hide one's shameful true self, something that many gay men become adept at doing, and perhaps also

reinforces the shame and stigma that some can feel in being a victim of DA. Andy's word "scary" emphasises the risk to one's personal sense of safety of being seen for who one is, in the simple act of holding his husband's hand, and the potential shame involved in doing so, something most heterosexual people are unlikely to have to consider when going about their daily business. Andy's powerful sense-making of a homophobic experience he had powerfully addresses them head-on:

> Andy: "When a stranger shouts a homophobic comment at you, then I have this whole battle, like, should I turn around and say something and challenge it, or do I have to look after my own safety."

Andy's conundrum highlights how gay men can become adept at / accustomed to hiding in order to protect themselves and feel safe. In doing so, they lose their voice, and suffer in silence, whilst abuse goes unchecked and unchallenged. Does this predispose gay men to absorbing abuse from others, and concealing / hiding shameful experiences? Might an internalised script of a gay man be, "Keep yourself safe by keeping your experiences to yourself. Don't talk about who you really are. Don't tell people". I explore these questions, including the impact of minority stress, in the discussion in Chapter 8.

The participants' sense-making of their relationship with their sexuality / gay identity highlights how feelings of shame, and the need for secrecy, do not originate in a vacuum, and are inevitably informed by interactions with others. I therefore now turn to an exploration of participants' relationships with their family of origin.

5.3.2 Self-with-Other in Family of Origin

As can already be seen, one's relationship with oneself is inextricably linked to one's relationship with others. All participants experienced difficulties in their families of origin with all five participants hiding their sexuality / gay identity from their families for some time.

As a result of the trauma associated with disclosing his sexuality and the ensuing rejection from his family, Andy left home as soon as he could, cutting contact with his parents:

> Andy: "I was still struggling with my sexuality, erm, coming to terms with my, so I ran away from home when I was 15, um, because I struggled to come out to my parents."

It seems that it was so hard for Andy to talk about himself authentically, and trust that he would be seen and accepted for who he was by his parents, that he literally ran away, thereby "hiding" himself from them. Whilst this is a physical act, I explore what this might look like psychologically in Section 6.3.1 of the next chapter: dissociation, dismissing and denial of one's reality.

The sense of hiding, or fearing the consequences of disclosure, could be especially amplified for people from multicultural backgrounds where pervasive expectations about normative masculine practice may be commonplace. Keith talked about the challenge of being the youngest of six siblings in a Muslim family:

> Keith: “I guess from a very young age you’re very much, and being the youngest out of six, it’s been built in you, you know, you are going to get married to a woman, you’re going to have kids, and in terms of the culture side of it, for me and mine was, the parents always live with the youngest son after he’s got married and had kids and that kind of stuff. You are telling yourself that being gay is not okay because you’re having all these messages, or I got all these messages say, going to the mosque, this is man and woman, this is abnormal, and actually around me there was nobody that I could kind of have as a role model, or think it’s okay, actually everything is a negative. I fell into the “good boy” trap and was only a good child because I supressed everything because I’m a disappointment.”

When Keith did take the “risk” of showing his true gay self, and came out to his family, “it didn’t go down well” and, like Andy, he lost contact with his parents:

> Keith: “When it got to the point where I came out and it didn’t go down well, I did have to leave home, I had no connection with my family for years, but even then, there was a mental struggle with it because even though I was on my own, I was still being making sure as I wasn’t trying to do things not to disappoint my parents.”

When after four or five years, Keith got back in contact with his parents, his life as a gay man still wasn’t spoken about:

> Keith: “I wouldn’t be talking about my boyfriends, I wouldn’t mention the names of whoever I was seeing, and it was okay but there was never anything talked about.”

Keith’s painful sense-making of his experience highlights the sense of isolation that many gay people experience within their culture and families, repeatedly being bombarded with heteronormative societal discourse that communicates that they are not acceptable, that they are a disappointment, and that they need to hide their “true selves”. Keith also brings into the frame the importance of having a “role model”, which links to the psychological concept of “mirroring”, a type of transference whereby as children, others (generally our parents) serve as a mirror that reflects back a sense of self-worth and value, making us feel recognised and accepted (Kohut, 1971). The detrimental impact of not being mirrored / not having role models in a heteronormative world, on gay men’s Self-with-Self and Self-with-Other configuration, including their self-esteem and confidence, will be explored further in the discussion in Chapter 8.

Our family of origin relationships are very significant as they strongly inform our relational dynamics, including our capacity to be our true selves; to be in touch with our needs; to be able to express / communicate those needs and to establish healthy boundaries. However, two participants labelled their experience with their family as DA. Peter’s abuse was as a direct result of his gay identity, which he had been hiding, only to be inadvertently “found out”. The abuse was such that he had to seek safe haven in a refuge:

> Peter: “I’ve had domestic abuse with partners but also with my family. So, when I was about 23 or something my family sort of, I think they sort of found out. I

went to a bar in Leicester, a gay bar, and one of my brother's friends saw me going in so he told my brother, and then the domestic abuse started. So, I didn't know at that point that they were being abusive towards me, and then as a result of that I started experiencing domestic abuse, and then that resulted in me going to a refuge."

When I asked Harry about the DA he had experienced, the first thing he said was:

Harry: "I grew up in a house with a lot of domestic abuse. My family was very dysfunctional, and I had separated myself at 18 **[years old]** from that dysfunction."

This comment linked to something he said earlier in the interview, when I asked him about his relationship with his gay identity:

Harry: "I had a shitty family history."

When I asked Harry about his partner's rages, he answered:

Harry: "My mother was very likely, I believe, she had something called borderline personality disorder, that is really what I think she had, so I was used to a, a, a situation, it wasn't, I didn't always see it as negative." **[He then explains how he "over-empathised" with his partner when he was pushed down the stairs]**

Harry's comment about not seeing abusive behaviour as "negative" therefore potentially sets the scene for abusive behaviour being minimised or explained away as "normal". Furthermore, at a deeper unconscious psychological level, he might not "expect" that a relationship could be different / other than "shitty".

Participants' experience of abuse in their family of origin is significant for two interlinked reasons, which I shall name here, and unpack further in the discussion in Chapter 8:

> Freud's "repetition compulsion" (1923) is such that we tend to repeat the same familiar relational patterns, often unconsciously, throughout life in the hope (again unconsciously) for a different outcome. That is, unless we actively take steps to lean into our phenomenological reality, learn about ourselves and do something differently. The plasticity of our brains, and therefore our capacity to change, is scientifically proven by the latest developments in neuroscience. If we grow up in an abusive environment, these relational dynamics are very likely to repeat: People who have grown up in homes with DA can be more likely to be both a perpetrator and a victim in later life.
>
> The other implication of childhood experiences of DA being familiar, even "normal", is that we might not necessarily be able to identify abusive relational dynamics as problematic / abusive when we experience them in other relational contexts. Furthermore, as humans, there can be comfort and safety in the familiar, even if the familiar is painful / abusive.

The impact of these two factors means that victims of abuse might unconsciously remain in intimate relationships characterised by DA for longer, because if their experience is their norm, and they are psychologically hooked into it, why would they think it is harmful / abusive, or that they need help or support? Furthermore, even if they did identify their experience as harmful or abusive, having learned to hide shameful things, and not having learned to trust others to support them, particularly when vulnerable, might preclude reaching out for support. That is, their formative experiences with their families of origin might mean that seeking support is counter-intuitive.

5.4 Chapter Summary

In this chapter, I have shown how Self-with-Self and Self-with-Other factors appeared to set the scene, or shape an environment or a mindset where participants might perceive or respond to abuse in complex ways. Some participants had poor relationships with themselves, including low self-esteem and a tendency to focus on the needs of others over their own, as well as shame for who they are, growing up in a sometimes-hostile heteronormative world in general, and sometimes also having been othered or abused in their family of origin, thereby not being mirrored, validated and accepted by an other for who they are. Through shame, some participants learned to hide. Sometimes, through the familiarity of being with a hostile / abusive / invalidating other, their relational pattern was unconsciously repeated in their intimate partner relationships.

With this in mind, I now turn to the participants' experiences of abuse with intimate partners, and how their road to realisation can lead to a turning point, the point at which

they realise that something needs to change. I explore the role of an other at this turning point, and how the turning point doesn't necessarily translate into seeking or engaging with professional support such as therapy.

CHAPTER 6: RESULTS II: THE ABUSED SELF, THE ROAD TO REALISATION, THE TURNING POINT AND THE ROLE OF AN OTHER

6.1 Introduction

Holding in mind participants' Self-with-Self and Self-with-Other sense making, explored in Results I, I now turn to the abuse participants experienced with intimate partners, and build on the superordinate themes by looking at how Self-with-Self and Self-with-Other organisation can shape the experience of them minimising, dismissing, dissociating from and / or denying their relational experiences, thereby potentially making it more challenging to identify their experiences as harmful, and increasing the possibility of them suffering in silence. In doing so, I explore their road to the realisation that they are experiencing harm, and the extremely significant turning point whereby some participants recognise that something needs to change, and that they might need support to help with that change. I would also like to emphasise that I am exploring the experience of participants, and the themes that emerged, in line with their general trajectory, and that naming their experience as DA only came later on their journey.

6.2 The Abused Self

After asking participants in the interviews how they would describe themselves as a person, and how they felt about being gay, the analysis of which unfolded and contributed to the superordinate themes of Self-with-Self and Self-with-Other, I asked them for a brief history of their experience of DA. In the sections that follow, I provide an account – in broadly descriptive terms – of their experiences of different forms of abuse, and the contexts in which this abuse occurred. In asking questions relating to

these experiences in the interview, my aim was not necessarily to examine the sense-making process but rather to provide an “experiential hook”. By this I mean a broad account of their experience without attending to meaning, similar to a descriptive phenomenology (Husserl, 1927) so that I and the reader of this thesis have a baseline understanding of the context of abuse, which can better enable understanding of the ways in which I subsequently sought to make sense of them making sense of their experience of recognising their abuse and engaging with professional support.

6.2.1 The Context of Abusive Same-Sex Relationships

Further to what I have said above, participants’ sense-making of their experiences of the DA itself were not the focal point of my research, but valuable accounts still emerged. Briefly, therefore, of the five participants, only Harry had been in more than one abusive same-sex relationship. Because he said he left his first relationship “pretty quickly”, as his abusive partner had “a drinking problem”, the interview focused on the second of his abusive relationships, which lead him to therapy. Charles, Andy and Keith experienced abuse in their first same-sex relationships (Charles and Andy when they were very young), with the abuse escalating to serious physical harm with all three participants. At the time of the interview, Charles, Andy and Keith described themselves to be in what I understood to be healthy relationships, with Peter and Harry describing themselves as single.

6.2.2 Types of Abuse

Participants described at length the diverse types of harm they experienced in their abusive relationships, which included non-physical types of abuse such as psychological / emotional abuse and coercive control, which involves a range of tactics

intended to humiliate, degrade, exploit, isolate and control (Stark, 2009), as well as types of physical and sexual abuse. All participants suffered more than one type of abuse within the same relationship, often frequently, and sometimes concurrently. As mentioned above, I now describe the abuse that participants experienced, in their own words, and offer some of my sense-making interpretations.

6.2.2.1 Psychological / Emotional Abuse and Coercive Control

All five participants experienced what I consider to be psychological / emotional abuse and coercive control. Charles talks about how abusive relationships can be fine, at first, with no indication that they will become problematic, before going on to describe how the abuse can start with “little comments” and “manipulation”, before becoming physical at a later stage:

> Charles: “I met my partner at the time in April, August, April but for a few months it was fine, and then at Christmas it started to get a bit ah, ah, odd. He would start ignoring me or making little comments or not really being as loving towards me, manipulation started to occur, I think mind games started to occur much more, eh, early on than the physicality ever did.”

Keith also uses the word “little” to describe some of the early relational transgressions:

> Keith: “But it also started happening where things have been monitored in terms of, I was coming home, what time I was coming home, and it was little things like, “Well it only takes you ten minutes to go from your job, you know you have

been slightly longer", and then those are the kind of things that started kind of happening."

Charles and Keith's use of the word "little" might illustrate how abuse often begins with more subtle forms of psychological / emotional and coercive control that can easily be minimised or dismissed. Charles' describes how research he did into DA mirrored his sense-making of his own experience, where they "break you down" as a precursor to potential escalation to physical abuse.

> Charles: "From my experience and a lot of the research, I discovered it always starts as the mental. They break you down, then the physical stuff starts, if it starts, sometimes it doesn't."

Peter, like Keith in the above quote, began to be asked questions about his whereabouts, another example of psychological / emotional abuse and coercive control.

> Peter: "He was really horrible and was asking me loads of questions about where I was and what I was up to."

Similarly, Andy's partner's psychological / emotional abuse and coercive control meant that he felt guilty when his friends contacted him:

> Andy: "There was also this whole, um, contact with my previous kind of friends, and like if they text me or something then that would start a whole argument and it would be, um, like, if you or clearly you want to have a relationship with

them, and not with me, so I would be made to feel guilty for having my friends contact me."

In abusive relationships, psychological / emotional abuse and coercive control is often used to isolate partners from their friends and family, as a way of consolidating control over them by separating them from their support networks. The implication is that victims might not have anyone with whom to reality check their experiences, even if they were to share them with someone else. Harry also reflects on this aspect of his relationship:

Harry: "He was very good at isolating me from my friends, and he tried to isolate me from my family. It is still funny when you look back in retrospect and you think, "Wow, how did I not see that?". It was just crazy."

Harry's boyfriend wasn't able to isolate him from his family, the importance of which I shall highlight below. However, his sense-making shows how difficult it can be to identify abusive behaviour as such at the time of its occurrence, and how it can become clearer with distance.

Manifestations of psychological / emotional abuse and coercive control are extensive and diverse. When I asked Peter to elaborate on the types of abuse he experienced, he said:

Peter: "Yeah, so if I want to do certain things, then he would be nasty towards me and he'd be quite, he was quite a tall guy, and he was quite strong, so he'd, there was an element, he didn't attack me physically but he'd sort of

> pounce on me sort of thing, and he'd be, lots of nasty racist comments, and this went on for about six months, and once he asked me to come out to a bar, and I said no and he started making really horrible racist remarks **[towards and about Peter]**."

Whilst Peter names the psychological / emotional abuse (the guy's nastiness and horrible racist remarks towards him), he seems reluctant to name being pounced on by a strong, tall guy as a physical attack. It might be that he was minimising the impact of this physical act, or reluctant to name it as abuse. Nevertheless, the implication of the diverse nature of psychological / emotional abuse and coercive control, and the potential greyness of some types of physical abuse, as seen by Peter's experience, is that it might be difficult to recognise as harmful, or abusive, which I explore later in this chapter. For now, I turn to further exploration of participants' experiences of physical abuse.

6.2.2.2 Physical Abuse

Three participants experienced repeated instances of physical abuse within their relationships. Keith described the first time his partner became physical with him, after returning home drunk:

> Keith: "He just pushed me onto the bed, and that was shocking to me, and I was just like, I just went quiet."

Keith went quiet because of the shock of being pushed onto the bed, seemingly confused about how to make sense of what he had just experienced. Whilst Keith's

partner subsequently broke up with him, they were still living together, and the physical abuse escalated:

> Keith: “My ex was in the kitchen chopping up vegetables and stuff like that and I just said we need to talk about stuff, about you know what’s going to happen, and he just got the knife and just went, and just literally went, “I don’t wanna talk about it”, and literally just did that **[cut his arm]**, and I was literally just bleeding.”

Charles also describes when the abuse started to become physical:

> Charles: “And then it started to get physical where he would pin me down on the bed and he would dig his nails into my wrists, and like you’d see the marks and they’d all be cut up. Or we perhaps would be lying in bed, I remember a couple of times I was reading or on my phone and he would be smoking, because at the time we both smoked, and then he’d lean his arm close to me, and he’d get the cigarette end closer to me, and then he’d just stub the cigarette end onto my hands. He did that a few times.”

When I asked Charles how this had felt for him, and how he had made sense of it, he seemed “nonchalant”, saying that there were lots of other things that had happened in the relationship and described how he had “turned to drugs as a crutch”. He added that because it had happened so long ago, he felt emotionally detached from the experience.

Harry describes and makes sense of his partner pushing him down the stairs:

> Harry: “He was upset about something and he pushed me down a flight of stairs. I remember telling my sister about it saying, “He had things happen to him when he was a child”, and my sister was upset: I think I over-empathise with people, so I was constantly making excuses for him based on his psychological make-up. I remember my sister saying, “Are you kidding me? That’s great, that’s wonderful that you can look at it like that, but at the end of the day he is an arsehole. Who cares why he is being an arsehole? What are you doing there with this guy?””

Harry explains how empathising with others can translate into minimising, or not recognising, abusive behaviour as such, and how important it can be to have other people in one’s life, such as his sister in this instance, who I believe can in essence reality check one’s experience. Isolating victims from their support network can remove this vital capacity to reality check one’s experience, and recognise behaviour as harmful, unacceptable, and abusive.

Like Peter’s experience of being pushed on the bed which I described above, Harry’s experience of being pushed down the stairs could also be seen to illustrate how even physical abuse can be confusing, minimised / dismissed / explained away.

6.2.2.3 Sexual Abuse

Only Andy experienced sexual abuse in his relationship, specifically naming that he was raped, and including the “emotional side”: Being “controlled” and “manipulated”:

> Andy: “I was raped and abused, sexually during that period, but also there’s that kind of emotional side of how I was manipulated, controlled, you know, those kinds of things.”

Andy’s quote exemplifies the fact that types of abuse are not discrete, often co-existing within abusive relationships and his words, “you know, those kinds of things” might be indicative of him dismissing what had become normal, typical experiences for him. I shall explore the powerful impact of Andy’s rape later. For now, however, I turn to some of the factors that hindered participants’ ability to recognise their experience as harmful, already alluded to in words such as “little” in the above quotes, a significant word as it points to potential minimising and / or dismissing in the sense-making process.

6.3 Recognising the Harm to Self

Recognising their experiences as harmful to self was pivotal on the road to realisation to the turning point, where participants realised that they needed to get out of the abusive relationship and might need support both to do so, and to process their experience with a professional. A multitude of factors hindered participants’ ability to recognise what they were experiencing as harmful. In the first results chapter (Chapter 5), I explored the impact that the familiarity of abuse in gay men’s families of origin had on their Self-with-Self and Self-with-Other organisation, increasing the likelihood of abusive behaviour being seen as normal, thereby stymying the recognition of the harm to themselves. Additionally, some participants’ traumatic experiences with their gay self (Self-with-Self), explored previously, had a significant impact on their self-esteem, also contributing to a sense of them minimising their experiences, and hiding

vulnerable parts of themselves due to shame. Further barriers to identifying their experience as harmful involved the potentially pernicious nature of DA in general, whereby some victims appeared almost like “frogs in slowly boiling water”, constantly adapting to psychological / emotional abuse and coercive control (which can be easier to minimise and dismiss) whilst it slowly escalated to physical abuse.

Minimising the experience of the self can take several forms, for several different reasons, the impact being that the harm isn’t necessarily recognised as such, and steps aren’t taken to seek external support. Whilst a few examples of participants minimising their experience have already been explored above, I now turn to a brief exploration of further examples of participants’ minimising the experience of the self, largely in the form of seemingly unconscious coping strategies employed in order to cope in traumatic circumstances / whilst still within their abusive relationships in a heteronormative world, which may have hindered their ability to name their experiences as harmful.

6.3.1 Leaving the Self

Dissociation is a complex psychophysiological process that alters the accessibility of memory and knowledge, integration of behaviour, and sense of self (Putnam, 1994), essentially a form of self-protection / way of coping with traumatic experiences that can also be seen as detaching from, or leaving the self, particularly when feeling overwhelmed.

Andy talks about the normalisation of the abuse, with him becoming “dissociated” from what he was going through:

> Andy: “And there was a level of normalisation around it **[the abuse]**, um, so in the end it became quite mechanical, and I dissociated from what I was going through.”

It seems that Andy became so adept at denial / suppressing his experience, that it was only many years after he had left his abusive relationship, and was in therapy, that he “couldn’t deny it any longer”, and was able to talk about his experience:

> Andy: “I couldn’t hold it, I, I couldn’t, I had held it for so long, and I couldn’t, um, I guess I couldn’t deny it any longer. I denied that it ever happened and didn’t, tried not to think about it, um, but things like not sleeping properly, dreams, you know, all of the stuff that we started to work through, it became apparent that, that I couldn’t push it down any longer, but I would need to tell her, um or maybe share what happened to me.”

Below, Keith powerfully illustrates another form of dismissing, or denying the experience of the self, confusing the controlling behaviour of his partner for “someone who was caring”. After his partner started monitoring how long it was taking for him to come home after work, he made sense of it in this way:

> Keith: “Then suddenly I kind of felt, for me, that was, that it was someone who was caring, because he was worried about **[me]**, and so for me even at that time I thought this was a really caring thing.”

Keith’s experience seems to show how psychological / emotional abuse and coercive control can be dismissed or misunderstood, with both Andy and Keith’s experiences

highlighting how coping strategies such as dissociation and denial, whilst helping victims of abuse to feel safe at one level, also decrease the likelihood that they will identify their experience as harmful, and reach out for support, thereby potentially staying in their abusive relationships and suffering in silence for longer, whilst the abuse escalates.

6.3.2 Equating the Harm with Domestic Abuse

Being able to identify their experience as harmful was difficult in and of itself, for the above reasons, yet even when the harm was recognised, it wasn't equated with DA, with all five participants only naming it as DA once in therapy, in two cases, years later.

In the below quote, Andy succinctly makes sense of some of the challenges of recognising the harm he experienced as DA, not only having come to the realisation that he had been separating sexual violence from DA, but also noting his assumptions that DA involves a female victim:

> Andy: "I work in sexual violence, um, and I'd kind of separated the two because we do separate domestic violence from sexual violence and so for me the automatic assumption is some kind of physical or emotional or violence and separated out from that is the sexual violence. The other assumption for me which is really interesting, is a male / female perspective of things and again that kind of cultural perception of you know I'm aware and reflect but there's still the assumption there of a man and a woman, the woman being the victim and the man being the perpetrator. So, I think even though I'm aware of that

> consciously there's always a kind of automatic assumption that does get made in some say, and that I have to challenge myself around, hold the other."

Keith also describes how he had thought of DA as something that only happens between a man and a woman, therefore only realising that his experience was DA once in therapy:

> Keith: "**[The therapy]** really helped me to understand that what I was feeling was normal, and something I could get help for; that this does happen in gay relationships, it **[domestic abuse]** is not just a man or a woman thing."

When I asked Andy when he came to realise that what he was experiencing was DA, he said that it only happened once he had started therapy as a trainee psychotherapist, ten years after he left his abusive relationship:

> Andy: "...and really the first time I really became aware it was domestic abuse was when I started therapy: It took that external place to say that this was domestic abuse."

Andy and Keith's experiences and sense-making highlight the dominant societal heteronormative narrative around DA being between a man and a woman, which it largely is, but sometimes it seems to be to the exclusion of other relational configurations. It seems that for my participants, heteronormative DA narratives made it harder for them to name their experience as such at the time of it happening, which may have shaped their ability to recognise the harm and reach out for support, thereby

suffering in silence for longer. I shall unpack this further in the discussion in Chapter 8.

Having explored some of the barriers to recognising their experiences as harmful, I now turn to what *did* help participants recognise the harm they were experiencing, and arrive at a turning point, at which they decided that something needed to change.

6.4 The Turning Point

The turning point is complex in that recognising and acknowledging the harm they were experiencing, and that something needed to change / they needed to leave the relationship, didn't necessarily mean that they recognised the harm as domestic abuse (as discussed above) and, whilst it was an important catalyst for some participants to get the support that they needed in order to escape their relationships, this didn't always translate into them engaging with professional support. Indeed, not one participant reported thinking words to the effect of, "Oh, I am experiencing domestic abuse, and need to get professional support". This is rather illuminating because, if I hold my research question in mind, no participants were motivated to seek or engage with therapy, given their experience of DA, of their own volition. The reasons for this will be examined in later sections and in the next chapter. I now turn to an exploration of how participants arrived at the turning point, and how they ended up exploring their experiences of DA in therapy.

Notably, three of the five participants experienced what I can only describe as horrific physically abusive experiences in order to reach the turning point at which they knew that something needed to change, and the priority became how to leave the abusive

relationship. All three participants were living with their partners, so leaving had further complexity. Andy's rape consolidated his growing sense of not wanting to "do this" anymore:

> Andy: "I was in bed and this guy came, he came in and I was lying on my front, and, eh, and he fucked me, and, um came inside me, and I knew, and then just left, and I was so…I felt so used, and so dirty, and then kind of had the thought that, that I just don't want to do this anymore…um...so that was a real, that was a real kind of first feeling, that feeling of being used in that way, that then led to, this isn't, it's not, this isn't right but I just don't want to do this anymore, and that *need* to get away from it or get out of it. Um, and then, I guess, I hit that kind of wall of how do I do this, and what do I do, and it went into some kind of plan of, how do I get out of this."

Later in the interview, Andy emphasised that:

> Andy: "That experience **[the rape]** resulted in my planning to escape."

Similarly, Charles reached a turning point after experiencing extreme physical abuse, and ending up in hospital after having an overdose:

> Charles: "We got into a heated argument, long story short he ended up smashing my head into a brick wall and I had to have reconstructive surgery on the side of my ear. So, I went into hospital and I had plastic surgery done on my ear and I unfortunately as a result delved into drugs a little bit too heavily and I overdosed in the morning. And my friend kindly found me and took me to

hospital where I was OD-ing and er, I contacted my parents and said I'm in problem, I'm having a problem, this person has destroyed my life, I've got a drug problem as a result of it all, I need some help."

After Keith's drunk partner slapped him across the face after getting home from a night out, the pain propelled him to visit a doctor the next day. After being told that his jaw had been dislocated, he started to realise that something wasn't right in his relationship:

Keith: "That's when I was just like, okay, something needs to, this isn't good, and at that point that's when I got home and I kind of started seeing things slightly differently."

It seems that it isn't a coincidence that incidents of extreme physical and sexual abuse experienced by participants lead to a turning point, perhaps because physical abuse is more tangible and visible, and therefore perhaps harder to minimise, deny or hide than psychological / emotional abuse. Charles emphasises the pernicious nature of mental abuse, which can remain hidden from self and others, as opposed to the visual signs of physical abuse:

Charles: "It's harder for people to see the mental stuff because there isn't a bruise on someone's face or a broken arm. I think that was why I was able to hide it from friends and family for so long because a lot of it was mental, um, which engenders the most awful feeling of isolation, you know, there is just, you feel detached from your friends and family, and you feel you can't approach anyone about it, or that you feel that because of the mind games

you're the one that's in the wrong and you shouldn't be talking about it because there is nothing wrong."

Charles highlights how psychological / emotional abuse can be hidden, hiding shameful things being an important part of many gay men's Self-with-Self and Self-with-Other configuration.

The other two participants, Harry and Peter, had turning points with a very different flavour, which I explore below in Section 6.5.3 and Section 6.5.4 respectively. Having looked at some of the experiences that lead to a turning point for some of the participants, I now turn to the role of an other in supporting the participants at the turning point, whilst holding in mind the themes of Self-with-Self and Self-with-Other.

6.5 The Role of an Other

To emphasise a point I made above, no participants actively and directly sought professional forms of support, such as therapy at the time of their turning point – the time when they realised that something needed to change and that they needed to escape. Because the abuse had escalated to such a crescendo, perhaps the priority was their safety / escaping the abusive relationship. Being able to recognise their experience as DA earlier, before the abuse spiralled to such an extent, might have added gravity to their experience, and propelled them to engage with professional support to make sense of and process their experience.

I now look at the role of an other once participants reached the turning point, the impact of the other's intervention having different nuance for all participants. For two participants (Keith and Charles), the other acted as facilitator, or bridge into therapy,

specifically to address the abuse they were experiencing at the time they were experiencing it. For Andy, the other acted as facilitators to help him to slowly leave the abusive relationship, but he didn't address the DA with a professional until ten years later when he was in therapy as a trainee psychotherapist.

6.5.1 The Role of Parents

Having reached a turning point, the first port of call for two participants (Charles and Andy) was their parents. As explored above, Charles' overdose and ending up in hospital resulted in him reaching out to his parents, telling them that he had "a problem" and, "I need some help". He described being "rock bottom", thereby admitting / validating the seriousness of his situation, and no longer minimising his experience, to both his parents and himself. It seems that he might have had to get to "rock bottom" in order to allow himself to ask for help. His mother helped him to start moving out of the house he shared with his abusive partner, and contacted the counselling service:

> Charles: "My mother contacted a counselling, a very good counselling service, and said I'd just have an overdose, and I then started a 22-week trauma counselling service."

Importantly, Charles might not have gone to therapy were it not for his mother's intervention when he ended up in hospital:

> Charles: "I don't think I would have gone to counselling if it weren't for my mum making the initial appointment. The biggest barrier **[to counselling]** was me. For a long time, I think my mum, my mum had mentioned maybe I needed to see a therapist, before she knew how bad it really was, because my parents

didn't know how bad it really was until I was in hospital, when I explained to them what was really happening. They knew something was going on but you obviously want to protect your parents from some things that are going to hurt them so instinctively I just sort of said I'm fine"

Charles' comments highlight how DA can be hidden from others in one's life, possibly due to a combination of factors such as minimising, denial and shame, as well as his Self-with-Other configuration explored earlier. That is, Charles' propensity for empathy in this scenario translate to him prioritising and protecting the well-being of the other / his parents over his own, not wanting to "hurt them". Putting the needs of the other over his own came at great cost to his mental health and well-being: Not reaching out for support sooner meant that he suffered in silence for longer.

After realising that he needed to escape his "messed up" relationship, Andy too contacted his parents:

Andy: "I used that messed up relationship to say I want to try and reconcile with my parents and get back in contact with them and have some kind of relationship with them."

Whilst Andy's parents helped him to escape the relationship, which included moving out of the house they shared, they didn't suggest that he might benefit from professional support, and he didn't enter therapy and talk about his experience of the abuse until ten years later, when he started therapy as a requirement as a trainee psychotherapist.

Notably, Keith didn't turn to his parents for support at any stage during his abusive relationship, not contacting them because of how he imagined they would respond based on their beliefs about his gay identity. Here he powerfully makes sense of his experience:

> Keith: "Sometimes my brothers and sisters when they were married and things were going wrong in their relationships for a whole load of reasons, very small to very big things, they could bring that into the family and talk to my parents. I just felt I couldn't do that, thinking that I've spent such a long time trying to justify to them that being gay is normal, that if I tell them that my relationship is failing, the only thing I can hear them say is, "Well its unnatural to be gay anyway, so"."

Keith's sense-making links to the superordinate theme of Self-with-Other, illustrating how one's relationship with others can increase the likelihood of protracted suffering in silence, in his case because he did not feel that he had a trustworthy other with whom he could talk about his relational difficulties. I now turn to an exploration the role of a trusted other in Keith's journey to therapy.

6.5.2 The Role of a Trusted Other

Before I explore how Keith ended up in therapy, I want to highlight a missed opportunity to identify that he might benefit from professional support at his turning point, which was after his partner dislocated his jaw. This is important because the experience made Keith "shut off", thereby delaying getting professional support for the abuse he was experiencing, and meaning that he continued to suffer in silence for

longer. When Keith went to the doctor after being hit by his partner, and was told that his jaw was dislocated, the doctor asked how he managed to do it. Keith, perhaps taking a risk of Self-with-Other by being authentic and honest, and not hiding, said his partner slapped him. The doctor replied, “So, does she do it often?” This heteronormative assumption by the doctor resulted in Keith thinking:

> Keith: “And I thought, you just assumed, and I just shut off.”

There was no follow-through, or signposting from the doctor, quite startling considering that Keith’s jaw had been dislocated by his partner. This is a significant example of how heteronormative assumptions can hinder support for the queer community, which I explore in further detail in the discussion in Chapter 8. Furthermore, whilst we don’t know what was going on in the doctor’s mind, there is a possibility that Keith being a man might have meant that the doctor minimised the impact of the abuse.

I now turn to a subsequent incident of physical abuse that Keith suffered at the hands of his ex-boyfriend, in which he was cut with a kitchen knife. Keith went to work as a volunteer at an LGBT organisation, where his manager noticed that he was bleeding:

> Keith: “I just put a little bandage over it **[the knife wound]** and that was it, but obviously, it was seeping through and he’d **[his manager]** noticed it.”

Keith’s manager took him aside, and respectfully wondered if he might be self-harming. Keith said:

> Keith: “I trusted him, and got on so well with him, that I said, “I didn’t, but my ex did”, and that was the moment: I was literally almost kind of going, tell me what you need me to tell you, because I’m happy to go into as much detail if you can help with this.”

Trust plays an important role here and, considering his experience with the doctor, on this occasion Keith disclosed what was going on to another gay man working at an LGBT organisation. Keith’s manager suggested that they get him some professional support in the form of both a support group, and individual therapy, which he arranged. Keith then reflects further on his manager’s intervention, and how it felt for someone else to take control, perhaps even more significant because, as discussed above, he did not feel able to turn to his parents for support and had therefore not experienced them taking control of his well-being:

> Keith: “I think it was the first time in my life that I felt a huge sense of relief that I wasn’t on my own, that was the thing, and actually somebody had just taken control and was doing something positive about it, so it was just a huge relief.”

Charles also movingly describes how an other, in his case his mother, took control:

> Charles: “She **[his mother]** was like, um this is going to be a really geeky reference, but have you ever seen the Hobbit? You know when Gandalf is being tortured and Galadriel comes along in the white robes and saves him, that was kind of the metaphor I would use for how my mum helped me. Like I was in this really dark place and I saw no way out of it, I was just in this circle of constant trauma from all the things that had happened to me – the car crash,

> the knife, the glass, the head smashing, the mental abuse – ah, you know, all sorts of things – the drug abuse and the alcohol abuse. Um, I mean I never hurt anyone else, I was just hurting myself. Um, and then yeah, when my mum come into the hospital and saw me, my dad was there as well, he didn't take it quite as well as my mum. He supported me but it was definitely my mum picked me up and helped me."

Returning to Keith: Whilst he initially had reservations about therapy, these dissipated quickly when his manager suggested that it would be good for him. Trusting his manager, he began therapy with the same LGBT organisation for which he volunteered the very next day:

> Keith: "I trusted, I got on so well with my manager, and there was no resistance when my manager said, "You know the therapists are experienced, they will understand", all of those things were just going, oh well, that's because they're gay and they know."

Keith also brings to attention the possibility that disclosing something potentially shameful might be easier within an LGBT context for gay men. Whilst he did not explicitly say as much, perhaps a gay man working in an LBGT organisation is less likely to make heteronormative assumptions and is more likely to foster trust because "they're gay and they know", and will not judge.

6.5.3 The Role of the Abuser and the Therapist

Anomalous with the experiences of other participants, it was Harry's abusive partner who convinced him to go to therapy, saying that he had anger management issues, and was the problem in their relationship. Whilst this scenario links to potential confusion in distinguishing the perpetrator and victim in abusive same-sex relationships, discussed in the literature review, this is not something that Harry spent time making sense of in the interview.

> Harry: "Bob **[not real name]** convinced me that I needed a therapist for anger management. When he suggested this, um, I felt relieved, almost, that he was going to give me an opportunity. I felt that he was right, and thank God, he won't leave me, and someone was finally going to allow me and help me to "fix myself": One of my big fears as a child, growing up, was that I would turn out like my mother who was just "bat-shit crazy."

At this stage, Harry was relieved that Bob had suggested he go to therapy to deal with his issues. However, this ironically seemed to backfire for Bob when after a few months, he joined some of Harry's sessions: In one of the sessions, the therapist challenged Bob for not listening to Harry, highlighting his part in their relational struggles. Bob was aggressive and belittling to the therapist, calling him fake, and saying that they were in therapy to fix Harry, and not him. Bob left the session. This had a big impact on Harry, with his turning point coming in the session:

> Harry: "There was a very dramatic and sudden change after that session, at the house. I saw **[the therapist]** stand up to him and Bob's reaction to that, and I thought, "no". That was when there was a huge turning point for me."

Harry and his therapist subsequently returned to individual therapy sessions, where they talked about Bob's narcissism, which propelled him to the breakup: He moved out and never spoke with Bob again. I go into more detail about how therapy helped Harry make sense of his abusive experience, in the next chapter. Harry's experience with Bob also made me wonder if some abusers might not even be aware that their behaviour is abusive, an idea that I revisit in the discussion in Chapter 8.

6.5.4 The Role of No Other

Peter's experience was also different in that the relationship in which he experienced abuse could perhaps be seen to be non-heteronormative, in that it wasn't characterised by a commitment, him describing the guy as "someone I had sex with for three years". The casual nature of the relationship, and the fact that they weren't living together (unlike all the other participants, who were living with their partners) meant that his turning point had a different impact and route, and didn't necessitate an escape plan in quite the same way. Here is an extract from the interview where Peter highlights the lightbulb moment that was his turning point:

> Peter: "That's when it hit me, that's the first time after about three years, it sort of, I think we were sleeping with each other or whatever, then his friend came and he panicked and he was really nasty, he started swearing, he said, "Get the fuck out now", kind of thing, and I didn't have time to get my trainers or anything, I remember wearing slippers and having to stand outside the back for I don't know, twenty minutes, and it was raining, and then eventually going to my car."

Me: “Can you remember how you felt then?”

Peter: “Yeah I was, that’s when, you know, when it hits you I kind of think you have that lightbulb moment, this massive lightbulb moment you have and you think, oh shit, I just think I got it wrong here, kind of thing, it massively just dawned upon me, that’s when I realised that hang on, something’s not right here, er, and then I felt awful about myself, and then it made sense about all the things he was saying and the way he was behaving.”

Peter’s turning point resulted in him not seeing the guy again, and didn’t have the added complication of having to disentangle joint lifestyles. In Peter’s case there was no other that he turned to for help and support. Like Andy, he only spoke about his experiences with a professional years later when he arranged and went to therapy for other reasons. Notably, he might not have turned to his family of origin because they themselves had abused him for being gay.

6.6 Chapter Summary

In this chapter, I have described the types of abuse that participants experienced and how some participants’ familiarity with hostility and abuse meant that harmful behaviour towards them was difficult to identify as such. Combined with the potentially pernicious nature of emotional, psychological abuse and coercive control in DA in general, some participants became like frogs in slowly boiling water as the abuse escalated, even dismissing, dissociating from, minimising or explaining away some forms of physical abuse. Low self-esteem, shame, the familiarity of the abuse, their adeptness at hiding, mistrust in others, and heteronormative narratives about DA

meant that only when things got exceptionally bad, possibly undeniable, did they reach the turning point at which they knew that something needed to change. Being in what appeared to be survival mode, the priority seemed to be safety, and getting out of the relationship, not professional support. When participants did engage with professional support, it was either organised by an other at the time of the abuse, or by themselves, years later, not necessarily specifically to address the abuse. Importantly, all participants only named their abusive experiences as DA once in therapy. I now move onto the next and last results chapter, where I explore participants' engagement with therapy, and the potentially reparative therapeutic relationship.

CHAPTER 7: RESULTS III: ACCESSING AND ENGAGING WITH THERAPY AND THE POTENTIALLY REPARATIVE RELATIONSHIP

7.1 Introduction

In this third and last results chapter, I explore participants' experience and sense-making of accessing and engaging with therapy, including the characteristics of the therapy setting and therapist that aided or hindered the therapeutic process. I also explore participants' reflections on their experience of therapy, including what might need to be done in order to improve therapeutic engagement for people with similar experiences. This exploration will take place whilst continuing to hold the Self-with-Self and Self-with-Other themes in the frame. I also introduce and explore the third superordinate theme, "The Reparative Relationship": The relationship with one's therapist has reparative potential, in that developing a relationship with a reliable / mirroring / trustworthy other can reconfigure the Self-With-Self and Self-With-Other organisation, thereby enabling participants to view themselves differently, relate to others differently, potentially break the cycle of repetitive abusive relationships, and be in the world differently.

7.2 Accessing Therapy

Having had an other identify that therapy might be helpful to deal with the current abuse they were experiencing, and organising the therapy for them, Keith entered therapy at the LGBT organisation where he volunteered the day after he disclosed that his bleeding arm was a result of his ex-boyfriend cutting him with a knife, staying in therapy for a year. Similarly, after ending up in hospital from an overdose, Charles' mother arranged for him to attend 22 weeks of trauma counselling, which he started

expeditiously. Harry, whose abusive boyfriend convinced him to go to therapy, was in private therapy during the abusive relationship, the therapy culminating in him reaching a turning point and leaving the relationship. Andy, on the other hand, only entered long-term private therapy ten years after the abusive relationship ended, and not specifically to address his experiences of abuse, but rather for general therapy as a trainee therapist requirement.

However, for Peter, who did not have an extreme physically abusive turning point; who did not have an other to act as a bridge to enter therapy, and who did not have the financial means to enter private therapy, the process was more challenging. Peter went to the local LGBT centre for general support, where he found out about their low-cost counselling service. He was added to a waiting list, and waited about two months before he was allocated a counsellor, being offered 6 sessions. When I asked how it felt to be put on a waiting list he said:

> Peter: “I think that’s how all the services work. It’s like I think they do it deliberately because of funding and all these types of things, you know they deliberately make appointments three months in advance or they’ve got a system, haven’t they, and they can only work within that system for whatever reason, so yeah being on a waiting list is horrible because you don’t know when you’re going to get called.”

Peter’s experience brings into question the support available for victims of DA where there isn’t a sense of urgency and when the person does not necessarily have financial means to access private therapy. Whilst Peter did go to therapy once he was called, perhaps other people might drop off the radar at the prospect of a waiting list,

particularly if they were already ambivalent about therapy and had taken a long time to reach out, resulting in them potentially continuing to suffer in silence for longer.

I now turn to what helped some participants engage with therapy once an other had organised it for them. This is important because someone organising therapy for someone else doesn't necessarily mean that the person for whom it is organised will be motivated to attend and engage with the therapy.

7.3 The Role of a Benevolent Other in Engaging with Therapy

As discussed in the previous chapter, an other played a significant role in arranging therapy for some participants. I now look briefly at some of the reasons some of the participants attended the first session, and were therefore able to engage at this vital stage of their journey to understand and make sense of their Self-with-Self and Self-with-Other organisation.

In addition to Keith going into therapy because he trusted his manager (who said that therapy would be helpful) to "take control", he also highlighted the importance of having had previously positive experiences of therapy in enabling him to engage on this occasion, which was to specifically address his abusive relationship:

> Keith: "I had got some counselling from a specific LGBT organisation and that was a really positive experience, so my expectations of this therapy, was very similar to that. I thought, this is going to help me, because it helped me before."

Having had a previous experience of therapy might mean that it was less daunting, and that there was hope that it would be of benefit. Additionally, Keith noticed that he continued to engage with therapy because he wanted to "please" his therapist:

> Keith: "We were working on my confidence, what it meant to be me, what I liked, what I didn't like, and I realised I was doing all this just because I wanted to please him **[the therapist]**. I wanted to know I would go back and get a tap on the shoulder, a pat on the back, you've succeeded."

Keith's very moving observation seems to indicate that he was wanting reassurance and encouragement from an other, perhaps in a way that he was not necessarily reassured and encouraged by his family of origin. Here we see what I believe to be an early flavour of the potentially relationally reparative relationship with one's therapist.

Charles' Self-with-Self and Self-with-Other organisation also enabled him to engage with therapy, being motivated by his empathy and prioritising of the other, in this case translating into loyalty to his mother, and not wanting to let her down:

> Charles: "I think I didn't want to let my mum down. I think I did it for her, really. It definitely wasn't for myself at the beginning."

Interestingly, one's Self-with-Self and Self-with-Other organisation can have both negative and positive impact. That is, whilst Charles' focus on the well-being of the other before himself might have played a part in him staying in his abusive relationship, in this scenario, not wanting to let his mother down enabled him to get the support that he needed to work through or process his experience of DA.

Having highlighted the impact of a benevolent other at the point of beginning to engage with therapy, I now turn to two participants' potentially retraumatising experiences whilst trying to access and engage with support in a heteronormative world.

7.4 The Potentially Retraumatising Other in a Heteronormative World

Whilst this project did not set out to look at any therapy beyond individual therapy for DA, I wanted to bring attention to the experiences of two participants beyond this remit that highlight some of the significant challenges to accessing support for gay male victims of DA in a heteronormative world, where the dominant DA narrative is of male perpetrators and female victims.

In addition to Kevin's individual therapy, he tried to access group support for DA victims, which proved to be much less accessible due to the aforementioned deeply entrenched gender-based narratives around who the victim can be in DA. Here, Keith makes sense of his experience:

> Keith: "Through the therapy I was having, there was also other support that was being offered, which I found really negative: Group therapy, that they **[the LGBT organisation providing him therapy]** couldn't provide because it was something they didn't have. In **[the place where he lived]** there wasn't really anything for men. The victim was very much women, so it was really difficult to access. The only thing there for men was for perpetrators, the people doing the abuse. So, it was the most difficult thing to try and access, and I remember saying to the therapist, "I know through you that this experience of mine isn't okay, in the gay world, it's **[gay DA]** normal, but in the outside world,

everywhere else the support there is, it's not normal, because it's all to do with men and women.""

Keith did eventually find a group that was not gender-based, therefore being for both male and female victims. However:

> Keith: "One group was for victims, men and women. But actually, when I went to that group, it was just women. So, it was almost like going to this group kind of emasculated me because everything was all, "it was my man who did this", "it was the men", so I was kind of going, "oh yeah, and mine was a man" but I was in a group where it was just the men **[who were perpetrators]**, so it felt very much like to be gay, you have got to be a woman or be female. This was difficult because as a teenager my family thought being gay meant that you wanted to be a woman."

For Keith, not having services tailored to gay men added to his confusion around gender and sexuality. These confusing messages resulted in Keith leaving the group:

> Keith: "I went to about six sessions, and I think I shut down, I was just like, this is not helping in any way, and also the fact that there was nothing for men because all of the men were all the people who were inflicting the domestic abuse."

Adding this experience to Keith's experience with the doctor who assumed that his partner was female puts the spotlight on the potentially destructive and confusing heteronormative narratives and assumptions outside of LGBT-specialist support, and

in the world at large. It also links to narratives around men, straight or gay, being the perpetrators and not the victim, the implication of which I shall explore in the next chapter.

Not dissimilarly, when Peter was accessing support for family DA, one of his support workers said to him:

> Peter: “I remember telling my support worker that I was having problems with my family and she didn’t recognise it, she goes, “It’s taken like 60 years for women to be recognised as domestic abuse victims”, she actually said those words, so I was like, “OK”, so I didn’t say anything, you know, because it’s taken a long time for women to get this justice kind of thing, and for them to recognise that, you know, they’re victims in these situations and get credit, credit if they do something horrible **[like the female members of his family]**. And that’s how the service is, and I’ve spoken with other female people, I remember talking to this girl, she was training to be a criminologist and she goes, “Men don’t experience domestic abuse and they don’t really want to access the service.””

Considering the Self-with-Self and Self-with-Other themes that I have been weaving through this project, and the long and treacherous journey that many gay men experience on their way to the turning point, whereby they start to engage with support services, it is worth considering the implications of having their experience minimised / invalidated by the services that are supposed to be supporting them. It could be retraumatising, potentially confirming the other as an enemy, amplifying their already-existing shame, and resulting in abused gay men going back into hiding, “shutting

down", as Keith puts it, and suffering in silence. Peter's experience with his support worker might have decreased the likelihood of him reaching out and engaging with support services when he realised that he was experiencing abuse in his intimate partner relationship. It might diminish the likelihood of them reaching out for support when this is the response and thus trying to engage with support such as therapy could be seen to be counter-intuitive. Not getting the right, informed support at the point of attempting to engage with support services could have a devastating impact on this group of individuals, and there might be benefit in having specialist LGBT services to meet their needs in a non-shaming, non-judgemental, non-retraumatising way. I discuss this further in the next chapter.

Having explored Keith and Peter's experiences as gay men in a world characterised by pervasive heteronormative assumptions about DA, I now turn to an exploration of the traits and characteristics of the therapist that helped participants continue to engage with therapy once they started.

7.5 Characteristics of the Therapist: Making Sense of a Gendered Other

In asking participants about the characteristics of the therapist that might have helped them to engage with therapy once they started, the therapist's gender and sexuality came out as an interesting factor for most of the participants. As a therapist myself, I know that in choosing a therapist, the therapist-client fit is important in enabling a therapeutic relationship to develop, thereby increasing the likelihood of engagement. In private practice, one can choose a therapist who is a good fit, but this is rarely, if ever, the case in other services, which is all the more reason that therapists in services

have some of the important relational characteristics that I explore in the discussion in Chapter 8.

There was a lot of variation in experience and importance in relation to the gender and sexuality of participants' therapists. Three of five participants had male therapists, and two had female therapists. The sexuality of only two of the therapists was known for certain (heterosexual female and gay male) whilst two participants (Kevin and Peter) assumed that their therapists (one male and one female) were from the LGBT community as they worked for an LGBT organisation and centre. Whilst Charles did not know the sexuality of his therapist, he said:

> Charles: **"**I felt uncomfortable talking to a guy but then, after a couple of sessions, I can't remember what he said, but he said something to me about gay relationships and being gay and all sorts of stuff, and he completely set my mind at ease, talking to him, and I really opened up to him a lot more."

Whilst Charles initially felt uncomfortable with a male therapist, it was the therapist showing awareness of gay issues that enabled Charles to feel safe enough not to have to hide, and therefore to open up to his therapist. For Keith, who attended therapy at the LGBT organisation where he volunteered, assuming that his therapist was a gay male was a positive thing:

> Keith: "I just connected that person to an LGBT organisation, everybody's got to be gay, that was my assumption, and I think as that, in my mind this person was like going to understand, because they're gay."

For Keith, the therapist being gay meant that they would be able to “understand” him, perhaps more-so in light of his experience of heteronormative assumptions made by the doctor when he was told he had a dislocated jaw. Being understood by a gay male therapist could allow for Keith to be mirrored in a way that perhaps he hadn’t before, which could potentially have an impact on his Self-with-Self and Self-with-Other organisation. In contrast, Andy knew that he didn’t want a gay male therapist and, because he was choosing a therapist in private practice, he was able to choose a woman. Here he explains why:

> Andy: “I knew that I wanted a woman, I didn’t want to be with a man. She was older you know, she was in her 60s, so there was that.”
>
> Me: “Can you tell me a bit more about, when you say you knew that you wanted a female therapist.”
>
> Andy: “I felt that I would be safer, um, that it wouldn’t be, that my experience and my sexuality wouldn’t be so much of an issue, so that sense of feeling that I could talk to a woman, that I wasn’t going to be judged in a way from a man, and there was that, I knew that **I didn’t [emphasised]** want, um anyone, I didn’t want a gay therapist because I just felt like that would encroach on my sexuality, or me coming there for me.”
>
> Me: “Tell me more about that, if you can elaborate a bit?”

> Andy: “I just felt like, I felt like I might be judged and that I didn’t just want to go to a, I didn’t want to go to gay therapist because I am gay, and even, I just felt safer with, with a woman.”

Andy highlights the important of safety and lack of judgement in a therapy setting. Having been raped and abused by his ex-partner, a gay man, it might make sense why another gay man would not necessarily feel safe for him. Indeed, an older woman might have felt less threatening.

Peter was allocated a female therapist at the LGBT centre, and here he talks about how he felt about it:

> Peter: “I didn’t feel uncomfortable or I didn’t feel worried about it, it was at the LGBT centre, so you know their job really is to help people tackle these problems as it were, and she was quite familiar with LGBT issues, I don’t know if she was LGBT herself, or whatever, I never asked. She was quite nice. I think if they’re LGBT they can relate more, possibly or they might have similar experiences, but that’s not necessarily the case.”

Peter alludes to the potential importance of the therapy setting: Being at an LGBT centre, he felt comfortable, which was helped by his therapist’s familiarity with LGBT issues. Such factors can contribute to one’s sense of safety and trust, and therefore engagement with therapy in a non-judgemental setting, and can perhaps be more important for some people than whether the therapist is LGBT or not.

Here, Harry talks about why he specifically chose a gay male therapist in private practice, having had two previous therapists, both heterosexual females:

> Peter: “My previous (heterosexual female) therapist was phenomenal, a great therapist. However, I had decided that maybe the reason I was still damaged was that she wasn’t able to help me as much as I needed because she didn’t understand certain things about gay people.”

Harry seems to suggest that, whilst a therapist of another gender and sexuality was great, they could lack an understanding of gay issues. Having explored participants’ sense-making of the importance of the gender and sexuality of their therapists, it seems that what was most important in fostering a non-judgemental therapeutic frame and sense of trust and safety was the therapy setting, therapist characteristics and therapist’s awareness of LGBT issues, rather than their gender and sexuality, in line with research by Burckell & Goldfried (2006) which found that participants valued therapists who had LGBT-specific knowledge, as well as general therapeutic skills, and would avoid therapists who held heterocentric views. I unpack this further in the discussion in Chapter 8, and now turn to a further exploration of other ways that participants made sense of the therapeutic journey, including what helped them to stay engaged.

7.6 Being Mirrored, the Potentially Reparative Relationship

There were a number of other elements that helped participants remain engaged with therapy by fostering a sense of trust and safety, and which enabled mirroring by the therapist in a relationally reparative way, thereby impacting participants’ Self-with-Self

and Self-with-Other organisation. I now look at some of the elements of the therapy that most stood out for participants, and which seemed central to their sense-making around the therapeutic experience.

Andy spoke about other things with his therapist for three months whilst trust developed, before risking talking about the abuse that he had experienced over a decade before. He succinctly makes sense of his struggle to talk about the abuse:

> Andy: “I was able to first tell myself that it **[the abuse and rape]** had happened, and kinda admit to myself that it had happened and then go, “OK, well I need to now talk about this because, because I can’t push it down any longer”. I mean it felt really scary: Is it safe, am I safe, am I gonna be judged, am I going to be hurt, can we do it, can I bring myself to even admit to another person, I mean it is hard enough acknowledging it and admitting it to myself let alone sitting across from someone.”

Andy highlights the power of coping strategies like denial and suppression, taking over a decade to admit to himself that the abuse and rape happened. Considering Andy’s Self-with-Self and Self-with-Other organisation, determined by his relationship with his family of origin and his abusive relationship, it makes sense that he would be reticent about coming out of hiding, and only doing so if he felt safe. For Andy, his therapist being “human” helped to facilitate trust and safety:

> Andy: “There was something, very homely about **[her burning frankincense at Christmas]** and a real, um, that real human part of her. Her birthday is the same day as my birthday, so we kind of shared that, so it was kind of like

> having a session you know, around or together on our birthdays. And just the make-up of their room, it was a bit like, my life can be a bit chaotic and messy sometimes, and her room was a bit chaotic and messy and it was in her home, so it wasn't in some cold clinical room, um, and I just felt at ease with her. There was a real, there was that kind of connection with her. If I was talking about things that she didn't quite get from a, um, from a gay perspective, she would ask me, and be really curious around that and be really open to, and trying to understand. Sometimes I got frustrated because it's like you don't have a clue what I'm talking about, you can't understand what it's like to be a gay, a gay person in the world, um, and so you know, she would allow that frustration and then come at it from a really curious kind of point of view."

Andy's experience highlights the importance of being mirrored by an other, in this case partly by their shared chaos and mess, as it helped him to feel at ease with, and connected to her. Furthermore, his therapist was able to tolerate his frustration, as a parent might hold and contain and absorb the frustration of a child. In this instance, being met where he was had great relational reparative potential because of his experience with his family of origin who did not seem to approach his gay identity with curiosity and try to understand him.

In stark contrast with Keith's retraumatising experience with the DA support group, he fortunately had a very different experience with his therapist at the LBGT organisation, one of the main elements being "no judgement". Here he makes sense of his experience:

> Keith: “I felt that it was like an “x-ray thing” where I was able to just be honest about how I was, and I felt I could do that with no judgement. I think it was the one place where for an hour I could just be, I could just talk about anything that was going on. It was my, almost like haven, really, where it was that he was just listening, I have to say, for the very first time I felt like I was being listened to.”

Keith pinpoints a number of reparative experiences in this quote alone. For example, the “x-ray thing” seems to suggest that he could be honest and seen for who he is without fear of judgement, and therefore without having to “hide”, which he had done for many years. His use of the word “haven” suggests that the space was safe for him, and that he trusted his therapist. And powerfully, Keith talks about his therapist “just listening” to him, making the therapy *about him*, even more impactful because he felt that it was the very first time he was being listened to and heard. The message here is that his life and experience and reality is valid and important, a new message for Keith considering his Self-with-Self and Self-with-Other trauma. Keith goes on to talk about other ways he felt mirrored and seen by his therapist in a way that he had never experienced before, in this case non-verbally:

> Keith: “And I think it was all the body language and everything, from the eye contact just, you know just certain things, I remember sitting there sometimes realising, oh, you are copying me, but actually they’re just mirroring my behaviour, and it just felt like the first time somebody was looking at me.”

Keith’s words about being looked at for the first time are very moving, highlighting how he had not been looked at, or truly seen whilst growing up in his heteronormative family

of origin. It sounds like Keith's therapist did a good job of mirroring him, thereby giving him a new and reparative relational experience.

Like Keith's therapist who made it about *him*, Charles' therapist also enabled him to have a different relational experience by helping him to focus on *himself* and how things made *him* feel, which is relationally significant because, as discussed, he had a tendency to focus on the needs of others before his own. Here he talks about his experience:

> Charles: "And he introduced these different homeworks, CBT homeworks and memory mapping, and all sorts of stuff, and I'd have a sheet of paper with different questions at the top and I'd have to write about how it made *me* feel, and I'd have to process that memory maybe looking at it from a different perspective, you know and the sort of questions other people might ask, and then sort of recondition myself into maybe just *thinking about myself* in a different light. That really helped. He would, you know, help me in the sessions but, I think it was my own development that he wanted to, to evoke."

Charles' therapist was focusing on helping him to develop a healthier relationship with himself, including his feelings and needs (Self-with-Self). He also alludes to the collaborative nature of therapy, that can be significantly reparative for people who have felt like they need to hide shameful parts of themselves from others, and deal with their struggles alone. In this way, there is potential for a shift in one's Self-with-Other configuration as one learns to trust others.

Peter's therapist was also collaborative, listened and "was there", perhaps unlike his experience in his family of origin:

> Peter: "We sat and filled in goals and er, so she did all the paper work with me and there were no issues whatsoever, I didn't feel uncomfortable, I didn't feel like she was rushing me, I didn't feel at any point there were small issues that might arise, she was there, she listened."

Comparing his therapist at the LGBT centre to the support he received in the DA refuge where he went as a result of his family of origin abusing him for being gay, which was a negative and retraumatising experience, he says:

> Peter: "They **[the mental health team linked to the refuge]** had a bit more authority and more power, and they could use it, whereas with her **[his therapist]** I felt on an even level, because the LGBT were running it **[the counselling service]**. She was interested in connecting with me around the sexuality type stuff: she tailored it around sexuality first, and then moved around areas like domestic abuse, and relationships and stuff like that."

Peter's experience seems relationally reparative because he was experiencing something different from a heteronormative authority wielding power, which he experienced with his family of origin as well as with his support team at the refuge. Feeling "on an even level" with an other (his therapist) who was interested in connecting with him and curious about learning about him, his reality and his sexuality, was conducive to feeling seen and valued for who he is.

The reparative potential of the therapeutic relationship is profound: Being with an other in a new and different relational way by being seen, heard and validated for who one is without having to hide, or feel shame, can greatly improve one's self-esteem (Self-with-Self), as well as help people to experience a trusting, nurturing relationship with another, thereby influencing their Self-with-Other configuration. In doing so, there is the potential for people to break the repetitive cycle of shame and abuse, which I explore further in the next and last chapter. Having looked at the common themes of feeling comfortable in a safe environment with a trusted other with whom one feels seen, heard, listened to and mirrored, I now turn to participants' reflections on the ending of therapy, and how they made sense of it, before drawing this final results chapter to a close.

7.7 The End of a Beginning

I now turn to an exploration of participants' reflection on and sense-making of the ending of therapy, including Andy who, at the time of the interview, was still in therapy. These reflections include how therapy shaped their understanding and relationship with themselves (Self-with-Self) and others (Self-with-Other) in the world at large.

Peter's therapy ended because his allocated six sessions at the LGBT centre ended. Whilst he had the option of asking for more sessions, which he "desperately wanted", he didn't want to "overstep" it as his therapist was a volunteer, and there was a waiting list. It therefore seems that he put the needs of others before his own, seeing himself as "too needy" for wanting more:

> Peter: “I wanted to **[continue therapy]**, I desperately wanted it to be longer but I didn’t say that to her because there was a waiting list, and I also recognised she was volunteering so I didn’t want to overstep it a little bit and I felt, erm, in the whole grand scheme of things it was better than nothing, so I was happy with what had happened but yeah, I would love to have extended it. They helped me, and I didn’t wanna be too, erm, I dunno, too needy.”

Peter only touched on DA quite generally and briefly as part of a larger discussion about relationships and, whilst he did not say so, perhaps being in therapy for longer might have enabled him to explore his experiences of DA further. Reflecting on his experience he said:

> Peter: “It was a good experience, um, I’m glad I did it. I learned some stuff and she made me feel better about myself. It was nice to talk about things and I felt more comfortable with my sexuality.”

Peter’s words “feel better about myself” and “more comfortable with my sexuality” already alludes to an improvement in self-esteem / Self-with-Self configuration, seemingly resulting from being seen and heard by an other.

For Andy, who was still in therapy at the time of our interview, there was an increased sense of comfort with himself, awareness of how to look after and support himself, and significantly, that he didn’t have to do it “on his own”:

> Andy: “What do I do to support myself when I’m not having a great day or, um, you know learning that it is okay to lean in, um, and I don’t have to do it on my

> own, and I don't have to go through the world on my own, and really becoming comfortable with who I *am* as a person, um, looking at the world a little bit oddly as I do, um, and being really comfortable with *that* began to really unfold for me"

Not having to do it "on his own" appeared very significant because through the reparative therapeutic relationship, he learned that an other can be trusted, a new relational (Self-with-Other) way of being. His improved comfortability with himself (Self-with-Self) as well as his new Self-with-Other configuration could be said to increase the possibility of him reaching out to a benevolent other for support when he is suffering, in stark contrast to his years of hiding and suffering in silence.

Keith had therapy for a year and worked towards an ending in the last month. At that stage, things looked very different for him at a practical level, which can be important when victims of abuse have been living with and are domestically and financially intertwined with abusers:

> Keith: "I was in a place where my situation was very different and I wasn't living there, by this time I had found somewhere to rent, money was manageable, and I had told my three close friends at work about it **[his abusive relationship]** and that was only two months before therapy ended, and that was just about trusting people. I then told a circle of a few more friends, so there was also a lot in place, I was ready to go because actually I was ready to move on and put the therapy to an end, so it was a very, it felt a very natural end."

Keith talked about how he was able to share his experience with friends, due to an increased trust in others, thereby having a support structure in place for when he left therapy. Again, this support network can be seen as a shift in his Self-with-Other configuration, sharply juxtaposed with the scenario where his manager saw his bleeding arm at a time he was suffering in shameful silence. Keith went on to talk about the shift from focusing on the other's needs and well-being before his own, to self-care and looking after himself in a "healthy way" (Self-with-Self):

> Keith: "Looking after myself in a very different and healthy way because looking after myself was no longer, in order to look after myself, I don't need to be in a relationship and get that from them. What it **[therapy]** changed for me is having relationships and friendships with very different values and stuff, so in order to look after myself, it was making sure I enjoy the things that I do whether it be volunteering, I enjoy my work, I build healthy friendships because actually other than sex, I can get trust, I can get kindness, I can go out and have a good time, go on holiday, form really good friendships. I learned about looking after myself and there were all sorts of other things that I could get that would make me feel good about me."

Keith's sense-making alludes to how he had desperately wanted his abusive relationship to work, and had felt reliant and focused on the other, despite the abuse. Therapy helped him to shift his focus to himself and what *he* enjoys, thereby being less preoccupied with pleasing the other. Considering that he had also identified that he wanted to please his therapist, if feels powerful that he was increasingly able to tap into what *he* wanted, put *his* needs first, and leave the therapeutic relationship when *he* wanted to. This is also linked to how therapy helped Keith to make sense of his

abusive experience by increasing his confidence (Self-with-Self) not to take responsibility for the abusive relationship, and recognise his self-agency in being able to leave:

> Keith: “Therapy also helped me to understand why I was putting up with stuff, so gave me, started to give me confidence to kind of go, “This isn’t you because everything at the moment to that point was, “I’m doing this, I must’ve done something wrong”, to finally go, “Actually, yeah, the main things are different choices, but the big picture of it is “This isn’t my fault”, what *is* my fault is if I don’t do something about this, if I continue this, that’s my fault.”

Charles ended therapy just short of the 22 sessions he was due to have, as he was feeling “so much better”:

> Charles: “On the 18th, 19th sessions, I actually was saying to my therapist, you know, I’m feeling *so* much better I don’t really have anything to talk to you about any more, you know, I wasn’t crying, I wasn’t upset, I was thinking anything, I was sleeping all night, I wasn’t having intrusive thoughts, But, on the 20th and final session, I think I was only there for 20 minutes. The therapist just said to me, “I don’t think you need counselling any more”, I think, “I think you’re fine”, and I agreed and said, “Yeah I feel fine”, and I felt, I just felt so happy. I’d just moved back to London and everything was on a positive step again, there was a lot of positivity and yeah, the last session was great, and I felt really great. I went away very happy.”

Whilst Charles did not say so himself, it feels important that he was empowered to end therapy when he felt ready and willing, and that this was collaboratively agreed between him and his therapist. This self-agency is juxtaposed with some of the violence he experienced when he had tried to leave his abusive relationship.

For Harry, therapy helped him to reframe his experience of Self-with-Self by seeing things from a different perspective. When I asked at what stage he started talking about his experience of DA in therapy he said:

> Harry: “I started talking about it from minute one, but I didn’t see it that way. I saw it as talking about all the things that were wrong with me. I was framing it in the perspective of, “I’ve got this guy who puts up with this crap from me”, and **[the therapist]** was the one who helped me to reframe those things and see them more for what they were.”

After three months of therapy, Harry suggested that his partner come to therapy with him, as he felt he might not be representing what was happening in their relationship correctly:

> Harry: “About three months into the therapy, we (he and the therapist) had come to the conclusion together, and I think it was my suggestion based on the feedback I was getting from Bill, that maybe we should do couples’ counselling, maybe it’s helpful to have him here, so we can talk about this and fix it together. I believe my thinking was, “I must not be representing this correctly, because the feedback I am getting from Bill is that I am not damaged,

and I must not be explaining this properly to him, as he isn't talking about fixing me.""

As discussed in the previous chapter, the couples' counselling was to highlight Harry's partner's abusive behaviour and help him reach a turning point. Here he reflects on how it shifted how he viewed himself:

> Harry: "I had come to realise that I was not the source of these issues. Yeah, anytime there are two people involved you are contributing, but it is when you are reacting to something, um, that, these issues were not my fault. My conclusion is that abusers, rather than accept any responsibility, when you get upset at something you should be upset about, they will take a credible, valid emotional reaction and twist it around into you have some sort of emotional issue."

Through therapy, Harry came to realise the nature of the abuse in his relationship, and it was therefore an opportunity for him to reconfigure his Self-with-Self configuration. As discussed in the second results chapter (Chapter 6), one of the other main impacts of therapy on all participants was that their experiences were validated and named as DA.

7.8 Chapter Summary

This chapter has highlighted the length of participants' journeys to therapy and that, once there, safety, trust and awareness of gay issues on the part of the therapist was most important for engagement. The therapeutic relationship has been seen to be potentially reparative by helping some participants to reconfigure their relationships

with themselves (Self-with-Self) and others (Self-with-Other), by the therapist mirroring, validating, and accepting them for who they are, thereby potentially breaking the repetitive cycle of shame and abuse. The end of therapy was significant for a number of participants, particularly where it involved a collaborative decision which emphasised self-agency.

CHAPTER 8: DISCUSSION

8.1 Introduction

Having outlined and explored the results of this research project, I use this chapter to reflect on how I have addressed the research questions set out in Chapter 2 Section 2.6 and reflect on my own personal relationship with the research questions, before discussing the results in the context of current literature in this area. Before drawing this research project to a close, I discuss its limitations, and offer a number of recommendations, from wider society down to individual psychotherapists.

8.2 Have I Answered the Research Questions?

For this research project, I set out to answer the following questions:

Main Question

- What is the experience of engaging with psychotherapy among gay male victims of DA?

Sub-questions

- How do gay men make sense of their experience of being a victim of DA?
- What motivated and maintained men's engagement with psychotherapy, or what experiences shaped their decision to end psychotherapy?
- How has psychotherapy shaped, informed or influenced how they reflect on their experience of DA?

As already discussed, I set out to answer these questions by conducting in-depth, qualitative interviews with five research participants, all of whom were gay men who had spoken about their experiences of DA in therapy. I analysed the data using IPA as my methodology, thereby identifying themes within and across the sense-making of the participants, producing results which I outlined and explored in the previous chapters.

First and foremost, it is important to note that, in allowing myself to stay open and curious to what might emerge in the interviews and analysis, I was surprised that, whilst I set out to look at participants' engagement with therapy, my results revealed much more than I imagined. That is, what has been highlighted in this research project is the richness, complexity and length of participants' journeys / the process of *getting to* the point where they engage with therapy. The initial ice-breaker questions I asked in the interviews, about how they view themselves and their relationship with their gay identity, and the opening questions about their experiences of DA, when analysed, yielded a far more complex project than the one I set out to investigate. Therefore, whilst I believe that this project has achieved what it set out to do by answering my main and sub-questions by shedding light on the experience of engaging with psychotherapy among gay male victims of DA; how they made sense of being a victim of DA, including what motivated and maintained their engagement, and the impact of therapy on their sense-making, it has also done much more in terms of helping to understand many of the factors that preclude reaching out for support and therapy engagement earlier in their abusive relationships.

Bearing in mind the hurdled journey that most participants endured in order to initiate therapy, allowing a space to talk about the abuse they suffered, and the severity of the

abusive situations that catalysed this for a number of the participants, this research project therefore also emphasises how paramount it is that gay male victims of DA get the affirming and inclusive support at the point of engagement with therapy. I explore this further in the section on recommendations.

Before moving onto the discussion of my results in relation to literature, I now share some reflections on my personal journey with this research project.

8.2.1 Reflexivity / Reflections

When I began the Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych) in 2011, I had no idea what I was getting myself into: Little did I know that both the clinical and research component of the course would have the underlying theme of reparation. That is, as a "wounded healer" (Martin, 2010), I was unconsciously seeking answers to my own pain and suffering. By deciding on this research topic, wanting to give gay male victims of DA a voice, and to understand why they didn't seek support, I was also ultimately and unbeknownst to me, wanting to give *myself* a voice, and understand why *I* didn't get the support I needed, and engage with therapy at the time of the abuse, not only in relation to the abuse I endured with my partner, but also in relation to the abuse in my family of origin. By listening to the stories of my participants as an insider researcher, I have ultimately been forced to confront the abused parts of myself that I very much wanted to deny, minimise, dissociate from, and disavow, eventually beginning to process them in my personal therapy once in the analysis phase of this project. Whilst the journey of this deeply personal project has therefore been exceptionally long, and gruelling, it has been reparative and therapeutic too, in line with what Kim Etherington (2007)

describes as a fine line between research and therapy, perhaps for both researcher and participants.

Indeed, had I gone to therapy at the time of the abuse, in order to make sense of my experience, I might not have wanted, or needed to do this research, and it could perhaps therefore be seen as a product of the unresolved nature of my abusive experiences. Interestingly, one of the other participants also only explored his experience of DA a decade after the abusive relationship had ended, and only once having entered therapy as a requirement as a trainee psychotherapist. Whilst it has not been the focus of this project, this makes me wonder about the impact on an individual of carrying around unresolved trauma for decades.

As mentioned before, when embarking on this research project, I naïvely thought that all participants would be / have been in an abusive relationship and, identifying it as harmful and unacceptable DA, would have urgently sought professional support to talk about it, process it, and leave the relationship if they hadn't already done so. Another naïve notion was that if someone was in distress, they would automatically think of professional support, as opposed to reaching out to friends or family. I thought that I would primarily be exploring what helped participants to stay in / continue to engage with therapy, or what contributed to them ending therapy.

However, as can be seen from the findings of this research, not one of the participants recognised that they were experiencing DA at the time they were experiencing it and sought professional support. I therefore now turn to a discussion of a much more complex and nuanced journey to, and engagement with therapy.

8.3 Summary of Findings

I begin with a summary of my findings, which I shall then expand on in later sections: Self-with-Self and Self-with-Other factors appeared to set the scene, or shape an environment or a mindset where participants might perceive or respond to abuse in complex ways. Some participants had poor relationships with themselves, including low self-esteem and a tendency to focus on the needs of others over their own, as well as shame for who they are, growing up in a sometimes-hostile heteronormative world in general, and sometimes also having been othered or abused in their family of origin, thereby not being mirrored, validated and accepted by an other for who they are. Through shame, some participants learned to hide. Sometimes, through the familiarity of being with a hostile / abusive / invalidating other, their relational pattern was unconsciously repeated in their intimate partner relationships. Participants experienced a broad range of forms of abuse and for some participants', familiarity with hostility and abuse meant that harmful behaviour towards them was difficult to identify as such. Combined with the potentially pernicious nature of emotional, psychological abuse and coercive control in DA in general, some participants became like frogs in slowly boiling water as the abuse escalated, even dismissing, dissociating from, minimising or explaining away some forms of physical abuse. Low self-esteem, shame, the familiarity of the abuse, their adeptness at hiding, mistrust in others, and heteronormative narratives about DA meant that only when things got exceptionally bad, possibly undeniable, did they reach the turning point at which they knew that something needed to change. Being in what appeared to be survival mode, the priority seemed to be safety, and getting out of the relationship, not professional support. When participants did engage with professional support, it was either organised by an other at the time of the abuse, or by themselves, years later, not necessarily

specifically to address the abuse. Importantly, all participants only named their abusive experiences as DA once in therapy.

Some participants had a very long journeys to therapy. Once there, safety, trust and awareness of gay issues on the part of the therapist was most important for engagement. The therapeutic relationship can be reparative: It helped some participants to reconfigure their relationships with themselves (Self-with-Self) and others (Self-with-Other), by the therapist mirroring, validating, and accepting them for who they are, thereby potentially breaking the repetitive cycle of shame and abuse. The end of therapy was significant for a number of participants, particularly where it involved a collaborative decision which emphasised self-agency.

I now position the above findings in relation to current research and literature, doing so in line with how I presented the results chapters: Chronologically, and at each stage of the journey to access and engage with psychotherapy, and ending with their experience of therapy itself. I shall also highlight my unique contribution to this area of knowledge.

8.3.1 Self-with-Self and Self-with-Other Organisation

All participants experienced difficulties in their families of origin, hiding their gay selves from their families for some time, whilst two participants labelled their experience with their family as abusive, one participant abused specifically *because* of his gay identity. Additionally, four of five participants described themselves as empathetic. Whilst being able to understand and share the feelings of an other can be positive for society and

human relationships, some participants went further by talking about how empathy meant that they were more focused on the needs of others than their own.

The impact on the self of growing up gay in a sometimes-hostile and threatening, homophobic heteronormative world, as well as a sometimes hostile and threatening, homophobic heteronormative family of origin, can be that the self adopts unconscious coping strategies, including hiding, in order to feel safe. Kohut's Self Psychology (1971) can help us to understand this: He espoused that we are driven by a grandiose sense of self and that the young infant has several needs, known as "self-object" needs. These are, to feel at one with a significant parent (merger); to feel seen, celebrated and enjoyed (mirroring); to look up at a parental figure who one can admire and feel safe and strong in their presence (idealisation) and later as you develop as a young infant and later adult to find people in the world "just like me" that is a source of joy and pleasure and strength (merger transference). Kohut (1971) goes on to say that the self will have depleted levels of self-esteem, self-cohesion and self-consistency and be prone to fragmentation and shame when their need for mirroring, idealising and twinship is not reciprocated. The implication for gay men growing up in a hostile heteronormative family without a gay role model, is that not being mirrored: Seen, accepted, validated and celebrated for who they are, can have a powerful impact on their sense of self and self-esteem. Furthermore, in learning to hide, children can adaptively develop an inauthentic "false self" (Miller, 1987) by suppressing or repressing (Freud, 1923) their own needs, instead attuning to the needs of the primary caregiver ("mothering the mother"), also ultimately in order to survive and feel safe. Consequently, the individual's separation / "individuation" (Mahler, 1968) is stunted and the resulting symbiosis / enmeshment renders them less able to tune into their

own emotional needs. That is, the gay self can learn to hide their true, authentic self, for fear of rejection, and develop an external locus of evaluation (Rogers, 1961), which is accompanied by a compulsion to please others at one's own expense, or to their own detriment. This Self-with-Self and Self-with-Other way of relating is one of many important factors that make it challenging for gay men to reach out for support when in a harmful and abusive relationship. I now further unpack the impact on participants of their relationship with their family of origin.

8.3.1.1 Familiarity of Abuse

Early traumatic relational experiences in their family of origin, including those where they have been abused, for being gay or otherwise, can predispose some gay men to unconsciously repeat the pattern in their subsequent relationships, that which, as mentioned in the first results chapter (Chapter 5), Freud calls the "repetition compulsion" (1923). I concur with Freud (1923), who posits that this can come from a place of unconsciously hoping for a different outcome, perhaps even a need to redress the homeostatic imbalance created by early relational derailments in one's maturational trajectory. The repetition compulsion is not restricted to gay men, with research showing that it is not uncommon for people who have been abused, or experienced DA in their family of origin, to end up in abusive relationships (Kwong et al., 2003; Weaver at al., 2008). This is partly because, for humans, there can be comfort and safety in the familiar, as it is known, even if the familiar involves abuse. This links to the other important implication of experiencing abuse or hostility in one's family of origin: Because it is their norm, it can be difficult to know when an experience is problematic, or abusive, as there is nothing with which to compare it. Furthermore, because as animals we learn from those around us, our early and formative

experiences with our families form the template that informs what we can expect from the wider world, and are reflected in our neurological pathways (Siegel, 1999). This is important for this study because it contributes to why gay men might not reach out, or seek support: Why would I reach out for support from an other when a) I am psychologically hooked into the relationship, b) I don't necessarily identify the behaviour I am experiencing as harmful / problematic / abusive, as it is my norm and c) even if I did, my experience with others is that they are unsupportive, hostile, invalidating, untrustworthy, even "the enemy" (Donovan & Hester, 2010), so the opposite to reaching out is safest, even if I am struggling, and particularly if I am feeling vulnerable: Hiding. The impact of these factors means that victims of abuse might unconsciously remain in intimate relationships characterised by DA for longer, which I shall explore further below, citing research in this area.

I now turn to a discussion of the wider, macro variables that contribute to why gay men can struggle to identify their experience as harmful and / or domestic abuse, and reach out for help.

8.3.2 The Public Story of Domestic Abuse: Physical Violence in a Heteronormative World

In this research project, participants struggled to make sense of their abusive experience as harmful, with none of the participants naming their experience as DA until in therapy to process the abusive relationship. How can this be? What can it tell us about societal narratives about DA? There are a number of factors that contribute to this, and I begin by exploring the heteronormative narrative about DA.

8.3.2.1 The Heteronormative Narrative

As discussed earlier in this thesis, the dominant narrative around DA, understandably due to it being the most common experience, is of a male perpetrator and female victim, within a heterosexual relationship. Whilst perhaps unconventional in a doctoral thesis, I would now like to introduce the reader to the 24-episode documentary series, “Meet, Marry, Murder” recently released on Netflix, one of the world’s largest streaming services with a very wide audience, meaning that it could have a large impact on how the general public perceive and think about phenomena. Released in 2022, this series could be said to reflect current thinking about DA. Each episode covers a case study of a domestic homicide that took place in the UK or US, including interviews of friends, family, law enforcement officials and DA experts. Whilst I am not providing an academic critique of the series, I believe it a valuable prism though which to view my results, and their position in relation to existing literature. Of 24 episodes, not one involved a same-sex relationship. Indeed, whilst gay men can now get married in some countries, the title of the series in and of itself can be seen to be heteronormative, as it does not appear to allow for diverse types of relationships in which DA and domestic homicide can occur. This links with observations from research by Estes & Webber (2017), which found that same-sex DA generally lacks mainstream news media coverage, with reporting mainly being on those stories that are most prominent, which are often shaped and presented within a white, heterosexual, upper-class, male framework that largely ignores or misrepresents those that do not fit these characteristics. The result is a gap in research and coverage of same-sex DA, the overall lack thereof, and how same-sex DA *is* covered, remaining problematic and limited, with them concluding that more mainstream and accurate coverage is needed

to effectively address the social issue (Estes & Webber, 2017). I shall return to this in the recommendations section below.

Whilst the above-mentioned documentary did include a couple of case studies involving a male victim, presenting it as revelatory that men can be victims of DA too, there was no mention of the fact that DA also takes place in same-sex relationships, thereby perpetuating the misconception that it only occurs in heterosexual relationships. Whilst being a male victim in a heterosexual relationship can be shaming enough, due to societal narratives around masculinity, being a male victim in a same-sex relationship is even further away from general societal discourse in the area of DA.

Two research participants had experiences that powerfully highlight the pervasiveness of the dominant narrative, and the implication for male and same-sex victims of DA. Firstly, when Keith went to the doctor about his aching jaw, and was told that it was dislocated, the doctor asked how he did it. When Keith risked sharing that it was his partner, the doctor asked if “she” does it often. The doctor was making a heterosexist assumption, echoing the public story of DA (Donovan & Hester, 2010) explored in Chapter 2, that effectively resulted in Keith “shutting off”, possibly going back into hiding, due to shame. The doctor did not ask any further questions, say anything about it being DA, or offer support, seemingly at odds with his duty of care. Had the doctor not made his heterosexist assumption and / or offered support, it could have been an important opportunity for Keith to get the help he needed before the abuse escalated further, with him getting cut with a knife in a subsequent incident. Keith’s experience is in line with research that suggests that several obstacles prevent LGBT people from getting help in cases of DA, heterosexism about all (Alhusen et al., 2010; O’Neal &

Parry, 2015). Conversely, in Episode 17 of “Meet, Marry, Murder”, when a woman had shared that her partner had assaulted her, the doctor was so concerned that he urged her to report the assault to the police, and offered support. Whilst we cannot know what was going through Keith’s doctor’s mind, he could have deemed the assault to be less serious because Keith is a man.

Further evidence of the dominant heteronormative narrative can be seen in Peter’s experiences, in which he was told by a) his support worker (connected to the refuge where he sought safety from his abusive family), that women have had to fight for a long time to be recognised as victims of abuse, thereby minimising men’s experiences, and b) another acquaintance, who was training to be a criminologist, that men do not experience DA, and do not really want to access services. Hearing these narratives, and having his experience invalidated, might explain why Peter only accessed therapy and spoke about his experiences of same-sex DA years after having been in the abusive relationship. The societal perception about male victims of DA can again be illustrated by Keith’s struggle to find a DA support group for male victims, reflecting research that showed that services are rarely available for LGBT people (Kay & Jeffries, 2010; Ford et al., 2013). When Keith eventually found one that welcomed all genders, he was the only man in the group and, what with men only being spoken about as perpetrators, this was shaming and confusing, resulting in him leaving the group, in line with a study by Cheung et al. (2009) that showed that gay men were not perceived as DA service consumers unless they were perpetrators. Furthermore, in two studies in the United States (Giorgio, 2002; Helfrich & Simpson, 2006), same-sex victims of DA reported heterosexism, discrimination, stigma, ridicule, disbelief, additional abuse, and hostility from services. It was only in therapy at an LGBT

organisation, that Keith was told that DA happens between men and therefore in gay relationships, challenging his perceptions of a) having to be a female in order to be a victim of DA and b) DA only occurring in heterosexual relationships. Can society hold and acknowledge the complexity that DA is not either / or, rather being both / and: Whilst women experience DA and need services to cater to their complex needs, men *also* experience harm and abuse, and *also* need support, and this does not lessen the voice of female victims. That is, surely everyone can have, and deserves to have a voice.

I now turn to a discussion of what is seen to constitute DA, and some of the challenges, in general, that can make it difficult for victims to name their experiences as such, whilst also specifically exploring the implications for gay men.

8.3.2.2 The Physical Violence Narrative

In Episode 13 of “Meet, Marry, Murder”, a DA specialist said that some behaviours, like control (non-physical) aren’t necessarily recognised as dangerous by society: “We only recognise violence as dangerous. We really need to recognise control as even more dangerous than violence”. They also opined that society might not be ready to accept that controlling one’s partner is abuse. This links into the public story of what constitutes DA, which is often that it is “violence” (Donovan & Hester, 2010), the implication being that it can be hard for victims of abuse, in general, to recognise, name and vocalise diverse forms of non-violent abuse such as psychological / emotional abuse and coercive control, as DA. This is in line with the findings of this research project, which showed that it was hard for participants to identify other types of non-violent abuse as harmful with Keith, for example, thinking that his partner’s

controlling behaviour showed that he cared. Non-violent abuse can therefore also be easier to dismiss / minimise / deny (Finneran & Stephenson, 2013) or even dissociate from, as a coping strategy, the implication being that non-violent abuse can be insidious, victims being like what I describe as frogs in slowly boiling water as the abuse escalates. It can therefore take a long time for DA victims in general to identify the abuse as harmful, particularly if they experienced abuse in their family of origin, thereby making it their norm. With gay men, there can be added layers of shame, and adeptness at hiding shameful things from a hostile, homophobic, heteronormative world, making it harder for them to recognise their experience as harmful, and reach out for support.

Even physical violence can be minimised, or explained away, with Harry making an excuse for having been pushed down the stairs by his partner, empathising and thinking about his partner's reasons for his behaviour, and how it linked to his partner's past. To add further complexity, the line between the perpetrator and the victim is not always clear, as abusive relationships can be messy. For example, Harry's partner sent *him* to therapy, saying *he* was the one with anger management issues. Perhaps Harry's partner was not aware that his own behaviour was abusive. Perhaps Harry *did* have anger management issues that manifested in such a way that he was perceived by his partner as abusive. People who have grown up in homes with DA can be more likely to be both a perpetrator and a victim in later life, therefore there can be an abuser in the victim, and a victim in the abuser. Perhaps, therefore, it isn't always useful to think in binary terms about who the victim is and who the abuser is, rather seeing the relationship itself as problematic for both parties. Nevertheless, scenarios such as this

can perhaps make it difficult for men to understand what is going on in their relationship and reach out for support.

As can be seen so far in this discussion, Self-with-Self and Self-with-Other organisation such as low self-esteem, shame, familiarity of abuse, adeptness at hiding shameful parts of self in a heterosexist world, mistrust in hostile others, as well as heteronormative narratives about DA, including who can be a victim, and narratives about what constitutes DA, can mean that gay male victims of DA can struggle to make sense of their experience as harmful, and indeed to name it as DA, and that only when things get exceptionally bad, possibly undeniable, do they reach a turning point, the point at which they know that something needs to change.

8.3.3 The Turning Point

Three out of five of my research participants only reached a turning point, the point at which they recognised the harm they were experiencing, and that something needed to change, once the abuse escalated to extreme physical levels: Charles ended up in hospital after an overdose, Andy was raped, and Keith's jaw was dislocated. Significantly, none of the participants named their experience as DA, even at this turning point, for all of the reasons discussed above, and reinforced by research by Donovan et al. (2006) which helps to explain why same-sex DA victims might not reach out to agencies even when they do recognise the harm they are experiencing: The research found that very few of the same-sex DA victims they interviewed reported or talked about their experiences with anybody or any agency, partly because DA is largely understood in Britain, including by the respondents, as a problem largely of heterosexual women being physically abused by their male partners. Therefore, most

respondents had not understood their experience at the time as being DA and it had thus not occurred to most of them to report their experiences to any agency or seek help (Donovan et al., 2006). All five participants only made sense of the experience and named it as DA once in therapy. Had they been *able to* label or name their experience as such earlier, perhaps the turning point could have come earlier. The implication for the mental health of gay male victims of DA is that they might stay in abusive relationship for longer without seeking support, a notion echoed by a study by Merrill & Wolfe (2000) that found that the lack of knowledge about DA was the third most commonly reported reason to remain in an abusive relationship, possibly due to the already-discussed fact that historically, DA was defined and studied from a heterosexual perspective, to the exclusion of any mention of same-sex relationships (Glass & Hassouneh, 2008; Little & Terrance, 2010).

Whilst we could say that reaching out to others for help is potentially counter-intuitive for this group of people, based on their layers of shame and adeptness at hiding, two participants reached out to their families at the turning point, seemingly in desperation, and primarily for help to escape their relationship. This finding accords with research findings, discussed earlier, that show that LGBT victims of DA are prone to seek help from informal sources (Salter et al., 2021), with a rather high percentage turning to family (Merrill & Wolfe, 2000; Scherzer, 1998; Turell, 2000). Being in what might be considered to be survival mode at the turning point, the priority for these two participants was safety, and escaping the relationship, not seeking professional support. As discussed in the results chapters, only one participant (Charles) who proactively reached out to his family at the turning point had professional support arranged for him after his mother took control. The second participant (Andy) who

proactively reached out to his family for help to leave his relationship did not seek or get professional support, only speaking about his experience in therapy over a decade later once training as a therapist. Keith did not reach out to anyone proactively at the turning point, with an opportunity to be offered support missed by his doctor. It was his manager at an LGBT organisation who saw him bleeding after a subsequent incident, who reached out *to him*, and to whom he disclosed his experience of abuse, who took control, putting support measures in place for Keith, including therapy. As discussed, Harry's therapy was arranged by his abusive partner, the turning point coming during a therapy session. Peter, like Andy, only spoke about his experience of abuse years later in therapy, his turning point being perhaps easier to navigate as he and the guy he was seeing did not live together, so he simply did not see the guy again. Therefore, three participants had therapy organised for them by an other, whilst two participants organised therapy for themselves years later, and not specifically to address their experience of DA. It might be that not identifying his experiences as DA helped to perpetuate Andy's denial of what he had experienced, as it was only in therapy with a trusted other that he eventually started to admit to himself, and then to his therapist, what he had endured in his abusive relationship. It might also be that Peter would have sought therapy sooner, had he not had the experiences of women invalidating his reality as an abused gay man, therefore making it even more difficult for him to recognise the harm he was experiencing, and name it as DA.

The profundity of the finding that no participants reached out directly for professional support such as therapy at the time of them struggling and suffering is of serious concern, yet makes sense based on the other findings of this research project, and other research in the area, outlined in the literature review in Chapter 2, which highlight

the barriers to recognising their experience as harmful (Donovan et al., 2006), and low levels of formal help-seeking (Guadalupe-Diaz, 2013; McClennen et al., 2002; Merrill & Wolfe, 2000). The implication for the mental health of gay men in DA relationships, if things have to get so extreme before they get support, and leave an abusive relationship, and / or only process trauma years later, is dire, and everything needs to be done to stop this group of people from continuing to suffer in silence. Considering the number of barriers gay male victims of DA face, I also believe that these turning points are critical: When victims do eventually take a relational risk by reaching out to an other / the enemy (Donovan & Hester, 2010) for help, appropriate and proportionate responses could literally be the different between life and death. Perhaps they need someone to rescue them, and take control, at that stage. Furthermore, some victims might reach out unconsciously: I believe that Keith going to the doctor with a dislocated jaw might have been a plea for help, particularly in light of him risking sharing with the doctor that his partner had hit him. Health professionals need to be better educated, which I shall expand on in the recommendations section.

As can be seen, participants faced a myriad of obstacles to getting to the point where they engaged with professional support such as therapy, over and above the already-existing challenges for general victims of DA. Obstacles seemed to include three layers of shame: Shame for being gay, shame for being a victim of abuse, and shame for being a male victim of abuse. The initial point of engagement with therapy could be seen to be them taking a risk in relation to an other (the therapist), considering their previous, hostile, experiences with other people: Why would they expect someone to be interested in helping them in a benevolent way, without judgement? Why would they trust that the therapist would not judge them for being gay, or for being a victim

of abuse, or for being a male victim of abuse? I now turn to an exploration of what enabled participants to engage with therapy at this vital stage, an opportunity to have a different relational experience with an other.

8.3.4 Therapy as a Reparative Relational Field

Once in therapy, my findings echo research by Burckell & Goldried (2006) in that safety, trust, and knowledge about gay issues were generally more important than the gender or sexuality of the therapist in helping participants return after the first session, thereby remaining engaged. Whilst Andy's therapist was heterosexual and did not know much about the "gay world", she was authentic and asked him about it, perhaps in and of itself reparative, as his parents might not have tried to understand him in this way, hence him leaving home as a teenager.

Therapy, or the "developmentally needed relationship" (Stern, 1994) has extraordinary reparative potential, not only to process and name the harm experienced as DA in a non-judgemental, contained space, but the co-created, collaborative therapeutic relationship with a benevolent other / therapist ultimately provides a different relational field (Stern, 2015) through which the social organ that is the brain can modify its connections / truncated neurological wiring and re-wire itself, particularly in relation to others, thereby helping to integrate disallowed and disavowed parts of self, and to be a more "individuated" (Mahler, 1968) and authentic "true self" (Winnicott, 1965).

Keith powerfully made sense of how he felt seen and heard in therapy for the first time in his life. Such an experience can greatly bolster self-esteem for someone who has never felt seen, heard or validated by an other. The therapist therefore ultimately offers

the client a new experience by assisting them to create a new narrative that holds new possibilities, and actively helping them to deal with fixed, repetitive patterns from the past, in order to effect change (Gilbert & Orlans, 2011). Furthermore, effective therapy offers the client "the possibility of obtaining an external perspective on self and the world that enables a change in self-perception and in view of life, the provision of new experiences that challenge past traumatic events, and the opportunity to consolidate new behaviours in a supportive environment" (ibid: 139). The therapeutic relationship can be reparative, restorative and healing by helping to reconfigure gay men's relationships with themselves (Self-with-Self) and others (Self-with-Other), by the therapist mirroring, validating, and accepting the gay man for who he is, and the gay male victim of DA for the experiences he has had, non-judgementally, thereby helping to dissipate shame, improve confidence and self-esteem, and equipping him to deal with the future with more honesty, congruence and self-awareness, and potentially breaking the repetitive cycle of shame and abuse. Having a more positive relationship with self and others can mean that gay men are a) less likely to tolerate abuse and b) more likely to reach out to a benevolent other for support, if needed. Whilst it was not the focus of this study, perhaps the impact of therapy could be evidenced by the fact that three of the participants reported having good / healthy relationships at the time of the interview, with one participant being married. Two participants were not in a relationship.

Having discussed the findings of this research project in relation to existing literature, research and theory, I now turn to the unique contributions that I feel it has made to counselling psychology and psychotherapy.

8.3.5 Unique Contribution

This research project has contributed to the area of same-sex DA in a number of ways, first and foremost by adding to the field of knowledge of the experience and sense-making of this vulnerable group of people. Whilst there is increasing research into the engagement with support services of same-sex victims in general (Donovan et al., 2006; Giorgio, 2002; Helfrich & Simpson, 2006) and gay male DA victims in particular (Cheung et al., 2009), as discussed in the literature review in Chapter 2, this project uniquely looked specifically at gay male DA victims' in-depth sense-making of their engagement with psychotherapy, highlighting the extent, complexity and myriad of barriers that this particular group of people can face on their journeys to *get* to explore the DA in therapy, where it was named as such for the first time. My unique contribution also includes the turning point, where the harm they were experiencing was recognised and acknowledged to themselves, sometimes resulting in them reaching out to an other. The knowledge that came out of this research project therefore contributes to the field of counselling psychology and psychotherapy by highlighting what therapists working with this group of people need to be aware of, in order for them to meet their needs more effectively. I shall discuss this in more detail in the recommendations section below.

8.4 Limitations

This research project has several limitations. Firstly, the findings are based on five gay men's experience of DA and engaging with therapy and, whilst IPA does not intend to be positivistic or generalisable, being a small, non-generalisable sample could limit how the research can be used in a largely positivist world in which extensive empirical data / proof is often required to secure funding for the provision of services. This is

particularly pertinent in an area that has been largely invisible to society for so long, and seemingly continues to be.

Further limitations also relate to the use of IPA as a methodology, as there is ultimately no perfect methodology, and different methodologies generally have a different focus. As discussed earlier in the introduction of the methodology chapter, in which I explored my rationale for choosing IPA for this research project (including the importance of safety and distance, considering my insider status of such an evocative subject matter, and the philosophical significance of IPA's double hermeneutic), narrative inquiry can perhaps give participants a clearer voice than IPA. For example, going back to participants for a second interview with the initial analysis can help participants to feel more included, and therefore for research to feel more democratic, co-created, collaborative and potentially empowering (Clandinin, 2006). IPA also has limitations in identifying power structures and dynamics, which can be very useful, but not ultimately what I set out to identify / highlight in this research project. Lastly, as mentioned earlier, whilst grounded theory (Strauss & Corbin, 1994) focuses on social processes, which can again be useful, this focus detracts from the individual's unique, phenomenological, lived experiences, which was the focus of my research project.

Another limitation pertains to the difficulties in defining my research area in relation to variations in definition of DA. As discussed in the literature review chapter, different terms are used for DA the world over, with the terms "domestic abuse", "domestic violence", "domestic violence and abuse" and "intimate partner violence" used interchangeably in research and literature. The impact of different terms being used by different researchers in different countries, and even different researchers in the

same country, highlights the complexity of ongoing discussion, debate, controversy and disagreement around what terms are best used (Geffner, 2016). Whilst for this research project, I used the term “domestic abuse” (DA) due to its widespread use among professional stakeholders in England, thereby hoping to ensure the findings of this thesis could be easily understood and integrated in this national context, this complexity is the tip of the iceberg because even if there were more consensus on which term to use, definitions of what constitutes abuse, and who can be a victim of abuse, are then hugely variable, something again highlighted in the literature review. The reality is that definitions of DA have not historically been attentive to gay men and, whilst there has been recent progress to specifically including same-sex partners (including non-cohabiting partners) in UK government definitions of DA, there still isn’t consensus across organisations and countries, so ultimately our understanding and responses to DA amongst gay men will continue to be complex, in a context in which they are generally not well defined, and in which definitions evolve. The lack of clarity of what constitutes DA due to variations in definition is, as discussed in the methodology chapter, also why I asked participants to self-define as having been a victim of DA. What I believe is most important is that definitions encompass a broad range of experiences, which can be specific to this population.

Lastly, the sample was made up of men who talked about their experiences of DA in therapy, thereby precluding gay men suffering from DA who had not had therapy. Understanding more about this hidden population would give us more insight into the barriers that gay male victims of DA experience in reaching out for and engaging with support such as therapy, and future research could try to access this group of people.

8.5 Recommendations

Having positioned my findings within the existing literature and discussed the limitations of this research project, I now look at the recommendations I propose as a result of this project, including the implications of my research on practice. Ultimately, the recommendations address what I feel needs to be done to decrease the likelihood of this vulnerable group of people from suffering in silence, and therefore to reach out to and engage with support services, including psychotherapy. I begin with recommendations for wider society, or the macrocosm, before turning to recommendations for health professionals in general; organisations working with DA victims and ending with individual therapists, or the microcosm.

Across all recommendations, the prevailing dominant societal narratives around DA need to be challenged by showing / educating people that DA a) can happen to anyone, including men, in all types of relationships, including same-sex relationships and b) is much more diverse than physical abuse.

8.5.1 Wider Society

Visibility and representation of all parts of our diverse society can help people feel recognised, validated and seen, thereby potentially decreasing the stigma and shame associated with being a minority / minority stress. Whilst acceptance and representation of the LGBT community has improved a lot over the last few decades, in the UK at least, I believe that more needs to be done specifically in relation to same-sex victims of DA.

8.5.1.1 Mass Media Interventions

Mass media interventions can be used to try to reshape discussions about DA to be more inclusive of gay men. Television and / or adverts are a medium through which interventions can be made. A gay male DA scenario, for example, could be written into television productions, or a documentary made on it. Television has a wide reach, and can help to educate not only gay men, who might be in an abusive situation without realising it, or know someone who is, but also wider society, about this important issue. Where there is an opportunity such as in the “Meet, Marry, Murder” series, producers could go further to say that DA can take many forms. Whilst they might not have a same-sex DA homicide case study, there is no reason why such a scenario couldn’t happen.

One of the participants has been on a television talk-show to raise awareness of this issue, and there could be more media coverage including talks and case studies on prime-time television.

I also recommend public health educational campaigns that highlight the diversity of DA victims, specifically including same-sex victims, without detracting from the VAWG (Violence Against Women and Girls) narrative, and the fact that the highest volume of victims are women. This could help society to think in more complex, and less binary / polarising ways. Campaigns could include case studies that highlight the diversity of abuse, and how destructive and damaging non-physical abuse can be.

One of the research participants, Keith, observed that, whilst there *are* DA advertising campaigns, they are advertised in the wrong places, and that they need specifically to

be on LGBT-specific social media platforms and in the LGBT community. He also suggested that it needs to be personal, with victims standing up and telling their stories to make it more real and relatable, and not only a short tweet on social media. Personal stories could also include the person talking about the benefits of engaging with therapy, thereby helping to destigmatise it. Further articles could help to destigmatise therapy within the LGBT community by espousing the benefits of therapy in general, for anyone wanting to improve their mental health, develop a better relationship with themself, and evolve as a person. That is, someone doesn't have to have something wrong with them in order to engage with therapy.

Other ways of raising awareness of same-sex DA in LGBT populations are posters and leaflets, that could be put up in LGBT venues, such as bars, clubs and saunas, and articles could be written for gay magazines. All advertising and articles should include the different forms that abuse can take, highlighting that DA is not just physical.

8.5.2 Health Professionals

I recommend CPD workshops or presentations for *all* front-line health professionals, in order to educate them about the prevalence and diversity of DA (thereby challenging heteronormative assumptions) including the variety of forms it can take. Furthermore, I concur with research that shows that clinicians must use inclusive language, avoiding any type of homophobic attitude, beginning from the first contact with the client (Eliason & Schope, 2001; Finneran et al., 2012). Doctors are at the front line and, with their duty of care, experiences such as Keith's should simply not happen. Front-line health professionals need to be vigilant to signs of abuse, and find ways of subtly, if

necessary, checking dubious scenarios out with patients. Indeed, Keith's manager handled the situation with his bleeding arm with great sensitivity.

8.5.2.1 Organisations Working with DA

I recommend that *all* organisations working with DA have training about the prevalence and diversity of DA, including that men can be victims, and that it occurs in same-sex relationships.

Additionally, I recommend specialist services that work specifically with same-sex DA victims, so as not to have a retraumatising scenario like Keith's where, as the only man, he felt like a perpetrator. The specialist service could be provided by a completely separate organisation or be within an organisation. For example, Victim Support works with DA in general, yet in the last 4 to 5 years, has evolved to provide specialised case workers for same-sex DA victims.

8.5.2.2 Therapists

I recommend a CPD workshop for *all* therapists, partly because, like Andy, gay men do not necessarily go to gay therapists, nor should they feel that they have to, in order to receive affirming care. Also, gay male victims of DA might go to therapy for general reasons, only for their experience of DA to subsequently / inadvertently come up.

In the CPD, I would highlight the length and complexity of the journey that some clients might have been on, before arriving to sit opposite the therapist in the first session. The first session is very significant and, whilst most therapists I imagine already do this, I would emphasise the Rogerian core conditions of empathy, congruence and

unconditional positive regard (1961), which provide the foundation for the client to feel seen and heard in a way they might not have experienced before. I would also emphasise the importance of not making heteronormative assumptions, and highlight the three layers of shame that could be present in such a client's process, including their potential level of vulnerability, particularly if they have come to therapy specifically to address the abuse. I would highlight that, because someone else might have arranged therapy for them, it does not mean that they do not want to be there, and that it might be more indicative of their level of distress, or difficulty functioning autonomously at that particular moment in time, which required someone else to take control and help them take the first steps to engaging with therapy. Them coming to therapy might be at the end of a very long and exhausting and painful journey to get there.

Lastly, I would emphasise how the client might see the therapist, being an other, as the enemy. The client might be in therapy out of desperation, as a last resort, and so them being there might be them courageously and counter-intuitively taking a relational risk by giving the therapist a chance to be something other than the enemy they have come to expect from the world. Working with these clients requires high levels of sensitivity, attunement, mirroring and collaboration as they learn to trust, and feel safe with an other. I would emphasise the reparative potential of the relational therapeutic dyad, which can help to break the repetitive pattern, and cycle of shame and abuse.

8.6 Conclusion

In concluding, I would like to revisit and reiterate the important themes that emerged from this IPA research project involving five research participants, which ultimately highlight how early developmental and familial relationships with others (and therefore themselves) informed their capacity to have healthy adult intimate relationships: Participants' Self-with-Self and Self-with-Other factors appeared to set the scene, or shape an environment or mindset where individuals might perceive or respond to abuse in complex ways. Some participants had poor relationships with themselves, including low self-esteem and a tendency to focus on the needs of others over their own, as well as shame for who they are, growing up in a sometimes-hostile heteronormative world in general, and sometimes also having been othered or abused in their family of origin, thereby not being mirrored, validated and accepted by an other for who they are. Through shame, some participants learned to hide. Sometimes, through the familiarity of being with a hostile / abusive / invalidating other, their relational pattern was unconsciously repeated in their intimate partner relationships. Participants experienced a broad range of forms of abuse and for some participants', familiarity with hostility and abuse meant that harmful behaviour towards them was difficult to identify as such. Combined with the potentially pernicious nature of emotional, psychological abuse and coercive control in DA in general, some participants became like frogs in slowly boiling water as the abuse escalated, even dismissing, dissociating from, minimising or explaining away some forms of physical abuse. Low self-esteem, shame, the familiarity of the abuse, their adeptness at hiding, mistrust in others, and heteronormative narratives about DA meant that only when things got exceptionally bad, possibly undeniable, did they reach the turning point at which they knew that something needed to change. Being in what appeared to be

survival mode, the priority seemed to be safety, and getting out of the relationship, not professional support. When participants did engage with professional support, it was either organised by an other at the time of the abuse, or by themselves, years later, not necessarily specifically to address the abuse. Importantly, all participants only named their abusive experiences as DA once in therapy.

Some participants had a very long journeys to therapy. Once there, safety, trust and awareness of gay issues on the part of the therapist was most important for engagement. The therapeutic relationship can be reparative: It helped some participants to reconfigure their relationships with themselves (Self-with-Self) and others (Self-with-Other), by the therapist mirroring, validating, and accepting them for who they are, thereby potentially breaking the repetitive cycle of shame and abuse. The end of therapy was significant for a number of participants, particularly where it involved a collaborative decision which emphasised self-agency.

By helping to give my research participants a voice by exploring their sense-making of their experiences, this research project has therefore highlighted the plethora of challenges that can be experienced by gay male victims of DA, and the barriers and enablers to getting professional support such as therapy. I would like to emphasise that therapy is important as it helped to improve participants' relationships with themselves and others, and therefore has the potential to break repetitive patterns of abuse. My hope is that the recommendations I have provided will raise awareness of this vulnerable group of peoples' struggles, thereby decreasing the likelihood of them suffering in silence, and having to get to an extreme place of harm: Violence, pain, suffering and blood before reaching out for help.

Just as the participants had multiple barriers hindering them from getting the support that they needed, I experienced multiple barriers to completing this research project, including *my* years of denial about *my* experiences of abuse: By doing this research project, I have ultimately been forced to come into contact with my own material that, for decades, was too painful to confront. Therefore, this project has also given *me* a voice, enabling me to make sense of *my* abusive experiences, and understand why I did not get the support I needed, and engage with therapy at the time. Perhaps some clouds have a silver lining: Had I gone to therapy and processed my experiences of abuse twenty-five years ago, perhaps I would not have felt compelled to carry out this research, and would not be writing this last sentence right now.

REFERENCES

Albuquerque, G., de Lima Garcia, C., da Silva Quirino, G., Alves, M. J. H., Belém, J. M., dos Santos Figueiredo, F. W., & Adami, F. (2016) Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review. *BMC International Health and Human Rights*, *16*(1), 1-10.

Alhusen, J. L., Lucea, M. B., & Glass, N. (2010) Perceptions of and experience with system responses to female same-sex intimate partner violence. *Partner abuse*, *1*(4), 443-462.

Alvesson, M. (2003) 'Beyond Neopositivists, Romantics, and Localists: A Reflexive Approach to Interviews in Organisational Research', Academy of Management Review, 28 (1) 13–33.

American Civil Liberties Union (2022) [Online]. Available from: Domestic Violence Protections for LGBTQ People | ACLU of North Carolina [Accessed September 2022]

Babcock, B. A. (1980) Reflexivity: Definitions and discriminations.

Baker, N. L., Buick, J. D., Kim, S. R., Moniz, S., & Nava, K. L. (2013) Lessons from examining same-sex intimate partner violence. *Sex roles*, *69*(3), 182-192.

Ballinger, C., & Payne, S. (2000) Falling from grace or into expert hands? Alternative accounts about falling in older people. *British Journal of Occupational Therapy*, *63*(12), 573-579.

Balsam, K. F. (2001) Nowhere to hide: Lesbian battering, homophobia, and minority stress. *Women & Therapy*, *23*(3), 25-37.

Barnes, P. G. (1998) It's just a quarrel'. *ABA Journal*, *84*(2), 24-25.

Barrett, B. J. (2015) Domestic violence in the LGBT community. In *Encyclopaedia of Social Work*.

Barrett, B. J., & St. Pierre, M. (2013) Intimate partner violence reported by lesbian-, gay-, and bisexual-identified individuals living in Canada: An exploration of within-group variations. *Journal of Gay & Lesbian Social Services*, *25*(1), 1-23.

Biggerstaff, D., & Thompson, A. R. (2008) Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative research in psychology*, *5*(3), 214-224.

Blumer, H. (1969) Symbolic interactionism: perspective and method. Englewood Cliffs: Prentice-Hall.

Blumer, H. (1981) George Herbert Mead. In B. Rhea (Ed.), The future of sociological classics (pp. 136-169). London: Allen & Unwin.

Bordin, E.S. (1979) The Generalizability of the Psychoanalytical Concept of the Working Alliance. *Psychotherapy: Theory, Research & Practice,* 16, 252 – 260.

Bourne, A., & Weatherburn, P. (2017) Substance use among men who have sex with men: patterns, motivations, impacts and intervention development need. *Sexually transmitted infections*, *93*(5), 342-346.

Bowlby, J. (1988) *A Secure Base.* Abingdon: Routledge.

Breen, L. J. (2007) The researcher 'in the middle': Negotiating the insider/outsider dichotomy. The Australian Community Psychologist, 19(1), 163-174.

British Psychological Society (2022) Therapies attempting to change sexual orientation. [Online]. Available from: http://www.bps.org.uk/ [Accessed March 2022]

Broomfield, N. M., & Birch, L. (2009) Primary care mental health teams: where are all the older people?. *Clinical Psychology*, *198*, 16-19.

Brown, M.J. & Groscup, J. (2009) Perceptions of Same-sex Domestic Violence Among Crisis Center Staff. *Journal of Family Violence*, 24, 87–93.

Burckell, L. A., & Goldfried, M. R. (2006) Therapist qualities preferred by sexual-minority individuals. *Psychotherapy: Theory, research, practice, training*, *43*(1), 32.

Burke, L. K. & Follingstad, D. R. (1999) Violence in lesbian and gay relationships: Theory, prevalence, and correlational factors. *Clinical Psychology Review*, 19, 487–512.

Burke, T. W., Jordan, M. L., & Owen, S. S. (2002) A cross-national comparison of gay and lesbian domestic violence. *Journal of Contemporary Criminal Justice*, *18*(3), 231-257.

Campbell, J. C. (2002) Health consequences of intimate partner violence. *The lancet*, *359*(9314), 1331-1336.

Carvalho, A. F., Lewis, R. J., Derlega, V. J., Winstead, B. A., & Viggiano, C. (2011) Internalized sexual minority stressors and same-sex intimate partner violence. *Journal of Family Violence*, *26*(7), 501-509.

Casement, P. (1985) *On Learning from the Patient.* London: Routledge.

Chard, A. N., Finneran, C., Sullivan, P. S., & Stephenson, R. (2015) Experiences of homophobia among gay and bisexual men: results from a cross-sectional study in seven countries. *Culture, health & sexuality*, *17*(10), 1174-1189.

Charlick, S. J., Pincombe, J., McKellar, L., & Fielder, A. (2016) Making sense of participant experiences: Interpretative phenomenological analysis in midwifery research. *International Journal of Doctoral Studies*, *11*, 205.

Cheung, M., Leung, P., & Tsui, V. (2009) Asian male domestic violence victims: Services exclusive for men. *Journal of family violence*, *24*(7), 447-462.

Clandinin, D. J., (Ed.) (2006) *Handbook of narrative inquiry: Mapping a methodology*. Sage Publications.

Clarke, P., O'Malley, P. M., Johnston, L. D., & Schulenberg, J. E. (2009) Social disparities in BMI trajectories across adulthood by gender, race/ethnicity and lifetime socio-economic position: 1986–2004. *International Journal of Epidemiology*, *38*(2), 499-509.

Clarkson, P. (2004) *The Therapeutic Relationship.* London: Whurr.

Conrad, P. (1987) The experience of illness: recent and new directions. *Research in the sociology of health care. Vol. 6: the experience and management of chronic illness*, 1-31.

Costa, B. M., Kaestle, C. E., Walker, A., Curtis, A., Day, A., Toumbourou, J. W., & Miller, P. (2015) Longitudinal predictors of domestic violence perpetration and victimization: A systematic review. *Aggression and violent behavior*, *24*, 261-272.

Crotty, M. (1998) 'Interpretivism: for and against culture', The Foundations of Social Research, Meaning and Perspective in the Research Process, London: Sage.

Cruz, J. M. & Firestone, J. M. (1998) Exploring violence and abuse in gay male relationships. *Violence and Victims*, 13, 159–173.

Davies, H. (2008) Reflexivity in research practice: Informed consent with children at school and at home. *Sociological Research Online*, *13*(4), 17-30.

Darwin, C. (1968) *On the Origin of Species by Means of Natural Selection*. 1859. London: Murray.

Dewaele, A., Cox, N., Van den Berghe, W., & Vincke, J. (2011) Families of choice? Exploring the supportive networks of lesbians, gay men, and bisexuals 1. *Journal of Applied Social Psychology*, *41*(2), 312-331.

Donovan, C., & Barnes, R. (2020) Help-seeking among lesbian, gay, bisexual and/or transgender victims/survivors of domestic violence and abuse: The impacts of cisgendered heteronormativity and invisibility. *Journal of Sociology*, *56*(4), 554-570.

Donovan, C., & Hester, M. (2010) ‘I Hate the Word “Victim”’: An Exploration of Recognition of Domestic Violence in Same Sex Relationships1. *Social Policy and Society*, *9*(2), 279-289.

Donovan, C., Hester, M., Holmes, J., and McCarry, M. (2006) Comparing Domestic Abuse in Same Sex and Heterosexual Relationships. University of Sunderland and University of Bristol.

Eliason, M. J., & Schope, R. (2001) Does “don’t ask don’t tell” apply to health care? Lesbian, gay, and bisexual people’s disclosure to health care providers. J Gay Lesbian Med Assoc 5, 125–134.

Estes, M. L., & Webber, G. R. (2021) "More Closeted Than Gayness Itself": The Depiction of Same-Sex Couple Violence in Newspaper Media. *Journal of interpersonal violence*, *36* (1-2).

Etherington, K. (2004) *Becoming a reflexive researcher: using ourselves in research*. London: Jessica Kingsley.

Etherington, K. (2007) ‘Working with traumatic stories: from transcriber to witness’, International Journal of Social Research Methodology, Vol. 10(2), 85–97.

Ferraro, K. J., & Johnson, M. P. (2000) Research on domestic violence in the 1990s: Making distinctions. *Journal of marriage and family*, *62*(4), 948-963.

Finneran, C., Chard, A., Sineath, C., Sullivan, P., & Stephenson, R. (2012) Intimate partner violence and social pressure among gay men in six countries. *Western Journal of Emergency Medicine*, *13*(3), 260.

Finneran, C., & Stephenson, R. (2013) Intimate partner violence among men who have sex with men: a systematic review. Trauma Violence Abuse 14, 168–185.

Ford, C. L., Slavin, T., Hilton, K. L., & Holt, S. L. (2013) Intimate partner violence prevention services and resources in Los Angeles: Issues, needs, and challenges for assisting lesbian, gay, bisexual, and transgender clients. *Health promotion practice*, *14*(6), 841-849.

Freud, S. (1923) *The Ego and the Id. In complete Works of Sigmund Freud,* Vol. 19, 2001. Vintage paperback edition.

Gaspar, M., Skakoon-Sparling, S., Adam, B. D., Brennan, D. J., Lachowsky, N. J., Cox, J., ... & Grace, D. (2021) "You're gay, it's just what happens": Sexual minority men recounting experiences of unwanted sex in the era of Me Too. *The Journal of Sex Research*, *58*(9), 1205-1214.

Geffner, R. (2016) Partner aggression versus partner abuse terminology: Moving the field forward and resolving controversies. *Journal of Family Violence*, *31*(8), 923-925.

Gerhardt, S. (2004) *Why Love Matters: How Affection Shapes a Baby's Brain.* London: Routledge.

Gilbert, M., & Orlans, V. (2011) *Integrative therapy: 100 key points and techniques*. Routledge.

Giorgio, G. (2002) Speaking silence: Definitional dialogues in abusive lesbian relationships. *Violence against women*, *8*(10), 1233-1259.

Glass, N., & Hassouneh, D. (2008) The influence of gender role stereotyping on women's experiences of female same-sex intimate partner violence. *Violence Against Women*, *14*(3), 310-325.

Great Britain. *Domestic Violence, Crime and Victims Act of 2004. Elizabeth II. Chapter 28. (2004) London.*

Greenwood, G. L., Relf, M. V., Huang, B., Pollack, L. M., Canchola, J. A. & Catania, J. A. (2002) Battering victimization among a probability-based sample of men who have sex with men. *American Journal of Public Health*, 92, 1964–1969.

Guadalupe-Diaz, X. (2013) An exploration of differences in the help-seeking of LGBQ victims of violence by race, economic class and gender. Gay and Lesbian Issues and Psychology Review, 9(1), 15.

Guadalupe-Diaz, X. L., & Yglesias, J. (2013) "Who's Protected?" Exploring Perceptions of Domestic Violence Law by Lesbians, Gays, and Bisexuals. *Journal of Gay & Lesbian Social Services*, *25*(4), 465-485.

Gunawan, J. (2015) Ensuring trustworthiness in qualitative research. *Belitung Nursing Journal*, *1*(1), 10-11.

Harari, Y.N. and Perkins, D. (2014) *Sapiens: A brief history of humankind*. London: Harvill Secker.

Heidegger, M. (1963) *The origin of the work of art*. University of Waterloo.

Helfrich, C. A., & Simpson, E. K. (2006) Improving services for lesbian clients: What do domestic violence agencies need to do? *Health Care for Women International*, *27*(4), 344-361.

Henderson, L. (2003) Prevalence of Domestic Violence among Lesbians and Gay Men: Data report to Flame TV. London: Sigma Research.

Hertz, R. (1997) *Reflexivity and voice*. London: Sage.

Horvath, A. O., Del Re, A. C., Flückiger, C. and Symonds, D. (2011) Alliance in individual psychotherapy, *Psychotherapy*, 48(1).

Husserl, E. (1927). Phenomenology. *Encyclopaedia Britannica*, *14*, 699-702.

Jablow, P. M. (2000) Victims of abuse and discrimination: Protecting battered homosexuals under domestic violence legislation. *Hofstra Law Review*, 28, 1095–1145.

Jacobson, C.H. (2007) A qualitative single case study of parallel processes. *Counselling and Psychotherapy Research, March 2007; 7(1)*, 26 – 33.

Johnson, W. L., Giordano, P. C., Longmore, M. A., & Manning, W. D. (2014) Intimate partner violence and depressive symptoms during adolescence and young adulthood. *Journal of health and social behavior*, *55*(1), 39-55.

Jørgensen, M. W., & Phillips, L. J. (2002) *Discourse analysis as theory and method*. Sage.

Jowett, A., Brady, G., Goodman, S., Pillinger, C., & Bradley, L. (2021) Conversion Therapy: An evidence assessment and qualitative study.

Karpman, S. (2014) *A Game Free Life*. Self-published.

Kay, M., & Jeffries, S. (2010). Homophobia, heteronormativism and hegemonic masculinity: Male same-sex intimate violence from the perspective of Brisbane service providers. *Psychiatry, Psychology and Law*, *17*(3), 412-423.

Kelly, E. & Warshafsky, L. (1987) Partner abuse in gay male and lesbian couples. Paper presented at the Third National Conference of Family Violence Researchers, Durham, NH.

Keogh, P., Weatherburn, P., Henderson, L., Reid, D., Dodds, C., & Hickson, F. (2004) Doctoring gay men: exploring the contribution of general practice.

Kohut, H. (1971) *The Analysis of the Self.* New York: International University Press.

Kwong, M. J., Bartholomew, K., Henderson, A. Z., & Trinke, S. J. (2003) The intergenerational transmission of relationship violence. Journal of Family Psychology, 17(3), 288 – 301.

Langdridge, D. (2007) Phenomenological psychology: theory, research & method. Harlow: Pearson Education.

Larkin, M., Watts, S., Clifton, E. (2006) Qualitative Research in Psychology, 3, 102 – 120.

Lee, R.M. (1993) Doing Research on Sensitive Topics, London: Sage.

Letellier, P. (1994) Gay and bisexual male domestic violence victimization: Challenges to feminist theory and responses to violence. *Violence and Victims,* 9, 95–105.

Lewis, R. J., Milletich, R. J., Kelley, M. L., & Woody, A. (2012). Minority stress, substance use, and intimate partner violence among sexual minority women. *Aggression and Violent Behavior*, *17*(3), 247-256.

LGBTQ Institute (2022) [Online] Available from: https://www.lgbtqinstitute.org [Accessed July 2022]

Lim, G., Waling, A., Lyons, A., Pepping, C. A., Brooks, A., & Bourne, A. (2021) The experiences of lesbian, gay and bisexual people accessing mental health crisis support helplines in Australia. *Psychology & Sexuality*, 1-18.

Lim, G., Waling, A., Lyons, A., Pepping, C. A., Brooks, A., & Bourne, A. (2021) Trans and Gender-Diverse peoples' experiences of crisis helpline services. *Health & Social Care in the Community*, *29*(3), 672-684.

Little, B., & Terrance, C. (2010). Perceptions of domestic violence in lesbian relationships: Stereotypes and gender role expectations. *Journal of Homosexuality*, *57*(3), 429-440.

Lusby, S., Lim, G., Carman, M., Fraser, S., Parsons, M., Fairchild, J., & Bourne, A. (2022) Opening Doors: Ensuring LGBTIQ-inclusive family, domestic and sexual violence services.

Mahler, M. (1968) *On human symbiosis and the vicissitudes of individuation.* New York: International Universities Press.

Marrujo, B. & Kreger, M. (1996) Definition of roles in abusive lesbian relationships. *Journal of Gay and Lesbian Social Services*, 4, 22–33.

Martin, P. (2010) Celebrating the wounded healer. *Counselling Psychology Review*, *26*(1), 10-19.

Maxwell, S., O'Brien, R., Stenhouse, R., Kerr, Y., & Ward, C. (2022) Experiences of Scottish men who have been subject to intimate partner violence in same-sex relationships.

McClennen, J. C. (2005) Domestic violence between same-gender partners: Recent findings and future research. *Journal of interpersonal violence*, *20*(2), 149-154.

McClennen, J. C., Summers, A. B., & Vaughan, C. (2002) Gay men's domestic violence: Dynamics, help-seeking behaviors, and correlates. Journal of Gay & Lesbian Social Services, 14(1), 23–49.

McKelley, R.A. (2007) Men's resistance to seeking help: Using individual psychology to understand counseling-reluctant men. Journal of Individual Psychology, 63(1), 48–58.

Merrill, G. S. & Wolfe, V. A. (2000) Battered gay men: An exploration of abuse, help-seeking, and why they stay. *Journal of Homosexuality,* 39(2), 1–30.

Messinger, A. M. (2011) Invisible victims: Same-sex IPV in the national violence against women survey. *Journal of interpersonal violence*, *26*(11), 2228-2243.

Meyer, I. H. (1995) Minority stress and mental health in gay men. *Journal of health and social behavior*, 38-56.

Miller, A. (1987) *The Drama of Being a Child.* Great Britain: Virago Press.

Murray, C. E., Mobley, A. K., Buford, A. P., & Seaman-DeJohn, M. M. (2007) Same-sex intimate partner violence: Dynamics, social context, and counseling implications. *Journal of LGBT Issues in Counseling*, *1*(4), 7-30.

Murray, C. E., & Mobley, A. K. (2009) Empirical research about same-sex intimate partner violence: A methodological review. *Journal of homosexuality*, *56*(3), 361-386.

Noone, J.H., & Stephens, C. (2008) Men, masculine identities, and health care utilisation. Sociology of Health & Illness, 30, 711–725.

Ortlipp, M. (2008) Keeping and Using Reflective Journals in the Qualitative Research Process. *The Qualitative Report,* 13 (4), 695 – 705.

Parry, M. M., & O'Neal, E. N. (2015) Help-seeking behavior among same-sex intimate partner violence victims: An intersectional argument. *Criminology, Crim. Just. L & Soc'y*, *16*, 51.

Pattavina, A., Hirschel, D., Buzawa, E., Faggiani, D., & Bentley, H. (2007) A comparison of the police response to heterosexual versus same-sex intimate partner violence. *Violence Against Women*, *13*(4), 374-394.

Pilgrim, D. & Rogers, A. (2003) Mental Disorder and Violence: An Empirical Picture in Context. Journal of Mental Health, 12(1), 7-18.

Pillow, W. S. (2010) Dangerous reflexivity: Rigour, responsibility and reflexivity in qualitative research. *The Routledge doctoral student's companion*, 270-282.

Platzer, H., & James, T. (1997) Methodological issues conducting sensitive research on lesbian and gay men's experience of nursing care. *Journal of Advanced Nursing*, *25*(3), pp.626-633.

Ponterotto, J. (2005) Qualitative Research in Counseling Psychology: A Primer on Research Paradigms and Philosophy of Science. *Journal of Counseling Psychology, Vol. 52, No. 2, 126-136.*

Potoczniak, M.J., Mourot, J.E., Crosbie-Burnett, M. & Potoczniak, D.J. (2003) Legal and Psychological Perspectives on Same-Sex Domestic Violence: A Multisystemic Approach. *Journal of Family Psychology,* 17(2), 252–259.

Putnam, F.W. (1994) Dissociation and Disturbances of Self. In D. Cicchetti & S.L. Toth (eds.), Rochester Symposium on Developmental Psychopathology: Disorders and Dysfunctions of the Self (Vol. 5, pp. 251-265). New York: University of Rochester Press.

Reid, R. J., Bonomi, A. E., Rivara, F. P., Anderson, M. L., Fishman, P. A., Carrell, D. S., & Thompson, R. S. (2008) Intimate partner violence among men: Prevalence, chronicity, and health effects. *American journal of preventive medicine*, *34*(6), 478-485.

Renzetti, C. M. (1997) Violence in lesbian and gay relationships. In L. O'Toole & J. R. Schiffman (Eds.), Gender violence: Interdisciplinary perspectives. New York: New York University.

Rogers, C. (1961) *On becoming a person: A therapist's view of psychotherapy*. London: Constable.

Rohrbaugh, J. B. (2006) Domestic violence in same-gender relationships. *Family court review*, *44*(2), 287-299.

Rolle, L., Giardina, G., Caldarera, A. M., Gerino, E., & Brustia, P. (2018) When intimate partner violence meets same sex couples: A review of same sex intimate partner violence. *Frontiers in psychology*, *9*, 1506.

Salter, M., Robinson, K., Ullman, J., Denson, N., Ovenden, G., Noonan, K. & Huppatz, K. (2021) Gay, bisexual, and queer men's attitudes and understandings of intimate partner violence and sexual assault. *Journal of interpersonal violence*, *36*(23-24), 11630-11657.

Sandelowski, M. (1995) Sample size in qualitative research. *Research in nursing & health*, *18*(2), 179-183.

Scherzer, T. (1998) Domestic violence in lesbian relationships: findings of the lesbian relationships research project. J. Fam. Stud. 2, 29–47.

Schore, A.N. (2003) *Affect Dysregulation and Disorders of the Self.* New York: W. W. Norton.

Scott-Storey, K., O'Donnell, S., Ford-Gilboe, M., Varcoe, C., Wathen, N., Malcolm, J., & Vincent, C. (2023) What about the men? a critical review of men's experiences of intimate partner violence. *Trauma, Violence, & Abuse*, *24*(2), 858-872.

Sheila, M. & Seelau, E.P. (2005) Gender-Role Stereotypes and Perceptions of Heterosexual, Gay and Lesbian Domestic Violence *Journal of Family Violence, 20(6), 363 – 371.*

Siegel, D. J. (1999) *The Developing Mind: how relationships and the brain interact to shape who we are.* New York, Guilford Press.

Smith, J. A. (1996) Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and health*, *11*(2), 261-271.

Smith, J., Flower, P., and Larkin, M. (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Sokoloff, N. J., & Dupont, I. (2005) Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence against women*, *11*(1), 38-64.

Spinelli, E. (2005) *The Interpreted World: An Introduction to Phenomenological Psychology.* (2nd Edition). London: Sage.

Stark, E. (2009) Rethinking custody evaluation in cases involving domestic violence. Journal of Child Custody 6: 287–321.

Stern, D. B. (2015) *Relational freedom: Emergent properties of the interpersonal field*. Routledge.

Stern, D.N. (1985) *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology.* New York: Basic Books.

Stern, D. N., Sander L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth , K., Morgan, A. C., Bruschweilerstern, N. and Tronick, E.Z. (1998) The Process of Therapeutic Change Involving Implicit Knowledge: Some Implications of Developmental Observations for Adult Psychotherapy. *Infant Mental Health Journal Vol.* 19(3), 300 – 308.

Stern, S. (1994) Needed relationships and repeated relationships an integrated relational perspective. *Psychoanalytic Dialogues*, 4(3), 317-346.

Straus, M., & Gelles, R. (1990) How violent are American families? Estimates from the National Family Violence Resurvey and other studies. In M. Straus, & R. Gelles (Eds.), Physical violence in American families. New Brunswick: Transaction.

Strauss, A., & Corbin, J. (1994) Grounded theory methodology: An overview.

Turrell, S.C. (2000) A descriptive analysis of same-sex relationship violence for a diverse sample. *Journal of Family Violence*, 15, 281–293.

United Kingdom Home Office (2022). [Online] Available from: Domestic Abuse Act 2021 - GOV.UK (www.gov.uk) [Accessed July 2022]

United Nations (2022) [Online]. Available from: What Is Domestic Abuse? | United Nations [Accessed July 2022]

Van der Hart, O., Nijenhuis, E. R. and Steele, K. (2006) *The haunted self: Structural dissociation and the treatment of chronic traumatization*. WW Norton & Company.

Van Maanen, J., Frost, P., Moore, P., Lundberg, C., Louis, M., & Martin, J. (1991) *The smile factory* (pp. 58-76).

Victim Support (2022) [Online]. Available from: http://www.victimsupport.org.uk [Accessed April 2022]

Waldner-Haugrud, L. K., Gratch, L. V. & Magruder, B. (1997) Victimization and perpetration rates of violence in gay and lesbian relationships: gender issues explored. *Violence and Victims*, 12, 173–184.

Walters, M. L., Chen, J., & Breiding, M. J. (2013) The national intimate partner and sexual violence survey: 2010 findings on victimization by sexual orientation.

Weaver, C. M., Borkowski, J. G., & Whitman, T. L. (2008) Violence breeds violence: Childhood exposure and adolescent conduct problems. Journal of Community Psychology, 36(1), 96-112.

West, W. (2002) Ethical dilemmas in counselling and counselling research. *British Journal of Guidance and Counselling, 30 (3), 261 – 268.*

Whitaker, E. M., & Atkinson, P. A. (2019) Reflexivity.

Williams, A. (2021) Alienated in Community: A Personal History of Homophobia and Conversion Therapy. *Transactional Analysis Journal*, *51*(1), 77-90.

Willig, C. (2013) Introducing Qualitative Research in Psychology. Open University Press. Berkshire, England. (Third Edition).

Winnicott, D.W. (1971) *Playing and reality*. Psychology Press.

Winnicott, D. W. (1965) *The Maturational Processes and the Facilitating Environment.* New York: Karnac Books.

APPENDICES

Appendix A: Interview Schedule

Interview Schedule

Being a phenomenological enquiry, I will try to limit pre-determined questioning, thereby allow for more fluidity and exploration in the interview. These questions could act as a prompt.

General (including masculinity and identity / sexuality)

- How would you describe yourself as a person? ***(Prompt – What sort of person are you? Most important characteristics: happy, moody, nervy)***
- How do you feel about being gay?

DA

- Could you give me a brief history of your experience of DA?

(I imagine it will automatically cover how it feels to have been a victim of DA and their thoughts and feelings at the time. If not, I can ask them these questions)

- How did it impact your everyday life?
- How did being a victim of DA impact how you saw and felt about yourself?

Accessing support

- Can you tell me when you felt that you needed professional support?
- Can you tell me about the practicalities of accessing the support?

(Prompt: How did it come about? Ask about them making the first call / contact and how they were feeling. Ask about how long it took to action / set up and generally what the experience was like)

What helped / enabled you to access the service?

Were there any issues or problems that made it hard for you to access the service?

(Prompt for both practical [timing, waiting list] as well as psychological [admitting I was struggling etc)

Therapy

- What did you imagine you might be able to take away from therapy / what did you think therapy does?
- What were your thoughts and feelings before you met with the therapist?
- What was your experience of the first session?
- ***(Prompt: What they you thinking / feeling. What do you remember about what you said / didn't say. What was your immediate reflections walking out of the room)***

What in the therapeutic encounter helped you to stay / remain engaged?

Were there specific qualities of the therapist that helped you to remain engaged?

In thinking about your last therapy session, how was it different from your first one?

(NOTE: What journey, if any, had they and the therapist taken together)

How did it feel for you to be in therapy as a victim of gay male DA?

What do they think of therapy as a whole?

- What did the therapy mean to you?

What do you think that therapists could do to increase engagement of gay male DA victims?

Appendix B: Participant Information Sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET (PIS)

1. Study title

A study of domestic abuse and psychotherapy amongst gay men.

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

3. What is the purpose of the study?

Being a victim of domestic abuse (DA) can be extremely stressful and traumatic and, whilst research shows that same-sex domestic abuse is just as prevalent as heterosexual domestic abuse, there is much less research in the area, particularly in relation to gay men. Because there is much we don't know about what motivates gay male victims of domestic abuse to seek professional help and their experience of this if they do take it up, this study will explore this area. A better understanding of the issues could help to ensure that health professionals and counsellors are in a position to support gay men who have been the victim of domestic abuse and possibly increase the likelihood of them getting the support they need.

4. Why have I been chosen?

This project will involve interviews with 4 to 6 gay male victims of domestic abuse. You have been chosen as you are a gay male who defines himself as a victim of domestic abuse with an intimate partner, for which you have attended a number of therapy sessions. This might mean you are able to reflect on how you found the experience.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?

You will be invited to attend an audio-recorded semi-structured interview at a mutually convenient time and location where I will ask you exploratory questions about your experience of accessing psychological therapy. The interview will generally last a maximum of 1,5 hours.

Three to four months later, you will be invited back for a non-obligatory second interview. The end of that interview will be the end of your participation. I aim to complete the research at the end of 2019, when you will receive a copy of the final report should you like one.

7. What are the possible disadvantages and risks of taking part?

If the interview stirs you up and you become distressed, you can ask to stop the interview at any stage.

To provide you with any support required, I shall conduct a debriefing with you at the end of each interview and arrange to contact you a few weeks after the interview to see how you are doing. I shall also provide you with a resource information sheet in case you get stirred up in / after the interview and would like further support from a DA organisation that is supportive of the needs of gay men, such as GALOP.

8. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. All interviews and conversations will be recorded and transcribed and stored in password protected and encrypted storage. Any information about you that is used will have your name and address removed so that you cannot be recognised from it, and I shall take the context out of the write-up to

decrease the likelihood of you being identifiable. All data will be stored, analysed and reported in compliance with the Data Protection legislation of the UK.

Whilst the informed consent form you will sign if you choose to participate will allow me to use your quotes, I shall also ask your permission again before using them, to provide you with an opportunity to review them.

With all these measure in place, it is extremely unlikely that you would be identifiable from the study, but note that anonymity cannot be absolutely guaranteed given the nature of the study and the uniqueness of your story.

9. What will happen to the results of the research study?

This research will be published as a postgraduate dissertation in the Middlesex University Research Repository within the next two years. I may also publish the findings in research journals and / or discuss them at conferences with health and social care professionals. You will be able to obtain a copy of the final dissertation through my access to the repository. You will not be identifiable in the event of the publication of any research articles arising from the study.

10. Who has reviewed the study?

The Metanoia Research Ethics Committee.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

11. Contact for further information

Researcher's name and contact details:

Name: Shaun Bruwer
Mobile: +44 (0)7900 674550
Email: shaun.bruwer@metanoia.ac.uk

Appendix C: Consent Form

CONSENT FORM

Title of Project: A study of domestic abuse and psychotherapy amongst gay men.
Name of Researcher: Shaun Bruwer
Participant Identification Number:

Please initial box

1. I confirm that I have read and understand the information sheet dated.....2019 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐

3. I understand that my interview will be taped and subsequently transcribed. ☐

☐

4. I consent to the researcher using my quotes in the write-up of the research. ☐

5. I agree to take part in the above study. ☐

6. I agree that this form that bears my name and signature may be seen by a designated auditor.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix D: Ethical Approval

Shaun Bruwer
DCPsych programme
Metanoia Institute

12th December 2016

Ref: 8/16-17

Dear Shaun

Re: A phenomenological enquiry into gay male domestic abuse victims' experience of engaging with psychotherapy

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

Dr Patricia Moran
Subject Specialist (Research), DCPsych Programme
Faculty of Applied Research and Clinical Practice
On behalf of Metanoia Institute Research Ethics Committee

Appendix E: Resource Information Sheet

RESOURCE INFORMATION SHEET

This sheet includes the details of a number of organisations known for their expertise in supporting victims of domestic abuse, and are known for being "gay friendly". Should you feel that you need support, it might be useful for you to contact one of these organisations.

GALOP (National LGBT+ Domestic Abuse Helpline)

About: Emotional and practical support for LGBT+ people experiencing domestic abuse. Abuse isn't always physical - it can be psychological, emotional, financial and sexual too. Speak out, don't suffer in silence.
Tel: 0800 999 5428
Email: help@galop.org.uk

London LGBT+ Domestic Abuse Partnership

About: If you are in London, the LGBT+ Domestic Abuse Partnership (DAP) can help too. The DAP is made up of 4 LGBT+ agencies who each provide different services for LGBT+ victims of domestic abuse. With one phone call, you will be linked in with Galop, Stonewall Housing, LGBT+ Switchboard, and London Friend.
Tel: 0207 704 2040
Email: referrals@galop.org.uk

Victim Support

About: Victim Support is the national charity that provides emotional and practical support to people affected by crime.
Tel: 08081689111 for Supportline
Tel: 08081689293 for Victim Information Service
Email: You can email Victim Support from their website page as follows - https://www.victimsupport.org.uk/help-and-support/get-help

Appendix F: Research Supervisor Confirmation of Consent

Research Supervisor Confirmation of Consent

Name of student: Shaun Bruwer

Name of research project: **A phenomenological enquiry into gay male domestic abuse victims' experience of engaging with psychotherapy**

This is to verify that as Research Supervisor for the above research project I have seen proof that appropriate consent has been obtained from the participants used in the project.

Supervisor's name: Dr Adam Bourne

Signature: 

Date: 25/10/2022