

A Client Informed View of Domestic Violence Counselling

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Domestic violence (DV) affects one in five people in the UK and may result in psychological harm requiring counselling or psychotherapy intervention. However, there is little research available on what this client group require from counselling. This qualitative study, using adapted grounded theory, interviewed fourteen women and six men from four different DV agencies in the UK and Eire (three female and one male) about their previous experiences of counselling.

The participants, many of whom had left their relationships, shared positive and negative experiences of counselling, allowing separate models for men and women to be developed. The women went through a multi-staged counselling process, which could include trauma work and exploration of previous experiences. The men had fewer resources available to them and the short term nature of the work meant a focus on resolving current issues.

Despite the differences in resources, there were features which were common to men and women. Finding someone who understood DV helped to build trust first in the agency, and then in the counsellor. Hopelessness appeared to be a factor in seeking help and developing hope in different ways throughout the process was important. The therapeutic relationship required caring and compassion from the therapist to be fully effective, although the way compassion was experienced appeared different for men (as receiving help) and women (as the counsellor's commitment).

Trust, hope and compassion were important aspects that were experienced by participants at different points in the process and ultimately within themselves. The outcomes reported by the participants suggested that the post-traumatic growth inventory may be an appropriate measure of the value of counselling for this client group.

The models developed could be used as part of the training and development required for counsellors working with clients who have suffered current or historic domestic abuse.

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List of Abbreviations

BWS	Battered Woman Syndrome
CBT	Cognitive Behavioural Therapy
DSM IV	Diagnostic and Statistical Manual of Mental Disorders (4 th Edition)
DSM5	Diagnostic and Statistical Manual of Mental Disorders (5 th Edition)
DV	Domestic Violence
EMDR	Eye Movement Desensitisation and Reprocessing
IPT	Inter-Personal Therapy
IPV	Intimate Partner Violence
MAPNI	Men's Advisory Project Northern Ireland
NICE	National Institute of Health and Care Excellence
NVAWS	National Violence Against Women Survey
PFC	Pre-frontal Cortex
PTGI	Post-Traumatic Growth Inventory
PTS	Post-Traumatic Stress
PTSD	Post-Traumatic Stress Disorder

1 Introduction

When a letter arrived one Saturday morning in the summer of 2007, I had no idea that accepting the invitation inside would prove to be life changing. I had applied for a counselling placement at my local Women's Aid agency as I needed a placement for my diploma course starting in September. The letter invited me to attend an interview for the agency's domestic violence (DV) training programme which had to be completed prior to being considered for counselling work there. I had applied mainly because the agency was within easy travelling distance and had no deep conviction for working in this area, although that was to change.

I learned that DV is not a new societal problem. The potential for violence within marriage was noted in the Bible (Colossians 3:19) and the apparent right to violence in the Qur'an (Sura 4:34). Then, as now, writers long ago recognised that avoiding conflict through building a relationship (1 Peter 3:7) or through arbitration (Sura 4:35) was preferable to violence. Although DV has been recognised as something to be stopped or avoided for centuries, it still occurs (Archer, 2006). The incidence of DV varies from nation to nation based on social factors such as individualism, equality and social acceptance of physical violence between partners (Archer, 2006). In the UK today, it is estimated that 30% of women and 17% of men suffer some form of DV after the age of sixteen (Smith *et al.*, 2012) with an estimated 1.2 million women and 800,000 men affected in 2010/11. Part of the reason for the large numbers of people reported to be affected is the recognition that DV is about not only physical violence but also psychological, emotional, sexual and economic abuse (Home Office, 2012b). This definition is regardless of sexuality, gender or race and includes relationships between family members and partners, recognising that the abuse is a pattern of behaviour aimed at controlling another person.

As the training continued, it became apparent that the impact of DV can be both significant and complex due to the many different types of experience: from witnessing or experiencing physical violence in childhood (Kepner, 1996; Briere, 2002; Seedat, Stein and Forde, 2005; Rushlow, 2009; Hague, Harvey and Willis, 2012) through to experiencing abuse in old age (Plotkin, 1996; Harris, 2006; Lundy and Grossman, 2009; Jackson and Hafemeister, 2011). In addition, different research assumptions, problem definitions, methodologies and measurements meant that many of the research findings could not be compared directly.

Quantitative researchers required access to significant numbers of participants to assess the impact of DV. This research included participants from: refugees to identify the effect of violent relationships on women who have escaped from longer term relationships (Campbell, Sullivan and Davidson, 1995; Bennett *et al.*, 2004; Hick, 2008; McNamara, Tamanini and Pelletier-Walker, 2008); universities to look at the impact of dating violence (Follingstad *et al.*, 1991; Oliver *et al.*, 1999; Graham-Kevan and Archer, 2008; McDermott and Lopez, 2013); the criminal justice system to examine perpetrators and their victims (Feder and Henning, 2005; Henning, Jones and Holdford, 2005; Goldenson *et al.*, 2009); the general population to look at abuse within current relationships (Straus, Gelles and Steinmetz, 1980; Carrado *et al.*, 1996; Esquivel-Santoveña and Dixon, 2012). These studies showed variations in the extent, type, frequency and impact of violence within their particular groups. The focus of much of DV research was on where the responsibility for the perpetration of DV lay, and what impact the abuse had on the victim.

Being trained in an agency embracing a feminist philosophy meant that my initial training focused on the cause of DV as male dominance within a relationship, supported through a patriarchal society (Dobash and Dobash, 1980). I was both aware of, and had benefited from, the feminist movement as a female growing up in the second half of the twentieth century. Encouragement to pursue my first career in engineering came as part of the drive for female equality. Working in the chemical industry first as an engineer and then as a commercial and customer service manager, I was well aware of the difficulties women can face and the abusive male behaviours that can be adopted by some men. This meant that I was initially receptive to the training and open to the concept of female victims of DV. However, as the course continued I became more uncomfortable with the stark presentation of men as perpetrators and women as victims. I knew from some of my work experiences that women were capable of similar abusive behaviours, resulting in emotional suffering for both male and female employees. I also knew that abusive behaviour can result from the interaction of two parties. The drive to allocate responsibility for DV began to seem inappropriate.

There was some support for my scepticism through evidence from family violence surveys involving a cross-section of the American public (Straus *et al.*, 1980; Straus, 2009). These showed that men and women perpetrated violence in roughly equal measure at home. This finding was replicated by other researchers in the field, including the UK (Carrado *et al.*, 1996). In addition, Straus (1979) had developed

the Conflict Tactics Scale (CTS) which acknowledged conflict as a part of a relationship and tried to determine how partners dealt with that conflict (Straus, 1979). The CTS was later revised (Straus *et al.*, 1996) to identify negotiation, psychological aggression, physical assault, sexual coercion and injury within a relationship (CTS2). This is much closer to the UK definition of DV (Home Office, 2012b) noted above. Given that there appeared to be some overlap of ideas, it seemed strange that Straus' view was not widely endorsed. This may be largely due to the criticism of his work by feminist researchers, suggesting that the conclusions relied too heavily on data analysis and lacked any understanding of the motivation behind, meaning of and context for DV (Ross and Babcock, 2009). By asking about specific, defined actions without linking those to a pattern of victimisation or control (which is required under the current definitions of DV in the UK (Home Office, 2012b)), CTS2 could simply reflect a desire to get one's own way rather than systematic abuse. Nevertheless, through CTS2, behaviours which had been described as abusive in men were also being measured in women.

The case for this argument for systematic abuse can be seen partly through the work done by the Duluth organisation, which defined patterns of abuse with tactics and strategies that men might use to dominate their partners (Pence and Paymar, 1993; Domestic Abuse Intervention Programs (DAIP), 2012). These strategies are still part of many DV training packages today, and were presented as male to female behaviours. Another model in common use was the Cycle Theory of Violence, a cyclical pattern of abusive and reconciliatory behaviour by the man which holds or binds the female partner to the relationship (Walker, 1979). This pattern was later confirmed by psychologists linking adult symptoms of trauma in male perpetrators with childhood experiences of abuse, which led to a build up and expression of anger within the relationship (Dutton, 1995). The Cycle Theory of Violence is still used in work with male DV perpetrators and female victims across the world today (Agnew Davies, 2013).

This cyclical pattern of male behaviour could produce feelings similar to those of learned helplessness (Seligman, 1975) in the female partner. As the partner was consistently unable to control her environment, she would eventually stop trying, a condition termed Battered Woman Syndrome (BWS) (Walker, 1977). Instead, she would live in a constant state of anxiety, not knowing when the next violent act would occur, resulting in psychological symptoms later defined as a sub-set of post-traumatic stress (Walker, 2009a). BWS had been used as a legal defence during

the nineteen eighties and nineties for women who had suddenly snapped after years of abuse, resulting in their partner's serious harm or even death (Schuller *et al.*, 2004). The aim was to increase awareness of the psychological effects resulting from the significant trauma of a violent relationship. Inadvertently, it led to the courts labelling such women as weak and mentally unstable, with the importance of the social context of psychological harm lost (Dutton, 1993). The potential for psychological harm through power and control did, however, appear real.

Yet the concept of psychological harm was not endorsed by all. Other feminist researchers introduced two new concepts to describe DV: patriarchal terrorism (the domination of a family by a male aggressor) and common couple violence (something which emerges from either party as a result of stresses in the relationship) (Johnson, 1995). This allowed differentiation of the severity and frequency of, and motivation behind, the violence. Patriarchal terrorism was presented as more severe, although Johnson noted that serious injury or death was possible with common couple violence, but much less likely. These concepts were later developed (Johnson and Ferraro, 2000) to include violent resistance (acknowledging that women will at times want to fight back to regain some control prior to leaving their partner), intimate (rather than patriarchal) terrorists (acknowledging that the domination of a family may not be completely about patriarchy or gender) and mutual violent control (where two intimate terrorists are fighting for control of the relationship). Although this appeared to accept that women were capable of exerting power and control, Johnson and Ferraro (2000) indicated that the psychological effects of abuse would be felt mainly by those suffering from intimate terrorism (male or female), which equated to a very small proportion of those involved in conflict situations and, in their opinion, almost all of them women. Thus they argued that psychological harm occurred in a very small number of female cases.

Linking psychological harm specifically to a combination of severe physical and psychological abuse was at odds with some of the earliest research in DV (Walker, 1979). This had clearly identified both psychological and physical abuse as separate and important factors in causing emotional harm. Although Walker's later research only included women who had experienced physical abuse (Walker, 2000), she commented that this was due to the complexity of measuring the impact of psychological abuse alone on women. She indicated that there were difficulties in assessing the severity of the abuse and the personal cost to the women, but noted

that (Walker 2000, p260) “the women’s ratings showed that the psychological abuse created longer-lasting pain than did many of the physically induced injuries”.

Concerns have also been raised elsewhere about the difficulties of determining an appropriate measurement of psychological abuse (Follingstad, 2007). This concern has some merit, as the categorisation of psychological abuse currently used in research papers can range from a positive answer to a single yes or no question (Kramer, Lorenzon and Mueller, 2004) to a multiple factor questionnaire investigating many aspects of psychological abuse (Follingstad and Edmundson, 2010). This means that research claims relating to psychological abuse have to be carefully considered in the context of the reported research question, methodology and definition. Some of the research may not be robust enough to be replicable or to withstand close scrutiny, thus highlighting a potential problem without providing the rigorous evidence to support action. Despite these issues, there has been increasing interest in the impact of psychological abuse, although there is still no methodological agreement for assessment.

One of the first studies to look at the physical and psychological implications for both partners concluded that DV had an impact on both male and female victims (Coker *et al.*, 2002). This was an important study, as it brought together existing measures of physical abuse (Straus, 1979) with two specific psychological measures developed in Canada: abuse of power and control, which was linked specifically to DV; and verbal abuse, which was linked to having a poor relationship (Johnson, 1996). The main conclusion from Coker *et al.*’s study was that both physical and psychological (power and control) abuses were associated with higher risks of poor health, depression and substance abuse. Importantly, the researchers’ regression analysis, using both physical and psychological abuse factors, suggested that higher levels of psychologically driven DV were more strongly related to poor outcomes. After so much focus on the effects of physical abuse on women, this began to support the concept of significant harm through specific types of psychological abuse.

In 2006, Dutton wrote a significant paper with Corvo challenging the accepted feminist position on DV (Dutton and Corvo, 2006). In it, they suggested that rigorous psychology research relating to the development and treatment of intimate partner violence (IPV) was being ignored. Dutton also published a book in the same year, *Rethinking Domestic Violence* (Dutton, 2006), stating that perpetrators of both genders could be found. The book was welcomed by those who supported the

premise of male victims and female perpetrators in the wider context of DV and opened up discussion about whether the dominant view of a patriarchal society as the underlying reason for DV was sufficient (Straus, 2007). The subsequent discussion among academics has been heated. Each side has tried to undermine the other and strengthen their own case through taking issue with the opinions, claims, methodology and ethics of the other's research, as Johnson and Dutton show (Johnson, 2011; Dutton, 2012). Whilst it may not be possible to assess the precise nature of abuse or the causal relationship, what seemed clear is that psychological harm from DV can be experienced by both men and women. Despite the potential for controversy, it therefore seems appropriate to include male as well as female victims in any future research on psychological harm from DV.

Although, there has been increasing evidence about the psychological impact of DV on both men and women (Coker *et al.*, 2002; Hines, Brown and Dunning, 2007; Hines and Douglas, 2009; Hines and Douglas, 2011) some feminist researchers have continued to focus the discussion on the use and impact of physical violence on women (Lombard, 2013). In a recent literature review on female and male outcomes following DV, Caldwell *et al.* (2012) concluded that women suffer significantly more than men as a result of DV. This was due to the greater injuries, fear and post-traumatic stress suffered, confirming the need to focus on reducing physical violence. However, there was no conclusive evidence of worse physical health outcomes for women or an increased risk of depression, anxiety and substance abuse compared with male victims. The authors suggested that post-traumatic stress disorder (PTSD) was caused by high levels of aggression in the relationship, yet other research had found that many participants involved in DV studies had experienced a history of abuse (Walker, 2000; Swan *et al.*, 2005). This could mean that the roots of fear, anger and PTSD reported by Caldwell *et al.* (and observed in agencies like the one I trained with) could pre-date the current relationship, and could have impacted on or been exacerbated by their current relationship. However, the presence of depression and anxiety in both women and men suffering psychological harm from DV suggests both are likely to benefit from counselling, for either current or past events (National Collaborating Centre for Mental Health, 2009; British Association for Counselling and Psychotherapy, 2013). Perhaps ironically, by focusing on the differences between men and women to build the case for female safety, rather than considering and validating the common need for psychological support, the authors potentially undermined the case for funding for counselling for women.

This is particularly important when considering the way psychological support for DV has developed in the UK. Many years ago, therapists working with female victims began to use their research and experience to construct models of counselling which incorporated social and community action as well as individual support (Walker, 1994; Whalen, 1996; Grigsby and Hartman, 1997). Since then, DV research has consistently explored the frequency and impact of severe and life threatening physical violence (Women's Aid, 2007) ahead of mental health. This clearly established the need to prioritise the physical safety needs of women and has been reflected in government budgets of over £3bn providing refuge, health, housing and legal support (Walby, 2004). With the focus clearly on safety, the mental health needs of the women appeared to have been put to one side, with spending on psychological support reported as just over 5% of the total. An update to this paper (Walby, 2009) did not separate out mental health costs, suggesting it is not recognised as a significant aspect of recovery.

In line with this articulated need to address physical safety as a priority, the case has been made for substantially more government support for female rather than male victims, as explained in Section 1.3, page 5 of the *Handbook for Health Professionals* (Department of Health, 2005):

“It’s true that men also experience domestic abuse. But about 90% of DV cases are committed by men against women.¹ Women are also more likely to experience repeat incidents of abuse, be frightened or be injured after an attack, and they are the lead carers at home, so abuse against them affects their children.”

This interpretation reflects the degree of physical injury likely to be sustained by female rather than male victims. Here, the government was primarily interested in assisting victims who had suffered from physical and/or sexual violence despite the development of a wider definition of DV to include financial, psychological and emotional abuse. This handbook focused on physical safety and appropriate referral to advocacy support and third sector refuge organisations, with only a short acknowledgement that women may also require mental health services.

¹ BMA, 1998, *DV: a healthcare issue*

Although research in the UK has shown that women can suffer significant psychological harm through DV (Humphreys and Thiara, 2003), there appears to be a reluctance to highlight a specific need for mental health support. It is possible that this may be due to a lack of knowledge about what sort of support to provide. A government funded report (Ramsay, Rivas and Feder, 2005) concluded that the quantitative evidence base for mental health interventions with DV was poor and, in alignment with previous reports (Chalk *et al.*, 1998; Wathan and MacMillan, 2003), there was little research of an appropriate quality available to make firm recommendations. However, Ramsay *et al.* (2005) suggested that, from the available data, advocacy should be preferred over counselling for women still in abusive relationships. Although psychological intervention was recommended for those who had left the relationship and subsequently suffered depression or lack of self-esteem, the researchers felt there was insufficient evidence to recommend a specific form of treatment. Regrettably, there was no mention of treatment for anxiety or trauma in the report, two conditions which have been specifically associated with DV (Walker, 1977; Dutton, 1992; Humphreys and Thiara, 2003). Instead Ramsey *et al.* (2005) suggested that further research was required to find out more about the women and their needs. This research project aims to support that quest for knowledge.

Although many individuals becoming involved with DV support become passionate about the injustice of abuse in our society, this has not been the case for me. Instead, I have become more interested in the psychological damage to men and women through abuse, and the lack of knowledge that surrounds the best form of treatment. The existing literature, as discussed in section 2.3., shows that there are significant mental health issues being measured in victims of DV and yet as can be seen in section 2.5, there appears to be very little client based research about what is important in mental health services for this group.

Whilst there is a growing body of evidence showing that counselling is effective in treating depression and anxiety (British Association for Counselling and Psychotherapy, 2013) and therefore could be helpful for DV clients, it is possible that they have different needs to general counselling clients (National Institute for Health and Clinical Excellence, 2014). When I began counselling DV clients, I became aware that the number of clients who failed to attend the first or second appointment, independent of therapist, was higher than at other agencies where I worked. This was considered to be a result of the amount of trauma that the client

had experienced and the understandable reluctance to engage with work which might involve the reliving of those experiences (Herman, 1992). Although this suggested a client problem over which we had little or no influence, I wondered what we could do to make it easier for clients to come to counselling. Much of the counselling literature began with the first counselling session (for example McLeod, 2003b) and much of the DV literature began with a list of psychological problems which may need to be addressed (Dutton, 1992; Walker, 1994; Sanderson, 2008). Neither discussed client access, although subsequently a small body of literature has emerged examining the difficulties of help-seeking (Beaulaurier, Seff and Newman, 2008) which can be read in section 2.2.

At the same time, I was also aware of the significant levels of emotional distress in clients beginning counselling, much higher than with clients I saw at the other agencies. In keeping with the literature, the clients presented symptoms of depression, suicidal ideation and anxiety (Golding, 1999). My training at the agency included working with trauma, as it was recognised that some of the anxiety presented could have been linked to traumatic events. Although this may have been symptomatic of PTSD, it was referred to in the agency as anxiety, as there were concerns in the UK at that time around the stigma associated with a diagnosis of PTSD (Abrahams, 2008). These concerns were not shared in the USA, and much of the research on PTSD comes from there. In addition to distress, the clients also exhibited a degree of wariness as they approached counselling, a factor mentioned early on in DV research (Walker, 1979). Although some authors (Walker, 1994; Sanderson, 2008) stress that it is important to build trust with DV clients as their experiences may have resulted in this wariness, it is not clear from the literature how this can be done. Section 2.3 reviews what is currently known about the mental health issues for DV and how they are treated in the UK, highlighting some current limitations.

There are views beginning to emerge that whilst both men and women suffer psychologically from domestic abuse (Coker *et al.*, 2002) they may present that suffering differently. More recent research suggests that women may show a greater range of mental health issues than men and that there may be differences in presentation between the genders (Afifi *et al.*, 2009). It has been suggested that men may be more likely to externalise their distress through anger and disruptive behaviour whereas women may internalise it through anxiety and depression (Stith *et al.*, 2012). This research is still in its early stages, but it suggests that the

measurement of depression and anxiety, generally used for female victims, may not be as appropriate when assessing the degree of distress in men. However, this seems simplistic as anger was a significant issue for some of the female clients at the agency where I worked. This was addressed through counselling and a punch bag was available in one of the counselling rooms if required. This perhaps raises a greater question of whether the presenting mental health issues relating to DV are properly assessed and understood for both men and women. Whilst this introduces the possibility that gender may need to be considered when criteria for assessment are chosen, it is also important to note that research into psychological treatments for DV experiences have also yet to agree on an appropriate set of assessment or outcome measures, as shown in section 2.4.

In keeping with Ramsey *et al.*'s (2005) findings, I had also wondered about the best way to respond to these clients and, perhaps due to my chemical (process) engineering background, what I really felt I needed was an outline counselling process for this client group. Whilst the model of counselling that we had been taught and practised at the agency was person-centred feminist, I was aware that sometimes this was not enough. I had previously trained as a corporate coach, and I found that using some of those skills could be highly beneficial for the client. However, as shown in section 2.4, there appears to be no commonality of view or approach. The broad conclusion from the literature reviewed was that integrative, rather than person-centred, counselling with a therapist who was skilled at developing strong and trusting therapeutic relationships and had some experience in DV, might be beneficial (Roddy, 2011a).

However, there was a predominance of the therapists' perspective in all of the literature on working psychologically with DV clients, which seemed strange to me coming from a customer service role. Undertaking market research to determine what was working well or not for our customers seemed a natural process, and yet as shown in section 2.5, was rare in this field. Given the apparent diversity of professional view, perhaps asking clients about their experience and what they found helpful could inform practice. Thus, the research project on which this thesis is based began to take shape: a client based study to determine what best aids recovery from psychological harm resulting from DV, involving both women and men, and the results from this are given in chapters 4 and 5.

Subsequent to Ramsey *et al.*'s (2005) report the UK government increased the amount of money available for advocacy resources and the number of sexual

assault referral centres (SARC) (Home Office, 2011) but has yet to invest in significant research to develop psychological interventions. Despite this, some third sector providers have been developing their own counselling services, learning through practice to good effect (British Association for Counselling and Psychotherapy, 2011). A recent taskforce report suggested that the third sector may now be producing more appropriate counselling services for DV than the health service and that referral pathways to those organisations ought to be considered as part of a broader strategy (Taskforce on the Health Aspects of Violence Against Women and Children, 2010b). The government response to this report (Department of Health, 2010) indicated agreement in principle to this proposal, whilst noting the funding implications. As service provision across the UK for DV support varies widely (Coy, 2009), developing a consistent service across the UK through the third sector would have significant cost implications. Nevertheless, doing research with third sector organisations that have consistently provided a good counselling service to clients is likely to begin to answer some of the questions about what clients need and value. The methodology adopted to do so is shown in chapter 3.

As a counsellor working in the third sector, I have been aware of the need for more financial support for counselling services. To date, the recommended increase in funding for services or research into psychological interventions has not been made available, and some counselling services for DV have had to close (Farmer *et al.*, 2013). Indeed, the agency where I did my counselling placement no longer offers a counselling service. Although the government suggested that there would be additional support for victims available through their new mental health strategy (Department of Health, 2011) this specifically mentions family therapy as an intervention for DV, rather than individual therapy for victims. It also precludes treatment for those not in a traditional family unit or those who have left their abusive partner. A recent briefing report for GPs does highlight the mental health impact of DV, but focuses on disclosure from women still in relationships and recommends referral to an advocacy service (Sohal, Feder and Johnson, 2012). A meta-analysis of research into DV and mental disorders (Trevillion *et al.*, 2012) could only conclude that those suffering depressive disorders, anxiety disorders or PTSD were at a higher risk of experiencing DV but not that DV caused mental health problems. In keeping with earlier research reports, they acknowledged that further research into the process for improving mental health post-abuse was required, whether or not DV caused the issue.

Whilst there is recognition that counselling for women survivors of DV is restricted and would benefit from research into what sort of counselling could be recommended, the case for men has not yet been accepted. As a result, there are very limited resources available (AMEN, 2009) and male DV charities receive no state funding in the UK (ManKind, 2010). In the USA, research is beginning to show the potentially significant psychological effects on men from DV (Straus *et al.*, 2009; Hines and Douglas, 2011). This suggests that current policy in the UK may be insufficient to support male victims of DV. Yet changes are being made. In March 2013, the government definition of DV was expanded to include threatening, controlling or coercive behaviour (Home Office, 2012b) from both male and female partners. Despite consistently maintaining a view of women as the main victims of DV (Taskforce on health aspects of Violence against Women and Children, 2010a), the government announced funding for services specifically for male victims of DV in December 2011. Although the funding was small (£2-£10k/service) and only 12 awards were made, it showed a change in direction. In the Government's strategy update (Home Office, 2012a) there was recognition that their position regarding male victims may need to be readdressed over the next period.

Although politically the door seems to be opening to the possibility of psychological harm to women and men suffering DV, this does not seem to be reflected in the funding being made available. There are still many questions in the UK about what an appropriate DV psychological service might be for women, and it is likely that in time the same question will be asked for men. Just as I struggled to find research to help my own practice in this area, so I anticipate that others may have the same difficulty.

With the realisation that more information is required, it is timely to undertake research to assist in answering these questions. In looking at the process to determine what is helpful to DV clients, it is important to understand what support is required for mental health issues, how those services can be accessed and used, and what the benefits of counselling are to clients. There is still much to do to develop a model for psychological services for DV within the UK and it is for this reason that this small research project has been undertaken, with the hope that it will provide useful information for practitioners and agencies working with DV clients in the future.

2 Literature Review

2.1 Introduction

Although much of the research in this area had been judged of insufficient quality to drive policy decisions on mental health treatment (see chapter 1), there was still a substantial body of work to review. The literature review was conducted using electronic data-bases such as CINAHL, PsycINFO and MEDLINE. In addition, Zetoc Alerts provided information on additional material in the field as it was published, and previously published literature in the area signposted other specific and relevant research. Much of the literature was published in the USA and Australia, and whilst a few of the papers identified were not available in the UK, much of the literature was available electronically or could be sourced via the British Library, or in the case of books, via international second-hand book sellers.

The review was conducted in two stages: before beginning the research field-work, and after the field-work was completed. The first focussed on the current literature on domestic violence, and initially used search terms such as: domestic violence or abuse; interpersonal violence; battered women or men; victims or survivors. As can be seen from the previous chapter, there has been a substantial amount of research conducted on DV and further modification of the search terms was required. In order to identify research specifically associated with mental health and relevant to this study counselling, psychotherapy, counsellor and psychotherapist were included as search terms. This resulted in literature focused on the psychological effects of suffering DV on adults, including access to support and treatment. However, the body of work for review was still too large, and further refinement of the selection criteria was required. Studies which involved participants within long term relationships and a recent history of being abused were included in the review. However, studies involving dating violence and students were excluded (except where there was no alternative data) as the experience of dating an abuser was considered to be different to living with one over a period of months or years. Studies specifically related to the impact of childhood abuse on later life were also excluded, as this study was specifically interested in the continuation of abuse into adulthood as domestic violence. Additionally, particular situations such as DV during pregnancy were excluded, as those may have had particular dynamics associated with them.

A further literature review was conducted after the findings of the research became clear. Specific search terms included: help-seeking; hope; trust; compassion; and endings. This was conducted in the context of both domestic violence and counselling and psychotherapy more generally. This chapter brings together both searches to provide a summary of the existing, relevant literature.

Although literature exploring the female experience of DV has been built up over several decades, research into the male experience is still relatively new. Therefore the literature base for men is small. This is reflected in the relative weighting of female to male literature throughout the chapter. It is also important to note that much of the literature comes from North America. Whilst this has allowed greater exploration of the issues surrounding DV, it is important to recognise that there are differences in, for example, legal, health and social care systems compared to the UK. Nevertheless, what has emerged is a picture of a client group with serious mental health issues struggling to identify, access, and engage with appropriate services to meet their needs. The literature reviewed within this chapter shows: the difficulties that adults may have in seeking assistance; the prevalence and treatment of diagnosed conditions; therapeutic recommendations for working with DV clients; and views obtained from clients about their preferences for and experiences of receiving assistance. Each of these themes is presented as a separate section, with a summary provided at the end of each one.

2.2 Problems in seeking help

It has been proposed that women are more likely than men to seek help for psychological problems (Greenley and Mechanic, 1976; Kessler, Brown and Broman, 1981). The decision to seek help has been linked to the ability to relate emotional distress to the need for help, with women considered much more aware of their emotional distress (Kessler *et al.*, 1981). Once this need for help was identified, the decision to seek help involved balancing the positive or negative consequences of doing so and/or the relative costs involved. This suggests that help-seeking behaviour can be increased through raising awareness of emotional distress or by reducing the negative consequences or costs of accessing help. Within a DV context, however, increasing levels of emotional distress may lead to further victimisation, and seeking help could risk the of loss of their primary relationship, resulting in additional family and financial difficulties. Help-seeking within DV can be a difficult choice.

2.2.1 For women

Recognising the complexity of this, qualitative research has been conducted through focus groups to identify the barriers to women of leaving (Dziegielewski, Campbell and Turnage, 2005; Beaulaurier *et al.*, 2008) and semi-structured interviews to determine the support that might be needed as they decide to go (McLeod, Hays and Chang, 2010). The woman's perception of her situation appeared to come from the positive and negative responses she received from her community, the public sector or family members; plus her assessment of her own personal resources and responses to her situation (Dziegielewski *et al.*, 2005; Beaulaurier *et al.*, 2008; McLeod *et al.*, 2010). Beaulaurier *et al.* (2008) produced one of the most comprehensive diagrams of barriers to seeking help. This was derived by analysing the responses of 134 women involved in 21 focus groups using grounded theory and showed the interaction of three main factors: abuser behaviours (such as creating isolation); external factors (the responses of the external world); and the woman's feelings, beliefs and values associated with the abuse. In the face of a constant pattern of abuse, the woman's views and the abuser's behaviour may remain unchanged without external assistance to change perception. If such support is not easily available, the woman may work to control her emotional distress and continue to tolerate her environment. In these circumstances, she would only be likely to seek external support if the abuse escalated, leading to increased levels of distress.

A qualitative UK study involving 18 mental health users and 20 mental health professionals in a London borough found similar themes in barriers to disclosure of DV within the mental health system but added a further dimension of working within a medical model (Rose *et al.*, 2011). As health-care providers have a limited amount of time with patients, their focus is on diagnosis and treatment rather than the exploration of other issues the patient might bring. The study noted that even with a professional who was interested in the individual, there appeared to be organisational and cultural issues which unwittingly prevented a dialogue. Although the patient may wish to seek help for DV, it is more likely that they will receive treatment to reduce their emotional distress, rather than support to deal with the cause. From the studies reported above, this may inadvertently decrease the likelihood of seeking further help.

Quantitative studies on help-seeking have also been conducted: in the USA, based on interviews with 389 women in Chicago identified as currently being abused

(Leone, Johnson and Cohan, 2007); in Canada, using data from 1,067 individuals responding to the 2004 General Social Study on Victimization (Ansara and Hindin, 2010); and in Norway, where 157 women identified as currently seeking help for domestic violence were interviewed (Vatnar and Bjørkly, 2009). Each noted that individuals accessed external support depending on the type of abuse suffered. All of the researchers concluded that severe physical violence increased the likelihood of a request for support from medical professionals and the police. This is illustrated in the Canadian data from Ansara and Hindin (2010) shown in Table 2-1 below. Here, participants were asked questions relating to emotional, financial, physical and sexual abuse to identify and categorise the level of abuse suffered. Those reporting at least one act of physical or sexual violence in the last five years were asked about how they sought help formally and informally.

Table 2-1 Differences in help-seeking behaviour related to type of abuse

	Ansara and Hindin (2010, p1015) Victims suffering physical aggression only	Ansara and Hindin (2010, p1015) Victims suffering severe violence, control and verbal abuse
Friends, relatives	63.8%	75.2%
Police	22.2%	58.5%
Co-worker	13.5%	29.7%
Health professional	34.9%	66.6%
Counsellor/therapist	26.2%	50.0%
Legal professional	13.3%	35.2%
Support services	8.2%	28.3%

The pattern of help-seeking reported by Ansara and Hindin (2010) appears to begin with support for the individual through family, friends, health professionals and counsellors. This indicates that as the level of threat increases, so does the need to involve the police and legal services. The services required vary according to the individual's particular circumstances and personally available resources. This introduces the concept that approaches for help can be needs based and may change over time, hence one service is unlikely to meet the needs of victims completely.

It is also important to consider this within a UK context. Table 2-2 below shows data gathered through the British Crime Survey in the UK (Smith *et al.*, 2012), together with Ansara and Hindin's data from Canada. The UK data comes from 647 female respondents to the 2010/11 British Crime Survey who indicated that they had experienced partner abuse in the last 12 months. As the two sets of data are derived from different research criteria, comparisons cannot be made directly. However the data suggests the apparent willingness of Canadian women to access support and help from a wider range of sources compared to British women.

Table 2-2 Sources of help approached by female victims in the UK and Canada

	Data from the British Crime Survey 2010/11 (Smith <i>et al.</i> 2012, p111)	Data from the Canadian General Social Study on Victimization 2004 (Ansara and Hindin 2010, p1015)
Friends, relatives	77% ²	68.2%
Police	29%	34.2%
Co-worker	12%	22.2%
Health professional	19%	47.2%
Counsellor/therapist	21%	35.1%
Legal professional	11%	22.3%
Support services	34% ³	14.3%

Women in the UK reportedly rely predominantly on friends, family, support services and the police, but it is hard to know what factors drive that decision. It is possible that the data responses could have been influenced because they come from a crime survey. It could also be related to the significant investment that has been made in the police and judiciary process over the last 15 years, including advocacy, which may have influenced the referral process and hence help-seeking behaviour.

² This is the figure for someone known personally to the individual and also includes the number for co-workers provided separately in the table.

³ This figure also includes the number for counsellor/therapist provided separately in the table.

It could also be due to the differences in survey methodology as incidents of abuse are noted for the past year for the UK (Smith *et al.*, 2012), and the past 5 years for Canada (Ansara and Hindin, 2010). It is possible that the immediacy of the experience for UK women prompts greater access to support services and the police as they seek physical safety. Nevertheless, the biggest difference between the two countries appears to be the degree to which women might seek help from health professionals. Women in the UK appeared more likely to access a counsellor than a health professional, suggesting some recognition of mental health issues.

This apparent lower level of disclosure to health professionals has caused concern within the National Health Service in the UK (Feder *et al.*, 2011), although there has been an increase from 10% in the last crime survey (Smith, Coleman and Roe, 2010). A cluster randomised control trial was conducted with 81 general practices in London and Bristol to see if disclosure of DV and referrals to DV services could be improved through pro-active discussion of DV with patients (Feder *et al.*, 2011). Overall, 877 disclosures of DV were made. This built on earlier work which indicated that asking specifically about DV would lead to increased disclosure rates (Jordan, 2007; Hegarty and Glasziou, 2011). In all, 235 referrals were made to DV advocacy services as a result of disclosure, and Feder *et al.*'s (2011) study showed that GP practices which had been trained to ask about abuse made 22 times more referrals to DV services than those which had not.

However, outcomes from the individuals referred into DV services were not included as part of this study. Although the increased referral rate appears substantial, the level of training and system changes required were considered too high by other medical professionals to support the relatively low numbers of patient referrals per practice, without evidence of positive change as a result (Hegarty and Glasziou, 2011). This comment on the success of referrals is pertinent, given the significant differences in the availability and quality of DV services, including counselling, across the UK (Coy, 2009). Simply rolling out a programme to increase the disclosure of DV without specialist services in place to take the resultant referrals would be inappropriate.

Hegarty and Glasziou (2011) were also concerned about importing information and ideas from non-UK health systems and suggested further UK research instead. The focus of the medical system in the UK on large-scale quantitative trials to assess a multi-dimensional problem like DV suggests there will always be more work to do. There is growing evidence that the impact of DV on the mental health of individuals

is being replicated in other countries (Unal, Yildiz and Avci, 2013). Therefore not using data from other sources which in turn places an extra burden on the limited research resources available in the UK is hard to justify in the current climate of austerity. Whilst the drive to increase DV disclosure within the health professions is to be commended, the requirement for additional research to inform the mental health treatment of victims (as outlined in chapter 1) appears not to be addressed.

A recent study from the USA investigating the use of mental health services by fifty women who had experienced intimate partner abuse in the last 12 months found that less than half of those diagnosed with PTSD and/or clinical depression had received mental health treatment (Edmond, Bowland and Yu, 2013). Participants were recruited from a legal advocacy programme. Using the Composite Advocacy Scale (Hegarty, Sheehan and Schonfeld, 1999), around 20% of the women were assessed by master's level social work students as having experienced severe forms of abuse and 40% from physical or emotional abuse, or harassment. Even with considerable mental health problems, the women were reported to be twice as likely to access support from the police or the family doctor rather than mental health services. This suggested that even if specialist services were available, individuals may choose not to access. Two possible theories for this response were offered by the authors: having a survival coping mechanism linked to isolation and disconnection which meant they did not see personal support as helpful; or experiencing shame and stigma associated with seeking help together with a sense of already being judged, that may make it difficult for them to acknowledge their problems. It is also possible that the women, in keeping with research on general client groups, sensed shame and stigma associated specifically with seeking mental health support (Vogel *et al.*, 2013).

Nevertheless, almost all of those who sought mental health support within Edmond *et al.*'s (2013) study had found it easy to access and helpful, suggesting that the problem with access lay with the individual's decision not to access, rather than service availability. Recent research with university students in the USA investigated help-seeking decision pathways relating to health care (Hammer and Vogel, 2013). This work suggested that a decision to accept help may be based primarily on the person's willingness to do so at that moment, that is a spontaneous act in response to a perceived opportunity, rather than a reasoned decision. This is important when considered in the context of a USA study examining the communication style of 177 women from a social service agency in Ohio, who had

been abused within the last 6 months (Williams and Mickelson, 2008). This study found that the communication methods used by these women were primarily indirect ('show some indication something is wrong and wait to be asked') form of help-seeking, rather than a direct ('tell it as it is') approach. This indirect style resulted in unsupportive responses or rejection, and therefore potentially fewer spontaneous opportunities to accept help. The research did not explore attachment or natural communication styles, but indirect communication was reportedly linked with the stigma of abuse and fear of rejection. Someone who has been constantly abused may not be direct about their needs, as they know responses can be unpredictable. They may not be skilled in identifying their own needs either, as it may be unlikely that these could be met within their relationship. Both of these issues would make it difficult for them to express themselves. Research on mental health services in the UK (Rose *et al.*, 2011), suggested that patients would need to bring DV to the attention of the mental health professional, which may require a direct communication style. Hence those with an indirect style may have increased difficulty in seeking mental health support in the UK. Williams and Mickelson (2008) do indicate that women are willing to seek and accept support when it is offered, but leave the issue of how to offer support without receiving a direct request unanswered.

Other researchers have investigated access patterns to DV services (such as advocacy, help-lines, information provision, group or 1-to-1 support) and how those could be improved (Abel, 2001; Henning and Klesges, 2002; Feder *et al.*, 2011). Abel (2001) conducted her research with 51 women who were accessing DV victim services in Florida, and found that only 38% of had previously accessed medical help, although two thirds had previously accessed victim services and were reaccessing. A larger study in Tennessee involving 1,746 women who had partners going through the court system for physical abuse found that on average only 15% of abused women reported using counselling/supportive services (Henning and Klesges, 2002). This suggested that the numbers of women accessing this sort of support was a very small fraction of those suffering quite serious abuse. An earlier study of 578 women, recruited from a major metropolitan area in the USA and who had been in a psychologically abusive relationships, used cluster analysis to categorise victims according to their relationship and the psychological, physical and sexual nature of the abuse (Marshall, 1996). This concluded that women who had experienced extreme physical and psychological violence requested help from all identified sources, including support services. However, women showing the

least psychological, physical and sexual abuse were more likely to access victim support rather than formal services (such as legal or medical professionals). Marshall's (1996) reported differences in help-seeking according to the type and extent of the abuse could account for the low levels of medical access in women experiencing lower levels of physical violence (Abel, 2001) and the limited access to victim support for women suffering sufficient physical harm for legal charges to be brought (Henning and Klesges, 2002).

The dynamic of identifying and seeking help is complex as the needs identified by the women at particular times change. As noted in the paragraph above, women at risk through extreme forms of physical abuse are likely to reach out for help to any source they can identify, whereas women suffering emotional abuse are more likely to access specialist support services, which might include counselling. This underlines the importance of access to a range of support services. However, even where services are available, there may be a complex engagement process to offer appropriate support to the woman in a way she can accept. It is possible that this may be part of the attraction of counselling, as many counsellors do not require a full disclosure of the client's problem in the first session. However, further research into what supports engagement with appropriate services would be beneficial to both service providers and clients.

2.2.2 For men

The concept of men being less likely than women to seek help was mentioned at the beginning of this section and literature going back several decades has suggested that men can be too self-reliant and can have difficulties with emotional intimacy (Addis and Mahalik, 2003). In a survey of 68 representatives of DV agencies for men from across the USA, factors stopping men from accessing DV support were identified and found to include shame, denial, fear and feeling he would be judged or misunderstood (Tsui, Cheung and Leung, 2010). As these factors have also been discussed in relation to men's general reluctance to access support, Tsui *et al.* (2010) suggests that this may be a gender issue, rather than specifically related to the experience of DV. Living up to a traditionally masculine role of being in control, unemotional, independent and achievement focussed can lead to what has been termed "double jeopardy" (Good and Wood, 1995). This is where adopting these characteristics risks the development of mental health problems such as depression. Treatments such as counselling can be viewed negatively due to the emotional focus presented by most counselling services

(Wisch *et al.*, 1995). Whilst Wisch *et al.* (1995) recommended resolution of this issue through cognitive or text-based interventions, Good and Wood (1995) discovered that there could be a difference in outcome dependent upon the individual's interpretation of counselling. Men who had difficulty sharing their feelings might see counselling negatively, whilst those who were predominantly achievement orientated may be open to the experience.

Recognition of some men's difficulty in expressing emotion led to investigations into the impact of alexithymia on help-seeking and the experience of therapy (Berger *et al.*, 2005; Cusack *et al.*, 2006; Judd, Komiti and Jackson, 2008). Each study concluded that this was not an important factor although, as with Good and Wood (1995), it was suggested that it may be the man's perception of expressing emotion in the context of therapy that was important (Cusack *et al.*, 2006). Good and Wood's (1995) study with 397 male psychology college students, concurred with Kessler *et al.*'s (1981) population survey into psychiatric help-seeking, by recognising that mental health help-seeking was assisted through the individual's recognition of a need for help, whilst also being able to tolerate others' views about attending counselling (Pederson and Vogel, 2007). In a comparison study of 579 male and female community participants in Australia, which looked at mental health help-seeking (Judd *et al.*, 2008), men were found to have higher levels of stoicism, stronger views about the personal stigma relating to mental health issues and lower levels of openness to trying out new ideas, all of which decreased the likelihood of seeking help. However, having confidence in the mental health profession and being able to be open about any problems they had, increased the likelihood of doing so (Pederson and Vogel, 2007).

There is, potentially, an additional problem for men who have experienced DV from their partner. As noted in chapter 1, low levels of funding for male DV support services means that there is a lack of service availability. Recognising the need to support male victims, some women's services are now also offering to work with men (IDAS, 2014), whilst others are clear that they are only there to support women (EVA, 2014). In Tsui *et al.*'s (2010) study from across the USA, the main factor in stopping men from accessing support was the perception that DV support services were for women and not appropriate or accessible for men. Other researchers have found that this is not only perception but reality in many cases (Cook, 2009; Douglas and Hines, 2011). Whilst part of the difficulty may be differences in policy between

agencies, it is also possible that men may require a different sort of service for DV (Caldwell, Swan and Woodbrown, 2012) although what that might be is not clear.

There have been a few studies that have explored how men have sought help for DV. In the USA, research has been conducted with help-line callers (Douglas and Hines, 2011), whilst in the UK and Canada population surveys have been used (Ansara and Hindin, 2010; Smith *et al.*, 2012). The data, shown in Table 2-3 overleaf, is not comparable numerically due to different methodologies, but does supply relevant information about how men perceived help to be available. Each of the studies found that men mainly talked to friends, family or co-workers and, in keeping with Tsui *et al.*'s (2010) findings, counselling was found to be important.

One of the key points reported by Smith *et al.* (2012), not provided by the other studies, was that 28% of male victims had not told anyone about the abuse. This compares with 13% of female victims in the same study. Also, the relatively low numbers of men who had interacted with the public sector and other services suggests that the level of male abuse in the UK has the potential to be under-reported. The surveys do not provide contextual data on the extent or severity of the abuse experienced and further work would be required to fully understand this.

Table 2-3 Sources of help approached by male victims in different countries

	UK (Smith <i>et al.</i> , 2012)	Canada (Ansara and Hindin, 2010)	USA (Douglas and Hines, 2011)
Friends, relatives	64% ⁴	45.2%	84.9%
Co-workers	17%	21.8%	N/A
Police	10%	16.7%	46.3%
Counsellor/therapist	14%	16.4%	66.2%
Health professional	4%	22%	18.1%
On-line/telephone support	2%	3.8%	63.4%
Lawyer	6%	11.6%	43.3%

⁴ This is the figure for someone known personally and also includes the number for co-workers

It is also noticeable that men participating in the UK study appear less likely to access external support than those responding in North American ones. In the USA, those men who have accessed support are reported to have found individual counselling and legal advice helpful (Tsui *et al.*, 2010). Research conducted in the UK with the Respect call centre, where callers are often referred on to appropriate services, reported that the three main issues that male victims wanted help with were legal advice, housing and counselling (Debonnaire and Panteloudakis, 2013). Counselling was the second highest referral rate at nearly 19% of callers, more than to the police, but lower than the 32% of callers referred to legal services. Counselling referrals were made to private practitioners who had been approved through Respect, as there was no agency funding available for male counselling.

The earlier literature suggested that men who have adopted traditional male views might be reluctant to engage with counselling, and research has shown that many DV victims have chosen stereotypical masculine occupations (Hines *et al.*, 2007). Almost 30% of callers indicated occupations in the police, armed forces, construction or manual labour. Yet despite this, counselling appears to be a preferred support service (see Table 2-3) accessed by men in each country, indicating some need for, and openness to, psychological support after DV.

Given the very limited amount of data, and different research methods used, it is difficult to draw firm conclusions. It appears that most men will preferentially access informal sources of support such as friends or family. Counselling appears to be a preferred referral service for those who seek further help. What is not clear is whether this referral to counselling is due to a lack of specialist support services available, the perceived professionalism of the counsellors or the significant psychological distress of the men. Further research needs to be conducted to fully understand the issues and dynamics of their situation. In addition, there may be cultural and sociological factors implicated in the help-seeking dynamic. It would be particularly useful for further work to be completed within the UK.

2.2.3 Summary

It has been recognised for some time that women suffering from DV do not all access support in the same way. Research has shown that factors relating to the scale, type of abuse and immediacy of the threat will lead to decisions regarding the kind of support accessed. As a result psychological support may not be utilised as

much as the potential demand identified in research studies would suggest. In the UK, counselling generally appears to be considered positively in terms of help-seeking. External assistance may be required for women to recognise, articulate and act on the need for psychological support, although this needs further investigation.

In the case of men, services appear to be embryonic and there is an argument in the literature that the lack of engagement with services is because men are less open to doing so, rather than the service not meeting their needs. Yet, in the context of DV, the limited number of studies which have been conducted suggest that counselling may be a service that men are prepared to access. It may be possible that DV creates a psychological impact sufficient to change the normal pattern of help-seeking behaviour in men, but that has yet to be explored. DV service development for male victims may require a different focus and different model for service engagement. This is also something that would benefit from further investigation.

2.3 The psychological impact of DV

2.3.1 Introduction

Although the focus of much of DV research until relatively recently has been around the impact of physical abuse, it is important to review the evidence for the type, degree and prevalence of psychological harm. If women and men find a way to seek help with mental health issues, getting the right diagnosis and support at that time is important. This section identifies current knowledge about the types of psychological harm that may present as a result of DV, together with current UK treatment options, with the exception of two specific areas that are considered briefly below: the impact of childhood abuse on DV mental health issues; and addiction.

Some individuals seeking treatment for mental health issues associated with DV may also have suffered abusive childhoods (see chapter 1) and a previous history of abuse is known to be a potential contributor to mental health difficulties (National Collaborating Centre for Mental Health, 2009). In 1979, Lenore Walker identified “learned helplessness” as a factor in DV, linking this with continued abuse inflicted by the male partner. However, in her later research involving 403 women from north west USA who had had physically abusive relationships, two thirds of her research participants had experienced domestic abuse as children and about one half had suffered some form of childhood sexual assault (Walker, 2000). These experiences

precluded feeling in control as a child, which Walker felt added weight to her previous argument of learned helplessness.

This characterisation of abused women having been previously abused has been found in other research (Howard *et al.*, 2003; Hegarty *et al.*, 2004; Rushlow, 2009), although the proportion measured has been as low as 25% of the participants. This still indicates a reasonable probability that some female clients presenting for counselling will have a childhood history that could impact on their present issues. Recent surveys conducted with men who have suffered DV from across the USA also indicated a possible history of childhood abuse (Afifi *et al.*, 2009; Douglas, Hines and McCarthy, 2012). Afifi *et al.* (2009) found that the proportion of male victims experiencing childhood physical abuse was broadly similar to that of female victims at around 9%, although 27% of female victims suffered childhood sexual abuse compared with 10% of men. Whilst these are significant numbers, it still suggests that more than half of the victims of DV will not have suffered childhood abuse.

There has been debate about the extent to which DV, rather than previous life events, plays a part in the individual's adult mental health (Ehrensaft, Moffitt and Caspi, 2006). One finding from a survey of 444 Italian women found that DV impairs mental health, but that the impairment is greater for those who suffered childhood abuse (Romito, Turan and De Marchi, 2005). On the other hand, a UK meta-analysis of 41 studies from across the world could only conclude that individuals with existing mental health issues were at higher risk of interpersonal violence (Trevillion *et al.*, 2012). A study involving 500 women who accessed counselling services in Illinois found many participants had experienced a range of previous physical and sexual abuses from both childhood and adulthood, and those who had experienced sexual abuse had more severe mental health difficulties than those who had not (Howard *et al.*, 2003). This is a complex issue which is difficult to analyse quantitatively due to an individual's continued experiences, both positive and negative, throughout life. Experiencing childhood abuse will not necessarily result in the abuse continuing through DV in adulthood. In addition, it is important to note that not all people experiencing DV will suffer from mental health problems. However, those who have experienced childhood abuse may have more severe mental health problems, but not necessarily different problems, to those who have not. Hence this literature review simply acknowledges that, for some people, the

experience of DV at any age can lead to or exacerbate mental health problems and explores the nature of those problems and possible treatment options.

The other area which has not been specifically addressed in this literature review is addiction. Although drug and alcohol problems have been highlighted as risk factors for DV, surveys involving 246 male help-line callers and 403 females who have experienced physical abuse in the USA indicated that this is primarily an issue for the perpetrator, male or female (Walker, 2000; Hines *et al.*, 2007). Both studies have reported alcohol use by the perpetrator in more than 50% of cases for men and women, and drug use about 20% of the time for men and 35% of the time for women. In comparison, Walker (2000) indicated drug and alcohol usage reported by the women in her study to be around 50% lower. This finding was confirmed by other researchers within a general population containing battered women (Dutton, 1992; Golding, 1999; Howarth *et al.*, 2009; Vatnar and Bjørkly, 2009).

In the UK, many refuges and women's services will ask for addiction issues to be resolved prior to access (Women's Aid, 2013) and so surveys of this population might show lower levels of substance abuse. One study of 1,268 women accessing USA health services suggested that substance abuse and a lifetime of emotional abuse were linked (Kramer *et al.*, 2004) although overall levels of substance abuse, in keeping with other research (for example Seedat *et al.*, 2005), were low.

A recent study of 302 male victims from across the USA who had sought help for DV revealed alcohol use of 17.9% and drug use of 21.5% (Douglas and Hines, 2011), which is within the ranges found for women, but this is a single study. Nevertheless, the data suggests that for this population, use of alcohol and drugs is less prevalent than for their partners, and less prevalent than other diagnosed conditions such as depression (Golding, 1999). As Walker (2000) mentions in her research, it is not clear how many victims will need assistance to manage problems with physical and psychological addiction, rather than finding alternative coping strategies for emotional difficulties.

The mental health issues that appeared most likely to be present (Walker, 1979; Walker, 1994) and have been explored by researchers over many years were depression, anxiety, suicidal ideation and, more recently, PTSD. In addition, Walker (1979) identified general suspiciousness as a psychological complaint, which has subsequently been researched through attachment theory and related to issues of trust. Each of these areas is considered separately and reviewed below.

2.3.2 Depression

A significant body of work was completed in the USA investigating the mental health symptoms of women who had experienced DV. These were summarised in a meta-analysis based on 18 studies from North America (Golding, 1999) and showed that many women were assessed, using a variety of instruments, as being depressed. However, with large variations in the data (15-83% of the defined populations) caused by differences in research methods and assessments, it was unclear how many were likely to be affected and to what degree.

There are multiple theories about how depression develops, including biology, stress, attitude to life or reaction to perceptions of past or present events, each of which can be linked with DV (Campbell, Kub and Rose, 1996). Golding (1999) calculated the prevalence of depression after DV within her meta-analysis as 47.6% and compared this with general population studies showing rates of depression between 10.2% and 21.3%. Golding also reported that studies relating to women in refuges reported significantly higher levels of depression (60.6%) than those studying primary care, emergency room or psychiatric service populations (39-44%). She suggested that this may be due to their more recent exposure to violent situations, although only 41.3% of abused women visiting the emergency department were assessed with depression.

In a study conducted with 101 women from 8 refuges in Israel learned helplessness was found to be a statistically significant factor in developing depression, although the total amount of violence perpetrated was not (Bargai, Ben-Shakhar and Shalev, 2007). These results aligned with an earlier longitudinal study following women leaving a refuge (Campbell *et al.*, 1995) that assessed 83% of the women as depressed to some extent on leaving. This cohort were assessed again after 10 weeks, when 59% of the women were assessed as depressed, but there was no further reduction after 6 months, even for those who had remained free of violence during that time. Campbell *et al* (1995) commented that the women who still felt powerless after leaving and had poor social support networks were more likely to remain depressed.

This lack of improvement after leaving an abusive relationship was also found in a three year longitudinal study of 2,639 women within families in the USA (Adkins and Kamp Dush, 2010). Although there was an increased rate of depression for the whole cohort over the study period, the greatest increases came from those living in a physically and psychologically abusive environment. However, there was no

reduction in depression according to DSM-IV criteria found for those women leaving the abusive relationship compared to those who remained. It seems that leaving the relationship can create physical safety but psychological aspects of the abuse, such as feelings of powerlessness, can remain unaddressed.

Other factors can play a part in the development of depression. An Australian study of 1,227 women who visited their GP (Hegarty *et al.*, 2004) found that 65% of those women assessed as 'probably depressed' indicated some history (current or past) of abuse. Around half of this 'probably depressed' group experienced abuse as a child and a third some form of abuse within an adult relationship. Although they also had factors known to be associated with depression such as living alone, having a low income, being unemployed or having a lower educational attainment, partner and childhood abuse were seen to be significant factors.

Recognising that leaving a relationship often means living alone, perhaps on limited income, there is a question of whether research showing continued depression is a result only of the abuse or whether changed life circumstances play a part. This group may feel depressed for a variety of reasons and it would be inappropriate to make assessments or judgements based only on the violence of the relationship, as past history, psychological abuse, relational issues and current life situation may also have a significant impact. Whilst depression can be linked to DV, the contributing factors will vary from person to person and may be difficult to establish.

There is very little research on depression levels for men suffering DV. One study involved 57 couples who sought counselling for their relationship at the University Marital Therapy Clinic at Stony Brook, New York (Vivian and Langhinrichsen-Rohling, 1994). This found that women were more likely to suffer from moderate depression as a result of aggression from either partner, confirmed in a later study (Cascardi, O'Leary and Schlee, 1999). However, men reportedly suffered moderate depression only when they were being victimised, that is the aggression was aimed at them, and this was assessed at a slightly higher level than their female partner. In that sense, a co-abusive relationship, where both partners respond aggressively, may have protective factors for men, whilst being detrimental to the female partner. Conversely, the National Violence Against Women Survey (NVAWS) in the USA involving 6,790 women and 7,122 men, found that all forms of IPV resulted in depressive symptoms for both men and women, although where psychological IPV through power and control (assessed using items from the Power and Control Scale (Johnson, 1996)) was specifically used these symptoms increased (Coker *et al.*,

2002). The data was collected via a telephone survey without being verified independently, but it nevertheless presents an interesting snapshot of the potential impact for both men and women of living with IPV. More recently, a study with 420 men enrolled in a health care system in north west USA concluded that both physical and emotional abuse can produce depressive symptoms in men over the age of 55 (Reid *et al.*, 2008), with more severe symptoms related to more severe physical abuse. Abused men who were under 55 were found to have lower social functioning than their non-abused peers, but the higher levels of depression found were not statistically significant. The research to date has shown a link between DV and depression, but has not reached a firm consensus on whether psychological or physical abuse is more likely to be the main contributing factor. However, there is increasing evidence that men as well as women can experience depression within an abusive relationship.

In the UK, guidelines for the treatment of depression (National Collaborating Centre for Mental Health, 2009) acknowledge the need for high intensity psychotherapy (16-20 sessions) for moderate to severe depression with either Cognitive Behavioural Therapy (CBT) or Inter Personal Therapy (IPT) in combination with drug treatment. For those who decline CBT or drug treatment, psychodynamic therapy is offered as an alternative. Although there is recognition in the guidelines that depression is more likely in those who are isolated at home, or those who have suffered a history of childhood abuse, there is no specific recognition of the potential impact of DV as an adult. In addition, the focus on symptoms within the guidelines means that a patient would need to bring the context of their psychological distress to the attention of the doctor to be able to access specific help with DV. Issues associated with help-seeking were discussed earlier in this chapter, and indicate the possible difficulties that this client group may have with disclosing. Much of the DV research has focused on the mental health impact of physical abuse rather than psychological abuse, and yet reports of continued feelings of powerlessness, even after the relationship ends, and which could result from either form of abuse, appear to be important. This could be an area for further research.

2.3.3 Suicidal Ideation

Suicidal ideation has been identified as a risk factor for women in domestically violent relationships since the 1970's and studies used in a meta-analysis in the USA have shown variations in prevalence from 4.6-77% compared to general population figures of 0.8-15.9% (Golding, 1999). The highest rates were found

amongst those admitted to psychiatric units, followed by those women who accessed refuges. These data appeared to show a relationship between the severity of the violence and suicidal ideation, but a more recent review from the UK has linked experiences of severe violence specifically with suicide attempts, rather than ideation (McLaughlin, O'Carroll and O'Connor, 2012). One telephone survey involving 637 women in the Memphis area found that 23% of those women who had experienced partner violence indicated at least one suicide attempt (Seedat *et al.*, 2005). In addition, research conducted over the last 30 years has consistently confirmed a direct relationship between DV and suicidal thoughts and/or actions (McLaughlin *et al.*, 2012) and a higher likelihood of suicidal thoughts if physical and sexual abuse was experienced in childhood or adulthood (Calder, McVean and Yang, 2010).

It is possible that psychological and emotional abuse may play a part in suicidal thoughts. In a study of emergency and primary care providers in Milwaukee involving 1268 females attending clinics, almost 90% of the women who reported physical or sexual abuse within their lifetime also reported emotional abuse (Kramer *et al.*, 2004). This survey also indicated that the most limiting physical and emotional difficulties were reported by those women who had been emotionally abused, with 93% saying they had thought of suicide compared to 83% of women who were sexually or physically abused and 7% of women who were not abused. These figures are generally higher than for other comparable pieces of research, which is possibly due to the simplicity of the questionnaire: a yes/no answer which indicated the presence of the item but not necessarily the degree or frequency. The results are of interest directionally but need further, more detailed, work.

A more comprehensive piece of research looking at lifetime and recent instances of physical and emotional abuse was conducted in Valencia, Spain (Pico-Alfonso *et al.*, 2006). The study recruited 182 women, 130 of whom were victims of IPV and 52 who had not been abused, from the local community. The 75 women in the study who had been physically abused had also been psychologically abused, and 25 of this group had also been sexually abused. Of the 55 women who had been psychologically abused, 9 had also been sexually abused. Interviewers assessed the type of abuse from participant responses during the interview. Whilst 7.7% of women who had not been abused had suicidal thoughts, this rose to 43.6% for those who had been psychologically abused, and rose again when combined with physical abuse to 58.7%. Roughly 1 in 4 of the abused women reported making a

suicide attempt and this rose to 1 in 2 where physical abuse was also present. Suicidal thoughts were noteworthy for women who had been psychologically abused, but when linked also to physical abuse, the chance of thought becoming action appeared significantly higher.

To date, there have been no general studies of suicidal ideation or suicide attempts for male victims of DV, although there has been a specific study of interpersonal violence among 178 HIV positive men accessing two university health care clinics in Seattle, USA (Pantalone, Hessler and Simoni, 2010). This showed a negative mental health impact of both DV and external adult violence on rates of depression, anxiety, suicidal ideation and PTSD. There have been two studies (Afifi *et al.*, 2009; Calder *et al.*, 2010) that included both male and female victims of DV. In Calder's study of 1692 males and 2389 females who participated in a telephone survey in Washington State, the assessment included physical and sexual abuse, but not psychological abuse. The study did show a clear link for childhood and adulthood abuse with suicidal ideation for both men and women. Although reported childhood physical abuse made suicidal ideation twice as likely, adult physical abuse made it 27 times more likely. However, in this study men were 30% less likely to suffer suicidal ideation than women. In contrast Afifi *et al.* (2009), who interviewed 190 women and 216 men who had experienced IPV from a nationally representative USA study and were looking at physical violence, found no correlation between experiencing DV and suicidal ideation or suicide attempts for men currently in a marital relationship, and no statistically significant difference between men and women.

What is puzzling about Afifi *et al.*'s (2009) data is that it has been known for some time that men are more likely to complete suicide than women and there have been suggestions that the higher rate of suicidal behaviour is due in part to some of the constraints of traditional masculine roles (Möller-Leimkühler, 2003). More generally there have been concerns about the level of suicide in middle-age men rising, (Mental Health Weekly, 2011; Office for National Statistics, 2014). It has been noted that many of the men responding to the male domestic help-line in the USA (Hines *et al.*, 2007) were middle-aged and had a gendered job role. It would be inappropriate to draw a conclusion from this in isolation, but it does raise a question about the need to investigate suicide rates among male victims of DV and is clearly an area for further research.

More generally, it has been suggested in DV texts that thoughts of suicide come from feelings of hopelessness (Dutton, 1992) and a sense that there are no other available alternatives (Dutton, 1992; Walker, 1994). Links have been made between DV and hopelessness (Frank, 1963) and hopelessness and suicidal behaviour (Beck *et al.*, 1974) for many years. It seems strange that this has not been more prominently addressed in the literature, particularly given the very high levels of suicidal ideation and suicide attempts noted in Calder *et al.*'s (2010) research above. Hopelessness, coping skills and social support are aspects of DV that have been linked with suicidal thoughts (McLaughlin *et al.*, 2012). Whilst coping skills and social support can be externally facilitated, hopelessness is something which is experienced internally (Beaulaurier *et al.*, 2008) and may play a significant part in the self-efficacy and welfare of someone suffering or recovering from DV.

However, studies trying to measure hopelessness in women within refuges in North and South Carolina, using the Hopelessness Scale (Beck *et al.*, 1974), have suggested hopelessness was not present (Clements and Sawhney, 2000; Clements, Sabourin and Spiby, 2004). It is possible that this was because the women had been able to take action and move to the shelter, thereby creating some hope for the future. More recently, feelings of hopelessness, gloominess, mournfulness, destruction, death and fear were reported as the prevailing emotions of a small group of 12 DV survivors attending a DV centre in Italy (Gainotti and Pallini, 2010). Although hopelessness has been identified as part of the psychology resulting from DV, it is unclear from the literature what part hopelessness may or may not play within DV, or in seeking help, and it is something that could perhaps be usefully explored.

Within the UK, hopelessness and suicidal ideation are seen as symptoms of depression (National Collaborating Centre for Mental Health, 2009). Disclosing feelings of suicidal ideation to a health professional may increase the level of mental health care available if the person appears to have immediate suicidal intent. Otherwise, the person will be treated for depression and, as highlighted in section 2.3.2, there is no requirement to specifically screen or treat for DV.

2.3.4 Anxiety

Although anxiety has been highlighted as a potential issue with DV through the description given of BWS (Walker, 1979), the amount of literature specifically looking at this is relatively small. This is possibly due to the emergence of PTSD as a diagnostic mental health category in the USA in the 1980's, which was considered

to be a better descriptor of the condition (Walker, 1994). Symptoms of PTSD can include hyper-arousal, emotional numbing and re-experiencing of previous events (American Psychiatric Association, 2000). Whilst Walker (1979) reported observations of hyper-arousal in her research, it became clearer at a later date that severe violence could also result in flash-backs to the event and emotional distancing from the event (Herman, 1992). Hence in the USA, descriptions of anxiety in the context of DV appear to have become synonymous with fewer or more symptoms of PTSD reported, rather than a specific issue in its own right. As much of the research is conducted in North America, the literature explores the prevalence and treatment of PTSD rather than anxiety. However, in the UK, as noted in Chapter 1, a diagnosis of PTSD as a result of DV has been resisted (Abrahams, 2008) and anxiety and stress more likely to be noted (Humphreys and Thiara, 2003). This will be discussed more fully in section 2.3.5, but it is important to recognise the cultural differences here.

Nevertheless, a small amount of research has been conducted into state anxiety in IPV. State anxiety has been defined as the belief that the experience of anxiety itself will bring negative consequences (Reiss *et al.*, 1986). This could be related to physical, psychological or social concerns (Stewart, Taylor and Baker, 1997). In a study of 818 university students in Canada, Stewart found that women scored higher on physical concerns and anxiety overall, whilst men scored higher than women on psychological and social concerns. Given that men have sought counselling as a result of DV (Debonnaire and Panteloudakis, 2013), it is possible that anxiety about psychological well-being helped to trigger that response.

Other research conducted in Spain (Pico-Alfonso *et al.*, 2006) used a different measure of state anxiety (Spielberger, Gorsuch and Lushene, 1970). This compared women who had experienced psychological and physical abuse (bi-abuse) with those who had experienced only psychological abuse and a control group who had not been subject to IPV. Women who had been abused showed greater state anxiety, and higher levels were present where depressive symptoms or the co-occurrence of depression and PTSD was found. Interestingly, psychological abuse was a stronger and more independent predictor for state anxiety than physical abuse, in keeping with the findings of other researchers (Lang, Kennedy and Stein, 2002; Blasco-Ros, Sánchez-Lorente and Martinez, 2010).

For male victims, available studies are even fewer and involve either dating violence in a USA university (Harned, 2001) or a cohort of young people in New Zealand

(Fergusson, Horwood and Ridder, 2005). In those studies it appeared that both men and women did report anxiety as a result of experiencing DV, but the impact on women appeared to be much more severe. However, it is possible that the way men and women express anxiety may be different. In comparing PTSD symptoms, a female only study, Pico-Alfonso *et al.* (2006) found that women appeared to report equivalent levels of re-experiencing and avoidance symptoms with slightly lower levels of hyper-arousal, whereas a male only study (Hines and Douglas, 2011) found that men reported higher levels of avoidance and lower but similar levels of arousal and re-experiencing. As anxiety measures examine the emotional response to feelings of anxiety (Lang *et al.*, 2002), it is possible that men report lower scores in this area because they may try to avoid the feelings, as noted in section 2.2.2. In comparing the mental health impact of physical violence on men and women in the USA, Afifi *et al.* (2009) found that women were more likely than men to suffer from anxiety, but men were more likely than women to suffer from disruptive behaviour and substance abuse, indicators of avoidance. Although this is only one study, it supports earlier concerns that assessments for the impact of DV that have been developed for women may not be wholly appropriate for men. Further work needs to be done in this area before firm conclusions can be drawn.

Within the UK, government guidelines have been developed for the treatment of generalised anxiety (National Institute for Health and Clinical Excellence, 2011). The guidance does not indicate particular client groups, and treatment recommendations use a stepped approach initially providing self-help support and then if the issues are still not resolved, either prescription drugs or a high intensity psychological intervention of CBT or applied relaxation is recommended. The final step, should the previous ones be unsuccessful, is to look at the social support available to the individual and to embark upon a specialist treatment and drug regime. With no particular approach seen as better than any other, treatment should be prescribed according to patient choice. It is possible that many patients would opt for medication, and yet there is evidence starting to emerge that this could reduce the recovery rate of an individual suffering from anxiety due to DV (Blasco-Ros *et al.*, 2010). For those who are able to make informed choices and engage with treatment, it may work well. However, as discussed later in section 2.4, challenges in working therapeutically with this particular client group may mean that a stepped pathway is not the best option for them.

Although there has not been a substantial amount of research on state anxiety, the difference in the way this has been identified in men and women is interesting. It appears to support the growing hypothesis of different psychological responses for men and women, and introduces the concept of psychological abuse as a specific contributor.

2.3.5 Post-traumatic Stress Disorder (PTSD)

Research into the impact of DV on women through the 1980's and early 1990's began to relate observed symptoms to the development of PTSD which now had a diagnostic framework (Walker, 1991; Dutton, 1992; Herman, 1992). However, there were some professionals who disagreed (Lockley, 1999) as they felt that DV experiences were only traumatic for children. Nevertheless, the wider psychological implications of trauma including: the levels of psychological distress experienced; difficulties with relationships; and the way the world was perceived, began to be recognised (Dutton, 1992). Since then, a number of studies have assessed the prevalence of PTSD within groups of female victims of DV (Cascardi *et al.*, 1999; Golding, 1999; Humphreys and Thiara, 2003; Araszkievicz and Dabkowska, 2010). Most of these studies were completed with women who had accessed shelter in a refuge and the levels were much higher than those measured in the general population of women. For example, Golding's meta-analysis reported rates of PTSD of between 31% and 84.4% in the study populations examined compared with rates of 1.3-12.3% measured within the general population of the USA (Golding, 1999). Higher levels of dissociation, anxiety, depression, sleep disorder and overall trauma have been reported in women within a refuge than would be seen generally within the population (Abel, 2001). Other research from the USA and Spain has linked emotional turmoil and issues of trust and suspiciousness to PTSD (Morrell and Rubin, 2001; Torres *et al.*, 2010).

There are different theories about what generates PTSD symptoms in this client group: high rates of re-abuse (39%) for women who had already experienced significant levels of DV (Krause *et al.*, 2008); the total amount of violence suffered in their lifetimes (Bargai *et al.*, 2007); and the repeated victimisation of a woman through several life events rather than the continued victimisation by one person (Matlow and DePrince, 2012). However, these theories could be seen as contradictory, as the total amount of violence over a long-term relationship could be higher than in multiple short term, but highly violent relationships. This suggests that there may be another unaccounted variable.

Johnson's intimate terrorist and common couple violence model, referred to in chapter 1, was used to explore this (Johnson and Leone, 2005) and found, in keeping with earlier work (for example Cascardi *et al.* (1999)), that a combination of psychological control and physical violence was most likely to result in PTSD. Indeed, the impact of psychological abuse on the development of PTSD was greater than expected, and more recent research in Baltimore, USA comparing sexual, physical and psychological violence has also shown the presence of psychological violence as most likely to result in PTSD (Norwood and Murphy, 2012). The impact of psychological abuse can last beyond the physical events, and PTSD symptoms, once developed, can still be present in some abused women 12 months, as reported in Australia (Mertin and Mohr, 2001), and over two years, as reported in the USA (Woods, 2000), after leaving their abusive relationship. This suggests that PTSD can result in longer term mental health problems.

From a technical perspective, research to date has used DSM-IV criteria (American Psychiatric Association, 2000) to determine PTSD rather than the new definition presented recently in DSM-5 (American Psychiatric Association, 2013). Hence symptoms from three different categories were identified: two or more of the defined symptoms of hyper-arousal, three or more defined experiences of avoidance or numbing, and one or more of the defined mechanisms of re-experiencing (National Collaborating Centre for Mental Health, 2005). Links to particular behaviours in women, as noted above, are not necessarily recognised medically as PTSD and could also be diagnosed as anxiety or depression. In addition, the symptoms presented by some women, such as rapid mood changes or impaired social functioning, could be diagnosed as PTSD, relational/attachment difficulties or borderline personality disorder. This overlap in presentational issues means that an incorrect diagnosis may result in inappropriate and unsuccessful treatment (Schwecke, 2009). Using medication to contain a diagnosed personality disorder when the individual would benefit from support to work through trauma is unlikely to resolve the problem. It has also been suggested that women showing some PTSD symptoms are more likely to need support with relationship issues and handling conflict than a diagnosis of personality disorder, as the relationship issues may be driving the behaviours noted (Morrell and Rubin, 2001).

As mentioned in Chapter 1, concerns have been raised in the UK that a mental health diagnosis, or label, of PTSD could be unhelpful for individuals due to the potential for stigmatisation and increased difficulties in obtaining work (Abrahams,

2008). Abrahams' preferred to consider PTSD as a natural response to a traumatic experience rather than a medical condition. This may be a reasonable position, as many of the assessments conducted by researchers focussed primarily on describing symptoms to participants which they then acknowledged, rather than attempting a formal diagnosis. The issue is not whether or not a diagnosis of PTSD is possible, but how clients can find relief from the debilitating effects of the symptoms.

Although the symptoms of PTSD can be incapacitating, research from Boston, USA has shown that women still in an abusive relationship are half as likely to engage with treatment to resolve PTSD as women who have already left the relationship (Iverson, Resick, *et al.*, 2011). This research suggested that accessing treatment for mental health may be as much a function of the client's situation and their capacity to engage with the treatment as mental distress. This also fits with research on opportunity patterns of help-seeking. It is possible that those who had left the relationship now recognised that leaving was not enough, and were motivated to participate as a result. Treatment to reduce PTSD and depression has also been shown to reduce re-victimisation (Iverson, Gradus, *et al.*, 2011) suggesting that appropriate and timely psychological treatment may reduce the overall incidence of DV going forward.

In another 3 year longitudinal study conducted in Spain with 91 women, groups containing physically/psychologically and psychologically only abused individuals initially showed higher PTSD scores than the group containing non-abused people (Blasco-Ros *et al.*, 2010). At the end of three years only the psychologically abused group had higher scores. The researchers found that those who had high levels of social support were more likely to make a positive recovery, in keeping with previous research from Canada (Ford-Gilboe *et al.*, 2009). However, those who continued to show concern about what had happened in the past showed more negative outcomes, whilst those who had developed greater personal resilience and could rely on their own resources had better outcomes (Ford-Gilboe *et al.*, 2009). Psychological abuse can be covert and hard to spot early on, potentially leading to a heightened fear of re-abuse in the future (Bell *et al.*, 2008). This may result in a continuation of PTSD symptoms in individuals who doubt their ability to deal with future events.

In the Blasco-Ros *et al.* (2010) trial, regression analysis linked a high intake of psychotropic drugs to the continuation of depressive symptoms, state anxiety and

PTSD for the duration of the study. A link between psychotropic drug intake and poorer outcomes has also been seen in a USA study (Gilbert, Morrissey and Domino, 2011) and concerns have been raised about the potential problems caused by prescribing drugs for this client group (Schwecke, 2009). As research into PTSD has continued, it seems that a significant factor in its development is psychological abuse, and that the provision of a healthy supportive relationship to counteract this, rather than drug treatment, could be highly beneficial.

There has been much less research on PTSD in male victims of DV. Those studies that have investigated male victims have generally concluded that they can also report symptoms of PTSD as a result of IPV (Coker *et al.*, 2005; Hines, 2007; Hines and Douglas, 2011). The study by Coker *et al.* (2005) assessed the degree of PTSD present in those who had indicated experiencing DV in the 1995-96 NVAWS, concluding that 24% of women and 20% of men reported moderate to severe PTSD. This is a lower figure for women than had previously been reported, which may have been a result of sampling the general population rather than groups of individuals already identified as significantly abused. However, it shows a similar proportion of male and female victims with symptoms. A study of male victims was conducted (Hines and Douglas, 2011) to investigate the impact of Intimate Terrorism on male victims as Johnson and Leone (2005) had done with female victims. As with women, there was significantly greater evidence of PTSD in men where Intimate Terrorism had taken place with 60% of men in this situation experiencing PTSD symptoms compared to 8% of men who were experiencing Common Couple Violence.

However, not all research has shown the development of PTSD in men as relating to DV (Ehrensaft *et al.*, 2006). This longitudinal, self report study of 456 men and 449 women in New Zealand at age 18 and then at 26, concluded after a regression analysis that men do not suffer psychological harm as a result of DV. However, the particular regression used by the researchers appeared to be gender biased. It was notable that an alternative research paper, which appeared to be based on the same cohort of data (Fergusson *et al.*, 2005) but used a wider basis of comparison found that DV did have a harmful impact on both men's and women's mental health. It would be helpful if further research in this area could use a different research methodology to reduce the need for complex assumptions and interpretation. Whilst the data available for men is very limited, the balance of evidence suggests PTSD can also be an issue for men suffering DV.

Finally, there is recognition that both PTSD and depression can develop after traumatic experiences (Foa *et al.*, 2001). One USA study indicated that 47% of women who were treated for marital problems and were diagnosed with either depression or PTSD, actually had both (Cascardi *et al.*, 1999), whilst another found both disorders in 49% of women from a DV service (Nixon, Resick and Nishith, 2004). This suggests that co-occurrence of disorders could be quite high. A more recent Spanish study of women recruited from a DV service suggested co-morbidity figures of 25-30% dependent on the type of abuse (Pico-Alfonso *et al.*, 2006), but this is still high. It is important to recognise that very few of the women had PTSD alone.

There is once again, very little data on the co-occurrence of disorders for men. In one USA population based study 13.5% of the men reporting symptoms of IPV and 17.5% of the women showed signs of two or more psychiatric disorders (Afifi *et al.*, 2009). This was just less than twice as high as the female control group and over two and half times as high as the male control group, indicating a significant result. These figures are lower than those given above, but the sample population included individuals who were experiencing IPV but had not yet sought help. The other studies were of individuals already seeking help which could account for the higher levels of reported distress. Nevertheless, these data suggests that further research into co-morbidity of psychological factors for men suffering from DV could be beneficial.

There is complexity in treating more than one diagnosed condition. The two main treatment approaches are either by addressing each diagnosed condition in turn or by working through an integrated care package. A study across 9 sites in the USA, involving 2,006 women, investigating treatment options for women suffering depressive and trauma symptoms combined with substance abuse, concluded that integrated counselling was more effective in treating the depression and trauma symptoms than the usual care package of separate treatments for each diagnosis (Morrissey *et al.*, 2005). However, they noted that substance abuse symptoms responded equally well to both types of interventions. It is not clear from the research what made the difference, but working with one individual on a longer term basis appeared more effective than two or more different therapeutic interventions.

Although there is a considerable amount of research literature in the USA and some from Spain supporting the hypothesis that PTSD can develop as a result of DV, there has been little research attention in the UK (Humphreys and Joseph, 2004).

Even today, National Institute of Health and Care Excellence (NICE) guidelines do not specifically recognise the possibility of developing PTSD due to DV (National Collaborating Centre for Mental Health, 2005). Instead the focus is on single traumatic events or major catastrophic events which can be treated effectively through Eye Movement Desensitisation and Reprocessing (EMDR). It has been recognised that if a trauma has multiple roots, as may be the case in continual abuse, EMDR may not be the best available treatment (Royle and Kerr, 2013) thus presenting a potential problem for DV referrals under the current system. Even where PTSD can be linked to a specific event, for example due to a life threatening act by their partner, diagnosis of co-occurring depression means that under UK guidelines, the depression will be treated first. A referral to CBT counselling as a first pathway option may provide some relief to the individual (Kubany *et al.*, 2004), however it is not clear from the guidance how treatment for trauma would be accessed. Additionally, the focus on treating each diagnosed condition in turn may not produce the best outcome for the client.

In conclusion, there is evidence to suggest that both men and women who experience DV have a much higher chance of experiencing PTSD symptoms than the general public, although diagnosis can be problematic. Newer research information suggests that PTSD may be linked to psychological as well as physical abuse and that those with symptoms may have more than one diagnosable disorder. Within a UK context, it appears less likely that PTSD would be diagnosed, and it is possible that appropriate treatment pathways may be missed. Further research specifically around the incidence of PTSD in DV would be of limited value in the UK whilst there is resistance to such a diagnosis. However, identifying appropriate mental health treatments for DV victims which could incorporate ways of working with PTSD might be beneficial.

2.3.6 General suspiciousness

This concept was first identified by Walker (1979) as an important safety measure within DV. By being continually alert to the abuser and the environment, another battering incident could be avoided. Whilst this was raised by Walker (1979) as a psychological symptom, the concept had not received a great deal of attention within DV research until recently, where increased levels of suspiciousness (measured as part of the Dimensional Assessment of Personality Pathology – Basic Questionnaire (DAPP-BQ)) were found in IPV victims (Torres *et al.*, 2010). To date, much of the academic research on suspiciousness has been associated with

paranoia and schizophrenia. This may be why it has not been followed up in this context, although Walker has described issues of misdiagnosis in her work that led to inappropriate psychological care. Although suspiciousness appeared in Walker's earlier writing and seemed to be an important aspect, it was not developed further. Instead, there has been continued acknowledgement of the potential for female victims to lack trust by DV writers (for example Sanderson (2008) and Nicolson (2010)), both for their partner and potentially the wider community, if an inappropriate disclosure by a community member to her partner might lead to further violence.

In psychology, the issue of trust has been linked to attachment theory (Nicolson, 2010), and descriptions of how trust developed from birth have involved two of the great names in psychology (Winnicott, 1953; Erikson, 1966). Winnicott suggested that individuals who did not have a sufficiently caring caregiver in early life (Winnicott, 1953) may struggle to form relationships or attachments in adult life. However, it is also possible that issues of trust and difficulties with relationship can develop at each stage of life (Erikson, 1966) including the period after leaving home and establishing an adult relationship. Thus in the case of DV, and as highlighted above, issues of trust can develop at any stage of life in response to events.

An additional complication is that terminology for attachment varies within the literature. Some researchers use the initial definitions associated with infant attachment: secure, avoidant and anxious or ambivalent (Ainsworth *et al.*, 1978), later updated to include a disorganised pattern (Main and Solomon, 1986). Others prefer the more recent adult related terms (Bartholomew and Horowitz, 1991): secure, pre-occupied, dismissing and fearful. In summary, secure attachment engenders a feeling that, in a difficult situation, the individual can trust themselves to look after themselves, and failing that, they can trust others to step in. However, insecure attachment may lead to individuals to feel that:

- a) They will be unable to take care of themselves and will need someone who can take care of them, as well as relying on others for their self-worth (anxious, ambivalent or pre-occupied style)
- b) The only person they can depend upon is themselves, and they minimise the significance of relationships (avoidant or dismissive style).
- c) No-one, including themselves, can truly be relied upon (disorganised or fearful style), often due to childhood experiences of abuse, yet they are dependent on others.

Whilst assessments can be completed on attachment style, attachment patterns can change over time in the light of new experiences, resulting in more or less security. This means that a securely attached individual who becomes involved in an abusive relationship may change their views of their own and others' abilities to assist them in difficult or frightening situations.

Studies of women who have suffered DV have found that most can be assessed as insecurely attached, although there is no agreement on how that insecurity will present. Two studies of women in the process of leaving their relationships (Henderson, Bartholomew and Dutton, 1997; Hick, 2008) each found that more than half of the participants were described as having pre-occupied attachment. Henderson's (1997) Canadian study involved 63 participants and assessed attachment using a semi-structured interview based on Bartholomew and Horowitz's (1991) four category model. On the other hand, Hick (2008) studied 9 American women as part of a PhD study using the *Adult Attachment Projective Picture System*. However, the two studies differed in their assessment of the remaining participants. A further third of the participants were found to have a fearful attachment style in Henderson's (1997) study, but a dismissive attachment style in Hick's (2008) study. Adding further complexity, a study using *The Revised Adult Attachment Scale* and involving 32 women from the USA who had reported a history of domestic abuse found that most of the women showed a predominantly avoidant style of attachment (Walker, 2009b).

It is intriguing that Walker's participants, with an average age of 43, were twelve years older than Henderson's and reported historic rather than current or recent abuse. One hypothesis for the difference in attachment results might be that the experience of leaving an abusive relationship and relying on their own resources changed the way they responded to situations. Alternatively, it may be that individuals who are securely or dismissively attached are less likely to tolerate an abusive relationship and simply leave, as suggested by the results from a community based study (Henderson *et al.*, 2005). It may also be that the tests used to assess attachment were insufficiently detailed to properly interpret the meaning of the results (Gormley, 2005). The main conclusion that can be drawn is that female clients presenting for counselling are likely to exhibit some signs of insecure attachment.

A study involving men experiencing abuse also found insecure attachment patterns, although here they were more likely to be assessed as anxious/pre-occupied

(Henderson *et al.*, 2005). In addition, this study indicated that for both men and women, anxious attachment was related to both the receipt and the perpetration of abuse, a finding repeated in other studies (Gormley, 2005). There has been some evidence collected that people with anxious attachment patterns were more likely to experience physical abuse, whereas men with avoidant patterns were more likely to experience psychological abuse, although this was not conclusive (Gormley, 2005). It could provide a possible explanation for anxious patterns of attachment appearing to be prevalent in refuge populations (as noted above) and raises an important question about whether there are different dynamics in psychologically abusive relationships compared with physically abusive ones.

From a therapeutic perspective, clients who are insecurely attached may find difficulty in establishing a therapeutic relationship. Attachment studies looking at the success of therapy have indicated that securely attached clients do particularly well (Cooper, 2008), whilst those with pre-occupied/anxious attachment styles are most likely to drop out of counselling. Thus DV clients may find it particularly difficult to engage with therapy. Cooper (2008) commented on the need to trust and engage with the counsellor to be able to make the most of the experience and that this would appear to be easier for securely attached individuals. However, the topic of trust and how to increase it with insecurely attached clients was not explored or reviewed, perhaps suggesting that most therapists can provide a trustworthy enough environment for most clients. Nevertheless, the issue of trust appears to be important for this client group and will be discussed further in section 2.4 of this chapter.

These issues are complex. There appears to be a common factor within abusive relationships of insecure attachment and indications that attachment style may predict the type of abuse. However, changes to attachment may occur with life changes. Unfortunately, clients with an insecure attachment style may find engagement in counselling difficult. Despite the evidence in the previous sections about mental health difficulties and the potential benefits of counselling, this suggests that this client group may find engaging with counselling challenging.

2.3.7 Summary

There has been a large amount of research conducted on the mental health impact of DV on women, showing the risks of developing PTSD, depression, suicidal ideation and anxiety, whilst drug and alcohol issues appear to occur at lower levels. These conditions also appear to affect men experiencing DV, although there is

conflicting data on the degree to which this occurs. This could be in part due to differences in the way men and women show the psychological impact of DV and further research in this area would be helpful. Nevertheless, there appears to be clear evidence that individuals experiencing DV may benefit from counselling.

Multiple abuses during the individual's life may also have an impact on the severity of the resultant mental health condition. Practitioners working in this area are likely to work with more than one mental health issue for either gender, due to the prevalence of co-occurring depression, PTSD and suicidal ideation. These levels of psychological distress suggest that mental health services are likely to be required and yet there is insufficient evidence to determine the most appropriate psychological pathway for this client group.

Under current UK NICE guidelines (National Collaborating Centre for Mental Health, 2009; National Institute for Health and Clinical Excellence, 2011), victims of DV (male or female) are not recognised as appreciably different to other members of the population suffering from depression or anxiety. It is likely that DV patients presenting in surgeries would be treated for depression, either through drug treatment or short-term counselling, or longer-term CBT or psychodynamic therapy. For many GP's in the UK the easiest option may be to prescribe medication initially, as there can be a significant wait for mental health services. However, there are initial indications that psychotropic drugs could be potentially harmful for treating DV, although this requires further investigation.

As noted in chapter 1, researchers have called for a better understanding of what mental health support DV patients might need, and yet current guidance does not recognise this as a potential issue. Difficulties with identifying their own needs, issues with relational trust and indirect communication, identified in sections 2.2 and 2.3.6, may mean that victims have difficulty in articulating their situation. Difficulties associated with insecure attachment may make it harder for this group to engage with counselling, even when offered. They may seek help, but the professionals approached may not be aware of the underlying difficulties. Further work, to understand whether generic treatment for each of the symptoms is sufficient or whether other approaches may be more beneficial, is required.

2.4 Working therapeutically with DV clients

2.4.1 Introduction

The previous section highlighted the significant psychological harm that can occur within a DV relationship. Although current NICE guidance (National Collaborating Centre for Mental Health, 2009) suggests that a referral to counselling for depression is most likely to be considered in the UK. However, there are practitioner views that suggest working with this client group can be quite different to normal clinical practice and it is this observation that has motivated professionals in the field to share their knowledge of working with female clients to help other counsellors (Walker, 1979; Dutton, 1992; Sanderson, 2008; Roddy, 2011a; Agnew Davies, 2013). Although, these practitioners concluded that a strong therapeutic relationship developed through a client-centred integrative approach is likely to be most beneficial, this is not the view of all.

Some quantitative USA studies, described in section 2.4.2, have investigated specific forms of therapy, showing improvements to the mental health of participants. However, both quantitative research and practitioner opinion show variations in both the assessment of client outcomes and recommendations for client work. Section 2.4 will review the outcome measures previously used and practice recommendation for counsellors. In reviewing the literature, factors previously identified in section 2.3 (trust, trauma and hope) emerge and will be discussed in more depth. It is important to note, however, that at the time of this review, no research describing counselling or psychotherapy with male victims of DV has been identified and therefore this section contains information on counselling female clients only.

2.4.2 Outcomes for DV counselling

Examples of quantitative research in the USA are shown in Table 2-4 overleaf. These studies have differences in the client groups recruited; the counselling delivered; and the outcomes chosen for assessment. Studies offering counselling to a general DV population have shown benefit, although they have been unable to say what was effective in the counselling (Howard *et al.*, 2003; McNamara *et al.*, 2008). On the other hand, studies specifying a treatment regime and showing success with carefully selected and screened participants may be of limited value for working more generally with DV clients (Kubany *et al.*, 2004). This makes them difficult to compare directly, but it is still useful to consider the diversity of approach.

Each of the studies in Table 2-4 (overleaf) selected different measurements, some based on improvements in psychological symptoms and some on improvements in life skills. The different choice of measurement is indicative of differences in the philosophical basis for the counselling delivered. Importantly, in each case, the selection of outcome measures appeared to be made independently of the clients. The need to ask the client what was most useful has been noted before (Lundy and Grossman, 2001) and yet seems to have been avoided. Instead, measures were determined by the organisation, researcher or therapy developer.

Making judgements about the benefits of DV counselling is an approach also adopted by counsellors and psychotherapists. A summary of the therapeutic goals suggested by five DV counselling authors is shown in Table 2-6, page 52, each with their own views about the goals of therapy. Nevertheless, there is agreement on strengthening aspects of self which would enable goal setting and choices about the future, despite differing views as to what this might mean. For example: Sanderson (2008) talked about increasing self-esteem, self-worth and self-respect; Dienemann *et al.* (2002) self-identity; and Walker (1994) believed that one of the main goals is empowerment. Only Lee (2007) suggested that there should be no assumptions about what is best for the client and no education about appropriate behaviour. Instead she felt that the client would ultimately find their own way through empowerment and self-determination.

Although this focus on self appeared to be a strong factor from the literature in DV, only a few quantitative researchers have elected to measure improvements in self-esteem and, as can be seen from Table 2-4, there was no agreement on the most appropriate assessment tool.

Both Coopersmith's Self-Esteem Inventory (Coopersmith, 1967) and Rosenberg's Self-Esteem Scale (Rosenberg, 1965), which contain different elements, were used. In addition, the range of outcome data quoted across the papers suggested there may be a problem with methodology. This was considered by Walker (2000) when she found increased levels of self-esteem in female participants compared to normal population levels in her research. She suggested it may be a function of the assessment tool used or the women's sense of success at surviving the abuse, but admits these data appear to be in conflict with other results. It is also possible, that with conflicting results, the most appropriate measurement for this client has still to be defined. This could be an interesting area to research with clients.

Table 2-4 Examples of quantitative research studies

Research paper	Number of sessions attended	Measures used
<p>Howard <i>et al.</i> (2003):</p> <p>The study used a naturalistic process involving 500 women accessing a variety of counsellors through Illinois state-funded DV programmes, over the age of 18, whilst still in, or having recently left, their relationship.</p>	<p>65% of women had <6 sessions</p> <p>18% of women had >11 sessions</p> <p>Data was available for 93% of the study participants.</p>	<p>Empowerment scale (Rogers <i>et al.</i>, 1997)</p> <p>Rosenburg Self-Esteem (Rosenberg, Schooler and Schoenbach, 1989)</p> <p>Personal Problem Solving Inventory (Heppner and Petersen, 1982)</p>
<p>Kubany <i>et al.</i> (2004):</p> <p>The study involved 125 formerly battered women who had been referred by victim services agencies in Hawaii and met the diagnostic criteria for partner-abuse related PTSD. A specific treatment plan covering 11 sessions was outlined, using cognitive trauma therapy.</p>	<p>80% of the women completed the programme, taking between 8 and 17 sessions.</p> <p>Average number of sessions = 9.5</p>	<p>Clinician administered PTSD Scale (CAPS)(Blake <i>et al.</i>, 1990)</p> <p>Distressing Event Questionnaire (Kubany <i>et al.</i>, 2000)</p> <p>Beck Depression Inventory (Beck, Steer and Garbin, 1988)</p> <p>Rosenberg Self-Esteem Scale (Rosenberg, 1965)</p> <p>Trauma Related Guilt Inventory (Kubany <i>et al.</i>, 1996)</p> <p>Personal Feelings Questionnaire Shame Scale (Harder and Lewis, 1986)</p>

<p>McNamara <i>et al.</i> (2008):</p> <p>The study included 119 women who were admitted to a DV shelter in Ohio and received feminist based, eclectic counselling from social workers. As the participants were also offered case management, refuge support and legal aid, the changes could not be specifically attributed to counselling.</p>	<p>The women received approximately 5 counselling and 9 case management sessions during an average of 5 weeks.</p> <p>Full data for analysis was received from 34% of the women.</p>	<p>OQ-45.2 (Lambert <i>et al.</i>, 2001)</p> <p>Life Coping Skills (Developed for the study)</p>
<p>Reed and Enright (2006):</p> <p>20 psychologically abused adult women, from a Midwest city in the USA, and who had left the relationship more than 2 years ago, were recruited via newspaper advertisements. They underwent a programme of forgiveness therapy.</p>	<p>The mean treatment time was 8 months, with a range of 5-12 months, with a one hour session per week.</p>	<p>Enright Forgiveness Inventory (Subkoviak <i>et al.</i>, 1995)</p> <p>Coopersmith Self-Esteem Inventory (Coopersmith, 1989)</p> <p>State Trait Anxiety Index (Spielberger, 2005)</p> <p>Beck Depression Inventory (Beck, Steer and Brown, 1996)</p> <p>Environmental mastery scale (Ryff and Singer, 1996)</p> <p>Post-Traumatic Stress Symptoms (derived from DSM-IV checklist)</p>

2.4.3 Practitioner views of DV counselling with women

For those authors who have considered the process of DV counselling (Herman, 1992; Walker, 1994; Grigsby and Hartman, 1997; Walker, 2000; Dienemann *et al.*, 2002; Sanderson, 2008), there seems to be general agreement on the importance of the process, first identified by Herman (1992), that builds upon a strong therapeutic relationship and involves:

- an initial phase of supporting the client, building their resources and creating a safe environment,
- a phase of working through specific issues, current and past
- re-connecting with the outside world and leaving counselling

This is not surprising as much of the literature cites and builds on Herman's clearly articulated work on trauma (Herman, 1992) and these three stages reflect the structure she outlined. However, as shown in

Table 2-5, there is disagreement about the number of stages in the counselling process.

Table 2-5 Recommendations for the DV counselling process

Author	Recommendation
Walker (1994, 2000)	7-stage process including assessment, safety and cognitive therapy
Grigsby and Hartman (1997)	4 distinct levels completed in specified order, working from external to internal factors
Dienemann <i>et al.</i> (2002)	5- stages of change model (Prochaska, 1979; Prochaska, DiClemente and Norcross, 1992). Each stage has pre-defined categories of work and client collaborates to establish the current stage
Sanderson (2008)	5-stages incorporating Herman's (1992) model, plus assessment and ending

Each of these models assumes that time will be available for the client to work through the multiple issues that the counsellor believes will need to be addressed.

However, it would be interesting to compare these models with the views of clients to see which most accurately represents the client view. The models also assume that the client will establish a trusting relationship with the counsellor early on to enable the work to be done. Trust, however, can be difficult to establish and this will be considered in more detail in section 2.4.3.1.

In contrast to these models, there are also brief therapies starting to emerge to deal with specific issues such as PTSD, as shown in section 2.3.5 (Kubany *et al.*, 2004; Johnson and Zlotnick, 2009). Both Kubany *et al.* (2004) and Johnson and Zlotnick (2009) offered a module consisting of pre-determined session content and based on a cognitive therapy approach to PTSD reduction and management in the USA. Both programmes showed lasting gains in the reduction of depression and PTSD symptoms, with 11 and 10 sessions planned respectively.

Both long and short term therapy options include the option to work through DV trauma. For those who offer longer term work, this could be extended to include childhood events. Trauma appears to be at the heart of almost all the psychological treatment models associated with DV. However, this focus on trauma treatment comes mainly from USA research. In chapter 1, it was noted that work done by the third sector in offering counselling services to women in the UK had achieved very good outcomes, although not necessarily adopting a formal psychological trauma model (Humphreys and Joseph, 2004). This is important when considering that trauma appears to be a major aspect of DV work. Therefore, it is worth considering what is required to make a difference to someone who has experienced trauma and this will be discussed in section 2.4.3.2.

In addition to the processes shared by practitioners, the principles and goals of therapy from a range of practitioners have also been examined (see Table 2-6 and Table 2-7). In keeping with many DV texts, these authors talk mainly about the processes that need to be undertaken as part of therapy, rather than the therapy alone. Ultimately therapy is driven by the values and beliefs of the therapist, and this can be seen here. Whilst Dutton (1992) and Sanderson (2008) both talk about grief as a part of the process, Walker (1994) is more focused on cognitive clarity. Whilst Dutton (1992), Walker (1994) and Dienemann *et al.* (2002) have a clear idea of the work to be done, Lee (2007) and Sanderson (2008) suggest a client-led process may be preferred. Each approach has been shown to be beneficial and recognises

	Dutton (1992)	Walker (1994)	Dienemann (2002)	Lee (2007)	Sanderson (2008)
Therapy Goals	<ol style="list-style-type: none"> 1. Protection (increasing her safety) 2. Enhanced choice making and problem solving 3. Healing post-traumatic reactions <ol style="list-style-type: none"> a. Reduction of specific symptoms e.g. anxiety b. Integration of traumatic experiences c. Facilitation of the grief process d. Reduction of shame associated with the trauma e. Rebuilding life without violence 	<ol style="list-style-type: none"> 1. Safety 2. Re-empowerment 3. Validation 4. Explore options 5. Cognitive clarity and judgement 6. Make own decisions 7. Heal trauma effects 	<ol style="list-style-type: none"> 1. Increase effectiveness of safety practices 2. Increase knowledge of healthy relationships 3. Increase effectiveness of coping skills 4. Rebuild survivors self-identity and increase survivors self-sufficiency 5. Decrease survivors trauma and stress symptoms 	<ol style="list-style-type: none"> 1. Creating a validating and collaborative process 2. Discovering, connecting with and amplifying life goals 3. Clients define their goals 4. Building their own coping strategies from past experience 5. More satisfactory life 	<ol style="list-style-type: none"> 1. Establish safe environment in which to work 2. Mourn the multiple losses 3. Reattribution of responsibility for DV and reduce shame and guilt 4. Facilitate movement from unpredictability to control 5. Movement from isolation to connection 6. Building emotional and social resources 7. Allows acquisition of self-regulation and containment skills 8. Exploration and expression of turbulent emotions 9. Restoring severely damaged self-structures: self-esteem, self-worth, self-respect 10. Restoring hope after grieving

Table 2-6 Examples of the therapeutic goals suggested by DV authors

	Dutton (1992)	Walker (1994)	Dienemann (2002)	Lee (2007)	Sanderson (2008)
Underlying Treatment Principles in Client Work	<ol style="list-style-type: none"> 1. Non-judgemental acceptance and validation 2. Providing immediate support and alliance 3. Advocating for safety and building options 4. Willingness to experience recounting of trauma 5. Assuming post traumatic stress (PTS) is due to traumatic events 6. Education about violence and abuse is therapeutic 7. Coping strategies are viewed as strengths 8. Substance abuse is self-medication in trauma victims 9. Transformation of trauma may result in positive changes 10. Prosocial action and self-disclosure facilitate the stress recovery process 11. Transformation of trauma is a lifelong process 12. Trauma and abuse results in noncompensable losses 13. Assumption of self-determination 14. Therapist self-care is essential 	<ol style="list-style-type: none"> 1. Safety 2. Empowerment 3. Validation 4. Emphasis on strengths 5. Education 6. Expanding alternatives 7. Restoring clarity in judgement 8. Understanding oppression 9. Making own decisions 	<ol style="list-style-type: none"> 1. Use of theory of entrapment and recovery as a framework (Landenburger, 1989; Landenburger, 1998) 2. Focus on relationship period after abuse starts 3. Incorporating concepts of considering and preparing for change from the transtheoretical theory of change (Prochaska, 1979) 4. Recognising that resolution through the partner changing as well as the woman leaving is possible 	<ol style="list-style-type: none"> 1. Focus on solutions, strengths and competencies 2. Future orientation 3. Client is the only expert of their unique experiences, realities and aspirations 4. Clients define the goals for their treatment and they fully own the work 5. No assumptions about what is best for the client 6. Does not seek to educate them in what is or is not the right way 7. Empowerment and self-determination 8. Staying in a violence-free relationship is an option 9. Catching the client doing things right helps change 10. Focus on safety rather than danger 	<ol style="list-style-type: none"> 1. Use a collaborative approach 2. Knowledge of trauma, stabilisation and self-regulation skills, impact of DA on relational dynamics 3. Balance between emotional support and CBT <ol style="list-style-type: none"> a. Emotional engagement and sensitively attuned 4. Psychoeducation 5. Links with DA agencies to offer comprehensive support: counselling not sufficient 6. Coping strategies as strengths not pathology 7. Attachment and relational styles 8. Validate and re-enforce survivor's positive actions 9. Assist client to be in control of therapy

Table 2-7 Examples of the underlying treatment principles in client work

that different clients will respond to different approaches. However, it underlines the need to hear the voice of the client describe what they felt was important as well.

There are areas of agreement, however, and in particular the risk that physical violence presents. The authors suggest that counsellors should address safety issues with clients as part of an initial assessment, which may be appropriate for the dual counselling/social work role common in the USA. However, in the UK, DV support workers or social workers, rather than counsellors, would normally take on that role. It is possible that a client could be placed at risk if a counsellor conducted a safety assessment without being fully aware of the risks associated with DV. As noted in Table 2-7 (Sanderson, 2008) counsellors in the UK should also provide clients with information about and encourage engagement with the local DV support team to ensure comprehensive support.

Finally, there is some agreement on educating clients about DV, although this appears to have different philosophical bases. For example, Walker (1994) suggests understanding in the context of oppression and Dienemann (2002) from the perspective of entrapment theory. Presenting DV as part of a larger social problem has been criticised, as it could suggest the abuse to something over which there is little immediate control and it could reduce the client's autonomy (Corvo and deLara, 2011). Corvo and DeLara (2011) suggested building on client strengths and instilling hope instead. This approach had already been mentioned by others in the field (Hage, 2006; Lee, 2007) and Walker (1994), Dutton (1992) and Sanderson (2008) also discussed building on client strengths as part of problem solving. More recent client based research (Roddy, 2011b) found that understanding DV was valued by participants by increasing the probability of preventing abuse in the future. However, the concept of hope is not clearly explored, although there are references to particular techniques that may help to build hope for the client. It is an emerging area of discussion within DV and will be explored in more depth in section 2.4.3.3.

2.4.3.1 Trust

A strong therapeutic alliance has been shown to be an indicator of successful counselling for some years (Kahn, 1996; Asay and Lambert, 1999; Paulson, Truscott and Stuart, 1999; Martin, Garske and Davis, 2000; Levitt, Butler and Hill, 2006; Cooper, 2008), irrespective of therapeutic orientation and from both a therapist and client perspective. Whilst trust has been acknowledged as an essential part of building that alliance, the identification of a specific need to build

trust as an active part of the therapy is more unusual, less well defined and therefore potentially more therapeutically complex.

Trust can be an important aspect of therapy. The secure or trustworthy base that the therapist provides can be a new experience for a client and can also help in resolving difficulties that arise in the course of therapeutic work (Klein, 1959). However, the way trust is defined or perceived can be different. In psychoanalytic terms, basic trust represents an optimism or hopefulness about the counsellor and secondary trust reflects openness to the counsellor's influence (Barwick, 2001). Trust has also been defined as having two other dimensions: relational, which can withstand interpersonal challenges, and existential, which provides a secure base and allows risks to be taken in exploring painful material (Bond, 2011). Both Barwick's (2001) and Bond's (2011) definitions are important. They show the complexity of trust for the client with internal, external and process dimensions.

Given the potential for DV clients to have suffered some form of trauma, resulting in interpersonal difficulties and painful memories, it seems that each of the described facets of trust will be required. The hard work of counselling was specifically highlighted by participants in one DV counselling study (Day, 2008) suggesting a need for primary and existential trust. In a therapeutic environment where alternative views of a client's DV experiences are likely to be explored, secondary and relational trust is required. This means that whilst trust between the therapist and client is needed for disclosure (as noted in section 2.2.1), the trustworthiness of the therapist, which includes their skill as a counsellor, may be an important factor in facilitating change. This would endorse Day's (2008) finding that working with the right therapist was important.

Regrettably there is little information about how to build trust in the literature, although examples of good practice such as affirming and validating the client's experience and assuring them of confidentiality are given (Herman, 1992; Walker, 1994; Sanderson, 2008). More importantly, given the importance of relational and secondary trust, there appeared to be disagreement on how to engage with the client. This could be related to each author's background and how they perceived the client's attachment issues.

Herman (1992) emphasised her expectation that the client was truthful and made a full disclosure of the experience from the outset. She focused on the need for clear boundaries, which might suggest she is expecting an ambivalent attachment

pattern (Barwick, 2001). This is unsurprising as her background is in trauma, and she is likely to see many clients who have felt their ability to protect themselves diminished.

Walker (1994) suggested actively listening to the client and providing information on DV or topics such as PTSD initially. This is a useful strategy for working with clients exhibiting avoidant attachment (Barwick, 2001) aligning with Walker's later research (Walker, 2009b). Her view is that the women have had to rely on their own resources to survive and have learned not to trust others. Focusing on practical issues provides personal value to the client and allows the relationship to be built at the client's pace, both found to be helpful factors when working with avoidant clients (Muller, 2009).

Sanderson (2008) believed that counsellors should be "resilient and robust in relating to the survivor" (p.104-105) as the client may react negatively to a close and caring relationship. This approach could be useful in working with someone who had a disorganised or fearful attachment style (Barwick, 2001). Sanderson's initial writing was on childhood sexual abuse where children learn that no-one, including them, can be trusted.

Each of the recommendations given could be appropriate given the variety of attachment orientation likely (see section 2.3.6). However, it is likely that counsellors will need to adapt their approach initially to meet specific client needs. This could be seen to be similar to working with any other client. Counselling ethics are designed to create a trustworthy environment which can help the client to make changes in their lives (British Association for Counselling and Psychotherapy, 2010). Yet the difficulty with establishing trust has been highlighted as an issue and requires more investigation.

Research into therapeutic trust is surprisingly scarce. Early studies indicated that a client's opinion was influenced more by how trustworthy the other person seemed than by the actual expertise of the individual (Strong, 1968; Rothmeier and Dixon, 1980). Strong (1968) defined a counsellor's trustworthiness through four factors: their reputation; social role or standing; sincerity and openness; and lack of motivation for personal gain. In Humanistic terms, this suggested that therapist congruence and positive regard for the client may play a role in building trust. Non-verbal, empathic responses received positively by the client (Lee, Uhlemann and Haase, 1985) and the therapist's interpretation, rather than a restatement, of what

the client said (Claiborn, 1979) have also been shown to help. In other words, trust developed when therapists demonstrated openness with clients, empathically sharing their thinking and reaction to the material. This could be generated by the practitioner's use of Roger's core conditions (Rogers, 1957) with advanced levels of empathy (Mearns and Thorne, 1999) and the client knowing of the therapist's good reputation.

However, societal and healthcare differences from 1968 in the USA to 2013 in the UK mean that many counselling clients do not know their therapist initially as they are referred to agencies or health centres where a counsellor is allocated. This means that two of the dimensions of trustworthiness highlighted by Strong (1968) of reputation and social role are not visible factors today. This is similar to the position of doctors in the health service. Previously in the UK, doctors were well-known in the community and had a professional reputation built up over many years of practice. However, with the development of larger GP practices and specialist hospital units, there is no longer a single point of contact.

Research has indicated that there has been a change in the way that patients respond to medical practitioners: from inferred trust, based on the doctor's reputation and position, to informed trust (Calnan and Rowe, 2008). Informed trust comes from the patients' opinion of their physician based on their work together, recognising that there may be variations in doctors' abilities and the facilities available to them. Calnan and Rowe (2008) found that trust was still required for the clients' disclosure of personal information and for taking advice on their condition, although the way that trust was established had changed. Key factors in building trust were perceived to be the doctor's competence, communication ability, openness, honesty and ability to empathise.

These factors also emerged from a USA study on health-care for IPV survivors (Battaglia, Finley and Liebschutz, 2003), but in addition this client group indicated that a caring relationship, with time to talk and share personal information, also encouraged trust. Whilst the importance of trust remained unchanged, it appeared to be conditional on the positive factors that generated trust continuing throughout the relationship (Calnan and Rowe, 2008).

It had been noted that some client groups, such as trauma victims, seem to need to develop more than the basic level of trust normally thought to be required for CBT (Castonguay *et al.*, 2010). Responding to that discovery has resulted in training

programmes being specifically developed for CBT therapists on how to address alliance ruptures (Muran, Safran and Eubanks-Carter, 2010) and research is being undertaken on how to repair ruptures within the therapeutic alliance (Eubanks-Carter, Muran and Safran, 2010). This suggests that a therapist from a more traditional CBT training may find DV work challenging. Some clients do continually test their therapist to see if they can be trusted (Fong and Cox, 1983). A need for consistency or reliability from the therapist was also found when researching trust in counselling with university students in China (Zhao, Jiang and Gu, 2011), suggesting it is a human, rather than cultural need. Trust can therefore be understood as a process continuing throughout therapy, and requiring ongoing attention (Herman, 1992). This suggests it is not simply about trust being established from the outset, but about managing and being aware of the dynamic within therapy too.

Although the discussion so far has focused on the counselling relationship, DV clients can experience additional stresses from court systems or social service involvement. Recent research in the UK showed DV victims to be frightened of, and lack trust in, the social work agency (Keeling and van Wormer, 2012). Where a therapist is involved with other services, it is important to handle disclosures appropriately and in conjunction with the client. Any breach in confidentiality can have a significant impact on the assessment of the counsellor as trustworthy (Merluzzi and Brischetto, 1983), and could mean an immediate end to counselling (Walker, 2009c). However, with counselling accessed through organisations, there is a further complication. It may not only be the trustworthiness of the therapist that is important, but also the trustworthiness of the counselling organisation, the relationship of the therapist with the organisation, and the consistency of both.

Trust can be developed through the reputation of the organisation delivering the service (system or institutional-based trust) as well as by an individual within the organisation (personal trust) (Bachmann, 2001). Trust may be placed in the organisation initially to deliver the service and may develop over time to include personal trust, which is merited by the individual delivering the service. Both personal and organisational trust can occur concurrently in an organisation, in relationships with suppliers, customers and employees (Dietz, 2011). Accessing counselling from an agency may therefore require trust in both the counsellor and the agency to maintain confidentiality, making the provision of a trustworthy space for delivering counselling more complex.

The factors involved in developing organisational trust to support an individual to take a risk have been defined as (Mayer, Davis and Schoorman, 1995):

1. Ability. This is related to the competence for the specific task undertaken, as was previously found with other healthcare organisations (Battaglia *et al.*, 2003; Calnan and Rowe, 2008).
2. Benevolence. This is being perceived as wanting to help the individual in need of assistance, not simply doing a job. It is notable that this does not specifically appear in the other papers reviewed. Only Strong (1968) mentioned the need for a lack of personal gain and Battaglia (2003) the benefits of someone who cares.
3. Integrity. This is defined as having a set of principles that are adhered to and that the individual finds acceptable. This is established through the consistency of action with words, not just in the moment, but over time. Importantly however, building trust also includes what the individual hears from other people, consistent with their own view. This suggests that the reputations of the organisation in the community and the therapist within the organisation are also factors.

An updated paper suggested that the more trust is developed, the bigger the risks that could be taken (Schoorman, Mayer and Davis, 2007). This aligns with Bond's (2011) view that trust worked best when reciprocated. From a counselling perspective, this also highlights the need for a therapist to have trust in both the client and the counselling process, a vital element of the therapeutic relationship (Hazler and Barwick, 2001b).

Building trust for counselling appears to be much broader than the therapeutic relationship, as it includes the client, the therapist, the organisation and the community. For clients working with authors in this field, such as Walker and Herman, trust may have been established to some degree from the outset through working with a leading figure in the field, with an established reputation in private practice. However, the personal characteristics required to generate trust include openness, honesty, caring, empathy and consistency in approach (Calnan and Rowe, 2008; Belcher and Jones, 2009). It may have been difficult for the author-practitioners to assess their own characteristics as factors for building trust with this

client group. In addition, changes to the methods of counselling delivery mean that organisational trust from both a client and a practitioner perspective may recently have become more important than has previously been acknowledged.

Nevertheless, the complexity of building trust and the many different perspectives involved suggest that more exploration of this issue could be helpful.

2.4.3.2 Trauma

There are a number of treatment options for working with trauma (Dass-Brailsford, 2007) including brief psychodynamic therapy, cognitive behavioural therapy and EMDR (as in the NICE guidance (National Collaborating Centre for Mental Health, 2005)), all of which have been acknowledged previously. Alternative models of trauma treatment have also been proposed, including Herman's (1992) model which specifically includes DV and others derived for treating trauma caused through childhood abuse (Briere, 1996; Chu, 1998). Although each of these three alternative approaches has their own nuances, there are so many similarities that Herman's model (see the beginning of section 2.4.3) could be assumed to be a generic framework for treating trauma (Dass-Brailsford, 2007).

The body of evidence about cognitive therapy for the treatment of PTSD has been growing for some time. However, there have been more recent developments in the use of mindfulness in the treatment of anxiety and depression in Italy (Chiesa and Serretti, 2011) and the USA (Hofmann *et al.*, 2010) which has created interest in its use with PTSD (Makinson and Young, 2012). There has also been a significant increase in our understanding of how trauma affects people through neuroscience research (Kirouac and McBride, 2009) which could begin to explain why some therapies appear to be more successful than others.

In the last 10-15 years, researchers have identified the importance in early life of the development of the right cerebral cortex with respect to social skills, emotional regulation and the individual's sense of self (Schoore, 2005). This development is associated with developing secure attachment and the capacity for trust, empathy and moral development. Poor childhood experiences may result in aggressive and socially inappropriate behaviour as this part of the brain is also associated with the expression of negative emotion (Kirouac and McBride, 2009). Interestingly, the psychological symptoms associated with DV, such as the lack of social support, difficulty with emotional regulation and reduced sense of self also seem to link with reduced activity on this right side of the brain (Schoore, 2005).

Later, the left pre-frontal cortex (PFC) begins to develop verbal expression and logical and analytical thinking. There are signs that this is also associated with positive thoughts and emotions, such as success, encouragement and humour (Herrington *et al.*, 2005). These elements are shown in Table 2-8 below.

Table 2-8 Aspects of brain development relevant to DV counselling

Left brain	Right brain
<ul style="list-style-type: none"> • Positive development (Herrington <i>et al.</i>, 2005) <ul style="list-style-type: none"> • Verbal expression • Logical and analytical thinking • Emotions <ul style="list-style-type: none"> • Encouragement • Success • Humour • Compassion 	<ul style="list-style-type: none"> • Positive development (Schoe, 2005) <ul style="list-style-type: none"> • Social skills • Emotional regulation <ul style="list-style-type: none"> • Mindfulness may increase emotional regulation (Smith <i>et al.</i>, 2011) • Sense of self
<ul style="list-style-type: none"> • Work with depression shows reduction in left brain activity and more negative emotion (Grimm <i>et al.</i>, 2008) 	<ul style="list-style-type: none"> • Lack of development (Kirouac & McBride, 2009) <ul style="list-style-type: none"> • Aggressive and socially inappropriate behaviour • Expression of negative emotion • Right brain takes precedence in times of stress, looking for non-verbal clues
	<ul style="list-style-type: none"> • Experiencing cruelty may focus attention on self protection (right brain activity) (Gilbert, 2005a)

Some brain imaging with patients experiencing major depression has shown a reduction in left brain activity and an increase in right brain activity leading to

negative emotional judgement (Grimm *et al.*, 2008). The right PFC can also take precedence at times of stress, looking for non-verbal rather than verbal clues to deal with the situation (Kirouac and McBride, 2009). Living under constant stress can reduce left brain cognitive functioning, with more reliance on the right brain survival instincts for the preservation of self. This, at the same time, reduces the ability to engage with external positive human affect.

This frontal part of the brain is believed to retain plasticity which means that neurological changes can continue to take place over the individual's life-span and improvement is possible (Kirouac and McBride, 2009). For example, an individual suffering from an irrational fear of something, even when the object is not physically present, can activate the hippocampus, which seeks emotional regulation through the right pre-frontal cortex (PFC) of the brain. Successfully addressing irrational fears through CBT psychotherapy has resulted in a physical change in the brain activation pathways (Paquette *et al.*, 2003). This has both positive and negative implications. People suffering from high stress may find the way their brain functions changes over time to match their life-style. Equally the process, under the right circumstances, has a chance of being reversed. Therefore activities related to increasing left brain activity, such as through cognitive work, may help to relieve some of the symptoms resulting from DV.

However, PTSD is different to normal anxiety due to the effect that trauma has on the limbic system. Here, the hippocampus, which processes and lays down memories for retrieval later on, becomes overwhelmed by the event and by-passes the emotion regulation function of the cortex (Kirouac and McBride, 2009). This triggers the left amygdala (Liberzon *et al.*, 1999) where the emotions are processed into a state of high alert: fight, flight, freeze or dissociate until the danger has passed. However, as the cortex (which is responsible for sending the information required for long term memory to the hippocampus) has been by-passed, the brain is not able to lay down accessible memories. This means that particular elements of the trauma, such as sound or smell, may be remembered in isolation causing frequent triggering and hyper-sensitivity in the amygdala (Kirouac and McBride, 2009). This sensitivity, in turn, keeps the individual on high alert and unable to process new information about the safety of the current situation, thus the trauma is never resolved and symptoms of PTSD continue (Hayes *et al.*, 2011). Ultimately, experiencing a frequent traumatic state can lead to a reduction in size of the

hippocampus, which can have longer term memory implications (Kirouac and McBride, 2009).

Mindfulness practice has shown some promising results in alleviating the symptoms of trauma through changes in brain activity (Lutz *et al.*, 2013). Further work is required to understand how this works, but it is hypothesised that mindfulness increases the emotion-regulation capability of the brain (Smith *et al.*, 2011), the part that involves the right PFC. Focusing on the present moment, on the surroundings, thoughts and feelings at that particular time, allows greater tolerance of traumatic imagery or feelings, allowing them to be processed (Follette, Palm and Pearson, 2006). Hypothetically, this could result in PTSD triggers being deactivated through changes in pathways rather than simply being managed. However, using only this approach potentially fails to address the reduced stimulation of the left PFC due to depression, an area of the brain associated with positive experience and affect, social connection and compassionate thoughts for others (Wang, 2005).

It has been suggested that experiencing cruelty can shut off the individual's ability to be compassionate, as their attention is focussed on self protection (Gilbert, 2005a) fitting with the physiology model emphasising the right PFC. Herman's (1992) model of trauma specifically addresses this issue by focusing on social reconnection as the third phase of her model. More recent work on brain activity suggests that feeling compassion for others can stimulate the left PFC and can also be developed and accessed more effectively (creating new brain pathways) through practising compassion based meditation (Lutz *et al.*, 2008).

The inclusion of compassion as a factor within therapy for treatment in cases of abuse may therefore have a physiological basis, and has gained researchers' interest (Gilbert, 2009; Briere, 2012). Compassion for the client by the therapist can result in positive feelings and promote well-being in the client. Both Gilbert (2009) and Briere (2012) recognise a strong overlap with person-centred theory (Rogers, 1957). However, Briere (2012) positions compassion as specifically different to empathy due to the additional need for caring, kindness and warmth. Interestingly, those aspects had also been highlighted as part of a helping relationship in person-centred therapy (Rogers, 1958). Perhaps his description of compassion is not simply about technique, as empathy might imply, but about a way of being with a client.

Although both Briere (2012) and Gilbert, McEwan, *et al.* (2011) have written widely about the need for compassion, the way they describe compassion is different: Gilbert *et al.* talk about a motivation to care, whilst Briere speaks of unconditional caring; Gilbert *et al.* encourage therapists to have the capacity for sympathy and empathy, whilst being non-judging or non-condemning, whereas Briere believes compassion requires attunement to, and acceptance of, the client. They appear to be discussing the same issues, yet the required degree of therapeutic engagement is different. This may be because Gilbert's (2009) view of compassionate therapy is positioned to be more widely applicable, whereas Briere (2002) has based his views on his work with adult victims of childhood trauma. However, research with practitioners in the USA nominated as being compassionate showed a closer alignment with Briere's (2012) views through identifying being engaged, attuned and fully present with the client, whilst also being connected to the client's suffering (Vivino *et al.*, 2009). These practitioners also noted that although compassion can be present from birth, it can also be developed through sensing it from others or feeling the pain of others. This suggests that a client, working with a compassionate therapist, may have the potential to develop their own compassion.

Earlier studies of the therapeutic relationship for victims of trauma has suggested that sensing an empathic connection (Payne, Liebling-Kalifani and Joseph, 2007) or a strong therapeutic relationship (Paivio and Patterson, 1999; Cloitre *et al.*, 2004; Follette *et al.*, 2006) within therapy is particularly beneficial, whatever the modality of the therapist. The strength of the therapeutic relationship has been identified as an important aspect of successful therapy in counselling generally (Cooper, 2008) but, as implied in Herman's (1992) model, trauma facilitates a withdrawal from human connection and may require a strong therapeutic connection to compensate.

Research on the development of self-compassion suggested that it could reduce depression and anxiety (Barnard and Curry, 2011) and create a more stable sense of self-worth than focusing on self-esteem (Neff and Vonk, 2009). It is possible that working with clients on reducing anxiety through cognitive therapy and mindfulness techniques together with encouraging compassionate exploration of their experiences could be successful in addressing known DV mental health issues. This could provide an explanation for 3rd sector volunteer counsellors providing successful therapy without using specific trauma techniques (Humphreys and Joseph, 2004). However, it is important to note that compassion can also be seen as something to fear by individuals who are insecurely attached and experiencing

depression, anxiety and stress (Gilbert, McEwan, *et al.*, 2011). Then, compassion could be perceived as manipulation or dishonesty, or it could generate an expectancy of inconsistency based on the client's previous experiences. Hence, it may be important to work with and develop the client's understanding and acceptance of compassion as part of the therapeutic process.

Although there are difficulties, not least with agreeing an appropriate definition of compassion (Gilbert, 2005b; Gilbert, 2009; Siegel and Germer, 2012), this may be a potentially interesting area of exploration for future research, as cognitive behavioural, person-centred, mindfulness and neurological research interests meet. It is also interesting to note that a compassionate approach to therapy could deliver a strong and caring therapeutic relationship, part of the foundation of a trusting relationship (Battaglia *et al.*, 2003). This theoretical base has yet to be incorporated into a DV counselling model, as it is relatively new research. However, it has a number of positive indicators to suggest it could be beneficial and it warrants further consideration.

2.4.3.3 Hope

Earlier in this chapter (section 2.3.3) the link between suicidal ideation and hopelessness was made, which could indicate a client's need for hope in recovery. However, the concept of hope within counselling is complex. One definition of hope (Oxforddictionaries.com, 2012) was given as: either feelings of expecting and desiring a specific outcome; or feelings of trust. These two aspects of hope have been identified in the literature: Walker (1994) linked hope with trust in the process; Lee (2007) created a hopeful alternative future; Herman (1992) acknowledged the part hope plays in helping clients at the beginning of their recovery; and Sanderson (2008) believed that engaging in therapy is an expression of hope for the client. More recently hope has been linked specifically with recovery from trauma (Allen, 2005) and the need for hope during recovery from DV has also been reported in other non-counselling publications (Stenius and Veysey, 2005; Allen and Wozniak, 2011). Since Dutton (1992), Herman (1992) and Walker (1994) wrote their texts, hope has been identified explicitly as a factor within client focused DV research (Davis and Taylor, 2006; Hage, 2006; Social Policy & Research team, 2009). There is general agreement about the principle of hope within DV counselling, but how that is expressed or defined is a matter of opinion and is explored further below.

Practitioners and academics have been aware for many years that hope was an important aspect of both life and therapeutic work which deserved more recognition (Menninger, 1959). It was, however, Frank (1963), who was generally credited with bringing hope explicitly into the therapeutic process. His concept of demoralised clients included those who had suffered DV. He worked on the principle that such clients respond to the common elements of psychotherapy, which meant that no particular modality is preferred, a position reflected in more recent writing for DV (Sanderson, 2008; Roddy, 2013a). Frank (1963) noted that such clients feel unique: they are sure that no-one has gone through their specific experience before and that no-one can understand them. This echoes the experience and feelings of those who have experienced DV (Abrahams, 2007). Later, he cited a useful quote (Bennett and Bennett, 1984) which describes the situation faced in DV when the victim finally realises that things will not change (Frank and Frank, 1991):

“In the acceptance of helplessness and hopelessness lies the hope of giving up impossible tasks and taking credit for what we endure. Paradoxically, the abandonment of hope often brings new freedom.” (p. 562)

This sense that a new way forward can emerge from hopelessness has also been expressed by Walker (1994) but it is equally important to recognise the tremendous loss that occurs as the hope that things can change dies. This has been described as moving from unrealistic hope, through hopelessness, towards realistic hope (O’Hara, 2011) and may form an important part of a counselling process.

Although hope was being explored as a significant aspect of the therapeutic relationship in contributing to positive outcomes during the 1950’s and 1960’s, this had changed by the early 1990’s. Research now linked hope with client expectancy and placebo effects. This new definition of expectancy was about the client knowing they were being treated and feeling that their therapist was credible (Hubble, Duncan and Miller, 1999). Walker’s (1994) view of listening to the client and providing literature and information early on suggests that this was not just about building trust but also about building hope for recovery.

Around the same time, medical professionals were becoming more interested in the role of hope in recovery (Scovern, 1999; Cutcliffe, 2004). Researchers had found that hopelessness could be related to higher mortality in patients with ischaemic heart disease (Anda *et al.*, 1993) and a longitudinal study in the USA found that men were at greater risk of death from cardiovascular disease and cancer where

hopelessness was identified (Everson *et al.*, 1996). This study can be compared with Beck's earlier work (Beck *et al.*, 1974), which found that levels of hopelessness were not related to levels of depression but to an increased risk of suicide. Hope appears to have an existential quality, to be separate and distinct from depression, and be an active rather than passive factor in supporting life.

One of the reasons for the change in emphasis of research into hope was the early development of a theory of hope from a cognitive behavioural stance (Stotland, 1969). This comprised seven different aspects, primarily related to the achievement of success and the importance of goals. However, it also highlighted the anxiety generated by not being able to achieve those goals, a factor likely to be present in DV. Stotland described the difficulty of entrenched thought patterns and encouraged movement towards positive and away from negative feelings.

This perspective later informed the development of a new definition of hope (Snyder *et al.*, 1991) which had two distinct cognitive aspects:

- a) Agency: a sense of successfully meeting goals in the past, present and future
- b) Pathways: the perceived availability of successful pathways relating to goals

Snyder's hypothesis suggested that both agency and pathways needed to exist to experience hope. He differentiated hope from optimism (Scheier and Carver, 1985), which he considered had too much agency and too little on pathways, and self-efficacy (Bandura, 1982), which he felt focussed mainly on the individual's ability to take action. Whilst Snyder's (1991) definition of hope fits with expectation and desire (Oxforddictionaries.com, 2012), the additional element of faith or trust that is required to take part in things beyond one's control is somehow missed. Although Snyder (1995) acknowledged that his definition had the benefit of being measurable rather than comprehensive, and a later paper stated that

“stress, negative emotions, and difficulties in coping are considered the result of being unable to envision a pathway or make movement toward a desired goal” (p.181) (Snyder, Michael and Cheavens, 1999)

Regrettably, with this perspective, a person who decides the only option is suicide and completes that intent fits the criteria for a hopeful act. Thus the definition above lacks the existential quality of hope. Nevertheless, this approach can play a part in generating hope for individuals and it formed a basis for Snyder's later work in

positive psychology (Snyder and Lopez, 2005) which included optimism, self-efficacy and compassion.

Since then, research on hope-based processes has concluded that hope can also be generated through the therapeutic relationship, the client's expectancy and specific features of therapeutic practice (Cutcliffe, 2004; Larsen and Stege, 2012). In that sense, hope can be seen as a dynamic part of the therapeutic process, not simply as a client variable or placebo. For example, if clients leave their first counselling session with a sense of hope they are more likely to return for a second session (Hanna, 2002). The role of the therapist is seen as crucial in taking actions from the outset to engender client feelings of hope which can make the start of therapy easier to bear (Larsen and Stege, 2010a; Larsen and Stege, 2010b).

It has also been suggested that counsellors need to have hope in themselves and their ability to work with the client; to be able to communicate that hope to the client (Frank and Frank, 1991; Cutcliffe, 2004); and to have hope for the client (Coppock *et al.*, 2010). However, this could place too much emphasis on the therapist to produce or provide hope (Larsen, Edey and Lemay, 2007). Instead, clients can also find hope within other areas of their lives, perhaps with the therapist's assistance, thus describing a process of co-construction of hope. It is possible that the process of hope is even more complex than this as it ebbs and flows between therapist and client, each impacting on levels of hope within the other, both positively and negatively. The construction of hope is not simply about a therapist remembering to support and encourage a client; it includes aspirations and feelings, as well as forming and achieving objectives.

Within DV, the maintenance of hope within the therapist is potentially more complex given the nature of the work and the potential for vicarious or secondary trauma or compassion fatigue (Sexton, 1999; Iliffe and Steed, 2000; Bush, 2009). This underlines the need for appropriate self-care for therapists as the impact of one client's story could unwittingly affect effectiveness with other clients. Hope is a complex idea in therapy, being seen as an inherent part of the client as well as a dynamic created and grown within the therapeutic relationship, and also contained within the therapist. There are aspects of this work that resonate with the presenting issues of DV clients, suggesting this could be an important area to consider in future research programmes.

2.4.4 Summary

This section of the chapter has shown that there are many dynamic areas to consider when working with DV clients. Although there are ideas about appropriate outcomes for DV counselling, there does not appear to be agreement. Therapists have generated their own therapy processes, each with an underpinning philosophy. It is not simply applying the tools and techniques for working with the diagnosed conditions associated with DV, but addressing and incorporating some of the more complex philosophical and practical ideas surrounding trust, compassion and hope. Although these concepts have been mentioned briefly within the literature for DV counselling and trauma work, they have still to be developed. This may be due to believing that these aspects happen naturally within therapy, or it may be that the work conducted in other fields has yet to be integrated. What is clearly missing, and could help to support the development of outcome measures or support one counselling process over another, would be research exploring the clients', rather than practitioners', experiences of DV counselling.

2.5 Research from the client's perspective

There have been a small number of qualitative studies from the UK, USA, Australia and Sweden conducted with women who have suffered DV, mainly to gain an understanding of different aspects of their experiences (Davis and Taylor, 2006; Hage, 2006; Morgan and Björkert, 2006; Scheffer Lindgren and Renck, 2008; Bostock, Plumpton and Pratt, 2009; Social Policy & Research team, 2009) and how they accessed help (Stenius and Veysey, 2005; McLeod *et al.*, 2010; Keeling and van Wormer, 2012). This research has been conducted consistently from a feminist perspective (where stated) using thematic analysis, with the exception of Davis and Taylor (2006) who used a narrative analysis.

Findings from these studies shared the participants' feelings relating to being abused, and described their sense of a loss of self and the perceived barriers to leaving through societal and relational pressures. As described earlier in this chapter (section 2.2.1), access to social support was important and reportedly helped to preserve the client's sense of self, which in turn helped them to make appropriate decisions to leave.

Some clients reported accessing counselling services as part of their support. They found that therapists recognising the experience of DV and being genuinely caring,

empathic and non-judgemental were helpful. Interestingly, being properly diagnosed and treated was specifically highlighted as helpful. Perhaps unsurprisingly, where the factors listed above were missing, this was considered to be unhelpful. In addition funding issues (a particular problem within the third sector, which could mean disruption to the therapeutic process and sometimes necessitated a change of therapist), were specifically cited as unhelpful. The continuation of the therapeutic process and relationship were therefore seen to be very helpful aspects of the counselling work, suggesting that clients valued the relationship developed with their therapist.

Counselling in these studies was mentioned, but played a small part in the reported findings. However, there have been four studies specifically looking at the counselling of female DV survivors (Seeley and Plunkett, 2002; Day, 2008; Oswald, Fonseca and Hardesty, 2010; Farmer *et al.*, 2013), none involving men. Two large multi-agency projects, one in Australia and one in Europe, involved both professionals and clients in assessing the counselling that clients had received (Seeley and Plunkett, 2002; Farmer *et al.*, 2013). One small USA PhD study investigated the client experience at one agency of going through counselling and triangulated the research data with two licensed DV experts (Day, 2008). Another USA study interviewed clients to understand the internal family dynamics of lesbian mothers experiencing IPV and then conducted a secondary analysis on the original study data to determine their reported experiences of counselling (Oswald *et al.*, 2010).

The first of these studies was based in Australia (Seeley and Plunkett, 2002). Workers from local and regional DV networks around Melbourne collected views from their clients about aspects of the counselling they had received which they considered to be negative. The counsellor not understanding DV and the resultant issues, or simply ignoring the DV and trying to treat the client for the symptoms rather than the cause, presented difficulties. In addition, trying to get the client to agree to specific pre-defined outcomes for therapy was seen as unhelpful. The clients reported that they needed to find their own solutions to their own defined problems. These issues were addressed in practice guidelines for counselling issued in Australia a few years later (Grealy *et al.*, 2008). However, as has been shown in the preceding sections (2.3.2, 2.3.3, 2.3.4 and 2.3.5), much of the guidance in the UK for referral for mental health treatment is based on the presenting symptoms rather than exploration of the underlying cause. As there is no

screening for DV prior to referral, there is a risk that counsellors could lack the knowledge and training required to deal with these issues. This could account for the unhelpful counselling experiences reported by participants in the UK part of the European study (Farmer *et al.*, 2013).

More recently, a PhD study was completed in the USA (Day, 2008; Day, 2009) to gather the experiences of seven women who were accessing DV counselling. This study highlighted the need to work with the right counsellor who could validate their perceptions of the abuse. Key additional themes that emerged from that work were being able to express the extent and effect of the abuse, how hard counselling was, being able to acquire tools, and empowerment. Unfortunately the thesis was not accessible from the UK and so further interpretation of what these terms might mean was not possible.

The third study conducted research into the family dynamics of lesbian mothers' IPV experiences in the USA (Oswald *et al.*, 2010) and explored (through secondary data analysis) what motivated clients to seek counselling, what prevented or helped them to do so, and which different types of counselling were received. As with the studies above, counselling was most helpful when the abuse was acknowledged and the client was guided to find her own solutions. However, the study also noted the problems that mothers in particular have within DV regarding custody battles, which might prevent them from seeking help if their counselling could be used in court against them. As a result, the participants accessed counselling because they had reached breaking point or they wanted help with apparently unrelated issues, such as concerns about their children. This is a helpful insight into some of the issues that may result from receiving counselling, as well as highlighting that initial access may not be about the client's psychological issues.

A fourth study has only very recently reported their findings (Farmer *et al.*, 2013). This involved five countries in Europe including the UK. Counsellors and clients at six different agencies were interviewed, and each agency had its own preferred approach to counselling. The results were presented for each country specifically addressing: how clients sought help; what sort of therapeutic models were used; and what outcomes the clients perceived as beneficial. There did not appear to be common themes across the agencies, however, there was some agreement between the clients that feelings of despair or a recognition of a change in the home environment were the most likely trigger points for seeking counselling, aligning with

Oswald's *et al.* (2010) findings. There was little agreement about what helped in therapeutic interventions, although that could have been, in part, a language problem. Transcripts were translated into English before being analysed and many of the comments described feelings about the therapist and therapy, which may have been subject to interpretation by translators. However, there was some agreement in the outcomes described by clients and observed by counsellors. These split into three categories: life functioning (problem solving, autonomy, coping strategies and confidence to get on with life); understanding their experiences; and perceiving a future again. However, it is important to note that the participants were specifically asked about problem solving, autonomy, how they now understood DV and decision making, which may account for two of the three emergent categories. Whilst this does not negate the client experience, the structured nature of the research interview means that the full client experience may not have been explored. The reported benefit of now seeing a future appears to be unprompted, and was described as an achievement by UK clients after the despair that triggered help-seeking (Farmer *et al.*, 2013).

The four studies described above were consistent in reporting similar themes about what was important in counselling: having the abuse acknowledged, being assisted to find their own solutions and having access to an appropriate therapist. This is quite different to the measures used in much of the other research reviewed in this chapter, such as levels of depression and anxiety.

Looking across the studies there are also suggestions that understanding DV and naming it is a key feature of the work being done, together with developing a stronger sense of self or a feeling of empowerment to be able to decide what to do next. These themes have appeared in DV literature for many years and fit well with the advice that has been given to social and healthcare workers about validating the experience of the victim (Lloyd, 1998; Morgan, 1998) as well as with the work done through the Freedom Programme (Craven and Fleming, 2008) and the many confidence and self-esteem building courses run by DV agencies within the UK. As such, these results are not simply within the domain of counselling, but all those working with DV. This raises the question of what counselling may add to the recovery of the victim.

There is a significant body of work indicating the need to address trauma, which could be undertaken as part of counselling, although this has not been highlighted in

these studies. It could be argued that working with trauma is what has been described as understanding their experiences, of expressing the extent of the abuse (Day, 2008). Yet trauma work requires a greater depth of engagement and higher levels of therapeutic skill than this description suggests. Also, the concept of understanding may not be simply the counsellor explaining DV to the client, but the counsellor being seen to understand the client and their experiences (Roddy, 2011b; Roddy, 2013a). The levels of empathy required to 'speak for' the client and thus assist with difficult disclosures are developed through counselling skill and extensive subject knowledge, reinforcing the need to find an appropriate counsellor. In addition, Farmer's (2013) finding that the participants now felt that they had a future suggests a more significant process than one of simply psycho-education. The client-based research aligns with the general principles of DV support and highlights some of the difficulties that can be encountered in counselling. However, it does not provide insight into the counselling process itself.

There have been a few studies conducted on the perspective of male victims. These look in particular at the DV experience of men being abused by their partners (Brothers, 2001; Migliaccio, 2002; Cook, 2009; Nayback-Beebe and Yoder, 2012). Much of the research in this field focused on men who were in abusive relationships, dating or longer term, and identified the individual or relationship profile, risk factors, symptoms and experience (Simonelli and Ingram, 1998; Brothers, 2001; Hines *et al.*, 2007; Cook, 2009). The embryonic nature of many male services makes substantial research projects difficult to undertake. There is one study which did include a reference to counselling for male victims of DV (Sweet, 2010). Here the men said that counselling had helped them to get over their experience of abuse through talking about it and dealing emotionally and mentally with the issues they faced as a result. Although counselling was a positive experience, the men also felt that more practical help, such as advocacy and support, would have been useful. The very limited coverage of counselling services for men suggests that future research that included men who had been through an abusive relationship and received therapeutic support would be a novel and interesting area for further development.

The brevity of this section highlights the current lack of literature on the client view of DV counselling. More strikingly, there is a lack of research investigating why counselling (rather than support) might work and the value of counselling to clients. This suggests that a more detailed look at the counselling process from a male and

female client perspective could provide additional information about what is important for DV clients. It could also inform what appears to be a significant gap in current client based research.

2.6 Discussion and research objectives

The development in understanding of DV has been driven in the past by particular philosophies to protect the most vulnerable and at-risk women by focusing on the physical safety of those individuals. One of the unfortunate side effects of this approach has been the minimisation of the psychological impact of living with DV. As evidence grows that male victims also experience psychological harm from DV, a continued focus on physical violence at the expense of psychological violence is likely to have a detrimental effect on both women and men. This chapter has shown the potential difficulties for DV clients seeking psychological help in expressing their needs, being reluctant to share their story and having difficulties with trust, all of which limit their capacity to access support. Nevertheless, counselling was identified as a useful service accessed by both men and women.

This is not surprising as there is a substantial body of literature surrounding mental health issues, associating DV and depression, suicidal ideation and PTSD. In the UK, medical guidelines (National Collaborating Centre for Mental Health, 2009) suggest that most DV clients will be offered medication or therapy for depression initially, with further treatment for other diagnosed conditions offered subsequently if symptoms persist. Yet research from the USA, Australia and Europe has suggested that clients find understanding the impact of the DV on them more helpful than focusing on alleviating symptoms of mental distress. Although the UK government has been advised that further research into appropriate DV mental health support is required (Ramsay *et al.*, 2005), this has yet to be funded. A counselling research study helping to establish what works and why may be helpful in planning future mental health provision.

Although there are counselling models and outcome measures developed by practitioners and researchers for female DV clients, there is no equivalent body of work available for men. Common areas of agreement can be identified, but there are also differences of opinion which are unresolved. What is currently missing from this work is the opinion of the client, female or male, about what they have found helpful in therapy and what they gained as a result.

This chapter has identified a range of possible research areas associated with DV. However, one of the significant gaps in the literature appears to be the client perspective of counselling and how it helps. The following chapters will outline a research study to investigate what DV clients (male and female) found helpful in both accessing and receiving counselling and to explore what outcomes are valued by the client.

3 Research Design and Methodology

3.1 Introduction

In this chapter, the specific research question is defined and ethical issues associated with working with this client group are addressed. The ethical considerations for the study were considerable due to the possibility of prompting further memories of trauma given the high incidence of PTSD noted in the literature review. Traumatic memories may not always be fully resolved, and aspects can be triggered again at future points, often unexpectedly (Herman, 1992). It was important that the research balanced finding out as much as possible about participants' counselling experiences with minimising any risk and upset resulting from reviewing their material (Bond, 2004). The chapter then goes on to describe participant recruitment, the characteristics of the individuals who took part and how the data for the study was collected. The chapter ends by providing a rationale for the selection of the philosophical and analytical framework and a description of the data analysis and presentation.

The process of research design involved two main sources of knowledge. The first came from the academic literature, identifying philosophical frameworks and methodologies which were appropriate to the research question. The second used the researcher's experience as a project manager, counselling practitioner (working with DV and childhood abuse) and counselling client. Both of these sources played important parts in shaping the project framework as well as the final research design.

3.2 Research question

A clear research question was essential to an appropriate research design and to producing relevant and high quality information in the area of interest. The literature review identified that little was known about the client view of what was helpful or unhelpful in the process of DV counselling. From this, the research question developed for this study was:

“What was significant, in going through counselling, for those who suffered DV?”

This specific question was selected for a number of reasons:

- The word 'significant' was used in the context of the clients' experiences and allowed flexibility to determine what was of significance to them during counselling, either positively or negatively, without the constraints of counselling theory and could include incidents, process or outcomes.
- The past tense indicated the decision to work with clients after counselling had ended (see section 3.3.1).
- A focus on 'going through counselling' to explore the client process from beginning to end, including any differences in need emerging as the process evolved.
- Using the word 'those' to include anyone who may have encountered DV, rather than a specifically defined client group.
- The word 'suffered' within the context of DV, rather than victim, survivor, perpetrator or co-abuser, was used to identify those who felt harmed as a result of their experience, without judgement.

This question, with its focus on client perspective, counselling process, and sensitivity to the vulnerability of the client, was used to identify an appropriate methodological framework for this project. DV research has been conducted using both qualitative and quantitative methodologies (see chapter 2) and both could have been used to answer this research question. However, with quantitative methodology the focus is on the measurement and analysis of variables (McLeod, 2003b) and it is important to understand, or infer with confidence, the factors that are likely to influence the outcome of the study. This ensures that appropriate measurements can be made to check the hypothesis, and to gain some understanding of what might have happened should unexpected results emerge.

The literature review identified that DV clients can vary greatly in terms of their past and current experiences of abuse, and the degree and type of harm suffered. To date, there has been little research to define which factors are specifically important from a DV counselling perspective rather than more broadly within DV support. There is also little data from a client perspective to inform appropriate variables for measurement. This suggested that there could be multiple variables possible within an ill-defined process. Key measurements were difficult to identify at the outset and this suggested that quantitative methods would be inappropriate for this study. Instead, a qualitative approach offered to uncover important elements about the counselling process from the client perspective through enquiry rather than measurement (McLeod, 2003a). This approach would also provide more information

to answer the research question, and could lay the foundations for better defined, quantitative research in the future.

3.3 Ethics

The focus for this research was investigating the client's perspective of DV counselling, to explore what was particularly helpful or unhelpful to their recovery. The key value of ensuring no harm to the participants was at the forefront of research decisions and care was taken to work within both BACP and York St. John University ethical guidelines (Bond, 2004; York St. John University, 2008). The research design proposal was submitted to, and approved by, York St. John ethics committee (Ref: UC/7/1/11/JR) prior to the commencement of any field work, and is shown in full in Appendix A.

3.3.1 Effect on research design

The study design had to recognise and minimise the potential to trigger any unresolved aspects of the participants' experiences. The researcher decided that this precluded the use of counselling process research techniques, which involved reviewing specific significant events from sessions in detail with clients as the therapy proceeds (Elliott, 1983; Lietaer and Neirinck, 1986; Llewelyn, 1988; Najavits and Strupp, 1994) for the following reasons:

- The researcher's experience of working in the sector suggested that many clients begin counselling in a heightened emotional state, making it difficult to ask for or gain properly informed consent at that time (Bond, 2004).
- The nature of working with traumatic memories suggests that the same experience may be worked on over several sessions (Herman, 1992). It may only be apparent to the client what was most important to them when they could reflect on the whole experience.
- Given the traumatic nature and emotional impact of some of the counselling, and the possible need for several sessions in working through a specific trauma, the researcher felt it inappropriate to revisit the material in each session shortly after disclosure. Indeed, other process researchers have found that levels of consent associated with reviewing sessions of significant emotional content were very low (Balmforth, 2011).
- The literature review indicated that there may be issues with trust, particularly at the beginning of counselling (see section 2.3.6). The introduction of a third person as a researcher could generate more

uncertainty about confidentiality, resulting in limited disclosure, and adversely affecting both the counselling and the research.

This led to two important research decisions, which significantly influenced the research design. The first was to restrict the research activity until after the counselling had finished so that the client could reflect on the whole experience. The second, based on the potential for unresolved material to be triggered, was to keep to a minimum the amount of time each participant spent in reviewing their specific DV counselling experiences whilst still producing trustworthy research data.

3.3.2 Safety of the participants

As a key part of the ethical approval submission was recognising the possible re-traumatisation of participants during the research, consideration was given to how participants' experiences of counselling could be explored to minimise and respond quickly to any emerging distress. Interviews were identified as a key data collection medium. Although interviews could have been held by telephone or on-line (Creswell, 2007), monitoring participants closely for any signs of distress can be more difficult using these two modes of communication. The researcher concluded that interviews would only be held face to face to facilitate appropriate and timely intervention, if required. Recognising that distress may occur, a plan for responding in the interview (see Appendix A) was developed and implemented as part of the interview process to minimise further difficulties.

Nevertheless, it was also recognised that, despite the precautions taken by the researcher, memories may be triggered during the research process which might require further counselling support. Meetings outlining the research study were held with each organisation involving the senior counsellor or support staff and the Chief Executive prior to finalising their agreement to participate. This provided transparency of the research process between the researcher and the agency (Bond, 2004). Each agency reviewed the York St. John University ethical approval submission and signed a document to confirm their agreement to work within that framework. This included the organisation's agreement to offer counselling services to any of the participants who needed support after the research interview. In addition, research interviews were held with participants at the agency where they had received their counselling to make the experience more comfortable for them and to provide immediate access to support if required.

Prior to the research interview, each agency provided participants with a detailed question and answer sheet (see appendix A), which advised them that there might be a risk of re-engaging with their traumatic memories. This provided the opportunity for anyone who felt this might be a risk for them to withdraw from the process prior to the interview. Several of the participants mentioned at the end of the interview that they had noted this warning and wanted the researcher to know that it had not been an issue for them.

On meeting each participant, the researcher discussed the question and answer document with the participant. The participants were briefed about the research and provided with supporting materials, outlining the background to the project, as shown in Appendix A. This included issues such as anonymity for the participant, confidentiality of the data and how the information would be stored and transcribed. All of the interviews were digitally recorded and the data was password protected. All transcription was completed by the researcher and saved using code numbers as file names, with encryption and password protection. Participants were given pseudonyms by the researcher to protect their identity and any personal information which could lead to them being identified was removed from the transcripts. The signed consent documents were held separately in a locked filing cabinet.

The participants were also advised that transcripts may be reviewed by university supervisors and thesis examiners, but that agency and counselling staff would not have access. Consent was also requested for small portions of their script to be used to support findings from the research to allow dissemination of the work. Participants were provided with full details on how they could withdraw their consent to their data being used if they changed their minds at a later date. They were then asked to sign two copies of the consent form, retaining one for their own use. After the interview, the researcher debriefed the participant, answering any additional questions and ensuring that they were ready to leave the interview room. This process formed part of the approved ethical consent document (as shown in Appendix A).

3.3.3 Safety of the researcher

There was also a need to ensure the safety of the researcher during the research process, both physically and emotionally (Bond, 2004). There is a physical risk associated with witnessing traumatic memories in flashback as the individual may re-enact their physical movements at the time of the event (Scott and Stradling, 2006), which in the case of DV may involve physical defence. As the research

interviews took place within the agencies involved in the research, the researcher observed the agencies' safety protocols and was mindful of the possibility of flashbacks when setting out the interview room. There was also the potential for emotional distress of the researcher due to the prolonged contact with traumatic material and the possibility of vicarious or secondary trauma (Bush, 2009). During the research process, the researcher accessed professional and academic supervision, as well as 1-to-1 counselling, to process the impact of the material.

3.3.4 Trustworthiness

In keeping with BACP ethical guidelines (Bond, 2004), the research approach also needed to ensure that the collection and analysis of data met the highest standards of trustworthiness, and specifically included the need for fairness and honesty in the collection and analysis of the data and the presentation of the findings. As this was a qualitative research project, the possible influence of the researcher on the study needed to be addressed.

Working in this research area did result in a close and intense experience for the researcher during both the interviews and the transcription process. Hence it was important to establish whether her reaction to the participant was an empathic experience reflecting the participant's story or something which had been triggered by her own values or experiences (Etherington, 2004). This was complicated as she experienced data collection from three different perspectives: as a researcher, as a counsellor and as an individual. As a counsellor it was interesting to hear how other professionals had worked with difficult situations, and hard to hear the participants' stories of poor counselling experiences. As an individual, it was difficult to hear the stories of abuse, hardship and suffering, and yet uplifting to hear how adversity had been overcome. As a researcher, it was important to be mindful of the interview objectives and of keeping to time, whilst exploring the participant's experience carefully and sensitively as things emerged. Being aware that her conduct and responses during interviews could have an impact on the results (McDougall, 2000) meant preparing for the interview, and reflecting throughout the interview process 'in action' and 'on action' (Cowan, 1998). Transcribing each interview provided another opportunity to review and learn from mistakes.

In addition to recognising the possibility of her influence on the interview process, the researcher also noted the potential for influence of the analytical process through her prior knowledge, experiences and training (Danchev and Ross, 2014) in DV and counselling. As part of the preparation stage of the research, she recorded

her answers to the interview questions regarding her own experiences as a counselling client. This helped her to be aware of what was most important in the counselling process to her, and served as a bracketing interview (Finlay, 2011). However, she also tried to recognise factors being introduced through her own unconscious processes during the research by stepping away from the material and reflecting on her responses (Rennie, 1998). Completing a journal entry at the end of each interview and undertaking further reflective writing during transcription and analysis were both helpful. Supervision sessions were useful for discussing issues that had arisen that were still unresolved or difficult to locate within the emerging model (Gabriel, 2009), whilst personal therapy helped to process information and feelings that were particularly challenging. These activities helped to clarify what the participants were bringing to the session and what came from the researcher, and provided a credible data interpretation process.

Although these activities were undertaken to reduce the risk of researcher influence on the analytic process, it was also important to verify externally that this had been effective. This was done through a number of activities. Written material was provided for supervision each month to develop ideas and check objectivity and understanding of the data (McLeod, 2003a). One in six of the interview transcripts were reviewed by the study supervisors which helped to check the consistency and dependability of the analysis (Lincoln and Guba, 1985). Aspects of the research have been published (Roddy, 2011a; Roddy, 2013a) and also presented at a number of conferences in the UK and Europe (Roddy, 2011b; Roddy, 2012; Roddy, 2013c; Roddy, 2013b) providing additional feedback from DV and counselling professionals.

In addition, as the theory emerged, all of the participants were invited to review the emerging model of counselling to ensure it represented their views, and six participated. This process helped to confirm the neutrality of the analysis (Lincoln and Guba, 1985). Although this may seem to be at odds with the stated aim of the research process to minimise contact with the material, it is important to understand the context. Firstly, the participants were able to choose whether or not to participate in further interviews, and some chose not to do so. Secondly, the purpose of the review interview was to examine the model that was emerging from the data, not specifically to ask the participant to provide further details of their experiences. In the initial research interviews, the participants spoke for more than 90% of the interview, compared with around 40% of the time or less in the review

interviews. Although the review did on occasion prompt some further discussion of participant issues, this was in the context of the research model and was offered by the participants. The review interview did not require further detailed exploration of their personal experiences. Thus the amount of time spent revisiting their own material was limited, and the participants were not faced with the detail of their own experiences, which was one of the objectives of the study design.

3.4 Participants and recruitment

3.4.1 Working with the agencies

This study has been focused on specialist third sector DV agencies, as they have greater access to this specific client base. The researcher approached two female agencies and one male agency with a view to participating in the study and the third female agency approached the researcher after reading one of her publications (Roddy, 2011a). Over 200 clients from all walks of life receive counselling each year through these organisations, from counsellors trained in a variety of theoretical orientations.

The three female agencies were located in the north east of England and the male agency in Eire. Whilst the researcher had approached a number of agencies working with men in England, either they felt they had not yet concluded their work with enough clients to be able to participate or they did not have the resources to be able to offer counselling if needed afterwards due to the waiting lists at the agency. The agency in Eire had been operating for 15 years and had an established client base. In addition, they had been involved in a number of research projects in Eire, the UK and the USA, and were pleased to participate.

To maintain client confidentiality, the agencies identified (in line with specified parameters) and contacted possible participants initially. Once the client had agreed to take part in the research, the agency organised the research interview at a mutually convenient time for the participant and researcher. This meant that the researcher had no knowledge of the participant or of the counsellor working with them prior to the interview. Subsequently the researcher identified that she had previously met five of the twelve counsellors who had clients taking part in the research either professionally or as part of the agency assessment process. Whilst this was important to note, the researcher's knowledge of the counsellors did not affect the interview or analysis process as the context of the two relationships were very different.

It is also important to note that counsellors in private practice, GP surgeries or other counselling settings were not part of the study, and therefore participants accessing these services have not been specifically included. This could be an area for future development.

3.4.2 Parameters for the recruitment of participants

Although each of the agencies had access to many clients who had completed counselling, recruitment was not straight forward as many of those contacted indicated that they had since moved on with their lives and did not wish to revisit the counselling. Hence, despite having a large number of clients, the number prepared to take part in the research was relatively low. This required the parameters for participants specified by the researcher to be as broad and inclusive as possible.

3.4.2.1 Length of time since completing counselling

The decision to interview participants after their counselling had finished to ensure that the counselling process was unaffected by the research also took into account that ending counselling can also provoke previous feelings of loss (McLeod, 2003b). It can take time for the client to grieve the loss of that relationship and to view the experience objectively. The literature review highlighted that those who have experienced DV may have an insecure attachment style and the loss of a secure and stable therapeutic relationship could be significant. In these circumstances, interviewing clients too early after counselling has ended could create difficulties for both the client and the study. Other similar research conducted with general counselling clients suggested a two month window was sufficient (Levitt *et al.*, 2006), whilst a slightly different research study allowed only three weeks after ending (Paulson *et al.*, 1999). Participants in this study were required to have had three months without counselling to take part, to allow time for losses associated with the ending to be assimilated.

It was also important that participants would remember enough about their counselling to contribute in detail to the research, and therefore a maximum time limit since completing counselling was also required. It has been argued that the more profound a critical event (or change experience) is, the more likely the person is to remember it in future (Webster and Mertova, 2007). A critical event in this case is different to significant moments of relational depth (Knox, 2008) or moments of empowerment (Timulák and Lietaer, 2001), which are specifically defined experiences. Some research findings have shown that 6 months after therapy has concluded, clients remember 70% of the critical incidents previously discussed with

them (Llewelyn *et al.*, 1988). This suggested that interviewing at a later time might elicit fewer memories, but those recalled will be of significance to the participant. Levitt *et al.* (2006) opted to curtail their interviewing at 12 months after counselling ended for this reason. However, taking into account that this study had a much smaller pool of participants to draw from and recognising that counselling through trauma may be particularly memorable, an upper limit of 18 months was set. This provided more flexibility to find participants initially, whilst noting that this limit could be reduced later in the research programme if participants were finding it hard to recall details. Details of the length of time since counselling for each participant are provided in Table 3-1 (overleaf).

3.4.2.2 Ensuring a mix of counselling experience

The agencies were asked to ensure that the participants had worked with different counsellors within the agency to ensure that the data generated did not reflect only one counsellor's approach to counselling. Each agency was able to meet this requirement. In total, 9 counsellors had worked with 14 female participants, and 3 counsellors with 6 male participants. In addition, some of the participants discussed the work they had done with other counsellors previously. This was confirmed during the interviews with participants as each would refer to their counsellor by name.

3.4.2.3 Other factors

Although agency staff had access to details relating to the counsellor involved and dates for beginning and ending counselling, they did not have specific access to client notes due to client confidentiality and therefore could not identify clients who had specific issues or experiences. As the data collection progressed, the researcher became aware that the participants were all white and in a very narrow age range around their forties. The populations of Eire and the North of England are predominantly white⁵ and this was being reflected in the agency client groups and precluded any additional selection criteria based on ethnicity.

⁵ Office for National Statistics in the UK measured the white population in the north east as 95.2% in the 2011 census (see <http://www.ons.gov.uk/ons/rel/mro/news-release/census-2-1---north-east/census-gives-insights-into-characteristics-of-the-north-east-s-population.html?format=print> accessed 18th February 2014)

Table 3-1 Participant details

Pseudonym	Sex	Age Group	Time since counselling (as recalled by the participant)	Length of interview (hours: minutes: seconds)	Length of review interview (hours: minutes: seconds)
Ailsa	Female	50-59	4 months	1:00:29	
Amanda	Female	30-39	6-8 months	0:59:04	0:22:04
Andrew	Male	40-49	5 months	0:46:30	
Elizabeth	Female	40-49	5 months	0:48:41	
Fiona	Female	50-59	4 months	1:13:54	
Hugh	Male	60-69	5 months	1:01:49	
Jackie	Female	40-49	9 months	1:05:30	1:01:32
James	Male	40-49	3 months	1:12:03	
Jenny	Female	60-69	6 months	1:05:12	
Karen	Female	30-39	6 months	1:01:24	
Lucy	Female	40-49	6 months	1:03:39	1:13:39
Mark	Male	40-49	12 months	1:11:19	0:53:55
Mary	Female	40-49	12 months	0:45:54	
Matthew	Male	40-49	17 months	1:08:31	1:06:51
Natalie	Female	30-39	5 months	1:06:56	
Paula	Female	50-59	4 months	0:57:42	0:28:26
Peter	Male	30-39	8 months	0:59:54	
Ruth	Female	40-49	3 months	1:02:55	
Samantha	Female	30-39	4 months	0:57:35	
Veronica	Female	50-59	5 months	1:00:40	

The narrow age range was, however, potentially problematic as the counselling may have been influenced by age-related life issues. The researcher requested that if the agencies had a number of clients they could approach, finding participants who

The Central Statistics Office for Eire measured the white population in Eire as 90.6% in the 2011 census (see <http://www.cso.ie> accessed 18th February 2014)

were younger than 35 and older than 55 would be helpful, as it was possible that what was required in counselling at a younger or older age may be different. Despite several attempts to recruit clients under the age of thirty (and three arranged interviews) no-one in this age-range participated in the research. Agencies confirmed verbally, however, that most of their clients were over the age of thirty and therefore the profile was representative.

3.4.3 Participant demographics

Although the selection of participants was not under the direct control of the researcher, the resultant demographics described below in Table 3-2 suggest that a wide cross-section of the population accessing DV services has been interviewed. Having such a wide variety of previous life experiences present in the research provides some confidence that what has emerged from the research is a reasonable presentation of what this client group find helpful. A more detailed review of each of these demographic categories is given below.

Table 3-2 Demographics of the participants

	Female	Male
Number of participants	14	6
Age Range (average)	33-64 (45)	33-64 (45)
Number of participants who were employed/self-employed	11	3
Number of participants in a relationship	6	2
Highest level of educational qualification	Post-graduate degree	Honours degree
Number of participants who had previously attended counselling elsewhere	11	4

3.4.3.1 Age range

The average age of the participants for both men and women was 45 years old and their ages ranged from 33 to 64. The women's ages were evenly split between their thirties, forties and fifties, but the men were predominantly in their forties. Although this is similar to some DV research for women (Walker, 2009b) where the age range was 18-69 (average 42.5) many other studies conducted with women indicated

average ages of participants in their thirties (Henning and Klesges, 2002; Stenius and Veysey, 2005; Hage, 2006; Moe, 2007; Allen and Wozniak, 2011). However, this was different for the men. Here the participants were only slightly older than in other research with males (Carrado *et al.*, 1996; Coker *et al.*, 2002; Hines and Douglas, 2010).

3.4.3.2 Employment

Eleven of the fourteen women were in employment, compared to three of the six men. One of the participants was registered as disabled. Many of the women had opted for a traditionally female career choice, such as working as a carer or teacher or more generally within the public sector, but it is worth noting that two were self-employed, a higher proportion than normal within the UK (Institute for Small Business and Entrepreneurship, 2014). It is hard to compare these data with other studies involving women, as the employment status of the participants is rarely presented. This may be due to many studies being conducted within a refuge environment where the individual may have had to leave employment when they left home. However, as a generally older group of women, with fewer childcare responsibilities, it is reasonable that there would be a higher percentage of the participants in employment than in studies where employment figures are given, for example Allen and Wozniak (2011).

The men had generally opted for traditionally male careers such as engineering and technology, which was in line with other studies of men who had experienced DV (Hines *et al.*, 2007). The men chose to disclose that at the time of their relationship break-down, they all worked full-time: three were employed and three self-employed. However, at the time of the research interview, only three of the men were still in full-time employment.

3.4.3.3 Relationship status

This question was not specifically asked, but data was supplied during the interview. Six of the fourteen women were in a relationship, three of whom had significantly improved the relationship with their abusive partner following counselling and three of whom were in new relationships. Two of the six men were in new relationships following the break-up of their marriages. Nineteen of the participants were heterosexual. One of the participants had been abused by a child, nineteen by a life-partner.

3.4.3.4 Education

The women had had a variety of educational experiences, ranging from leaving school at 15 to attaining post-graduate qualifications. Just over half of the participants had achieved GCSE or A level equivalent qualifications, or further education qualifications; four had achieved higher education qualifications; and the rest had left school without qualifications. This broadly matched other research conducted in the field (Hage, 2006; Allen and Wozniak, 2011) but is at a higher level than some (Walker, 2009b). Similarly the men's educational attainment ranged from leaving school at 15 to attaining higher education qualifications, and was in keeping with other published research (Douglas and Hines, 2011).

3.4.3.5 Past and present counselling experience

The women had spent between two months and 21 months in 1-to-1 counselling. Nearly 80% of the women had accessed some counselling before. Only one reported having a single, very positive counselling experience previously which had resolved their issues, but this was for an issue unrelated to DV.

The men also reported counselling ranging from 2 months to 21 months. Two thirds of the men had accessed counselling before, with two reporting unsatisfactory experiences and two reporting a referral process to the agency once the issues presented became clearer. It is important to note that the men included telephone and one-to-one support, as well as group counselling in their assessment of counselling and this cannot be directly compared with the level of support provided to female participants over the same time period. This is discussed in more detail in Chapter 5.

It would be wrong to draw generalised conclusions about counselling from such a small sample, however, the number of reported unsatisfactory counselling experiences is notable.

3.5 Data collection

3.5.1 Methods

Face to face interviews were selected as the preferred means of data collection both for ethical and research design considerations. Interviews were relatively easy to set up, were appropriate for participants who had undergone counselling to engage with, and provided some flexibility for exploration as different concepts arose. A semi-structured research interview fitted best with achieving the research objectives of allowing deep exploration whilst answering the research question

(Creswell, 2007). Literature describing how to conduct semi-structured interviews to best advantage (Wengraf, 2001; Kvale and Brinkmann, 2009) overlapped with the researcher's counselling training, giving some confidence that data quality could be delivered with this approach.

Data collection could also have included observation, interview, documents or audio-visual materials (Creswell, 2007). Observation and audio-visual recordings were considered to be inappropriate, as this study focused on reviewing counselling experiences rather than exploring the current moment. The lack of available documents associated with counselling precluded this as a data source. Written questionnaires were briefly considered but discounted, as the researcher's previous experience of market research and some of her counselling clients' reluctance to engage with writing tasks suggested that not all respondents would have the written skills or interests required for this approach (Charmaz, 2006).

3.5.2 Developing interview questions

Three specific areas of inquiry were developed to answer the research question. These were: to hear what clients felt worked well or could have been better ; to hear the clients' views of outcomes, what they got from counselling and where they started from; and to determine what clients felt was effective in the counselling process. A number of potential interview questions were developed from these topics. These questions were then ordered to provide a journey (or narrative) from beginning to ending the counselling process, bringing the participant back to the present day at the end of the interview. Questions related to demographics were included at the beginning, as an introduction. A test interview was conducted with another PhD student on an unrelated topic to check that the interview structure worked prior to beginning the research (Appleton, 1995) and minor modifications were made to the order of the topics. The final script is shown in Appendix B.

The open-ended nature of the questions provided some flexibility for the participant to explore whatever seemed most important to them at the time (Hollway and Jefferson, 2000), and provided scope for prompting should the participant feel there was nothing to say (Wengraf, 2001). The researcher was aware that there was a time delay between finishing the counselling and being interviewed which carried the risk of participants' memories of counselling being changed by external factors (Lincoln and Guba, 1985), for example by discussing their counselling experience with others. However, this risk was reduced by asking participants about their own specific memorable experiences, rather than a general view of the process.

3.5.3 Conducting the interview

Each interview lasted around an hour, plus or minus 15 minutes (see Table 3-1 for details). The whole interview process took about an hour and a half. Options for future involvement in the research process were also outlined to the participants, an important part of the research process (Wengraf, 2001). All of the participants gave permission to be contacted again and to be involved in reviewing the research findings. Although this had been planned as a group activity, the reviews were actually conducted on a 1-to-1 basis as only one participant attended the review on each arranged day. However, this allowed more in-depth discussion for those who preferred to do so and was commented on favourably by the participants. Six review meetings were held involving four women and two men, and were variable in length, depending on the level of the participants' interest in discussing specific aspects (see Table 3-1).

3.6 Data analysis

3.6.1 Philosophical framework

The decision to undertake a qualitative research project excluded a positivist framework (Grbich, 2007), but provided the opportunity to consider a range of others, as highlighted by different authors (Creswell, 2007; Grbich, 2007; Silverman, 2010). With so many different frameworks available, it is perhaps more important, as Silverman says, "to work with a model that makes sense to you." (Silverman, 2010, p109).

Much of the qualitative research into DV has been analysed through a critical emancipatory (Grbich, 2007) or feminist framework (Creswell, 2007) (see section 2.5). The adoption of a feminist position has been recognised as having a positive impact on highlighting the plight of women in abusive heterosexual relationships, but has been less helpful in understanding DV within other sexuality or gender dynamics (Nicolson, 2010). Such a position has also made it difficult to determine issues of power and control in a relationship independent of gender. With so much research in this field being aligned with social change, the researcher felt it was appropriate to consider other frameworks which might be appropriate given the focus on personal change in counselling.

In the context of this study, the relationship in question is between the counsellor and the client, rather than the abuser and the abused, although one may influence the other. Ethical guidelines mean that professional counsellors will strive to create

an environment which allows the client freedom to make their own decisions (British Association for Counselling and Psychotherapy, 2010) reducing as far as possible any power imbalance. It is likely that the therapist will help the client with a variety of issues outside the abusive relationship, whilst also addressing the issues which brought the client into counselling (McLeod, 2003b). A critical emancipatory approach (Grbich, 2007) looks at how identity has been created by culture and circumstances; however the work in counselling may help clients to discover and claim their own identity, whatever their circumstances. This research aimed to explore and understand counselling practice rather than to influence society or government policy. Although it is recognised that results from the research could assist with some of the policy issues highlighted in the literature review, this was not the primary focus of the research. It is also acknowledged that exploring the relationship within the counselling room, as separately constructed between the counsellor and the client, can result in links to environmental, cultural or social factors as appropriate but again this is not the primary focus.

Instead, the researcher considered that a key factor in this study was the interaction between the client and the counsellor and between the client and the researcher. The philosophical frameworks that can describe this interaction between individuals are constructionist and constructivist and each has a different perspective on how knowledge is constructed. In constructivism, new knowledge is considered to be constructed through interacting with the experience and context of the environment (Grbich, 2007; Creswell, 2009). This is something a researcher or therapist may do in working with a participant or client. In constructionism, the focus is on constructing something for others to experience (Silverman, 2010), as a client may do as they try to explain their experiences to the researcher or therapist.

Within this study, the participant may be working from a constructionist position, as they try to describe their story to the researcher. At the same time, the researcher is engaging from a constructivist position, as they try to understand what the participant is saying, gaining new knowledge about the person and their experience. Even as the participant is speaking, the therapist or researcher can play a part in the construction of the story through their responses to the material presented. For example, a negative response from the researcher may result in both the story and the interview being shortened by the client, with key learning missed. However, an invitation to explore may result in new insight for both parties. Although each individual story is unique, for example in the way violence unfolded, elements of

these stories may be common across clients, such as a concern that the client somehow provoked the violence. This new knowledge, which crosses the boundaries between participants, is also indicative of a constructivist approach. Ultimately, as the research interview is conducted from the researcher's perspective, with the aim of new knowledge being created in the context of the author, a constructivist framework was chosen.

3.6.2 Methodology selection

The decision to conduct the research after counselling had finished suggested a qualitative outcome study (Timulak, 2008). Five methodologies were identified as potentially appropriate for this type of study within a constructivist framework: phenomenological, hermeneutic, ethnographic, linguistic (McLeod, 2001; Timulak, 2008) and grounded theory (Dallos and Vetere, 2005). Each methodology provided a different approach and analytical focus, which would influence the research process and results (Creswell, 2007).

3.6.2.1 Ethnographic, phenomenological and hermeneutic methodologies

The earlier decisions of taking a time limited and historic stance to review what had happened within counselling meant that ethnography was inappropriate for this study, as it used mainly observational techniques over a period of time to investigate the currently emerging phenomenon (Creswell, 2007; Silverman, 2010).

Phenomenology initially looked promising as it had often been used for counselling research (McLeod, 2001) in trying to understand or make meaning of client experiences (Langdridge, 2007). The more recent development of interpretative phenomenological analysis (IPA) (Dallos and Vetere, 2005) which described a process of understanding emerging for both the individual and the researcher was also considered (Smith and Osborn, 2003). This can be particularly useful where a detailed and in-depth understanding of an experience can be generated in conjunction with a few individuals (Finlay, 2011). Although the researcher wanted to understand the client experience of counselling, this was from the perspective of identifying notable events occurring within counselling rather than the meaning participants made of those events. In addition, there was sufficient uncertainty from the literature review about the process for DV counselling to make it difficult to define a particular area for in-depth exploration, and it was therefore discounted.

Finally, the focus of hermeneutics on written texts and the need for perspective and interpretation whilst understanding historical and cultural context (McLeod 2001) suggested it would be ineffective as the main methodology. However, the concepts of perspective and interpretation have been linked philosophically with other methodologies (Packer and Addison, 1989; Rennie, 2000), suggesting that whilst it may not be appropriate as the basis for the research project, some of the concepts may be useful at a later date.

3.6.2.2 Linguistics

Three types of linguistic methodologies were considered: conversational, discourse and narrative analysis (McLeod, 2001). The focus of the research on what was significant for the client within counselling, rather than the specific communication and interaction between the participant and researcher (Dallos and Vetere, 2005), suggested that conversational and discourse analysis would be of limited value and were discounted.

Narrative analysis seemed a more promising approach through focussing on the client's story of counselling, pulling together the past, present and future, the impact of feelings on what happened and allowing their personal view to emerge (Dallos and Vetere, 2005). This seemed relevant to the research question of what was significant during counselling, and the description of thematic analysis (Riessman, 2008) provided the potential to look at common story features across participants.

Within the research question, there is an underlying but reasonable assumption that the client would be able to tell the researcher about the experience, by sharing it as a story (Polkinghorne, 1988). Within the story lies the possibility of exploring the inner and outer world of the participant, the past, present and future as they see it, and the story setting (Clandinin and Connelly, 2000). This description put the client experience at the heart of the process, but suggested a process which explored the life experience of the participant, including DV and counselling, rather than exploring counselling within a life that has experienced DV. There have been previous studies about the experiences of DV and life after leaving abusive relationships (Abrahams, 2007; Cook, 2009; Abrahams, 2010) and any narrative would have to be carefully focussed around the counselling itself.

Narrative has been used as a research methodology with survivors of abuse (Etherington, 2000; Etherington and Bridges, 2011) by working in depth with a small number of participants. One of the key steps in this research technique is to take the

participant's interview and then rewrite the narrative into a chronological story (Etherington, 2009). This rewritten narrative is continually shared with the participant for comment until a final version of the story is agreed. This can take some months to achieve, and there are risks with the client losing interest or deciding that they no longer wish their story to be told (Etherington and Bridges, 2011). Given that a previous objective of this study was to minimise the participant's exposure to the counselling material, the need for continual review of the story with the participant meant that this type of approach was inappropriate for this study.

However, narrative could be used as an interview technique as this would build on the process used most often in counselling (Polkinghorne, 1988), creating a more familiar environment for the participant. The interview data could then be analysed using a different methodology. In addition, story construction by the researcher from the narrative could be used independently as a tool to understand the context of the participant better, leading to more robust data interpretation. Narrative techniques could therefore be valuable in collecting and reviewing the data. This left grounded theory as potentially the main analytical methodology for the research study.

3.6.2.3 Grounded theory

Grounded theory was developed to generate theories to help understand human experience (Glaser and Strauss, 1967) and the methodology assumes that participants have fairly stable views about their beliefs (Dallos and Vetere, 2005). This seemed a reasonable assumption, as a period of time would have elapsed between the interviews and counselling, reducing any influence of the counsellor on the research interview. Grounded theory also allowed discussion of the counselling experience and what the participant found important within a single interview. It provided the possibility of generating a theory reflecting that experience. This seemed to fit both the ethical requirements and exploration of the research question well.

However, there would be different audiences for the output from the research. Both academics and practitioners may have an interest and whilst some may value focus on a technically precise emerging theory, others may prefer greater understanding of the impact on the client. Given the depth of interviewing possible with this methodology, particularly in conjunction with narrative techniques, writing for different audiences could be achieved and the participants' voices heard within the context of their experiences of the process. The involvement of different agencies, different therapists and different practice orientations could minimise the likelihood

of effects generated by a particular environment, and in turn could make the findings relevant to a wider audience.

Grounded theory had been successfully applied to research in related fields (Morrow and Smith, 1995; Dale, Allen and Measor, 1998; Bostock *et al.*, 2009) suggesting that it was a credible methodology for this study. In addition, the paper by Morrow and Smith produced a theoretical framework that was both useful and informative about the process for survivors of sexual abuse. Semi-structured interviews, identified earlier as a data collection method, also fitted with the interview approach recommended for grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1998; Charmaz, 2006). This suggested that what was important to DV counselling clients could be described in a clear and structured way.

Although it has been noted that significant theoretical claims using grounded theory require more interviews, attention to data thoroughness and analytical rigour to withstand scrutiny (Charmaz, 2006), any research used to influence and inform opinion, even with a small scale study, must ensure that data collection for the research is of a high standard. This aligns well with the ethical position for counselling research (Bond, 2004), and the research design developed (see section 3.3.1) incorporated ideas for delivering high quality data that have been used in qualitative methodologies for over 20 years (Lincoln and Guba, 1985). Grounded theory was therefore selected in principle as the main methodology for the study.

3.6.3 Defining grounded theory for this study

The methodology for grounded theory was initially published (Glaser and Strauss, 1967) as a tool for sociologists to generate sociological theory from data. It was presented as a way of systematically comparing data to produce a theory. The concept of a theory emerging from data was a significant step forward at that time, as data was normally used by positivist researchers to verify a previously determined theory (Charmaz, 2006). Many researchers have since used and developed grounded theory fitting with the authors' stated aim "to stimulate other theorists to codify and publish their *own* methods for generating theory" (Glaser and Strauss, 1967, p8). This in turn led to lengthy debate about how the methodology can be used (Charmaz, 2006), with some disagreement from one of the originators about what can now constitute grounded theory (Glaser, 2012).

Although Glaser and Strauss (1967) wanted to encourage the development of grounded theory rather than consider it as a rigid methodology, they have

subsequently disagreed publicly about the way to approach grounded theory. Each has tried to clarify the original text according to their own philosophical position (Kelle, 2007). Whilst there were many areas of overlap between the authors, there were also areas of difference. Hence, in considering the use of grounded theory, it is important to understand how the methodology can be applied to this study.

Three commonly cited descriptions of grounded theory have been compared to establish differences and issues which were pertinent to this study. These issues include: the timing of the literature review; coding and analysis; client selection; and the position of the researcher in the study. These are described below and acknowledge the first (Glaser and Strauss, 1967), second (Strauss and Corbin, 1998) and third (Charmaz, 2006) versions of grounded theory to reach the final research position.

3.6.3.1 Timing of the literature review

The methodology for grounded theory places a different emphasis on conducting a literature review compared with other more traditional qualitative methods.

Grounded theory purists, such as Glaser, are concerned that a comprehensive literature review prior to beginning the research will affect the researcher's impartiality in data analysis (Glaser and Holton, 2007). However, it is difficult to know whether the research is likely to produce new findings if the researcher does not know what has already been discovered (Charmaz, 2006). Charmaz (2006) goes on to suggest that there is a balance to be struck between having an informed grasp of the literature to meet the needs of academic examination boards, whilst not using the literature review to force pre-conceived ideas onto the data. One of the motivations for this researcher was recognising as a practitioner that the process for DV counselling was unclear. An initial literature review was conducted to determine what was currently known, resulting in the identification of a research gap. As the research progressed and final models emerged, a further, more extensive literature review was carried out to include areas of interest which had emerged from the data. This allowed a focused exploration of specific or unexpected concepts discovered through the process and enabled judgements to be made about the uniqueness and relevance of the findings.

3.6.3.2 Coding and analysis

When grounded theory was first introduced (Glaser and Strauss, 1967), it encouraged the emergence of conceptual categories, described by properties, from the data. As more data was collected, more categories were produced and

compared with the previous data, generating hypotheses. Substantive theories were based on hypotheses linking across a range of data sets, and could then be placed within existing theories and literature. This process of starting with the data enabled the researcher to look at the data, theoretically unencumbered by previous knowledge or constructs, thereby increasing the possibility of detecting new theories. Whilst the methodology presented opportunities for insight and creativity, it also lacked a definite structure for analysis which some researchers felt was required (Strauss and Corbin, 1998).

The response to this criticism was to create a much more systematic process that could be followed carefully by researchers (Strauss and Corbin, 1998). In doing so, Strauss and Corbin created new terms specifically for grounded theory: open coding, axial coding and selective coding. This ensured that the data was methodically analysed and that specific aspects were not skipped over or forgotten about. Whilst this provided the analytical structure missing from the first publication (Glaser and Strauss, 1967), it also risked the researcher forcing data into a particular structure, losing the fluidity and creativity of before (Charmaz, 2006). In addition, there was the risk of being overwhelmed by the volume of data created by the intense fragmentation of lengthy and detailed interviews.

This issue of flexible versus rigid approaches was addressed by attempting to pull together the best parts of both (Charmaz, 2006). Charmaz defined initial coding, focussed coding and theoretical coding, which looked very like the model initially proposed by Glaser and Strauss (1967). However, she also mentioned Strauss and Corbin's (1998) axial coding as potentially useful if it fitted with the researcher's approach to data analysis.

At a conceptual level, the three writers concur on a systematic process of pulling concepts from the data, which can then be reassembled across the data source(s) to form a theory. By applying rigour, bracketing preconceived ideas and looking beyond the words to potential meanings, perspectives and contexts, each will deliver a successful grounded theory project. In the case of this study, the researcher decided to use the original description of the grounded theory (Glaser and Strauss, 1967) methodology. This offered the greatest opportunity for conceptual thinking, whilst still maintaining a cohesive, analytical structure.

3.6.3.3 Client selection

Another factor specific to grounded theory is the selection of clients for the research. In this case, all three authors (Glaser and Strauss, 1967; Strauss and Corbin, 1998; Charmaz, 2006) are in agreement about best practice where there are no constraints. Within grounded theory methodology, client interviews generate data, which allows the development of an emergent theory. This theory is then tested through the theoretical sampling of clients with identified characteristics or experiences. The process assumes that the researcher will be able to define the next client to interview, depending on what aspect of the emerging model is to be explored. This is quite different to selection methods generally adopted for qualitative methodology, where the criteria for inclusion are defined in advance and aim to achieve a representative sample of the researched population (McLeod, 2003a).

However, it is not always easy to find a specific research participant with particular experiences, and as noted in section 3.4.2.3, client confidentiality precluded this as an approach. In recognising this may be a common research experience, each of the authors suggested an alternative approach: that of using the experiences that emerged during the research interview of the participants who could be recruited. In this way, theoretical areas or emerging concepts could be explored where a participant presents relevant experiences during the interview, although it would not guarantee that all the emerging concepts could be explored. This is an important point for this research, as the combination of a vulnerable client group and the deeply sensitive and personal nature of counselling did restrict the number of clients who were prepared to be interviewed.

Ultimately, the research was conducted with participants who were available and willing to participate. Twenty interviews were held in total, including fourteen women and six men, which was considered sufficient to meet the needs of a small-scale grounded theory study (Charmaz, 2006). As it was impossible to know what experiences each participant would bring to the research, a standard list of questions (shown in appendix B) was used to encourage discussion. During the interview, incidents particularly relevant to aspects of the emerging model were explored as they arose.

An example of this was in the apparent self-selection of participants who volunteered to help with the research. Almost all had a good experience of counselling at the agency, and therefore wanted to show their support. In grounded

theory, it is also important to find the negative impact of something not being there, to support the emerging theory (Strauss and Corbin, 1998) and more generally in qualitative research to improve the credibility of the data (Lincoln and Guba, 1985). As the research progressed, this became problematic as it was difficult to assess what did not work. This was resolved by asking participants if they would also be prepared to explore their previous, earlier counselling experiences where this came up in interview. This provided the opportunity to compare and contrast what happened in each setting, providing valuable data for the research. Whilst it could be argued that the counselling services discussed were different and the experience was not like for like, the participant narratives supported what was seen as good practice, and also provided evidence of what was experienced as poorer practice.

Although using participant experiences as they emerged during the interview, rather than pre-selecting clients on the basis of experience, could be seen as a weakness for this methodology, difficulties with client selection are likely to occur with any research in this area of work. In addition, the selection by the researcher of particular issues to explore needed to be driven by the emerging model outside the interview rather than researcher response during it.

An additional area for the researcher to consider was balancing the focus on exploring aspects of the emerging theory with hearing the participant's story. During the interview process, it was important to be aware of the ways that the participants were responding to a particular exploration (Silverman, 2010). On occasion, a participant would take a completely different path to the one envisaged when a question was asked, often revealing more than the original question intended and providing valuable data in other areas. The researcher considered it important to stay with the participant's process, and whilst being mindful of the research agenda, tried to be flexible in allowing other issues to emerge.

3.6.3.4 The position of the researcher

Glaser and Strauss (1967) initially suggested that the researcher is wholly objective in the research process, as they considered that the emerging theory was there to be discovered by whoever did the research. Strauss and Corbin (1998) later revised that opinion to acknowledge the possibility of the researcher becoming too close to and involved with the data, which could result in interpretative bias and hence reduce the credibility of the data (Lincoln and Guba, 1985). However, Charmaz (2006), in alignment with her constructivist position, believed that the theory only emerged in the context of the researcher, indicating a need for researcher

reflexivity. This is something Glaser (2002) has consistently disputed, believing that the researcher's reaction is simply a variable to be assessed with others. His noted exception was for a very small sub-category of grounded theory studies which involved a very close and intense researcher experience bordering on therapeutic. Here he suggested that Charmaz' constructivist position may have merit (Glaser, 2002). Since then Glaser's earlier paper, suggesting that Charmaz' constructivist grounded theory is not grounded theory as he created it but a form of qualitative data analysis, has been republished suggesting that this is still his view (Glaser, 2012).

In the context of this study, as the research progressed, the researcher found that there were two distinct paths of enquiry and analysis being created. The first was in the production of a model of counselling that could be seen to accurately represent the experiences of the participants and therefore supported Glaser and Strauss' (1967) position of a theory waiting to be found. However, the researcher was aware that she had made choices during the research process about which topics to explore with participants in more depth, and therefore the resultant model may only be part of a theory. Secondly, she was aware that the interpretation of the model in relation to counselling practice was subject to her interpretation of the literature, aligning with Charmaz' (2006) view that research exists in the context of the researcher.

Thus, for this study the philosophical debate about whether the emerging theory exists and is discovered whoever the researcher is, or is discovered only in the context of the researcher is resolved. The argument is dependent not only on the methodology selected, but also on the additional analytical processes undertaken by the researcher. As such, both aspects can be seen to co-exist within this research, supporting the need for researcher reflexivity for this study. With Charmaz', Glaser's and Strauss' views all present within this methodology it can be considered to be grounded theory. However, the use of researcher reflexivity and the sensitivity of Glaser to this, suggests he may not endorse its description as grounded theory.

3.6.3.5 Conclusion

Grounded theory (Glaser and Strauss, 1967) offered a methodology that could deliver both a counselling process and a client view. The grounded theory approach outlined above has adapted concepts from a number of grounded theory scholars to reflect the needs of the study, participants and researcher. Although Glaser,

Strauss, Corbin and Charmaz all consider their approaches to reflect grounded theory methodology, there are differences of opinion. Glaser (2012) in particular has strong views about what constitutes grounded theory, and believes that Charmaz' (2006) version, particularly in her approach to researcher reflexivity, does not. As the methodology in this study does include aspects from both authors, the researcher has chosen to describe the analytical model as adapted grounded theory, to avoid confusion with the original version (Glaser and Strauss, 1967) and constructivist grounded theory (Charmaz, 2006), which are both quoted extensively in the literature.

3.6.4 Data analysis

The data from each participant was analysed using the same process to ensure consistency. Following the interview with the participant, a verbatim transcript was completed by the researcher. Each transcript was coded and analysed separately. Although the researcher had intended to use NVivo as a tool for analysis, the recorded interview files were too large for the new version of the program available at the university. As a result, much of the programme functionality was lost. Further problems emerged relating to data transfer and system integrity which led to a decision to analyse the data by hand.

The coding from each transcript, which mostly used the words of the transcript rather than the researcher's interpretation, was analysed using a mind-mapping technique (Rennie, 2000). This allowed clusters of words and phrases to be put together visually into larger categories (see Figure 3-1, page 104, as an example). These categories were then written up in a text document which included coding from the transcript in support of each category to ensure the context was retained. Presenting the data in this way showed how each interview had a different emphasis. As more interviews were added, specific aspects emerged across the interviews. However, it also showed that different aspects of the model could develop after each interview. This highlighted the importance of an end point based on consistency across categories over several interviews (Glaser and Strauss, 1967).

3.6.5 Building researcher confidence in the data

During the research process, the initial data from four female participants from two agencies was fully analysed. This provided an opportunity to test out the research design and methodology, as well as to make a preliminary assessment of emerging aspects of the counselling process. The participants had worked with counsellors of

different therapeutic orientation and came from a range of educational and economic backgrounds. This preliminary analysis encompassed wide variation in terms of counselling practice and counselling clients and generated a basic model, which was written up and described as a pilot study (Roddy, 2013a). This provided the researcher with confidence to continue with the study as planned, and the subsequent model for female counselling included and built upon this initial data.

The same process was undertaken with the first three male participants. Here, however, the agency provided only limited amounts of counselling and so they arranged interviews with clients who confirmed by telephone that they had received counselling, whether at the agency or elsewhere. During the interviews with the participants, it became apparent that what they had described as counselling was either support work or group work. This was subsequently confirmed by agency staff. Nevertheless, the interviews provided valuable information about the issues that the men felt needed to be addressed, as well as other counselling experiences which had not been helpful.

Consideration was given to looking for alternative male participants who had experienced 1-to-1 counselling to replicate the female process and provide an opportunity for direct comparison. However, the predominant method of support for men suffering DV in the UK is via support help-lines and the internet, with only limited access to counselling. Hence the experiences of the male participants may not be directly comparable with the female participants, but may be indicative of the position of men in the UK. Instead, the researcher went back to the agency with a clearer specification for the parameters for research participants for the next phase of the work, to include one participant who had had only counselling.

This additional step of stopping the data collection early in the process to complete a full data analysis to check for issues or limitations in the research process was helpful to the researcher. It provided both direction for further data collection as required by the grounded theory methodology, and confidence to adjust or re-enforce the selection criteria of the participants.

3.6.6 Developing theories from the larger data-set

As more interviews were completed and the analysis continued, more categories were added and themes across the data-set emerged. A mind-map from the collected data was produced. Each set of participant data was added to the mind map using a different colour, as shown in Figure 3-1 (overleaf). This showed

clusters of data clearly and also indicated whether particular factors had been especially relevant to one individual or to a large group of participants. This colour-coding was particularly useful in identifying common experiences across the group quickly and easily, and highlighted the need for coding to include source as well as content.

From these data clusters, a number of steps in the counselling process were determined which were common to the participants. These steps are presented in the findings chapters for both male and female participants and include hierarchical diagrams to show how each one is constructed. A more detailed description of data presentation can be found later in section 3.6.7.



Figure 3-1 Example of the mind-mapping technique used to analyse data

Initially the planned analysis for each interview was expected to cover the beginning, middle and end of counselling, in keeping with the recognised counselling process (McLeod, 2003b). However, this changed after the first interview when categories related to before and after counselling emerged, as well as an unexpected emphasis on beginning counselling that required further

development. Analysing transcripts during the research process provided information about emergent categories which was useful in choosing particular areas to explore during the next interview. The pictorial representation in Figure 3-1 was useful in generating the counselling steps pertinent to all of the participants. In principle, this appeared to represent theoretical saturation, a term used in grounded theory to indicate that the emergent categories are no longer changing with the introduction of additional data (Charmaz, 2006). Although this acknowledged the variety of the experiences contributed, the researcher became aware that there were issues discussed in the female interviews that did not appear in the final analysis. To try to understand how this had occurred and to determine whether these were real issues that had been missed or simply ideas that had resonated with the researcher, a diagram using the developed model (similar to Figure 4-1) was assembled. Each participant's journey was mapped onto the model.

This highlighted that the initial analysis was incomplete. Some aspects of the interviews had not appeared consistently in the analysis, as the participants had described them in different ways, using different words. Either the factors had been lost in the coding process, or the issues had been coded but only for a few of the participants, which meant they did not appear as part of the larger model. These aspects included 'doubts during the counselling process'; the 'impact of revisiting trauma on their lives'; and 'their felt sense of their counsellor'. This shows one of the limitations of grounded theory. As the coding process drives the construction of the final model, too strong a focus on common features may result in missing important nuances that may impact on the findings. Being able to stand back from the model and consider whether it fully represented the experiences the researcher had heard, as well as checking whether the data sources were correct, was an important aspect of the work.

A further review of the data was conducted based on the emotive content of interviews and the context, including not only the words but the emotion behind the words when considering the coding. This allowed identification of further underlying issues and benefits associated with the counselling process, which could be related to counselling theory and would ultimately form part of the discussion of the research. These concepts were not checked with participants, however, as the findings clearly related to the researcher's interpretation of the data.

Finally, the transcripts were reordered alphabetically by pseudonym and re-analysed, as the researcher believed that if the theory were robust, it would show similar findings from the data irrespective of the start point. Although the model developed in a different way, the final categories remained unchanged. This provided final confirmation of the key points from the research.

Initially it had been hoped to combine the data from the male and female interviews, but there were too few men who had received professional counselling to make this possible. Instead, models of male and female experiences were generated and are presented and discussed separately in the following chapters. Whilst the model of female experience appeared to achieve theoretical saturation (Charmaz, 2006), there were too few male participants to achieve the same level of confidence. However, it could provide a base for additional research in this area.

3.6.7 Presenting the research data

Just as there are differing views about the methodology associated with grounded theory, so there are differing views about how the emergent findings should be presented. On the one hand, it is suggested that the theory should be presented simply as discovered (Glaser and Strauss, 1967); on the other, that it is more important to focus on what is new and original in the findings rather than what was already well known (Charmaz, 2006). Nevertheless, it is important that the findings are presented clearly in terms of both the emergent theory and the originality of any findings.

Discussions with academics and researchers suggested that it is also of value to know which of the aspects of the model were most endorsed by participants and to what degree, and which the least. However, this level of detail does not appear very often in grounded theory research. Most researchers appear to identify the key categories with supporting data (Morrow and Smith, 1995; Wuest *et al.*, 2002; Bostock *et al.*, 2009; Humphreys, Thiara and Skamballis, 2011; Reisenhofer and Seibold, 2012), whilst a few, such as Levitt *et al.* (2006), have provided greater clarity through numerical representation.

Although numerical representation may seem an appropriate step to provide more detail, the researcher believes that this would imply a degree of accuracy which is not present. As the interviews were semi-structured and the questions open-ended, a participant may have experienced or recognised a particular aspect of counselling, but did not feel it was relevant or did not wish to mention it at that time. For

example, on seeing that others had indicated a suicide attempt when reviewing the emergent model, a participant may note that this had also been their experience, although it had not been disclosed in the original interview. In addition, the nature of grounded theory and a limited interview time means that more detailed exploration in one area could result in less exploration in another, which impacts on data collection. Finally, there was a degree of interpretation required by the researcher during coding. These sources of error mean that a numerical value could be misleading, as it may not be an accurate representation of the number of participants with that experience.

In balancing the need to present useful information without inferring accuracy, the concept of data ranges has been introduced as shown below in Table 3-3. This allows the data to be presented diagrammatically, with the use of text style to indicate the categories most and least often mentioned by participants. Female data appears in bold, normal or italic text as per the boundaries given in Table 3-3. Anything that was mentioned by fewer than three of the female participants was considered to be helpful and supportive to the overall component but insufficient in itself to be highlighted within these findings.

Table 3-3 Description of the textual representation of research data

Description of data range in text	Number of female participants	Text format on figure	Description of data range in text	Number of male participants	Text format on figure
"Most participants"	11-14	Bold text			
"More than half of the participants"	7-10	Normal	"More than half of the participants"	4-6 (steps 1 and 4) 3-5 (steps 2 and 3)	Bold
"Fewer than half of the participants"	3-6	Italics	"Fewer than half of the participants"	1-3 (steps 1 and 4) 1-2 (steps 2 and 3)	Normal

Given that there were fewer participants in the male study, different boundaries were drawn. Those factors mentioned by more than half of the participants are represented in bold, whereas for less than half of the participants, normal text is used, as shown in Table 3-3. This represents an approximation of the research findings that matches the data collection method whilst also affording the reader a sense of which components appeared most often within this data analysis.

The emerging theories had data contributed by all of the participants from a number of factors which had been mentioned by participants. Each of those factors was important in not only developing that part of the emerging theory but also in providing some context to the experience. The emerging theories as presented in this thesis are supported by quotations from the participants.

The quotations were taken from participant interviews, which were transcribed word for word from the recording and included the natural rhythm of speech, including for example sounds made or repetition of words and phrases. Whilst this worked well in the transcription, it did not translate well into a written thesis. These speech patterns have been removed from the quotations to allow the words to flow more easily as text. In addition, some participants added additional clarifying pieces of information to provide context to their statement, some of which contained personal and identifiable information, and some of which was relevant to their story but not to the particular point made in the context of that particular aspect of the counselling process. These extra pieces of information have also been removed from the quotation and replaced by [...]. However, where this information was required for the context of the sentence, this has been replaced with a generic word. For example, a word like "Fred" in the transcript might be replaced by [friend]. Although some of the grammar and colloquialisms are not Standard English, these have been left as stated by the participant.

Finally, the researcher was aware that some participants were more specific and concise than others. However, it felt important to give each participant a voice in the research and so the selection of quotations has been a balance of presenting the best supporting data whilst ensuring equal contributions from the participants.

3.6.8 Outline of research process and timings

The steps included in developing the study and collecting and analysing data reflected a grounded theory process and are shown overleaf in Table 3-4.

Table 3-4 Timings and description of the research process

<u>Research process timing</u>	<u>Activities undertaken</u>
Pre-PhD	Literature review and initial research proposal
Quarter 4, 2010	Preparation of submission to ethics committee
Quarter 1, 2011	Pilot study interviews and analysis for female participants
Quarter 2, 2011	Review of emerging model with female participants
Quarter 3, 2011	Further interviews and data analysis with female participants
Quarter 4, 2011	Interviews with male participants
Quarter 1, 2012	Review of female model with participants. Final female interviews
Quarter 2, 2012	Review of emerging male model with participants. Final male interviews
Quarter 3, 2012	Final female data analysis
Quarter 4, 2012	Final male data analysis
Quarter 1, 2013	Begin thesis write-up/significant literature review
Quarter 2, 2013	Literature review extended
Quarter 4, 2013	First full thesis draft completed

3.7 Conclusions

The project's qualitative research design is based on 1-to-1 interviews with previous counselling clients sourced through DV agencies. The trustworthiness of the data has been addressed by confirming emerging models with participants, transcript analysis review by supervisors and presentations to DV and counselling conferences to test the credibility of the findings. The consistency of the researcher was a key factor, and was addressed through reflexivity, supervision, extensive analysis and transparency in presentation. Participants in the research were demographically similar to other research studies on DV, with the exception of age, where the average age of the female participants was higher (see section 3.4.3.1). Hence, the participants are representative of this client group. This combination of factors provides a robust, qualitative research design.

4 Findings from Female Participants

4.1 Introduction

A model of the counselling process has been developed. This is presented as a broad framework underpinned by detailed findings, and includes aspects of the client process both before and after the period of counselling. Although the study set out to investigate the therapeutic counselling process and how it could be improved for this client group, participants also highlighted the value and importance of other factors to them. Many participants also provided the context of what had happened in their lives and why particular aspects of therapy were significant for them, providing both depth and quality of information. This resulted in the extended framework for the study shown.

In general, the participants were keen to share as much as they could about their experience of counselling and why it was important to them. The exception to this was their responses to questions later in the interview. These asked specifically about their understanding of the terms 'outcomes' in counselling and counselling 'effectiveness' and consistently caused a pause in an otherwise relatively relaxed and fluid interview. However, questions following on about what they found effective and which outcomes could be measured brought further rich data about what had been important within the counselling, and how differently they felt now. As a result, the findings do not contain any definitions of outcomes or effectiveness although the questions were asked. The model described in this chapter represents the participants' view of DV counselling, not just the counselling received, but the paths taken before and after counselling too.

The framework (shown in Figure 4-1 overleaf) provides an overview of the counselling process made up of eight separate Steps. This shows progress from the participant recognising the need for help prior to starting counselling, through to their experience of life after counselling had ended. However, the process was not simply about moving through each Step. There were also phases of work, described as Stages, which are also shown in Figure 4-1. In keeping with general counselling models which define a beginning, middle and end of counselling (McLeod, 2003b) this model also contains three distinct stages: Stage 1 (red) represents decisions about beginning and then continuing counselling, Stage 2 (blue) is working more

deeply with significant issues and Stage 3 (green) is leaving counselling and getting on with life.

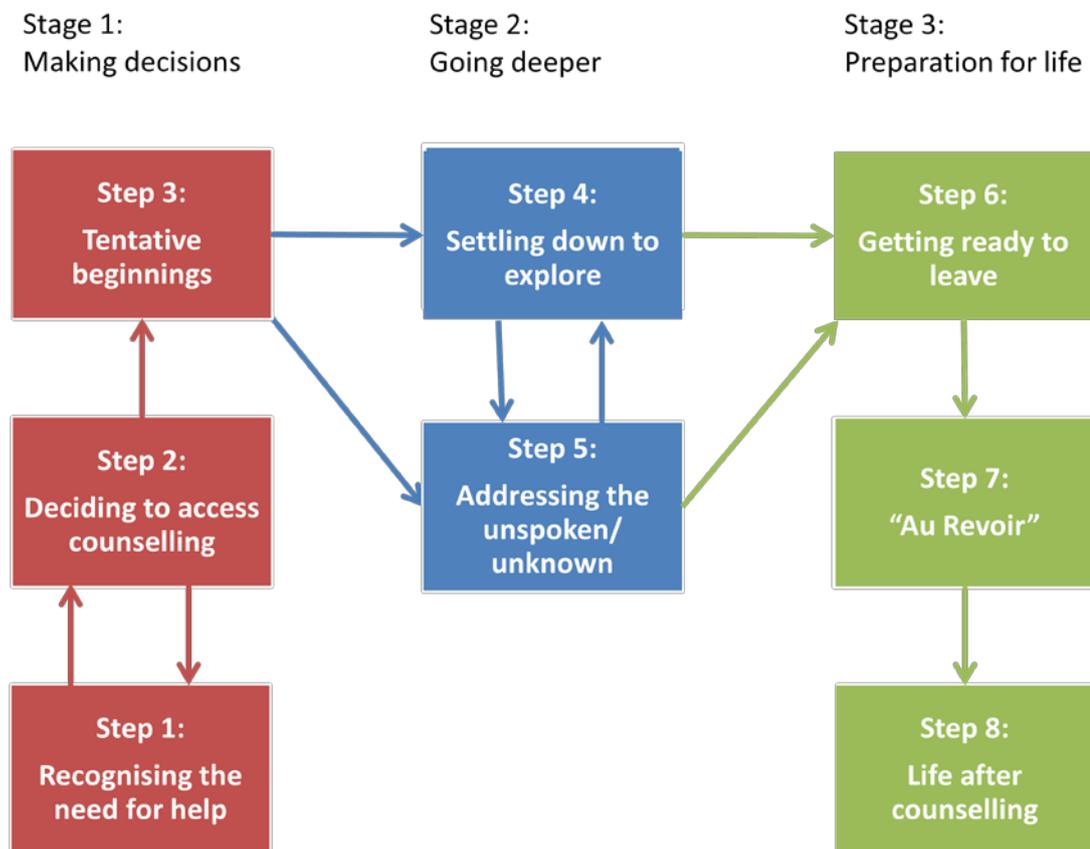


Figure 4-1: The female model

Stage 1 has been coloured red for “stop”, as there are aspects which could encourage or discourage the participant from moving on to Stage 2. Recognising the need for help and deciding to access counselling can occur sequentially or in parallel, as recognising the need for help could be prompted through the offer of counselling. However, the third Step, “Tentative beginnings”, indicated that the decision to start counselling had been taken, but whether to continue was still being reviewed.

Those who were able to settle down and continue then moved into Stage 2, coloured blue. Here, the participants felt more settled and wanted to engage with working through what they had brought, beyond the initial disclosure. The scope of the work depended on the number and type of issues, the length of time available

for counselling, and the objectives of the participant. The two processes operating here could be conducted in any order, and could be switched between as part of the work. During this time, counselling was important and continuing seemed a natural part of the process.

As Stage 2 came to an end, the participants felt that they had resolved what they had wanted to address in counselling. They then moved to Stage 3, coloured green, and began to prepare for leaving counselling by building their own confidence that the progress they had made in counselling could be continued independently. This could take several weeks, might occur in one session or might be combined with ending. They were aware that they could go back to counselling if they needed to and that helped them to leave. The participants felt that life had subsequently changed quite a lot for them and yet they were still reflecting on and learning from the work undertaken in counselling.

This chapter presents each Stage in turn, describing the Steps within each in detail. Each Step is constructed from a number of factors which are presented pictorially as a hierarchy, as shown, for example, in Figure 4-2 overleaf. The different textual representations in the hierarchy are as detailed in Table 3-3. The participants described these factors according to their own experiences and these differences in perspective have been highlighted for each factor, as shown for example in Figure 4-3 (section 4.2.1.1, p114). Comments from the participants are included throughout the chapter to provide context and support the analysis. This also provides an opportunity for the participants to tell their story of counselling, beginning at Stage 1, Step 1, when they realised that things could not continue as they were at that time.

4.2 Stage 1: Making decisions about counselling

Stage 1 included three different Steps: recognising the need for help, deciding to access counselling and tentative beginnings, that is, beginning the counselling process and then deciding whether or not it was helpful to them. This showed that decisions about counselling for the participants began well before entering the counselling room. Each Step is described in detail below.

4.2.1 Step 1: Recognising the need for help

In describing what brought them into counselling, the participants highlighted two specific areas: issues which were presenting difficulties for them day to day and recognition that previous life events were continuing to have an impact on them. At this point some were suffering from the impact of past life events, but had yet to remember what had happened. This would emerge later through the counselling process (see section 4.3.2.1).

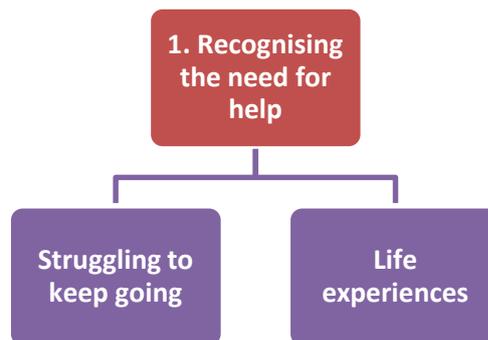


Figure 4-2 Factors contributing to recognising the need for help

These two factors were mentioned by most of the women, and therefore are strong contributors to recognising the need for help, but as neither was fully endorsed by all of the participants, they contributed to Step 1 rather than being distinct and separate. Descriptions of the difficulties which contributed to these factors are shown below.

4.2.1.1 Struggling to keep going

There were three areas associated with the women's struggle to keep going as shown in Figure 4-3 below: the intense emotions they were experiencing; an increased inability to cope with the outside world; and reaching a point where they were no longer sure what to do next. Whilst the phrase 'intense emotion' can be

ascribed to situations as diverse as competitive sport or reality TV, here intense often described the existential struggle between life and death.

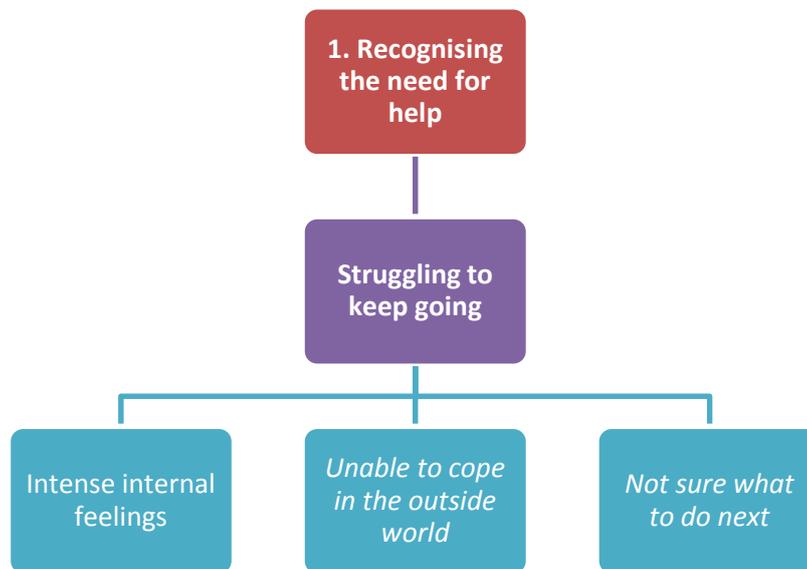


Figure 4-3 Three aspects of how the women struggled to keep going

More than half of the women reported feeling unhappy and/or depressed and slightly fewer had felt suicidal.

Karen: “I was just in bed crying. I was sort of doing what I had to do, but that was all I was doing.”

Paula: “I went to my doctor’s feeling a bit suicidal and she asked me why”

Veronica: “I can’t take it any more, I’ve had enough and that’s how I felt, I’d had enough of life and I thought I don’t want to continue.”

Just under half of the participants reported not coping at home or work and they were aware that they could not continue in this way. It was the realisation that their home life (past or present) was spilling over into their work life that helped them to realise that they needed some support from elsewhere.

Fiona: “I was either angered by people or very nervous about people and I just felt everyone was judging. Because I felt such a mess emotionally, and

physically, and such a low opinion of myself that you know I couldn't function"

Lucy: "I'd reached the stage where I wasn't coping any more and I wasn't coping at work"

In addition, some of the participants expressed a feeling of not being sure what to do next, of having run out of options, hoping that counselling could provide help in some way, but unsure of how it could.

Natalie: "I think I was at that point where I was, I didn't know what to do. Because I thought well everything's, I'll try anything sort of thing"

Samantha: "I suppose I felt in quite a desperate state really. And I wanted to begin to get over everything that had happened"

Many of the women had described themselves as previously being able to cope with life and the realisation that they could no longer do so was significant for them.

4.2.1.2 Life experiences

As well as the most recent abusive relationship, almost all of the women felt that some of their experiences prior to seeking counselling had impacted on their decision to seek help as shown below in Figure 4-4.

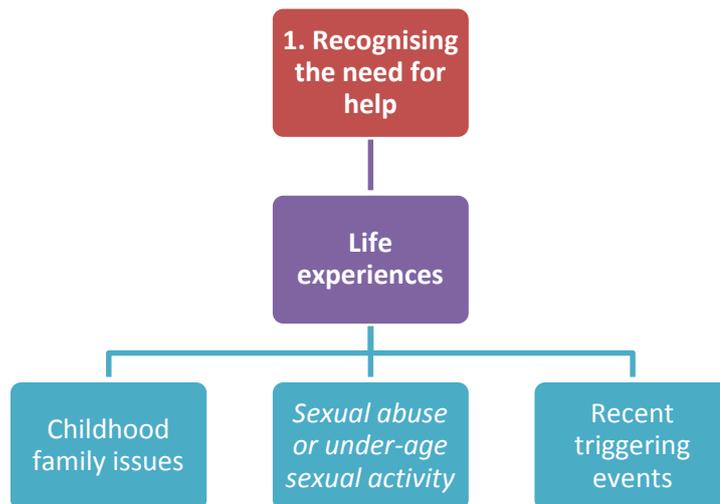


Figure 4-4 Previous experiences making life harder

The three areas that emerged as particularly important were having a difficult relationship with their family (involving over half the women), sexual activity before the age of 16 (described by just under half of the women) and a recent event occurring in their lives which had become a tipping point or trigger for them (reported by over half the women). Whilst not all of the participants were aware that their previous history might have had an impact on their situation at the time they sought counselling, they were aware that their childhood had not been as well supported as it might have been. As a result, they found that it was difficult to ask for support from their families and they noted that the way they had adapted to their family situation had impacted on relationships in other parts of their lives.

Ailsa: “If somebody else is talking then I don’t talk, because I tend to get talked over.”

Mary: “you deal with things the way you deal with things, but when you’ve got family and friends going on at you all the time, just wears you out.”

Veronica: “all my life I’ve been, I didn’t really want to bother people, I used to hide away because I knew that whatever happened, I’d be punished for, I’d take the blame, it was my fault”

As they were often blamed for things, not listened to or valued this, in turn, could create barriers in seeking help outside the family.

Sexual activity under the age of 16 was highlighted by just under half of the participants. The question about sexual activity was not expressly asked and it is not necessarily an experience that would be openly shared with the researcher without enquiry, and therefore it may be under-represented here. However, what was significant was the range of different experiences that were shared: those who had been abused regularly by a family member, those who had been attacked once but left with traumatic memories or those who had embarked on sexual experiences from a very young age without any real understanding.

Jenny: “I got so angry about it, about what he put my parents through, because it was like I said me Mum finding out [...] her daughter’s been raped at 6 years of age”

Jackie: "I did whatever I thought it took to be liked, so I lost my virginity very young"

The women described these experiences as specifically impacting on their adult lives, hence their inclusion as a separate contributor to their difficulties.

Over half the women linked the timing of seeking help with a particular incident in their lives. Something had happened recently which had tipped the balance from coping to not coping, and could be indicative of a traumatic response. However, the events described covered a range of different experiences each being unique to the individual. For example, it might have been the death of a family member, starting a new relationship, or a change at work or home, or in the abuser's behaviour.

Elizabeth: "the loss of someone can trigger other things on, and it made me re-evaluate everything that had happened in me life, and I knew I had to sort it out."

Mary: "his behaviour mimicked what was going on with his Dad [...] and so I brought him here for counselling. [...] and his counsellor basically told me that we can't sort him out until we sort you out"

As this research was conducted after the counselling, it is possible that the participants were not fully aware of the potential harm of their previous experiences as they began therapy. Some of the participants were aware that both their childhood and adulthood experiences were causing them distress although they may not have known why or how. Others had been unaware of their childhood experiences until memories of traumatic incidents had returned during the counselling. Although some of the participants had decided it was the right time to deal with difficult issues, others had suffered overwhelming emotion due to a critical event, which forced the decision upon them. It is important to acknowledge that even for those who considered themselves psychologically aware, the roots of their distress were not necessarily recognised at the beginning. Although these experiences could be regarded as risk factors for DV, they would not necessarily have appeared in any assessment interviews prior to counselling.

The participants spoke at length of the situation they found themselves in prior to seeking counselling. The level of emotional distress expressed was noteworthy, with some participants feeling unable to cope or deal with life and contemplating suicide.

There appeared to be a link between increased feelings of hopelessness and seeking help. The overwhelming nature of triggered emotions may have pointed to post-traumatic symptoms, although this was not specifically addressed in the research interview. There was significant emotional suffering, yet most of the women were not currently in physically abusive relationships and therefore current violence could not be a factor in their distress. As Ailsa, Jackie and Veronica describe above, the impact of their earlier abuse resulted in longer term issues.

4.2.2 Step 2: Deciding to access counselling

Whilst the participants were aware that they were struggling with life, they were often unaware of what could be done to help them. The factors involved in deciding to access counselling are shown in Figure 4-5 below.

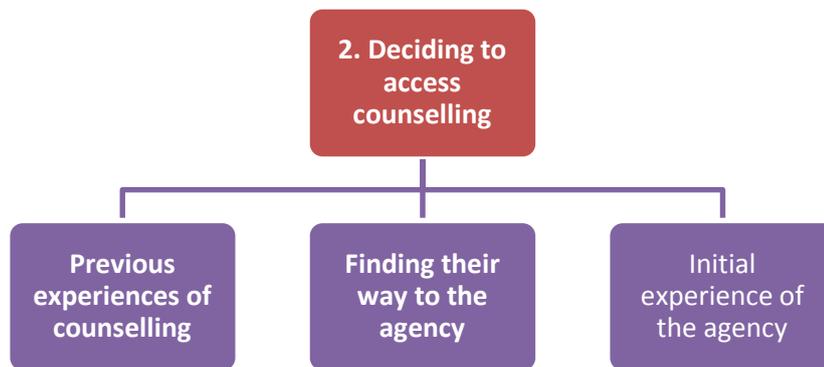


Figure 4-5 Factors involved in the participants' decision to access counselling

A combination of no, mixed or poor previous experiences of counselling meant that this was not necessarily the first option considered. The participants needed some encouragement from a trusted person (a professional or personal contact) or through their own research before they were prepared to contact a specialist counselling service. Their approach to the agency often resulted in a preliminary assessment interview and a positive experience at that stage helped them to take the next step into counselling.

4.2.2.1 Previous experiences of counselling

Initially, the participants were asked about any previous counselling as the researcher wanted to see if that had any impact on how the counselling was

described. However, as the interviews continued, this became an area that was explored in more depth. The participants all had positive experiences of counselling at the interview agency and were keen to share their helpful experience through the research in the hope that other people might be able to access appropriate counselling more quickly, given their own previous experiences. Working with only those experiences meant that there was no opportunity to check the impact of negative experiences on the emerging model. This question became an opportunity to explore some of the theories that were emerging from the study where participants were happy to provide detail from previous counselling they had received about things that had worked or not. This meant that they could share their positive experiences of the agency whilst also providing a rich source of data regarding other counselling. This is shown in Figure 4-6 below.

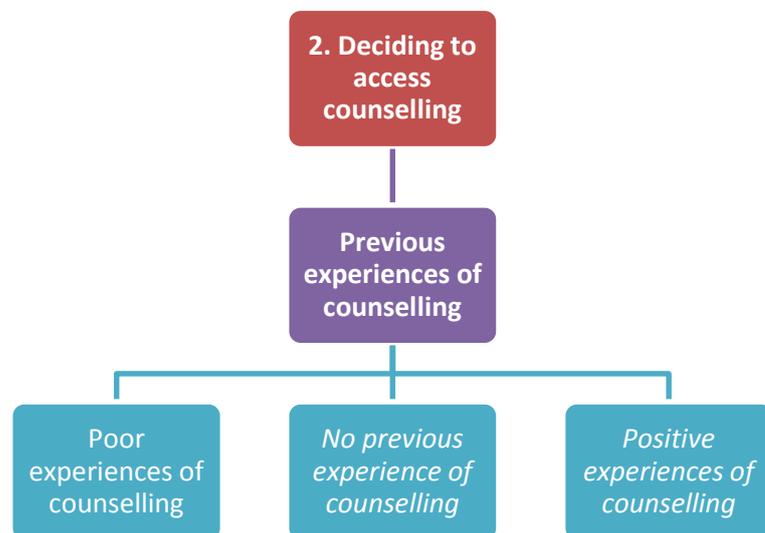


Figure 4-6 Mixed experiences of counselling

Only a very small number of participants (fewer than three) had not accessed any other counselling before coming to the agency. It is hard to give a precise number, as some of the participants who said they had not received counselling then remembered previous unsuccessful counselling experiences during debrief or review sessions. However, their decision not to go to counselling was about keeping things a secret.

Paula: "I'd once told my best friend about 10 years ago and she said 'go to counselling' and I said I couldn't, I didn't want anyone else to know."

Paula's comment here reflects the experience of many women who have been abused. Although her friend may have suggested a counsellor as the best alternative to help her, Paula felt she could not disclose to anyone else and instead chose to continue on her own. However, a sudden event changed this dynamic and seeking help became such a high priority that it overcame her reticence to disclose.

Although the literature review suggested that help-seeking is difficult for those who have experienced DV, as Paula expresses above, most of the participants in this study had accessed some form of counselling before. Given the degree of emotional turmoil they had indicated feeling and the potential for counselling to be helpful with emotional issues it was surprising that over half of the women had reported poor experiences of counselling previously. For some, even for those who had previous positive counselling experiences, the first visit to the counsellor was a difficult experience. Here the participants felt that the environment created by the counsellor was not helpful to disclosure, and led to a decision not to come back for a second session.

Ruth: "the first session I had was completely, phew. It just didn't work you see, I was, it completely didn't work."

Others continued to work with the counsellor for a while in the hope that something might change and for a few there were multiple attempts to engage, feeling at some level that it could help. For each, there was disappointment that both they and the therapist were unable to provide what they needed from counselling.

Veronica: "Where with other counsellors and that, I've never felt that connection, never felt that they were there, as I say, just session, right it's time, go home now, see you after. And coming home and really no different."

Amanda: "The [organisation] counsellor, she was good, that was paid for, but she still didn't get, still didn't get to the root of it. [...] I had a bad experience at a different [organisation] branch, where the counsellor there he just totally didn't know"

These experiences suggested that there was something specific that the participants required from counselling that did not seem to be generally available and yet, despite that, they continued to try.

Finally, two of the participants had had positive experiences relating to counselling for the abuse they had suffered. Where this had occurred, the participant had returned to the same agency for help when other aspects of their previous abuse emerged.

Jackie: "I did come to [agency] before and I had a big chunk of counselling then"

Other positive experiences of counselling were related to issues they had faced earlier in life, prior to the DV. The helpfulness of their previous experiences with a therapist encouraged them to seek counselling help now.

Natalie: "Because, I think, because I'd done it previously and [...] I found it really helpful"

The varied nature of the counselling the participants had previously experienced was unexpected. There was evidence from their recent experience that each of the participants could form a strong working relationship with a therapist and yet some described many previous occasions where that had seemed very difficult to achieve. At this point, it is sufficient to note that previous counselling had been a disappointing experience for most of the participants. It was therefore not something they were necessarily ready to engage with immediately when it was suggested.

4.2.2.2 Finding their way to the agency

One of the questions asked specifically during the interview was how they had found their way to the agency and all of the participants contributed to this. Over half of the women followed a recommendation from a professional, whilst a few had had recommendations from friends or colleagues or had used their own resources. This is shown in Figure 4-7 overleaf.

The most common way of accessing the agency was through taking the advice of professionals that the women had contacted as a result of legal or health issues. Over half the women found their counselling in this way.

Jenny: "My doctor said you know, I'd, I told him what I've told you about counselling when he mentioned it to

me, he said 'There is good counselling out there' and he said 'Leave it with me and they'll get in touch with you'."

Mary: "I'd called into a refuge when my little boy was [younger] and they'd given my information"

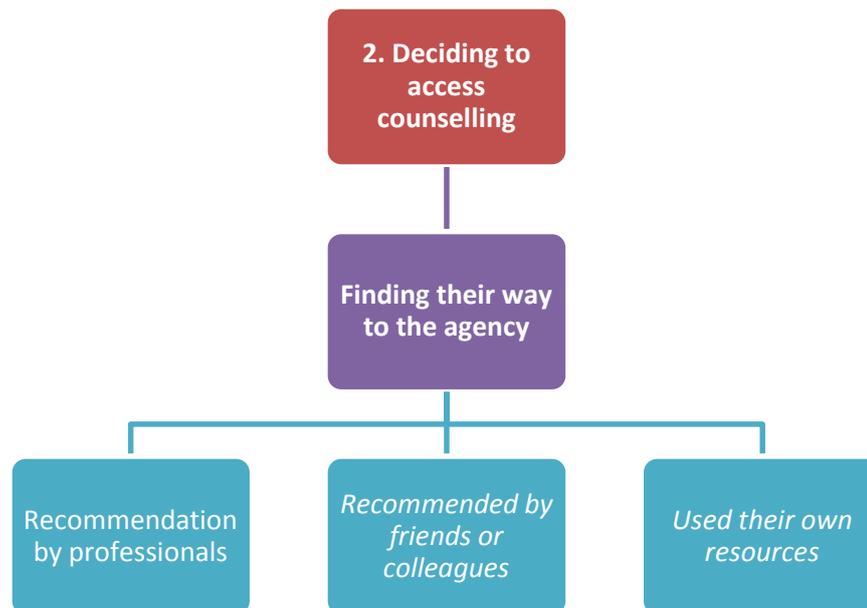


Figure 4-7 How women found out about counselling

Samantha: "I was really very strongly advised by the Police [...] Pushed me is the wrong word, but encouraged me strongly, so, having had fabulous advice and support, the counselling side of things was, it felt fine, it felt like the next step."

One of the features identified by Jenny and Samantha above was that of accepting the recommendation from a professional who had already been helpful or understanding and was seen to be trustworthy. For Jenny, counselling happened because she saw her GP whom she liked and he was able to provide a referral for her straight away. However, the Police referral had to be made more than once, as the participant had to act upon it herself, as Samantha describes above. This period of reflection prior to accessing counselling indicated the difficulty of taking that final step to access support, even when it seemed appropriate. However, the confidence

of the referrer in the service, as Jenny's doctor indicated, also built hope for the participant that this service might be able to help them.

In this study, the participants who disclosed that they had experienced sexual abuse to their GP were more likely to be referred for specialist counselling, whereas women who were experiencing mental health problems as a result of physical and psychological abuse were more likely to be referred for specialist counselling by the police, a point illustrated by Fiona's experience of her doctor.

Fiona: "A complete lack of appreciation of the impact that it has on that person's personality [...] it took its toll physically on me and I got no, I was just sent away by my doctor and I felt absolutely lousy"

Often health professionals assess DV through signs of physical abuse, and the signs of psychological impact and resultant physical symptoms may go unrecognised and untreated. Whilst some professionals were seen as helpful and caring, not all were seen in this way.

The next most common method was through friends or colleagues who had previously had positive personal experiences of the agency.

Ailsa: "one of my [colleagues], she mentioned [agency], she said 'Ailsa, give it a try', she said 'I used to go myself'. She said 'They're very good.'"

Karen: "I think if I hadn't been pushed by my friend to come here the panic attacks would have got worse and I think I would've been where I couldn't get out of the house"

Here Karen talks, as Samantha did above, about being 'pushed' into counselling, of someone else having a very clear view of what might help. Although they were aware of their own distress, hearing that acknowledged by others seemed to help them to take action. External factors can be significant in achieving a shift or change for the individual. Whilst words like 'pushed' were used, as Samantha says the sense was more encouragement and perhaps feeling that someone else was concerned about them. In both cases, the previous personal experience of the person making the recommendation was important. The participant was aware that

they had to trust the recommendation of that individual, as they had no personal knowledge of the agency.

Lucy: "I didn't know any of the people here and I was only going on the say so of a friend that these people could be trusted."

It is interesting to note that the care and concern came from friends and colleagues and not family members which means, as highlighted in the literature review, that these women did not access support in the way most often identified in population studies (See Table 2-2).

Two of the participants, who had previously had poor or mixed experiences of counselling and/or referrals and knew it was important to find the right support, used their own resources to find the agency rather than relying on a recommendation. Others may also have used their own resources but did not specifically mention it at the time of the interview.

Fiona: "I saw [agency]'s em number advertised on the back of a door [...] and I put the number in my phone"

Here there was a period of reflection after obtaining the details for counselling, before making the telephone call to ask for literature first.

Ruth: "I think I may have asked them if they had any material I could look at, books or anything like that [...] and then they basically said 'come and meet you and go through it'."

Asking for literature was a good way for them to assess how well the agency understood their situation. When offered the opportunity to come and have a chat, both responded positively based on the telephone call. As Ruth indicated above, she attended the meeting to support self-help rather than to request counselling. During the meeting, counselling was offered by the professional and accepted. This parallels the other participants' process in that access to counselling was by professional recommendation, although the professional involved was based at the agency.

For participants who had mixed experiences of counselling and already knew something of what was involved, a positive recommendation from someone they

trusted or respected was reportedly more helpful, although as will be discussed below, that needed to be supported by a positive reception at the agency.

4.2.2.3 Initial experience with the agency

Although the interview questions had been structured to ask the participants about their counselling and then their first session, many of them interpreted the inquiry about their first session to relate to their initial interview with the agency, as that had been an important experience for them. This is shown in Figure 4-8 below. Some of the participants did want to clarify what was meant, and early on each participant was given the choice about what to explore. With other participants it became obvious during the interview that they were describing an assessment, rather than counselling, session and so the interview then followed on with a question about the first counselling session.



Figure 4-8 Initial experience at the agency is an important factor

What became clear during the descriptions of these sessions was the importance of that first physical contact with the agency, particularly for those who had had no prior contact through DV outreach or advocacy services.

Natalie: “I came here and spoke to one of the girls [...] she said she thought I would benefit from counselling after her initial assessment and would I be interested [...] I believed it was all my fault and I was getting manipulated and twisted round in my head and the lady who I saw just made it clear.”

Paula: “And I remember when the lady was talking to me, it was like nothing like I thought it was, you know, I thought they would come in like the Gestapo,

interrogating me but she said 'you just tell me what you want to tell me'."

These positive experiences were helpful in overcoming reservations they might have had about beginning counselling. As Natalie describes above, the assessment session was often the first time the women had come across someone who seemed to really understand their experiences. It also began the process of helping them to see that their situation may not be quite as they perceived things.

For those who had received counselling before, this session gave them hope that this time might be different, that the counselling might be helpful.

Ailsa: "I hope it does some good, not like last time, I do, I did think that. I remember being put at ease, I remember feeling easy as soon as we started talking."

Jenny: "I went away thinking there might be light at the end of the tunnel, I'll give it a go"

As the participants engaged with the agency, the personal trust that they had in the person recommending the counselling at the agency and the hope that the counselling could help, had the potential to be built upon or undermined. It is worth comparing these experiences with one from a different agency which also offered DV counselling, although this was not its primary activity.

Fiona: "I didn't realise the person I was seeing wasn't going to be a counsellor, but during that session I was just completely, it was just like 'whoosh' you know. [...] she explained that it would be about three or four months before I would hear because they had a waiting list [...] the following day I had a phone call, inviting me in the following week, we've fitted you in."

Fiona's description suggested that she would not have responded in the same way during the meeting had she known that the person was not a counsellor and that there was a three month waiting list. Other participants also noted their surprise, and sometimes relief, that the first meeting at the agency was not with a counsellor. The difference here was that the support worker did not make that clear to Fiona.

Ultimately, this particular piece of counselling ended badly. During the research interview Fiona clearly linked this beginning of the process with her feelings of being upset later in the process, when she felt the counselling was being dictated by the therapist and once again out of her control. She ended the work abruptly feeling very uncomfortable.

She made her next approach for help through her own endeavours as she no longer trusted her previous referrer to make an appropriate recommendation and she did not know whom else to ask. This shows how important it is for the person making the referral to have knowledge of and confidence in the agency to be able to help the client, as the failure of the agency to help can have a negative impact on their own relationship with the client.

4.2.3 Step 3: Tentative beginnings

Beginning counselling was a key stage in the process. What became apparent from the research interviews was the complexity of the first few sessions. This was a time of difficulty and uncertainty, and yet there were specific aspects of the counselling which helped. These are shown in Figure 4-9 and then described briefly below.

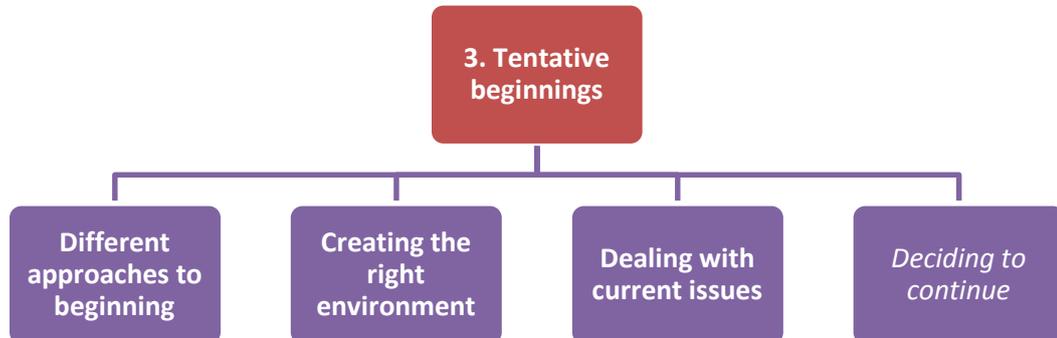


Figure 4-9 Key aspects in the first stage of counselling

As the participants began counselling, their approach towards the counsellor varied. The majority felt guarded and careful about what they said, whilst a few felt the story spilled out as they now had somewhere to share things. However, there was strong agreement from participants that it was the therapists' skills in creating the right environment for them which had made the difference. This helped the participant either to disclose more or to work with whatever had already been disclosed.

Participants' stories suggested that looking at how relationships work in the context

of DV or helping to develop coping strategies for specific issues were seen to be helpful. Fewer than half of the participants reported leaving counselling sessions feeling very upset. Where this happened, the upset was not associated with emotional release during the counselling but with the issues uncovered in the session which had continued to prompt an emotional response away from the agency. This led to contemplation about whether or not to continue. All of the participants continued with counselling, and this provided valuable information about what helped to sustain a counselling relationship through a difficult period which will be discussed later.

A key aspect of this part of the work was the length of time it took to complete. Later in the research, when asked, the women indicated that it took four to eight sessions to start to feel comfortable enough with the counsellor to be able to disclose more of their difficult experiences. This suggests that the relationship building phase for this client group, even with skilled practitioners, could be longer than most short-term therapies would allow.

4.2.3.1 Different approaches to beginning

As shown in Figure 4-10 below, the way that the participants interacted initially with the counsellor appeared to fall into two distinct categories, either feeling very guarded or experiencing an unexpected release of emotion, leading to disclosure of some life events.

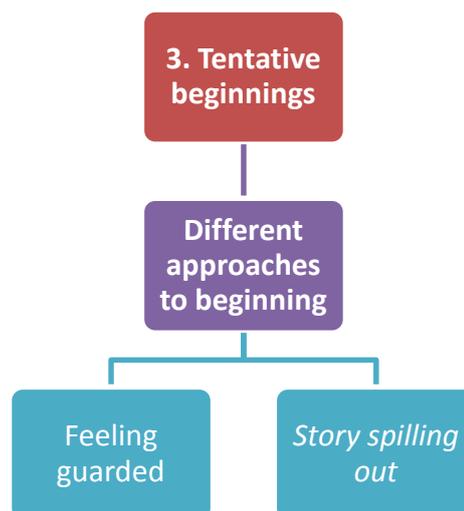


Figure 4-10 Differences in the way counselling was approached initially

On reviewing this with some of the participants, there was a sense that even for those who had experienced emotional release on beginning counselling, this could combine with a degree of apprehension leading to some care being taken in what to disclose after that.

Over 70% of the participants reported feeling guarded in their initial counselling sessions. The way participants described this varied greatly. Some talked about being careful about responses to questions:

Jackie: "I knew I was thinking about answers rather than just answering naturally"

For others, their previous history and background made it hard to trust the counsellor:

Karen: "you can see when you are telling people things that have happened you do tend to watch people, and watch what they say [...] Do I trust you? [...] can I tell you these sorts of things?"

The participants needed time to work out how far they could trust the counsellor before fully opening up about their experiences.

Natalie: "I think maybe's it's because we built a relationship as well, so I become, I got more confident with her"

For some, like Karen, previous disclosures to other people had not been received well, so there was a reluctance to disclose too much until she knew it was fine to do so. The majority of the women, most of whom had already left their relationship, took time to decide whether the counsellor could be trusted. This made sense as they had left their abusive relationship and had to rely on their own resources, often as a single-parent, to survive.

In addition, many of the women reported having had mixed or poor experiences of counselling and therefore could not assume that the counsellor would be able to deal with the issues brought. Hence the therapist needed to balance the woman's right to choose what and when to disclose with a process of exploration that could help to build trust that they could handle any disclosure.

In contrast to this, about a third of the participants found that beginning counselling allowed them to share experiences that had been bottled up for years and once they began to talk, they found it difficult to stop. This group contained women who were still in their relationship at the time of entering counselling and found that counselling initially relieved their feelings. As their story spilled out, so did their emotions, and they reported feeling relieved at the end of the session, lighter and less burdened.

Mary: “And it was like it just all rushed out of me, like where’s all this coming from? [...] you’ve just held it all back for years and years and years.”

” although there was upset while we were doing it, when you come out of it there was sort of lift. You sort of, it felt like there was a burden coming off your shoulders.”

Even although there was relief in sharing their story, this could also prompt anxiety about how much the counsellor knew and understood about her situation.

Lucy: “I used to come still feeling nervous, and still feeling, I felt as if the counsellor knew everything and I didn’t know everything.”

Here the therapist reportedly balanced Lucy’s desire to off-load her problems with supporting her to identify and address her issues for herself, thus giving her more confidence in herself. For Lucy, there was a gradual change over the next few sessions as she began to recognise how much she knew herself and how helpful the counsellor was in helping her to explore what was important to her. For Mary and Lucy the initial emotional release changed into an exploration of areas they chose.

However, the therapeutic relationship was not built by simply witnessing and facilitating the early release of emotion, as experienced by Fiona at a previous agency she had attended for counselling.

Fiona: “initially I was just grateful for the opportunity to sort of share what had happened and [...] I didn’t really

need to be reminded about it [...] I found it was very upsetting so I stopped going.”

In this case, the therapist, who was described as being a specialist in DV, decided to make specific interventions after an initial period of sharing.

Fiona: “weeks one, two and three we’re going to look at this and then weeks four, five and six we’re going to do this, and then by week 6 you’re going to be great”

However Fiona had a growing feeling that her counsellor had an agenda that she did not share and some of the areas he chose to explore led to her feeling embarrassed. Her desire to share information to facilitate her counselling was then balanced with her desire to self-protect. With the therapist asking specific, intrusive questions about areas of the relationship she did not want to discuss, Fiona felt prevented from exploring those areas she felt would be helpful and her trust in the therapist diminished.

4.2.3.2 Creating the right environment

From the description that the participants gave above about their feelings going into counselling, it would seem that the counsellor’s ability to relate to the client and respond appropriately to the changing situation during the first sessions is important.

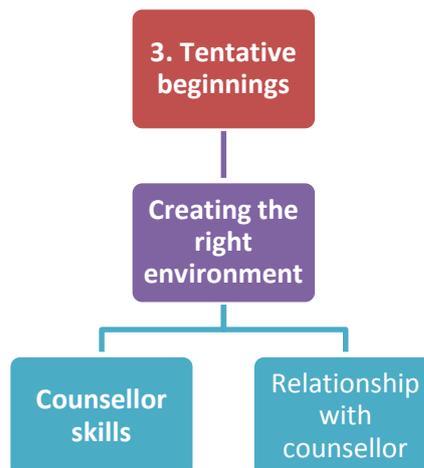


Figure 4-11 Factors associated with creating the right counselling environment

This was highlighted and confirmed by all of the participants, with the skills of the counsellor and the relationship that they built up with them being identified and valued, as shown in Figure 4-11 above.

Counsellor skill was an important aspect for all of the women interviewed. Although understandably each participant valued different aspects of their therapist, there was some commonality of view. The main aspects are described below.

It was important that they felt 'comfortable' with the counsellor, initially.

Mary: "you were made comfortable and everything else"

Natalie: "I felt really comfortable with her, she made me feel completely at ease, but I don't think I said a great deal about anything. I think I was just too, a part of me was relieved that I got to that point but I was still struggling with the whole, talking to somebody else about it I think."

Much has been written in counselling about the skills required to help clients to disclose, reflect and process things noteworthy. In this case, the initial feeling of being comfortable with the counsellor presented a starting point to build the therapeutic relationship, but Natalie still identifies her reluctance to disclose, even though she felt at ease in the room.

The process of increasing the level of disclosure appeared to be linked to the therapist's technical skills and knowledge.

Samantha: "it was more that she had seen things and noticed things I think"

Fiona: "it was just genius where I could say this one word and it would just (Snaps fingers) be picked up on [...] and often it was something I thought I'd completely, deliberately, expertly skipped through and it would be like 'oh, hang on a second'"

The perceptiveness of the counsellor in picking up small changes in voice tone or physical movements was appreciated and provided an opportunity for further

exploration in areas the participants found useful. However, it was also important that the counsellor was non-judgemental about what they had heard.

Paula: “you just think everybody’s out to judge you. You know when you come here you’re not being judged and that made me feel really good.”

Mary: “you’re talking to someone who’s not judging, and it gives a different feeling ‘cause you can get out what you need to get out without people jumping down your throat.”

Much of the work that was valued by the participants was the provision of an explanation for what had happened, without judgement or the allocation of blame. Instead, the abuse could be reviewed objectively as something that had occurred and time was spent on how the incident had developed and what the options were to prevent it happening again.

Veronica: “[counsellor] made me realise, I didn’t have to be like that. I didn’t have to have them feelings, I didn’t have to beat myself up in my mind constantly thinking ‘I’m scared of life, I’m scared of this, I’m scared of that, what if this happens?’”

Elizabeth: “I’d say something and she’d make me understand why whatever had happened or, why I was seeing it such a way, and kind of turned things around and put a reason on it for me”

Fiona: “That, that one sentence that someone who had the expertise and the knowledge could say that to me, [...] it wasn’t just for me that behaviour, it would be with other people too and that was a real breakthrough for me [...] it sort of helped take the lid off the responsibility”

The counsellors’ ability to relate the participants experiences to DV through describing the characteristics of abusers and their behaviours was important. It helped them to realise that their situation was serious and explained their difficulty in

being able to change the relationship. Their need to understand the dynamics of abuse provided an indication as to why previous general counselling had not been as effective.

Amanda: “the reason it didn’t help was because [...] I was in an abusive relationship, that’s what was making me depressed.”

Working with someone who could clarify the mechanisms of DV helped to affirm and validate their experience. Their realisation that their reactions to the abuse were normal was also beneficial. However, the additional step of understanding what DV meant to them personally, changing how they felt about themselves was, as Veronica and Fiona mention above, invaluable.

In addition, more than half of the participants appreciated the freedom and time to talk about whatever they needed to talk about.

Jackie: “she allowed me to speak freely, and allowed me to realise that those things I’d gone through before, I don’t have to go through again.”

Karen: “her never, ever pushing me, you know. She knew there was more and more, and all the time there would be a little bit more things coming out”

Although some of the participants had counselling lasting many months and, in some cases, years due to significant and complex multiple lifetime experiences, others received fewer than 20 sessions. Even with shorter term work, however, there was flexibility around the number of sessions. Hence, the participants did not feel under pressure to disclose before they were ready and they were also able to use the sessions to explore issues which had arisen whilst attending counselling. Having counselling that allowed them to explore at their own pace was important.

However, there appeared to be a difference in practice regarding how counsellors reacted to the disclosure of information. Some participants explained that they were able to touch on something particularly difficult with the therapist, knowing that they did not need to address it fully at that moment, but could bring it to a future session when they were more ready to explore. It appeared that being able to work at their own pace and deal with things a bit at a time had a positive impact on how these participants felt leaving each counselling session.

However, other participants suggested that any issues that emerged would be explored with the counsellor in depth, during the session. In some instances, this decision led to the client feeling overwhelmed by the memories and emotions this evoked, which in turn had implications for them as they left the session.

Samantha: "I really tried to leave having anything to do afterwards, because it was just too much. I was in a state, quite frankly."

Often difficult issues had been hidden away because of their enormity or potential to cause pain at the time. In bringing those things back to the surface gradually, they could be dealt with as the participant was ready to face it. This could result in an uplifting session. However, looking at past experiences as they emerged, as in Samantha's case, could become overwhelming. The skill of the therapist here is not simply in creating the right environment for disclosures to be made. It is also in being able to manage the session to explore issues at an appropriate pace and assist the client to leave the session safely. For other participants, when they did feel upset on leaving, it was important that they found a way to cope with the emotional distress after counselling.

Ailsa: "Some days I quite upset in my head and when I get home and I sit and relax and think about things, it helped."

When emotions were high, ensuring the client had coping strategies, such as Ailsa's relaxation technique, to deal with the material outside of counselling was not simply good practice but showed a level of genuine care and concern, which could help the therapeutic relationship.

Although there are many relational issues described above under the skill of the counsellor, for more than half of the participants, the relationship they had with their counsellor formed an important part of their therapy. However, these participants also appreciated that the counsellor was separate from their normal lives. Impartiality and confidentiality were important to them given the issues they were bringing.

Amanda: "They're coming at it from a completely separate stand point, an uninvolved stand point [...] any kind of decisions that might arrive, there's nothing

affecting those, they're not gaining anything in any way from making it."

Natalie: "Completely separate and I know I leave the room that's it. It's left in this room"

Although there was a separation, a few participants described the counsellor as particularly interested in or caring about them. The connection they felt was important to them and reduced their feeling of isolation:

Paula: "whereas I'd been on my own for years thinking 'nobody knows, nobody cares, nobody understands' and all of a sudden I've met somebody who did all them things"

Veronica: "Where with other counsellors and that I've never felt that connection"

Natalie: "Even although you're still holding it together, it's sort of like you're not on your own any more, you've got some [one] there."

It is also interesting to note, as Natalie describes above, the different aspects of the relationship that were valued. On the one hand, it was good to be able to come and talk to someone with whom there was no ongoing relationship and who was separate from their daily lives. On the other hand, during those moments with the counsellor, the feeling of being connected to someone and no longer alone was also very important. This suggests that whilst appropriate boundaries as part of the counselling service were welcomed by participants, the personal relationship that developed with the counsellor themselves was also important and beneficial.

Different aspects of the therapeutic relationship have been shown in this section: the therapist's ability to offer a different perspective about the abuse was seen as particularly helpful, as was feeling understood by the therapist; working with the client to increase her understanding of her situation showed the therapist's ability; the therapist listening attentively and being able to infer and describe relevant pieces of the participant's story showed an interest in her and her situation. In addition, a therapist who took care of session timings, supported the participant to go at her own pace of exploration, and helped and trusted her to manage her

feelings at home, showed awareness of her situation as well as care and consideration for her. Finally, the structure and boundaries around counselling provided a level of integrity which the participants found helpful. This implies that it is not simply the knowledge and skill of the counsellor that are essential to building sufficient trust for the client to make good use of the sessions, but also the organisational framework and relational capability and sensitivity of the therapist.

Within this section, the dynamics of trust can be seen to be building, as the competence of the therapist, her ability to see the best in and trust the client, and helping the client to process most of the material within counselling were all having an impact. Generating trust at this stage of the counselling was an important part of the foundations needed to move on to the in-depth exploration of the difficult and complex issues covered in Stage 2 of the process.

4.2.3.3 Dealing with current issues

Almost all of the women referred to dealing with current issues as beneficial in their counselling. The women had entered counselling anticipating that they would have to disclose many painful aspects of their life with their partner. However, a focus on understanding what was happening today and help to resolve particular issues that were making life harder boosted their confidence. This is shown in Figure 4-12 below.

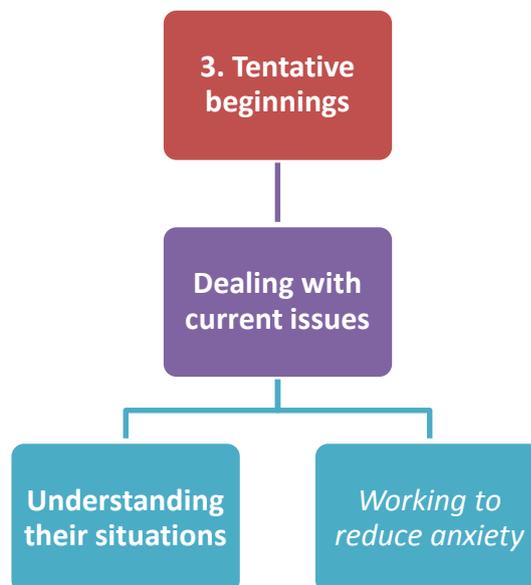


Figure 4-12 Current issues that were explored early in counselling

Dealing with current issues as part of their introduction to counselling was helpful in building a constructive and trusting relationship with the counsellor, and led to hope that the counselling would be helpful.

Just under half of the participants valued the use of models and provision of tools by the counsellor, to explain things and to offer solutions to current problems. Having resources was important as they could use them at home and in the future, not just within counselling.

Fiona: “it sort of healed a lot of those areas and it’s equipped me to not beat myself up so much.”

Karen: “And now I just have a moment on my own if I really need to. [...] I could never deal with that before, because I never knew what to do.”

Most of the participants talked about beginning to understand what had been going on in both their adult and childhood lives. More than half reported that gaining insight into what had happened was important.

Ruth: “the kind of pattern to it, and what happens and [...] it seems as though what was happening as a child means I lost my ability to defend myself. I didn’t have a mechanism to defend myself, and I’d blamed myself for years [...] why I was doing this wrong all the time [...] and then suddenly you realise that you’ve not been set up for all that and it allowed me to sort of forgive myself really”

Lucy: “suddenly she starts to explain things ‘well look this is the pattern of behaviour of your husband. This is how you’re behaving, this is how it’s disrupting his cycle, this is what he will do when you do disrupt his cycle’ and gradually we were able to see the clashes that were occurring”

Although the benefits of the counsellor being able to explain aspects of abuse were discussed earlier in Step 3 as a counsellor skill, this is also introduced here in a slightly different context. Here, the participants had been blaming themselves for

something that was currently a problem in their life and that they were unable to address. They had a sense of helplessness about the situation. Being able to see the experience in the context of things that had previously happened not only increased their understanding of the situation but also allowed them to identify new actions to alleviate the situation. They could not deal with it before as they had not had the understanding needed to do so. Now that they had a different view of the situation, they knew that they could deal with it in the future. This new knowledge helped to change previous negative thought patterns, providing hope for the future.

The literature review suggested that anxiety was a significant mental health issue with DV, yet less than half of the women in this study raised this as a particular issue. For those who did mention it, their concern was less about the feelings, and more about the impact it was having on their day to day life.

Amanda: “A lot of things were freaking me out or bringing back flashbacks [...] so it was just about rationalising that and [...] managed to change my thinking so that I wasn’t suddenly panicking and thinking he was following me”

Paula: “I had OCD, I used to brush my teeth about 20, 25 times a day. I would wash my hands until they were nearly gone, my nails were bitten to nothing.”

From these descriptions, it is possible that the participants had experienced some symptoms of PTSD, but they described it as anxiety. Here, from the descriptions of the counselling given in the transcripts, the therapist appeared to work on controlling the symptoms before addressing the underlying issues. The participants descriptions suggested that treating the anxiety was relatively straightforward once the root cause of the issue was established.

4.2.3.4 Deciding to continue

Leaving a counselling session feeling upset prompted thoughts of stopping the process, yet the participants continued because they felt this was the only way to get over their experiences. In these cases past issues had arisen early in the counselling as a result of counsellor facilitation, as shown in Figure 4-13 below.

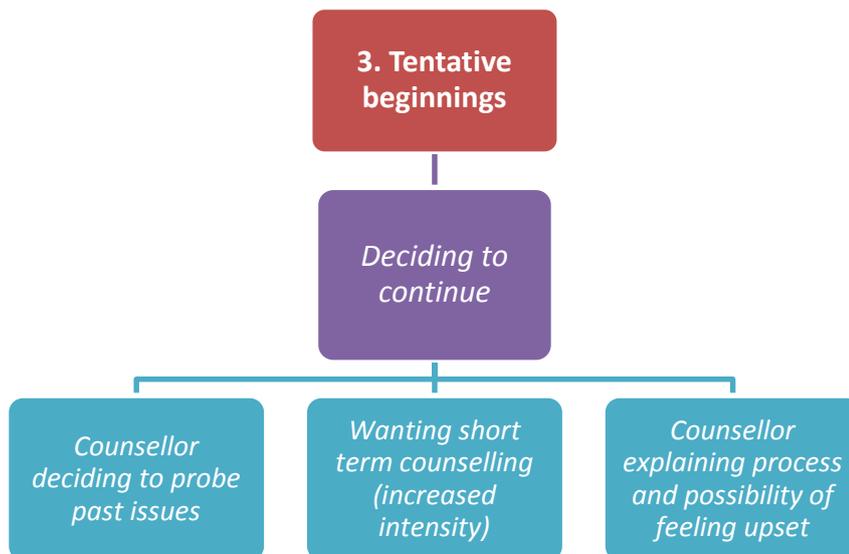


Figure 4-13 Difficulties for participants and reasons to stay

Samantha: “I wanted to avoid it in a way, but I didn’t want to stop it or to step out of it, no. Because I knew the value of it, and I felt we were in a process and I didn’t want to cut it because what would have been the point of doing everything we had done.”

In these cases what was unusual was that the participant had been surprised by both her own disclosure, as it was not something she had previously considered to be important, and the emotional impact it had on her.

Ruth: “it just unlocked loads of stuff in me mind. I kept on dreaming it, it was just unlocking all this stuff, I mean I felt like I was going bonkers. I was just a massive roller-coaster of emotion for like 2 months.”

In counselling, there is often a balance between clients going at their own pace and a need for the therapist to bring things to the client’s attention or challenge thinking. For the participants, it appeared that going at the client’s pace initially and building up the relationship slowly, rather than an early focus on bringing things to the client’s attention was important. More than half of the participants who reported these feelings of upset were women who had requested short term counselling to fit with other commitments, and as a result were perhaps pushing themselves, or

being encouraged by their therapist, into deeper disclosure than they were ready for emotionally.

Amanda: “she said ‘you’ll probably feel a lot worse before you feel better, because we are getting to issues’. That was helpful to know that, yeah, I’m in counselling and I might go home and just feel really upset that night, or whatever, and to just know that that’s ok and it’s part of the counselling process, and it doesn’t mean the counselling isn’t being effective, in fact, quite the reverse, so, that was good.”

As mentioned by Samantha above, whilst there were difficult aspects of the counselling process that led to a desire to disengage from therapy, the main factor in encouraging her to stay was that at a deeper level, despite the emotional cost, she felt she was either gaining or would gain some benefit. In addition, as Amanda reflected, it helped that she had some assurance that her reaction to counselling was normal as this helped her to tolerate her feelings. However, the decision to continue appeared to be made as much emotionally as cognitively.

Ailsa: “I just knew when I was coming [here], even though I didn’t want to know these things, it was helping.”

Karen: “Sometimes I was almost going to cancel and then at the last minute I’d get the determination and I thought just do it, get this done, you know and I’d be running down here sometimes just because I needed to make it, and I’d come out and I was so proud that I’d done it because it was really, really hard”

Ailsa reflects here on her sense that the counselling was having a positive impact on her, despite the difficulties of the process. However, Karen also notes that being able to face those difficulties was also beneficial.

Within this study, the agency participants had all completed their counselling and felt generally happy with the experience. Even although some of the participants had had some difficult moments during their counselling, they had been sustained by the relationship with the counsellor and the progress that had been made. This

contrasted with earlier experiences of counselling that had resulted in a different decision.

Elizabeth: "I saw a person from [organisation] and [...] I just couldn't relate to her at all and just didn't carry on with that at all."

Ailsa: "I didn't feel comfortable there at all. I just didn't want to be there."

Given the difficulties with trust and the need for many of them to explore difficult, secret areas of their lives, the slow establishment of trust through relationship and knowledge can assist with the client making the decision to stay, even when the going gets tough. Clearly, both Ailsa and Elizabeth found something which made them wary with their earlier counsellors, resulting in difficult, uncomfortable feelings and termination of therapy. It is important to note that, other than Amanda, there were no reports of discussion by the participants of their discomfort with their therapist. Living in an abusive relationship may preclude open acknowledgement of difficulties, and from a counselling perspective this suggests that the counsellor may need to pro-actively address any problems.

It is also important to note the experiences of Ruth. She explained that she had some good, some not so good, counselling before, and was quite aware of both the benefits of the therapeutic process and its potential limitations. As a result she had spent time deciding where to go for counselling.

Ruth: "I just felt, as I say, that these people would know all about what they were doing."

The therapist was linked to an agency which the participant knew specialised in abuse, and this helped her to trust the process she was going through. She had already decided on the area of her life she wanted to explore when she began counselling and she wanted to finish it as quickly as possible.

Ruth: "I think if you want to be counselled quite fast [...] I was like trying to think about things [...] I think I pushed myself a bit fast through it, actually."

She had wanted to work through her issues quickly and the therapist correspondingly worked quickly. Despite her previous experiences, she found

working with this particular therapist very different. Ruth put her feelings of being out of control down to the nature of the counselling work she was doing.

Ruth: "I'd spoken to one of my friends one evening and I said 'I feel absolutely mad' and she said 'Yeah, well it's normal to feel absolutely mad after these'. I said 'Oh is it?' So I think you do need [...] people to know that this is normal to feel [...] out of your normal realms of experience during the counselling"

Ruth's experience contrasts with Amanda's comment reported earlier, who was warned when the counselling covered work of a deeper nature that it might impact on her feelings after the counselling session, and was therefore prepared for her experience.

Despite her preparation for counselling, Ruth did wonder if she had rushed things a little and the discussion with her friend suggested that at some point her trust or belief in the process was tested. It is interesting to note that the person she turned to was someone already known and trusted and not the therapist. This would be in keeping with the research findings reported later, in section 4.3.1.1, which suggest it takes a number of sessions (>4) for the trust in the counsellor to develop. Yet despite her reservations, she was prepared to take responsibility for feeling overwhelmed because she had specifically asked for brief therapy.

4.2.4 Summary

Stage 1 of the DV counselling process illustrates many of the difficulties of accessing support faced by survivors. Taking the step to find help can be difficult due to previous life events and experiences of unsuccessful counselling. Trusted professionals and colleagues helped to highlight appropriate services, and early experiences at the agency helped to develop trust in the organisation. This trust in the agency could support early counselling work, as there was a period after beginning therapy of getting to know the counsellor before being able to settle down comfortably to fully share their experiences. It was helpful during this period to focus on solving specific issues affecting day to day life. . Building the therapeutic relationship required high levels of skill and knowledge from the therapist including knowledge of domestic violence and the needs of this client group, empathy, pacing of disclosures and informing the participant of the possible effects of counselling outside of sessions. In the reported counselling experiences where the therapeutic

relationship did not develop successfully, early and sudden termination of counselling appeared likely. Successful navigation of this Stage of therapy resulted in movement towards Stage 2 of the process, where longer term issues that affected the individual could be addressed.

4.3 Stage 2: Going deeper

The beginning of Stage 2 saw a shift in the relationship between the participant and the therapist, as the wariness of participants finally began to give way. Participants began to share aspects of their stories and could see that the therapist was still there, listening and offering a relationship, whatever they had shared. This helped them to move to the next stage.

Jackie: “you really know me, did I really want that? Well, you know me now so here, have the rest”

This acceptance of a positive relationship where anything can be shared, and where trust between the participant and therapist is possible, changed descriptions of the mood, structure and content of the sessions. The participants settled down to explore and in doing so began the journey of revisiting past difficulties both known and unknown.

Lucy: “Because we were settled with discussing what was going on in the present, that section of the counselling then started bringing up memories of the past, some memories from childhood and times that had made me really unhappy.”

This was an important period in the counselling as it presented the opportunity for beneficial change. These two Steps, settling down to explore and addressing the unspoken and unknown are detailed below. As shown in Figure 4-1: The female model, on page 111, these two Steps can happen in parallel or in series and there can be movement between the two during this Stage. However, they are presented as two distinct Steps here to show the different contributions of each.

4.3.1 Step 4: Settling down to explore

Descriptions of this part of the process in the interview felt more comfortable and relaxed, and the participants were focused on the changes they noticed in themselves during this period. The different factors involved in this step are shown below in Figure 4-14.

This was an important time in the counselling. The participants were starting to feel more comfortable in the relationship, the earlier completed work had enabled them to feel better and they were more open to viewing things from a different

perspective. Now the counsellor began to make substantive challenges about how the participants viewed the world and/or themselves

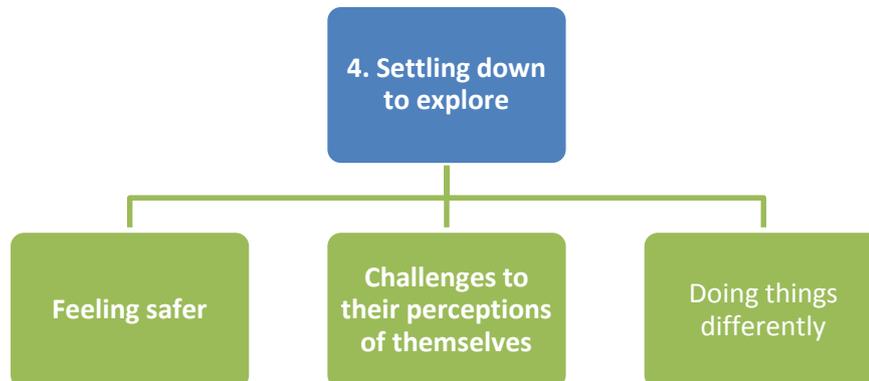


Figure 4-14 Factors involved in the “Settling down to explore” Step

Almost all of the participants reported feeling better about being in counselling at this time, valuing the changes they had made in how they viewed life. More than half valued the changes in the perceptions of themselves. It is appropriate to note that the value of these aspects of the work depended on the individual’s starting point. Some participants may have viewed the world positively but saw themselves negatively, whereas others may have valued hearing a different view of the world and themselves compared to the one most commonly shared by family and friends. These are described in more detail below.

4.3.1.1 Feeling safer

Almost all of the participants talked about feeling differently at this stage of the counselling, and as shown in Figure 4-15, some related this to trust in or comfort with the counsellor and others expanded this to include people in their external environment too.

Some of the participants talked about having trust in the counsellor at this point, although it was difficult to ascertain precisely when trust was established. They simply recognised that it was now there and that, as a result, they were able to share more of what had happened.

Elizabeth: “then after a while, the trust comes [..] and then the real nitty-gritty of it came out.”

Natalie: “You’ve got to be able to trust that person [...] you’re saying things and you think ‘oh god I can’t believe I’ve done that’ or ‘I can’t believe that happened to me’ or ‘I can’t believe I allowed that to happen to me’.”

Natalie’s comment shows her recognition that her difficulty around disclosure was not specifically in telling the counsellor, but in recognising the reality of what happened herself. She now trusted that the therapist would be able to cope with her disclosure, but she also had to cope with the disclosure herself now that it was no longer hidden and needed support to do so. The shift for the participants from withholding, and in some cases suspicion, to trusting and being prepared to take risks, took time.

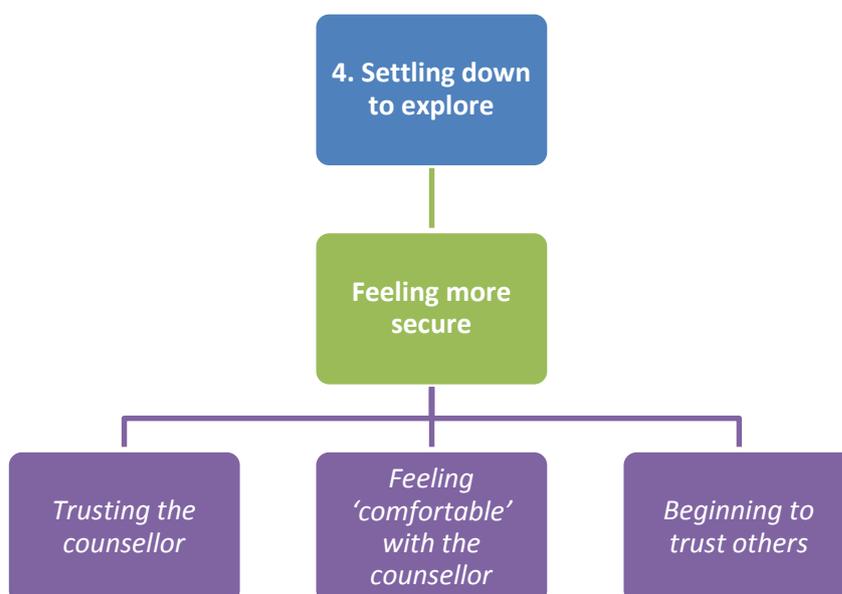


Figure 4-15 Signs of feeling more secure within counselling

The process of building trust is shown in Stage 1, through the referral and assessment process with the agency, before ultimately becoming something felt between the counsellor and participant. Some participants linked feeling ‘comfortable’ with the counsellor to having a feeling of confidence and trust.

Amanda: “I reckon it probably took [...] 3 to 5 sessions to feel more comfortable with the different counsellor, but I think I trust the set up in here and it was working.”

Here, Amanda specifically mentions the time taken to feel comfortable with the counsellor, that is, to move through Stage 1. She indicates that trusting the agency was sufficient to make progress until that point was reached. Now, however, trust is beginning to be established within the counselling relationship. Other participants described how this enabled them to disclose more and also to express emotion about their experiences.

Jackie: "I felt really comfortable with [counsellor] and she could just say a couple of words and it brought things flooding out of me and I felt so relieved at times to walk out, even though I had cried for an hour solid."

Mary and Natalie had previously mentioned feeling comfortable with their counsellor (see section 4.2.3.2) meaning that they felt they had been put at ease and were happy to come back for the next session of counselling. Above, Jackie was providing a different meaning of comfortable, as feeling free to bring all of the things that she had not talked about before. These things had been hidden and may have been associated with guilt or shame, but the participants felt the counsellor would listen, help them to understand the situation and help them to resolve their feelings.

The benefit of building up a trusting relationship with the counsellor was not just about using the counselling sessions effectively. The participants noticed that trusting the counsellor and what she was saying provided a base for them to begin to trust other people as well.

Karen: "I definitely gained trust of people. I don't know how they do it [...] but they do things that puts little things into your head where you go round and you do start thinking things and trusting people."

Lucy: "And [...] the sense to be able to trust somebody again, because in trusting the counsellor and informing that relationship where everything that was said there was just between the pair of us, I actually began to trust other people more."

Although this is clearly an important change for these participants, it is perhaps surprising that this aspect has not been discussed in the literature more widely.

Links between a lack of social support and poor mental health have been shown in the literature review and there is great value to the individual of being able to reconnect with others.

Factors mentioned at the beginning of the process, such as no longer feeling alone and not being rushed, continued to be important to the participants. The participant's trust in the therapist's view of them and the world outside provided a platform for challenge to perceptions of themselves and their responses.

4.3.1.2 Challenges to their perceptions of themselves

As trust in the therapist built, more than half of the participants described becoming ready to engage with different ways of thinking. These aspects are shown below in Figure 4-16.

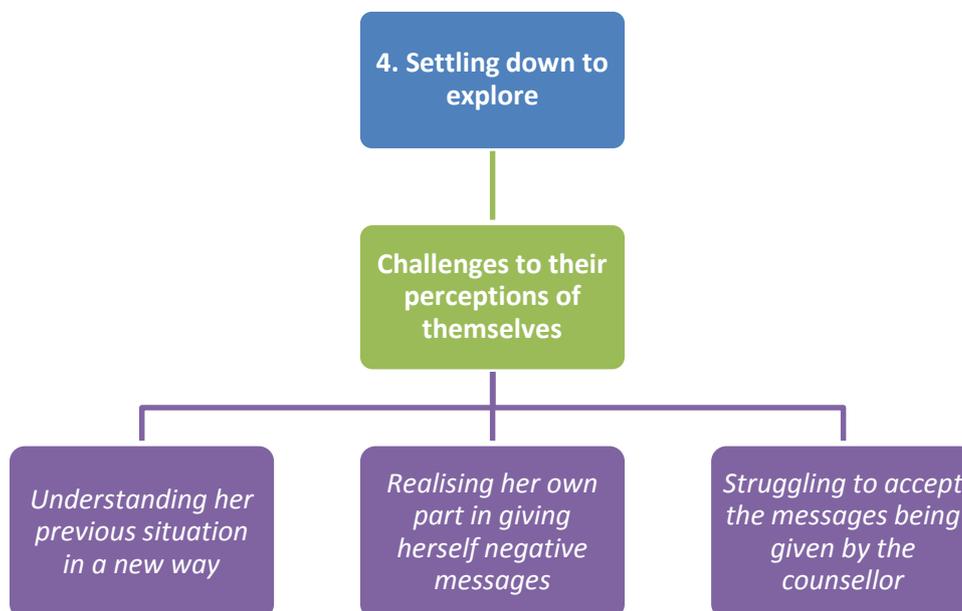


Figure 4-16 Participants' views of how their self-perception was challenged

First, there was a difference between hearing and considering messages of no blame during Stage 1 of this process and now believing that this might be true. Second, some participants began to understand the impact of their negative self images on their lives. Third, for some participants, where the messages received were at odds with their own self-concepts or values, this process became a new internal struggle. These three concepts are explored below.

For some of the participants, this phase of the counselling provided a new view of their experiences. They began to see their experiences and the way they had responded in a different way, and no longer saw themselves as wholly responsible. As they could see what had actually happened more clearly, they were less critical of themselves.

Mary: “And also realising that it wasn’t your fault [...] it’s always been put on you that you’re the one to blame [...] and suddenly you realise [...] It’s not what you’re doing, it’s what’s being done to you that’s creating it.”

Jackie: “I look back and I used to regret some of things that I did, but, I can see that I did them for my own safety, and [...] because I needed to keep my environment safe. It was the best of a bad lot of options.”

However, part of the challenge was realising that it was not just the past abuse that was the issue: it was also the negative messages that she continued to use.

Fiona: “I wasn’t judged or undermined. You know it wasn’t ‘are you being an absolute..?’, the only person that was judging or undermining me was myself.”

Veronica: “[counsellor] made me realise, I didn’t have to be like that. I didn’t have to have them feelings, I didn’t have to beat myself up in my mind constantly thinking ‘I’m scared of life’”

As the therapeutic relationship deepened, the participants were able to hear both positive and negative messages from the counsellor about their experiences or observations, which in turn began to influence change in the client. Feedback can be used positively to influence the self-concept and self-esteem of the client whilst also strengthening the therapeutic relationship, as long as the therapist has credibility with the client. This shows the importance of Stage 1 of the process, as it creates the therapeutic environment that can lead to change at this later point.

However, some of the participants found the challenge harder to hear. Ailsa, whose life and work had been about service to others, could recognise the issues arising

from this position, but the new proposed philosophy of putting herself first was difficult.

Ailsa: "I'm sort of letting people tell me what to do, I think that's how we put it. Going along with people [...] and please people. I used to get upset over that, thinking 'how am I going to change that?'"

Rather than hearing this message and feeling free to disagree with the counsellor, she now felt obliged to make time for herself, even although that presented some difficulties.

Ailsa: "I've actually said I was meeting somebody [...] and I haven't [...] and I felt guilty 'cos I'd lied."

Although she felt guilty about deceiving her family, she felt this was more acceptable than saying she wanted time on her own, even although she knew there was a benefit to doing so. What could have been a new found freedom had become another constraint on how she lived her life. This shows how carefully therapists must work with clients who may need encouragement to begin to make their own choices about how to live their lives.

In the case of Elizabeth, the counsellor had spent time trying to support her to have a more positive view of herself, and to see what a valuable and precious individual she was.

Elizabeth: "I just tell myself what [counsellor] has told me and try and try and believe it which is easier said than done."

Although she could see the logic behind the counsellor's statements and could accept the evidence also presented, Elizabeth still found it hard to believe that this could be true. She emphasised the difference between hearing and believing a consistent message from another.

4.3.1.3 Doing things differently

As the participants began to explore different aspects of their life, just over half of them began to look at things in different ways, with a positive impact on how they felt day to day. These split into two categories: changes to the way they viewed life events and changes to how they responded to issues, as shown in Figure 4-17.

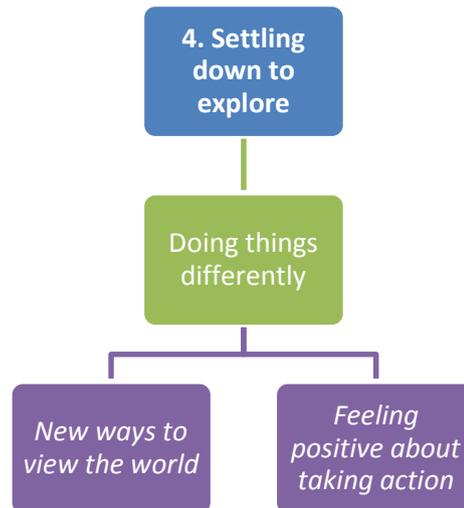


Figure 4-17 Aspects of doing things differently

Alongside changing perceptions about themselves, the participants also began to recognise patterns of their behaviour that were unhelpful to them and this changed the way they thought about and approached life.

Jackie: “I didn’t feel so angry towards the other party because at the same time, as much as it was wrong and everything else, I knew that I’d made that decision for me. So I wasn’t looking to apportion so much blame”

Jenny: “she said ‘How have you been?’ [...] ‘Oh I’ve been really depressed for a couple of days this week’, she said ‘You know it’s all right to have a down day.’ I don’t put it down to depression any more, it’s just a day where I don’t particularly feel good or something like that”

These examples show the participant’s openness to accepting feedback about their current view of life and to make changes as a result. The women began to recognise that their coping strategies were not always helpful when there were other choices available to them. At this stage of the counselling relationship, they also began to feel more positive about themselves and their ability to take action in their lives. Although each of their stories was different, each reflected an achievement that they related to the support received from their counsellor.

Paula: “I just went along with what everybody else wanted, and she made me realise that I could go out on my own, the first time I went out on me own [...] when I got home [...] I just sat down and cried my eyes out. I can do things.”

Veronica: “she said ‘right I’m here for you, never mind anyone else, I’m here for you’. [...] I think that’s given me a lot more confidence as well, and made me have that assurity that yes I can achieve this, and yes I can achieve that.”

Using counselling as a platform for trying out new behaviours is not a novel outcome. However Veronica’s comment is important as she talks about how the therapist was able to help her to focus on this one good relationship rather than continuing to mull over all of the others in her life, which in turn provided a platform for change. For the others, it was implementing behaviours that they had discussed in therapy and had gained confidence to try outside the counselling room. It is important not to underestimate the difficulty an abused person faces to change behaviours that may have previously kept them safe. The realisation that they are unnecessarily restricting their lives is important and being able to take action to improve things shows that they are no longer feeling hopelessness.

4.3.2 Step 5: Addressing the unspoken/unknown

All of the women talked about a process in Stage 2 that allowed them to talk freely about their past experiences, and this is shown in Figure 4-18.

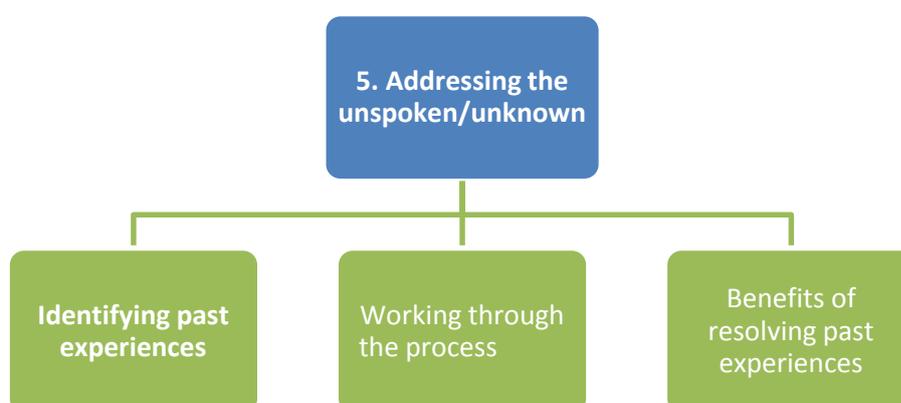


Figure 4-18 Key factors involved in addressing past experiences

For most of the participants this included past childhood experiences. For a few, it was talking about aspects of their DV experience that had been hidden until then. Part of the process was identifying those experiences that were important and for over half of the women this also involved undertaking specific work to resolve those memories. During the interviews the women also identified the immediate benefits they gained from the resolution process.

4.3.2.1 Identifying past experiences

For many of the participants, finding themselves in a secure, trusting relationship enabled them to address past issues. Whilst some of those experiences were known about at the start of counselling and were part of the reason for accessing counselling, others emerged during the process. Each of these factors is explored in Figure 4-19.

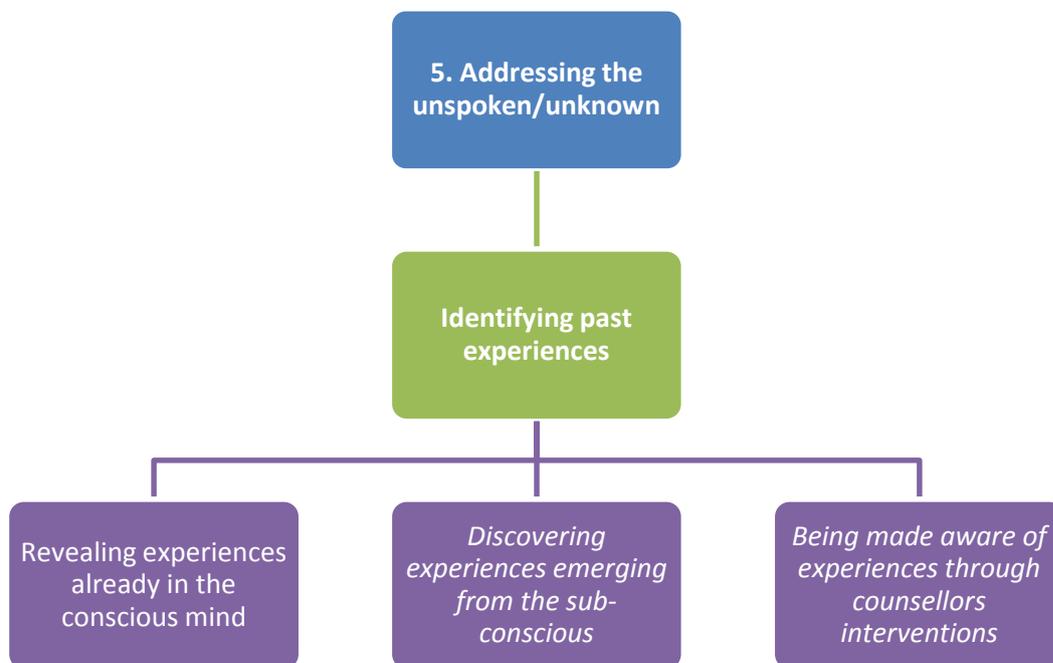


Figure 4-19 Aspects associated with identifying past experiences

Almost all of the women mentioned the benefit of discussing their past experiences. Whilst they were aware of some of these things coming into counselling, other aspects had been forgotten. Much of what was shared had not been spoken about before, that the participant had kept to themselves, consciously or unconsciously. More than half of the participants came into counselling already aware of their past experiences and of the need to explore them. Even with that knowledge, it took time

for them to feel safe and comfortable enough to properly explore the issues. It was a question of how and to whom they could say what they needed to say.

Elizabeth: "It took about 4, I think about 4 sessions until I, you know, said what had happened."

Paula: "she said she'd been through something similar herself, and obviously she didn't tell me more, and she made me feel relaxed. I told her things that I never, ever dreamt of telling anybody, detailed things and that."

For a small number of participants, memories emerged as they went through counselling either through making sub-conscious links as a result of the counselling or through the counsellor's observation.

Amanda: "it's more just the [...] talking about things that you've never told anybody ever and that triggers other memories, and other things that I haven't even admitted to myself"

Ailsa: "She [counsellor] noticed, when I can't concentrate, I'm just always looking that way."

In the example above, Amanda found herself remembering things she had forgotten. This, as highlighted in section 4.2.3.4, caused some emotional discomfort which she was ultimately able to resolve with her counsellor's help. For Ailsa, the exploration of this idiosyncratic movement, mentioned above, brought about a memory which helped to explain many of the fears and coping strategies that she had developed over the years, and which she could now choose to address. This process of recollection is potentially a risk for any individual accessing counselling who has experienced DV and/or childhood abuse.

Although many of the participants reported a gradual and manageable process associated with revisiting the past, a few had a very different experience as they were pressed by their counsellor to explore past experiences during the counselling that they had forgotten about or not considered to be important.

Samantha: "all my brushing away of things and minimising of things didn't quite work with her. She still stuck at it

and it was a while until, it was a few sessions before we really got down to what was really at the heart of it.”

This process of directed exploration led to difficult emotional experiences from the first session as Samantha described. She reported during the interview feeling out of her body (which can be a form of dissociation brought on by being overwhelmed by past memories) and physically shaking at the end of a session to the extent it was difficult to walk. However, Samantha felt that this degree of upset was recognised by the counsellor and she felt supported by her.

Samantha: “there were times when she said ‘I know you don’t want to come back next week, but you are going to’.”

and

Samantha: “I think, particularly in those places you didn’t want to have to revisit, just knowing she was there with you, and quite literally ‘I am standing here with you looking at this’ then that felt ok, that felt safe.”

As will be seen from the rest of this study, clients can gain from DV counselling in many ways, depending on their histories and what they need at that particular point in their lives. There appears to have been an assumption on the part of the counsellor that this was the most appropriate approach for Samantha.

4.3.2.2 Working through the process

More than half of the women needed to process memories after identifying a significant past event. The amount of time working through the specific memory was reported to be relatively short, although the work leading up to the processing and then integrating the new information could take longer, depending on what had emerged. This is shown in Figure 4-20.

The work with those memories was generally facilitated by the counsellor for most of these participants in keeping with recommended practice, through exploring the memories the participant was already aware of, followed by others as they emerged (Herman, 1992). Once a particularly difficult memory emerged, participants usually explored it through discussion with their counsellor, using imagery. However, a few participants were offered Eye Movement Desensitisation and Reprocessing (EMDR)

by their counsellor to support the process. This allowed a detailed discussion between the therapist and client about the technique and the use of equipment, which meant that there was clear, informed, consent to do the work.

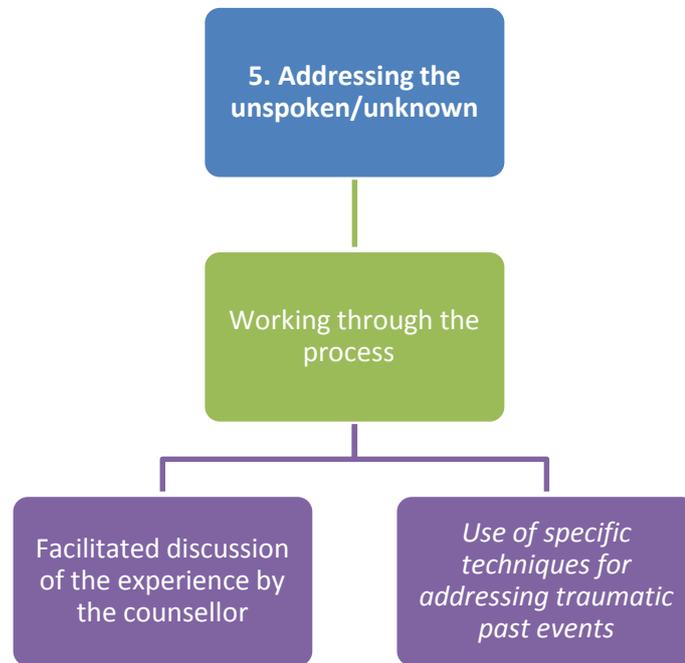


Figure 4-20 Participant descriptions of remembering the trauma

Although Samantha’s experience (see section 4.3.2.1 above) was led/directed by her counsellor, this was unusual within this research and did not reflect the way other participants saw the process. The process was generally seen as the counsellor facilitating the client’s process, and working with what emerged.

Karen: “I was never asked any questions, and it was never anything like right, and what happened here then”

Even though some of the participants began counselling with the desire to work through previous trauma, as Elizabeth mentions above in section 4.3.2.1, it still took time to disclose. Even then, when they got to the point of recalling the incident, it sometimes presented difficulties that they had not expected.

Jenny: “But I said to her, ‘it’s as though it wasn’t me’, and she explained to me, she said ‘What you’ve done in your mind is you’ve stepped back from it.’”

Here, going back to the event and apparently seeing it through the eyes of someone else was disturbing for Jenny. The knowledge of her counsellor and her ability to explain a complex idea in an easy to understand and non-threatening way allowed her to stop worrying about how she saw the event and instead work through what she remembered. This highlights the need for counsellors to be able to take what might seem a strange experience to the client and normalise it in the context of trauma work.

Those participants with counsellors who preferred a more structured approach to trauma work had a slightly different experience. In the example below, the counsellor became aware of a traumatic memory appearing and the potential impact. She then followed a process of informed consent.

Lucy: “the counsellor asked ‘can we try a few different ways of exploring them?’ [...] and I asked loads and loads and loads of questions, but then I thought ‘well this could be the way forward to explain the thoughts that I’d had for years and years that I couldn’t explain’.”

This allowed the memory to be processed in a safe and appropriate way, and also allowed the client to plan for the emotional difficulties of dealing with revealed memories by, for example, arranging to take the day off work. The nature of EMDR processing meant that the exploration appeared to be covered in a single session as the participants only reported the use of the equipment once. However, the exploration of the issues leading up to the need for EMDR and the processing of memories explored during that session reportedly took some weeks. The participants who engaged with this treatment felt it went well and it suited them.

More generally, the participants had become curious about their memories and were aware of the potential impact of those on their lives. This curiosity seemed important for addressing trauma, as it provided motivation to explore and facilitated processing of the memories.

4.3.2.3 Benefits of resolving past experiences

More than half of the participants talked about the benefits of resolving past experiences. These tended to split into two categories: those who felt physically different as a result of the work, lighter and unencumbered, and those who felt relief

because they now felt that they knew what had happened. These two aspects are shown overleaf in Figure 4-21.

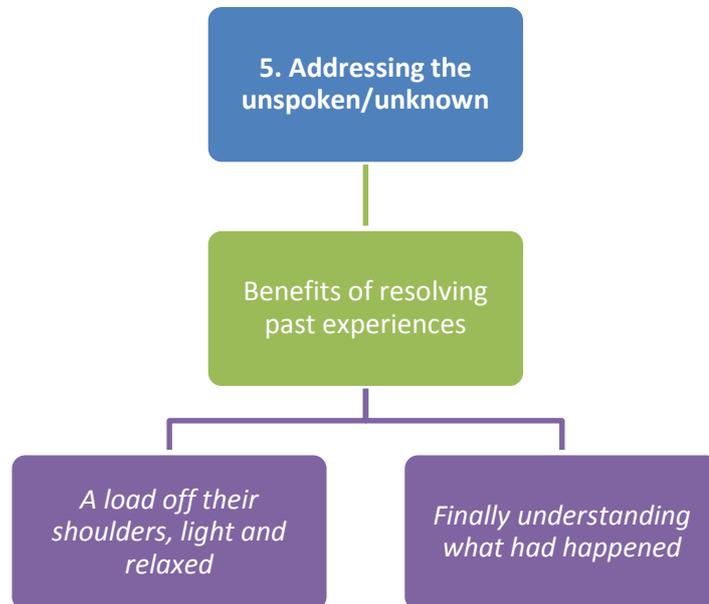


Figure 4-21 Benefits of resolving past experiences as described by participants

One of the participants described how not remembering something can be frightening, as the imagination can offer a multitude of scenarios. Feeling that she now knew what happened, even if it was not pleasant, provided relief as there was no longer any uncertainty and the experience could be processed. After working through really difficult memories, some participants talked about the intangible benefits they felt after doing so, whilst others reported that the process enabled them to understand more about what had happened.

Ailsa: “Oh it was such a lovely feeling, and when I went out as well, and I had that feeling for a long time. I can still remember it, it was lovely, I felt so relaxed and so light.”

Jenny: “I couldn’t believe it. Wheewww! I just can’t describe the immense relief it felt to confront it [...] and once I did the difference it made.”

This sense of a release of energy was described by a few of the participants. Much of the trauma literature focuses on the difficulties of this work and yet there can be considerable benefits from processing memories beyond the cessation of symptoms. As Ailsa mentioned above, those physical feelings could be remembered at a later date providing a very positive reminder of the benefits of addressing a fearful experience.

For other participants the process described was more cognitive.

Ruth: “it was full on [...] I talked much less about the current situation because I realised, you know, I had to go to the past to see why this had happened”

Ruth found that understanding how her life had unfolded enabled her to see why she behaved in the ways she did, presenting the opportunity for her to choose to be much more in control of her life.

Working through and processing these memories appeared to be important as it changed the way some of the participants valued themselves. As Jenny said above, having the courage to face something that had frightened and intimidated her for years helped to change her perception of herself. As Jackie reflected on the many group sessions, courses and previous counselling she had, she identified how this particular counselling had differed.

Jackie: “although I have had the coping mechanisms and I knew tools and things that worked before, I really feel and believe that I deserve it now, and that’s a big difference”

This change in the way she viewed herself was echoed by others, including Veronica.

Veronica: “it’s made me be happy with who I am. For the first time in my life, it’s made me look at me and go ‘I’m happy, I’m, I’m a person in my own right’”

Although fewer than half of the women reported this effect, this still appeared to be an important element. When investigated more closely, what appeared to be different for this group was the reported quality of their relationships with the counsellor, as evident below:

Jackie: "I actually came to see (counsellor) the morning that [family member] died. I had stayed with her overnight in hospital and I witnessed her last breath and [...] she said "you didn't have to come in" and I said "I did, and I wanted to"

Karen: "I've never felt loved. I have now but, I'm not saying that she, she loved me, but I thought she was bothered about me, and she showed me some signs of, like, motherly, sort of in comfortable and warmth, and I thought this is nice to have this"

Veronica: "I know there's somebody there that's been there for me and cared, and I know she's doing her job, but at the end of the day, I think she give me more than 100% of her job."

The participants talked about feeling cared for and believed in, and felt genuine affection. They felt that the therapist was not simply doing their job, but was interested in them and would go further than expected. For people, such as Karen, who perhaps had never had the backing and support they had needed or, for a variety of reasons, had kept people at arms length, the very human dynamic of having a consistently caring and interested other transformed the way she felt about herself.

However, for one participant the trauma appeared to remain unresolved. As described earlier (see section 4.3.1.2), Elizabeth had struggled to accept or believe the positive personal messages her counsellor had tried to give. Although she had made progress in being able to discuss a specific traumatic event in her life, she was aware that there were still things which needed to be addressed.

Elizabeth: "I just have to nip it in the bud and say 'stop it Elizabeth', just deal with it that way. I can't keep coming back 'cause like I say it's just going over the same old thing. I know what the problem is, I've just got to deal with it, I've just got to be strong and deal with it."

Elizabeth did not offer any recollection of specific trauma work, but it is important to note that the question was not directly asked as part of the research. This interview was different to the others described here due to Elizabeth's emotional response in recounting her trauma and also her reluctance to accept at an emotional level what she clearly understood cognitively. She felt she could not keep going back into counselling even though things were not yet fully resolved and she could potentially benefit from doing so. However, she wanted to take part in the research because she had received very positive support from her counsellor when she felt able to take some action as a result of discussing her memories. If the purpose of the counselling had been to resolve the trauma, then it would appear the work was unfinished. However, if the purpose of the work was to help the client to confront previous experiences, then it was highly successful, and Elizabeth was very grateful that she had been able to do so. It is important to recognise the value of the work to the client, even when the therapeutic outcome may not appear complete.

4.3.3 Summary

Stage 2 of the work was clearly very important to the participants, although there were a variety of different experiences. Those who were invited to address past issues from the base of a well-established therapeutic relationship appeared to have more positive experiences than those who felt directed at an earlier stage. However, confronting issues from the past was beneficial, whichever model of treatment was selected.

4.4 Stage 3: Preparing for life after counselling

As the counselling continued, the participants began to realise that they no longer needed quite so much support from their counsellor. This prompted thoughts that their counselling could or should come to an end and a period of reflection was needed as they considered this. This could take one session or a period of weeks. Most of the participants discussed the ending with their therapist, either at their own instigation or when the topic was introduced by the counsellor. An important aspect of this part of the process was hearing that they could reaccess the service if they needed to in future and that the counsellor supported their decision to end now.

Very few of the participants had re-accessed counselling at the time of the interviews and those who had done so had defined very specific goals for the work requiring a few sessions with their previous therapist. As a group, the participants reported continued progress since counselling, having a future orientation, whilst also acknowledging that life was not perfect and there was still more to do. In comparison to the other Stages, this one is less detailed as participants' descriptions indicated that most of the work had already been done.

4.4.1 Step 6: Getting ready to leave

During the interview process, participants were asked how the subject of ending came up, as a way to lead into the end of the process. However, what emerged was a specific part of their decision making process, sometimes, but not always, prompted by the counsellor. These factors are shown below in Figure 4-22.

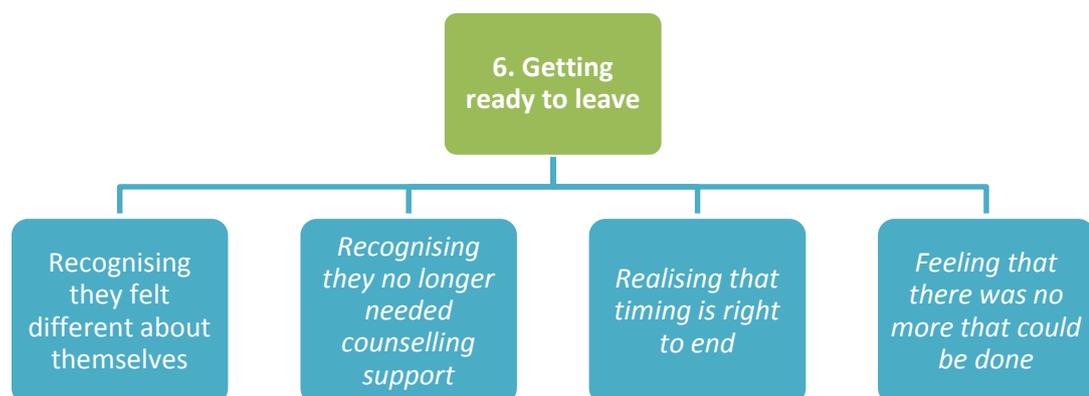


Figure 4-22 Factors contributing to female participants' decisions to leave counselling

For some of the participants, who had had many months and occasionally more than a year of counselling, there was a period of adjustment, of getting used to the idea. For others, where the counselling had been shorter, the decision seemed to happen quite naturally within one session. There were a variety of emotions at the end, from positive feelings of having concluded the process, to more ambivalent feelings about timing and the potential for further gain. An additional concern for some was that, as all of the agencies offered free counselling, they were taking up more time than was necessary when others could benefit. These are all highlighted below.

Some of the participants were aware of feelings of well-being, of feeling that they had made significant changes, that they felt different: happier, more self confident, independent, hopeful, strong.

Lucy: "I had my self confidence, probably not back, but in a totally new way. I felt more independent than I'd ever felt before, [...] I also had a renewed sense of hope that actually things can go very, very wrong, you can be in a terrible situation, but actually you can work through it"

Natalie: "I felt happy, I felt strong. [...] So I think I was on that up for quite a while before it was my decision for the end of the therapy."

Veronica: "I felt happy with who I was, I didn't feel as though I was that person any more. So I think that was the end of it [...] because I'd finally got to where I needed to be."

Others felt they had gained enough from the counselling for the present, that they could deal with what they needed to without further support. What was different for these participants was acknowledgement of feeling better, but without claiming the deeper sense of change as the group above.

Amanda: "I just felt like actually I don't feel like I need counselling any more. I feel much better."

Fiona: "it was the right point, because I mean you don't want to feel like you're sort of coming here and there's other people that, I mean they're a charity and there are other people that they help [...] she just made me feel really, like intelligent again"

Ruth: "Well I just didn't have anything to say. I just felt as though it was all said. I was just completely blank"

There did not appear to be any reason from a client perspective for this difference in how they felt on ending, although both Amanda and Ruth had reportedly experienced some difficulties during the counselling process (see section 4.2.3.4).

For two of the participants, there was recognition of getting to a point of ending and a need to end, although they did not necessarily feel they had addressed everything.

Samantha: "I thought I know we're kind of getting there, so I was preparing myself away from here that this would be my last one."

During the interview Samantha indicated that there was a small amount of reluctance to end but external pressures of being within a voluntary service plus life events prompted the decisions, and she made preparations as she described above.

Finally, there were two participants who indicated that they felt that there was nothing else that could be done, rather than feeling they had reached an ending. There might have been something else that they needed from counselling, but they did not seem able to identify it.

Elizabeth: "we just seemed to have been going over the same ground and with the same result [...] I don't think there was anything more she could have done for us"

Karen: "it got less and less, and it was once a week and then it got to once a fortnight, and I felt I was coming towards the end [...] I felt there was nothing much else could be done"

The decision to leave, whether planned or unplanned, seemed to be a significant step in the process of counselling. The participants reflected on how far they had come compared with where they began and, where there was choice, whether they felt more could be gained by staying. This period was also a chance to try out the things they had learned during counselling, to check that they could live autonomously without access to therapy.

4.4.2 Step 7: Au Revoir

Once the participants had decided that it was the right time for them to end, the ending with the counsellor took place where that was possible. The factors associated with endings are described below in Figure 4-23.

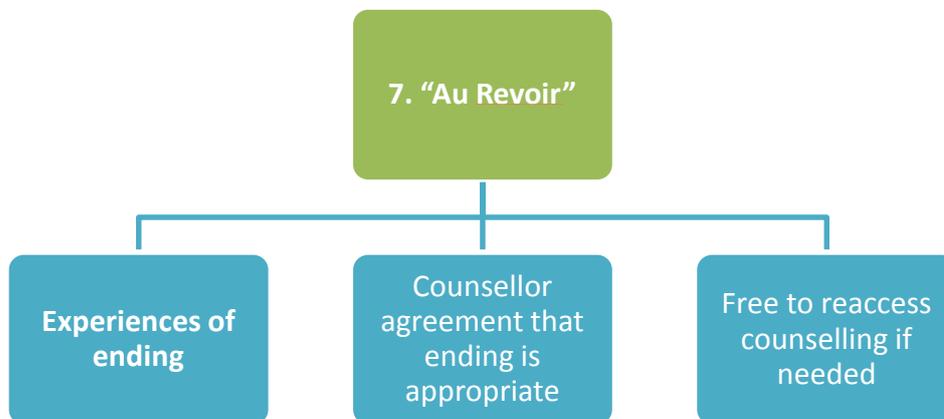


Figure 4-23 Factors involved in the final ending of counselling

Whilst some were ready or had decided to leave, others were leaving due to external pressures, such as agency funding constraints or a return to work. However, for more than half of the participants, hearing that their counsellor also felt it was appropriate for them to leave and that they were free to come back later if needed was said to be important. These factors are developed further below.

4.4.2.1 Experiences of ending

The ending felt like a natural next step in the counselling process for more than half of the participants. They felt that they had achieved what they wanted to and were ready to leave. For some of the participants the ending happened as part of a counselling session, in discussion with the counsellor.

Natalie: “she said ‘so how do you feel about the sessions? Do you feel like you need, you want some more?’ ‘What do you think?’ ‘It’s not what I think, it’s what you feel.’ ‘I feel like I’m ready to go out on my own.’ [...] So she said ‘Right. Well the door’s open, we’re always there, I think you’ve done a fantastic job’ ”

Paula: “I think because [counsellor] said I’d done so well. [...] She said ‘You can come back any time you want, we’re always on the end of the phone, but I think you’re ok to go off into the big wide world. You’ve done really well.’”

For others, a final session to end the counselling was offered and felt more appropriate.

Jenny: “she said ‘How do you feel now?’ I said ‘I could take on the world.’ And I do feel that and she said ‘Well, do you want to have our last session next week, or come back after [the holidays] and finish?’ I said ‘No, next week’ll do’.”

Lucy: “I said ‘I would like to say this is my last session and I don’t need to come any more but I’m scared’ [...] so she very kindly arranged a session a month later if I wanted it and I had the choice whether to come”

Each of these participants felt they had gained a great deal from counselling, and a part of their ending process was acknowledging their new found confidence to leave their therapist.

A third group encompassed a small number of participants who simply felt that they no longer needed or would benefit from further counselling and made the decision to end themselves.

Ailsa: “I just felt I didn’t need it any more. And [counsellor] thought I didn’t, but if I ever did, I just had to get back in touch.”

Elizabeth: "I don't think there was anything more she could have done for us, you know. [...] I hope I don't but I'll probably will relapse and get so low that I've got to come back, but I know that she's there, you know, if I need to see her."

Ruth: "I'm completely empty'. She said 'well that, that's fine. That's, you know, don't force yourself'. I really had absolutely nothing else bugging me. I felt as though it was all sorted."

Whilst all of the groups talked about feeling better as a reason for the ending, the first two groups had an active discussion with their counsellor about ending, and talked about how well they felt. The third group seemed to make the decision to end and then informed the counsellor as soon as they felt they had reached a place of stability. It was observed during the research that this group had struggled more with some aspects of the counselling process, which may have encouraged their decision to leave as soon as they felt able to cope, without discussion with their therapist. Perhaps the painful nature of the work had an impact on that process.

Finally, a small number of the participants formed a fourth group, expressing the view that finishing counselling was a relief, as the process of going through difficult experiences and memories, whilst valuable, was not pleasant.

Mary: "I think the counselling got me through the worst bit of it, what I needed to do, and I think when I went on the [other] course that just give me the lift.

For the remaining participants, the ending was brought about by other factors, and here the participants tried to rationalise the position they were in and how they wanted to respond to it.

Karen: "I got a phone call to say that she could no longer counsel me but somebody else could take over. [...] they've said, you know, that they'll keep the door open, and I can come back any time. I don't feel like I am in a place now where I could go back again to the beginning and explain to another person the ins and outs again"

Although Karen had heard and understood the explanation for having to stop the counselling, there was still a sense of a dull ache in the interview, of unfinished business, even though she had come to terms with her situation. She knew she could go back in principle, although she had no desire to do so.

4.4.2.2 Counsellor's agreement that ending is appropriate

One of the factors that encouraged the participants to leave, and was described by more than half of the participants including Ailsa and Ruth above, was that the counsellor agreed with them that the time was right for them to leave, irrespective of who had introduced the topic.

Amanda: "when I turned up for that final session I just felt like actually I don't feel like I need counselling any more. I feel much better. She said she could feel, tell that that session I hadn't really needed to talk about it any more, so we just agreed there and then that that would be the last session."

Natalie and Paula talk above about how well the counsellor thought they had done, whilst Lucy was free to make the decision about whether to attend a final session, which she took to mean that the counsellor was happy either way. Whilst this could be interpreted as seeking permission to leave, which could indicate a problem with self-efficacy, this was not how it appeared during the interviews. Rather, it seemed that the counsellor was now a trusted ally and confidante and would only agree with them if they believed it to be the case. Rather than permission, it was more confirmation that they were able to make their own decisions fully and well, thus adding to the confidence that had grown.

4.4.2.3 Free to reaccess counselling if needed

In addition, more than half of the participants mentioned, like Elizabeth, Karen, Natalie and Paula above, that they had been told they could come back to counselling if they ever needed to and that helped to give them additional confidence to leave. This sense of having a place to go back to is the reason for calling this Step 'Au revoir'. Whilst most of the participants have not had to reaccess counselling, they found it comforting to think that they could, if they were ever in need.

Samantha: "I think it was, what helped that was knowing that I could dip in again if I needed to [...] and I haven't.

But just having that safety net made the ending easy. Easy, easier, made it ok.”

Most of the participants began counselling from a place of not knowing what they needed, largely on their own in coping with life and their emotions and with little faith in their own ability to decide what to do. These last few steps in the counselling process show growing trust in themselves to make their own decisions and at the same time their trust in another to support them in doing so. This part of the process reflects the internal changes that had come about.

4.4.3 Step 8: Life after counselling

Although counsellors can see the end of therapy as the point where they have no further contact, the participants reported that the impact of their counselling continued beyond their weekly sessions. All the participants reported positive changes to themselves and/or their lives since receiving counselling. They still valued the counselling and almost all saw that they had made subsequent progress.



Figure 4-24 Factors discussed in “Life after counselling”

Whilst more than half of the participants acknowledged that they still had more to do, almost all of them were looking forward positively to the future. Participants saw the value of the counselling not only in helping them through what had been a particularly difficult period of their life, but also in terms of the positive changes to their lives going forward. These factors are shown in Figure 4-24 above and are discussed in more detail below.

4.4.3.1 Has made progress

This aspect of the work contained a number of different factors, and so has been shown pictorially as well as descriptively below in Figure 4-25. In general, the progress made was either about how much better they felt in themselves or changes to how they interacted with others.

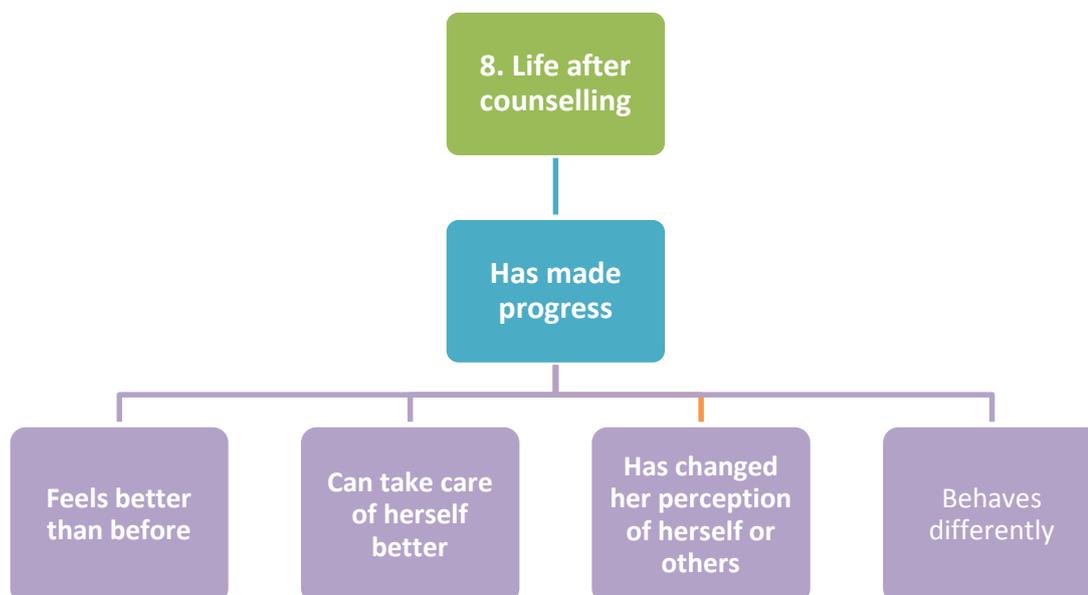


Figure 4-25 Progress made as a result of counselling

After counselling, almost all of the participants talked about how they felt better now, although some months had elapsed between finishing counselling and taking part in the research. They mentioned being happier and more confident most often.

Jackie: “I just feel stronger and more able, more confident to do things”

Veronica: “it’s been fantastic for me, it’s made me a new person, it’s made me a happier person, and a more confident person.”

Other participants highlighted specific areas that were important to them, such as being able to go beyond day to day activities.

Jenny: “My life. In two words, my life. I didn’t have a life before, I existed. And there’s a big, big difference between living and existence.”

Mary: “to be able to be myself and to be a better Mam, which is why I come, and to be able to go do my job, and know I do it good and I can do things well on my own”

Paula: “It changed my life completely. And I look back and I think I could be like that now, I’d be, I felt like I was in prison. Now I can wake up in the morning and think ‘what shall I do?’”

Almost all of the participants talked about how they were able to take care of themselves better. Here the participants acknowledged that they were able to deal with issues that arose better, in terms of both skills and their own response to the situation.

Elizabeth: “And you’re learning a new, a new way of dealing with things [...]. Which is really good isn’t it, but you’ve got to keep doing it”

Lucy: “I’m a lot more flexible, I’m a lot more relaxed about things, I don’t get wound up about things any more and it’s nice to be like that.”

Mary: “Whereas before, I would have just gone along with it [...] but when you realise no, you don’t have to put up with this, then you can get on with your life and do what you want to do, and move on.”

Almost all of the participants talked about changes in the way they perceived themselves and/or others in their life. For some of the participants, changes to the way she saw herself were particularly important.

Amanda: “it has helped me to ultimately decide that I’m ok”

Natalie: “we’re getting on [...] and I don’t feel like I’m doing all the compromising. I feel like I am just being who I want to be.”

Samantha: “I freed myself up from carrying round a huge weight of negativity about myself.”

The participants did report, as mentioned previously by Lucy and Karen in section 4.3.1.1, a sense of trusting or having more faith in others and some, like Natalie above, reported changes in their relationship with their family.

Jenny: “My boys are over the moon. [...] He said “It’s lovely to see you like this, you’re like a different person.” And that helps. That boosts your confidence doesn’t it?”

As the participants reflected on differences in how they were, more than half of them said they were aware of their own behaviour changing.

Ailsa: “But everybody has noticed a difference. I can talk to more people. Once over, I don’t think I would have been able to talk to you, because I didn’t know you.”

Lucy: “I wasn’t as suspicious of other people as I used to be [...] So that gives me a bit more self confidence into be able to voice my opinions when I have an opinion about something, rather than thinking ‘I’d better keep quiet!’”

These are a few examples of how specific behaviours have been helpful to the participants. Others talked about being able to go out on their own, being able to share their experience with friends, or of being happy to provide opinions. Whilst they are all different, they all share the same root: that of being able to exist differently in the world in a way that is helpful to them.

4.4.3.2 Still more to do

Whilst there were clearly some helpful aspects of counselling, for more than half of the participants there was an acknowledgement that there were still areas of their lives that indicated some discomfort and may need further attention.

Fiona: “We still don’t answer the house ‘phone. We let people leave a message and then we ring back [...] even though that’s fine now.”

Mary: “But he’s still in our lives, and we’ve said we’ll see how we’ll work it that way”

Paula: “he’d been choosing my clothes if I went anywhere. I didn’t have any choices myself and [counsellor] said ‘you have got choices’ and [...] it causes a lot of arguments actually with my husband at the moment, I say ‘No, I don’t want to do that’ and [he says] ‘Oh no, you’ve got choices!’”

In general, these were specific issues that the participants were aware of, and were dealing with in their own way, at their own pace. For the few participants who had needed further support to resolve them, they had sought help specifically for that issue.

4.4.3.3 Looking to the future

Almost all of the participants reflected on how they now saw the future more positively. They were all at different life stages. This meant that the things that were important to them in the future varied from dealing with new, intimate relationships to being fully in the life they could now see. They also recognised the need to draw boundaries with abusive individuals.

Amanda: “I am doing the right things and I am recognising if I am bringing some kind of behaviour, [...] and rectifying it, so I don’t need to worry [...] that I’m gonna make problems in this relationship.”

Elizabeth: “but now, this is the rest of me life now, my new life that I’m getting on with as opposed to what I had before.”

Ruth: “you know invaluable in terms of the future and not allowing abusive people to get into my life again.”

Samantha: “at the beginning all I could do really was kind of get through each day and I couldn’t really think

beyond that. And at the end, I was able to look much more widely in my life”

Whilst there are positive aspects to looking to the future, it is also important to reflect on how far the participants came on their counselling journey, and for some, seeing the benefits of counselling brought sadness that they were unable to access the help they needed earlier.

Jenny: “But, my biggest regret is that it didn’t happen years ago. You know, because I’ve missed out on a lot.”

4.4.4 Summary

Although endings formed a small part of the participants’ counselling experience, the participants benefited from being able to determine how and when to leave. However, even when this was not possible, the participants were able to understand the ending and to take comfort in knowing they could reaccess at a later time if they required. A key part of the participants’ process was becoming comfortable with the concept of leaving and gaining confidence in their ability to make decisions independent of counselling. Perhaps as a result, the participants felt that they had continued to grow and develop since leaving, as they continued to practice their new skills and approach to life. This ensured that the positive benefits they had gained from counselling were sustained.

4.5 Review with participants

The model outlined above was reviewed with four of the participants during its construction. The first two interviews took place after the conclusion of the pilot study and confirmed the broad process emerging from the data which was later published (Roddy, 2013). The other two interviews discussed a version of the model very similar to the one presented here. The participants confirmed that the model reflected their own journey through counselling. During the interview, the participant compared what had been presented with their own experience, and as there were a number of perspectives presented for many of the stages, she was able to find her own experience reflected within the detail. Most took the opportunity to retell aspects of their story to support the model, and this aligned well with the previous interview, as the context presented was similar although there were occasionally subtle differences in detail. Nevertheless, this provided a high level of confidence in the experiences shared. Of those who suggested changes, this was invariably about

the way the data had been presented rather than the content or structure. As a result, there is a reasonable level of confidence that the data presented here are a good reflection of the experiences of the participants.

4.6 Summary

This chapter has shown the development of a model of DV counselling from a female client perspective. The representation is based on features of the process significant to the participants which extend beyond the counselling room. The first stage introduced issues related to the degree of emotional distress, accessing support, and the uncertainty about the process at the beginning of counselling and for up to eight sessions into counselling.

The second stage indicated a period of stability which included the potential to work through trauma as well as exploring new ways of looking at themselves and others. It is also important, however, to recognise the difficulties of working with trauma, and the importance of counsellors working within their own limits and with the full consent of the client.

The third stage shows the process of ending. The participants spent some time confirming that they could manage on their own without counselling, using all of the strategies and skills they have learned independently. This helped them to make the decision to end either in discussion with their counsellor or independently. The possibility of being able to return at some point in the future helped them to leave. However, more than this, they felt a new commitment to life and a reconnection with people, in some cases reportedly for the first time that they can remember. The counselling process had been life changing for some of the participants.

5 Findings from Male Participants

5.1 Introduction

Although the arrangements for interviewing male survivors of DV were the same as for the female survivors, the outcome was slightly different, as discussed in the Methodology Chapter. In keeping with the female DV organisations, the male DV agency offered a counselling service. However the scale of the services offered was different. The female organisations had more than one counsellor, working on a number of days per week and had access to a range of counselling clients. The male agency had one counsellor who offered 3 sessions per week, and thus had a limited number of clients to access. The agency addressed this by contacting men who had accessed other services at the agency and asking if they had previously received counselling. The men were included in the study if they responded positively.

During the interviews, it became apparent that the men had identified three of the agency programmes as 'counselling':

- Support workers offered telephone and 1-to-1 support sessions for men who were struggling with their emotions. Although these were not formal therapy sessions, the men referred to and identified this support work as counselling.
- The agency also offered a group programme, which involved personal disclosures from group members as part of the process. Referrals were also made to and from 1-to-1 counselling and support workers into this group.
- Formal 1-to-1 counselling sessions with a qualified therapist. Access to counselling was restricted to six sessions unless there were extenuating circumstances, to allow more men to benefit from counselling. This meant that less complex cases tended to be offered support or group work rather than 1-to-1 counselling.

In addition, one of the men who responded had used his own resources to obtain both private and employee assistance counselling. The breakdown of the interviews and the type of counselling experiences related by the male participants is given in Table 5-1.

Table 5-1 Reported counselling experiences by male participants

Counselling Experience	Number of participants
1-to-1 counselling only	2
1-to-1 counselling plus group	1
Group work only	1
Group work plus 1-to-1 support	2

The men's agency had been established for over 15 years and service delivery had evolved to fit the needs of the client group. It could therefore be regarded as client - as well as funding - driven, as the agency strived to make the most of their limited resources. Whilst the interviews did not generate the amount of data on the counselling process that had been envisaged, it did give a fair representation of the services currently available for men, including counselling.

The agency had a history and track record in gaining referrals and delivering services that may be missing from newer agencies in the UK. It therefore provided insight into a mature male DV service. However, the small number of participants involved in this part of the study and the smaller numbers involved in each of the counselling and support activities, meant that there was insufficient data to produce a robust model of preferred counselling practice.

The variance between the men in the number and type of services they had accessed caused some analytical difficulties, as they did not follow a single process and therefore their counselling journeys were not directly comparable. Instead the transcripts were split into data sets containing before counselling experiences (6 participants), 1-to-1 support (5 participants), group work (4 participants), and after counselling experiences (6 participants).

During the interviews specifically associated with 1-to-1 counselling, the researcher became aware of some commonality of experience with the female participants. Whilst not generating sufficient data for a conclusive model, it does provide a useful starting point for further research. This chapter will describe the findings for men, beginning with the overall model of support outlined below.

5.2 Emerging model of DV support for men

From the interviews with participants, an outline of the process offered by the agency was identified and is shown schematically in Figure 5-1 below. Although the research was primarily focused on the counselling experiences of men suffering DV, what emerged was a flexible process of support that the men could engage with to meet their needs.

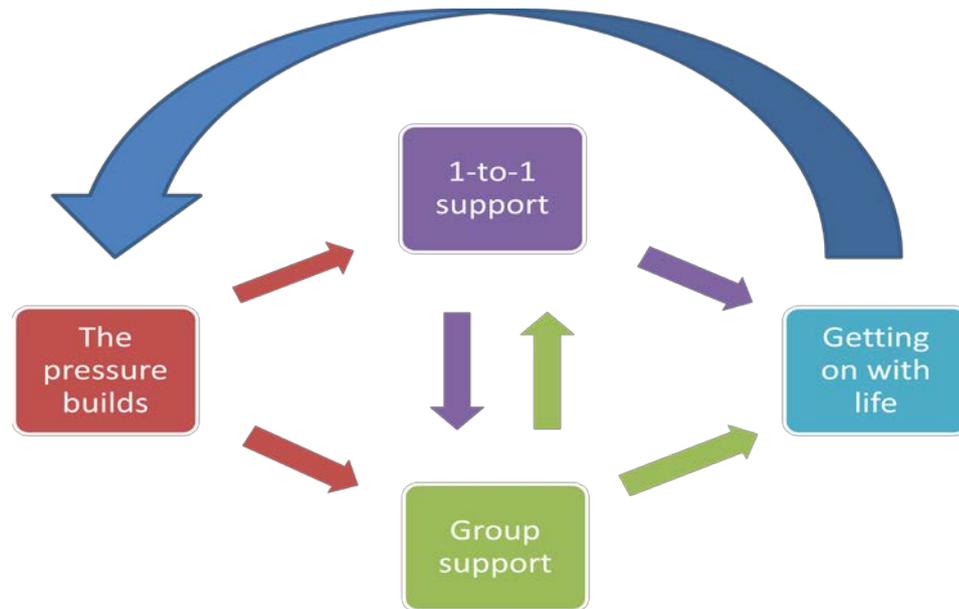


Figure 5-1 Schematic diagram of the support paths of male survivors of DV

Those who received 1-to-1 support could also opt for group work and those who accessed the group could go on to 1-to-1 counselling, usually by recommendation from the group leader. Even though those beginning counselling could go on to access the group, none of these participants did so, although the study size is too small to draw any firm conclusions from this. Due to the lack of resources, counselling support was very limited and men accessing the agency were more likely to receive 1-to-1 support from agency staff members than to be referred into counselling.

As the male participants went through different combinations of support, some men have provided more quotations than others in the sections that follow, as they accessed more services. However, each of the four sections identified in Figure 5-1

has been presented as described in section 3.6.7, providing both pictorial and text representations of the data.

5.3 In the beginning: The pressure builds

All of the participants had separated from their partners and had been aware that their relationship was in trouble prior to the split, although they felt they should tolerate or work through their issues. Descriptions of their lives with their partners suggested physical, emotional, financial and psychological abuses. None of the participants mentioned sexual abuse.

Andrew: “waking you up at night [...] hitting you, waking you up [...] to fight about it, about nothing and then you done something wrong [...] not having her speak to you for maybe two weeks and then when the two weeks would be up [...] she would never remember what.”

Hugh: “I had my redundancy money and that also went in my wife’s name so that she would have control of it”

James: “my wife stabbed me [many] times. I went out of the house and called for an ambulance and she walked out of the door with my two children and turned around and told the police that I self harmed and she was believed.”

Peter: “the mental and the emotional abuse far outweighed the physical, and the damage that it did was a lot more severe than any physical violence.”

Changes in the marriage, either through finding out their partner was having an affair or through an escalation of their partner’s difficult behaviour, brought things to a head.

Hugh: “there were nights when I would go home I couldn’t take the violence, so it was nice just to be away from the wife. So I’d tell her that I would be sleeping in the car, sometimes I’d go to my brothers or sisters”

Matthew: “She started becoming violent then, throwing stuff at me, giving me a broken finger, came at me with a knife”

These incidents provoked the break up of the relationship, with five of the six men leaving the family home and one becoming a single parent.

This change prompted personal and relational difficulties, as shown in Figure 5-2 below, which they reportedly struggled to manage on their own. After years of abuse, they experienced guilt and anger at their situation and felt lonely and isolated after losing touch with family and friends. All of the participants reported that their ex-partners continued their abusive behaviour from a distance. This combination of factors increased their feeling of pressure to an unbearable level prompting them to seek help.

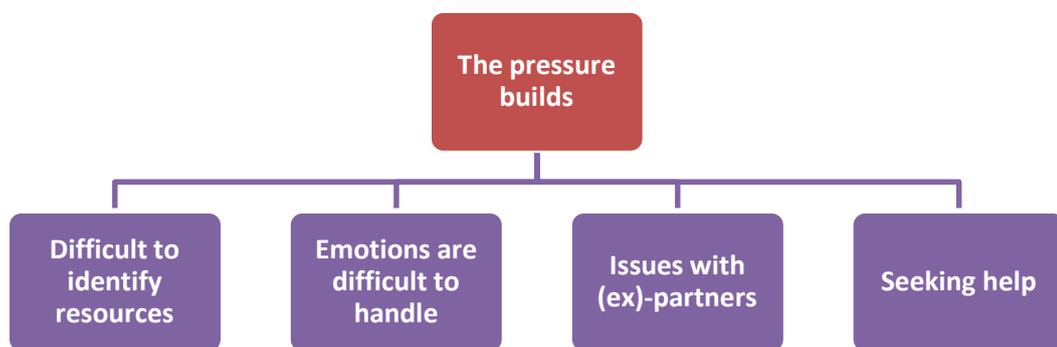


Figure 5-2 Analysis of how pressure built up for the participants following the break up of their marriage

The pressure began to be released once they had access to the agency staff and from there access to ongoing support. Each of these elements is described in more detail below.

5.3.1 Difficult to identify resources to help himself

The men reported that the previous resources they would normally have accessed no longer seemed to be available to them: their family and friends or their ability to cope on their own, as shown in Figure 5-3 overleaf.

They had become isolated and no longer found it easy to engage with people. They Felt that they should be able to handle this on their own and yet acknowledged that they were not coping, which led to feelings of guilt and failure.

Hugh: “I held back on a lot of stuff, because you’re afraid that they’ll say ‘you’re a man, I mean why could you not stand up for

yourself? Why can you not do this, why can you not do that?
You should be in control.”

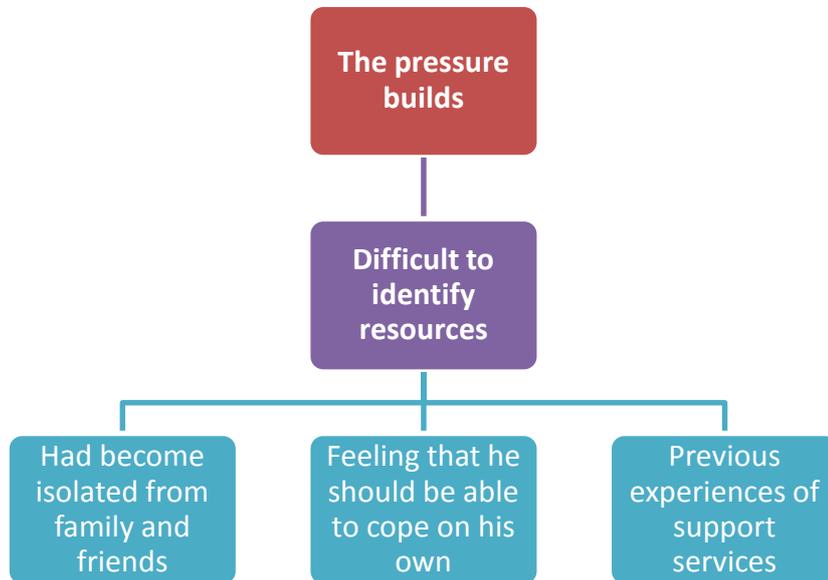


Figure 5-3 Issues with identifying resources to help himself

Matthew: “I had no friends, no family, it was so much less hassle not to go down to me Ma’s for dinner or whatever, and before I knew it I was just on me own. I’m not saying she did it consciously, but she definitely did do it.”

As with many individuals experiencing DV, the changes in these men had taken place over a period of time. They were largely unaware of the impact of each small change reducing the amount of contact they had outside of their relationship.

Two of the men had tried to access counselling previously. Peter had gone at the request of his wife without really understanding what it was about, and they did not continue.

Peter: “I found it extremely difficult in marriage counselling, to kind of get my mind across, and to kind of, actually to explain my emotions. [...] I probably didn’t understand myself what I was feeling.”

On the other hand, Mark had sought out a number of different counsellors but had yet to find one who could really help him with his situation.

Mark: “what I needed to a large extent were [...] tools to be able to cope with difficult stuff and counselling wasn’t hugely good at providing me with that.”

The men also reported difficulty with some of the police, health and social workers they had met.

James: “It’s funny because no matter what I said, it didn’t matter, it didn’t count.”

Mark: “it left a very sour taste in terms of health workers [...] where people are basically running away from you in case they become embroiled in something.”

Although the men knew they needed help and were trying to access support services, they found it hard to find people who understood what they were saying and were prepared to help.

5.3.2 Emotions are difficult to handle

The men had become isolated during their relationships and had spent much of their time focussed on trying to keep their partner happy. Without their relationship, they felt alone in the world and unable to discuss the marriage break-down with anyone. As shown in Figure 5-4 overleaf, this prompted a surge of emotions which they found difficult to manage.

The participants spoke about their difficulty in talking to anyone they knew about the abuse, as they had been covering up and making excuses for their partners for years. In keeping with DV literature for women, some of the men reported they were still hoping to find a way to make the relationship work.

Andrew: “I always, you know, they did say things you know ‘you shouldn’t let [wife], that’s not normal.’ I’d say ‘I know, sure, she’s just in a bad mood’”

Hugh: “Nobody’d know, brothers, sisters, nobody, and they would say ‘is there something wrong with you? Is there trouble out there?’ and I’d say ‘oh no, just feeling a bit down’”

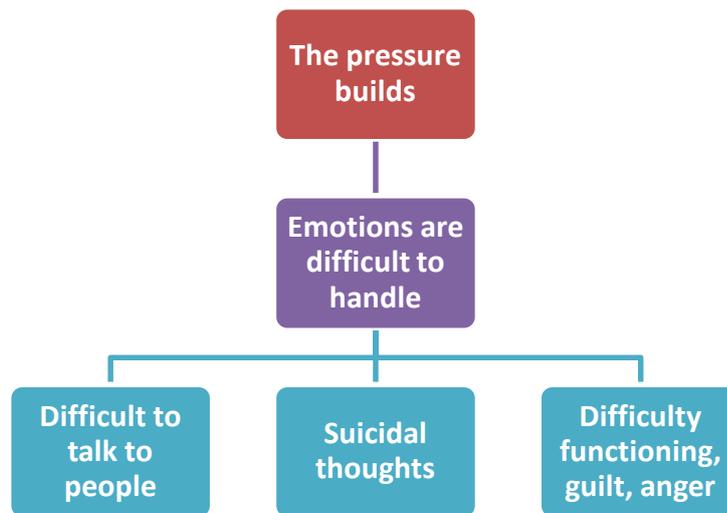


Figure 5-4 Emotions resulting from the relationship breakdown were overwhelming

Peter: “at the time, I didn’t want any kind of, saying anything about my wife to anybody, because I still in my heart wanted to reconcile and get back with her, so it was very difficult for me to talk about it, especially negatively.”

The participants reported a tendency to hide what was going on within the relationship to others in the outside world, and here it seemed to be a sense of loyalty to their partner that prevented them from saying more. Whatever the reason, not being able to share and talk about what was happening made it very hard to change things.

Although life was difficult when they lived with their partners, it seemed much more difficult with separation. There was a feeling of anger and desolation that the family they loved had gone.

Andrew: “my ex-wife had moved out and she had taken the children and I was at a, at a loss, I just had so much anger with everybody”

Matthew: “initially when our marriage broke down, like I was in a hell of a state [...] I swear to God that I didn’t sleep for 5 days, I

just couldn't go to sleep [...] within a week or two I'd lost loads of weight"

Peter: "I was in a very distressed state at the time, it's hard to remember back now, like it's kind of hard to remember the kind of frame of mind I was in at the time, it was quite chaotic and hectic"

The loss of the person they loved, often suddenly when she simply announced she was leaving, left the men emotionally distressed and they referred either directly or indirectly to suicidal thoughts.

Andrew: "Because you know there was very dark moments when I had terrible thoughts, you know, terrible thoughts"

James: "Thank God I'm here, like as I said. Deepest and darkest thoughts, absolutely, I'd be lying if I said I didn't, but the counselling I got here, it did, it saved my life."

The impact of breaking up resulted in other losses too, for some their home and ultimately, their livelihood.

Peter: "I've lost my business, I've lost my wife, I've lost 5 nights a week with my child, you know, I've lost the house".

As mentioned in the methodology chapter, three of the six men were unemployed at the time of the interview, although all had held jobs prior to the break down of their relationship. This is indicative of the impact of the separation process over which they reportedly had no control.

5.3.3 Issues with (ex)-partners

As well as the emotional cost of the relationship breakdown, the men continued to have problems with their ex-partners, such as spreading rumours and lying to the courts and social services. This is shown in Figure 5-5 overleaf.

Andrew: "she spread rumours around, all over the area about me, and some people were concerned about what they heard [...] nobody believed it but at the same time she was throwing out rumours there that I, from a rant, told them that I beat her to a pulp".

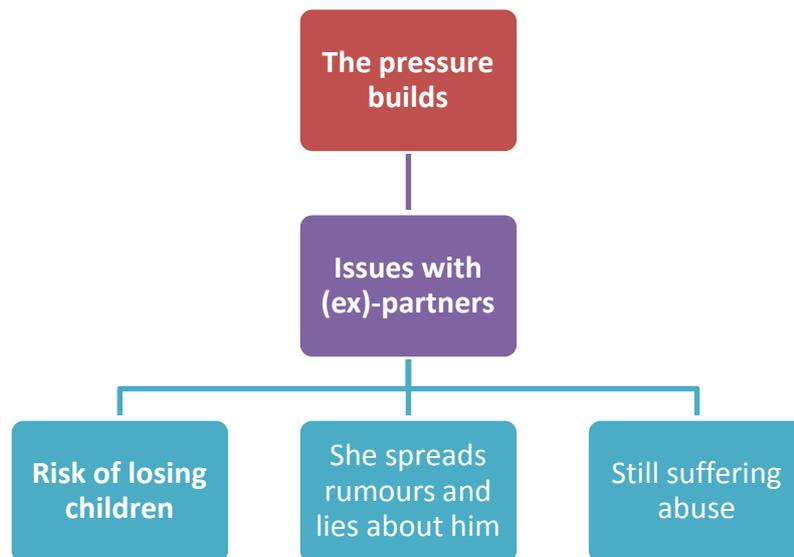


Figure 5-5 Issues with ex-partners mean the pressure continues to build

James: “my [young] daughter told me ‘we know what you’re doing [..] Mammy told us. You want to get her into trouble. You want us, you want the house, and you want to put Mammy into jail.”

Mark: “the fact that anybody could try and take away her innocence at [primary school age], by making that kind of allegation, for whatever kind of game or whatever, is something that I’ll never understand.”

The main concern of the participants was that the seriousness of the allegations had the potential to affect decisions made by the courts on access rights to their children. Since the men wanted to be involved in their children’s lives, the impact of their ex-partner’s actions was difficult for them.

James: “I still feel a bit lost. I’m a Daddy and I can’t be there and I want to be there. I don’t want anyone else’s children, I want me own children”.

Mark: “my daughter’s a little girl and she’s absolutely the light of my life”.

Whilst each of the participants reported having taken action to minimise the amount of harm done to themselves and their children, they were left feeling that the harm

done could never fully be removed. The men were aware of the influence of their previous partners on their children as she sought to undermine their relationships with them. They worried about the impact of her behaviour on the children and yet they felt powerless to change things. They were also aware that her actions were still impacting on them personally.

Mark: "I would go to pick up my daughter and at times, I would be bitched at and screamed at on the doorstep, and I don't react, I can't react."

Matthew: "On Christmas Eve, I remember she came, there's the family all hugging and kissing and then I went out to work, came back the next day, she was gone again. The kids were all deflated, and 'ooh' then they get all angry and aggressive and take it out on me, like I was the bad guy."

Peter: "some of the correspondence I get, there's still an awful lot of bitterness in it, and stupidity there, so while I don't want to be her friend, [...] I'd like to be able to send her an e-mail and get a reply, you know, about my daughter, or about finances, or about whatever needs to be done, but I can't."

Even where the relationship did not involve younger children, there were still issues that had to be addressed.

Hugh: "I'm still paying all the bills, still. Probably I'm feeding into her habit because the money is still there to buy the drink."

Although the relationship was, in principle, over, the men described in their interviews that the continued need of their partner to find a new way to control the relationship meant that there were always new pressure points to be handled.

5.3.4 Seeking help

The men found their way to the agency through referral from a trusted source, mainly the police, but also through GP and counsellor referrals, and the helpful factors in seeking help are shown in Figure 5-6 overleaf.

The participants were unaware that their experience could be explained as DV and relied on others to make the assessment and refer them into the agency.

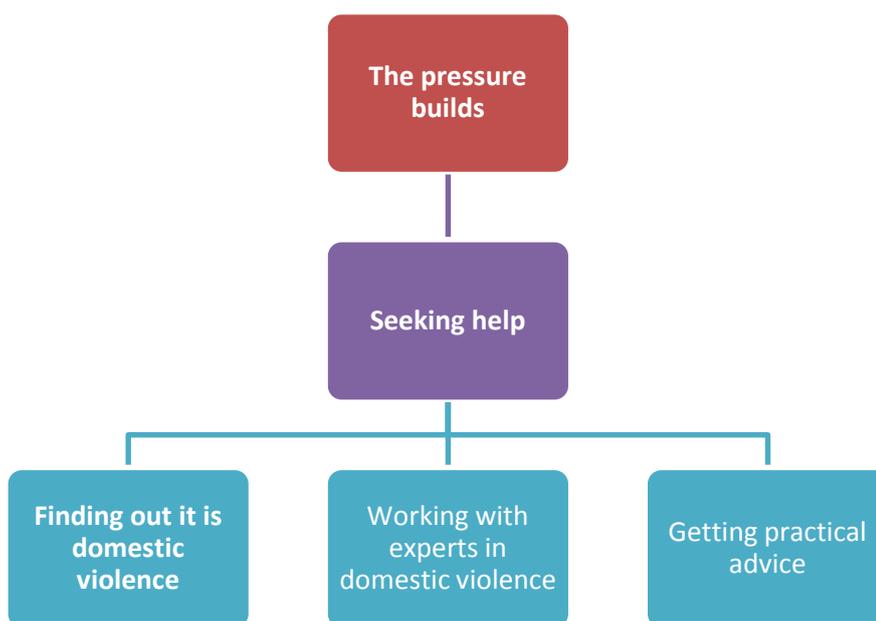


Figure 5-6 Finding a way to helpful, accessible resources

Andrew: “[counsellor] says, you know, maybe, maybe you should, eh, speak to [agency] and I asked her ‘what was [agency]?’ and she told me it was for men that had gone through exactly what I had gone through.”

Matthew: “I didn’t know about them until the [Police] told me, but as soon as I become more aware of it, like I saw on the back of buses, posters saying [agency] [...] I didn’t want to hand anyone my problems until I come here.”

Peter: “I was referred, my GP referred me and said ‘you know, because there was physical and a lot of emotional abuse’”

Two of the men had talked to family or friends about how they felt prior to contacting a professional, and this led to an agency referral. The group as a whole had received good and helpful advice from each of the previously identified sources of support, although as discussed in section 5.3.1, this may have been the first time that had happened. In addition, having professionals who were able to identify the domestic abuse and refer appropriately, knowing that the agency specialised in their type of experiences, were positive factors in their decision to contact the agency.

Once they had engaged with the agency, trust appeared to be established quite early on in the relationship. This built from their sense that the professionals believed their story and that they had been referred to an agency that specialised in their situation. Descriptions of coming into the agency were accompanied by a sense of relief or release, that at last they could tell their story to someone who would understand and know what to do. They were no longer on their own.

Hugh: “she made an appointment with [agency worker] and I met her at the [building] and she was also so, so helpful and she says, ‘won’t you come down’ she says ‘you look like you’ve been carrying cares around”

James: “to have someone believe you and listen to you was priceless. And no matter, no matter what you told them, they weren’t shocked, and if they were, they didn’t let on to be, put it that way! [...] they made you at ease.”

Here it is interesting to note that the professional counsellors working with Andrew and Hugh above quickly acknowledged their need for specialist support for their clients. On the other hand, Peter’s (marriage guidance) and Mark’s (general) counsellors (in section 5.3.1) did not refer them onwards, leaving them feeling that there was something missing. In terms of identifying resources, all of the participants needed to be referred to the agency to find support, despite their own initial attempts to do so.

In addition, the participants placed enormous value on the information that was available to them from the agency about their position regarding the separation and their children, in terms of what was and was not possible.

Andrew: “My ex had threatened that she was going to take the children away down to [town] [...] I couldn’t believe she could take them away. But anyway [agency] reassured me that she couldn’t take them away from me”

James: “just as I thought I had it clinched and another door closed in your face. [...] there was nothing that I could do but they brought me back down to reality”

Whilst there was a great emotional cost as a result of the abuse, it seemed as if the abuse did not end with separation as unreasonable demands from their partners continued and needed to be addressed through the legal system. As with many of the female support agencies in the UK, the agency provided DV Advocates to support their clients in court. As many of the men had no previous court experience they appreciated the support with court processes.

The men now recognised the agency as a place where they could find help. Although for some agency clients, access to information might have been enough, these participants were offered and accepted further support from the agency, through 1-to-1 and group work.

5.4 Experience of 1-to-1 support

At this agency, the men were offered crisis support by agency workers. For some, the support sessions were their first experience of 1-to-1 work and they found it a helpful experience.

James: “I just thought it was only me, this was only happening to me
[..] And [name] was like ‘first of all calm down and relax’.”

As the agency also offered counselling and group sessions, subject to funding, there were options for the men to choose which path they wanted to follow.

Hugh: “he asked me about group sessions, and I didn’t want that and I told him no, and he said ‘yeah that’s fine’.”

Even for those who had opted to begin the group, it was sometimes clear that 1-to-1 counselling would be helpful to some group members.

Peter: “the guy in charge [group leader] recommended that I see [counsellor] the counsellor here, for a one-to-one, and initially it should, I think it was six sessions but it went on for about 10 months. He was brilliant, really helpful and he wouldn’t let me go until he was happy”

In accessing 1-to-1 support, whether through the agency crisis support team or a counsellor, what was important was being able to talk to someone who genuinely cared and having greater understanding of their relationships and behaviour. As the

work progressed, the men also described a sense of beginning to live again. The common factors in this work are shown below in Figure 5-7.

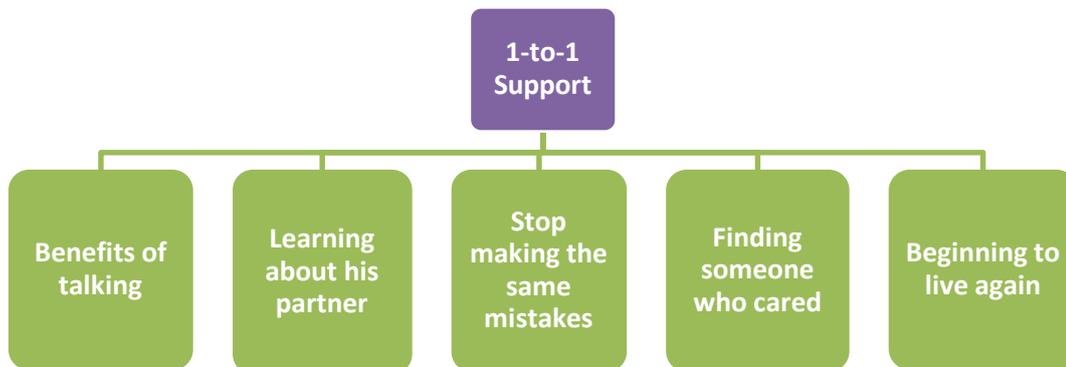


Figure 5-7 Aspects of 1-to-1 support that male participants found useful

Whilst crisis support work was identified here as counselling, the agency also offered practical support and advice, which were valued for their technical content and expertise. The remaining part of this section describes each of those services regarded as 1-to-1 counselling in more detail and includes participant descriptions of their experiences.

5.4.1 The benefits of talking

More than half of the men described the benefit they felt in simply having someone to talk to about things that were challenging or difficult for them. These benefits are shown in Figure 5-8.

The main reported benefit of 1-to-1 work was the feeling of relief after sharing what had become a burden.

Hugh: “he’d ask me a question and he’d let me carry on, and there was no shutting me up then, because I felt I was free of this burden.”

Mark: “I suppose the most important thing, is that it was very useful to off-load painful and difficult things that I couldn’t necessarily expect my friends to be able to cope with”

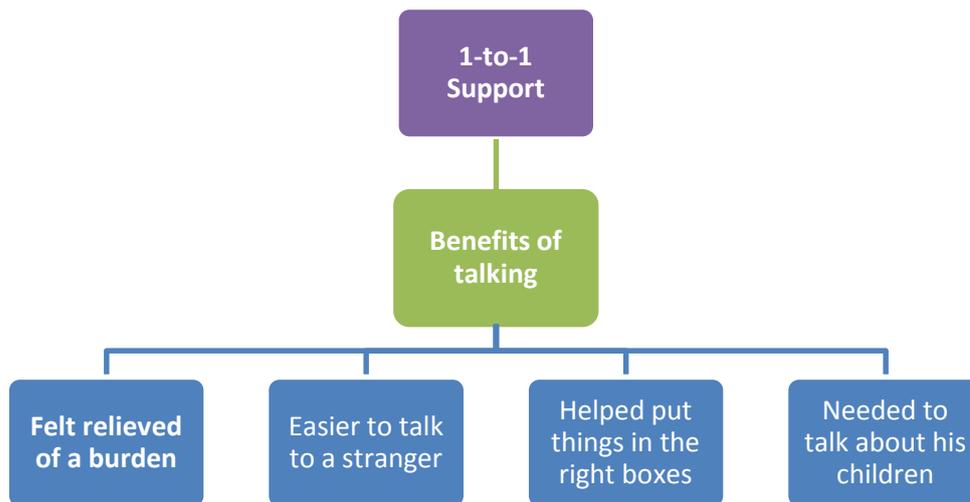


Figure 5-8 Significant benefits from talking one-to-one reported by participants

The men also commented on how much easier it was to talk to a stranger about the details of their relationship, rather than family and friends.

Hugh: “I says, well I tell them [family], I can talk to these people the way I can’t talk to you’s. And they understood that.”

Matthew:” The family are great, but I just found it easier talking to a stranger you know, I’d be embarrassed talking to my Mam or me brothers or sisters, about certain things or issues”

They found that by talking to a counsellor or support worker things became clearer and they were able to leave feeling happier about things.

James: “Things are put into their right boxes.”

Hugh: “I’d leave here, I’d sit down in the car myself and I’d be going through everything that had come up and everything he said would bring me back and it all made great sense. And I’d leave here feeling very good.”

For some men, whether they had custody of their children or were missing them, the support team provided somewhere that they could share their feelings and was considered very valuable.

James: “I needed someone who could talk to me about my children”

Matthew: "I can ring up the girls there saying 'Oh, I had a bad night with the young guy' or 'they're giving me a lot of stick because they hate me' [...] I get upset, you know, and I just ring up the girls and it's a shoulder to cry on"

This was an important aspect to them, and yet it may also suggest a difference in how the participants experienced male and female support. They valued having a female support team who understood children and could give them advice or simply understand what had happened. On the other hand, there were times when having a male counsellor to talk to was also very much valued.

Hugh: "Now, the fact that he's a man and he'd have certain understandings of life, what way life, the role as a man, the man's role and as I say, that's where the comfortability come into it, whereas with [female counsellor] as I said, I held back on a lot of stuff"

Peter: "It was like, it was like talking to my Dad, but I couldn't speak to my Dad about anything like that"

From this small sample, it seemed that the men were able to assess the resources available to them and find an appropriate person to talk to depending on the issue. Whilst the gender of the person appeared to be important to him in the context of what the man needed help with or to talk about, it is possible that this was recognition of particular skills rather than a gender issue. The number of participants is too small to draw a firm conclusion on this, but it is an interesting finding.

5.4.2 Finding someone who cared

After finding many doors closed to them through the focus of most public sector services on supporting the female partner, the men reported the value they found in finding someone who cared about what might happen to them. This is shown in Figure 5-9 overleaf.

More than half of the men placed value on having someone there who was interested in him and what had happened to him, either that week or previously.

James: "They know me inside out and upside down now. It's very important for me, personally, to pick up the phone and hear one of their voices"

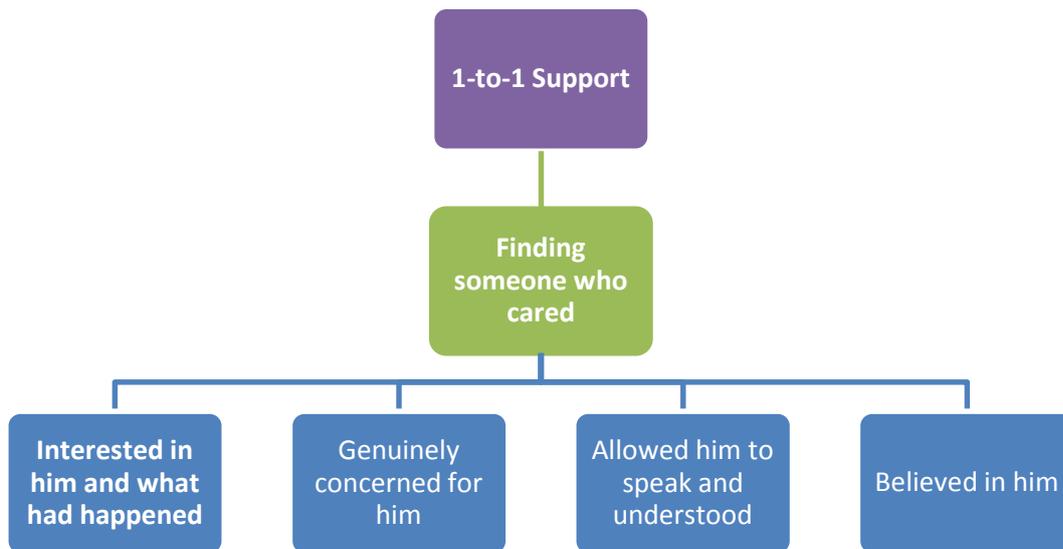


Figure 5-9 Characteristics of a caring counsellor

Peter: “somebody who is genuine and somebody who genuinely cares about what you have to say and who’s genuinely, you know, cares about your welfare, which is strange coming from a stranger”

This is in contrast to the experience of counselling when the participant felt that was not present.

Mark: “Do you know the whole idea of compassion fatigue, that’s kind of what it felt like with him. He was there and he was going through the motions and waiting for a thirty second pause, and then he’d say go on”

Here Mark is describing an experience with a counsellor whom he felt lacked empathy. He concluded that he did not think the counselling had been of “any use at all”. His link between the lack of usefulness of the counselling and the lack of connection supports James’ and Peter’s views about the importance of working with someone who cares.

Being allowed to speak and be understood as well as having someone who believed and would not judge him was also important.

Hugh: “with [counsellor] I felt there was somebody who actually allowed me to speak, to understand.”

James: “the very first thing, the most important thing was to be believed. That was essential as far as I was concerned... and not to be judged.”

Peter: “it just felt like there was somebody there, [...] someone there on my side all the time.”

This aspect of having someone on their side, who believed in them, cared about them and allowed them to speak came through very strongly from the participants as a positive change to their environment. They felt a sense of relief that they now had a place to go where they could be supported and accepted, which could indicate a high level of psychological stress within their previous relationship.

5.4.3 Learning about his partner’s and his own behaviour

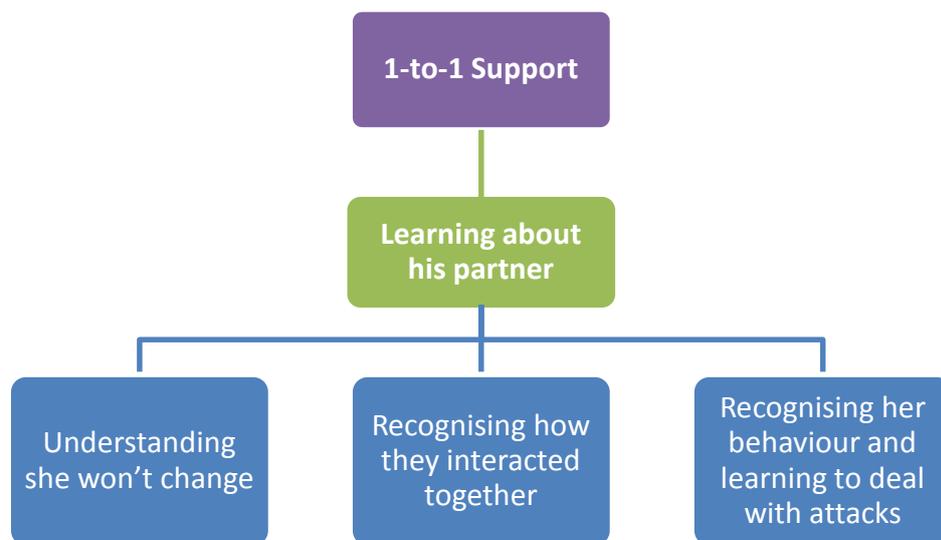


Figure 5-10 Acknowledging the difficulties of being with his partner

More than half of the men also found it very valuable to find out more about the motivations for his partner’s behaviour and the reasons for his own responses. These factors are shown in Figure 5-10. For some of the men, realising that their partner would not change their behaviour, however long they stayed, was important.

Hugh: “she’s still drinking and drinking and drinking. I’m left now a year, nothing has changed, but I have changed.”

Mark: “I got out of my DV situation [x] years ago, and since then the DV has continued with its perpetrator through [daughter]. So you have [daughter] is being used as the stick”.

For others, gaining insight into the dynamics of their relationship was important.

Matthew: “we had our time of crisis then and it either pulls you closer or apart and it pulled us apart. We showed that the relationship was really a stack of cards as opposed to a stack of bricks”.

Peter: “I got to understand the kind of person I am and why I kind of, what attracted me to my wife [...] I wanted to know why I was drawn to somebody who would make me feel less about myself”.

However, sometimes the counselling did not provide the help that was needed.

Mark: “I can certainly accept the past as awful and rich, what’s going to happen in the future I have much more difficulty with accepting as inevitable, and that there must be some way that I can change that”.

Working with a counsellor who could see no way to improve the relationship with his partner and tried to help him to accept the apparent hopelessness of the situation, left Mark feeling frustrated rather than relieved as he was looking for hope for the future.

Other participants were encouraged to make changes in the way they viewed things. At a practical level, they began to recognise their own responses and make choices about how it would affect them.

Peter: “if I change my perception of things, I can deal with them better like when my wife was doing stuff [...] like a solicitor’s letter or something, and [...] I’d take it to heart [...] but if I step back and look from a different perspective I could say ‘Oh, I’m

not going to let that bother me, it's trivial in the overall scheme of things”.

This is something that also came out strongly from female participants (see sections 4.2.3.2 and 4.2.3.3): that sense of wanting to know why and how it had happened and what they could do to improve both today and tomorrow.

5.4.4 Stop making the same mistakes

The men became aware of negative relational patterns that continued despite being separated, as shown in Figure 5-11, overleaf.

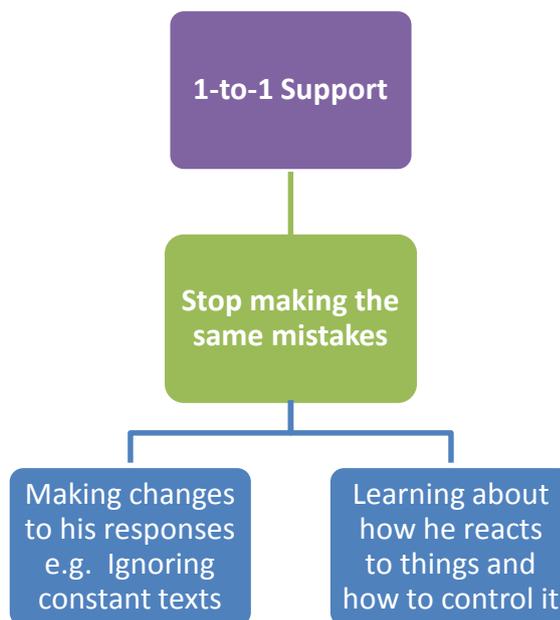


Figure 5-11 Changing his behaviour with his ex-partner to alter outcomes

One of the factors the men found valuable was beginning to understand how to respond to their ex-partners, how to reduce or stop the ongoing abuse.

Hugh: “I was feeding into things like, you know, the ‘phone would be ringing, geez, my ‘phone might ring maybe 20 times a day, and it would be ‘you f’in this and you f’in that’ so [counsellor] says ‘look, you don’t, you just don’t answer the ‘phone’”

Matthew: “she used to call into the house and she’d stand at the door, and she’d shout and roar [..] I used to give it back then but after coming here for a few weeks, then I would just say

something like ‘Calm down, you’ll give yourself an aneurysm or a heart attack. Do you want a cup of tea or something’”

It was also helpful to understand how their own behaviour had contributed to developing patterns of behaviour within the relationship so that they could be more aware of it in future.

Peter: “So there’s a pattern and I didn’t realise it and it was only by answering questions that I made the link.”

By becoming aware of these things, the participants were able to make constructive changes to their responses to their ex-partners, which resulted in an improvement to the quality of life. This in turn helped him to begin to believe that life, far from being over, could begin again.

5.4.5 Beginning to live again

More than half of the men reported that during the 1-to-1 work, they had a sense of beginning again, of changes to the way they viewed life that were helpful and positive. These are shown in Figure 5-12.

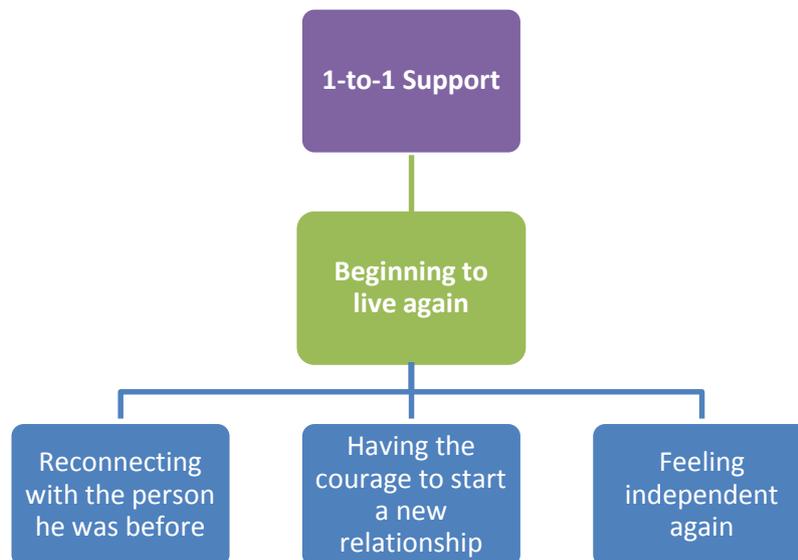


Figure 5-12 Aspects of knowing life had begun again

For some of the men, that involved beginning a new relationship.

Hugh: “I met this lady walking the dog [...] and we both just felt so comfortable with one another and I just said it to [counsellor],

he says 'did you never ask her out?' I says 'no' and it was actually him put that into me head."

For another it was reconnecting with the person he had been before starting his relationship.

James: "when I think I'm the me that I was when I was [age], I got married at [age] and he was gone. I've got me back."

And for others it was simply enjoying a different way of looking at life.

Matthew: "definitely calmer, I mean, better, better holding it in, peaceful or whatever, I'm not sure what the word is. I mean maybe it's acceptance".

Peter: "I was able to start looking forward and kind of closing the lid on the past".

The changes that the men reported as a result of the counselling or support seemed to be deep-seated and long lasting, impacting not only on their personal lives, but on their work and families too. They felt better about themselves, felt they had made positive changes, and that they could now engage with life again.

However, when it came to endings there seemed to be a difference between those who had accessed support from the agency, and those who had accessed counselling. With counselling, the ending was clear.

Hugh: "I knew coming in that night, I don't need much more of this and he actually said that he had that feeling coming in, [...] he could see by my attitude, I was bubbly, smiling. "

Peter: "towards the end it was fine and then I think it was around [month] of last year I said 'you know, I think I'm ok' and he said 'No, you are' he said 'now keep my number though, and if you do ever need to call, you call me.'"

However, with the support work, the team are only ever a telephone call away.

Matthew: "Myself, from time to time, I'd ring up the girls and have a chat"

It was clearly beneficial to have the support line available and the deep relationships formed with the support team meant that the men continued to want a link with the agency. Whilst the participants accessing specialist counselling felt they had moved on with their lives and were self-sufficient to deal with issues that arose, the participants accessing agency support continued to value the input of the agency staff when they felt pressure building in their lives again. Agency support meant that they dealt with each issue separately as it arose and they felt they benefited from discussing it with someone independent but on their side. The two groups are too small to draw any firm conclusions about this, but it is an interesting observation about potentially different outcomes from different service models.

5.5 Group support

Some of the men were able to access group support after contacting the agency. This section specifically discusses the group aspects arising, but it is also important to acknowledge that the men continued to make use of the support staff during the group process as, for example, legal issues arose.

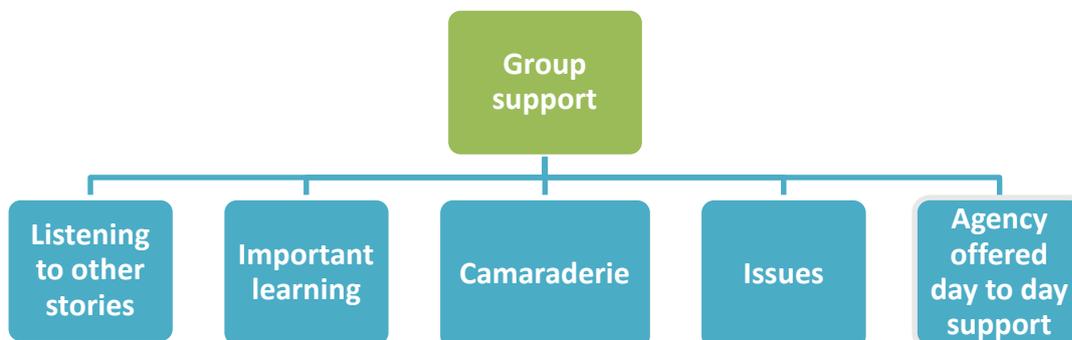


Figure 5-13 Aspects of group working that the men valued

The groups were recruited by the support workers contacting men they believed would benefit from and be interested in participating. Only one of the participants, Andrew, took part in group work without additional 1-to-1 support but reiterated a comment made earlier.

Andrew: "it is easier, much easier to talk to an absolute stranger than to talk to a family member about what happened, and talking about it has been such a great part of the healing process".

There were three different positive aspects to group work that emerged from the group members' interviews: the value of listening to other men's stories; learning from the weekly presentations given on relevant topics; and the camaraderie that developed between them. At the same time, there were observations about some of the difficulties associated with group working. All four aspects are shown in Figure 5-13 above and are described in more detail below.

5.5.1 Listening to other men's stories

The men were initially a little daunted at having to talk within the group setting. They found it challenging to speak for the first time in a group of strangers, as shown in Figure 5-14, but were able to recognise some commonality too.

Andrew: "the first night, we all kind of told our stories, and thank God I was the very last one, because at the start I felt like an icicle".

James: "Well I know our stories were different, but they were all the same. They all had one underlying situation or whatever you want to call it".

Matthew: "I was a bit nervous at first, coming up, I didn't know what to expect, but then again, like you're feeling sorry for yourself".

Most of the men also shared that they felt that other people in the group were worse off than them, which helped them to feel better about their own position.

Andrew: "You know, I think the guys have got more of a raw deal than I've got".

Peter: "Now, I don't know if this is just with me, but I came out of the first session thinking 'God, Jesus, I'm not that bad, like', you know, because some of the guys had worse stories than I had".

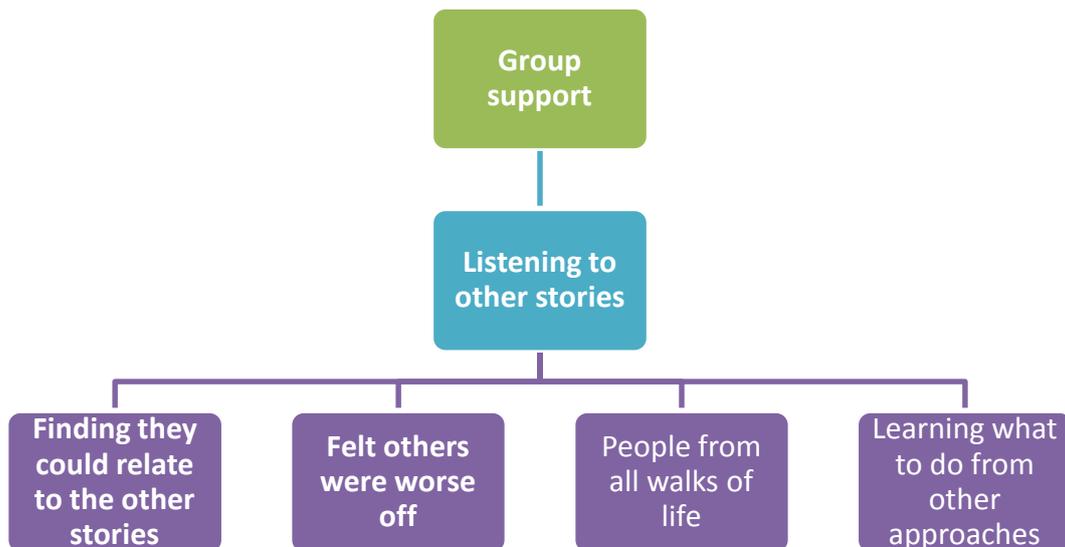


Figure 5-14 Finding support in the stories of other men

The participants were also surprised by the variety of people who were involved in the group, people from all walks of life. This made them feel better about their own experiences, as it suggested the problem affected many more people than they had realised.

Matthew: “There was some of the guys were unemployed, one or two were big shot business guys or sales guys, you know the suits and the big cars, and there’s agricultural guys and there’s all walks, so it affects everyone. Makes you feel better!”

Peter: “I know there was one guy, [...] big, strong guy, a very successful [...] and he was sitting there, crying like a baby at the end of the table, I was kind of going ‘God, like it can happen to anybody’.”

But as well as listening and relating to the other stories, they recognised that others had found ways of coping and dealing with things that they currently found difficult and that they could learn.

Andrew: “you were listening, but you were also learning from other people’s stories, [...] how they were handling it and that”.

Peter: "I came here and I sat down and there were three or four other guys there and started talking and [I] found it very, extremely difficult to kind of open up and to talk about myself. I don't know if it's a 'guy thing' or what, I just found it very hard, but again after a few sessions it was fine."

The men, on reflecting upon the stories they had heard, concluded that it was the psychological rather than physical nature of the abuse that was hardest to take.

Peter: "what made sense for me was that all of the guys that I met, it was the emotional and the mental [...] abuse far outweighed the physical, and the damage that it did was a lot more severe than any physical violence."

In this sense, the men seemed to minimise the physical violence as being something they could cope with, something they were perhaps used to in their dealings with other males whilst growing up. As Matthew reflected:

Matthew: "I mean, my wife did attack me with a knife, she did throw things, she did break my finger with a knife an' all, but it was more just threats as such, she just was trying purely to get me to go. It was the mental, the mental bullying, or the mental torture that was worse".

Group sessions seemed to provide support for the men simply in terms of feeling they were not the only ones and in understanding that the psychological abuse suffered was a common problem. This was something they had all struggled with and wealth or lifestyles were not protective factors. Realising this boosted their self-confidence and self-esteem. Equally, the process of having to talk about their own experiences helped them to develop skills which would be useful outside of the group too.

5.5.2 Learning from the sessions

There was a topic scheduled for discussion and/or presentation each week as part of the group work to fulfil the educative needs of the group, the terms and conditions from the funding body, as well as the therapeutic objectives. Some of the topics

were seen as particularly useful by the participants, as shown in Figure 5-15.

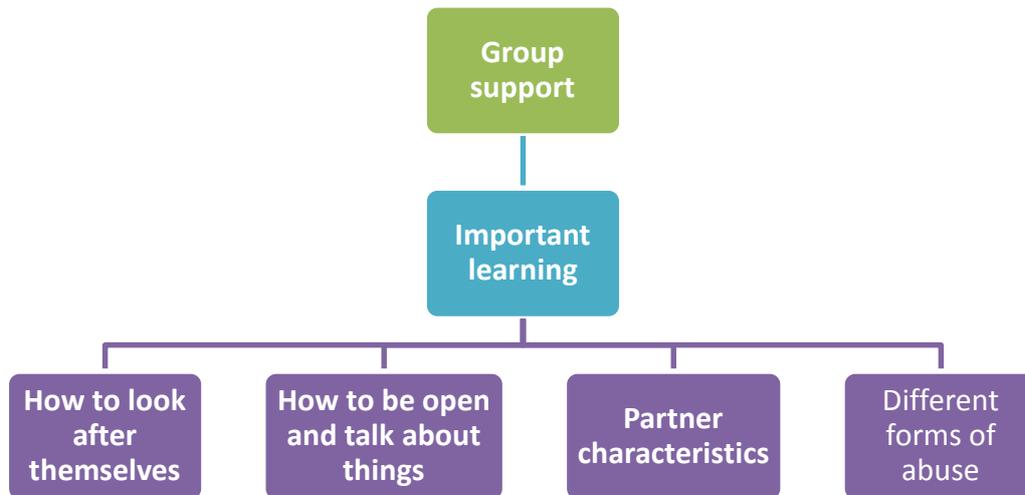


Figure 5-15 Educational topics that the men gained most value from in group work

The topics that were particularly remembered by the participants were the ones on looking after themselves. As men who had recently been removed from a traditional family environment, things like remembering to eat and finding people to talk to were timely reminders that they were responsible for themselves.

Andrew: “The most helpful things were, I suppose, was that we could look after ourselves, first and foremost, and how to start the healing process, and how to learn how to move on, and to, you know, like be eating properly and not dwell on stuff and not be on your own.”

As men who felt that their role as husbands and fathers had been principally to provide economically for their family and thus play a smaller role in family life, the change in circumstances was significant. Without a family, their role was now to care for themselves. However, where the man had obtained custody of the children, his role as carer within the family had increased dramatically. This new function of caring, whether for themselves or others, was usefully highlighted and discussed in the group.

The men also felt that the group gradually encouraged them to become more open and share more about what was going on for them personally, as well as what was happening in their lives.

Peter: “meeting the guys at the start of the group, it probably opened me up to being able to discuss and share my thoughts a bit more. Because I could see other guys doing it”.

As James and Matthew noted, this was not the way they had perceived their role as men, but it is something they both learned to do and felt they had benefited from.

James: “going back to being a man again, [...] I have learned to be very open. I don’t care any more. I’ve got nothing to hide.”

Matthew: “It’s like we couldn’t talk about feelings or emotions or anything like that, it wasn’t a man thing, but at the end of it, we was openly crying in front of each other”

But in being more open about what had happened, it allowed better exploration of what the factors in the break down of their relationship might have been.

James: “it showed me first of all the things that were said to me, because that was the game. I’d get up in the morning skipping and jumping and before I went out the door I would be in the doldrums, because my wife would have come down and got a load off”.

Matthew: “I’ll show you who your wife is, and who you are. They showed us who we were, it didn’t make us a better person but they showed us that our good points were more important than our bad points and that we could maybe improve on them.”

And finally the group helped them to learn about and understand the different forms of domestic abuse.

Andrew: “different forms of abuse, yeah. It seemed to be like everyone went through such similar, and I was wondering, are they reading the same book”.

The learning from the group encompassed a wide variety of issues, from practical help with day to day living, to understanding the dynamics of domestic abuse. But

as well as that, the group offered an opportunity for self-development, and a space to explore sharing their feelings which felt relatively safe as others in the group had already shown the way.

5.5.3 Camaraderie

One of the main benefits of the group working was the camaraderie that built up, shown in Figure 5-16, as the weeks passed.

Whilst the group appreciated learning different things, many of the group members spoke about how much they appreciated the support from others in the group.

Andrew: "I didn't know any of them thank God, but it was, they were great support and then I wasn't the only one going through it."

James: "at least once a week one of us had had a traumatic week and it was just priceless to let it flow out and get people's feedback. If you wanted the feedback".

Matthew: "You could say anything, it felt comfortable in that room with ten guys to say anything [...] your deepest, darkest secret".

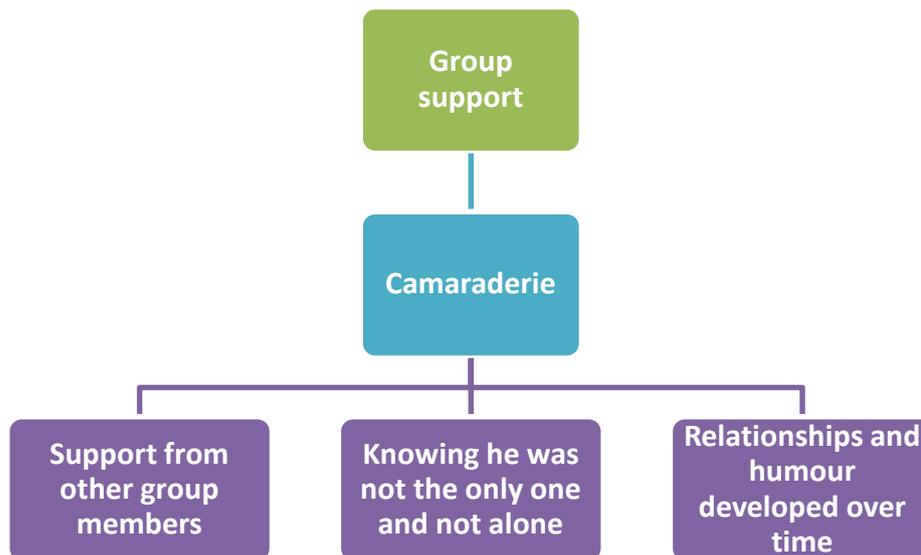


Figure 5-16 Benefits of camaraderie in a group environment

The comments from Andrew and Matthew are also revealing in their recognition of confidentiality. Andrew was glad that he would not have to meet up with the men

outside the group and Matthew was clear that what was said in the group stayed there.

They also felt that being able to share their experiences in the group meant that they were no longer on their own.

Andrew: "it was just like knowing that I'm not on my own, [...] I can't believe that I thought I was the only one [...] I thought I didn't fit in anywhere, that I was the only one going through this, which was totally wrong"

James: "Support, it's very important. Now and again, when you're on your own, like you really do feel alone"

Although the group was dealing with a serious topic, the men slowly relaxed in each others' company, and appreciated the humour that gradually found its way in.

Matthew: "you can imagine with five or six men we did have our schoolboy moments there, you can imagine some of the answers to 'what do you think intimacy is?'"

Peter: "there were things that we could laugh about as well, so it was fine. It wasn't all doom and gloom."

The group process had a larger impact than simply learning about DV and how to look after themselves. The men also talked about how important the sessions were to them and how they arranged their lives so that they did not miss any of them. The sense of belonging and creating friendships had a wider impact in their lives, as will be shown in the next stage, Getting on with life (section 5.6).

5.5.4 Issues

Whilst the groups were seen very positively by those who contributed to the research, there were also some issues reported as problematic, although not by all of the group participants. These are shown in Figure 5-17 below.

Matthew: "there was a few fellas who had addiction problems and it wasn't good: [...] There was a few boys there and you wouldn't know what way they would behave."

In this particular circumstance, clear boundaries and standards of behaviour were set and adhered to, and what could have been a potentially difficult situation failed to materialise.

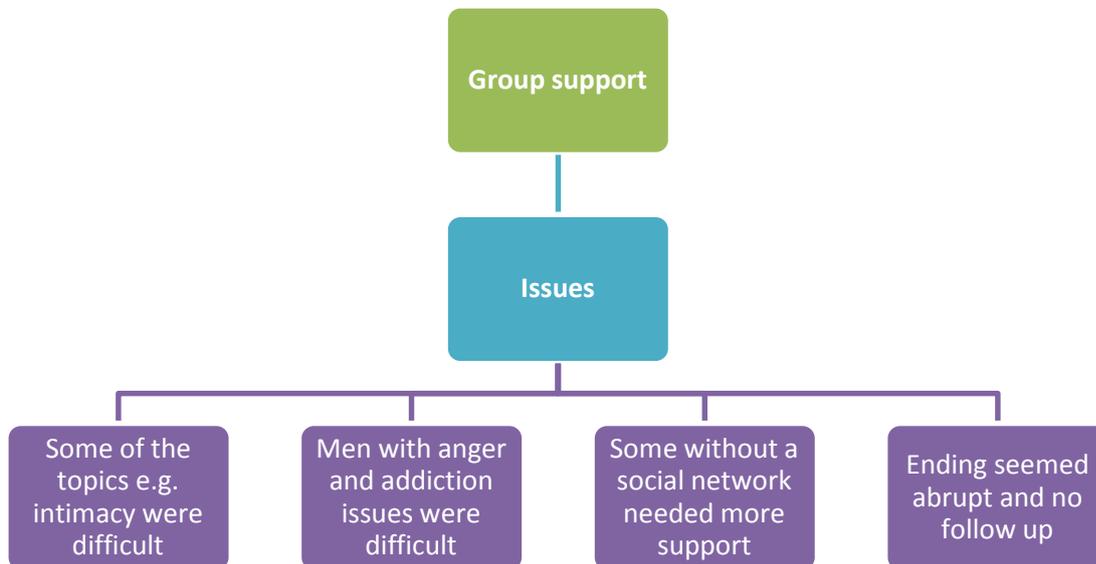


Figure 5-17 Issues with group working which raised some concern

One of the negative aspects of the educational process which was mentioned several times was the exploration of intimacy. In the introduction to section 5.5.3 above, when Matthew described some of the humour that emerged, the topic of intimacy was one with which the men felt uncomfortable. Peter also mentioned that particular aspect of the education delivered to his group.

Peter: “one of the stipulations for the government funding was they had to do health education. It was funny because there was stuff like sex education and stuff that we were taught at school and there’s men in their thirties and forties having to go through it again”.

Whilst this may have been an appropriate topic for discussion, it is perhaps worth considering which aspects needed to be covered and how those could be introduced and taught. This may be a topic for further investigation, as this would be an unusual age group for this sort of intervention.

The men were also aware that some of the group members needed more support than others, either because they were in a heightened state of emotional distress, or because they lacked family and friends outside to support them.

Andrew: "he hadn't got very many family, and friends weren't that plentiful for him either like, but I could see he was having it tough enough. So I kind of feel for him, [...] you could tell that he wanted more out of it".

For Andrew, that was less of a problem as he had family and friends who re-engaged with him once he had left his wife, and yet it raised the difficulty of potentially mixed expectations from the group. James summed up the degree of support and intimacy he found.

James: "We were all leaning on each other as well. So we went from having one on ones with the phone to one on ones in here, to having five of them or six of them, you know that kind of way."

Although the group was set up to run for a set number of weeks and then disband, the men found that process difficult. Due to the nature of the discussions and disclosures, the group became a secure place, offering support and encouragement, and the ending seemed abrupt. The group process did not include the possibility of keeping in touch afterwards.

Andrew: "It was parting that night from the lads, [...] it was a bit strange that, just how it all came to a stop".

Whilst there had been no encouragement to socialise outside the group, some men had taken the initiative to keep in touch as part of their process, which seemed to work well.

Matthew: "We often bump into each other either down here, or we have each others 'phone numbers, and every few months I might say 'oh I'll give so and so a ring and see how he's getting on'."

Whilst not all of the men would want new friendships from the group in their lives, there was a sense that meeting up again to see what happened and offer support would be helpful.

Andrew: “It would have been nice maybe just to cut it back, [...] maybe once a month for five or six months [...] just to keep following up on how things were progressing”.

However, Andrew had indicated earlier (in the introduction to section 5.5.3) that not knowing the group members outside was something he was grateful for, yet this also seemed to create a bit of a problem for him, which he wanted the agency to resolve by having a reunion. Given the extreme isolation some of the men felt prior to engaging with the agency, having some form of optional social contact for this group could be beneficial.

5.6 Getting on with life

Finally, all of the participants reported improvements in their life as a result of accessing support at the agency. Whilst some men continued to access support staff either for legal advice or support, others had not needed to call. They each felt that life had begun again, to a greater or lesser extent.

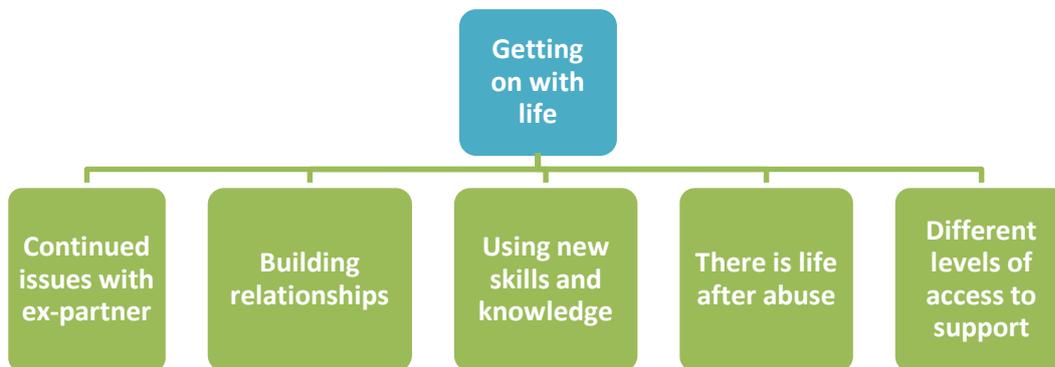


Figure 5-18 Aspects of life following agency support

Figure 5-18 above outlines the main aspects of how getting on with life appeared to the participants. Each of these aspects is described in more detail below, together with participants' quotations.

5.6.1 Continued issues with ex-partner

The main issue that the men brought forward was their perception that whilst they had been supported to make the changes that they needed to make to survive, their

ex-partner had not. This made it difficult for them to move on, as she continued to see the same issues even after time had passed.

Matthew: "like relationship wise with her spouse, partner, whatever it's all the same issues, not that we went to the same school and learned the same tricks".

Peter: "I don't think my wife did the same level of counselling and I don't think she was able to, she hasn't dealt with a lot of the emotional stuff".

In discussions with the men, two of the six indicated their partner had had serious issues with alcohol and two that their partners had come from a family where abusive behaviour had been common. The other two did not comment. There seemed to be genuine compassion for their ex-partners and a desire that she could find a way to be happy for her own sake, and not simply because it would make their lives easier. They felt that if she could access support, she would find it helpful, but they also recognised that even if offered appropriate help, there was no guarantee that she would acknowledge her need for or engage with it.

This meant that some of the men continued to have concerns about the effect their ex-partner was having on their children.

James: "I find it very hard to see what my wife is doing to my children because you love your children [...] I would daily struggle with that."

Mark: "I had very strong concerns about my daughter and how positive her view was of the sort of stuff that was going on and I could find nobody in the health service or anywhere else, who was prepared to stand up and be counted".

Discussions with health professionals and social services continued to be frustrating, as the services tended to assume the children were better off with their mothers. Fathers trying to raise issues were regarded with some suspicion about their motives and they found being seen as the potential perpetrator in these situations hard to bear.

Some of the men reported that their ex-partners continue to try to manipulate them, although they felt they could deal with it better now.

Andrew: “she’s still after doing something with the kids or that, she’s still throwing emotional abuse and [...] she’s still trying to be the bully and she’s still trying to take the power”.

Hugh: “for instance, money problems now, I just don’t give her money any more, if there’s a bill there to be paid, well I would go out and say, [...] ‘this is your problem now, this ain’t my problem any more.’”

The men understood more about how power and control played out in their relationships and tried to be more assertive. They reported that they did not give in to their wives as much and they tried to maintain the relationship as fairly as they could by being assertive.

5.6.2 Building relationships

Whilst the men still had complex and difficult issues to deal with in respect of their ex-partners, they also began to create a new life for themselves by re-engaging with family and friends and by making new friends and relationships.

Andrew: “I have a friend who is in a similar situation [...] and we just speak maybe every other day and rather than react or something like that, we just talk to each other, just say ‘ignore it, just ignore it’”.

James: “I speak to me Mam now. I used to come down and I wouldn’t see her from one end of the month to the other.”

Hugh: “now I wake up in the morning and I say it’s a lovely day out and I go and enjoy the day with the lady I’ve met, meeting up with her and having a coffee or whatever, and I love it”.

The sense of re-connection with the world was noteworthy, and being able to enjoy their relationships with people from the past as well as people they have just met felt like progress. It provided evidence that the isolated, abusive situation they were in had gone as they gained support from a wider network of friends and family. Although some of the steps described appeared tentative, the pleasure that the men were getting from these new relationships was apparent during the interviews.

5.6.3 Using what has been learned

The two aspects that the men felt had been useful were their increased ability to talk to people and being able to deal with things as they arise.

Hugh: "I wouldn't have to come back to [counsellor] to have to ask, because I can stand up for myself to her now."

Matthew: "now I find, since I've gone to that meeting, I don't shut up. Because I never used to talk, I never opened me mouth, I'd just sit there."

Peter: "all the worries were still there, but I know I can deal with it now."

These statements show not only that skills have been learned, but also that the men have grown in confidence.

5.6.4 There is life after abuse

This phrase was used by Andrew in his interview, and seemed to describe going from a hopeless place of suicidal ideation to a place where the future held more hope and promise.

Andrew: "counselling is, it is great to be backed, like, to pick up the pieces, to start living again. And like that, there is life after abuse."

Hugh: "I look forward to the day. I actually look forward to [it]".

James: "But at the same time, the battles that I've been doing in court, or continue to do in court, they've worked."

Although the men, each in their own way, felt that their lives were moving on and that they could see a future for themselves, they still felt held back by the problems of their relationship. Nevertheless, they were making progress in their new lives, and in dealing with their ex-partners. They also perceived their new self awareness and their ability to share their thoughts and feeling positively.

5.6.5 Different levels of access to support

Whilst those who accessed 1-to-1 counselling were aware that they could re-access counselling if they needed to, they had not had to call.

Hugh: "I don't think I would need any more counselling, because I know I can handle [...] things more, gentler without being this stressed."

Peter: "I'm fine and I haven't had to call him since."

The process of counselling seemed to work well for these participants as it allowed them to make changes to their lives and the way they perceived things, whilst still having the security of counselling. Once they were happy that they could manage their lives again, they left and have subsequently been self-sufficient.

Although there was a need for some of the men to access the support staff for emotional support as James suggests below, contact was also required for practical advice. As Peter notes, for men still having issues with their partner, access to agency support staff as experts in this field was invaluable.

James: "Hopefully the ray of hope will come through, hope. But if it doesn't, well then I'll be ringing [agency] up and giving them my tale of woe."

Peter: "actually just a couple of months ago, I had a question that my solicitor wasn't too sure about, but the girls here [knew]".

This also highlights the problems that men may have because their situation is still relatively new to professionals. This means that people like solicitors and social workers may not know the answer to questions straight away as it is not something they have come across. This is where the agency service can be a valuable additional asset.

5.7 Reviewing the research

The model of support which emerged after the first three interviews was reviewed by two of the original three participants. The participants compared the model with their own experience and it was seen to cover aspects of their story. There was one area of disagreement regarding the therapeutic relationship. Mark had been unique in the research process as the person who had struggled to find the counselling he needed.

Mark: "I'd have difficulty with the bit where the therapist helped by x, y, z. They did some of those things [...] I didn't necessarily

feel a huge amount of experience or knowledge from the therapist and [...] the therapist [...] didn't necessarily offer a huge amount of different perspectives".

This was in keeping with the research from the female experience, where working with a therapist without knowledge of the sort of situations that can arise from DV can be detrimental to the counselling. Mark also disagreed with the ending described.

Mark: "I think because the abuse is ongoing there's no real kind of let's draw a line under this. That's one thing, and the other thing is that I didn't really feel that the counselling gave me any tools to help me cope better with what has been an ongoing situation".

Here, he is linking his inability to close the door directly to lack of provision of knowledge and skill to deal with his situation. This is in contrast to the support the other men reported receiving from their counsellors, where handling difficult behaviour and changing responses was very much part of the counselling received.

The researcher particularly enquired about the cyclical nature of the counselling work and both participants endorsed that view.

Mark: "I've been through counselling a couple of times, and I suppose I have gone back to the beginning and tried to do a certain amount of work".

Matthew: "Yes, I was just saying to [support worker] it does feel like going round in circles [...] going round in circles but spiralling up".

Matthew's point is an important one. Although there were reports of re-accessing services, there was reported improvement with each turn around the loop and at some point there may be a way to move on.

When asked about why this was the case, Matthew put it down to needing support for life circumstances as he had little control over external events, rather than emotional support. Mark agreed that it was mainly external issues that caused this effect, and offered a theory.

Mark: “Dr Lissa Corbley. [...] her PhD thesis was dealing with DV with particular emphasis on men [...] the difference between the male and the female DV is that often for men the abuse doesn’t stop, it continues [...] through 3rd parties through the system and [...] she puts this down as secondary abuse and one of the huge things that I really needed to have from counselling, was [...] tools to help me deal with that, because [...] it’s going on to this day”.

Comparing the women’s and men’s models showed that the main difference was the lack of a step associated with dealing with past issues. The men were asked why this might be different for men. Mark thought that because of the secondary abuse above, men never get to the point where the trauma is over and they have the space to deal with things. However, he also wondered whether men really wanted to do that sort of work.

Mark: “I’m pretty certain that most kind of men, including me would have had these issues and [...] I’m not sure whether going back and digging it all up again would be useful, but it seems to be for the women”.

However, when asked about this, Matthew reflected that during his group work, the dynamic between the men had changed over the weeks, leading to differences in how the group was used over time.

Matthew: “All the emotions and issues came at the end of the course. I don’t know if we were relaxed enough in each others company or trusting each other enough [...] it was like getting something off your back [...] It did help, definitely, [...] but I’m sure a few more sessions on that would have been even better.”

Mark and Matthew both believed that it would have been difficult for them to be able to do the sort of in depth work described.

Mark: “the only really good counselling that I’ve had was one that I paid for [...] because I’m paying for it I have to get a move on, so I don’t necessarily go back to stuff that isn’t what’s going on now [...] a lot of employers [...] do this where you can get

six free sessions counselling if you're having difficulties, but it's six, [...] that's the magic number."

Matthew: "I mean we only had 10 sessions for the whole lot."

Mark was very interested in the female model of counselling as an alternative, whilst recognising that this was not currently available. He identifies clearly his difficulty in only having access to short-term counselling for free, and not being able to afford long-term private counselling, even where it was helpful. Despite his reservations above about whether there was a need to investigate the past, when asked whether he would be interested in accessing such a service should it be available for men he responded:

Mark: "I'd bite your hand off".

Overall, there was support for the model developed. The areas of discussion with Mark were those expected, as many of his more difficult experiences of counselling had supported the testing of emerging theories of 1-to-1 support. Clearly the model is not yet fully developed as new aspects are still emerging with each interview. However, it provides a sound basis on which to develop further study.

5.8 Summary

The model of support for male participants that has been developed highlights the difficult emotions that the men suffered following the break down of their relationship and the subsequent abuse from their partners. They needed to access external support as they had issues they needed to discuss that they felt were inappropriate to share with family and friends. They also found some relief in having their experiences identified as DV, and valued working with professionals who could help them to understand what happened as well as offering practical support with the issues that arose.

Although there were two different models of support, 1-to-1 and group work, the two pathways both indicated the value that participants placed on the relationships they formed with the counsellor and others in the same situation. Those receiving 1-to-1 support reported the benefits of being able to talk about their experiences and work through strategies to deal with their specific issues. Those receiving group support listened to other people share their stories and how they coped, adjusting the ideas to suit their own situation. Although the methods of delivery were different, the men

adapted to this and were able to gain from either pathway. Those receiving 1-to-1 support were able to utilise the service to meet their needs, whilst the group work had a pre-determined end point that was independent of the progress the men had made.

It is also important to note the different experiences of Mark, who had been unable to access a counsellor who understood the dynamics of DV and felt that counselling had not been very useful in helping him to deal with the issues that continued to arise. His responses during the review session indicated that being able to access a counsellor with knowledge of DV; strategies to deal with abusive behaviour; plus the time to explore any other relevant issues; would all have been helpful.

Life after counselling was a combination of continuing to deal with ex-partner issues, knowing now that they had the skills to cope, and building new relationships with friends and family that had become strained whilst living with their abusive partner. Perhaps more importantly they also had a renewed sense of purpose and hope about what the future would bring. These findings will be discussed in the context of the existing literature in chapter 6.

6 Discussion

This research study aimed to find out what helped DV counselling clients to recover from their experiences. The process that has emerged has provided a description of the client journey from recognising that something was wrong, through accessing and attending counselling, to leaving and getting on with life.

Although the original intention was to compare a male and female counselling service, this was not possible. The differences between the two services were too great to allow meaningful comparisons of the models. However, keeping the two models separate has allowed greater exploration of the counselling experiences of women and men and what they valued. It has also provided some insight into common aspects of the male and female counselling process as well as differences. There are a number of specific elements in each of the models that have been highlighted as important and which will be discussed in more detail below.

This discussion chapter is separated into two main sections: section 1 discusses the female model and section 2 the male model of counselling. Each section considers the main stages of the particular model in turn, comparing it with existing literature. At end of section 2, a summary of some of the similarities and differences between what the men and women valued in counselling has been added. The chapter is concluded with section 3, which briefly considers the findings in the context of general counselling literature.

6.1 Female findings

The emergent model has a number of similarities to those described in the literature review (see section 2.4). As the counselling begins, there is an introductory period of working with current issues to create a secure base. This base is then used in the next stage of counselling for the exploration of limiting values and beliefs, plus any difficult or traumatic memories, if required. Once the participant felt she had addressed the issues she needed to, she moved to the next stage of ending the counselling. This follows the accepted path for trauma work described in the literature review (Herman, 1992) and is also similar to the counselling process expected more generally, with a beginning, middle and end (Horton, 2006).

However, from the clients' perspectives, the boundaries and interpretations of the beginning, middle and end were different. The three stages that emerged were:

making decisions about counselling, that is, whether to access therapy and then whether to continue the work or not; deciding to stay and then going deeper in their exploration of their experiences and beliefs; and finally preparing for life after counselling, which began prior to a discussion about ending therapy. This presents a slightly different view of the therapeutic process. Each of these stages is discussed in more detail below.

6.1.1 Stage 1: Making decisions about counselling

6.1.1.1 Emotional distress and hopelessness

One of the difficult moments in the interview process, also reported by other researchers (Davis and Taylor, 2006), was taking the participants back to the point before they accessed counselling. As they began to remember how they felt, as well as what was happening around them, their descriptions of emotional turmoil were vivid. The interviews suggested a sense of hopelessness, of being at the end of their known resources. These feelings are known to be a risk factor for suicidal thoughts (Beck *et al.*, 1974) and 20% of the participants disclosed previous suicide attempts.

Hopelessness is believed to develop when women realise that they will not be able to control their partner's abuse in the future (Clements *et al.*, 2004) and this was seen in interviews with the few participants who were still in their relationships. Although most of the women in the study had left their abusive relationship, memories of the abuse were being triggered, resulting in unexpected and uncontrolled emotional and behavioural responses. Hence, irrespective of their relationship status, they had reached a point where they acknowledged they could no longer control the impact of their partner's (historic) abuse. It seemed that they had to pass through this sense of hopelessness (O'Hara, 2011) to facilitate change. For those who had considered suicide, the threat to their life appeared to overturn any previous barriers to disclosure (Beaulaurier *et al.*, 2008) and may be indicative of why it was mentioned by so many of the participants. However, for some participants the hopelessness they felt with regard to their partner's abuse was not reflected in other areas of their life. Those participants were able to access counselling in a measured way and provide clearer direction for their counsellor, often requesting short-term counselling for specific issues. Nevertheless, hopelessness may be an important concept from a client perspective in seeking help and beginning the recovery process from DV.

6.1.1.2 Accessing help

One of the key findings in DV research has been the psychologically protective nature of strong social networks (Campbell *et al.*, 1995; Blasco-Ros *et al.*, 2010; Kamimura, Parekh and Olson, 2013) and, as shown in Table 2-2, the majority of people will seek help from their family and friends when suffering DV. However, individuals who have endured childhood abuse have an increased risk of experiencing DV (Howard *et al.*, 2003; Hegarty *et al.*, 2004; Rushlow, 2009). This study provides evidence that abusive childhood experiences can also impact on the participants' ability to seek help as they can lack the confidence and ability to communicate more widely outside.

With family relationships strained and previous difficulties in finding and building trusting external friendships, these participants were already at a higher risk of psychological harm. Their historic reliance on their own resources, which had been learned in childhood (see section 4.2.1.2), made it harder for them to seek possible sources of help from elsewhere and running out of options led to emotional distress. Whilst the level of emotional discomfort was high enough for them to recognise the need for help (Greenley and Mechanic, 1976), there were differences in how the women sought help. A few of the women were able to look at their lives objectively, identify what help they needed and then access that help (Kessler *et al.*, 1981). Others felt driven to seek help due to the emotions that they experienced and responded spontaneously to their situation (Hammer and Vogel, 2013). It is important to recognise that both types of help-seeking were present.

However, most of the women had referrals from professionals, which means the difficulties of disclosing DV (McLeod *et al.*, 2010) and the barriers to doing so (Beaulaurier *et al.*, 2008), had already been passed. Any stigma felt about DV (Overstreet and Quinn, 2013) had already been challenged as the people chosen for disclosure had professional experience of the participants' situation and had been supportive. In addition, any stigma attached to accessing mental health services (Judd *et al.*, 2008) did not seem to be reported for this group, as almost all had previously accessed counselling services. This suggests that the issues for accessing counselling services for DV may be different.

There has been research showing the positive influence of a professional referral on taking the first step to begin counselling (Hampton-Robb, Qualls and Compton, 2003). However, Hampton-Robb *et al.* concluded that it may not simply be about the

source of the referral, hypothesising that it may also be a function of the quality and credibility of the source. In this study, it was important to the participants that the person making the recommendation was someone that they had already dealt with in other circumstances in a positive way. Having trust in someone working within an organisation has been related to the person's knowledge of their topic, being seen to have the person's best interests at heart, and having integrity (Mayer *et al.*, 1995). These factors appear to have been addressed through their previous relationships with the professional, leading to a trusted recommendation for counselling that could be acted upon.

These are important findings from the research in two ways. First of all it suggests that it is not sufficient to simply provide a counselling service for this client group. It is also important that the service is visible to potential clients and to trustworthy professionals in the area. In turn, those professionals must be able to recognise the signs of domestic abuse and emotional distress, and have confidence in the counselling service, so that appropriate referrals can be made. Finding ways to reach prospective clients through new, rather than existing, pathways may be a challenge. However, secondly, and perhaps more importantly, it shows that this client group is responsive to assistance and acting on recommendations, where the right conditions are present.

6.1.1.3 Contacting the agency

Although it may seem obvious that participants valued their first contact with the agency, there is surprisingly little written about the impact of this on the therapeutic process. The importance of the agency experience prior to beginning counselling has been raised before in the context of reception services and pre-counselling literature (Quintana, 1974) but this does not appear to have been developed within counselling research. In addition, viewing a video-tape of a good counselling session has been shown to have a much more positive impact than being given leaflets to read (Stewart and Jessell, 1986) and it is possible that the initial interview was seen in this way, as a taste of what counselling might be like. This could indicate a preference for active rather than passive processes. In the context of feeling emotionally overwhelmed, it may be easier to respond and form a view in an assessment session than to concentrate on and process literature.

However, there is another factor here, as attending an assessment session allowed the individual to form an impression of the organisation. Trust in an organisation can

be developed where an individual perceives a level of competence in delivering the service, a genuine desire to help the individual and adhering to a set of principles that are agreeable to the individual (Mayer *et al.*, 1995). However, these factors do not appear to have been specifically addressed within counselling practice despite the changes in service delivery models discussed in the literature review. The assessment interview can be seen to play an important part in nurturing the trust and hope for the counselling process, seeded from the first referral. Here, the participants were looking for evidence that the agency could help them, that they could be trusted, in line with research from the National Health Service (Calnan and Rowe, 2008).

On the other hand, inconsistent processes or responses from staff, a lack of knowledge about the client issue and not understanding what the client wants could affect the counselling process before it begins (see Fiona's experience in section 4.2.2.3). It is in this context of organisational trust that Fiona's first agency contact can be reviewed. Inconsistencies regarding the agency's policy on waiting lists and a lack of clarity around agency roles each had the potential to undermine Fiona's trust in the organisation initially, however much the agency may have had a genuine desire to help her. However, it is important to note that it was the delivery of this service within the agency that caused Fiona concern, not the process of being interviewed by a support worker first. Indeed, one of the additional benefits of having an initial interview completed by a support worker is that there was no pressure for the client to deal with those items which she may have reserved for counselling either immediately or in detail. It has been recommended practice for some time that, in supporting clients who have experienced DV, there is a need to conduct an initial interview to check there were no safety issues which needed to be addressed prior to accessing counselling (Walker, 2000). In Fiona's case, the second agency took the opportunity to share the range of services available. This meant that the organisation and client were both clear that counselling was appropriate, additionally showing care for the client and professional standards of practice.

Whilst an early positive experience of the agency in the beginning will not guarantee successful counselling, it helps to create a conducive environment. The issue of the client's experience of the organisation prior to beginning counselling is often not specifically covered in counselling text books (for example McLeod, 2003; Feltham and Horton, 2006) and there may be an assumption that the counsellor will have the

first discussion with the client (Horton, 2006). This study suggested that building trust is something that needed to be addressed actively at each level of the organisation and forms part of the foundation needed for successful counselling.

6.1.1.4 Building trust

Having positive expectations on entering counselling, however derived, has been shown, in general, to lead to a higher likelihood of a successful outcome (Cooper, 2008). It has been estimated that about 15% of the improvement in therapy can be accounted for by this (Asay and Lambert, 1999). In addition, research indicates that positive, realistic expectations of counselling can help to establish the therapeutic alliance more quickly, leading to better outcomes (Cooper, 2008; Messer and Wolitzky, 2010). It is important in this context to recognise the additional step of having a positive first experience of the agency. Feeling understood and supported helped the participant to make the decision to take the next step to begin counselling, and to feel hopeful that it might be helpful this time.

Despite being referred by a trusted individual, and having a good first experience at the agency, half of the participants still described a sense of wariness as they began counselling, of being careful initially about what to disclose to the counsellor. This is different to general research (Lambert, 2007), which found that the predominant emotion prior to beginning counselling was uncertainty about what to expect in counselling and whether it might be helpful. However, as three-quarters of the participants in this study had a background of unsuccessful counselling and were aware of the counselling process, this may have prompted wariness rather than uncertainty. The findings of this study are perhaps better aligned with why clients avoid counselling (Vogel, Wester and Larson, 2007), that is, mainly low expectations of the outcome. Vogel *et al.* (2007) suggested expectations could be improved through educating people about what to expect in therapy, but many of these participants already had counselling experience. What appeared to hold the participants back was feeling that whilst they could recognise poor counselling, they did not feel confident in identifying a good counsellor or counselling. The perseverance of women who had suffered DV in seeking the right source of help, despite many disappointments, has been reported by other researchers (Holly, 2013). Trusting in the referrer to recommend a good counselling service led to hope that this time things might be different. This apparent deference to the referrer could be identified as a lack of self-confidence in making decisions or a sign of helplessness brought on by the experience of DV (Walker, 1977). Here, however, it

appeared to be driven by their previous experiences and perhaps a desire to protect themselves from more disappointment, particularly given their emotional states. The participants were clear that they had made the decision to access counselling themselves.

This wariness or lack of trust as a result of DV experiences has been noted before in the literature (Dutton, 1992; Herman, 1992; Sanderson, 2008; Nicolson, 2010) and therefore this response is not in itself surprising. There are theories about why a lack of trust develops which include: the realisation that their life partner cannot be trusted, and they do not know who can (Dutton, 1992); the psychological impact of a traumatic experience (Herman, 1992); specific actions taken by the abuser to undermine the victim's trust in others to increase their isolation (Sanderson, 2008); and attachment issues which have reoccurred through the lifetime of the victim (Nicolson, 2010). The participants told of life experiences which would fit each of these theories and of testing the counsellor through gradual disclosure over a period of time. However, there was an additional issue, the difficulty of not only admitting what had happened to the counsellor, but to admit it to themselves (see Natalie in section 4.2.3.2 and again in section 4.3.1.1). To do so required a confidence that the counsellor would be able to cope with the material in the disclosure.

It has been suggested that this testing process occurs over a relatively short period of time (one or two sessions) (Walker, 1994; Sanderson, 2008). However, participants in this study indicated it may have taken up to eight sessions to feel fully comfortable with the therapist. Both the participant's DV experiences prior to beginning counselling and the therapist's ability to understand and respond to what has happened to them could impact positively or negatively on the first and a reasonable number of subsequent sessions. When participants described previous unhelpful or short-lived counselling, it appeared to be related to being unable to form a bond or connection with the counsellor (see section 4.2.2.1), although this has also been reported by general counselling clients (Paulson, Everall and Stuart, 2001). However, as Amanda noted, (see section 4.2.2.1) it was her sense that the counsellor did not understand her situation sufficiently to be able to help or had been so far from understanding the issue as to potentially cause harm that was hindering. Whilst research with counselling clients in general has shown gaining knowledge and increasing personal resources as being helpful to the therapeutic relationship (Paulson *et al.*, 1999), the lack of this has not appeared to hinder therapy (Paulson *et al.*, 2001). However, this was seen to be unhelpful here.

Acknowledging and naming the abuse is an area that has been highlighted in many DV studies (Davis and Taylor, 2006; Hage, 2006; Day, 2008; Oswald *et al.*, 2010). In this study, as has been found before (Seeley and Plunkett, 2002), participants noticed when the counsellors did not have sufficient knowledge to understand their situation. The continual testing process suggests that DV knowledge is not just about developing client understanding, but a part of building trust in the counsellor and process. As the participants' confidence and trust in counsellors increased, in part due to their knowledge, the level of disclosure also increased (Schoorman *et al.*, 2007).

Although trust has been presented as a specific issue for DV clients (Dutton, 1992), it is interesting to note that trust is not highlighted as an issue to be addressed in standard counselling text books and rarely appears in the subject index. It may be that the need to establish trust is taken as an implicit requirement for all counselling, and therefore does not need to be highlighted. Whilst this study did not set out to explore trust as a particular aspect of third sector service provision, elements of building trust appear throughout this stage of the process. The transfer of trust from the referrer to the organisation and then on to counsellor requires each to provide a professional and competent service. The complexity of this dynamic may begin to explain the significant number of DV clients who have dropped out of counselling within a few sessions (Howard *et al.*, 2003; McNamara *et al.*, 2008). Although this may be a new area to consider and requires more research, aspects of this work could be usefully taken into account when designing counselling services for DV in the future.

6.1.1.5 Building a solid therapeutic relationship

Empathy, non-judgement and caring

This client group is recognised as having particular difficulties in forming a therapeutic alliance, both in the literature (Barber, Khalsa and Sharpless, 2010; Breger, 2012) and from the accounts of previous counselling given by the participants. There is evidence that for clients with trauma or abuse histories, it is the growth of the alliance over time that may be more important than initial therapeutic interactions (Stiles and Goldsmith, 2010). This fits with the issues of trust discussed earlier, as well as the overall model structure which shows an extended period of deciding whether to continue with counselling. However, this

study also highlighted a number of factors relating to the way therapy was delivered which contributed to a strong relationship.

A therapist working at the highest levels of empathy showing an understanding of the client beyond their immediate awareness (Mearns and Thorne, 1999), which in this case involved offering thoughts about possible client actions or feelings as a result of DV, allowed the participants to talk about something they may have been withholding or unable to mention (see section 4.2.3.2). This could be an example of the indirect communication style noted in the literature review (Williams and Mickelson, 2008) where well-developed empathic skills could be helpful. Enabling clients to respond reflexively in counselling requires the therapists actions to match what the client wants as well as the client feeling it is safe to respond (Rennie, 2001). Here the therapist's action fitted Rennie's criteria, although his initial findings did not include the possibility of counsellor subject knowledge matching client need, and was an addition to his findings (Rennie, 2011).

As counsellors enabled the discussion through empathic responses, participants' disclosure came with less fear of judgement. More general research on PTSD has found that those who felt judged by others as being at fault or to blame for what happened, as can be the case with DV, found it harder to form a therapeutic alliance (Keller, Zoellner and Feeny, 2010). Keller *et al.* (2010) found that showing and reiterating that the individual was not at fault or to blame was helpful. It is also a technique that appears in recommendations for DV work more generally and has been found in this study. Importantly, non-judgement by the counsellor in this case was an expression of congruence. Consistent views being given by the therapist were helpful to the participants. Over time, the participants came to accept that they would not be judged, which allowed more to be shared (see Paula and Mary in section 4.2.3.2).

The expression of non-judgement by counsellors is sometimes also described as unconditional positive regard, one of Rogers' (1957) core conditions. However, unconditional positive regard can also be described as acceptance, caring, warmth or affirmation (Cooper, 2008) and was reflected (see section 4.2.3.2) by Jackie when her therapist helped her to realise she did not have to be abused again, and by Veronica when she recognised she did not need to feel or think of herself in that way. Here, the participants were clearly differentiating between the non-judgement of their experiences, actions and responses, and the valuing of them as people.

This is also an important distinction therapeutically for a counsellor in working with DV.

The benefits of a therapist being clear that her client should not have had to experience abuse (Day, 2009) has been reported before, and could be indicative of compassion in wishing for the safety and well-being of the other. Although Rogers' (1957) core conditions are now accepted as part of the common factors required for psychotherapy (Hatcher, 2010), researchers have reported that feeling cared for (Stenius and Veysey, 2005) or connected to the therapist (Social Policy & Research team, 2009) is very important to DV clients. Experiencing a caring and compassionate counsellor has been linked to an increased client ability to explore vulnerable areas of their lives (Levitt *et al.*, 2006), that is, greater disclosure.

Careful application of technique

The degree of therapist engagement described by participants appears to go beyond the relational model assumed within CBT, that is, a collaborative relationship which is strong enough to engage with counselling (Castonguay *et al.*, 2010). In addition, earlier research found that clients with attachment issues, as can be the case in DV, may not respond especially well to standard CBT treatments for depression (Saatsi, Hardy and Cahill, 2007). The participants' descriptions of counselling interventions appeared to be similar to those recommended for depression (Gilbert, 2006) or anxiety (Donohoe and Ricketts, 2006) suggesting that cognitive behavioural or psychodynamic approaches are appropriate as long as the relational aspects above are addressed. Thus a combination of therapy approaches may be effective. This is not a new conclusion, as Gilbert (2006) has also noted the need for a "mixture of treatments" (p.392) although in this case he was referring to cognitive behavioural and psychodynamic therapy. The complex nature of the client history in DV suggests that a single, focused approach may be less effective than an integrated approach, as has been found previously (Morrissey *et al.*, 2005). Although much of what the participants described could be covered technically by a general counselling practitioner, building trust to enable disclosure, sharing knowledge of abuse and creating a compassionate therapeutic relationship may require specific training (Gilbert, 2009).

Another area of potential difficulty is the use of high levels of empathy by the counsellor. The therapist has to balance the woman's right to choose what and when to disclose, with a process of exploration. In helping the client to decide what

to share, the counsellor helps the client to build trust in themselves and the therapist (Stenius and Veysey, 2005) and also builds confidence that any disclosure could be handled without harming the relationship (Sanderson, 2008). However, Fiona felt let down by her first counsellor after making significant disclosures early in counselling (see section 4.2.3.1). Although this could be explained in terms of trusting her therapist too quickly (Sanderson, 2008), Fiona's description of what happened could be more of an ethical issue around the counsellor directing the client into specific areas of exploration against their wishes (British Association for Counselling and Psychotherapy, 2010). By setting the topic for each session, the counsellor was expressing power in and control of the environment and did not appear to take Fiona's views into account. For someone having little confidence in herself and now also suspicious of and lacking confidence in her therapist, further disclosure is likely to lead to unpleasant feelings (Saypol and Farber, 2010) increasing client distress.

A therapeutic approach, based on pre-determined session work which the client had not agreed to and which then caused distress could be experienced by the client as secondary abuse (Hattendorf and Tollerud, 1997), that is, the therapist increasing the client's pain through their intervention rather than relieving it. Whilst the counsellor may have attempted to provide boundaries and structure, which can be appropriate for some clients, it is important that this is done as a means to facilitate rather than control the client. Appropriate boundaries as part of the counselling service were welcomed by participants, but the personal relationship that developed with the counsellor themselves was also important and beneficial (Muller, 2009). It is important to recognise and work with both.

Knowledge of DV

An important aspect of relationship-building mentioned in DV literature is the need for a discussion about DV within therapy. Although this has already been discussed in the context of trust, this has a wider context. Walker (1994) felt the abuse needed to be identified, assessed and labelled, whilst Dutton (1992) believed educating the client about the abuse and their normal reactions to it had therapeutic value and Sanderson (2008) talked about affirming and validating the client experience. All of these principles were mentioned by the participants. However, the focus that emerged from this study was slightly different. It was not just about educating the participant and confirming the impact of DV. Rather, it was the counsellor's ability to understand the participant and her situation and to be able to interpret what she was

feeling through observation or interpretation that was the most important aspect mentioned by participants.

This is in keeping with other client research in this area where the therapist's ability to offer different perspectives about the abuse was seen as particularly helpful (Stenius and Veysey, 2005; Day, 2009; Social Policy & Research team, 2009; Oswald *et al.*, 2010), as was feeling understood by the therapist (Stenius and Veysey, 2005; Social Policy & Research team, 2009; Oswald *et al.*, 2010). Although building the counselling relationship and providing information on DV often appear as two distinct aspects of the work, it seems the two may be intertwined.

Taking time to develop the relationship

In taking these factors into consideration, it is not difficult to understand why participants reported taking up to 8 sessions to "settle down" into counselling. Although the participants entered counselling at different points in their lives, it still took time to develop a new kind of relationship with the therapist which allowed an honest exchange. Previous research has suggested that some changes in attachment pattern between client and therapist are possible during the first six sessions of counselling (Strauss, Mestel and Kirchmann, 2011). The participant descriptions suggested a change in the way they related to their therapists over that time period, which was important in continuing the counselling. However, further research would be required to investigate and verify this observation.

Much of what has been discussed in this section is part of the wider knowledge regarding good counselling and DV practices. However, what has been described also suggests counsellors are working with very high skill levels in creating a highly empathic and non-judgemental environment, whilst also providing a caring presence. Helping the client to understand DV is not simply helpful to the client, but essential to building the relationship. These factors suggest that therapeutic work in this area may require particular therapist characteristics and training. This would be worthy of further research.

6.1.1.6 Working with hope

At the same time as the relational aspects of counselling were developing, the participants were beginning to believe that they had not been able to deal with the abuse before because they had not understood what was happening (see section 4.2.3.2). Now that they were gaining a different perspective, they were beginning to

feel that they could deal with things more appropriately in the future. This change from being unable to take action to being able to identify and carry out actions provided hope for the future (Stotland, 1969). It also signified a change from feeling they had no control over the abuse (hopelessness) (Clements *et al.*, 2004) to some control over future abuse (hope). Perhaps more importantly, it created realistic hope based on actions that could be taken (O'Hara, 2011).

Hope has previously been identified as important to victims of DV (Davis and Taylor, 2006; Social Policy & Research team, 2009; Allen and Wozniak, 2011). Yet the need for hope is not unique to DV clients and has been identified as part of the process of treating depression (National Collaborating Centre for Mental Health, 2009). These guidelines specifically identify the need to share hope that the counselling will work at the outset of therapy. However, given that many of these participants had previously accessed counselling, the therapist's assertion that the counselling will work without providing any additional evidence may not be heard. In addition, concerns have been raised by practitioners about the explicit discussion of hope early on in counselling as potentially undermining the client experience and appearing to set a therapeutic agenda (Larsen *et al.*, 2007).

For this client group, it seemed important that hope for the counselling was established earlier than the beginning of therapy, with the referral, and continued throughout. The referral pathways which indicated that others had benefited from the service were helpful. Hope was not built simply through understanding the abuse, but also through the possibility of change (section 4.2.3.3). Initially focusing on small things that could be resolved relatively easily enabled the client to feel more positive and more in control, by achieving goals (Snyder *et al.*, 1991). Achieving small things created the possibility that bigger things might be possible. In other words, dealing with things of immediate concern helps to build hope, and providing tools and understanding for the future can lead to longer term resilience (Stotland, 1969).

Agency, defined as the confidence established from previous successes (Snyder *et al.*, 1991), was also addressed in this counselling. Showing that previous decisions had been made to the best of the individual's ability and that poor outcomes were dependent on factors beyond their control or knowledge have also been noted to create hope (Larsen *et al.*, 2007). This meant that the past was no longer an indicator of the future as those conditions were unique to that time.

New action pathways began to be created through recognising that the barriers and difficulties created by abusers were no longer there and that the participants were now in control. These changes in perceptions also helped the participants to see themselves in a more positive light for the future (Larsen and Stege, 2012). Valuing the strengths of the individual in coping with the abuse and helping to reframe experiences can be seen as ways of building hope implicitly (Larsen and Stege, 2010a). Not only was hope generated from changes in cognition about the past and the achievement of goals now, but also by the realistic possibility of freedom in the future. Of course, these successes also helped to increase the levels of trust in the therapist and the counselling process, leading to the participant adopting the views of their experiences presented by the therapist rather than those previously presented by the abuser.

Trust and hope appear to work hand in hand during this early part of the process, although trust appears first. Trust in the referrer brings hope that the counselling may be successful, and trust in the therapist brings hope of lasting change. As these two aspects grow, so the relationship grows, and equally, if they diminish the relationship may also diminish. Hope has been mentioned briefly in DV counselling as a factor to help motivate a client at the beginning of therapy (Walker, 1994) or as being renewed at the end (Sanderson, 2008). This study suggests that hope is being developed before beginning and is both present in the individual and as part of a process (O'Hara, 2013). The actions of the participant, prior to and during this initial period of counselling, changes to their perception of the past, present and future and an increased sense of control, all have a positive effect.

6.1.1.7 Working too deeply, too quickly

Although the participants in this study had completed their counselling and felt they had gained from the experience, some of them reported difficult moments during therapy (see section 4.2.3.4). It has been suggested that the therapist's ability to work with the level of disclosure and exploration that the client can tolerate is also a factor in building trust (Crits-Christoph, Crits-Christoph and Gibbons, 2010). For some of the participants (see Samantha, section 4.2.3.2, and Ruth, section 4.2.3.4) it appeared that the therapist was working very close to the boundary of what they could tolerate in counselling. What seemed to sustain them was the progress that had been made (Hill, 2010). Of those reporting these experiences (see section 4.2.3.4), only Amanda appeared to have had a discussion with her therapist about her distress, and she found the therapist's explanation helpful in dealing with the

situation. The others appeared to make the decision to continue outside counselling, considering that the benefits they had found from the counselling (discussed above in the context of building hope) outweighed the immediate emotional discomfort caused by the sessions and that the therapist ultimately was trying to help rather than harm them (discussed earlier in the context of trust). This underlines the need for counsellors to raise and address any relational difficulties that appear (Muran *et al.*, 2010).

In this study, two of the participants had received some guidance from their counsellors at the beginning of their therapy about the possibility of overwhelming feelings later in the process. They were given advice on how to cope with their feelings at home, before it was needed. This enabled the participants to cope with their emotions during the process and also to acknowledge their achievement in being able to do so. However, it also required some trust in the therapist to implement the actions required to manage their emotions successfully. Having done so, this generated hope that they could do so again. However, it is possible that if they had not been given this sort of advice and developed a positive therapeutic relationship, a decision to leave could have been taken instead.

A decision to leave counselling prematurely can be prompted by a relationship rupture, where a disconnection has occurred in the relational process leading to a deterioration of the relationship in therapy or a breakdown in the collaborative process (Safran and Muran, 2006). In this study, the emotional pain experienced by the participants could be directly related to issues that had emerged during the counselling, either through the direct or indirect intervention of the counsellor. Individuals who have been abused are familiar with the experience of trusting someone only to be hurt or harmed (Sanderson, 2012).

However, it was important to recognise that this was a different process. Bringing memories into consciousness, which were difficult or painful for the client and might have involved trauma, can result in a sense of disconnection (Herman, 1992). The skill of the therapist here is not simply creating the right environment for disclosures to be made. It is also in managing the session to help the client to explore issues at an appropriate pace and assist them to leave the session safely. Under these circumstances, the participant can gain comfort from knowing that the therapist had the best of intentions and that the discomfort was part of the process and not an attempt to hurt them.

Counselling relationships can contain fluctuating emotions including periods of trust and mistrust, of intimacy and isolation (Stiles, 2006). Understanding the counselling process has been shown to be important to clients (McGregor, Thomas and Read, 2006) and if this understanding is not present, clients may decide to confront the therapist with their distress, or withdraw (Safran and Muran, 1996). Here, it appeared that withdrawal was the more common response, but counsellors need to be aware of, and able to deal with, both.

The participants' decisions to stay in counselling despite their problems suggested that the relationship might have been stretched or damaged to some extent, but was sufficiently strong at the time to be able to survive. What these events had in common was their occurrence near the beginning of the counselling (Stiles *et al.*, 2004). It could be that approaching difficult issues too early in the relationship before the participant was fully ready could be problematic. It is worth considering Ruth's experience (see section 4.2.3.4) in more detail.

From her interview, it seemed clear that there were times during her counselling that she felt out of control emotionally. She put this down to the nature of the experiences she was exploring, which can invoke a sense of disconnection (Herman, 1992). However, the process that her therapist followed was different to that described by other participants. As the therapy took place in a short time frame (5 sessions), there was no time to build up a relationship prior to beginning quite intense therapy. Good practice indicates that clients should be consulted regularly about the pacing of the work (McGregor *et al.*, 2006) and this did not appear to happen in this case. Ruth held on to two facts to sustain her during the counselling: she had specifically asked to cover the work as quickly as possible and she trusted the agency. In framing her situation in this way, she took responsibility for her feelings as something she had prompted by asking to work quickly, and she trusted that the agency would recruit competent therapists.

An important precursor to trauma work, as highlighted in the literature review, is to build the client resources required to cope with exploration of her memories. As a resilient individual, Ruth did have the resources to find her way through the process and it is possible that the therapist had already made that assessment before agreeing to work quickly. However, Ruth felt obliged to check whether her feeling of destabilisation was described in the agency literature (it was not) and then checked whether her experience was normal with a friend. This suggests that the

implications of the process undertaken were not explicitly explained to her. It is also important to note that Ruth did not mention addressing this with her therapist, in line with the other participants who had some difficulty with the work. This may suggest that DV clients may benefit from a pro-active, rather than reactive, discussion about the counselling process and the possible implications of the work.

Ruth ended her counselling when she came to a point where she felt well again, and had nothing more to say. She decided she had covered what she set out to explore and had agreed with the agency, even though her counsellor appeared to suggest that there might be more work to do. As she concluded the work, she retained a positive view of the agency as she felt she had benefited greatly from the therapy, intense and challenging though it was, and was glad she had been able to do it.

This particular counselling experience raises a question about whether it is appropriate to accede to client wishes of brief therapy without further exploration. A discussion about the nature and risks of the intended approach, together with support to develop additional coping strategies, may have been appropriate and ensured informed consent. In addition, Ruth struggled to remember details of the work although there were only a few (very intense) sessions. Other participants did not appear to have the same difficulties with recollection, leaving the researcher wondering about possible traumatisation through the process. Although there was benefit to this approach, not least completion of the work in 5 sessions, there are questions in the researcher's mind about the impact of such an approach on a less resilient individual or one who did not have such faith in the organisation. It seems clear from other participants that this stage of the process is vital to engagement with and continuation of counselling, and Ruth opted not to continue. However, more positively, her experience suggests that some useful work can be supported early in counselling through organisational trust at the outset, allowing counsellors time to build their own relationship with the client.

6.1.1.8 Problems with general counselling referrals

During the interviews, a few of the participants talked about having been referred for general counselling by their GP's, and each indicated that they had been unable to relate to the therapist they had seen, feeling that the counsellor had really not understood what they were saying.

From the findings in this research study, this is perhaps not surprising, as many therapists in general practice will not have received detailed training on DV. In addition, it would be difficult for a GP in a short consultation to identify a psychologically abusive relationship. Words such as guilt, blame, crying and anger were used by the participants. These would show up positively in screening for depression (Beck and Steer, 1971) resulting in a referral for counselling for depression. Yet, as Amanda described (see section 4.2.3.2), the specific link between the words used and the hopelessness of the participants' relationship could be missed (Beck *et al.*, 1974). The focus of GP's on treating symptoms more generally may explain why many of the referrals for DV counselling came through the Police or via work colleagues, rather than health professionals.

Some of the earlier research would have predicted that this set of participants had a lower risk of suicidal ideation and depression (Campbell *et al.*, 1995; Golding, 1999): not all had experienced physical violence; some were still with their partners; and those who had left their partners had done so some years before. More recent longitudinal studies (Adkins and Kamp Dush, 2010; Blasco-Ros *et al.*, 2010) have reflected continuing mental health issues even after leaving the abuser (see section 2.3) as, for example, the negative comments from the abuser have been internalised (see section 4.3.1.2). However, current health guidance (National Collaborating Centre for Mental Health, 2009) is based on research which pre-dates these advances in knowledge, and the longer term risks to mental health through DV are not acknowledged.

There has been an increased focus in the UK on trying to address DV within health services (Jordan, 2007; Taskforce on the Health Aspects of Violence Against Women and Children, 2010b), including training for staff in asking appropriate questions and dealing sympathetically with responses. However, this still focuses primarily on screening women for physical harm and has not been widely adopted (Feder *et al.*, 2011). Women such as those taking part in the study are unlikely to be identified. Even if screening for psychological abuse were to be considered, there is no agreement currently about how that assessment could be made (Follingstad, 2007). Further research into developing a screening tool would be beneficial.

Given the current difficulty with screening and the client's reluctance or inability to disclose, it may also be useful to provide specific training in DV to general counsellors. Currently DV is not a required topic in undergraduate counselling

courses, and additional training in this area is dependent on therapist interest or a requirement of a counselling organisation. A combination of developing a mental health assessment tool for DV, to include present and past physical and psychological abuse, as well as providing training on how to work with DV experiences for all counsellors, could help to improve outcomes.

6.1.1.9 Differences between client and therapist models

In this section, specific details relating to the client experience and the existing literature have been identified, and differences highlighted. Now it is important to consider differences between this model and others in the literature. Some of the therapists who had written about DV counselling had also worked in private practice (see Table 2-6). This, together with the difference in perspective from therapist to client, makes a distinction when considering the findings from this study.

At the beginning of counselling, clients may know something about the background and experience of their counsellor if they contract with them privately. They may have already decided as they began therapy that the counsellor could be trusted to some extent and may already have held hope or expectation that they could be helped. In this study, the participants did not know which therapist would be allocated and had to trust that in attending a specialist agency they were more likely to find helpful counselling through an appropriate counsellor. This immediately raised the potential for a different dynamic in the counselling room for agency-referred clients compared with private clients, and may reflect some of the differences noted in how long it might take a client to settle. This is something that would benefit from further research.

Perhaps the most surprising aspect of the participants' descriptions of beginning counselling was the lack of comment about safety assessments and strategies, which form an important part of most books on counselling for DV. It is important to remember that most of these women had left their abusive partners some time before and some were in new relationships. Only one participant had recently left her relationship and was potentially in danger, as she was still in contact with her abuser. For those who were still living with the abuser, but not considered to be in physical danger, understanding his thought and behaviour patterns allowed for alternative strategies for living with him which brought relief and benefit to the whole family. Whilst it is important to remember that physical safety assessments will be required for some clients who are still living with or in regular contact with their

abuser, over half of these participants had left their relationships some time before. Their mental health symptoms had persisted long after the relationship had ended, however. The safety factors for working with trauma mentioned by Herman (1992) in terms of stabilising client emotions, for example in terms of anxiety, and in checking for the continued influence of the abuser in the client's life, appear to be much more important to this group. As such, the safety assessment perhaps required for these participants was not one of physical, but of psychological safety. This is a concept that could be usefully developed in the future.

The first few sessions of counselling appear to be critical to the overall success of the process. The importance of the therapeutic relationship has been seen as a central underpinning feature of counselling whatever the philosophical stance (Hazler and Barwick, 2001a; Muran and Barber, 2010). However, the meaning of therapeutic relationship can differ. From a humanistic perspective, an authentic relationship, appropriately caring and empathic, is more important than directive interventions (Watson and Kalogerakos, 2010). Cognitive behavioural therapists believe that building rapport within the relationship to be strong enough to engage with appropriate techniques is sufficient (Castonguay *et al.*, 2010) and not a specific aim of the therapy. Meanwhile, psychodynamic and psychoanalytic therapists encourage the projection and exploration of relational difficulties through working with transference, whilst encouraging the concepts of alliance and real relationship. The relative importance of these three aspects is a topic of debate (Messer and Wolitzky, 2010). What seemed to be described by the participants here is a relational approach that mixed the core competences of person-centred counselling, with techniques and information sharing more normally found in solution-focused therapy, together with exploration of the impact of past experiences and projection on life today.

Substantial therapeutic skills appear to be required for working with clients in this area, and whichever type of counselling background the therapist comes from, they would need to be open to developing the required skills and adapting their philosophical position to allow psycho-educational and integrative elements. Whilst the existing models in the literature have been developed using the knowledge, techniques and experience of the therapist, this client model offers no particular preferences on technique or modality, but is clear about the characteristics of the therapist and the types of intervention that they find helpful. DV authors, such as Walker (1994) and Sanderson (2008), have reflected primarily on the content of

their practice with the clients, rather than on their personal contribution to the therapy. It is possible that each was a warm, empathic and caring individual, who naturally created the right environment for the client to make the best of the techniques on offer. Certainly, being motivated to write about how to help such clients suggests a degree of compassion. The benefit of looking at this from the client perspective is to see a broader picture of counselling, and to hear a timely reminder about the importance of the human relationship in therapy, particularly when a client's previous ones have been abusive.

Finally, Stage 1 of the model has also offered some client insight about preferences when different authors have presented different ideas. For example Sanderson (2008) talked about building trust during the beginning of counselling, suggesting that the client will then begin to explore their own needs and vulnerability. However, the process outlined by the participants is much closer to that described by Lee (2007) as a validating and collaborative process building on the client's own previous experiences and coping strategies. The participants reported extensive feelings of hopelessness prior to accessing counselling and it is important to recognise the importance of this in the process. Not only does building on existing strengths help to resolve short term issues, it can also build confidence and hope for the future.

Many of the aspects reported by these participants have already been written about and could be referred to as best practice. Hence it is possible that the research is simply reflecting the practice of counsellors who were skilled, compared with those who were not. Nevertheless, there is a process within and out-with the counselling room. This reflects both the mental health difficulties described in detail in previous research and the possible impact of attachment. It highlights the need for a consistently high standard of counselling be able to work with the uncertainty of what might emerge for the client and to provide consistency. The elements of hopelessness, referral sources, communication difficulties and the need for high therapeutic skill levels have been reported to some extent in the literature, but this appears to be the first time they have been brought together. What has emerged is complex. Although this single stage could be sufficient for some clients like Ruth, who are resilient and have specific, well-defined issues to work on, for others this part of the process provided the foundation to move on to Stage 2, which was more demanding and yet critical to the overall outcome.

6.1.2 Stage 2: Going deeper

6.1.2.1 Working with trauma

This stage of the work is most often discussed in DV literature, and at first inspection this study might appear to offer little new to the field. The need for a strong, trusting therapeutic relationship or alliance to underpin trauma work has previously been suggested (Herman, 1992; Allen, 2005; Pearlman and Courtois, 2005; Sanderson, 2008) although not specifically addressed in earlier DV texts (Dutton, 1992; Walker, 1994). Equally, the methods for trauma work, such as visualising, metaphor and EMDR, described by the participants, match those generally included in trauma work reviews (Dass-Brailsford, 2007).

EMDR is still a relatively new treatment and although there have been mixed results in research (Dass-Brailsford, 2007) a recent trial involving female survivors of DV provided positive results (Tarquinio *et al.*, 2012). In the present study, EMDR was reportedly used to work with a single traumatic event and in both cases the need for EMDR emerged: neither had been referred to counselling for this treatment. It had benefits for those participants and is worthy of further consideration in working with this client group. One of the reported physical effects of working through trauma, reported by three of the participants (see section 4.3.2.3) was a sense of relief or energy release during the process. This aspect of trauma work is not mentioned often, but it has been noted before (Kepner, 1996). The concept of storing trauma in the body, and the impact of that on physical health has also received attention (Rothschild, 2000; Etherington, 2003). However, in the present study, the release appeared to happen without any focus on bodywork, as a consequence of reprocessing the trauma. There is no clear research base to explain the reasons or mechanisms for this occurring, but it is enough to note that it was perceived positively by the participants.

Most of the participants had positive experiences of trauma work. In general, the counsellors appeared to work with standard cognitive behavioural techniques initially to reduce anxiety (Donohoe and Ricketts, 2006; Ricketts and Donohoe, 2006), without making assumptions about the root cause. Whilst many of the participants later addressed childhood issues that could have resulted in underlying anxiety (Nicolson, 2010) or in post-traumatic symptoms (Walker, 2006), these factors were generally allowed to emerge when the participant was ready to discuss them.

There was one exception to this. Samantha was encouraged to address her childhood issues immediately by her counsellor, and found that her physical stress symptoms worsened as a result. Although she had expected to use counselling to talk about her experiences with her ex-partner, she reflected: “about two or three months later I remember saying ‘It’s funny how I barely mentioned him’.” During the initial counselling process, the depth of her experience in counselling meant she was unable to walk steadily from the counselling room at the end of the session, and she talked about “out of the body” experiences as a result of the therapy. The emotional impact of the work left her unable to go back to work on the day of her counselling (see section 4.2.3.2) and her description of the process suggested that it was led or directed by the counsellor. Ultimately the symptoms resolved and Samantha felt better as a result of the counselling, but her particular experience of feeling worse early on was quite different to other participants.

It is not unusual for counsellors to help people to work through issues from their past or present, which are causing difficulties for them today. Often these difficulties will be due to things that have not been previously addressed because they were too painful or tough to face. As a result, it is reasonable to expect that there will be emotional distress during counselling. However, trauma work has the potential for the distress to be so great as to cause dissociation. As Briere (2002) highlights, there is a balance to be struck between avoidance and re-traumatisation. In general, trauma therapists spend time understanding the experiences of people reliving trauma and developing knowledge of traumatic processes including dissociation (Herman, 1992). Then appropriate action can be taken to support a client in difficulty.

It is considered appropriate for the client to choose which areas are best to be explored at a given time (Herman, 1992). Constant monitoring of the client to ensure they can tolerate the emotional intensity is important in trauma work, and sessions should explore new material at the beginning and allow for a period of reorientation and calming in the last third of the session (Herman, 1992) to enable them to leave the session safely. It is not clear from Samantha’s description of the process that these guidelines were followed during her counselling. There may be an implicit assumption within an organisation that the therapist will adhere to the ethical standards associated with their professional organisation and it provides a reminder of the need for appropriate training and supervision in doing this work.

Concerns could be raised about Samantha's experience under the BACP ethical framework values of autonomy, beneficence and non-maleficence (British Association for Counselling and Psychotherapy, 2010). The BACP ethical principles (p.3) identify the need for practitioners to act in accordance with the trust placed in them, to seek freely given and adequately informed consent and to act in the client's best interests particularly when their capacity is diminished through extreme distress or lack of understanding. As a counsellor, it could be easy to assume that the client decision to seek counselling is equivalent to consent to undergo the counselling process. In that case, prompting the client to work with previous trauma is in line with acting in the client's best interests and therefore making good use of established trust. However, there is a difference between prompting distress in a counselling session, which can be managed by the client both at the time and during the following week, and prompting a physical and emotional response that affects the person's capacity to function.

As with all ethical issues, there is a matter of judgement about the degree of distress that a client can manage. However, given the risks associated with reliving trauma, it seems that a higher ethical standard when working in this area would benefit both the client and the counsellor. A statement by the counsellor at the beginning of counselling highlighting the potential difficulties that could arise if hidden trauma emerges during counselling might be helpful. In addition, highlighting appropriate coping strategies and options for the client to continue or withdraw from therapy safely would show caring and ethical practice. This could also, as identified earlier by Ruth, take the form of written guidance for clients on the process about how to make a properly informed decision about whether or not to continue. Given the potential harm of re-traumatising a client, it is not simply a matter of the counsellor developing the courage and skill to work with these issues, but also of ensuring that the client wishes to benefit from that courage and is prepared for the potential impact.

Finally, it is important to review Elizabeth's narrative (see section 4.3.2.3). As the story emerged in the interview, it seemed that she had forced herself to tell her story, perhaps before she was really ready, and as the memories came back she felt drawn to take action. It may be that Elizabeth's early focus on action distracted the focus of the counselling away from reprocessing the memories and into coping with the new issues her actions had created. Literature on trauma work consistently follows a pattern through recollection to integration, and perhaps this process was

inadvertently interrupted part way through. An interruption can mean that the process is held at that point until completion can occur later (Clarkson, 2004). From Elizabeth's story, it appears that the unfinished nature of the work is problematic for her as she feels progress has been made, but not quite enough to allow her to move on fully with her life.

The premature ending of counselling can sometimes be due to traumatic counter-transference (Walker, 2009c) due to inadequate support from, or supervision of, the counsellor and is a question of ethics. Whilst it is not possible to judge whether this was the case for this participant, it does highlight the need for therapists to be able to make an informed decision about their capability and their access to supervision to be able to work effectively with the issues presented. Secondly, the therapist needs to understand the process and techniques of therapy to facilitate the transformation of the trauma through to the end. Simply revisiting the trauma is not enough, as this can cause re-traumatisation (Herman, 1992). Finally, time is required to do in-depth trauma work, and practitioners must ensure that the work can be concluded, given any time or economic constraints and the motivation of the client. As such, practitioners must also be clear about the ethical qualities required of a practitioner (British Association for Counselling and Psychotherapy, 2010) in terms of humility, competence, wisdom and courage.

6.1.2.2 Empowerment

Another key area often discussed within DV is empowerment. Although empowerment has been put forward as an important therapeutic goal by leading researchers in the field (Dutton, 1992; Walker, 1994; Sanderson, 2008) multiple definitions such as Dutton's (1992, p115) "choice making" or Sanderson's (2008, p167) "restoration of control" (Sanderson, 2008, p167) suggest that there is no clear agreement. Walker believed that empowerment came from understanding the dynamics of abuse, something described by participants in Stage 1 and also the basis for an intervention programme in the USA (Islam, 2010). An empowerment scale has been developed with self-efficacy, power, community activism, righteous anger and control over the future as underpinning constructs (Rogers *et al.*, 1997).

However, the sense of the word empowerment is about providing power to the individual, of enabling them to do something, that is, an external action. There are aspects of these definitions of empowerment in the participants' descriptions in Stage 2 of the work, as they hear the messages they give themselves and take

action to resolve issues today and in the future. However, it is important to note that the participants did not describe themselves as empowered, more that they felt more confident to try out skills, to take action and to get on with life. In other words, the driving force for action came as a result of changes to the way they felt about themselves.

In the case of Ailsa (see section 4.3.1.2), the external voice of her therapist encouraging her to put herself first clashed with her internal values of being of service to others and this led to internal conflict. Therapists may offer different world views in an attempt to empower, but the power for change comes with client belief in the message. As Jackie said in section 4.3.2.3, she had heard the messages before, but it was only now that she believed them. Whilst Ailsa could see that she needed more time for herself, it was the concept of putting herself 'first' that caused her difficulty. This highlights the importance for therapists to understand and respect, as well as challenge, the client's frame of reference. Ultimately, it is not about providing power to clients, but facilitating the generation of power within them.

6.1.2.3 Compassion

In trauma work, the benefits of a deep therapeutic relationship with tolerance and compassion for the client (Allen, 2005) have been noted and link with more recent work on compassion within trauma treatment (Briere, 2012). This deep therapeutic connection allowed the client to move from a place of understanding that what had happened was not right, to a place of believing or feeling that it was not right and then, that the memory would no longer control her life.

Recent research on compassion (see section 2.4.3.2) aligns with humanistic values, the core conditions (Rogers, 1957) and the need for a caring relationship to prompt personal growth (Rogers, 1959). During her interview, Karen linked her feeling of comfort with maternal love (see section 4.3.2.3), a third dimension of meaning for the word comfortable beyond those identified in the literature review (Social Policy & Research team, 2009). However, in the context of these participant remarks, compassion seems to be slightly different to that defined either by Rogers (1958) or Briere (2012).

In this study, the participants' descriptions appear closer to the definition of compassion given by the Dalai Llama (Bstan dzin rgya, 2010). This incorporated compassion as seen by the major religions across the world and, interpreted within

the context of DV counselling, including the safety of both therapist and client, the ability to empathise, and the willingness to go beyond what is expected.

This definition seems particularly appropriate in this instance. Although the psychological safety of the client has already been discussed as part of Stage 1, a key topic for research from a therapist perspective is that of compassion fatigue which can prevent counsellors from working effectively with a client and cause them psychological harm if not properly addressed (Figley, 1995; Sexton, 1999; Baird and Kracen, 2006). In that sense, both the therapist and the client have to be able to work safely together. There is research to suggest that there are risks to the mental health of the counsellor of empathic engagement (Bush, 2009). These risks have been noted to increase where the therapist has a high case load of trauma work (Baird and Kracen, 2006) or lacks experience and training (Canfield, 2005). It is appropriate to note that the characteristics of the therapists as noted by the participants indicate both training and experience, which would help to create safety for the counsellor and the client.

The important role of empathy both in Stage 1 of this model and in other definitions of compassion is supported. It could perhaps be argued that to some extent all of the therapists working with these clients addressed the first two aspects, of safety and empathy, but it was the third aspect, the concept of going beyond what was expected by the client, that seemed to separate the participants who made progress from those who appeared transformed by the experience (see the end of section 4.3.2.3).

The participants' sense of having a special relationship seemed to link with their perception that the counselling had gone beyond their expectations of therapy: providing comfort in bereavement; having belief in their potential; and being prepared to go beyond the limited scope of the job. Although this is linked to aspects of the valuing process (Rogers, 1964), the description from the participants related to connection rather than separation. Whilst it may be questionable whether this level of relationship could be sustainable by a therapist with every client, particularly given the potentially high personal cost, it did indicate a high level of commitment from their counsellors.

It is possible that this deeper change in the participant, as they not only thought differently but also felt differently about themselves, had a physiological basis. The literature review suggested that compassionate feelings are processed within the

right pre-frontal cortex area (Lutz *et al.*, 2008), close to the region of the brain which is associated with social connection, the positive feelings associated with interacting with people (Wang, 2005) and the individual's sense of self (Schore, 2005). For clients who have suffered some form of trauma, there is a possibility that the self-protection mechanism associated with the left pre-frontal cortex had been over stimulated. With a growing belief that compassion is something which can be transmitted from one person to another (Vivino *et al.*, 2009; Briere, 2012), it is possible that the depth of feeling experienced with the therapist was successful in stimulating the right brain's positive experience and affect function, resulting in the participant feeling differently as well as thinking differently. Perhaps working with a compassionate therapist and talking through trauma whilst still mindful of the present allowed them to connect with the right side verbal function of the brain and at the same time the positive feeling function. Clearly this is a hypothesis, but perhaps one worthy of further investigation, whilst recognising that there may also be other mechanisms involved.

6.1.2.4 The positive work of Stage 2

In concluding, it is pertinent to note that, despite the difficulties of working with past issues, this felt from a participant perspective to be a very positive part of the process. Issues that had been weighing the participants down were resolved. Whilst in Stage 1 of the model it was important that therapists knew about DV and could build trust, in Stage 2 they needed to be able to work with trauma safely and ethically for both the client's and their own sakes. The process of being client led, and of working collaboratively with the client continued, and the need for active client consent to the process was underlined. Whilst there has been a focus for supporting DV clients on knowledge, technique and interventions, the present research suggests that the personal qualities and approach of the counsellor are of at least equal importance. The role of compassion is still being researched and this study suggests that could be a fruitful avenue of work. Future studies assessing client improvement should include some form of therapist assessment as well as client baseline and outcome. This is in line with current research on the therapeutic alliance (Del Re *et al.*, 2012), which suggests that therapist variability could be a confounding factor.

6.1.3 Stage 3: Preparing for life after counselling

6.1.3.1 Ending counselling positively

The final stage that the participants talked about was a process of recognising and becoming comfortable with ending counselling. As can be seen in the findings, there were a number of experiences of ending, although for almost all of the participants this was positive. In retrospect, there were a number of factors that would have suggested these participants were more likely to have a positive ending: they had reported a positive therapeutic relationship and a discussion with their therapist about endings (Knox *et al.*, 2011); they had initially sought counselling due to feelings of hopelessness, rather than hope of improvement, (Elliott and Williams, 2003); and the participants had mostly undertaken counselling before, they knew they had had enough counselling for that time and were ready to leave (Manthei, 2007). Having an ending process that allowed the participant to make the decision to end, whilst also discussing it with their counsellor, helped to maintain their positive outlook beyond counselling.

Part of the ending process for participants included their own testing of whether they were able to continue with the progress they had made without the support of counselling. This is not something that has been described before in client based studies, although it appears to follow the same principles as relapse prevention techniques in CBT (McLeod, 2003b). As Natalie and Lucy mentioned (see section 4.4.1) there were still things which happened in their lives but they noticed that they now had ways of coping and were starting to believe they could manage on their own. The realisation that they now had the necessary skills themselves was critical and allowed the possibility of independence. The time to take the next step to end counselling depended on the participant, with some taking weeks to feel confident on their own, and others realising they were ready to leave within a single session. Sanderson (2008) suggested that endings created anxiety for both therapist and client and therefore endings should be planned and discussed carefully between therapist and client as part of goal setting. However, the findings in this study suggested that clients were more likely to feel a sense of pride and accomplishment on ending (Fortune, Pearlingi and Rochelle, 1992). The role of the counsellor here was in confirming their decisions, reviewing successful outcomes and sharing their positive future expectations for the client, providing hope for the future (Larsen and Stege, 2012).

It has been suggested that the more effective the therapy has been, the more important it is to have a proper ending (Elliott and Williams, 2003) and this would appear to be the case here. Each of the participants who had discussed endings with their counsellor felt they had gained enormously from the experience and a part of their ending process was using their new found confidence to leave their counsellor. A number of the participants (see section 4.4.1) may have ideally liked a little more time and this can be indicative of a less substantive therapeutic relationship and poorer outcomes (Knox *et al.*, 2011). However, this did not seem to be the case here, as the participants recognised that external, rather than therapist, factors were at play. The therapist's ability to ensure the participant understood that the ending was related to organisational factors and not to their progress in counselling or to them personally helped to ensure a positive outcome.

Finally, the ending was made easier for the participants because they had been told they could re-access counselling again if they needed to, and whilst almost all had not had to do so, each had remembered they could. This has been described as creating an image of interrupted counselling rather than termination (Cummings, 2001; Etherington and Bridges, 2011) and was also found to be helpful in a general study on the process of counselling (Manthei, 2007). This suggests this aspect of ending is not unique to DV and is more generally part of a positive ending.

The topic of endings was not explored as well as other aspects of the model, in part due to the time limit for the interview and in part due to the presentation of ending as a much less complex issue by the participants. Exploration of any endings that may have caused concern to the participants and the impact of those appeared a useful idea at the time of the beginning of the research interviews. Yet the participants seemed to reflect the situation reported in general counselling, that a planned and managed ending is easier to bear than a sudden and abrupt one (Knox *et al.*, 2011). The ending process described by the clients is well supported by the literature, and reflected a positive outcome, encouraged by their counsellors. It is interesting to note that the concept of hope followed through into the ending session. However, this study's main contribution to this area of work is in the outline of a positive ending process that could be incorporated into practice. Further more detailed research to understand the impact and nuances involved in endings could be useful.

6.1.3.2 Outcomes from DV counselling

After leaving counselling, the participants felt that they continued to grow personally and to enjoy their lives more than they had done before. As this research was conducted some months after concluding counselling, it supports previous research (Nicholson and Berman, 1983) that the gains in therapy can be maintained for a 3-6 month period after ending. Although many therapists are asked to measure the degree of improvement in the client's presenting symptoms to show the value of their counselling, here the participants talked about what had made a difference to them in their lives. One participant mentioned that the changes to her depression and anxiety on her exit questionnaire from the agency suggested little improvement, but she wanted to take part in the research to share how much the counselling had meant to her, and how much her life had improved as a result. The changes she mentioned were aligned with those mentioned by other participants: they felt they had moved on a long way and the main benefit was how they were now engaging with life.

This raises an important question about how we assess DV counselling. As shown in the literature review, much of the quantitative research has assessed reductions in depression, anxiety or PTSD and yet it would seem that this does not express enough of the value of the work. Other studies have sought to recognise the wider changes possible within counselling by measuring self-esteem (Bennett *et al.*, 2004; de los Angeles Cruz-Almanza, Gaona-Márquez and Sánchez-Sosa, 2006; Reed and Enright, 2006), empowerment and problem solving (Bennett *et al.*, 2004) or interpersonal functioning and life coping and satisfaction (McNamara *et al.*, 2008). As noted in the literature review, there has been no agreement to date on what an appropriate outcome measure for women after domestic counselling is other than relief in their diagnosed or self-reported symptoms.

In comparing self-esteem measures (Coopersmith, 1967; Rosenberg *et al.*, 1989) with the outcomes reported by the participants, there was evidence that they felt more confidence in doing things and that they felt more valuable as individuals. However, there was not a good match between other aspects of self-esteem measures and what has been reported in the study. A similar pattern emerged when looking at the empowerment scale (Rogers *et al.*, 1997). Whilst there may have been a reduction in powerlessness and an increase in optimism for some participants, this was not common to participants. There was little mention about community activism and righteous anger. Indeed, not feeling angry any longer,

whether righteous or not, was more likely to be mentioned. This is a surprising conclusion as increases in self-esteem and empowerment have been discussed as treatment objectives for this client group by feminist researchers for many years. In addition, there is no data from the study to assess whether the participants' problem-solving ability (Heppner and Petersen, 1982) had improved. Finally, the Life Coping Inventory (McNamara *et al.*, 2008) included issues such as finance and housing, which were not raised as issues for this group, and work, which was mentioned by a few women as a particular issue.

More positively, a survey constructed specifically for DV (Bennett *et al.*, 2004) showed to some extent the counselling process developed in this study, investigating outcomes of knowing the abuse was not the client's fault, having coping strategies, and trusting the client's ability to solve problems and make decisions. However, there is little about the positive aspects reported in this study of undergoing counselling, instead focusing on attaining goals. The Outcome Assessment (Lambert *et al.*, 1998) appears to be a good assessment tool for the beginning of counselling as it focuses on much of the emotional distress that was reported at the outset. However, this would then simply show an improvement in those symptoms over time, rather than reflecting the outcomes reported by the women. As such, none of the assessment methods used for outcomes appear to match these findings very well.

This raises a second question about whether this particular group of women are in some way different from others and therefore not typical. A further review of the literature suggests that most qualitative studies have been focused on the process of DV and gaining assistance (Stenius and Veysey, 2005; Hage, 2006; Social Policy & Research team, 2009; McLeod *et al.*, 2010; Oswald *et al.*, 2010) rather than the outcomes. However, one report on the outcome of group-work in DV (Allen and Wozniak, 2011) did report improved connections with family, more focus on things they enjoyed and their ability to make their own choices now. In a more recent European study (Farmer *et al.*, 2013) findings from the UK suggested that the key outcomes for counselling clients were being able to perceive a future after previous suicidal thoughts, as well as being more positive and confident in themselves. In other parts of Europe responses also included improved family relationships. As such, there is some support from recent publications for the findings in this research.

The factors valued by the participants in completing counselling, such as improvements in relating to others, seeing new possibilities within their lives, feeling self-reliant again and appreciating life each day fits more with the post-traumatic growth inventory (PTGI) (Tedeschi and Calhoun, 1996). Although there is a fifth spiritual dimension suggested, which was not a factor mentioned in this study, this could be a cultural difference between the USA and the UK. The scale is believed to be useful in determining how successfully individuals will reconstruct their perception of self, others and the meaning of events following trauma. In the case of this study, the women had mostly been victims of domestic abuse prior to the counselling and had been unable to complete that reconstructive process on their own. This implies that working through and resolving the experiences that they had had in some way resulted in post-traumatic growth. The introduction of post-traumatic growth as a potential indicator of benefit from DV counselling is not necessarily a new concept as Sanderson (2008) mentioned it briefly as a potential benefit. However, taking it from being a potential benefit of counselling to being an objective will require further research and development.

This finding of post-traumatic growth is important, both in acknowledging the potential benefits to women undertaking DV counselling and in assessing the value of the work to a client group who may struggle to engage initially. On this basis, it is possible that measurement of symptom relief may under-rate the benefits of the work. It is also possible that the previous focus of DV support on autonomy, decision making and understanding DV may not on its own be sufficient to resolve the trauma. The need for closeness, compassion and valuing of their own lives, as described by participants and also included within the PTGI, is very important. As well as aligning well with the reported experiences of the participants, the PTGI shows links to the depth of the therapeutic relationship described by participants offering theoretical support for both the model and outcomes.

It is also important to note recent research indicating that self-compassion may be a better indicator of long term improvement rather than self-esteem (Neff and Vonk, 2009) and Neff's self compassion scale (Neff, 2003) tends to better reflect the changes the participants reported. This link through from the compassion offered by the counsellor to the compassion the participant could now feel for themselves as their perception of the abuse changed, was developed earlier in the discussion on Stage 2. However, it was apparent to the researcher from many of the comments made during the debriefing sessions with participants that they felt great

compassion for others who had suffered DV and also for the researcher, listening to their stories. The presence of compassion within the participants as part of post-traumatic growth also shows the longer term benefit of counselling beyond the natural end of the therapy.

This research focused on the client experience of counselling. The participants have clearly stated that what was really helpful for them was recovering from the trauma of their experiences. It appears that the concepts of trust, hope and compassion that were interwoven through the counselling process also appear as part of life for participants after counselling. Rather than presenting these as concepts to be aware of whilst counselling, these appear to underpin successful therapeutic encounters and form a significant part of client preferred therapy.

This is particularly interesting when considering counselling outcome research that has recently emerged (Baldwin, Wampold and Imel, 2007). This showed that outcomes were related specifically to the therapist's ability to build relationships rather than the client's. Further research showed clients' improvement was related to the ability of the therapist rather than to their own starting position or issues, and some therapists had consistently better outcomes with clients than others (De Re *et al.*, 2012). This is of particular relevance to this study when considering the high level of counselling skill employed by the majority of the counsellors working with participants in this study. The therapists involved in this research were experienced and had been selected and trained by agencies that offer DV support. All of the agencies had stories of the service being continued through funding shortages showing their commitment to the client base. In the light of this research, however, it has to be considered whether the client view of DV counselling being developed here is dependent upon the skill level of the therapist.

Finally, it is worth reflecting that from a client perspective many of the things that these participants said were helpful in therapy have been previously reported (Bohart and Tallman, 1999; Paulson *et al.*, 1999). Other research about unhelpful or hindering factors from a client perspective (Paulson *et al.*, 2001) produced issues of client vulnerability also reflected in this research, as well as a number of factors such as counselling structure or barriers to feeling understood, which appear to have been managed out of the process by the way the agencies are set up. This suggests that the quality of the therapeutic engagement, together with the back up provided through the agency approach may also positively influence outcomes.

6.1.4 Summary

The outline structure of the female client view of DV counselling appears at first sight to replicate the models of earlier researchers. However, there have been many developments in counselling and psychology since these models were developed which have allowed a different picture of what is happening in each stage to emerge. The changes to the structure of counselling delivery from mainly private practice to agency and public sector therapy mean that the client process for access is also changing. The trust issues which often develop as a result of DV have been shown here too, but the participants have been able to share how they were able to build up enough trust to be able to access services. Although there are referral processes, the extended nature of mental health problems beyond the abusive relationship mean it may be difficult for health professionals to identify those who would benefit from this type of work. Further work on assessment is required.

Within the process of recovery from DV, hope and compassion have been shown to be very important, and working with skilled professionals with the right personal as well as professional characteristics has also been shown to be vital. Although the stories of participants were mainly positive about their last experience of counselling, there were other stories of therapy which could be seen to be unhelpful at best and at worst warranted consideration alongside an ethical framework.

Finally, there is evidence to suggest that the benefits of counselling for this client group are not only in symptom management or improvement, but in working through traumatic memories to find post-traumatic growth. Consequently, the current assessment process for DV counselling would benefit from further research.

6.2 Male findings

One of the most striking aspects of continuing the research with male participants, after female ones, was the disparity between the resources for counselling offered to women compared to men. Although the women could have up to 20 sessions of counselling and in some cases more, the men were limited to 6 sessions, unless special circumstances could be shown. The women in this study could access an agency serving a local population of around 140,000, whilst the men had access to an agency serving a population of 6.3 million. These disparities in funding, referred to in chapter 1, could be seen clearly in the different model of support that emerged from the research.

The participants in this small study reported emotional, psychological, physical and financial abuse. In keeping with the literature review the men did not mention instances of sexual abuse. Nevertheless, the participants experienced significant harm as a result of actions taken by their female partner. This study supports the view that serious violence and control by women of men is possible within partnerships, but it is beyond the scope of this research to draw conclusions about the nature and frequency of abuse from female to male partners. Much has already been written about the possibility and likelihood by other authors without any apparent consensus (Straus, 2009; Johnson, 2011; Dutton, 2012). Nor is it for this study to comment upon the relative numbers of male and female victims and their respective levels of suffering. For these participants, female to male abuse was a painful reality and that, in the UK, even this modest level of support is generally unavailable for men in a similar position. As the first stage of the model for the men is a description of how the pressure has built up for them to an unbearable level, and then released through contact with the agency, the unanswered question in this research is what happens to those who cannot access support?

This study is small and the routes to support that the men had available to them varied in each case as described in section 5.2. It is more appropriate with this divergence of data to reflect on the shape and scope of the model emerging, rather than drawing specific conclusions about a potential model of counselling as was possible in the case of women.

6.2.1 Stage 1: The pressure builds

6.2.1.1 Pressures before relationship break-down

One of the common elements of the male experience was finding, as their marriages broke down, that they were isolated from their family and community and as a result had no-one to turn to in their time of need. Although this was a significant factor, it is not specifically addressed by common quantitative assessment tools such as the conflict tactics scale (Straus *et al.*, 1996). Isolation has been identified as an issue through qualitative research (Migliaccio, 2002) although in that study it was presented as being a specific objective and means of control by the partner.

In this study, the men talked about the isolation emerging as part of the pattern of life with their wives, which made it harder to recognise and address, as there were no, or few, specific requests or acts to challenge. The isolation had been a gradual process and they had been unaware that it was happening or of the potential

consequences of being isolated (Bloom and Lyle, 2001). Although the men were experiencing abuse, they were trying to make their relationship work by, for example, excusing their wife's behaviour when in public (Hines and Malley-Morrison, 2001).

The description of the struggle with the relationship prior to it breaking down was important. There has been evidence to show that in cases of female spousal abuse, both partners' mental health was affected (Vivian and Langhinrichsen-Rohling, 1994). This would fit with the findings of this study, as some of the participants expressed concern that their partners had not accessed psychological support since they had left.

In addition, it has been suggested that some DV may result from either one or both partners being previously traumatised from childhood or sexual abuse (Bloom and Lyle, 2001; Matsakis, 2001). Almost 92% of callers to a male DV help-line indicated that their partner had a history of childhood trauma (Hines *et al.*, 2007). Several of the participants talked about the difficult childhood their partners had suffered and the additional pressures that brought to their relationship, and two also indicated that they had had childhood difficulties. It is possible that one or both partners could have benefited from access to psychological support earlier in their relationship, although the treatment focus for the two might have been different (Bloom and Lyle, 2001).

With both partners potentially at risk of becoming a victim of DV, it is beyond the scope of this study to draw any firm conclusions about this. It is simply noted that childhood abuse is a significant factor in this field, and that it can cause psychological harm to both the individual and his or her partner later in life. This suggests that the simplistic model of treating individuals as either the victim or the perpetrator may be flawed.

6.2.1.2 The personal impact of relationship break-down

It was the female partner who made the decision to end the relationship for four of five participants. This came as a shock to the men, as they had believed they could find a way through the difficulties of the relationship (Cook, 2009). Despite their efforts to meet their partner's needs, it was still not enough. There was shock that she had decided to end things, followed by feelings of guilt and anger (see section 5.3.2) reflecting a normal process of grief (Syme, 2012). However, the one male participant, who had decided to leave his wife, had feelings of guilt about the part he

perceived he had played in his wife's problems and whether he had done enough to help her, together with anxiety and concern about how his wife would now cope on her own (Cook, 2009).

Both responses can be seen to fit with previous research in this area. However, when put in the context of other DV research, the decision of the female partner to leave and the expressions of guilt and anger by the male partner could be misinterpreted as a sign of male to female abuse (Abrahams, 2007). Although the literature is beginning to acknowledge that male victims may present their distress in this way (Stith *et al.*, 2012), current training on DV suggests that male perpetrators will try to control their partner through the use of anger. With no easy way of assessing the male partner for what was mainly psychological abuse, most DV services will support the woman in the first instance.

The emotional pressures were building as their partner's decision to end the relationship left them cut off from their children and home-life, and socially isolated after years of mainly emotional and psychological abuse. In addition, the men found it difficult to engage with a system that did not believe them, and although the men in this study had been abused in the relationship, four out of five lost custody of their children to their partners. This added to the men's frustration, as they could recognise harm being done to their children through their wife's influence (see section 5.3.3). The issue of identifying female perpetrators is therefore wider than whether men can be appropriately identified as victims. It could also impact on the protection and future mental health of the children involved. As this is an issue that has been raised through the research, it seems appropriate to note it here, although it is not the focus of the study. Nevertheless, it does highlight the need for a form of assessment for psychological as well as physical abuse.

In keeping with the findings from the literature review, some of the men contemplated suicide. However, this had a different motivation to that suggested by Cook (2009), who found that suicidal feelings were seen as a way out of the relationship. This study found that those thoughts were prompted in response to the loss of their family and/or relationship and the hopelessness of the situation, particularly where children were involved. The emotional stress of losing their family units was a greater stressor than living with the abuse. The men had not taken the decision to end the relationship: that decision had been taken for them. This, combined with a system that would not listen, left them powerless. A combination of

isolation, hopelessness and not knowing how to cope has been identified as prompting suicidal thoughts (McLaughlin *et al.*, 2012), and therefore it is not surprising that this was the response of the participants. However, thoughts of suicide, as with the women, prompted them to seek help.

6.2.1.3 Experiences of general counselling

Some of the men were referred to or had accessed general counselling first, and two were then referred on to the agency as their counsellors felt that they did not have the skills or experience to work with them. The difficulty that counsellors may have in working with male survivors has been highlighted before (Hogan *et al.*, 2012) and if there is a specialist agency available locally, it may be easier for therapists to provide a referral, as happened with the participants. However, in the UK, where there are only a few agencies offering DV counselling for men, general counselling may be the only option.

As with the female participants, the men did not seem to gain what they needed from general counselling, highlighting the need for a counselling service for male victims of DV. Recent research (Dennison and Thompson, 2011) in Australia suggested that counselling would be the most suggested option by community participants for men seeking help with DV. Men in the UK appear to be open to accessing psychological support (Smith *et al.*, 2012) and most of the participants in this study had some sort of counselling previously. Yet specialist agencies in the UK such as Respect and the Men's Advice Line offer links to general counselling support such as MIND.

A research report based on the Men's Advisory Project in Northern Ireland (MAPNI) for male victims which offered only counselling services or anger management classes for DV or relationship breakdown, found that the men would also have appreciated advocacy services and support for dealing with public sector agencies (Sweet, 2010). Whilst counselling can be an important aspect of recovery from DV, it can be seen from this that the men needed practical support as well. As Mark pointed out (see sections 5.3.1 and 5.7), counselling which focused only on his own emotional state was of limited use. It would appear that, in keeping with the experiences of the female participants, being able to sort out current difficulties and relationship dynamics is part of the work required prior to addressing deeper issues. However, with few specialist services generally available within the UK for male victims and the difficulties highlighted above, this presents a potential problem for

both counsellor and client, as the counsellor may not have the resources or skills related to DV experiences to match the needs of the client. Further research and development of appropriate counselling services for male victims of DV in the UK is required.

6.2.1.4 Finding support

There were a number of differences in this research compared with other published studies. One of the most noteworthy was the speed at which an appropriate referral appeared to be made. Research in the USA (Douglas and Hines, 2011) suggested that many of the agencies the men identified were only for women, or that the agency made a further referral for them into a perpetrator's program. Only 25% received an appropriate referral first time. In this study, where there was the possibility of a suitable referral, the participants felt that they had been referred to the agency appropriately and that the prior supporting services had been helpful. It is possible that the length of time the agency has been established, the regular radio, poster and newspaper advertising and the reputation of the agency may all have helped to provide quick and appropriate pathways. It is important to note that any agencies starting to provide such a service to male victims in the UK may need to address referral pathways through existing services for women as well as through police and health services.

Another difference was the participants' approach to the agency. In line with other reported incidents, many of them had negative experiences with court systems and social services indicating that sympathy for the family break down was firmly with the mother (Cook, 2009). Although the participants had previously negative experiences with other agencies, they seemed able to accept that this was because they were the wrong clients for that service. The agency referral was the first time they had encountered a service that was specifically for them and they accessed with a view that this was their service. The team were sympathetic, knowledgeable and interested in helping as much as they could, all dynamics which would increase trust (Mayer *et al.*, 1995) in the organisation. However, the participants did not appear to need the endorsement of the referring professional to engage with the agency. It seemed to be sufficient that the person indicated that agency might be able to help because of their experiences, and the men then accessed the service and made their own judgements about whether the service would be helpful to them (Kessler *et al.*, 1981).

There is very limited data available on the male experience of DV, and only part of the study appears to fit with previous research. It is possible that the focus of this study in interviewing mainly men who had been left by, rather than leaving, their partner changed the dynamic of help-seeking as the motivation is different. In addition, it is possible that the established nature of the service in this study created a different referral pathway compared with those for services which are still being developed. Nevertheless, this small study contributes additional data to a relatively new research area.

6.2.2 Experiencing 1-to-1 support

6.2.2.1 Working with male and female support

Although much has been made in the literature of the difficulties that men have in talking about their emotions and feelings (Betz and Fitzgerald, 1993), the experiences of the participants suggested that this was only a problem initially. Working with someone who was interested in what they had to say and facilitated the discussion meant that it became very easy to talk. As they did so, they recognised the benefits of sharing their experiences with both male and female agency staff.

The possible impact of gender within counselling relationships in DV has been raised (Hogan *et al.*, 2012) when it was suggested that men may be reluctant to work with a woman given their experiences with a female perpetrator, or that they may be scared to disclose to a male therapist if they felt they had to present a manly image to him. This study suggested a different dynamic. Hugh had previously worked with a female counsellor (see section 5.4.1) and whilst he found her personally very pleasant and helpful, it took him quite a long time in counselling to disclose his situation. He explained this as his feelings about being a man and the difficulty of sharing his perceived weakness of being abused by his spouse with a woman (see section 5.4.1). This particular aspect could be related to Gender Role Conflict (O'Neil, 2008), which describes the tension felt by men when not living up to their perceptions of masculinity, and this might also have been a factor for other participants.

The men appeared to utilise the services available to them by deciding what they needed and saw the female support workers as very professional and able to deal with a whole array of questions and issues. However, in terms of gender, they were most likely to want female support for issues associated with their children, where

they perceived greater expertise. Previously research has indicated that gendered pairing of counsellor and client tends to produce better results (Betz and Fitzgerald, 1993) and there is a suggestion from this research that the men gained a great deal from being able to share their experiences with another man. Whilst the all female support team provided a valued service, the men were also appreciative of the opportunity to hear another man's view when given the opportunity.

Within the UK, a number of female counselling services have indicated an interest in expanding their work to include male victims, sometimes at the request of government departments seeking equality. Currently female DV services in the UK are outside equality legislation as the case has been made for female only services (Exempt under the Equality Act 2010 pursuant to Schedule 9, Part 1). From the limited data in this study, it appears that there are aspects of this service which would be acceptable to men in some circumstances. However, there may be particular issues where there would be a preference for a male counsellor. For some men, like Hugh (see section 5.4.1), having access to a male counsellor was essential. Whilst it would be wrong to draw firm conclusions from such a small sample, it does suggest that gender issues in the context of talking to someone who may be able to help are not yet fully understood and would benefit from further research. Meanwhile the current extension of female only services may not fully meet the needs of male victims.

6.2.2.2 The value of the support relationship

The benefits of talking to someone on a 1-to-1 basis were not only about the relief felt in sharing their experiences. The participants talked about how important the 1-to-1 relationship was to them. Identification with being a victim during an abusive relationship can continue even when the abuse has ended, leading to feelings of low self-worth and depression, that he does not deserve to be cared for (Matsakis, 2001). In this context, finding someone who was prepared to care and give him space and time, helping him to see he was worthy of care, would be a significant factor in recovery. This concept is very much in line with the basis of person centred counselling (Rogers, 1957) and it is worth noting that both the therapist and support workers in this agency had specific training in this orientation.

This aspect of the work has been noticed before and recommendations for counselling male victims specifically highlighted the need to work with someone who was warm, caring and compassionate (Cook, 2009). Whilst the compassion valued

by the women could be defined in terms of their own and the counsellors' safety, experiencing empathy and sensing commitment from their counsellor (Bstan dzin rgya, 2010), the men valued feeling cared for and understood by their counsellor and helped, both emotionally and practically. This suggested a link to a definition of compassion as "(1) "I feel for you" (affective), (2) "I understand you" (cognitive), and (3) "I want to help you" (motivational) (Hangartner, 2011)⁶" (Siegel and Germer, 2012, p12)

Whilst it would be useful to develop this part of the study through research at different agencies and with other counsellors to better define this finding, it is reasonable to hypothesise that, as with the women, the need for caring and/or compassion appears to be central to the work required with this client group.

However, the needs associated with compassion may be different. What is not clear, because of the limited nature of this research, is whether this appreciation of help is a difference in gender or a difference in the service delivery structure. There is some evidence to suggest that help given or received is valued by men (Addis and Mahalik, 2003) and the helpfulness of longer term counselling was emphasised during the research interview. In addition, the research at MAPNI suggested that practical as well as emotional help was required (Sweet, 2010). However, it is also possible that this definition of compassion relates to the earlier stage of the support process, where gaining help to resolve issues was a priority. This is an area where further research would be beneficial.

6.2.2.3 Working through issues

As the participants settled into a supportive and caring relationship, they found it useful to be able to look at what had happened during their marriage and how their own and their partner's behaviour had contributed to what had happened. Perhaps surprisingly, this has not appeared as a specific recommendation for male counselling. In discussing counselling support with two leading experts in the field, Cook (2009) suggested that there was no point in trying to understand the dynamics of the situation, as this will ultimately lead to victim blaming. Agency research in the

⁶ Hangartner was the presenter of the conference paper, but the authors of the paper were Ricard, Kerzin and Hangartner (2011), and this reference is used later in the text rather than the one given by Siegel and Germer (2011) above.

UK has recommended counselling for coming to terms with the abuse, which may include this aspect (Sweet, 2010; Debonnaire and Panteloudakis, 2013). However, this research suggested, as for the women, that an understanding of the two people involved and how the situation evolved can be very helpful. It is possible that the difference in approaches is simply context. Cook's (2009) writing on counselling seemed to suggest that counselling will only be accessed while the men were still in their relationships, whilst the men here had ended or were in the process of ending their relationship. The exploration of the issues presented may be different depending on the context of the situation. Where this is ongoing abuse, strategies focused on minimising harm rather than understanding the dynamics of previous abuse, may be appropriate. It is surprising that Cook (2009) indicates that attending counselling could result in victim blaming. This study suggests that when the relationship is over, it is helpful to focus on some of the dynamics in a constructive way, to include strengths in coping behaviour and to understand rather than seek to allocate blame. In this way, the men could feel more confident that if they embarked on a relationship again, they would know how to recognise signs of abuse and know how to respond, creating hope for the future (Snyder *et al.*, 1991).

The participants also talked about how helpful it was to discuss their ongoing difficulties with their partners, and recognise a pattern of behaviour between the two which could be changed. They were able to question their assumptions about responsibility and role and create more balance, for example, recognising that not every text message needs a response. Taking small steps to address issues, and seeing positive change as a result, led to more confidence that they would be able to deal constructively with their partners in the future (Snyder *et al.*, 1991). This provided a sense of freedom and control of their lives that they had not felt before. Importantly, the outcomes from the participants at this agency aligned well with the study from MAPNI (Sweet, 2010) which reported:

“counselling was a very important source of help to those men who accessed it in coming to terms with the abuse and moving on from the relationship, as well as in being emotionally and mentally able to deal with the issues they face as a result.” (p.85)

6.2.2.4 Differences between counselling and support

Although there was much in common between counselling and 1-to-1 support in what the men valued about the interaction, there was a difference in outcome which

could be related to the depth and scope of the issues that could be addressed. Whilst for some men, a discussion which led them to a new course of action seemed to be sufficient, for others it was more appropriate to explore things more deeply. It is possible that this was related to the individual's feelings of isolation, as men who had a strong social network were less likely to need weekly support. Counselling at this agency dealt mainly with relationship issues and how those had contributed to the abuse. This allowed exploration of the man's belief system and developed new coping strategies. Ultimately it supported the individual to form new relationships, whilst working towards self-sufficiency. On the other hand, support work addressed issues as they emerged, providing relief for the individual at that time. Underlying problems or beliefs that emerged as a result of the particular issue were also addressed at that time. This equates to Matthew's sense that going through the support process several times led in an upward spiral (see section 5.7). The lack of resources for counselling, however, meant that the agency mainly dealt with crisis points as they arose.

Both models of support are valuable, and have delivered benefits to the participants. However it is important to note that, as identified in the review session, there was no indication of trauma work for men. Although trauma in female on male DV has been discussed in the literature as predominantly a problem for a female perpetrator, some of the participants reported difficult childhoods (see section 5.7). The counselling that was offered by the agency was relationship based, and the counsellor maintained his boundaries by focusing on that area of counselling. In part this may have been due to time constraints which affected the counselling he could offer. However, this meant that the opportunity to explore the past, should the participants have wanted to, was not available. Just as some of the female participants in the study were victims with a history of abuse, so it would seem that this was also a possibility for the men. Although both Mark and Matthew indicated time to explore those issues could have been helpful during the review, it is still unlikely with current funding that this could be provided. This would appear to be an area for further consideration both in terms of service development and future research.

6.2.3 Group support

6.2.3.1 Issues with group work

The agency, perhaps in recognising the limitations of their resources in providing 1-to-1 support to everyone who needed it, set up a time limited group session for the men. It included an educational element and an opportunity to share their stories and gain support. In some ways, this was quite an ambitious project for the agency, as the research for group work with men in DV is generally associated with perpetrator programmes (Day *et al.*, 2010). Although the idea of group support as a positive experience for victims has been around for a while, this has been developed primarily for women in the context of rape and sexual abuse experiences or bereavement (Coates and Winston, 1983). Men have been involved in victim group support mainly in the context of being the partner of a female victim (Coates and Winston, 1983; Barcus, 1997) to be able to provide better support to her. There is a case in the literature for group therapy for men although the potential for the group to reinforce the male belief system was highlighted as possibly problematic (Heppner, 1981). Instead, Heppner (1981) proposed group therapy as particularly appropriate for men who would benefit from trying out new behaviours and could learn from others in the process, without having to articulate their needs. In fact this was seen as one of the benefits of group working described by the participants: that of listening to the other men's stories and learning from them.

However, there was some acknowledgement by the participants that some of the men who were involved in group processes had both anger and addiction problems which the other men found difficult. Ultimately these issues were resolved in the group. Although it has been shown that some victims will have addiction problems (see section 2.3.1), it is also possible that some of these men could have been abusers in their relationship. Nonetheless, they still gained benefit from the group programme through learning life skills, recognising relationship and behavioural dynamics and hearing from other men.

In the UK, Respect have recently published some research conducted to determine whether those calling the help-line were perpetrators or victims (Debonnaire and Panteloudakis, 2013). In assessing the callers they used a multi-page assessment tool. The research suggested that about half of the men who call are victims of DV; about a quarter cannot be identified as being abused although they may have unhappy relationships; and about a sixth were described as perpetrators. The

participants' agency did not categorise those who called the help-line, although the staff were aware that some clients needed more support than others. The researcher is unaware of a perpetrator/non-victim screening process for female callers to women's help-lines, although the female agencies were also aware of differing levels of support needed. This perhaps indicates the value of providing support from an assistance programme as needed, as these agencies have, without the need for categorisation.

6.2.3.2 Participating in the group

It has been suggested that disclosure is one of the most difficult aspects of group work with men (Heppner, 1981) as society has conditioned them to believe that they should not have problems, and that it is "unmanly" if they need assistance to deal with them. However, men can view accepting help in different ways and they are more likely to seek help: if they believe they are not the only ones to struggle with a particular task; if they feel they have been able to make a conscious decision to seek help; if they feel they may be able to help others at the same time; and if the others involved are likely to be supportive and remote from normal life (Addis and Mahalik, 2003). In this study, these factors could be found within the group setting, as each had sought out the agency following a referral and the group provided evidence that they were not the only ones to suffer. The group also provided the opportunity to share knowledge and advice with each other. Finally, they did not know anyone within the group as they started. In effect, the dynamics valued by the participants in the study matched well with other research into male group work.

One of the consistently reported aspects of the group was feeling after the first session that there were others worse off than themselves. This has been described as early male competition in the group (Heppner, 1981) but it is also possible that perceiving someone else with more problems might increase the chance that the individual could be helpful within the group (Addis and Mahalik, 2003). This factor could also be related to values and, with variations in background and experiences, they may each have had their own views about what was tolerable. What was tolerable for one may have been intolerable for another and there was no-one in the group who was consistently in the worst position. Having come into the group feeling that no-one had suffered as they had, finding someone that they perceived was in a worse position created hope. In this case, however, hope was not about taking action, but about believing they were in a better position than they had thought (Larsen *et al.*, 2007).

Another valuable aspect of the group was the sense of connection that developed. The men's increased ability to share their feelings with other men showed their development in emotional intimacy (Garfield, 2010). As the group went on, the men found they could both give and receive support. However, as with 1-to-1 support, it was a sense of caring that seemed to be important. The experience here again seemed best to reflect the previously given definition of compassion (*Ricard, Kerzin and Hangartner, 2011*): of feeling for individuals, understanding them and wanting to help. There was a sense that the men were genuinely interested in what had happened to the others during the week, particularly if there had been a court date. They wanted good outcomes for each other, perhaps feeling that if one had a good day, the others might too. The success of others led to hope for their own situations as their perspective on what was possible changed (Larsen and Stege, 2012).

Although the participants valued the sense of connection in the group, there appeared to be no encouragement to make contact outside the group, but neither were there restrictions. Other groups that have focused on men's emotional intimacy encouraged participants to meet each other outside group sessions (Garfield, 2010) to get used to having normal friendships outside as well. However, in structured therapy groups, contact outside sessions is generally discouraged (Yalom and Leszcz, 2005) to maintain the group process. In this study, the work of the group was part therapy, as individuals were encouraged to reflect on and share their experiences and feelings, and part support with information offered and support from the group encouraged. This left the development of relationships beyond the group up to the men themselves.

Some of the issues reported by the men included acknowledgement of some members' lack of and need for social support and a feeling of abruptness at the ending. In some ways the sudden ending and enforced separation could be seen to mirror the loss of their family. Some individuals within the group built friendships and kept in touch through their own efforts. However, it is questionable whether, as a group, they had the skills necessary after a relatively short intervention to be able to set up their own group contact process without some facilitation. This is perhaps something that could be usefully addressed with groups in the future.

6.2.3.3 Learning new skills

Within the group, there was recognition that there were things that could be improved. However, the focus on the strengths of the individual and understanding

the relationship dynamics rather than accepting or allocating blame was helpful and aligned with the philosophy outlined in the literature review for working with female victims. This created an environment for the participants of making choices rather than completing tasks, which can assist with self esteem and confidence. In addition, in keeping with more recent literature from women's DV (Craven and Fleming, 2008) there appeared to be a pattern to behaviour that was recognisable in their partners (see section 5.5.2). This helped their sense of not being the only victim and not being wholly responsible, as well as seeing new ways of dealing with her difficult behaviour.

However, one of the factors appreciated by the participants about the group was the work done on self-care. The participants had previously been employed and some had interpreted their role as working hard and bringing home money to feed the family: a traditional male view. This meant that they were not used to planning meals or cooking. The dominance issues in their relationship meant that they had little say in their home life, and now being on their own brought with it a deficit of life skills that were not described by female participants. Whilst on reflection, this seems like a very sensible aspect to include within the group work, it is also indicative of the position the men were left in that it was both included and valued.

On the other hand, the session considered to be most inappropriate was the one on intimacy. The difficulty with this topic is not a new finding. Although Heppner (1981) suggested group work might be useful for those who have difficulty with intimate relations, thirty years later this aspect was still being developed (Garfield, 2010). This may have suggested that it is an area of work that required more development and yet it was an area that the funding organisation had specifically requested to be included. The men reported that the session was at a very basic level. In this context, there is an additional question about the perception of the funding organisation of the issues presented by male victims.

The group programmes appeared very successful and helpful to the men. Whilst the 1-to-1 support offered a direct relationship and exploration in detail of the individual's specific issues, the group support offered a place of connection and shared experiences that allowed the men to evaluate their own issues. The nature of group work for these participants seemed particularly helpful for the issues that emerged through DV. Further consideration should be given to the development of the format and inclusion of group support within a men's DV support service.

6.2.4 Getting on with life

6.2.4.1 Continued issues with ex-partner

Although the participants reported wanting to get on with their lives, some of them felt held back from doing so by the continued issues with their ex-partners. This study showed, in line with other research (Hines *et al.*, 2007), that female partners involved their children in their attempts to control their partners. One of the themes that came through was the need for the men to continue to address issues from their marriages through the court systems, including: legal expenses; having no previous experience of the court systems; being given erroneous information by well meaning individuals; and not being listened to or believed. This has not been addressed in detail by this study, as some of the issues were driven by the social and legal system in Eire and were not directly transferable to the UK. This aspect of their lives required advocacy support more than emotional support but shows how life as a male victim of DV can be difficult and why support can be needed (Cook, 2009; Douglas *et al.*, 2012). It is possible that some of the attitudinal difficulties reported within organisations may also be found in the UK (Debonnaire and Panteloudakis, 2013). However, access to support resources may not be as easy due to the lack of a local agency presence for men. It is therefore pertinent to note this, as a reminder of some of the difficulties that UK men may also face, even after the relationship has ended.

One of the differences between men who had accessed counselling and those who had not, appeared to be the degree to which they could cope with the additional stresses of these situations. Those who had completed 1-to-1 counselling felt that they were coping with the additional challenges with by their ex-partners and did not need to re-access although they were aware that they could. On the other hand, those who had accessed support workers were more likely to want to re-access the support workers to talk things through, as highlighted earlier in this discussion section. The study sample is too small to draw firm conclusions about the efficacy of counselling, but it is an area that could be usefully developed as part of a follow-on research programme and is currently under-researched.

6.2.4.2 Outcomes

The participants also talked about how they were starting to reconnect with friends and families. The two participants who had accessed counselling had started new relationships, although that had not been something they had considered before.

Coming out of a relationship where they felt isolated, they seemed to appreciate the freedom to connect with people. They could also see the benefits of being able to share aspects of their lives with someone who was interested in them. They reported using the skills they had learned, such as being able to be more open about things, and felt more in control of decisions they had to make.

In general, the participants who had been through group work or 1-to-1 support had improved relationships and felt a greater appreciation of life. Although they talked about improvement in their lives and their self-esteem (Rosenberg, 1965) they did not appear to have made all of the changes related to the PTGI (Tedeschi and Calhoun, 1996). However, those who had received counselling appeared to have made those changes and in addition had a greater awareness of their strengths and of possibilities for the future, aligning more closely with the PTGI. The sample size is too small to draw firm conclusions, but it leaves an interesting question for further research regarding the relative benefits of support work and counselling, and how best to assess and provide the right service for an individual.

It is also interesting to consider that elements of the PTGI can be seen with these men, and yet there was no description of specific trauma work completed in counselling or described in their interviews. This could simply indicate that the categories selected for the PTGI reflect the changes described as a result of abuse (physical and/or psychological): isolation, living day to day, and a reduced sense of self. However, it could also represent their recovery from the traumatic loss of their family. Further work to determine whether the PTGI would be a useful and appropriate measure of the success of DV counselling would be valuable.

6.2.5 Summary

The issues that have emerged from this study suggest that men may require a much broader counselling service than the one suggested by Respect (Debbonaire and Panteloudakis, 2013), dealing with abuse, internalised anger and resentment. Instead, the men had much in common with female participants: feelings of being emotionally overwhelmed at the beginning; referrals to general counselling services; the need to understand the dynamics of the abuse; the appreciation of caring and understanding support staff; finding new ways to deal with problems in life; finding ways to reconnect with friends and family; and in ending, being able to look to future. Elements of hope and compassion appeared in both.

However, there were also differences. The men experienced the unplanned loss of their relationship; they reported secondary abuse through court and legal systems; they needed more help with practical self-care; they needed support to develop a new relationship with their children; and they valued help. There were also issues of gender and the need for the men to have access to both male and female staff. Although there were elements of DV counselling which were common, particularly the need for knowledge of DV, it is possible that the way that the abuse is perpetrated may be different. Issues around work, health and social care interaction, self-care and weekend parenting may also require a specific and different approach to that required by women.

This study highlights some of the issues that may need to be addressed in a men's counselling service, suggesting that male DV services may require further development. However, further research is clearly required.

6.3 Findings from a counselling perspective

Much of this discussion has focused on positioning the findings from the perspective of existing DV literature and with a male-female division. The context of gendered presentation and social issues cannot be avoided in the detail of the models developed. There are differences in how the two groups perceive the abuse, the relatively short time required for men to settle into appropriate counselling, the differences between depression for women and anger for men, and a need for men to explore their experience in the context of 'being a man'. There may be a common process associated with moving towards feeling better but the experiences and resulting issues are different for the two groups. It is important that counsellors working in this field are aware of this and have the skills and knowledge to accommodate the differences as well as the commonality.

It could perhaps be argued that if there is a common process underpinning the two groups, it is simply what is already defined as good counselling practice. Other research has been conducted to look into helpful and unhelpful aspects of therapy based on the whole experience of counselling as perceived by clients (Paulson *et al.*, 1999; Paulson *et al.*, 2001; Levitt *et al.*, 2006). Those studies included both male and female clients, and looked for a range of therapist orientations and also a range of presenting issues. The focus of the research was to look generally at what was unhelpful or helpful from a client perspective at any point in the counselling.

There is common agreement that the relationship with the counsellor is central to successful counselling. However, in keeping with the nature of qualitative research, findings are presented in the way that makes sense for the researcher doing the work, and therefore do not have a common format for comparison. For example, Paulson *et al.* (1999) reported self-disclosure as the most important aspect for her participants, but she included items that are relational in nature. These included: speaking to someone who is neutral and feeling like someone was on their side; being treated like a human being; and feeling safe to say anything that they wanted to say. These factors were also present in this study, but have been represented as a part of building the client-therapist relationship as these were not factors that this client group would have necessarily anticipated.

The next most important category emphasised in Paulson *et al.*'s (1999) paper was the counsellor's facilitative style, which matched the descriptions in this study well. However, two of the categories she introduced as new from her research, those of gaining knowledge and finding resolution in therapy, were two of her lowest ranked categories, yet those aspects were very important within this study. Paulson's participants included those who attended counselling for childhood and/or relationship issues, which could have been the reason for this category to emerge, but as they were part of a larger group these may not have appeared as strongly as it has here. What can be shown is that the DV counselling process valued in this study does appear to have a similar basis to other research, but with a different emphasis.

Paulson *et al.* (2001) also conducted research on what hindered therapy, and once again their sample included people with relationship and/or abuse issues. Generally, a lack of responsiveness by and a lack of connection with the therapist were seen negatively. What is interesting is that those items were reported as hindering therapy, and yet these were the sort of items that the participants in this study cited as being reasons to end therapy. Paulson *et al.* (2001) noted that during their research, their participants clearly differentiated between hindering and unhelpful aspects. Their participants suggested that hindering aspects could be overcome and successful outcomes achieved, whilst unhelpful aspects could be linked to poor outcomes, or as in this study, leaving therapy. However, when they reviewed their data, they found great similarity between the events described as hindering or unhelpful, although the outcomes were different. This led them to call for further research in this area. It is possible that, as indicated in this study, some clients may

be particularly sensitive to relationship issues, thus reinforcing the need for a careful introduction to the counselling process with time spent establishing and reinforcing relational links to reduce the risk of early termination.

Another piece of research with similar methodology to this study (Levitt *et al.*, 2006) specifically asked clients about significant moments in therapy, recruiting participants from a range of therapies with a variety of presenting issues. In keeping with this study, one of the key features of helpful therapy was developing a strong enough therapeutic relationship, such that trust could be built which would withstand threat. Their description of this category fitted well with the data from this study, although less than half of the participants indicated the need for the therapist to establish professional credibility as part of building trust, which seemed to be a significant aspect of this study.

Levitt *et al.* (2006) also suggested that the therapist showing caring during times of significant disclosure helped those participants to trust their therapist, although it had to be the right amount of caring, as too little or over-involvement had negative consequences. This method as a means of building trust was not as clear in this research. It certainly seemed to be a significant factor for the men who accessed counselling, as both described positively the concern their therapist showed for them from the outset. However, this aspect of the relationship tended to be described as happening later in therapy by the female participants. It seemed that they needed to trust the therapist first, which involved some disclosure, to begin to believe that the caring was real and genuine. This is perhaps not surprising given the levels of abuse many of the participants had suffered. However, it leads to a question about whether caring from the therapist appeared later in the counselling as a result of the relationship growing, or whether it took some time within the relationship for the participant to acknowledge and accept the caring that was being offered. This would require further research to determine, but could be a very interesting aspect of the initial therapy dynamic. Nevertheless, caring as an aspect of counselling, irrespective of when it occurred, was mentioned by both male and female participants, and therefore supports this earlier work.

Finally, Levitt *et al.* (2006) go on to talk about compassion and self-compassion as being important within therapy as they sustain the client to explore issues which they feel responsible and cause them emotional pain. In keeping with other authors, they do not go on to describe what they means by compassion or self-compassion,

although they do state earlier in the paper that a client may have a negative experience of therapy if they feel they are being pitied by their therapist. This idea of compassion has also been discussed as part of the findings within this research study with both male and female participants, but there may be differences in how it is experienced. In addition, they noted that her participants regarded outcomes more globally than perhaps expected, citing improvements in relationships or how they felt about themselves rather than the reduction in specific symptoms normally measured. This finding also aligns with results from this study.

Clearly there are many aspects of Levitt's *et al.*'s (2006) work that are reflected in this study. However, the emphasis of their findings compared to those here is different. Within this study, there is a balance throughout of client and counsellor activity, together with relationship dynamics. In part it is the sense of improvement within participants, through their own actions, that motivates and encourages the participant to continue to engage with the process. This aspect of within and outside therapy is mentioned by Levitt *et al.* (2006) primarily in the context of increasing reflexivity and adjusting to life outside counselling after a session, rather than the activity presented by this group of participants. As such, this study once again suggests a particular process emerging for DV that has links to the literature, and yet has its own particular dynamic.

At the beginning of this research study, the researcher aimed to find out more about what women and men might need from DV counselling. As the different models for male and female clients have emerged, it seems that there are aspects of counselling that are common to both, such as building trust through the organisation, encouraging activities that generate hope, understanding DV and offering appropriate compassion that create unique and helpful processes. It was noticeable during the interviews with men who had received 1-to-1 counselling that the structure of the counselling they had received could be matched with the female model. For example, the three steps of Stage 1 could be clearly seen as could the three steps of Stage 3. Further analysis suggested that the descriptions of these steps were slightly different, but the basic structure appeared similar. There is insufficient data to make a detailed comparison or draw firm conclusions, but it may provide a useful starting point for research specifically related to DV counselling for men.

These specific nuances in the female and male experiences of counselling may require different skills and knowledge bases. It is possible that counsellors experienced in working with female victims may need additional training to be able to work with male victims, as the perspectives and issues presented can be different. This suggests that it may be appropriate to develop female and male services independently to meet the different needs of the two groups. However, the study has also shown the difficulties within the UK of accessing counselling support for DV due to funding issues.

Encouragingly, many of the factors in the models can also be seen within general counselling, although DV clients appear to place greater emphasis on the knowledge and professionalism of the counsellor, and the caring and connection experienced than has been reported in general counselling studies. This supports the view that this client group have specific needs in terms of therapy. However, it also suggests that counselling could be delivered by general counselling practitioners with appropriate training.

7 Conclusions

7.1 The significance of the research findings

The thesis title “A Client Informed View of Domestic Violence Counselling” was originally chosen to reflect listening to clients about their experiences of DV counselling. The methodology allowed for the construction of a model of counselling for women grounded in the expressed views of the participants on their counselling experience. In the case of men, the same process was used for the support services accessed, regarded by the participants as counselling. The information provided by the participants permitted an extension of that process to include the perspective of the researcher in the context of what is currently known about both DV and therapeutic work. Thus the research presented combined the process models reflecting the views of the participants with the researcher’s interpretation of those in the context of existing literature. It is therefore neither a client nor a researcher view, but a combination of both.

The research question “What was significant, in going through counselling, for those who suffered DV?” was constructed at the outset of the research in the belief that the research would focus on the interaction between the counsellor and the client. However, from a client perspective, particularly for the female participants, there was also significance in the decision to access support prior to beginning counselling and in the continued gains after counselling ended. Although these aspects are external to specific counselling sessions, they appear to be an integral part of the client process and have been included in the models. It is also appropriate to note that for many of the participants, the abusive relationship had ended, and yet they needed help to deal with overwhelming emotions that were present.

An additional variant that emerged as part of the research process was the interpretation of the word ‘counselling’. Although from a researcher and counsellor’s perspective this was clear, the experience of conducting research with male participants showed that this was not necessarily clear from a client perspective. However, those offered counselling on a 1-to-1 basis appeared to have moved beyond the difficulties of their abusive relationship into a new life, whilst still addressing ex-partner issues. Meanwhile, those offered short term group work or 1-to-1 support reported coping strategies that had alleviated some of their distress,

but still needed to access support when the difficulties mounted again. Although the sample was small, there appeared to be slightly better outcomes for counselling rather than support, which could be usefully investigated further.

There was value in the exploration of group work, support work and counselling. This showed that the important factors across the different support experiences for men included the human connection and sense of caring, finding out about the dynamics of DV and how to change their responses to their abusers, and realising the benefits of being more open and talking to people about what is wrong. These factors were also reported by the female participants as important parts of their counselling experience, suggesting there is some commonality between the male and the female experience.

Although the helpfulness of reviewing the dynamics of DV with clients was not a new finding, in this study it appeared to be an integral part of establishing trust with this client group. Both men and women felt that finally meeting someone who understood their situations and experiences was very helpful in being able to engage and share more of what had happened. One of the significant issues for many of the female participants was their poor experiences of counselling previously which made it difficult to identify a source of help. Even for those who had not attended counselling before, there was a reluctance to engage with a service they did not know. Overcoming this reluctance to attend counselling required them to trust the person recommending the service. This trust then needed to transfer to the organisation providing the service, and then finally to the counsellor before more in-depth exploration of the participant's experience could take place. This process was slightly different for the men, as they received information about the agency and then decided to access support, sensing there were no other options. However, like the women, they decided whether the agency could be trusted to help before building other personal relationships within the organisation. Part of this assessment process for both men and women was finding someone who could understand and relate to their experience. This process of building and transferring trust is a key element in this counselling process, and yet is not currently highlighted in the literature.

The importance of a caring relationship was also highlighted by both men and women although there were differences. Whilst women reported a collaborative relationship initially, they felt a connection growing with the therapist as they

explored issues, which ultimately transformed into a deeper therapeutic relationship. This appeared to reflect compassion as defined in safety, empathy and commitment. On the other hand, the men seemed to value a caring relationship which allowed them to feel understood and where they were also receiving help, which has also been defined as compassion. Whilst both valued caring relationships and both received care based upon the counsellors' desires to relieve their emotional pain, the way that pain was relieved and was valued by the participants appeared to be different for men and women. This is an interesting observation which would benefit from further exploration.

Both groups of participants also reported the importance of their emotions prior to accessing support. Although the participants reported varying symptoms of emotional distress, there appeared to be a common factor in having reached the end of their personal resources and not knowing what to do. This sense of hopelessness was very apparent in the research interviews, and it was also apparent that building hope again in a positive and constructive way began prior to contacting the agency. Again, however, the process for men and women appeared to be slightly different. For the women, hearing from a trusted source that there was a service which had been beneficial to others provided hope that they too might benefit. For the men, hearing that there was a service specifically set up for men who had experienced domestic abuse provided hope that someone might be able to help them. The process of building hope then became similar for the two groups as each began to succeed at small tasks; to see the past as no longer an indicator of the future; to see how well they had coped before given the circumstances; and to see a future that was abuse free. This sense of gradual and perceptible improvement helped to sustain the counselling and also formed a significant aspect of their outlook on life post-counselling.

The nature of the participants' emotions at the beginning requires further exploration, however. It had already been noted that experiencing DV may prompt symptoms of more than one mental health condition and from the descriptions of the participants even with hindsight it was difficult to determine what specifically might have been diagnosed at the time. However, it is also appropriate to note that the cause of their distress was primarily their relationship. It raises a question about how well we are currently able to identify the emotional crisis brought on by what seems to be mainly psychological abuse. There are no recognised assessment tools for this, and yet such a tool could be helpful for mental health professionals in

assessing and signposting clients to appropriate services. This is something that could be developed with further work.

Finally, the study indicated surprising results in terms of participants' reported outcomes. Although many studies have looked at the improvement in mental health symptoms or in self-esteem, the benefits reported by the participants fitted more neatly into the variables assessed by the PTGI. Participants reported improvements in relating to others, personal resilience, looking forward to the future and appreciating that they now have a life. This could be important in evaluating DV counselling services, as the value here is in self-sufficiency and well-being rather than only symptom relief.

All of these aspects of work within DV counselling have been highlighted as important by both female and male clients. The models developed provide a framework and structure to work from which reflects the client view of positive DV counselling. As such, this study provides useful information for professionals seeking to work with this client group, informed by counselling clients.

7.2 Originality of the research

There are several key areas of originality within this research study, which have been discussed in more detail earlier in this thesis. In summary, these are:

1. The investigation of the male experience of counselling and support after the experience of DV. The male experience of DV is a relatively new research area within social science where the focus has been on the circumstances and impact of DV. Whilst counselling and psychotherapy have been identified as useful to this client group, this is the first study to explore what is important to the men in this work.
2. The counselling process identified with the female participants is unique, and encompasses new information about the access and ending processes. It provides a framework which could be usefully used in counsellor training in this specific area.
3. The issues of trust have been known about for this client group for some time. However this study identifies mechanisms that generate trust, which

have not previously been described. These are important factors in considering the design of counselling services for this client group.

4. The importance of the therapeutic relationship in counselling has also been recognised for many years. This study identifies the need for a strong therapeutic relationship to sustain the work, based on knowledge, skill and compassion. The factors involved create a specific type of therapeutic relationship which contains some aspects which have been previously reported in general counselling research, but indicate that a different emphasis may be required.
5. The role of compassion in working with trauma is beginning to be recognised, and both groups of participants indicated a traumatic response to their experiences. However, this study suggests that the way compassion is valued may be different for men and women and this may have implications for how services are delivered.
6. The concepts of helping clients to take action and having a greater future focus have been discussed before in DV texts. So too has the concept of hope as an important aspect of the process. Here, hope is shown to be developed throughout the process, through a number of different techniques as well as the personal characteristics of the counsellor. This offers a new way of looking at existing concepts.
7. Prior to ending, the participants noted that having a period of reflection to check that they were ready to leave and could manage on their own was helpful. This is an important finding in terms of managing the ending process.
8. The outcomes measure closest to the benefits reported by the participants is the PTGI. Whilst post-traumatic growth has been discussed recently in the literature, this is the first time that using this as a measure for the outcome of DV counselling work has been suggested.

8 Research Limitations and Recommendations for Further Work

8.1 Limitations of the study

This study was conducted within the North of England and Eire, and therefore the participants in the study reflect the predominantly white population of those areas. This means that issues of culture or race were not addressed. All of the agencies involved in the study were from the third sector. This may have had an effect on the models which emerged, as working in private practice or in the public sector may have provided different access routes, client constraints and opportunities. In addition, the research is limited in its ability to make comparisons between the male and female experiences of counselling due to the differences in context of the service provision and differences in the profiles of the two groups recruited. Further research would need to be conducted to determine these effects.

It is important to acknowledge that the participants volunteered to take part in the research because they had a good experience of counselling. It is possible that in their presentation of this other aspects have been missed or overlooked. In addition, the researcher has worked with DV clients before and, whilst trying to remain impartial, will have influenced the interview content. Therefore, whilst the models reflect the experience of the participants as interviewed, it is possible that there are other elements.

Finally, the small number of men involved in the study and the wide range of experiences they discussed means that the findings are indicative only. Further, more detailed, work would need to be done to properly evaluate the counselling, support and group processes.

8.2 Further work

The possibility of different outcomes for support work and counselling using the PTGI has been hinted at by both male and female participants. It would be useful to conduct research into these factors involving agencies where both methods of support are offered. If the PTGI is found to be useful, it may also provide a way of assessing individuals who have experienced DV for appropriate methods of support.

The participants' descriptions of their emotional difficulties prior to counselling provide examples of the difficulty health professionals might face in diagnosing and recommending treatment for this client group. It is very likely that they will show signs of a variety of mental health issues. However, there is a suggestion by the female participants that the mental health problems were being caused by the recent and historic psychological abuse. It would be helpful to have a means of assessing the degree and type of psychological abuse experienced by an individual as that may help to inform a referral to DV specialist counselling.

Compassion has been shown to be an important aspect of the therapeutic relationship, although it is possible that this may be expressed differently for women and men. It is possible that there may be different forms of compassion that occur throughout the counselling process. Further work to determine how compassion is viewed from male and female perspectives and whether it transforms from stage to stage would be of value.

It is possible that some of the positive factors reported in this study are not simply about counselling process, but also about the characteristics, skills and experience of the therapist. Further work to develop a practice evaluation tool for DV counsellors, to include specific therapist factors such as advanced empathy, building trust and the ability to work with trauma, could be useful in both counsellor training and assessment.

Finally, there are some early indications from the research that there may be gender issues associated with DV support. Whilst the men were happy to access support from both male and female staff members, there appeared to be some preferences around which topic they would address with the staff member according to gender. At the moment, the UK protects female services from equality legislation which means women can only access female staff. As many female DV agencies are now trying to offer services to male victims, this may mean that men are mainly offered support by female staff. It is also possible that some female clients may prefer support in particular areas of work from a male counsellor. Further research to determine the gender preferences for both male and female support staff and counsellors would be of value in developing services in the future.

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Appendix A Copy of Ethical Approval Submission

SUBMISSION OF PROPOSED RESEARCH PROJECT TO THE RESEARCH ETHICS SUB COMMITTEE

Name of researcher(s)	Jeannette K Roddy
Title of research	Developing a client informed approach for counselling survivors of domestic violence
Name of Research Supervisor (if applicable)	Lynne Gabriel, Hazel James
Objectives:	
<p>To study domestic violence survivors experiences of counselling:</p> <ol style="list-style-type: none"> 1. To determine what clients found effective in the counselling process, and what effective means for them 2. To hear what clients felt worked well or could have been better and how 3. To hear the client's view of outcomes, what they got from counselling and where they started from 	

Please give a brief justification of your proposed research project:

Domestic abuse is a significant issue in the UK, with estimates that 1 in 4 women and 1 in 6 men have experienced some form of domestic abuse since the age of 16 (Smith et al, 2010). Government resources have been predominantly focused on facilitating the safety of women through crisis support, refuge and advocacy services, leaving other services, such as counselling, less well defined.

Counselling is thought to form an important part of a positive health response to domestic violence survivors. Yet books and papers on counselling domestic abuse survivors are largely theoretically rather than empirically supported. Whilst there is good agreement about the need for a strong therapeutic relationship, the recommended approach differs. Dutton's (1992) much cited book describes the need for a variety of approaches in working with domestic violence survivors, whereas Lockley (1999) , Sanderson (2008) and Lee (2007) suggest approaches ranging from person-centred-feminist to attachment to solution focused. What seems to be missing in all of this, is the voice of the client, and their view of what works well. This observation is echoed by Cooper (2008) where he identifies a general need for subject area client-focussed counselling research.

This project is a starting point for research into the client view of domestic violence counselling. It will involve clients who have received counselling after suffering from domestic violence. The counsellors they worked with will have come from a range of professional orientations, such as person-centred, psychodynamic or CBT, helping to determine a generic way of working, of relevance to professional counsellors in the UK.

Please outline the proposed sample group, including any specific criteria:

The sample group will come mainly from two voluntary organisations on Teesside, My Sister's Place and EVA Women's Aid, both of whom have already given agreement in principle to the work. These agencies have been selected as they both offer counselling services to domestic violence survivors, are available locally, and offer a range of counselling approaches, including person centred, cognitive behavioural therapy (CBT) and psychodynamic. These agencies only work with female survivors.

The counselling clients will have completed counselling at least 3 months ago and

no longer than 18 months ago. This will allow the client to have fully left the counselling relationship and be able to reflect on it at distance, whilst still being able to remember some of the detail of the sessions.

The initial pilot study will interview 4 female volunteers, each having worked with a counsellor of a different professional orientation. The clients will be approached by the agencies or counselling services/research project and asked if they would like to participate in the research. Those who are interested in participating will be asked to attend an interview where the research process will be explained, and consent forms signed (see appendix 1). This process of recruitment also provides control over the number of clients recruited, which means there is little risk of over recruitment. A Q&A will be provided for each client summarising the outline of the research and providing contact details, as well as details of the complaints procedure (see appendix 2). Clients will also be able to choose how much they wish to be involved in the research at this time (see appendix 3).

After the pilot study, further interviews will be conducted. Male clients will be included in this second phase of the project where they can be recruited via agencies offering counselling for male domestic violence survivors. There will be an upper limit of 30 interviews, which will include the pilot interviews. This number is based upon the number of interviews that can reasonably be conducted, transcribed and analysed within a PhD programme as well as following the guidance for the proposed grounded theory methodology, which suggests that this number is generally sufficient for a small project (Charmaz (2006)).

As the analysis starts to show some key themes, two groups will be formulated to discuss the findings from those interviewed, one for female survivors and the other for male survivors. This is due to the observed sensitivities of some survivors within mixed sex groupings. Clearly an adverse reaction in the group situation could negatively impact the outcome of the research.

Some additional one to one interviewing may take place on specific issues arising from the analysis and/or discussion, where clients with a specific experience or a lack of specific experience may be interviewed a second time to provide more depth to a particular area highlighted by the research. This is in line with the approach for theoretical sampling in grounded theory described by Charmaz (2006)

It is likely that the study will have a higher proportion of female subjects due to the potential difficulties of recruiting male clients. This is in keeping with the much larger

number of female only, compared to male only, counselling services available in the UK.

Describe how the proposed sample group will be formulated:

Access to the female client group is relatively straight forward. Together the agencies offer counselling to over 200 women each year. In the initial stages of the work the only requirement for the client to participate is that the counselling has concluded between 3 and 18 months ago.

As previously discussed, one of the few areas of agreement about domestic violence counselling is the need for a deep therapeutic relationship. Recent research (Hick, 2008) has shown that survivors of domestic violence have been classified as having insecure attachment, hence the counselling therapeutic relationship has the potential to provide a more secure relationship, to allow personal exploration, than any previously experienced. In these circumstances, ending counselling may provoke previous feelings of loss (McLeod, 2003b). It may take time for the client to grieve the loss of that relationship, and to view the experience objectively. Interviewing clients too early after counselling has ended can therefore create difficulties for the client and for the research. Levitt *et al.* (2006) conducted a similar project with general counselling clients, and suggested a 2 month window for this process. This research has defined a minimum period of 3 months given the particular issues that domestic violence survivors bring.

Research (Llewelyn *et al.*, 1988) has shown that 6 months after therapy has concluded, clients remember only 70% of the critical incidents previously discussed with them and Levitt *et al.* (2006) opted to curtail their interviewing at 12 months for this reason. Webster and Mertova (2007) argue that the more profound a critical event is, also described as a change experience, the more likely the person is to remember it in the future, which suggests interviewing at a later time will bring to the fore more of the deeper change experiences within therapy. This could be the case for this research, and an upper limit of 18 months provides more flexibility for finding volunteers. However, if a volunteer was interviewed around 18 months after leaving therapy and found recall difficult after such a period, the criteria for client selection could be modified to take this into account.

Restricting the time after leaving counselling to 3-18 months therefore attempts to

take into account both positions.

The agencies will identify suitable clients from the time finished with counselling as well as a range of different professional orientations. This research attempts to find what is important, independent of the counsellor's orientation. That is to say that this research is about what clients find helpful, and is not trying to assess different professional approaches to determine which is better. The agencies will contact the clients and invite them to participate in the research. Those who agree will then be invited to a research interview where the details of the research process will be shared in more detail and consent forms signed.

Recruitment of male clients will be conducted using the same principles. Initially contact will be made with the two agencies known to provide counselling to male domestic violence survivors to invite them to participate in the research. The agencies which want to participate will be asked to work with the same process as conducted with the female agencies. They will be asked to identify clients who finished counselling 3-18 months previously, with a range of counsellors and then invite them to participate in the research. The same research recruitment process will be undertaken with these clients as with female clients (with appropriately amended Q&A).

Indicate clearly what the involvement of the sample group will be in the research process:

Each volunteer client will be interviewed for up to 90 minutes by the researcher about their experience of counselling. An interview debrief will be conducted on completion of the interview.

The volunteer clients will also be offered the opportunity to participate in a further focus group session with other volunteers later on in the research process to debate and add to the preliminary research findings. Separate groups will be held for male and female clients, owing to the depth of emotion sparked in some survivors in confronting members of the opposite sex. The group session will last up to 90 minutes, and will be followed by a debriefing.

Finally some of the clients who have indicated that they are prepared to be interviewed a second time will be invited back to discuss in more depth some aspect

of the first interview that seems to be of significance to the research outcomes.

The volunteer clients have choices about how much involvement they would like to have, as detailed in appendix 3.

All volunteer clients will also have the opportunity to attend a final presentation of research findings at their agency. Separate presentations will be given to volunteers and agency staff to maintain boundaries and confidentiality.

The presentation to agency staff/counsellors will also provide an opportunity for the research to undergo professional independent review prior to completing the thesis.

Specify how the consent of subjects will be obtained. Please include within this a description of any information with which you intend to provide the subjects:

Each volunteer will be invited by the agency to take part in the research. Those who are interested in taking part will be invited to a one to one meeting with the researcher where they will be briefed verbally on the project by the researcher, and provided with a copy of the consent form (Appendix 1) and Frequently Asked Questions sheet (Appendix 2).

The volunteer will then be given the opportunity to ask any questions, before being asked to read, complete and sign a copy of the consent form for retention by the researcher (Appendix 1). The researcher will conduct the interview once consent has been given.

On completion of the interview and debriefing session, the volunteer will be asked if they would like to participate further and, if they are interested in doing so, will be asked to fill in the Expression of Interest Form (Appendix 3).

Indicate any potential risks to subjects and how you propose to minimise these:

Counselling, by its nature, potentially covers a wide range of highly emotional material. During the counselling process, it is expected that this material will be discussed, and the emotional aspects reduced. However, it is possible that discussing the counselling experience will trigger memories or thoughts that have not yet been processed. This is particularly a problem with survivors of domestic violence as they are a vulnerable client group. The nature of their experience may

mean, for example, that they could have suffered symptoms of Post-Traumatic Stress Disorder.

The researcher is a fully qualified counsellor and has experience of dealing with domestic violence clients and with clients suffering flashbacks. She will be aware of how the interview is developing and will minimize the risk to the volunteer. However, there is a finite risk that memories will be triggered. From a process perspective, it is important that the researcher remains as researcher and does not deal with the memories therapeutically within the research interview. All volunteers recruited will have access to counselling services through their agency, if required. This will be explained to all volunteers prior to taking part in the research.

The research interview will be conducted as follows:

1. The interview will be structured as an open ended discussion rather than a Q&A to allow the volunteer more space to tell their story in their own way.
2. If the volunteer is upset by an aspect of the interview, they can decide to stop the interview at any point and leave the interview. If the volunteer chooses to do this, support will be offered by the agency to work through whatever has been triggered for the volunteer. The volunteer can then opt to leave the research programme, or schedule another interview.
3. If the volunteer is upset by an aspect of the interview, but wants to continue, the researcher will pursue one of three courses of action:
 - a. She may explore what it was that upset them during the interview if they are willing to do so and if, from a research perspective, it seems that this could offer valuable information and insight. This might be the case if, for example, their emotion was caused by positive memories of their counsellor. This will then form part of the debrief session after the interview with the researcher.
 - b. She may begin the interview again in a different place to explore a different aspect of their story, keeping away from the specific aspect that came up. This would be appropriate where, for example, the emotion was caused by triggered memories of their domestic violence experience. In this case, the volunteer will be reminded about the option to access counselling on completion of the interview.

- c. Where the volunteer continues to appear upset and yet still wants to complete the interview, more care is required. This is a difficult situation, as the need to continue can be driven by a number of factors. It could be that they are naturally very expressive with their emotions, and continuing really is fine for them, or it could be that they are putting their needs to one side for the purposes of the interview, as many survivors have a tendency to do. On balance, it is better for the researcher to curtail (shorten) the interview in this situation, to let the volunteer know that the information they have given is valuable, and that the interview is complete. In this case, the volunteer will be reminded about the option to access counselling on completion of the interview.

If the volunteer finds that troubling thoughts or memories emerge or persist subsequent to the interview, they will be able to access agreed levels of agency counselling services.

If the volunteer has concerns about the research process or data after the interview is completed, they will have access to the researcher to discuss the research, and if this fails to alleviate their fears or concerns, they can request the deletion of the interview tape and transcripts and withdraw from the research process.

If they still have residual concerns, they will have a written description of the formal complaints process contained within the Q&A sheet provided for them, which they can invoke.

Separately there is a risk to the researcher of being exposed to descriptions of traumatic events. She is in regular counselling supervision, has research supervision, and also has access to a counsellor. As she has experience of working in this area, she recognises the value of regular and timely debriefing of traumatic material.

Agency volunteers will be interviewed within the agency, which is a busy, working environment. The researcher will adhere to all health and safety guidelines for working within the agency.

Describe the procedures you intend to follow in order to maintain the anonymity and confidentiality of the subjects:

All recorded sessions will be destroyed 60 months after the submission of the thesis, or in the unlikely event where a thesis is not submitted, as the project ends. Computer files, such as transcripts, will be encrypted, password protected and given a numerical code to ensure anonymity.

All information retained in hard copy will be stored in a locked filing cabinet. Any contact details supplied by research volunteers will be held separately from the research data, in paper form only, and will be destroyed 60 months after submission of the thesis, or at the end of the project should a thesis not be submitted.

A different name will be created for the participants in all published work, and key items within stories which could lead to a participant being identified will be changed.

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Please submit the completed form to the Chair of the University Research Ethics Sub Committee (Dr Simon Rouse, s.rouse@yorksj.ac.uk) or to the relevant Faculty Research Ethics Committee where applicable.

Ethical Approval Appendix 1 Research Consent Form (Copy)

Name of Researcher: *Jeannette Roddy*

Title of study: *Development of a client informed approach to domestic violence counselling*

Please read and complete this form carefully. If you are willing to participate in this study, ring the appropriate responses and sign and date the declaration at the end. If you do not understand anything and would like more information, please ask.

- ◆ I have had the research satisfactorily explained to me in verbal and written form by the researcher.

YES / NO

- ◆ I understand that the research will involve an interview with the researcher, which will last up to 90 minutes, and will be audio recorded.

YES / NO

- ◆ I understand that the research includes a one to one interview initially, and may also include a group interview and/or a follow up interview.

YES / NO

- ◆ I understand that I have the right to decline to answer any questions during the interview process.

YES / NO

- ◆ I understand that I may withdraw from this study at any time without having to give an explanation. This will not affect my future care or treatment.

YES / NO

- ◆ I understand that counselling facilities are available to me during the course of this research should I choose to access them.

YES / NO

- ◆ I understand that all information about me will be treated in strict confidence and that I will not be named in any written work arising from this study.

YES / NO

- ◆ I understand that a full or part transcript of the interview may appear in an Appendix to the PhD thesis and that this may be seen by tutors and the External Examiner. It will be removed from any copies of the thesis retained by the library.

YES / NO

- ◆ I understand that small sections of the transcript of the interview may be used in external publication.

YES / NO

- ◆ I understand that any audio material of me will be used solely for research purposes and will be destroyed within 60 months of submission of the thesis, or where a thesis is not submitted, at the end of the project.

YES / NO

- ◆ I understand that you will be discussing the progress of your research with others at York St John University

YES / NO

I freely give my consent to participate in this research study and have been given a copy of this form for my own information.

Signature:

.....

Date:

.....

Ethical Approval Appendix 2 Frequently Asked Questions

What do you hope to achieve?

Although much has been written about the impact of domestic violence on survivors, little has been written about counselling survivors, and still less has been written about the counselling experience from the client perspective.

This research project has been put together to listen to domestic violence survivors who have gone through counselling, to listen to their story of their counselling experience, to hear what was effective for them, what worked well, and what didn't. Using this information, the project will identify key themes for working with domestic violence survivors which counsellors can use to help them to address the issues of domestic violence in a way that works well for the survivor.

What will it mean for me?

There are five parts to this project that you could become involved with. The first is a general introduction to the research, what it means, and allows you to decide whether or not you want to be involved. If you are happy to go ahead, you will be asked to sign a consent form.

The second is the interview with the researcher, Jeannette Roddy. This will be an opportunity to tell her about your counselling, how it started, what happened during the counselling, and how it ended. It will take about an hour and no longer than an hour and a half, and will involve talking through in some detail different aspects of the counselling you received.

The third part, if you wish to continue to be involved, is to take part in a group discussion with other volunteers for the research, to discuss some of the things that have come out of the research so far. This will also take about an hour and no longer than an hour and a half.

As the research develops, particular themes emerge, and it is sometimes useful to explore specific areas in more detail with people who have experienced, or sometimes who have not experienced, a particular event. The fourth part of the research will be to invite specific people back to explore certain aspects of their counselling in more detail. This interview is also likely to take about an hour.

Finally, the fifth part will be a presentation of the research results to the volunteers who took part.

If you prefer just to be involved with the first part of the research that is absolutely fine. The important thing is that you are free to decide how much time you wish to give to the project.

How will the research be done?

All of the interviews will be audio recorded and then transcribed. The transcriptions are saved using file code numbers. All electronic files containing interview data will be encrypted and password protected. The person talking within the interview is given a new name to protect their identity. The transcription is then analysed by the researcher to pick out themes between interviews, and then to build up ideas of what works best for clients. It will be these ideas which form the basis of sections three and four of the research, where the same process will be undertaken, until there are no new aspects emerging. At this point the data gathering part of the research is concluded, and writing up the research begins.

What will happen to the research?

The purpose of the research is to provide new and useful information to counsellors working with people who have survived domestic violence. The minimum requirement for the research is to write up the material as a PhD thesis. This thesis will be read by the examiner, as well as by the university supervisors, and may contain substantial sections of transcripts from the interviews within an appendix. If the thesis is passed as a PhD, the transcripts will be removed prior to being made available from the university library.

In general, other writing will relate mainly to the themes that have emerged during the interviews with people. It can be helpful to provide an example of a comment made during an interview to explain the point better. Sometimes that will be through creating a new comment from a few similar ones. Sometimes it is much better to provide the actual words used by the client. In this case, it will normally be a sentence or two only, will not contain any personal material that could lead to someone being identified, and your real name will not be given.

What will happen to my personal information?

Any personal information collected, such as contact information, or information on ethnicity, will be held on paper copies within a locked filing cabinet, separate from the research data. Audio files and transcripts will be held electronically and will be password protected and encrypted. All of the personal information will be destroyed within 60 months of submission of the research thesis. In the unlikely event that the research concludes without a thesis being submitted, the data will be destroyed at that point.

What happens if I change my mind about being part of the research?

If you are thinking about withdrawing from the research, it may be helpful to talk it through with someone first, to explore what it is you are concerned about. You could discuss your concerns with a member of agency staff or with Jeannette, your researcher. However, it is your choice as to whether or not to have that discussion, and your decision about whether to continue to be a part of it or not.

If you do decide that you no longer wish to be a part of the research, then you must let the researcher know in writing. You can e-mail her at j.rodny@yorks.j.ac.uk, or write to her at Jeannette Roddy, DG110, York St. John University, Lord Mayor's Walk, York YO31 7EX.

Once she has received your request, she will permanently delete all transcripts, audio recordings, plus any analysis completed on the interviews conducted on a one to one basis, and will confirm to you that this has been done.

If you have participated in the group session, she will delete your comments from the transcript and any analysis related to your comments. As it is difficult to edit out comments within the group, the audio recording will be left as recorded until the end of the research when the whole recording will be deleted.

What if talking about the counselling triggers troubling thoughts about my experiences?

Although we hope the interview will be a positive experience for you, there is a risk that memories from your previous relationship could be triggered. You will be able to stop the interview at any point, if you would like to do so and access support from the agency.

If you are left with any troubling memories or feelings that have been triggered through the research process, you will be able to access counselling from the agency.

If going through the interview process is very difficult for you, we would prefer you withdraw from the research, rather than relive difficult or painful experiences.

Will my counsellor hear what I say about the sessions?

No, the interview will only be heard by the researcher. Your counsellor will not hear the interviews or see transcripts of the sessions. Any quotations presented as a result of the research will be anonymous and could be from a number of clients at a number of agencies.

It is worth knowing that the agencies and counsellors are very keen to participate in the research, as they want to know what works well and what doesn't too. They want clients to be as honest as they can be about the sessions so that the key messages about what to keep doing and what to improve come through.

If I am unhappy about how the research has been conducted, what do I do about it?

First of all, you should contact the researcher to share your concerns about what has happened, and to discuss it with her. She will agree a way forward with you about the best way to resolve the situation.

If it proves difficult to resolve things with the researcher, then you can write to her supervisor Dr. Lynne Gabriel, at York St. John University, explaining your concerns. She can be contacted by e-mail at L.Gabriel2@yorks.j.ac.uk, or by letter at Foss 108, York St. John University, Lord Mayor's Walk, York YO31 7EX. She will arrange for a review of the situation, and will write back to you formally with a response.

If you are unhappy with this response, then you can write to the British Association of Counselling and Psychotherapy, BACP House, 15, St. John's Business Park, Lutterworth, LE17 4HB. They will formally investigate and respond to you in writing.

When you say the research is confidential, what do you mean?

The sessions will be taped and transcribed. The transcriptions will be available to the researcher, tutors and examiners. Names will not be included within those transcriptions, not unlike the process in place for counselling supervision.

As with counselling sessions, the content of the session will be held within normal counselling limits. All information disclosed will be treated as confidential to the research with the exception of any disclosures relating to acts of terrorism, or harm to self or others, where the agency rules around the disclosure of these items will be implemented.

My friend wants to take part, but she wasn't invited. Why can't she join in?

The research involves a relatively small number of clients over more than one agency. Part of the research objectives are to work with clients who have been counselled by different types of counsellors. Another part is to find clients from a variety of different backgrounds. You have been invited to participate in the research because your background and the background of your counsellor fit with the research at this time. Because the project has very limited resources we can only speak to a relatively small number of people, and so we have had to choose those whom we believe can provide the most insight for the research.

Ethical Approval Appendix 3 Expression of further interest in the research programme

I would like to be involved in

- | | |
|----------------------------------|--------|
| 1. The group session | YES/NO |
| 2. Further one to one interviews | YES/NO |
| 3. The final presentation | YES/NO |

I would prefer you to provide the dates for these sessions

a) Through the agency _____

OR

b) Directly to me.

I would prefer you to contact me by telephone/ post/ e-mail (*delete as required*).

My contact details are:

Address: _____

Tel. No: _____

E-mail: _____

Signed: _____

Date: _____

Name: _____

Appendix B Interview schedule

Preamble

First of all thank you for giving up your time today to take part in this research. What I would like to do with you today is to look at what was significant for you as you went through your counselling. In some ways it is a bit like the story of your counselling, with a beginning, middle and end, and we can explore some of the important things for you in each of those parts of the counselling. I have some short questions at the beginning to find out a little bit about you, and then we will move into the story of your counselling. Towards the end of the interview, I have a few more specific questions for you to gain your views on some aspects of counselling. After we have finished, we will have a short chat about the interview and you can give me any feedback you want to. And, as we discussed, you can stop the interview at any point. How does that sound?

Questions

What ethnic group would you say you belonged to?

How old are you (age range is fine)?

When did you leave education?

What careers have you followed since leaving education?

What career are you currently in?

How long did you attend counselling for?

How long is it since you finished counselling?

Have you had any other periods of counselling?

If so, how many, and how long did they last?

Looking back at when you started counselling, what brought you to counselling?

What can you remember about that first session?

As you look over the counselling from that first session, what are the key moments that you can remember? Can you tell me more about them?

(Optional) Those sound very positive experiences for you. I wonder, though, during the counselling were there any moments where you felt things could have been better?

What, in your counselling, did you feel worked particularly well for you? Can you tell me a bit about it? (and what didn't?)

As you continued with your counselling, how did the subject of ending come up? Can you tell me a little bit about your ending with your counsellor?

As you ended the counselling, what did you feel you had gained from it?

Looking back now, what would you say you had gained?

In counselling today, there is a lot of focus on 'outcomes' for clients. What do you understand by the word 'outcomes'?

If you were to advise counsellors on what to look for in terms of things to measure or record at the beginning and end of counselling to show benefits for DV survivors what would you suggest?

One of the areas that counsellors are often interested in is the 'effectiveness' of the counselling. What does effective mean for you?

Looking back over your time in counselling, can you describe the times in your counselling that you believe were most effective? (repeat participants definition if required)

Looking back at your counselling 'journey' or 'story' now, how would you describe it to someone who perhaps hasn't had counselling before?

If you had any words of advice for someone thinking about starting counselling, what would they be?

Looking back now over the whole period of counselling, how would you sum it up?

Is there anything else you feel you would like to add to the interview now, before we finish?