Chapter 7 Working with protective behaviours

Authors: Linda Dubrow-Marshall and Rod Dubrow-Marshall

Chapter Authors

Linda Dubrow-Marshall

https://orcid.org/0000-0003-4092-6599

Rod Dubrow-Marshall

https://orcid.org/0000-0001-6916-0780

Abstract:

Domestic abuse survivors sometimes present in counselling with a series of self-destructive behaviours that at first glance might seem mentally unhealthy and may inhibit understanding, empathy, and compassion from the psychotherapist. These behaviours can include a variety of self-harm behaviours, addictive behaviours, ambivalence, and the perplexing pattern of staying with and returning to the abuser. Psychotherapists can find these behaviours very frustrating especially if they have been working with the client for some time, seen good progress, only to see them slipping back into self-destructive behaviours, leading to intense countertransference. This chapter will examine these behaviours from the perspective of 'protective behaviours', similar to the concept of 'protective emotions' where the behaviours serve the function of protecting the client from overwhelming pain and intolerable feelings. The therapeutic value of exploring the meaning and purpose of the behaviours with the client in an empathetic and compassionate which will aid their recovery much more than labelling the behaviours as pathological and self-destructive.

Learning Objectives

1. To understand the concept of protective behaviours
2. To understand the ambivalence experienced by people in abusive relationships which can prevent action
3. To understand self-harm, returning to an abuser and addictions as protective behaviours
4. To consider our own responses to these behaviours and identify constructive ways to work with clients

Understanding the concept of protective behaviours

Domestic abuse survivors sometimes present in counselling with a series of self-destructive behaviours that at first glance might seem mentally unhealthy and may inhibit understanding, empathy and compassion from the psychotherapist. These behaviours can include a variety of self-harm behaviours, addictive behaviours, ambivalence, and the perplexing pattern of staying with and returning to the abuser. Psychotherapists can find these behaviours very frustrating especially if they have been working with the client for

some time, seen good progress, only to see them slipping back into self-destructive behaviours. This can lead to intense counter-transference reactions that are best addressed in supervision. In this chapter, we will examine these behaviours from the perspective of 'protective behaviours', similar to the concept of 'protective emotions' where the behaviours serve the function of protecting the client from overwhelming pain and intolerable feelings. In this way, the protective behaviours provide the counsellor with a window into the intensity of the painful feelings and experiences of the client. A respectful perspective can facilitate both empathy toward the client and the establishment of a safe therapeutic relationship that can contain overwhelming emotions. The client can learn to let go of the protective behaviours and adopt more adaptive coping mechanisms that facilitate a deeper recovery from the trauma of having been abused.

Through the lens of protective behaviours, therapists facilitate a deep exploration of the more painful feelings behind the behaviours to uncover what lies beneath and to consider the purpose served by the behaviours. For example, protective behaviours may involve taking risks or making unsafe decisions so while not overtly protecting the person, they may keep the person from confronting the danger they are in by staying with an abusive partner. Protective behaviours may serve to numb painful feelings, distract from the danger, and help the person to dissociate from the pain.

The perspective of protective behaviours aligns with the British Psychological Society's Power Threat Meaning Framework (PTMF) (2018) which replaces the usual concept of 'symptoms' which pathologises people with the concept of 'threat responses' where the behaviours can be understood as what the person had to do to survive. The PTMF advocates that practitioners understand these behaviours from the perspective of functionality and meaning and as an understandable and not necessarily pathological response to the abuse, recognising that:

> "These strategies arise out of core human needs to be protected, valued, find a place in the social group, and so on, and represent people's attempts, conscious and otherwise, to survive the negative impacts of power by using the resources available to them" (BPS, 2022, p. 12).

The framework further suggested that people

> "can be recognised and validated as activating threat responses for protection and survival. The experiences that are described as 'symptoms' are therefore better understood as reactions to threat, or 'survival strategies'" (p. 192).

The practitioner can assess if the threat responses are adaptive and helpful to the client under the circumstances or whether they have lost their meaning and can be replaced with more adaptive behaviours. They can only do so by carefully considering the context for the behaviours and through providing a safe therapeutic environment in which the person feels free to break the secrecy and isolation of their abuse and to tell their story without being judged or devalued. This acknowledgement and empathetic acceptance of the client no matter how negative their behaviours may appear will offer a relationship that is the

antithesis of the experience of a person who is actively being abused by a partner, where they will have been made to feel worthless and utterly dependent on the abusive, overly critical partner. The irony is that the perpetrator will make the person feel that they are nothing without them (and therefore dependent on them for their very survival)while simultaneously trapping the person in a dangerous relationship which can escalate to murder (Monckton-Smith, 2022).

Guidelines for a client-centred approach to helping survivors of domestic abuse include accepting the behaviours as valid in their own right, while helping clients to recognise which feelings are behind or underneath the behaviours. The therapist can help by not negatively judging the person who is displaying unsafe behaviours, instead offering unconditional positive regard to gently explore the meaning of the behaviours, ultimately helping the client to reconsider their choices and behaviours. Therapeutic tasks can include helping clients to notice their feelings and pause and reflect on them before acting, a strategy that is commonly used with impulsive and self-destructive behaviours.

In this chapter, we will examine some protective behaviours which are commonly exhibited by survivors of domestic abuse: ambivalence, self-harm, returning to the abuser, and addiction. Sometimes these protective behaviours appear together or lead into one another where they represent a negative interweaving of attempts to ward off the pain. For example, you can have a negative trio of protective behaviours where ambivalence leads to self-harm, which leads to returning to the abuser, and this cycle can repeat in any order as illustrated in figure 3.

Add Fig 7.1 here

Figure 7.1: A trio of protective behaviours

Addiction is a further challenge to recovery as it sometimes begins at the instigation of the perpetrator and may have created a physical dependency which requires treatment. Other times it is an understandable response to coping with a very painful and difficult situation from which escape seems impossible.

> Reflection: Have you ever been ambivalent and stayed too long in a romantic relationship or a friendship when it has become painful to you? Can you identify how your difficulty in leaving may be understood from the viewpoint of a threat response/what you had to do to survive at the time?

Ambivalence

People who are in intimate relationships involving violence can be expected to express feelings that reflect ambivalence as well as exhibiting ambivalent behaviours, and therefore ambivalence can be viewed through the lenses of both protective emotions and behaviours. It can be bewildering and even frustrating for psychotherapists to observe ambivalence in

their clients towards their abusers following a violent incident, but this becomes more understandable when seen as protecting the clients from overwhelming and intensely painful feelings that underlie the ambivalence. For example, a person may simultaneously feel very positive and negative feelings towards their partner which leads to ambivalent behaviours where they move both toward and away from their partner. These behaviours may protect the person from facing the terror of leaving a partner who has convinced them that they are completely incapable of survival without them and the despair of labelling their relationship as abusive. Survivors of domestic abuse, and current victims, regularly report feelings of ambivalence towards their partner who has also been their abuser (Courtois & Ford, 2015) and this chapter focuses on an understanding of the resultant behaviours.

Classical theories of learning (Olson & Hergenhahn, 2015) can explain the persistence of ambivalent behaviours. When people are positively reinforced for their behaviours on a consistent basis, they will learn to continue these behaviours. If they are consistently negatively reinforced for certain behaviours, they will learn to discontinue or 'extinguish' these behaviours. However, 'intermittent reinforcement' leads to the most resistance because the same behaviours are rewarded and subsequently punished. This makes it impossible for the person to predict the response of the abuser so they keep returning to the behaviours in the hope that this time it will lead to a positive response. This theory can help explain the persistence of Walker's (1979) cycle of violence (see chapter 3) where the person is always hoping and believing in the return of the attentive, romantic partner if they can just work out how. If the abusive partner is a substance abuser, their reactions may become even more unpredictable. It can become even harder for the victim to let go of behaviours which they think may placate or sooth their partner only to be devastated by the next episode of emotional and/or physical abuse.

Lewin's (1935) influential theories of conflict and conflict resolution identified three basic types of conflict: plus-plus (approach-approach), minus-minus (avoidance-avoidance), and plus-minus (approach-avoidance) which can further enrich the understanding of the role of intermittent reinforcement within intimate relationships. Victims of domestic abuse are torn between push-pull factors in their ambivalence about their relationship, and approach-avoidance conflicts may persist as the barriers to resolution remain high. Levinger (1957) extended Lewin's concept of conflict to interpersonal relationships and noted that interpersonal elements of the conflict must be considered in addition to intra-personal elements. This can deepen our understanding of tensions within the relationship, such as the consequences if one person does not comply with the wishes of the other, or conflict between each person's goals. It can be assumed that the exertion of power and dominance is a central goal for the perpetrator of domestic abuse and that this can be expressed both physically and psychologically, contributing centrally to the distress and painful feelings of the victim who becomes trapped within the approach-avoidance conflict.

Festinger's (1957) theory of cognitive dissonance helps to explain some of the ambivalent behaviours that are present within an abusive relationship as he postulated that conflicting beliefs or behaviours lead to an uncomfortable state which results in people changing their

beliefs or behaviours in order to feel consistent and more comfortable. These behaviours can include a series of protective behaviours which can be seen to lead to a reduction in that dissonance. At its core the ambivalence reflects the psychological investment or contract (Rousseau et al., 2013) which the survivor has had with their partner. This has often been entered into with great hope and enthusiasm for the future. It is also enshrined in marriage or civil partnership contracts and financial contracts including for property and savings. However, the initial prospects which are often sold so persuasively by the abuser (Walker, 1979) are not realised and the recognition of betrayal this constitutes is sometimes both shaming and humiliating, as well as deeply depressing to the survivor.

The psychological profundity of this betrayal explains why the pattern of post-traumatic distress amongst survivors of domestic abuse is often characterised as complex (Herman, 2015). As well as recovering from high levels of fear and anxiety, wrought by a continued pattern of psychological and physical abuse and threats thereof, the breaking of the psychological contract or trauma bond (Courtois & Ford, 2015) can also leave survivors asking critical existential questions about who they are and their place in the world, in a context where some of their key previous certainties about life and love have been seemingly destroyed. All these mixed feelings lead to a liminal state in which ambivalent behaviours towards oneself, the erstwhile partner and abuser, towards friends, family, work colleagues and towards the world in general, often thrive. Such behaviours are also protective against the growing and visceral understanding of the betrayal and trauma which the survivor has suffered.

The challenge to the counsellor is to create a therapeutic relationship in which the client is able to trust the therapist to share their innermost feelings despite the betrayal trauma which they experienced at the hands of someone they believed loved them (see also chapters 2 and 4). Freyd (1996) has articulated the conundrum where the therapeutic relationship has the potential to help the client to recover but also has the potential for harm given that the conditions for trust have already been profoundly violated. Patience on the part of the therapist and openness towards clients' questions or expressions of anger and distrust can be helpful in this regard.

Humanistic and existential approaches to psychotherapy can be incorporated into other therapeutic approaches and emphasise the importance of exploring deeper issues of meaning and purpose. Hartman & Zimberoff (2004) conceptualise that ambivalence is a form of 'existential resistance' where the potential for 'existential embrace of life for being fully alive' is sabotaged, denied and thwarted (p.3). They reinforce the idea of ambivalence as a protective behaviour by pointing out that it focuses attention away from the underlying anxiety such as "fear of annihilation or engulfment (loss of self)" (p.3). This characterises the experience of victims of coercive control in an intimate relationship where power is abused, and the person is made to feel completely dependent on their partner.

An empathetic stance toward the expression of ambivalent feelings and behaviours and a curiosity to explore what these mean for the client will deepen the therapeutic relationship and facilitate recovery.

> "It is important for psychotherapists to acknowledge the client's need to express the positive side of their relationships or what they may have learned or enjoyed during an otherwise traumatic experience, and to deal with personal anger and countertransference in supervision and consultation" (Dubrow-Marshall, 2013, p.22).
>
> Reflection: In what areas of their personal life do psychotherapists experience ambivalence and in what ways is the ambivalence protective? Does the ambivalence that the client exhibits become mirrored in the countertransference of the psychotherapist? How can the psychotherapist use their own ambivalence to enhance the therapeutic relationship?

Self-Harm

Living in a continuous state of protective ambivalent behaviours within an abusive relationship where it may feel like there is no way to escape the underlying pain can lead to a host of self-harm behaviours. Although self-cutting is often the first example that comes to mind when people think of self-harm, self-harm behaviours can be very varied and can infuse many aspects of being in an abusive relationship. In the United Kingdom (UK), the National Health Service (NHS UK, n.d.) includes as examples of self-harm: cutting, picking skin, pulling hair, eating disorders, poisoning oneself, excessive work, and addictions (which will be discussed separately in the next section). Taking the perspective of self-harm as protective behaviours puts the emphasis on the meaning of the symptom, which means that treatment should include medical treatment where necessary for the harm that was done (e.g., dressing of wounds, treating burns; nutritional interventions) and psychological treatment should focus on uncovering the underlying meaning and functionality of the symptoms, which transcends the symptom itself, and exploring the role of the abusive relationship in the aetiology and development of the self-harm behaviours.

Self-harm behaviours can be challenging for practitioners to work with whether or not they occur within a violent relationship. For example, while some people hide their self-inflicted wounds where they cannot be seen while they are dressed, other clients may want to show their wounds to the counsellor, who may find this distressing or even disgusting, and therefore difficult to resist being judgmental and to maintain unconditional positive regard.

Mind (2020) reported some of the ways that people have described self-harm:

> "a way to express something that is hard to put into words; turn invisible thoughts or feelings into something visible; change emotional pain into physical pain; reduce overwhelming emotional feelings or thoughts; have a sense of being in control; escape traumatic memories; have something in life that they can rely on; punish themselves for their feelings and experiences; stop feeling numb, disconnected or dissociated; create a reason to physically care for themselves; express suicidal feelings and thoughts without taking their own life. The NHS (n.d.) included the above reasons for self-harm and

added that it can be a way of "relieving unbearable tension; a cry for help; a response to intrusive thought". "

These lists can be helpful to clients in letting them know that they are not alone if they recognise their motives in the list. The lists can be helpful to therapists in suggesting possible meanings for clients' self-harm behaviours, but helping clients to uncover the *individua*l meanings that the behaviours have for them is of utmost importance. The Power Threat Meaning Framework (BPS, 2018) reminds us it is important to help the client to tell their story of what happened to them, how power has been abused, the threats that they have experienced, and how this has led to threat responses. Similarly, Mind (2020) advises people who are seeking help for self-harm that although the behaviours may provide a temporary short-term sense of release, it is necessary to address the "difficult feelings, painful memories or overwhelming situations and experiences" that are driving the behaviours. Such feelings might include anger, rage or shame or it may be a means of punishing or attacking either themselves or others for any perceived wrongdoing and a way to gain a sense of power and control, if only fleetingly (Pickard, 2015).

It is important to include self-harm in the assessment of domestic violence survivors as it has been noted by Boyle et al. (2006) that people going to emergency departments for self-harm in the United Kingdom were more likely to be victims of domestic violence, and they also advised assessing for suicidality. The National Institute for Health and Care Excellence (NICE) guidelines (2022, 1.61) advocate for an individualised approach to assessment of self-harm and warn: "Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm", instead advocating to "focus the assessment on the person's needs and how to support their immediate and long-term psychological and physical safety" (1.65).

NICE (2022) stresses the importance of establishing a safety plan, which is often the overall approach taken by counsellors when working with survivors of domestic violence, and safety has been emphasised as the first step in recovery from trauma by Herman (2015). NICE (2022) encourages collaborative and compassionate working with the client in 'shared decision making', which is in alliance with principles of client-centred therapy. It further recommends (1.11.6): "Work collaboratively with the person, using a strengths-based approach to identify solutions to reduce their distress that leads to self-harm", which is supported by research on resilience training (Padesky & Mooney, 2012). However, NICE guidance to work collaboratively with family and other support systems may not be possible because of the abuse survivor's isolation.

Psychotherapists should tread carefully and respectfully when helping clients to change their behaviours to more adaptive ones as if the therapy is paced too quickly, clients may become overwhelmed by the powerful and extremely painful feelings underlying the protective behaviours. For example, although self-harm is distinct from suicidality, it is important for psychotherapists to continue their assessments of suicidality especially if the person is cutting and over time may begin to cut more deeply, accidentally putting their lives in danger. There have been reports in clinical practice of perpetrators of domestic violence mocking their victims and 'goading' them to engage in self-harm behaviours,

including cutting, withholding food, addictive behaviours, and parasuicidal or suicidal behaviours, and the therapist should work towards establishing a safe therapeutic space where clients might feel free to reveal such painful and shameful experiences.

Supervision can help practitioners to explore their own painful reactions to working with client self-harm. In the United Kingdom, the NICE guidelines (2022, 1.15.1) recognise the impact that working with clients who self-harm can have on professionals and recommend that supervision should include reflective practice and "promote the delivery of compassionate care". Working with survivors of domestic violence who self-harm can truly pose challenges of practicing compassion towards clients as well as self when it may be so difficult to remember the protective function of the self-harm behaviours.

> Reflection: How can a psychotherapist reconcile the BACP ethical values of protecting the safety of clients and alleviating symptoms of personal distress and suffering with the ethical value of autonomy: respect for the client's right to be self-governing when working with clients who self-harm?

Returning to the abuser

Ambivalence and self-harm are both embroiled in the actions of a domestic violence survivor who then paradoxically returns to the abuser, and it is this very pattern that is most bewildering to those who are unfamiliar with the concepts of coercive control and trauma-coerced attachment. It is of upmost importance for the practitioner to have a deep understanding of these dynamics so that they can maintain unconditional positive regard and help clients to develop insights into their destructive patterns of returning to the abuser.

SafeLIves (2015) reported that in a survey in the United Kingdom, victims lived with their abusers an average of two to three years before getting help, with 68% of high-risk victims attempting to leave an average of two to three times in the year before they were effectively helped and 78% of them having reported the abuse to the police. 23% of high-risk victims had been to Accident and Emergency in the prior year, many of them more than once. Leaving the abuser is clearly a process that is riddled with obstacles and the answer to why a person has not permanently left a relationship may be that they have already tried but were unsuccessful or the abuse may have escalated after they had left in post-separation abuse (Spearman, Hardesty, & Campbell, 2022).

Doychak and Raghavan (2020) have described trauma-coerced attachment in victims of sex trafficking which is also applicable to victims of domestic violence as coercion and abuse exist side by side with intimacy and affection. They describe how victims deny and minimise their abuse and even take personal responsibility for it, something perpetrators encourage as they deny and minimise and blame their victims for their abusive behaviour.

It is important to remember that the abusive partner may be or may deliberately be manipulative in appearing to be very sincere in apologising for their behaviours that temporarily gives the partner hope that that the abuse will not reoccur. The abusive partner may have reinforced victim fears about not being able to survive on their own, and may have removed resources and capabilities to prevent them being able to do so. The desire to

believe the partner's apologies should not be underestimated in understanding the trauma bond/attachment.

Furthermore, the concepts in 'totalistic identity theory' (Dubrow-Marshall, 2010) add another layer of understanding to the tendency of victims of abuse to return to the relationship by describing the process through which multiple identities that the person may have had prior to the relationship (e.g., mother, daughter, nurse, volunteer) become subjugated and replaced by the dominant identity of being the partner in an abusive relationship where abiding by the wishes and whims of the perpetrator is the only thing that matters (see also chapter 3). Dubrow-Marshall (2010) describes this as a process of

> "how normal cognitive processes of categorisation can go awry; of how the normal formation of psychological groups and movement between them in terms of psychological salience can become restricted and dominated on one specific identity that is extreme within the frame of reference" (p.12),

He has applied this to intimate partner relationships where the partner becomes the entire existence of the person and the focal point around which everything else revolves. This is also akin to the 'dispensing of existence' in Lifton's (1961) theory of 'thought reform'.

> Reflection: What are some of the internal (psychological) and external obstacles to leaving an abuser and how do these interact? How can the therapist both accept the ambivalence about the relationship and help the client to move towards safety?

Addiction

Some clients will present with addictive issues which will require therapeutic attention in addition to the issues of being in an abusive relationship. The aetiology of the addiction is important to assess in devising the treatment approach, for example, was the person addicted before the relationship or is it part of the process of being in the relationship? If the client's partner has been involved in the development of the addiction, it is important to determine if the influence to become addicted was direct or indirect, forcibly accomplished or through persuasion, as these have different implications. If the partner actively forced the client to abuse substances, it may be easier for them to recover as it was not something that they ever thought they wanted. If the primary mechanism for becoming an addict was due to coercive persuasion, such as 'Come drink with me, get high with me, don't spoil my fun, come on relax, isn't this better now', the pressures may have been internalised and the client blames themselves. If the perpetrator is an active addict, they may want their partner to be in the same position and may fear that they will lose control if not and so the pressure to stay an addict will intensify if the victim is attempting to abstain from substances or at least minimise the harmful behaviours associated with their addiction.

It may also be useful to use the lens of addiction to view the relationship that both the perpetrator and victim of abuse have with each other in terms of understanding the dynamics and *addictive processes* that may be present. Caution must be observed in order not to label the client as an addict, which could be stigmatising and shaming and alienate the client from engaging in the therapeutic relationship. The World Health Organization

(WHO, 2022) gives criteria for disorders due to substance abuse or addictive behaviours (including gambling and gaming disorders) which include increased use to obtain the same effect, cravings, and withdrawal. Addictive behaviours are described as repetitive behaviours over which there is little control; giving increased priority to the behaviour over other aspects of their life; and continuing the behaviour even when there are negative consequences. This description can be mapped against Walker's (1979) model of the cycle of domestic abuse and the addictive lens adds appreciation for how the violence in the relationship escalates over time. The controlling and coercive behaviours are no longer enough to produce the same effect, so they are intensified. The victim of these behaviours becomes increasingly dependent on their partner and attempting to please the abuser takes over their lives, mimicking how other addictive and compulsive behaviours (including eating disorders) increasingly dominate more energy, time, and resources, and ultimately steal from the person their personal integrity, dignity, sense of self, restrict their emotional and cognitive functioning, and cause increasing amounts of despair and impairment.

Recovery principles that have been proposed for 'love addiction' may be helpful to incorporate into the therapeutic process, including identifying peer support and possibly group recovery meetings, and adding a spiritual component for those who are open to such an approach. The term 'codependency' is also sometimes welcomed by people in abusive intimate relationships, although we prefer the term prodependency (Weiss, 2018) which is less stigmatising and recognises the good qualities of the desires to please one's partner, emphasising the pro-social aspects of the behaviours rather than just focusing on pathological behaviours. Weiss (2018) recommends that:

> "We can simply acknowledge the trauma and inherent dysfunction that occurs when living with an addict, and then we can address that in the healthiest, least shaming way" (p.72).

This can be seen as a metaphor for living with someone who is compulsively controlling of their partner who may or may not also be addicted to substances.

> Reflection: What did you previously know about addiction? What is your own relationship with addiction? Consider how the answers to these two questions might impact on your practice?

Summary

In conclusion, it is helpful to view behaviours exhibited by survivors of domestic violence including ambivalence, self-harm, returning to the abuser, and addictions as having a meaning and purpose which can be gently explored with the client in an empathetic and compassionate manner which will aid their recovery much more than labelling the behaviours as pathological and self-destructive.

Key Learning Points

1. Client ambivalence about the relationship, situation and events can show in counselling. Careful exploration of the ambivalence in a supportive and caring way can help the client to understand what is going on for them.

2. There are many different ways to self-harm and many reasons for this to happen. Exploring the underlying feelings relating to the behaviour can be helpful for the client.
3. Returning to the abuser is documented as a factor in domestic abuse which can be frustrating for those trying to help. Understanding the psychology behind this can help counsellors to empathise more with the client.
4. Understanding the background to how any addiction came into being can provide helpful pointers in how to work with the client.

References

Boyle, A., Jones, P., & Lloyd, S. (2006). The association between domestic violence and self harm in emergency medicine patients. *Journal of Emergency* 23, 604–607. doi:10.1136/emj.2005.031260

Courtois, C., & Ford, J. (2015). *Treatment of complex trauma: a sequenced, relationship-based approach.* Guilford Press.

Doychak, K., & Raghavan, C. (2020). 'No voice or vote:' trauma-coerced attachment in victims of sex trafficking. *Journal of human trafficking,* 6:3, 339-357.

Dubrow-Marshall, L. (2013). Curiosity and willingness to learn. *Therapy today.* May 2013, p. 22.

Dubrow-Marshall, R., (2010). The influence continuum – the good, the dubious, and the harmful – evidence and implications for policy and practice in the 21st century. *International Journal of Cultic Studies,* 1, 1-12.

Festinger, L. (1957). *A theory of cognitive dissonance.* Stanford University Press.

Freyd, J. (1996). *Betrayal trauma.* Harvard University Press.

Hartman, D., & Zimberoff, D. (2004). Existential resistance to life: ambivalence, avoidance and control. *Journal of Heart-Centered Therapies.* 7:1, 3-63.

Herman, J. (2015). *Trauma and recovery.* Basic Books.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. British Psychological Society.

Levinger, G. (1957). Kurt Lewin's approach to conflict and its resolution: a review with some extensions. *The journal of conflict resolution,* 1:4, 329-339.

Lewin, K. (1935). *Dynamic theory of personality.* McGraw-Hill.

Lifton, R. (1961). *Thought reform and the psychology of totalism*. W.W. Norton.

Mind (2020). *Self-harm*. Mind.org.uk. https://www.mind.org.uk/media-a/5783/self-harm-2020.pdf.

Monckton-Smith, J. (2022). *In control: dangerous relationships and how they end in murder.* Bloomsbury Publishing.

National Health Service, United Kingdom (n.d.). https://www.nhs.uk/conditions/self-harm/.

National Institute for Health and Care Excellence. (2022). *Self-harm: assessment, management and preventing recurrence* (NICE guideline NG225). https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm

Olson, M., & Hergenhahn, B. (Eds). (2015). *Introduction to theories of learning* (9th ed.). Routledge.

Padesky, C., & Mooney, K. (2012). Strengths-based cognitive behavioural therapy: a four-step model to build resilience. *Clinical Psychology and Psychotherapy,* 19, 283-290. DOI: 10.1002/cpp.1795

Rousseau, D., Tomprou, M., & Montes, S., (2013). Psychological contract theory. In E. Kessler Ed.). *Encyclopedia of management theory.* (pp. 635-639). Sage.

SafeLIves (2015). *Insights IDVA national dataset 2013-14.* Safe Lives.

Spearman, K., Hardesty, J, & Campbell, J. (2022). Post-separation abuse: a concept analysis. *Journal of advanced nursing,* 00, 1-22.

Walker, L. (1979). *The battered woman.* Harper Collins.

Weiss, R. (2018). *Prodependence: moving beyond codependency.* Health Communications.

World Health Organization (WHO). (2022). *International classification of diseases* (11th Revision). WHO. https://icd.who.int/en