EU COMPARATIVE: COUNSELLING SURVIVORS OF DOMESTIC VIOLENCE

COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING: COUNSELLORS AND CLIENTS

UNITED KINGDOM, LATVIA, BULGARIA, ITALY AND THE NETHERLANDS.

A two-year research project into the effectiveness of counselling and psychological services for survivors of domestic violence, examining funding provision and exchanging expertise, experiences and best practice.

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REPORT 1

COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING:

COUNSELLORS AND CLIENTS

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COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING: COUNSELLORS AND CLIENTS

FOREWORD

This report is dedicated to the women and children in United Kingdom, Italy, Bulgaria, Latvia and the Netherlands who shared their stories with us.

We acknowledge the financial support of Daphne III Programme

In my time as Chief Executive Officer at The Haven Wolverhampton it has been a huge privilege and honour to work with women and children who have struggled to survive the most appalling and insidious forms of domestic violence; women and children who have experienced violence and abuse in all its terrible forms; from life-threatening acts of violence through to incessant behaviours which erode the spirit and the will.

Just as their experiences differ, so too will their readiness to make changes and their willingness to talk about the abuse which has cast a shadow over lives and their prospects. Often believing that love for the abusive partner will transform their situation; women’s endurance is such that it is believed that she will endure 35 acts of violence or abuse before calling for help. This example of patience and strength is played out in the prioritising women make when finally they take the decision to change their lives.

Experience tells us that while women prioritise the pressing and practical problems they have; the desperate need to be in a safe place and to protect their children, the need for space to breathe, to take stock of their lives, the need to break their financial dependency on abusive and controlling partners; we know too that the time will come when the need to have someone listen to their stories will come to the fore. It may be in the immediate aftermath of their experiences or it may take months or years for women and children feel able to share with another the truth of what has happened to them.

Among the Refuge movement, The Haven led the way in acknowledging the need for specialist counselling support. We know that effective Counselling Services should be responsive to women and children at a time when they are ready to engage, should be staffed by highly trained, experienced specialist Counsellors and should be stable enough in terms of funding to offer Domestic Violence Counselling free at the point of delivery for all women and children who need it. Long term sustainability is critical to Domestic Violence Counselling. Here we speak from sad experience. The Haven’s Domestic Violence Counselling Service closed its doors in April 2012 when funding expired. We saw at first-hand the devastating impact this had on women and children using the service. It is the heartfelt desire to ensure that services are maintained which provided the impetus for this research.

The Haven’s proposition to the EU Daphne III Programme in our submission was to examine the provision of Domestic Violence Counselling as provided in other European States. The outcome, a Comparative Study with partners in academic and research institutions in the United Kingdom, Portugal and Germany, and provider partners in Italy, the Netherlands, Bulgaria and Latvia is presented here and I commend their collective efforts on behalf of women and children.

Kath Rees
Chief Executive
The Haven Wolverhampton.

The Haven Wolverhampton aims to support women and dependent children who are vulnerable to domestic violence, homelessness and abuse.
ACKNOWLEDGEMENTS

‘Firstly, thanks go to project research partners: Angela Morgan from the University of Wolverhampton, Sabine Bohne from the University of Osnabruck, and Mario Jorge Silva, Alexandra Silva, and Paula Carrilho from CESIS - Centro de Estudos para a Intervenção Social.’

We wish to personally thank the individuals in provider organisations who conducted interviews and focus groups with clients and counsellors. Liz Berreen, Henna Patel, and Kath Farmer conducted client and counsellor interviews in The Haven Wolverhampton (United Kingdom). Juris Dilba conducted client and counsellor interviews in Marta (Latvia), and Ritma Lasmane conducted client and counsellor interviews in Skalbes (Latvia). Client and counsellor interviews in the Nadja Centre (Bulgaria) were conducted by Rossanka Venelinova and Cristina Peeva. Client and counsellor interviews in Artemisia (Italy) were conducted by Elena Tosi and Giulia Calvaresi. Hellen Felter and Rita Naloop conducted client and counsellor interviews in Projob (the Netherlands).

The European dimension of the project was facilitated by the translation skills of a number of individuals: Theodor Asenov who translated interview and focus group transcripts from Bulgarian to English, Ivan Neirotti who translated interview and focus group transcripts from Italian to English, and Anita Rode who translated interview and focus group transcripts from Latvian to English.

Warm regards and gratitude from the University of Osnabrueck go to Mart Busche, who primarily developed the literature review and also to Keisha Henry for analysing the interviews. Many thanks also to Stephanie Moldenhauer who developed an overview on prevalence studies within Europe. Without their excellent work these reports could have not been finalised from the German perspective.

The University of Wolverhampton would like to thank Emma Bodycote who provided support at the early stages of the project. Also thanks go to Fatemeh Fathzadeh who attended the University from 2011 to 2012 on an Internship in the School of Education Futures and provided research assistance on this project. Many thanks are tendered to Cyril Eshareturi who provided invaluable research assistance in the early stages of the project.

Finally, we are indebted to the survivors of domestic violence for allowing us to intervene in their recovery for the purpose of research, and for providing frank and in-depth accounts of their experiences of and views on domestic violence and its aftermath. Many told harrowing stories of the abuse they had suffered and the impact counselling had on their journey to recovery and living violence-free lives. We commend their courage and fortitude.
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ABBREVIATIONS

COUNTRY ABBREVIATIONS

BG Bulgaria, Nadja Centre
DE Germany
IT Italy, Associazione Artemisia
LT Latvia
LV-M Latvia, Marta
LV-S Latvia, Society Skalbes
NL The Netherlands, Stichting Projob
PT Portugal
UK United Kingdom, The Haven Wolverhampton

FREQUENTLY USED ABBREVIATIONS

CBM Cognitive Behavioural Model
PCA Person Centred Approach
PP Provider Partners
(UK, BG, IT, LT-S, LT-M, IT, NL)
RP Research Partners (UK, PT, DE)
NGO Non-Governmental Organisation
(Civil Society Organisation)
INTRODUCTION

1. INTRODUCTION TO THE REPORT

An understanding of specialist domestic violence counselling services in partner countries from the perspectives of counsellors working in domestic violence support services and clients who have accessed those services is a key objective of this project. Primary data collection by way of interviews with clients and counsellors has the benefit of providing a rich comparative analysis of similarities and points of departure between psychological services for women and children affected by domestic violence in the United Kingdom (UK), Latvia (LT), Bulgaria (BG), Italy (IT), and The Netherlands (NL).

The purpose of this report is to present the views and opinions of both clients and counsellors on the services they have received and delivered, and to share the learning from this in order to raise awareness of such services to public, private, and charitable bodies, also funding bodies and service commissioning agencies who support counselling and psychological services for women and child victims of domestic violence in participating countries. This report is hereafter divided into four sections:

- Methodology and data collection
- Clients’ perceptions of receiving domestic violence counselling
- Counsellors’ perceptions of delivering domestic violence counselling
- Summary comparative analysis

2. METHODOLOGY AND DATA COLLECTION

2.1 METHODOLOGY DESIGN - A QUALITATIVE APPROACH

The decision on methodological approach was guided by the sensitive nature of the research topic and by a dearth of research on this topic. To conduct research on points of view and knowledge, with which to better understand the approach and profile of NGOs providing counselling and psychological support to women and children affected by domestic violence, is something that can only be done through qualitative research methods. Qualitative research provides in-depth contextual material on how people experience a given issue; it gives the topic its human facet, revealing behaviours, beliefs, opinions, and emotions. The project partners embraced two key qualitative methods, in-depth interviews, and focus groups. Assessing how women perceived psychological support received in a particularly difficult period of their lives is not an easy task; feelings of gratitude or criticism can be raised during interviews, thereby damaging sincerity of response. On the contrary, interviewing counsellors about their own practices and professional experiences can be understood as an unwanted evaluation of their practice. Design of data collection instruments was made by a team of researchers from the UK, DE, and PT, all of whom were experienced in design and implementation of data collection tools for use with women affected by domestic violence. The final versions of those instruments were then distributed to the project’s provider partners (PP) in which the instruments would be applied; BG, LT, IT, NL and UK. At a transnational meeting in the UK, the instruments were discussed with PP, stimulating debate on the rationality of the main themes within the research tools. This procedure provided a shared understanding and framework to the research with key input from all stakeholders. The project design included the following components:

**Survivor interviews:** Face-to-face interviews were conducted with female survivors of domestic violence who had been receiving psychological support from professional counsellors (psychologists or psychotherapists). A total of 60 interviews were conducted in six counselling services in the UK, LT-M, LT-S, BG, IT, and NL. The interview comprised three main areas: help-seeking behaviour and service contact; features of the therapeutic process; and outcomes. The first set of questions enquired about clients’ help-seeking behaviours and the circumstances that led them to seek help. It is important to understand women’s first contact with supporting services, how important this first contact was for them, and subsequent contact. The second set of questions identified perceived characteristics of the therapeutic process and how women valued it during their recovery. This set of questions also allowed women to assess features of the counselling process they most appreciated. The third set of questions identified perceived gains and to understand if and how clients felt empowered by the support (See Appendix 1). All questions were designed to allow openness and to have no negative impact on respondents. Interviews were conducted with respect for ethical principles that a work of this nature requires. Approval was gained from the Research and Enterprise Committee, Ethics Sub-Committee, School of Health and Wellbeing, University of Wolverhampton, UK, to allow the research to proceed, although investigations into the ethical requirements of participating countries revealed that no ethical approval was required other than in the UK. Nevertheless, informed consent forms were provided to respondents assuring them of confidentiality and anonymity of data, also that the use of the data would only
be for research purposes only; only those who understood the terms and signed were interviewed.

**Counsellor interviews:** Face-to-face interviews were conducted with counsellors who provided psychological support to women survivors of domestic violence. The sample was mostly drawn from the project PP with 12 interviews conducted in total. The interview schedule was developed around three topic areas. The first section addressed the educational and professional background of respondents; it was important to know the experiences counsellors have had in the field of domestic violence. The second section focused on theoretical models counsellors employ when working with victims of domestic violence and what were viewed as the foremost constraints of these models. The last section sought understanding of counselling outcomes and to what extent outcomes are assessed in practice; it was also important to explore if victims were involved in designing their therapy, if it was a shared process or not (See Appendix 2).

**Focus group with counsellors:** A focus group with counsellors was conducted in each provider partner organisation, with six focus groups totalling 21 participants. The purpose of focus groups was to share experiences of barriers and facilitators to counselling, and difficulties faced when supporting victims of domestic violence. Two sets of questions were facilitated, focusing on theoretic models most used and perceived outcomes of the therapeutic process (See Appendix 3). The combined methods and instruments allowed access to a wide range of views, perceptions and experiences, complemented by shared reflection amongst peers on therapeutic and psychological methods used by counsellors of victims of domestic violence. The data collected was very rewarding and enlightening in the context of previous literature (See Research reports 1 and 2). Cultural variations, in that both clients and counsellors came from different European countries, allowed access to similar and dissimilar views, thereby broadening and deepening the research.

As previously stated, NL selected a number of counsellors from various organisations to participate in the research due to Stichting Projob not having specialist domestic violence counsellors within their organisation. Seven freelance counsellors participated in interviews and a focus group, four who also worked at Vrouwen Opvang, Amsterdam. Counsellors from frontline organisations included one from VIEJA, ambulant counselling and domestic violence, and two from the Police Department Midden NL / Gelderland.

### 2.2 SAMPLE – RESPONDENT DEMOGRAPHY

Table 1 shows client characteristics across countries. Although the average age was quite high (youngest average 35 years for UK, highest average 53 years for IT), the youngest ages mostly fell into the 20s which, apart from one respondent at 41, were quite young. LT-S and BG had the highest proportion of married respondents, both at 70%, whilst the UK had the highest proportion of separated or divorced respondents at 80%. This may reflect differences in culture or religion; some EU countries consider divorce or separation socially unacceptable. Almost all respondents had children, many having between one and two, although respondents from NL had mostly one child. Italy’s respondents had the oldest children (average age of oldest 27 years, youngest 23 years), reflecting the average maturity of respondents. Although most respondents reported no serious health problems that affected their counselling, of those who did, all but one were stress-related conditions (high blood pressure - BG, high cholesterol, panic attacks - IT).
TABLE 1: COMPARATIVE DEMOGRAPHY – CLIENT CHARACTERISTICS

<table>
<thead>
<tr>
<th></th>
<th>UK</th>
<th>LT-S</th>
<th>LT-M</th>
<th>BG</th>
<th>IT</th>
<th>NL</th>
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<tr>
<td>Total interviews</td>
<td>10</td>
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<td>Average age</td>
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<tr>
<td>Youngest/oldest</td>
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<td>38</td>
<td>42</td>
<td>49</td>
<td>53</td>
<td>37</td>
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<td>(22, 45)</td>
<td>(24, 60)</td>
<td>(20, 60)</td>
<td>(31, 83)</td>
<td>(41, 66)</td>
<td>(24, 48)</td>
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<td>Marital Status Married</td>
<td>0%</td>
<td>70%</td>
<td>30%</td>
<td>70%</td>
<td>37.5%</td>
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<td>Marital status</td>
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<tr>
<td>Separated/divorced/ex-cohabitating</td>
<td>80%</td>
<td>30%</td>
<td>50%</td>
<td>20%</td>
<td>12.5%</td>
<td>33%</td>
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<tr>
<td>Marital status</td>
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<tr>
<td>Single/widowed</td>
<td>20%</td>
<td>0%</td>
<td>20%</td>
<td>10%</td>
<td>30%</td>
<td>11%</td>
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<tr>
<td>Total with children</td>
<td>80%</td>
<td>100%</td>
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<td>100%</td>
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<td>55%</td>
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<td>Number of children</td>
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<td>Average age of oldest child</td>
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<td>16</td>
<td>19</td>
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<td>27</td>
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<td>Average age of</td>
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<td>Youngest child</td>
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<td>Have serious health</td>
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<td>90% British</td>
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<td>10% British Asian</td>
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<tr>
<td>10% Russian</td>
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<td>90% Latvian</td>
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<td>100% Bulgarian</td>
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<td>100% Italian</td>
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| 2.3 DATA COLLECTION AND ANALYSES

Data were collected by PP, transcribed, and translated into English. The research partners (RP) initially analysed data by PP organisation (by interviews and focus groups) and, secondly, compared the results from clients and counsellors, then a European comparative analysis was conducted.

2.4 LIMITATIONS OF DATA COLLECTION

It is important to note that interviews were conducted by non-researchers in the interviewers’ native language, and transcribed into English by non-researchers. Qualitative research requires meaning to be made from textual data, yet if the quality of the material is below standard, then conceptual understanding may be compromised. The quality of the data gathered in this study ranged from very deep and rich to somewhat shallow and light. There were differences in professional standing of those conducting interviews, as well as differences in the way data were captured, transcribed, and translated. Data analysis and interpretation relied heavily on data that had been sifted twice, firstly by transcription and secondly by translation (or vice versa). Data collection methods from LT-S, LT-M, BG and IT were all conducted and transcribed in their native languages (Latvian, Bulgarian, Italian) and translated into English by volunteer translators. Interviews in NL were conducted in Dutch and translated into English by PP, and interviews in the UK were conducted and transcribed in English. Caution should be observed regarding the accuracy of data; this is not easily resolved. Presented here are other possible sources of bias:

- **Dialect and meaning:** Even thorough and conscientious translators can often omit nuanced phrases, inflections, and meanings arising within language. Errors in translation might have occurred due to differences in dialect, and nuances in terminology between speakers and translator. Although sensitizing concepts within the area of domestic violence and especially counselling models and approaches should have been available to transcribers and translators, in reality this may not always have been the case.

- **Absence of non-verbal communication:** Due to time and geographical constraints of the project’s European dimension, there was no capture and understanding of non-verbal body language and facial expressions, as translation was conducted in a different country and at a later time than when interviews actually took place. Analysts therefore could only interpret the written word as presented by translators.

- **Gender bias:** For interviews that took place in BG and IT, many respondents were older women whilst translators were young male students thus possibly introducing gender bias; translators might not have been in sympathy with or understood respondents’ experiences of domestic violence and/or counselling.

- **Timeframe:** The length of time taken from interviews to the first thematic analysis was lengthy and it would not have been feasible to return to respondents after a number of weeks had elapsed, so any
inconsistencies or questions raised by the data were rendered unresolved.

Data comparability: Counsellors who participated in data collection in NL were social workers (not psychologists or psychotherapists), which could indicate that the work conducted by them did not have a therapeutic approach. Also, the focus group that took place in NL combined clients and counsellors, which were not the defined target participants; therefore, this focus group was not analysed. So although a comparative analysis with NL data was conducted, readers are advised to be mindful of this issue.

3 FINDINGS: CLIENTS’ PERCEPTIONS OF RECEIVING DOMESTIC VIOLENCE COUNSELLING

Notwithstanding the limitations presented above, most responses were complete and straightforward. The women were open about their experiences of domestic violence, and reflective about their past and current situation. There was a clear division between women who have been through counselling for a longer period of time than those who are in early stages, demonstrated by a more developed and independent outlook, whilst others were still struggling to continue a life free from violence. Regardless of the women’s situation and perspectives at the time of interviews, their feedback and openness paints a clear picture as to the challenges that face women suffering from domestic violence and the strength of will it takes to overcome them. Some responses go into detail whilst others were monosyllabic; however the information gathered is rich. In the analysis that follows, where a country/service provider is not included, this is because the data show no findings in relation to that sub-theme. For clarity, summaries are presented in shaded boxes.

3.1 HELP-SEEKING BEHAVIOUR

Overview - This section analyses the circumstances under which clients sought help. It is important to know the motivation behind their help-seeking behaviour, and to determine if they sought help after a period of reflection or without prior plan.

3.1.1 REFERRAL ROUTE AND SUPPORT

UK: All but two respondents had been referred to the counselling service by their support worker. The community team, police, and support workers from non-disclosed services were fundamental to referral although, in the main, support workers from the organisation were the most frequent referral agents.

‘I was already in the Haven. From there my support worker referred me. Well, I asked to be referred. I had been in the refuge for 10 months.’ (UK06)

Self-referrals often happened after years of abuse culminating in separation from the abuser. Some respondents were struggling to live with violence at home yet were not able to leave due to complex family factors, although they still needed emotional support.

‘I was really struggling with the domestic violence at home. I was still living in the situation and was returning to the situation every day. I was at home and still living with it and was becoming increasingly depressed, and to move into the hostel was not a choice.’ (UK02)

LT-S: In three of the ten cases women had access to information about support groups from home and abroad which made it easier for them to access the service.

‘I heard this information somewhere... about Skalbes, about a support group for women who has suffered from violence. Some time ago I had read about such support groups in America, and I thought it is a pity there is not such in Latvia. And when I heard that there is one, I wanted to try it. I guess at some point life gives you opportunities. When you are ready for it. Everything had piled up so much that I did not know where to go, because I could not take care of myself anymore.’ (LT-S02)

Access to information was beneficial as it gave a sense of comfort and confidence in approaching the service because clients understood what they were getting into. In two instances, the condition in which the women were in made their need for help difficult to hide from the outside world. Many respondents received help from outsiders or acquaintances because their physical appearance or personality created cause for alarm. Three clients who had sought help for past violence were already in contact with a public institution that referred them to Skalbes, and the remainder were referred by lawyers, close acquaintances, and family members.

‘My mum was working at the administrative part of the Orphans’ court, and therefore she knew about Skalbes. In the beginning she wanted to make an appointment for me, but they...’
said that it is not possible, and I have to come or call myself. And then I went there.’ (LT-S10)

In one instance, the respondent was already going through family counselling and realised that she had been living in an abusive relationship for the past four years. She was referred to Skalbes by a family consultant.

**LT-M:** Eight respondents accessed the service through social workers, school psychologists, teachers, friends, and other counselling centres that specialise in domestic violence (these centres had recommended Marta to clients who could not afford to pay for therapy). Three of the eight were referred by friends or professionals who already knew of the violence, whilst five were referred by professionals who had no pre-existing knowledge of their situations.

’I got the information about Marta from the school psychologist who knew about our family problems’. (LT-M11)

’A friend recommended me to look for help. She is a psychologist and she knew about my problems’. (LT-M08)

Three respondents came to LT-M on their own initiative after having known about the service or had searched online just after deciding to seek help. Of these, one had not made a firm decision to seek help, wanting only to gain further information of LT-M’s services, whilst two had decided they wanted help.

**BG:** The majority of respondents sought help through telephone helplines found on the Internet or television. Secondly, word of mouth was a great source of information which led clients to the service (family members, friends, colleagues). Two respondents had been referred from Child Protection Services and another was a returning client.

’From the internet. There is a lot of information over the Internet, and many different organisations and websites, but I have heard about Nadja Centre before and I decided to try.’ (BG06)

’My daughter from the countryside has written down your number long time ago and she was trying to talk me into calling you, but I didn’t have the courage, until eventually there was another incident with my son; then however awkward it might be I gained the courage to call. Thanks God that you immediately took me in, because otherwise I might have discouraged myself from coming.’ (BG09)

**IT:** An important role was played by police in helping victims of domestic violence; the police advised women to contact support services and often made the first call themselves.

’I was advised by the marshal of police (...) he told me exactly like this: ‘take my advice, call this association because, you will see, they can really help you!’’ (IT02)

Some women had been informed of the support service through other services and professionals. Also, the national campaign to end violence against women had an impact on raising awareness and encouraging women to seek help.

’I heard on the television that was the international day against violence. I call the toll-free number and the operator gave me your number to call’. (IT05)

**NL:** The first aspect concerned the importance assumed by support networks with proximity to the victims in the detection and referral of situations identified as domestic violence. The arrival of respondents to the support office happened mainly through the support of relatives and friends as well as through information provided by family doctors. Promotional material about the service and the Internet were two means of finding help.

**Summary:** Statutory services such as criminal justice and health referred clients to counselling services in the UK, LT, BG, and NL. Third sector refuge support workers brought clients to counselling services in the UK, whilst family and friends appeared to be key referral agents in LT, BG, and NL. The national campaign to end violence against women resulted in referrals in IT, whilst other promotional material and Internet sources were used by clients in LT, BG, and NL. Self-referrals were received in the UK and LT.

**3.1.2 DECISION TRIGGERS IN HELP-SEEKING**

**UK:** Decisions to seek counselling help were often borne out of feelings of despair and hopelessness. A
deep need for help triggered many respondents, as they believed they could not come back from the brink of despair on their own.

‘Sheer desperation because I was suicidal literally and I thought that at that point that if I didn’t get some help via counselling or something that there would be tragic consequences.’

(UK02)

For others, decisions to pursue counselling support appeared to be an accumulation of long-standing suffering of domestic violence which had been sparked by a specific incident.

‘It was seeing how the stuff that was going on in my head was affecting the people closest to me and I could see the pattern starting again so I kind of wanted to stop it.’

(UK05)

**LT-S:** Most women sought help when they were no longer able to maintain control over their own lives and felt helpless. Many were longing to speak with someone about their problems without judgment. They needed a specialist who could advise them effectively so they could exit a dire and weary situation. Many had been abused to the point where they were without further recourse except to seek professional help. Some had received psychiatric help but had not received effective treatment and wanted a different type of support. In four instances, the common factor that triggered clients to seek help was their own realisation of the situation; a breaking point was reached where they understood that violence had been a part of their lives for so long that it needed to change. Also, a shared issue for three respondents was that the thought of seeking help existed but they did not act upon it until a severe physical attack.

‘I had this understanding that next time he will beat me to death. I realized that I have to start protecting myself, look for help, because otherwise there will not be a happy ending. And then I started to look for help in a determined way. I had that thought for two years. In the beginning I knew that I don’t like it. I remember clearly that I thought – I do not want to live like this. And then after the last beating up I realized that I have to run and save myself now.’

(LT-S05)

One respondent sought help when already in a healthy relationship in order to deal with past trauma.

‘I, together with my husband and one of the children, were going to family consultations, and during these consultations I realized that, although I’ve lived in a violence-free relationship for the last four years, until then I had lived with violence all my life, both from my parents and my first husband. And that the effect of this violence is still bothering me. I have regular episodes of depression, black days when I cannot do anything and do not want to live, I have a feeling then that I cannot be a good wife and a good mother to my three children. I have two sons from the first marriage and my husband also has a son, who lives with us. I have difficulties communicating with other people. We were talking with the family consultant and she suggested that I go to individual consultations, and gave me the phone number of Skalbes.’

(LT-S09)

**LT-M:** Inability to deal with family and partner played a role in triggering help-seeking behaviour. Some clients were in very difficult situations and no longer able to meet challenges successfully. Many clients felt helpless and shame which manifested externally, through loss of employment, close acquaintances noticing a change in behaviour, differential treatment by family members or deteriorating health.

‘I started to look for help when I could not deal with myself anymore and I was encouraged by my conscience. It did not take long, because people at school noticed that something was wrong with me. Then I went to a teacher and she helped me. My decision was planned. I got support also from my mum.’

(LT-M01)

Although violence and abuse often caused depression, clients seemed to be acutely aware that, aside from feeling depressed, they were also discontent with their personal circumstances. That said, they were encouraged by how they felt, and decided themselves to get help. The time between when women first decided they needed help and when they actually sourced help ranged between six months and three years. For one respondent, the threat of impending violence was a deterrent for help-seeking and, as such, had to wait until her husband was away before she fled. This created a two to three year gap between when she decided to get help and when she actually received it. In another instance, a client only took two weeks to seek help after realising her predicament. However, she subsequently waited six months because of a long waiting list. Other instances implied that clients needed months or years to consider their feelings before making the decision (or having the opportunity) to change the situation. In some cases, abuse went on for decades, while for others the abuse lasted a couple of years.
COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING: COUNSELLORS AND CLIENTS

BG:- All respondents had very thoughtfully and carefully planned their decisions and actions in seeking help; for some this took a very long time whilst for others the decision was made swiftly. The key trigger for help-seeking was escalating violence, and that violence was affecting the children.

‘He harasses my daughter at school. He has rented an office right in front of the school and every school break he visits the kid and talks to her, even wants to pick her up after school... and actually, if it was not for the kid, I still would have done nothing... he wants to take our daughter there, play family, and brainwash her that her home is there and they would live wonderfully without me.’ (BG11)

One respondent told how her health started to fail due to the violence, and this triggered the need to seek support. Another client suddenly realised what she was experiencing was unacceptable; that was the point at which she sought assistance. Others were simply exhausted with the stress from the violence at home. It is clear they had taken as much as they could living with chronic and escalating violence, reached desperation, and sought help for what they perceived was hopeless, especially for one very elderly woman.

‘I am an elder woman and all the pressure, stress, which my daughter and me go through caused by my grandson, and the position a person falls into and doesn’t know whom to turn to. My grandson has drugs and alcohol addictions, he doesn’t work, but he needs money. He takes his mother’s money, as well as my pension. If we refuse to give it to him, he starts throwing and breaking things, and spoils for a fight with us. I bore for a long time, but after all, I decided to seek help and disclose with somebody. I don’t know how long I can endure this.’ (BG07)

IT:- The length of time clients had experienced violence, ranging from six to 25 years, triggered the decision to seek help; they were despondent and needed to change. Time was also strongly connected with increasing violence and with increasing feelings of desperation and incomprehension.

‘I was in despair. The desperation, hopelessness, the loneliness, the emptiness, the sense of helplessness, of bewilderment. A great sense of despair. Seven years, with a progression to worse...until you get to the point of psychological and physical violence, physical neglect, threats, and everything, everything!’ (IT02)

Women had difficulty recognising their own experiences of violence: violence was considered a normal feature of an intimate relationship. One client reported that the moment she was beaten was the moment she realised she had been living in an abusive relationship where frequent episodes of psychological violence had occurred. Another respondent, although being victim to physical and sexual violence, did not perceive it outside normal behaviour of a loving person. Age, gender, and generational perspective likely played a part in the way respondents perceived violence in their intimate relationship. In particular, Italian respondents were relatively old (average age 54), and violence against women and children was frequently associated with marriage. However, these were women who often did not have paid employment, therefore were economically dependent.

‘In fact 25 years of marriage (...) suddenly you have nothing, no house, no car. In short you have exactly nothing, and three children who were hurt too.’ (IT06)

Children were also a key element of help-seeking behaviour. Making a complaint to the police led these women to other life choices, for instance to contacting counselling services.

NL:- Respondents sought support mainly without planning; decision-making was derived from a saturated situation of violence. Two other situations with potential to trigger the decision to leave home included escalating violence to new levels of extreme severity and to the extension of violence towards children.

Summary: Respondents’ decisions to seek help were widely similar across countries, with help-seeking behaviour triggered and planned primarily due to chronic abuse over a long period of time which resulted in absolute exhaustion and despair; they had reached breaking point. For many, escalation or the fear of escalation of violence prompted help-seeking. Deterioration in health, observations of others, and the point at which children were affected were also significant in help-seeking. Italian respondents were considerably older than others; there was historical normalisation of abuse within marriage, yet sudden realisation that what women were suffering was unacceptable.
3.1.3 CLIENTS’ EXPECTATIONS OF COUNSELLING SUPPORT

UK:- Most respondents had no expectations of counselling due to lack of knowledge and understanding of what counselling is and how it might help; also because there was so much chaos and confusion that there was no time to think about what counselling would mean. Many were at a very low point in their lives and thought they had to relieve the pressure, but had no expectations of what to do or how. For those who held some expectations there was caution, although they were willing to allow themselves to be the focus of the counsellor’s gaze.

‘It was seeing how the stuff that was going on in my head was affecting the people closest to me and I could see the pattern starting again so I kind of wanted to stop it.’ (UK05)

One Asian respondent, although holding no expectations of counselling itself, was concerned that the counsellor would be the same ethnicity, and this is something she did not want. Furthermore, one respondent was fearful of having control taken away from her.

‘To be honest, I was expecting for someone to come into my life and take over my life, my decisions with the house, my children and everything involved in my life and I think at first that’s why I didn’t want to get in touch with the Haven and when I did, I was greatly shocked because I felt like I was in control, all the time.’ (UK07)

LT-S:- Many respondents only expected help and some kind of positive outcome. They wanted to find understanding of themselves and their situation, and to determine how to gain support which was lacking within their family. There was similarity in personal expectations: to receive support, and to be heard and understood. Even though two respondents said they did not know what to expect, they made it clear that some sort of help was expected.

‘I did not know what to expect. I did not have any such experience. I was hoping for a miracle, that the psychotherapist will do something that makes me feel better. There was no one who could support me. I was alone in Riga, I did not have friends. My mum was in the countryside together with my drunken father, being ill herself. I did not even tell her how I was really doing. I said that everything is fine, that I am working, studying. It was enough that she was already judging me about the fact that I had relationship with an older man.’ (LT-S07)

LT-M:- Respondents did not have any definitive expectations from the service besides overall help, however there were things they hoped to gain from their experiences: they wanted to understand more about themselves so they could understand how they came to arrive at their current situation, to find out how to get out of it and end the violence. Clients also wanted guidelines as to how to live their lives in the aftermath of domestic violence.

‘During the divorce I realized that I am all the time together with the ‘wrong’ man, and that it is not good. Therefore I wanted to solve this problem.’ (LT-M06)

Respondents hoped they would receive an understanding ear from the counsellors whom they hoped would help them understand themselves from different angles and would make them feel free of judgment and blame. Respondents also hoped to gain a new perspective on their roles within their families and relationships. In one instance, the client fully expected the counsellor to blame her for the violence and was very frightened when she arrived at the centre.

‘I expected that there will be a discussion that they will say that it is my own fault, that I am just pretending to be innocent, but there are always two people who are guilty. I thought that they will start to analyse the situation and point out my mistakes. I was already in the corner at that time.’ (LT-M04)

Regardless of the circumstances surrounding their arrival at LT-M, the need for an outsider perspective was predominant in many responses. This implies respondents were no longer able to assess their personal situation effectively, and that it made them feel better, or alleviated their pain. Respondents were expecting help from a psychological perspective whether or not they came as a last resort or with the expectation of another type of service. This need for a lifeline outside of the immediate family and social circle implied that some women felt trapped in their current situations and may have felt unable to trust people closest to them.

BG:- In order of frequency of replies, clients expressed the following expectations of the service: practical advice on a range of issues from controlling the violence to judicial advice; someone to share experiences
with and to listen to them; no expectations due to limited knowledge; and someone to structure and define the problem.

‘I needed someone to listen/hear me and I expected an advice on what should we do. It is very delicate matter; we do not want to undertake actions, which might lead to his arrest or other prosecutor’s actions. Maybe I expected help in sending him to a rehabilitation facility.’

(BG07)

All respondents had the support of family or friends. One respondent said she had an expectation that her problem would be defined. One respondent had no support from her children:

‘I have had support from friends, but not from my children; they are girls and reproached me for taking the psychological abuse from their father without reacting or saying anything.’

(BG02)

IT:- Most respondents did not know what to expect from a counselling service, apart from being listened to by someone. Also, this was the first time some respondents had contacted support services so they had no prior knowledge. However, safety and security were suggested.

‘Here I had the chance of being hosted in a safe place with a guarded gate.’ (IT07)

Family support was a relevant feature of help-seeking, either being there when presenting a complaint to the police, or providing emotional and psychological support in decision-making. But family support was not always a reality at first contact with support services. Some families did not support the partnership break-up, but finally they saw a good outcome. The support of friends can play an enormous role in increasing women’s capacity to seek help.

‘I have talked with some friends... I wasn’t brave enough to call and I asked a friend of mine to do it (…). The fact that she called made me quieter and calmer and this made things start, put things in motion.’ (IT09)

But sometimes women did not feel they could share everything with friends, particularly violent episodes, because they were ashamed; they tried to find ways of coping with the situation without being too open.

NL:- For two respondents, the domestic violence was not known by anyone else. In one case, having to disclose domestic violence to the family doctor triggered the decision to seek help. This example reflects the importance of formal support services, namely the health sector, where established relationships and types of care provided can mean the end of isolation for victims and accurate identification of the situation, often with impact in judicial decisions. The secrecy of domestic violence arose again when respondents were asked about their prospects regarding the service and the eventual support of their family takes place. Half the respondents stated that decision-making and seeking help happened without any support from the family since, in some cases, the violence was not known. One respondent feared her family's reaction, but generally there were no clear expectations; the majority of responses only showed the need for help, without specifying what sort of intervention was expected.

Summary: The general consensus was that, upon service access, women in all countries had no prior expectation of counselling: no previous knowledge and no time to think about what they needed or expected; they only knew they needed help. When prompted, some said they needed to regain control, a safe and secure environment with someone to listen, acceptance of cultural issues, and to learn about themselves. The main difference was that women in BG expected to receive practical advice, whereas in IT, the support of family and friends was important in deciding to seek help. However, in the Dutch context, there was no family support in half the cases.

3.1.4 BARRIERS AND LEVERS TO SERVICE ACCESS

UK:- Although in the main there were no barriers to accessing the counselling service, waiting times did pose a problem for some respondents, although in one case this was overcome by fast-tracking due to the severity of symptoms.

‘To be honest, I was expecting for someone to come into my life and take over my life, my decisions with the house, my children and everything involved in my life and I think at first that’s why I didn’t want to get in touch with the Haven and when I did, I was greatly shocked because I felt like I was in control, all the time.’ (UK07)
One respondent perceived a barrier in personal terms as she was an employee of the domestic violence service and did not want her colleagues or clients to know.

**LT-S:** The majority of respondents did not experience any major barriers to service access. The only barrier perceived was difficulty to find the time to get the help they needed. This was a practical barrier on the part of the client, as opposed to a lack of availability on the part of the service. One respondent initially had some logistical problems because of her financial situation.

‘In principle, no. In the beginning I had problems with money. I was long-term unemployed, no stable income and therefore it was sometimes difficult to even buy a trolleybus ticket to get to Skalbes.’ (LT-S06)

Another had financial problems that did not allow her to continue after ten consultations.

**LT-M:** Half the respondents identified financial constraints as a primary barrier to service access. They could not afford to pay for consultations with specialists and this had delayed their attempts to get help. Only one respondent identified their working schedule and lack of funds to pay for counselling as barriers.

‘It took a long time, because I was working every day without holidays and we could not agree with the specialist about the meeting hours. Of course, also the finances were a barrier.’ (LT-M09)

Although LT-M provides free services, perceptions of this barrier would imply that respondents were unaware that services were free. Other respondents claimed the only barriers to arise were emotional barriers; some clients feared there was no one who could help them, whilst another made several appointments before receiving help.

**BG:** The majority of respondents experienced no barriers to service access. The only minor issues to arise were childcare for one respondent, a high workload for another, and service location for two respondents.

‘Not exactly, I was worried, when I was explaining on the phone, that I could not leave my child anywhere and I didn’t know how this would be accepted; however, I was very pleased that you had the opportunity to talk with my daughter too, and that there was somebody who stayed and played with her during my counselling.’ (BG11)

**IT:** Although most women did not encounter barriers in accessing support, some women mentioned barriers related to the service; for instance, a working schedule not compatible with that of the client, or living far away from the cities where this kind of service exists.

‘I had problems in the office where I work to come here... they didn’t give me the permission.’ (IT07)

**NL:** Seven out of ten respondents experienced two types of obstacles in accessing the service. Personal difficulties such as shame and anxiety, service processes such as an extensive application form that had to be completed in the admission process, and the office was too loud. A waiting list also posed barriers.

**Summary:** Whilst the majority of respondents said they experienced no barriers to service access, a small number admitted they faced certain difficulties: for the UK and NL, some women thought waiting times were too long (although in the UK fast-tracking was available); incompatibility between clients’ working schedule and counselling office hours combined with geographical location were barriers for clients in LT, BG and IT; and time and financial barriers were experienced by clients in LT, childcare issues in BG. Clients in NL appeared to experience most barriers to service access: shame and anxiety; overly bureaucratic admissions paperwork; and a noisy office environment.

### 3.1.5 PRIOR EXPERIENCES OF COUNSELLING AND THEIR INFLUENCE ON HELP-SEEKING

**UK:** All respondents said it was the first counselling for domestic violence they or their children had received, and that previous experiences of generic counselling through other sources had been negative.

‘I tried and tried and tried through my GP to get counselling and he referred me and I was on the waiting list for CBT, but that never happened. Then he put me on the waiting list due to an
extremely violent rape and I was on the waiting list for 12 months and still never got any counselling. And then I’d been having counselling for 6 months at The Haven.’ (UK02)

**LT-S:** Six respondents had no prior experience of counselling with regards to violence. One respondent had received prior treatment for domestic violence, another received treatment at school. Two respondents had prior experience of counselling regarding violence. However, therapy for those who received it was ineffective in remediing pre-existing issues; respondents did not feel comfortable or could not relate to the therapist and consultations were terminated. However, the need for help did not stop there and respondents sourced help in the future in spite of being unsatisfied with previous assistance.

‘No, I already mentioned that shortly before this I tried to see psychotherapist individually. But somehow we did not have a good contact. He more focused on my personal characteristics, and I had a feeling that the violence that I have lived with for a long time was not important to him. It was also too expensive for me. I stopped seeing him after the fourth visit.’ (LT-S03)

**LT-M:** Five respondents experienced counselling for the first time at LT-M. Of the others, one had previously sought help from a sister who told her to solve things on her own, which was unsuccessful, and the other five sought treatment previously from specialists, however satisfaction varied as one stated having a positive experience while the other respondent was unsatisfied with the treatment and having to pay for it.

‘I went to counselling also before, when it was the first crisis in my family, but I was not fully satisfied and it was a service that I had to pay for.’ (LT-M09)

**BG:** Nine had accessed counselling for domestic violence for the first time, whilst two were returning clients.

**IT:** For all respondents, this was their first contact made with support services. Only one respondent had already made previous contacts with the service but regarding other people.

‘Years ago I became aware of the centre but in another role because I work as a teacher (...) I thought I would need it only as a teacher; in fact, I used the services in case of a child.’ (IT04)

**Summary:** For the majority of respondents in the UK, LT, BG, and IT, this had been their first contact with a service offering specialist counselling for domestic violence. Some clients in the UK had received counselling for other non-domestic violence issues and their experiences had been negative, and Latvian clients had found prior domestic violence counselling to be ineffective. A few clients in BG were returning clients.

### 3.1.6 INFORMATION RECEIVED PRIOR TO COUNSELLING AND CONFIDENTIALITY ISSUES

**UK:** All respondents had received information on confidentiality and other features of the service offered before commencement of therapy. Counsellors went to great lengths to explain the procedures and processes of counselling in order to manage clients’ feelings of anxiety. The complexity of confidentiality of counselling children was explained and managed very well.

‘Yes, my counsellor made it very clear that, because I think she recognised how nervous I was about that whole, you know. And she did keep reiterating that anything you say here will be kept completely confidential, I’m not going to be going out speaking to colleagues and things, unless she needs to obviously, with any policies or procedures.’ (UK05)

**LT-M:** All respondents were fully aware of their rights. One respondent gave a vague answer implying she felt unclear and unsure if she would continue after the first session, but did not expand further. All respondents agreed they were made aware of their rights regarding confidentiality.

‘Until the moment that I came here and talked, I was not sure about anything. I did not know whether I will continue the cooperation after the first session.’ (LT-M03)

**BG:** All respondents were informed of their rights prior to counselling and it was the confidential nature of
the service that appealed to many. Some provided additional information on their rights, whilst there were some comments that questioned the reality of confidentiality.

‘I know that in an organisation like yours, I will be heard and if possible, you will help me with advice and all the information will remain confidential.’ (BG07)

‘I understand the importance of confidentiality in counselling, as well as the fact that you spare and protect the child from listening and worrying. However, she has witnessed such beatings; her father never spared her...’ (BG11)

**IT:** Everyone said they were informed about confidentiality and that they had signed a prepared document acknowledging that.

‘Yes, absolutely, yes. Yes, yes. But this is something I could perceive myself too.’ (IT03)

**NL:** Only one respondent claimed to have been informed about the service’s confidentiality rules.

**Summary:** All respondents in the UK, LT-M, BG, and IT confirmed they had been informed of their rights in relation to the counselling code of confidentiality and that they understood their rights. In the UK, the complexity of confidentiality of counselling children was explained to mothers and managed very well. Only one respondent from NL claimed to have been informed of her rights and about confidentiality.

### 3.2 FEATURES OF THE THERAPEUTIC PROCESS

**Overview** - This section analyses clients’ perceptions of the therapeutic process and how they valued it. It also presents an understanding of the quality of the relationship the client and therapist built together and the level of client involvement in the therapeutic process.

#### 3.2.1 KNOWLEDGE ABOUT THE COUNSELLING MODEL AND APPROACH

**UK:** Respondents did not have much understanding of the counselling model or approach used. Instead, they spoke of their counsellor’s personal qualities, how good and supportive they were, that they always waited for the client to talk, gaining their trust and being able to talk. They stated that they were always well-informed with what they were doing. Respondents remembered there was often silence within the therapeutic environment, but in retrospect the silence mattered because it was time for them to reflect, and also time for the counsellor to listen and process what was being said. Coping strategies were taught during counselling to help with behavioural issues such as self-harm. Counsellors often introduced themselves as person-centred, although respondents considered them to be rather more eclectic, in that they brought in many different theories and types of working with their clients.

‘We’ve done loads of different types of therapy. We’ve done CBT, and it depends on the issue, we started the trauma counselling, we tried to touch on the historical sexual abuse.’ (UK02)

I do know a little bit because I did a course. I think initially when I first came up here, I didn’t really feel I was thinking about it that much because I was a mess. But I probably think humanistic.’ (UK03)

**LT-S:** No-one was aware of the counselling approach they received.

**LT-M:** Only four respondents identified the type of therapy they received, naming it ‘sand therapy’, but did not go into further detail on the nature of sand therapy. The rest could not identify the type of therapy they received, with the exception of one who claimed to know what therapy she had received but could not identify or comment on it.

‘I understand that I am having counselling and sand therapy. In general I rely on what’s happening here.’ (LT-M02)

**BG:** Responses were mixed and often confusing. Although all respondents said they knew what model and approach their counsellor used, there were markedly different understandings of what was being offered, although the concept of complexity was often raised.

‘The psychodrama is not exactly for me, this is how I feel it, but the holistic approach is something that works better for me. Except the psychological work, the social and juridical
are also appropriate, it is very complex. I myself am well-informed and progressing homeopath. This is my approach and the specialty is very comprehensive. Anaesthesiology is holistic on a physical level. The work helps me see and realise this.’ (BG04)

There was also little understanding of the counselling approach and that what the service offered was not counselling, in that those delivering the service were said to be allowed to prescribe medicine, give general advice as well as prescriptive advice on how a client should communicate to their partner about his violence.

‘Counselling is a sealed book for me; this is the doctors and psychologists’ job. I know that you examine me, you can prescribe medicines, and that you are giving me advice on how to behave, but approaches and methods – you can explain these to me all day, and I still won’t grasp a thing. On the other hand, if you explain that to my husband – oh, he will understand everything at once and even might give you an advice.’ (BG08)

IT:- Respondents did not have clear knowledge about the counselling model or the therapeutic approach upon which counsellors based their intervention. Nevertheless, women hinted at it and provided some reflections of their own.

‘No, frankly, this I don’t know. I noticed that it is a kind of approach which is target to listen to the emotions, the feelings of the person, and it is also a way of support.’ (IT02)

Most highlighted support based on emotions and feelings or self-reflection. Respondents also presented some characteristics of the model they were involved in, without naming it; they communicated their own understanding of the model by identifying some of the key features of the model. Nevertheless, some respondents were curious about the therapeutic model, and also about counsellors’ interactions with each other in relation to their clients. For most respondents, it was not only lack of knowledge but confusion of interventions and counselling approaches.

‘There is an idea… there is an emergency plan, there is a secret house… on the other side, there is service for less severe situations with information, psychological support, the legal part, the psychiatric.’ (IT09)

NL:- All responses reflected lack of knowledge about the model used. In three cases, respondents assumed they did not know anything about more than one counselling approach, and one of them even devalued the necessity of knowing about the models since that was not her priority. In addition, responses showed significant misinformation about the joint work to be carried out with the therapist.

Summary: Very few respondents were able to identify the counselling model or approach used in their counselling. However, respondents in the UK, IT, and LT were able to describe some of the key elements that made up their counselling sessions (for example, sand therapy, working with emotions, skills to reduce harmful behaviours). There was a general sense of confusion for respondents in BG, IT, and NL, whereby respondents could not decipher any theoretical underpinning or even the process that they were going through. Respondents from the UK could not describe the model, rather referred to the qualities of counsellors. Respondents in BG were not sure that what they had received was counselling, as practitioners could prescribe medication and offer practical advice. In the UK, although counsellors had introduced themselves to clients as person-centred practitioners, respondents’ own perceptions were that they were eclectic in their application of many different theories and types of working. It was not the priority of one respondent from NL to know what model or approach was being used.

3.2.2 PERCEPTIONS OF THE COUNSELLING PROCESS

UK:- Perceptions of the counselling process were quite mixed. The most collective theme was the positive benefits and outcomes of counselling. Many said they would highly recommend the service and indeed had referred many people. Counselling was considered hard work, and clients need to be motivated and determined to work hard to get the best possible outcomes for themselves; they need to be willing to talk and delve deep into their issues, otherwise it will not work. Respondents talked about how much they valued the service in that it has helped them to better understand domestic violence, to better understand themselves, to feel genuinely listened to, and to regain autonomy and move on. Whilst some respondents said they came because it was free, others said they would have paid a lot of money to have been given the service. Above all, continuity of counselling support was said to be vital for success.
‘It’s hard but it’s worth it. I needed it, there are days when I still need it and I think that the process that I’ve gone through because …when I was in the hostel I was seeing her every week and I did it for probably about a year and a half, but since then I’d been able to pick it up again as and when I’ve needed it. So when things got far too stressful for me and triggers started or I just started to experience more of the depression again and the other things that I suffered from, I’d been able to pick up the phone and say ‘I need help, now’ and she’d been able to get me in and see me again.’ (UK10)

**LT-S:** One respondent felt insecure about her ability to communicate with someone of a different ethnicity; however her counsellor was able to overcome this caution resulting in an effective connection, a necessity for on-going therapy. Other women attributed patience and understanding to their counsellors. Encouragement and support from counsellors were among quality attributes identified. Many respondents were pleasantly surprised by their experience and found they became stronger and were able to allow their emotions to be expressed without fear of reprisal or judgment. Respondents described starting to feel more positive with sessions becoming much easier; in turn, counselling was successful. Respondents felt as though they and their experiences became more important, were able to place themselves at the centre of the issue, and gained greater self-worth. This was attributed to the counsellors, their ability to make clients the focal point, and facilitate their ability to express themselves and work through their issues in a safe atmosphere.

‘I think that both group’s therapists were very supportive, encouraging, tolerant. With each of the counsellors I had different type of relationships, but overall the attitude was very understanding… It was interesting. Several things were very interesting for me. I think that before I had not thought about what is happening with me in such a way. I think that there probably was some theory behind why we did things in such a way and order. But at that moment it was not important. Was important to understand what is happening with me and other women. It was surprising that the issues collected for so long, for years, for tens of years start to unfold.’ (LT-S03)

**BG:** Two themes emerged from the data: empowerment and strength - improved feelings of self-worth and validation of self; and improved knowledge and awareness. Respondents had learned a great deal about domestic violence and the effect it can have on women, and this was instrumental in behaviour change. Moreover, improvement in self-esteem was said to lead to behaviour change.

‘One understands how meaningful and important one is. We are women experiencing the same problems…’ (BG02)

‘It was very beneficial for me to be heard and not blamed for all consequen charts of my marriage.’ (BG10)

One respondent was firm in her opinion that she would not change her attitude towards her abuser, but she had nevertheless received the support needed to be able to cope with her abuser’s drug and alcohol addiction;

‘I started thinking more about my own behaviour and utterance, this reflects on my husband. And when he starts drinking beer in the evening, I withdraw and go to take care of my own matters, and I stop paying attention - I have noticed we argue less.’ (BG06)

**IT:** Even without knowing the model or approach being applied, respondents assessed the counselling process very positively. Often respondents expressed loneliness and said the counselling session was a way of overcoming loneliness. In that regard, they also frequently mentioned the need to be listened to.

‘It’s linked a little bit with the method, isn’t it? I feel accepted, I feel listened to and welcome.’ (IT03)

The counselling process had an impact on overcoming loneliness based on the listening capacity of counsellors. But it was not a straightforward process; it was a process that takes place step-by-step, and this was assessed as a relevant guiding procedure for women experiencing violence.

‘I have my own ideas, but it’s always important to listen to other opinions. Then after, I decide on how to work on myself. However, at all times it’s vital someone from the outside who shows you another view. (...) I overcame the weakness that I had.’ (IT01)

**NL:** The majority of responses were favourable of the existence of such a process, because mainly respondents were enabled to face the world without fear. Respondents felt the counselling process impacted
on their decision to leave the violent relationship.

‘... after the counselling session, at the end, I was a totally different person who could face the world without fear.’ (NL09)

Summary: General perceptions of the counselling process were favourable across all countries. Two key themes emerged from the data: empowerment and emotional strength with improved feelings of self-worth; and improved knowledge and awareness of domestic violence and the effect it can have on women. Respondents in the UK stressed the need for clients to be willing to work hard with their counsellors, and that continuity of provision was vital in order to achieve maximum benefit. To be genuinely listened to were key features valued by clients in the UK and IT. An objective yet patient and sensitive approach with a slow and gradual progression were valued by respondents in LT and IT. A key aspect of effective therapy for clients in LT-M was the counsellor’s qualities. For clients in NL, counselling helped reduce fear, and improved strength to leave the violent relationship.

3.2.3 PERCEIVED ATTRIBUTES OF COUNSELLORS

UK:– Reciprocal respect between counsellor and client was highly valued by respondents. ‘Brilliant’, ‘great’, ‘understanding’, ‘amazing’, ‘supportive’, ‘encouraging’, and ‘patient’ were all adjectives used to describe their counsellors. Freedom for personal expression was also valued; often domestic violence has elements of control and subjugation, whereas in the counselling relationship, there is choice and lack of restriction. The work of the counsellor enables relief from feelings of blame and shame. There was an unambiguous contrast between the suffering and anger expressed by one client interlaced with laughter and joking; this has the capacity to normalise feelings and reduce anxiety.

‘She helped me see that there is a life and that the abuse that I suffered at the hands of other people was never my fault, which has been a massive thing.’ (UK08)

All respondents said they felt sufficiently confident with their counsellor to talk openly. Although there was an initial element of uncertainty and apprehensiveness, all said they swiftly relaxed into the relationship and were soon able to talk freely and confidently; the qualities of counsellors enabled this. Professional and personal empathic response of counsellors was crucial in building trust and respect.

‘There’s nothing that I wouldn’t be able to say, and then if I felt that there was an issue or I was upset about something, I know I would always be able to tell her as well, which I find is really, really good.’ (UK02)

LT-S:– Respondents were unanimous that they felt understood by their counsellors, and felt confident opening up to them either from the onset of therapy or during its progression. The counsellor’s ability to provide a safe, non-judgmental environment was integral to this feeling of safety. The outcome is that clients feel relief and comfort by going to therapy because they are able to express themselves without reprisal and, importantly, without abuse. This atmosphere allowed clients to understand and rebuild their lives without interference. The ability to ‘just be’ created an environment for development.

‘I had a feeling of security. And the situation is like it is, one cannot change it. I also understood that the more open I will be, the easier it will be for the therapist to help me.’ (LT-S10)

Clients had complete trust in their counsellors which differed greatly from past counselling experiences. As such, one respondent felt more expressive this time around and was satisfied with the results.

‘Somehow this time I had a therapist who I could trust, who allowed me to feel safe, helped me to find necessary answers. If I compare it with the previous time during those few consultations I received even advices on how I should act, and I think that made me protect myself because I could not follow those advices.’ (LT-S09)

LT-M:– Respondents said they trusted their counsellors: not just trust in the sense that counsellors will keep their disclosures secret, but rather trust in the sense that they know their counsellors understood their thoughts and feelings. Respondents trusted the skills of their counsellors. Two respondents developed a bond with their counsellor and as that bond strengthened, so too did the trust between them; this environment made the therapy successful. Another respondent felt a maternal connection to her counsellor and found her own voice through her counsellor’s words when confronting her own husband.

‘In that situation I felt she was like my mum, I could openly tell her completely everything.'
When I met my husband I was talking with her words and he was very surprised, and asked who has taught me that.' (LT-M04)

'I came here with a lot of hopes, high expectations. When I was offered psychotherapist help it felt like a shining star in the sky. I had my doubts whether I will be able to deal with it, whether I will meet all the requirements.' (LT-M02)

This is an example of a client’s trust in her psychological treatment and subsequent empowerment that emerges from specialist care and understanding.

**BG:** Respondents agreed on the positive strengths of their counsellors, in terms of honesty, trust, compassion, integrity, and having a non-judgemental approach.

'I have one counsellor. [Name] is very punctual, precise, direct, and thorough in her work administratively and verbally. Never saves the truth, whether it is nice or unpleasant, which helps to position yourself adequately, and be real.' (BG01)

Although most respondents had only one counsellor, some had more than one. Furthermore, counsellors were quite young, and operated within a multi-agency organisation which included legal and medical services. This arrangement appeared to be highly beneficial to clients who had to bring their children along to sessions.

'Both the lawyer and the doctor are from the same organisation, which makes things easier for me since there is nobody with whom I can leave my daughter. Something that impresses me a lot is the fact that during my counselling session, there is someone who takes care of my child and she is happy, draws and writes me notes. I am personally pleased with my both counsellors and adhere to all advices.' (BG11)

**IT:** At least four out of ten respondents had only one counsellor during the time they were being attended by the support service. An equal number had two counsellors or made no reference to the number of counsellors; so their assessment is only based on one person. Nevertheless, counsellors were seen as important in the healing process.

'She was very important, because she wasn’t intrusive but respectful. She helped me because she saw the situation from the outside, fairly, and when I needed support if I was insecure, she really helped me in this.' (IT01)

Some respondents referred to having social workers accompanying them. Respondents believed that counsellors were supportive and ‘present’ in their daily life. Counsellors simplified things and were practically-oriented about the way relationships should progress. Counsellors also had a positive impact on empowering women, granting them a new way of thinking about their violent experiences.

'I understood many things about me and also about him and his violence. And I always said: thanks to you that I understand this, no? But in reality they let me understand that is not thanks to them, but thanks to me, because it’s me seeing this, feeling this. I see myself in a different way. I perceive myself in a different way, but because they put me on this road.' (IT03)

**NL** - All responses tended to move in a positive direction. About half the answers shared the opinion that the counsellor was a ‘nice person’. One respondent was referred to another therapist to develop specific skills, something that was positively valued.

**Summary:** Professional and empathic responses of counsellors was said to be crucial in building trust and respect in clients in the UK and IT. The counsellor’s ability to provide an empowering, safe, non-judgmental environment was integral to feelings of safety in LT-S, BG, and IT. Counsellors in the UK and LT-S understood their clients’ thoughts and feelings.

### 3.2.4 THE THERAPEUTIC RELATIONSHIP BETWEEN CLIENT AND COUNSELLORS

**UK:** The positive aspect of trust between client and counsellor was a major issue for respondents, particularly when domestic violence had resulted in substantial mistrust of others. The relationship was important in helping clients to channel their negative thoughts into more positive and enjoyable outlets. The listening skills of the counsellor contributed to a good therapeutic relationship, and in some cases resulted in suicide prevention.
‘Well when I first came I was, to put it bluntly, I was a mess. I was always, always, always shaking. I would always fidget or I would always be messing with my hands and my legs would always shake. I was always so nervous, I couldn’t concentrate, and I never could make eye contact because I was always so nervous of new people and throughout the sessions she would be able to help me calm, be calm, and to be able to trust, is always a massive issue with me. To be able to trust new people just because I felt that in my life, no matter who I’ve trusted, it’s always come back on me and it’s always been, it sounds stupid, but it’s always turned into an abusive situation for me so trust is always a massive issue. So I never know what I’m going to face, so I’ve always been really nervous of new people. So with my counsellor, it was kind of like, I never knew how far I could trust her. But over the first few weeks, it was kind of there like that.’ (UK02)

The ways in which positive support from counsellors resulted in reduced feelings of self-blame was an important element of the relationship respondents had with their counsellors. Importantly, the depth of the relationship improved over time and it was only with continuity and constancy that positive outcomes developed. The high level of understanding and support provided by counsellors was not undermined.

‘I think it is important because obviously the more that I’m seeing her, the more comfortable I am with her. And obviously the less I’m holding back because I very much question everything I say, before I say it. That’s being less of an issue now because I know her and I’m comfortable saying what I think I need to say to her. So I think the therapeutic relationship, as it grows stronger, the counselling and disclosures from me will continue to improve.’ (UK05)

LT-S:- The therapeutic relationship between respondents and their specialists was integral and meaningful for respondents. All of them took comfort in having someone who understood them. Even if they did not see the specialist anymore, just the knowledge that someone understood sustained them. Those who were unable to divulge much at first praised their specialists for being able to help them disclose by using prompting questions that did not cause any discomfort. Counsellors helped them find answers they were searching for. Because they felt confident in speaking to their counsellor and because they felt understood, they felt confident and understood themselves better. Many claimed that if not for these relationships with counsellors, respondents may have stayed in their abusive relationships; the relationship with counsellors was able to help them cut the connections between client and abuser. Respondents were conclusive in their view of the professionalism of their counsellors. The main point made by all respondents was the trust they felt towards their counsellors, how their counsellors made them feel safe; it was about being able to talk about their experiences in a safe non-judgmental environment.

‘Now in my life I have two such people, who I will definitely not see every day, but it is important for me to know that they exist. I have gained wings. On one side is the group therapist, on the other a doctor (...) That gives me the feeling of security. The doctor is from different professional area, but anyway, I often think about the group counsellor. When I feel bad, and I know that I will soon feel really bad, that I do not know how to cope with it, I can call or visit her. And that calms me, and things get solved somehow, and things change. I want to deal with it by myself, but they give me the security feeling. And during the group therapy was the same – you think and do yourself, but you have the feeling that you have someone near you and you will have support, if needed. These relations were very important – trust, belief that this person will understood. I liked how she spoke, asked questions. For me it is very important to be able to trust and believe, and I received it here in Skalbes.’ (LT-S02)

One respondent compared her relationship with her therapist to that of a student and teacher. This was because one of the most beneficial aspects of the counselling process is that it provides the tools necessary for women in abusive relationships to move forward effectively with the necessary knowledge to avoid future violence and maintain confidence and autonomy. This approach can be attributed as being effective at decreasing the risk of return to abusive relationships.

LT-M:- The development of the client-counsellor relationship was just as integral to the success of treatment as the client’s willingness to seek and work towards change. The professional approach coupled with an objective perspective was an important aspect of client recovery as the counsellor, while providing therapy also acts as a beacon of hope for clients. However, the specialists ensured that the feeling of empowerment was one which is steadily developed in clients. Two respondents stated that the understanding and independence attributed to them by their counsellors made it easier for them to accept their ability to make their own choices.
'Until now, I had the experience that the staff / specialists condemn me, that I do something wrong, and now I was afraid to face that again. Here the specialist allowed me to make mistakes and do something wrong, because I do it in a way I do it, and that is my choice.' (LT-M09)

Also, one respondent maintained that the level of independence attributed to the client by the counsellor created a positive challenge in that sometimes she wanted her counsellor to point out all her issues for her, but she was always confronted by the fact that she had to determine issues for herself, a concept she was currently struggling with.

'I liked most how the therapist works at Marta. Sometimes I would have liked that she more directly points out to a situation or my difficulty; but I always received an answer that I have to do it myself.' (LT-M05)

Respondents demonstrated an appreciation for this approach in that they were now more self-reliant, and especially confident that their counsellors would be there for them regardless of how they chose to proceed.

BG:- All respondents stated they had sufficient trust in their counsellors to be able to talk openly about their problems and about the violence that had impacted them.

'From the first time I share everything freely, I don’t feel uncomfortable; on the contrary: I realise that there are much more severe cases than mine is, and I am even afraid sometimes that I might be wasting your time. On the other hand, I understand the delicate nature of family relationships and that a person could be emotionally abused as well.' (BG06)

However, two respondents claimed they had not felt so confident at the outset of therapy due to feelings of shame and guilt. However, over the course of time, these feelings dissipated and trust was built with the counsellor which enabled open disclosure. Respondents realised that the relationship with their counsellor was open, honest, genuine, trustful, and dynamic; there was a transparency that rendered clients no longer embarrassed to speak about their experiences and to talk in depth. Yet there is still a sense that the relationship takes time to develop.

'It makes me relax and talk about the things close to my heart. Transparency, openness, and honesty. Sincerity is not for the first date.' (BG02)

One respondent provided an example of the impact of her relationship with her counsellor whereby, at a time of crisis, she remembered the advice her counsellor had given, felt immediately empowered, and altered her behaviour accordingly. The result was a positive outcome. Respondents were in full agreement that they felt understood and supported by their counsellor.

IT:- Respondents felt very comfortable with their counsellors, having developed a trustful relationship, in most cases, from the beginning of the process. The word ‘free’ was repeated often in their opinions of their counsellors. Part of that trust was also a reflection of feeling welcomed and accepted. Not all respondents shared thoughts about the therapeutic relationship; those who did based their thoughts more on the relationship between them and their counsellor than on the therapeutic claim of it.

'Now I have realised and am aware that I don’t want to be hurt by no-one anymore, and moreover I realised and saw the link between me and [counsellor’s name], apart from the esteem, the respect and the gratitude, now I am conscious there is a lot of affection and it’s very nice this; I am happy to have understood this positive feelings I have towards her.' (IT04)

Therapy helped respondents re-think their opinions about many events and contexts framing their lives. The ability to talk about their feelings, and of being listened to, made a difference to respondents’ perspectives. The therapeutic relationship made women stronger and capable of standing independently.

'No one can’t hurt me anymore (…) I am aware that a lot of things about reality are coming out, that show to me my path from another sight.' (IT04)

Respondents mentioned that, during the counselling sessions, they could express themselves without shame; they felt understood. This feeling was not always felt about other professionals who could play a significant role in supporting women escaping domestic violence (namely statutory social workers); one woman mentioned that social workers were not comprehensive about the way she was treated by her partner, clearly not understanding the human rights violation dimension they were facing.

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1 Note from translator - there is an old Bulgarian expression which, literally translated, means ‘Sincerity is not for the first date’; it means that disclosing to others requires time.
COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING: COUNSELLORS AND CLIENTS

NL:-- One respondent referred to the difficulty of establishing a relationship of trust at the beginning of the therapy, demonstrating the need to pay special attention to the construction of a therapeutic alliance in the early stages of the process, particularly among clients who demonstrate difficulties in sharing stories that had been hidden for quite some time. This need for trust was demonstrated when respondents were questioned about their ability and trust to talk openly about their problems. One respondent referred to lack of empathy in the therapeutic relationship, the client stating that the therapist annoyed her for constantly looking at the time. The majority of answers reinforced the importance of the therapeutic process and the good relationship established with the therapist. Some respondents felt that specific behaviours of their counsellor (such as aggressiveness) also contributed to the establishment and development of the therapeutic relationship.

‘Sometimes I have the feeling that she is very hostile, but at the same time she is very nice. I guess that is the way she wants to deal with me.’ (NL01)

Moreover, there was some confusion of roles presented by their counsellors.

‘She was listening to what I had to say. She assisted me to have a temporary income from the welfare office.’ (NL02)

‘It becomes as my good friend, I think it is important for my progress.’ (NL03)

Respondents attributed importance to counsellors’ expressions of comprehension as well as the feeling of being heard. The vast majority of respondents showed that they felt understood and had the opportunity to talk freely. The problems pointed out seemed to be rare and mostly where the therapeutic relationship was not valued.

Summary: The therapeutic relationship between clients and counsellor appeared to be integral to the counselling process and meaningful for all respondents across countries. In addition, the trust that comes with being understood at a deep level was shared across countries. Importantly, the therapeutic relationship was perceived as a means of suicide prevention for clients in the UK as well as enabling clients to sever the bonds with their abuser in LT-S. The key element to successful positive and effective therapeutic relationships was that they develop gradually.

3.2.5 TIME, FREQUENCY AND DURATION OF THERAPEUTIC PROCESS

UK:-- Respondents were at different stages of counselling, having been in counselling for between four weeks and eighteen months. One respondent had known when it was time to end the counselling. Frequency of support sessions was normally once a week, which appeared to be sufficient. However, there was also an understanding that, although it would be beneficial to have additional sessions, there was a corresponding need not to become too dependent on the counsellor.

‘It’s once a week. I do feel it’s enough because I feel... I do and I don’t. I do in the sense that I know when I come to counselling, it’s been like 7 days and I’ve got stuff that I need to, not need to but I discuss what’s happened, how I’ve felt in the past week. But there is times when I do feel that ‘I wish I could talk to my counsellor right now’, but then I suppose again from another point of view it’s not having that dependency because obviously the counselling at some point is going to come to an end, so I need to not be dependent. I need to at some point not feel the need to have that understanding from the service.’ (UK05)

There was also a large degree of flexibility in the frequency of appointment sessions. For some clients, counselling began weekly but then declined gradually in a staged approach (fortnightly, monthly); this appeared beneficial for some clients whilst, for others, fortnightly sessions were changed to weekly once trust had built up or because the violence at home was escalating and additional support was required.

‘One of my sons started off with weekly sessions, then fortnightly, then every 3 weeks then once a month. And then his counsellor said, ‘I think he’ll be OK but I’m going to keep his file open for a little while, leave him and see how he gets on. If you need an appointment, then just phone.’ (UK07)

LT-S:-- For most respondents, the amount of sessions and length of therapy varied. However, the frequency of therapy was relatively similar in being once or twice a week, once every two weeks and then once a month as therapy progressed. This sequence of counselling was evident in statements of most respondents and signified uniformity in routine and effectiveness of therapy. The frequency for consultations under one year was optimal at weekly, then monthly after a year of consultation.

‘Actually quite long. In total almost two years...In the beginning the individual consultations
and the group was once a week. Afterwards we saw each other for a year once a month. At first it was really necessary to have the meetings often. With every time I felt a little bit safer. And then that work brings better results. I think the frequency of meetings was adequate. More often was not necessary, and it would also be too difficult to travel there.’ (LT-S05)

Two respondents complained that they wanted to continue the therapeutic process and found the amount of consultations insufficient, because they felt safe in the counselling environment and group therapy, and this safety did not continue when they left the counsellor and returned to their regular lives. In essence, they were not prepared and did not have a chance to fully internalise the skills necessary to move on.

LT-M:- Three clients received counselling for six months, one for two months, one for one month, while the remainder had an average of ten consultations each. The frequency in most cases was weekly.

‘Six months. We meet once a week and it has not changed. For me it is optimal.’ (LT-M02)

Four respondents maintained that they would like to continue the sessions while one stated that she was satisfied with the number of sessions she received.

‘I came here for a month and then the specialist worked a little bit with my child. My problems started to resolve successfully and I did not need help anymore.’ (LT-M04)

BG:- The length of therapeutic support received ranged from one month to 12 months, with most respondents having been in therapy for four months at the time of interview. There were no fixed times for counselling to occur, rather it was needs led. Counsellors made themselves flexible for extra sessions when necessary. At the outset, sessions were more frequent to provide important assurance and support. Later, sessions become less frequent. Once or twice a week was the average frequency of sessions, although fortnightly sessions were attended by some respondents.

IT:- Three respondents received psychological support for approximately one year, one for two years, but the majority had been supported in excess of two years. One respondent had received support for ten years, although she had to interrupt temporarily due to illness (without specifying the duration). Two key results emerged from the frequency of support sessions. At least four respondents had received weekly support; and there were cases where the frequency changed over time, being more frequent at the beginning of counselling (weekly) then progressing to monthly. It was also mentioned that session frequency changes according to many things. At least one respondent also received support within group sessions. The vast majority felt that session frequency was right.

‘This is fundamental, it’s important the continuity in this kind of therapy.’ (IT04)

Nevertheless, some mentioned that if they could choose, they would probably prefer to have more frequent sessions.

‘Logically, selfishly, if I could have more, this could be useful for me. In fact, for example now we stayed almost three weeks without meeting, I felt bad. It’s because she becomes a key figure... she becomes as a person of your family, or in any case a support.’ (IT02)

NL:- One criticism of the counselling process had to do with its slowness, despite its efficacy. Respondents’ counselling processes had a length that varied between six months and two years. In general, sessions started out weekly (even though for one respondent that frequency was higher), after which sessions fell into fortnightly and then monthly intervals. Nevertheless, one respondent valued more the learning and support found in contact with other women in the same situation than the benefits gained through the therapeutic process.

Summary: Respondents had been in therapy for between four weeks (UK) and 12 months (BG), although one client in IT had received counselling for 10 years. There was generally a large degree of flexibility in frequency of counselling sessions in the UK, LT-S, BG, IT, and NL. For many clients, counselling began weekly but then reduced gradually in a staged approach (fortnightly, monthly). Overall, one year was the optimum duration of a successful course of counselling.
3.2.6 CLIENTS’ INVOLVEMENT IN THE DEFINITION OF THERAPEUTIC GOALS

**UK:** In the main, therapeutic goals were defined by the client but the counsellor helped in articulating their issues. So although goals were client-led, they were jointly developed and agreed between counsellor and client. For one client, therapeutic goals were set by the client.

‘Goals were defined in the sense of [my counsellor] asked when we had our first session, actually it was the first two, we talked over stuff and [my counsellor] kind of got a spider map on the go of different things that I mentioned and then she asked me to write down what I want to change about myself. So goals in the sense of my goals, what I want out of the counselling have been defined...no, it was all me.’ (UK05)

**LT-S:** For most respondents, no specific goal was defined at the outset. Most respondents just did not want to go back to their abusers. Many stated that goals developed over time, but at the onset of therapy the idea of creating goals was obscured because they were too emotionally damaged and upset to focus. The setting of goals was difficult for women to do during the initial stages of therapy. The most important thing for them was to be able to escape their immediate situation and gain immediate help.

‘Probably was, but I do not remember. I felt that attitude and that it is visible that results will come. That they maybe will not be tomorrow but they will come. I am generally very ambitious. I remember only that moment when leaving my husband became my main goal. And then see what happens further. One cannot predict everything. My goal was to get out of that situation, but I did not know myself how to make those small steps, what and how to do, I needed help for that.’ (LT-S10)

The patience of counsellors was crucial if goals were to be created by clients. However, counsellors were able to facilitate an atmosphere whereby clients could formulate goals later. For those who did formulate goals, counsellors made sure to revert and re-evaluate regularly for consistency. All respondents except two had determined their own goals.

‘Yes, I had a clear goal – I wanted to feel different, without the ‘black holes’, and I wanted to be able to act differently with my children, not to shout at them, to not be so unrestrained.’ (LT-S09)

**LT-M:** Four respondents specified that at the outset of therapy there were no set goals, because at the time clients were distressed, confused, and unable to determine what they wanted in the future. Instead, they came to the service with the immediate goal of assistance as opposed to long-term plans.

‘When I started seeing the counsellor I was so confused that I did not define any goals. The goals came up during the process and the conversations. Now I know better what I want.’ (LT-M08)

As the process of therapy continued, goals became more distinguishable, and clients were able to ascertain what they wanted for themselves in the future. More importantly, respondents emphasised that goals set out during therapy could only be set by clients, as this is integral to establishing their independence. Goals were subject to change since the thoughts, feelings and development of clients evolve over time and new goals arise. Moreover, respondents said that specialists emphasised that the focus should be kept on the clients themselves, since they are their own advocates and affect the environment around them.

‘The specialist encouraged me to choose conversation and consultation topics. I wanted to talk more about my children, but the specialist encouraged me to talk about myself.’ (LT-M05)

Respondents affirmed that clients set their own goals and topics of discussion, and the counsellor was there as a form of assistance. The emphasis of counselling on independence and freedom of thought whilst providing a solid support system for clients’ thoughts and actions was at the core of the approach.

**BG:** Rules of engagement and goals of therapy were clearly defined at the beginning, and goals were met through small steps. Goals were defined by either the client or the counsellor, or jointly.

‘Very easy and simple steps were taken in the beginning set by my counsellor.’ (BG01)

‘Concerning the problem, there were mutually agreed specific goals with well-defined steps. These were my ideas.’ (BG04)

‘The rules and goals are well defined by the counsellors.’ (BG07)

**IT:** For all respondents, no goals were defined at the beginning of psychological support. Most respondents...
stated that the establishment of goals was achieved step-by-step along the support process.

‘Step-by-step we set goals, topics which I have to think about also at home. I suppose at the beginning we were vaguer, but when we are faced with some issues, we try to tackle them.’  
(IT05)

Some women felt that by not defining concrete goals there was no definition of the process; this left them doubting counselling itself. On the other hand, respondents felt that by not defining rigid goals, they were able to talk about relevant things they faced daily. There also appeared to be confusion around goals of psychological support and the client’s goals for short-term life prospects.

‘Well, I had few goals and I didn’t really believe in them, now I can say I have real goals… but when I arrived here I didn’t know if I did right or not in lodging a complaint against my husband, maybe I created a lot of problems coming here, maybe I could solve everything. I didn’t love myself. Now I have goals, now I know I can be happy, although I am still not very well.’ (IT07)

NL: Only one respondent stated that goals were not established jointly. However, the majority of responses pointed to an unclear notion that objectives were jointly established. The lack of information can markedly influence perceptions of the therapeutic process.

‘Sometimes I did not understand anything. It was like she wanted to hurt me, by asking these questions that reminded me of the physical and mental abuse.’ (NL01)

It can be observed in this expression that therapeutic goals might not have been sufficiently clarified, and that communication channels might not have been strong enough so that issue would not be discussed. The approach to traumatic situations is one of great sensitivity and it becomes fundamental for such an approach to be framed within the therapeutic model in a way that may have meaning to the client and not just the idea that what is being discussed is difficult and pointless.

Summary: Across all countries, clients perceived their involvement in defining therapeutic goals as highly important in ensuring success. Although therapeutic goals were described as client-led, counsellors in the UK, LT-S, LT-M, and BG shared in the formulation and articulation of those goals, therefore they were jointly developed. For LT-S, LT-M, and IT, no goals of therapy were defined at outset; they were developed in a developmental process over time. Goals were generally subject to evaluation and alteration throughout therapy as clients change within that process.

3.2.7 CLIENT EMPOWERMENT AND DECISION-MAKING WITHIN THE COUNSELLING PROCESS

UK: Respondents particularly valued counsellors being truthful and honest, non-judgemental and supportive. There was a high autonomy in clients’ decision-making. Counsellors expressed no judgemental attitudes within therapy, even when clients blamed themselves for the violence. Counsellors were said to want to support their clients in moving on and choosing their own life options.

‘Very supportive, she was challenging when she had to be, so if she could see me doing something that maybe she could see wasn’t in my best interests, then she would voice her concerns. If the situation would call for it, I think sometimes she was that voice of reason, to help me see that maybe I shouldn’t be doing it that way, what would happen if you did it this way? But she was just generally supportive with anything that I was doing, any decisions I was making.’ (UK10)

Domestic violence has elements of control and subjugation so in the counselling context it was imperative that clients were allowed to regain personal control and autonomy in current and future decision-making. Even though it was understood that decisions may later prove to be right or wrong, counsellors respected clients’ decisions. Counsellors were said to encourage clients to make their own decisions, that what the client wants is what matters, and the counsellor’s opinions do not matter; they encouraged their clients to be independent.

‘Because they were my goals, during the counselling they kind of triggered a lot of things and the goals that I chose were correct for me, and they were my goals, somebody didn’t set those goals for me. If somebody sets it for you it’s like putting a condition or an expectation and I’ve come from a background where expectations were always put on me and I hated it, I absolutely hated it. So if she did expect me to do something, I don’t think I probably would have done it. And because I set it myself, I did it.’ (UK04)
However, there were times for some respondents when their counsellor could see behind the defences clients had needed to create to cope with violence and abuse. At these times, counsellors encouraged clients to talk about things they did not necessarily want to talk about; this was viewed positively by clients.

**LT-M:** Support, encouragement, and understanding given by counsellors were identified by all respondents as facilitators for internal analysis. Two respondents stated that the help and direction were given invisibly, in the sense that the counsellor tried to give some direction without directly imposing it, which might have had the effect of violating their decision-making and autonomous position.

‘The specialist supports and respects my decisions, but invisibly she tries to direct them in a direction that is good for me. When I see the results, I understand that there has been some movement.’ (LT-M03)

This was effective in that respondents were able to be self-reliant in conjunction with being given the help they needed to find confidence in themselves and their decision-making abilities. This marked a delicate balance struck between counsellor and clients, which was effective.

**BG:** Very supportive, non-judgemental, positive, tolerant, patient, objective, and completely natural, were all adjectives used by respondents to describe their counsellor’s attitude towards their decision-making.

‘Very supportive, optimistic as well as realistic and outlines all the directions in which my decisions can go.’ (BG01)

Most respondents had the courage to talk and decisions were very much client-led. Their counsellor encouraged them to think and speak about what they wanted from life, yet also advised how to successfully reach their potential.

‘Yes, and I think this is the point of the whole counselling. Additionally, I don’t feel like I am given direct advice, neither like things are shown to me against my will, nor like I am presented with direct solutions. No, I don’t think the counsellor determines my outlook on life.’ (BG06)

However, one respondent, a senior citizen, held little hope for the future and little motivation to plan ahead.

**IT:** According to respondents, most counsellors demonstrated strong empathy towards clients’ life decisions. Nevertheless, time taken by psychological support played a role in changing counsellors’ acceptance of clients’ decisions. Although counsellors did not seem to impose any decision, they did express their reservations or concerns.

‘In so long a period it’s clear that there has been some change, but there has been because I was changing myself, so about some decisions which I thought were right, at the beginning (anon) didn’t agree, she made me understand, in a very calm, clear and polite way; from the beginning there has always been this kind of listening, I noticed there was attention but also she didn’t agree with my choices; now the relation has changed.’ (IT04)

Counsellors led the way to self-reflection, perceived as a positive feature of counselling. Counsellors were trusted by clients and looked to them for guidance. However, respondents strongly stated that when giving guidance their counsellors always valued women’s opinions and decisions. No respondent felt that her counsellor made choices for her. Instead, they said they were encouraged to think and to speak frankly about their own decisions, feelings, and opinions.

‘Sometimes I thought she could have some supernatural intuitions, that she pulled the best out of me, because actually today I feel good.’ (IT06)

Importantly, counselling sessions were spaces of freedom of thinking and feeling. Although having gone through difficult times on their own, respondents had never had difficulty in understanding their counsellors. When there were problems to be solved, they solved them immediately. Nevertheless, there were times when some misunderstandings developed, making the relationship between counsellor and client uncomfortable and in need of a boost of trust and confidence. In those tense periods, women gained awareness about their situation and took a step forward either in their therapeutic relationship or in their re-conceptualisation of life.

**NL:** Respondents all felt understood, and the therapists’ professionalism was also praised.

‘She was supportive and gave me the feeling that she believed in the options I chose. When I trusted her we could understand each other and she supported me.’ (NL02)

‘Her attitude was professional, polite, and nice. She respected and supported my decisions related to my life options.’ (NL05)
3.2.8 THERAPEUTIC SUPPORT FOR CHILDREN

**UK:** For those who had children living with them who had also accessed counselling from a children’s counsellor, it was found that empathy was an important element in supporting children; children needed connection on their own level which resulted in positive experiences for children. Some children needed counselling as a vehicle by which to vent anger that had built up inside due to hopelessness and helplessness to influence the violence and abuse at home.

‘My son’s counsellor was great, he didn’t act as though he was higher than him, they spoke as they were on the same level. He never said ‘you should do this, and then do that’. I would be sitting in the waiting area some days and all you could hear was laughing! Seriously, you could just hear them laughing. He was so good. I think everything was done on his level; it was never like ‘I’m older than you so you’re going to do it this way’. It seemed to me like it was always done on his level and I think it was that which made the difference to be honest. It wasn’t just another adult telling them what they could and couldn’t do.’ (UK07)

However, cultural issues impacted on the ability of some victims of domestic violence to access counselling, especially when children were involved.

‘Now when we’re talking counselling, maybe I should show him, get him to speak to a counsellor…but then I’m afraid that he’ll go off and tell everybody and they’ll probably start questioning me, ‘why have you started taking him there, is he a crack head…has he gone mad or mental, that he needs counselling at that age. That’s what it is, that’s the other reason why I didn’t tell my family. They just don’t see counselling as….they just think there’s something wrong with you….I think with the Asian culture they just expect everything to be within the 4 walls, within the family and no outsider has the right to intrude in our lives and we sort it ourselves.’ (UK04)

**LT-S:** The children of two respondents received therapy, although one was dissatisfied with it.

‘My daughter went to sand play therapy. But I don’t know, somehow I wasn’t satisfied with it. Yes, she went there, she occupied herself, but I think she just enjoyed the chatting…building things. About my son – I don’t know… just don’t know, what he needs, being 12 years old, to understand what needs to be done to make everything better. Maybe it could help after all, but I don’t know, I wasn’t satisfied with them going to therapy. I didn’t see any results. Maybe I didn’t see them for myself. I didn’t see that they have changed somehow. My daughter did become closer to me, but I was expecting a different outcome. But on the other hand, they are children, they don’t understand a lot of things yet, they don’t want to understand. Maybe when they are older, all of it will be different.’ (LT-S01)

Two other respondents said they brought their children for one session of sand therapy. One respondent had a son who was too young for therapy. However, she was giving him support through what she learned during her counselling. Furthermore, she was going to family counselling with her family but this was not directly related to violence. One respondent’s son followed ten consultations at Skalbes.

**LT-M:** Six respondents stated they had brought their children to receive therapy. However, there was no further expansion on the outcome of therapy. One respondent did not answer the question and the remaining four did not seek out therapeutic support for their children.

**BG:** Just over half the respondents said their children did not receive any support, with only one of these providing a reason.

‘No, here I learned that children should not always be taken to specialists. I have suffered much during the trials. I have too much expertise, but my children need more love and support. Children are my responsibility.’ (BG04)
Of those who indicated that their children had received support, provision came from specialist psychologists and educational assistance.

‘He was counselled by a specialist psychologist. However, thankfully he did not need to continue counselling for a long period of time. Fortunately, he has no deviations and despite the many emotions, he develops well.’ (BG10)

**IT:** Eight respondents had children, mostly adult children, the majority of who did not receive any psychological support.

‘No, for now, unfortunately, no. In fact for the little girl it would be useful, because she has personally experienced the whole thing.’ (IT02)

Only one woman had arranged for her three children to go to a statutory psychologist. However, her experience was so bad that she turned to the private sector, and this had a strong impact on the family budget. One woman received psychological support for her young child. It seemed that most younger children as opposed to older children received some kind of psychological support, either within the support service where the mother was a client, or outside that service.

**NL:** Of the seven women who had children, two did not want any kind of support for their children and the remaining had different kinds of support.

‘My oldest daughter went to training how to deal with domestic violence as a child. The others went to a playing counsellor where they could express their feelings like a game, playing the home situation. Later, me and the kids had some sessions together.’ (NL05)

**Summary:** The extent to which female clients of counselling had sought and received counselling for their children was mixed. Negative experiences and dissatisfaction with previous counselling for their children were expressed by some respondents in LT-S and IT, whilst for clients in the UK whose children had received counselling from a children’s counsellor, empathy was an important element as children needed connection on their own level; this resulted in positive experiences for the children.

### 3.2.9 DIFFICULTIES ENCOUNTERED WITH COUNSELLOR

**UK:** Respondents indicated no difficulties with their counsellor and there was clarity and understanding in everything. The accent of the counsellor caused an initial difficulty for one respondent but this was soon overcome. There were no difficulties perceived in children’s counselling.

‘I’ve never had one session when my son’s come out with his counsellor and he’s come out angry, where he had a nasty mannerism about him...there was nothing like that when he went to see his counsellor.’ (UK07)

‘Not really. To start with it was a little difficult because she had an accent that I had to work out but once I got used to that, there was no problems. I think to start with there was a lot of ‘could you say that again’ but no, no misunderstandings.’ (UK10)

**BG:** Respondents experienced no difficulties in understanding counsellors, and for some this was because the relationship was always specific and precise.

‘No, in most situations, we always had the possibility to discuss and explain things further when necessary. On the contrary, I shared with ease, maybe because from the beginning I was left to fully unburden my heart. I remember that I was angry, although now I can’t remember about what…I was surprised that I was left to talk without being interrupted.’ (BG10)

**Summary:** No specific difficulties were found to exist between clients and counsellors in the UK, LT-S, LT-M, BG, and IT. It was said there was clarity and understanding between both parties in the UK, and that therapeutic relationships were always specific and precise in BG.

### 3.3 THERAPEUTIC PROCESS OUTCOMES

Overview - This section of the comparative analysis examines perceived outcomes acquired through counselling and therapeutic support, and to know if and how women felt empowered by that support.
3.3.1 POSITIVE PERSONAL OUTCOMES OF THERAPY

**UK:** The key themes to emerge regarding positive personal achievements from counselling were: perceiving a future after feeling suicidal; being more confident and positive about oneself; and lessons learned and generalised to everyday activities and problems, including not returning to the violent relationship.

> ‘I know it probably sounds dramatic but I would say that it saved my life because I went to the point that I wanted to not be alive, I really did not want to be alive. Because I wanted peace, I wanted peace from everything and I wanted to just lie there and go to sleep...I just wanted to lie down and go to sleep and never wake up. So without my counsellor, I wouldn’t be here because at that point in my life when I walked into the room that day, I did want to die.’

(UK08)

> ‘Had I not had this counselling, I’d still be in the same situation, exactly like I say, I may have even gone back...therapy has had a real effect on me that has been positive.’ (UK03)

On a lesser scale of severity but not importance, themes included: planning ahead for the future; going into education; and improvement in children’s sleeping, eating, school work, trust, and confidence.

**LT-S:** Respondents had a calmer, more sensible approach and were able to put even the darkest of days into perspective. They were not so worried about themselves anymore, and were more able to focus on their children and worry about them without overdoing it. They did not feel as much stress when it came to confrontation and can now take an effective stance against aggression. Feelings of helplessness had dissipated and they no longer felt as lost as they used to. The impulse to panic had gone, and mentally they were able to take a deep breath and analyse their situation, an ability which was lacking before but which had developed through self-analysis and reflection facilitated by therapy.

> ‘Yes, definitely. I am much calmer. And at the same time more active and jovial. I feel better. But the most important is that I do not blame myself anymore, that I realize that I do everything as good as I can, and if I make mistakes it is not the end of the world. I do not feel useless anymore, how it was often before the counselling process. I live like I can, and actually I can do a lot.’ (LT-S09)

Respondents were also conclusive on the issue of not feeling helpless and having a more positive outlook. They described a decrease in dependence on their partners as well as a notable decrease in pessimism as it related to ‘me versus the world’. They let go of their former guilt and were able to proceed through life more freely since they did not think that everything they do will have inherent negative ramifications.

**LT-M:** The ability to communicate with loved ones and members of the outside world with a greater sense of security was one positive outcome of therapy. The loss of a sense of hopelessness in exchange for rejuvenated sense of self-worth and willingness to live was achieved. Seeing the positive things the world has to offer instead of negativity was an important perspective gained, as was the ability to clearly ascertain who they are and what they need.

> ‘I had a feeling that it is not worth living and the specialist helps me to overcome it, shows me why it is worth living, and that I am necessary as much as other people. I have not taken wrong decisions. She teaches me not to put myself grades for every step I take. There starts to appear other colours in the black-and-white world. There cannot be negative ones. For me the most important is to get back into the present and not live in the past. Thanks to the specialist I have started living again. I have difficulties taking decisions at the moment, but I try doing it myself. The specialist respects it.’ (LT-M02)

In terms of moments of doubt, uncertainty, and weakness, memories of the counselling experience acted as a safety net, as if to remind respondents that they were not alone and that they had already discussed these doubts, so respondents were able to dispose of doubt and tackle tough issues as they come.

**BG:** Clients felt more empowered with new perceptions of self; the realisation that there were other women and children in similar positions as themselves resulted in knowledge that they did not suffer alone; family bonding was a positive outcome and family life had improved; positive impact on their children’s development had been invaluable.

> ‘It was helpful because I became able to see myself in a different, more individual, and independent light at this crucial and important stage.’ (BG01)

> ‘I assert my position as a parent, as a mother. I successfully kept my child next to me this holiday. Every year they take my child away – my husband takes the kid to his mother by the
countryside, he says he would be back in time, that we will be together for the holidays, but every year he comes back after New Year. However, this year I kept my child with me, they wanted to take it in the car, but I kept him. We were happy, we were waiting for Santa Claus; it was very nice.’ (BG03)

**IT:** Respondents assessed psychological support outcomes only in a positive way. There was consensus in affirming that counselling helped respondents considerably; it made a difference to their lives, and in the way they now see themselves and the world around them. It also contributed to putting aside feelings of shame. As a main outcome of psychological support, women rediscovered themselves and redirected their feelings.

‘It was really helpful because it has encouraged me to talk with people without the shame of being judged.’ (IT10)

The support they received also contributed to breaking the relationship and to change the way they viewed their violent partner.

‘As a result...break away from him and break away from that illusion I had about him.’ (IT07)

Through support they conquered their fears, in particular related to the violence, and gained strength. Although freedom was a frequently emerging word, eight out of ten women did not respond to the question about the option to make decisions freely, whilst the other two women responded positively.

**NL:** With the exception of one respondent who mentioned that her biggest support came from other women in the refuge, respondents stated that the therapeutic process was very useful.

‘It was very helpful. The result is that I have learned to see what my situation was. I always thought it was my fault, but it is not. Now I can see clearly what has happened to me.’ (NL01)

Other outcomes included less stress and more self-confidence, willingness to get out of the violent context, more emotional autonomy, getting perspective on the future, and empowerment.

**Summary:** In a hierarchy of frequency of personal achievements and positive outcomes of therapy (with the most frequent first), respondents experienced the following: increased self-esteem and self-worth; confidence and empowerment; being able to separate from the violent relationship or otherwise deal with aggression; improvement in children’s attitudes and behaviour, and family bonding; reduced stress and feelings of shame; having a more positive outlook, and feeling happy and optimistic; seeing and planning a future, and wanting to live; reduced feelings of hopelessness, helplessness and of being alone; increased and generalised problem-solving skills and communication; greater security and freedom; and going into education.

### 3.3.2 DECISION-MAKING

**UK:** All respondents stated that they felt free to make their own decisions as a result of counselling. No-one stated that their counsellors imposed their own views; rather counsellors respected their clients’ views and decisions.

‘I’m responsible, I feel stronger making those decisions, I think more about what I am doing, or what are we doing. Yes, a lot more positive, I don’t feel as if I’m hiding or walking on eggshells. It’s just utterly, whatever decision I make, whether right or wrong, I benefit from them.’ (UK06)

Respondents overall had previously been very poor at making decisions, but now that they had grown as a result of counselling, they now had to decide what was right for them. So there was a sense that therapeutic support had given respondents the ability to make their own life decisions. But there were a few occasions in which respondents stated that decision-making did not yet came easily, usually due to the long-lasting and persistent form of abuse they had endured for many years. Some respondents were still on the journey of growth.

‘It doesn’t come 24 hours a day sometimes but I sit and I think ‘I need get that work done’ without thinking someone’s coming through the door. But it is 30 years or something, it’s not going to go in two or three months.’ (UK03)

**LT-S:** All respondents claimed to feel more confident in their ability to control their lives and make decisions. They understood that challenges will arise but these should not be challenges that they create themselves but ones that they overcome if and when they appear.
‘Yes, for example, I have gained complete confidence, and I know I can deal with everything on my own...I can achieve everything myself. And I definitely will achieve. Definitely, I already want to go and get my driver’s license. I want to. While I was living with [name], I didn’t want to, and he kept saying, “Why do you even need that?” But I want to. A small car, in which I can put my kids, and myself. Well, I have started to aspire for something. Certain goals have appeared. I want to achieve something.’ (LT-S01)

They had also developed new goals that they will not allow to be impeded by anyone else.

**LT-M:** Respondents did not appear to be pushed into any particular direction by their counsellors, and though some expressed difficulties in their ability to make decisions themselves, they recognised this and made an effort to make decisions themselves. Most important was that they did not feel pressure from their specialist; rather they felt respected and supported. All respondents affirmed that they were better able to handle their own problems and make their own decisions, although it was an on-going process of personal evolution.

> ‘I have difficulties making decisions at the moment, but I try doing it... The specialist respects it.’ (LT-M02)

**BG:** Most respondents felt free to make their own life choices and also believed their counsellor respected their decisions.

> ‘The counsellor respects all my decisions and opinions. This is the reason why people go to therapy, in order to be respected, valued and sometimes to hear another opinion. Yes, lately I feel different very often, and this results from the therapy.’ (BG06)

However, some older respondents showed a wider, balanced view of their lives, stating they did not feel able to make changes in their lives at this point.

> ‘Now I don’t have a choice, before when I was younger it was different; before I went to Italy, then I had many opportunities, but now – no!’ (BG08)

**IT:** Almost all respondents believed they gained autonomy by receiving psychological support, not resorting to ineffective strategies to overcome difficulties. The ability to be autonomous also came with strength and the ability to stand for what they were entitled to, regardless of the way they did it.

> ‘From one side I’m a very fragile person, from the other side I’m a fighter and I don’t give up, but sometimes I use too much energy to fight and I could seem aggressive.’ (IT10)

Nevertheless, not all seemed to gain autonomy. As respondents gained personal self-sufficiency and an ability to protect themselves, some aggressors began to apply different strategies, impacting on the women’s autonomy. Nevertheless, this was overcome by the feeling of being able to defend themselves.

> ‘No, autonomy has worsened the situation. Why is this? Because my husband sees me more determined and then... because of the labour crisis, because now I have more determination and I am less subdued and subject to what he pretends and maybe I have some good answers and naturally he is tightening me... economically.’ (IT03)

**Summary:** Almost all respondents felt free to make their own decisions as a result of counselling; counsellors did not impose their own views, rather they respected their clients’ decisions. A minority of respondents did not yet feel completely able to make decisions due to the chronic abuse they had suffered (UK), their advanced age (BG), or the perpetrators’ change in strategizing in response to growth in victim autonomy (IT).

### 3.3.3 Emotions and Self-Perception

**UK:** There was a theme in the data of strength, of becoming emotionally stronger due to counselling received. Outward displays of emotion were reported to be considerably reduced through the therapeutic process of releasing hidden thoughts and emotions. It was suggested that people should think that if they can do something positive for someone every day, then they should; negativity should not be stored or conveyed. It was also felt by some that victims should not hold hatred for their abusers, but should spend time on their own needs and recovery.

> ‘I need to get rid of all the hurt that’s in my life and I have so many bad nightmares. But I don’t hold any malice for the people that have hurt me., I don’t hold any hatred for any of
them. I just wish that I could find me, I’m kind of lost, and that’s all. But I don’t hate them, any of them. ’ (UK08)

However emotionally stronger clients reported during and after counselling, it must be remembered that life events can have the effect of triggering negative thoughts and emotions, subsequently regressing the client.

‘I think probably if I really analysed it in depth, I do feel a bit stronger emotionally but because I’ve had a recent trigger that’s really played on my mind a lot at the moment, I kind of feel the same as I did when I started it!’ (UK10)

LT-S:– Respondents shared a positive view of the outcome of counselling and were conclusive about how counselling helped them trust other people, share experiences, and enjoy increased self-esteem.

‘Yes. A lot more well-balanced. I don’t get stressed out as often, I don’t freak out or worry as much. Before I used to have a pessimistic attitude towards life. I used to think all the time that something bad will happen to me. Now I sometimes get bad thoughts, but it’s more like a fear about my children, just in case something suddenly happens.’ (LT-S01)

For many, counselling provided an opportunity to speak freely which was something victims of domestic violence lacked in a heavily controlled and violent relationship. Although some expected immediate answers, through patience they were pleased with the experience and renewed sense of self it gave them.

LT-M:– Reduced naivety, attainment of personal freedom, increased internal fortitude and confidence, and more positive personality and outlook were the emotional changes described by respondents. One respondent felt more sensible and serious, whilst others reflected on their previous and current selves as being as different as ‘day and night’.

‘Yes, as day against night. I have become more confident and do not feel like a loser.’ (LT-M04)

One respondent felt calmer when facing new challenges, which she attributed to lack of fear which was once experienced when looking towards the future. Respondents were also more in tune with themselves as human beings and were more aware of their personal needs.

‘I am much calmer on the inside, I have less stress, and my fear has disappeared.’ (LT-M07)

BG:– Most respondents had changed considerably since they started counselling, and these changes manifested in many ways: they were more confident in themselves; they were more knowledgeable about and familiar with social structures and benefits; they were no longer scared of their abuser; they accepted the consequences of decisions and had strength to see future challenges through. For one respondent, psychosomatic problems had been overcome as a result of counselling. They could now think and reason differently, and were more open to new experiences outside the home.

‘I think I grew up emotionally, I became more mature and patient. My child likes me more now than before – it is truly interesting that he is only 4 year old and tells me that I am better and calmer. As I mentioned above, I feel more distant and less involved. This is a big success.’ (BG10)

IT:– Most respondents felt emotionally different; they were empowered and felt stronger, being able to defend themselves, not doubting their abilities, and even gaining new competencies.

‘I still have the problems I had before, the same fears, but I learned to manage them and she also taught to me methods to react and tricks to be able to decide how to behave.’ (IT06)

NL:– All respondents (with the exception of one client for whom fear of her family prevailed) acknowledged the improvements they had started to feel. The majority of answers identified sensitive alterations, especially those related to self-confidence, self-reliance, and the capacity to look to the future in a more assertive way. The same happened when autonomy in the future was questioned.

‘Yes I’m not so emotionally dependent anymore.’ (NL04)
3.3.4 PERCEIVED AUTONOMY

UK:- All respondents were either on their way to being totally independent or that they had achieved total independence as a direct result of receiving counselling.

‘Totally independent. I was independent before, very independent but I was always hesitant in making the decisions and I was kind of afraid of making those decisions and I thought those decisions, ‘why am I afraid of making those decisions?’ Now I don’t think that, I just make them. I’m in total control of my life. I don’t let anybody influence me anymore.’ (UK04)

However, one respondent shared her frustration in that her new-found independence had been quelled when she moved into hostel accommodation. A useful and effective method taught by counsellors to achieve independence and improve decision-making was to write down everything that was upsetting them, how they thought they might change the situation, and how they would subsequently take action to do so.

LT:- The majority of respondents now had a sense of independence which they lacked before counselling. A state of internal freedom was expressed by nine respondents, yet one respondent still felt that a sense of independence might come if she could find employment. However, she did feel some independence as her ex-partner can no longer force her to be with him.

‘I do not know. I think I still have to get there. Maybe when I find a job I will feel more independent. But in one sense yes – he cannot force me to be with him, whatever he does.’ (LT-S08)

LT:- The majority of respondents felt more autonomous as a result of counselling. However, some respondents described autonomy in other words, such as courage, daring, and self-assurance.

‘I cannot say about autonomy, but I gained courage and daring to do something.’ (LT-M09)

Some respondents emphasised having more courage to speak up, as opposed to greater independence, whilst two could not say that they felt autonomous yet.

‘Yes, definitely, but I have not reached the autonomy yet.’ (LT-M11)

BG:- All respondents felt more autonomous in that they were realistic, patient, and thorough in planning and decision-making. There was more autonomy in action as well as thought. One respondent was rebuilding her life by job searching, when once she was suicidal. Another felt more autonomy in her domestic situation.

‘Before, I was thinking about suicide. Now I want to fix my life. I am ready to look for a job.’ (BG03)

‘I have gained more autonomy among both my husband and my children. This is a very specific feeling, I even feel younger, very strange.’ (BG06)

Positive outcomes of counselling included a sense of empowerment and increased knowledge. For one respondent, this had resulted from the process of ‘theatrical enactment’ offered through psychodrama.

NL:- In the majority of situations, respondents felt they could make their own choices and that the therapeutic process had helped them have more courage to make those choices.

‘Since the therapeutic support I’m free to take my life into my hands and feel free to make my own decisions and she is proud of me. Yes she respects my decisions.’ (NL09)

Summary: Respondents across all countries experienced an improved sense of self and emotional regulation as a result of counselling. Emotional strength was a strong theme from respondents in the UK.

Summary: Independence and autonomy of thought and action were achieved by the majority of respondents who had undergone counselling, although a few felt they were still in the development stage of becoming independent; some respondents in LT-S and BG were still in search of employment and thought they would be more independent when working.
3.3.5 PROBLEM-SOLVING ABILITY

UK: Most respondents used to suppress problems, which meant that problems usually got worse. This coping mechanism appeared to be a way to detach from the negative effects of domestic violence. However, respondents said that during the course of counselling and therapy they became more adept at recognising problems and made attempts to deal with them right away.

‘Now, I see a problem and I deal with it in the home. It’s dealt with and that’s it. Before it gets out of control.’ (UK06)

The children’s counsellor was instrumental in helping child clients to better manage their anger and to solve problems in a non-violent manner. One respondent demonstrated this by saying:

‘[My son] used to have a real problem with anger at school. Yes, he still gets into scuffles, but that’s just teenage boys, but on the whole, his anger levels are down. He does have one person who still triggers his anxieties, a teacher, but even then, his anxiety only lasts for 10, 15 minutes at the most. It doesn’t last long at all, as he remembers what [his counsellor] said. I don’t know what [his counsellor] said, but I say that to him, and it just calms him right down. His anxiety is a lot, lot less than what it has ever been. I think [my son] having a male counsellor has proved to him that not every male is the same.’ (UK07)

LT-M: All respondents were better able to deal with problems, or were developing that ability.

BG: There was a mixed response as to whether respondents were more able to deal with problems as a result of counselling. Of those who stated they felt more capable of problem-solving than before, they said that communication with external (to the family) individuals had improved; there was more confidence and self-esteem to maintain eye contact whilst holding a conversation. They also felt able to deal with conflicts and quarrels more objectively.

‘Now I see how I overcome barriers and cope after all, although not perfectly, I still improve/progress.’ (BG11)

A few respondents were not sure whether they could deal with problems yet, believing that things did not change at once and they needed time. Also, because some respondents did not have many social contacts outside the immediate family and therefore did not communicate with many people, it was difficult to gauge whether they would feel able to confront problems. The majority of responses indicated that counselling enabled clients to feel less depressed, more determined, and more relaxed. There was a sense of hope that life would return to normal. But such positivity was tempered by the perception that they will have to continue to fight for what they want to achieve and protect.

IT: The ability to deal with problems comes with the skill to say no. Sometimes respondents faced problems that were not linked with domestic violence, but because of the psychological support received, they were now able to deal with problems in other areas of their lives. For instance, one respondent gave an example of the need to establish boundaries between her family life and her parents’ family life, and how the support received empowered her to stand for what she wanted.

‘A result is that now I learnt to say no also to little things, for example with my parents and my children. My parents always horn in and they are not aware that maybe my life is different from their life, for that I put the boundaries: “This is not your life, it’s mine”. I put the boundaries to the others, before I did everything for them and afterwards I thought of myself, now I also think of me. I don’t exclude myself no more, this is another important goal: in these years I put aside my way of being to satisfy this person, to please that one; now I am more aware in the relationship with the others and in dealing with problems.’ (IT01)

Nevertheless, one respondent felt the support received so far did not contribute significantly to enabling her to deal with problems more easily.

‘No, it’s not improved neither worsened. My difficulties in the problems and the criticism of the other, or when others hinder me, these things for sure. For the moment... I don’t want to face some problems because I still feel I’m on an uncertain road.’ (IT03)

Another respondent, although acknowledging the importance of receiving support, was critical of the judicial system and, regardless of her capacity to make decisions, still experienced difficulties in facing particular problems in that context.
Concerning the ability of dealing with problems following the therapeutic process, whilst some responses indicated respondents still experienced difficulty, half the answers were positive.

‘Yes I have learned to look at the problem and learned how to solve it by myself or to look for help to help me solve it.’ (NL01)

**Summary:** Counselling helped respondents in their problem-solving abilities on many different levels. Whilst many reported improved ability to deal with daily problems, others found problem-solving remained quite difficult due to lack of social capital in BG, and problems in the judicial system in IT. In the UK, the children’s counsellor was instrumental in helping children to solve problems peacefully.

### 3.3.6 VIEWING THE FUTURE

**UK:** Almost all respondents said the therapeutic support received helped them to view the future more positively. Counsellors periodically asked their clients whether they could see a future and, if so, how they perceived that future. Whereas at the beginning of therapy clients could not see a future for themselves, during and towards the end of counselling they could anticipate being in employment, returning to normal life, and addressing challenges the future will inevitably bring. There was an element of wanting and needing to help other victims of domestic violence by becoming counsellors or by other support means. Some respondents were glad to be alive, whereas before they had been suicidal.

‘It’s changed a lot, a really big thing. If you love somebody and they’ve abused you for 30 plus years, it is hard as I’m Catholic, and it’s a lot to be getting divorced. I think it’s saved me, that’s what this has done, it has saved me.’ (UK03)

‘Yes, before I thought I was dying! Yes, I’m moving up and I want the kids to see that they can move up as well. Life just gets better.’ (UK06)

However, one respondent stated that she did not plan too far ahead, and felt more comfortable knowing what the immediate future holds.

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One respondent used to be afraid of the future but no longer feels helpless, but was determined to improve her situation for herself and her daughter.

‘In a way that I do not feel helpless anymore and at least try doing something so that me and my daughter can live better. But I still am very afraid from what will happen in the future.’

(HT-S08)

One respondent did not share the same positive outlook as other respondents; although she did not feel so helpless after counselling and she felt calmer, there was still uncertainty about the future and fear of her ex-boyfriend who sometimes reappears.

**LT-S:** Respondents had a more positive outlook and appreciated small freedoms and the greater freedom that implied. There was demonstrable ability to wish for something more than what they previously had; they appreciated their potential to achieve. Respondents had a bright outlook with security and self-esteem.

‘Not see the future differently, but to see it at all. I have so many wishes now...’ (LT-S04)

One respondent used to be afraid of the future but no longer feels helpless, but was determined to improve her situation for herself and her daughter.

‘In a way that I do not feel helpless anymore and at least try doing something so that me and my daughter can live better. But I still am very afraid from what will happen in the future.’

(HT-S08)

One respondent did not share the same positive outlook as other respondents; although she did not feel so helpless after counselling and she felt calmer, there was still uncertainty about the future and fear of her ex-boyfriend who sometimes reappears.

**LT-M:** The ability to imagine the future appeared to be a difficult question for clients to answer. While some were able to envision a future, others were slowly beginning to visualise a future in a life free from abuse. Two respondents said their views of the future were still in early stages and were yet to develop. Two respondents did not rate their ability to envision the future but said they did have a positive outlook now.

‘I did not believe that a different kind of life is possible, because my two previous family experiences were negative. Now I experience a completely different life.’ (LT-M04)

**BG:** Hesitancy was expressed by some respondents who were uncertain of what the future may hold for them. One respondent clearly saw how her view of the future had changed from once considering suicide.

‘Yes, and no! It appears as nothing has changed, but inside it feels as if my prism is changed and now my viewpoint is slightly, slightly different.’ (BG10)

‘To say that everything is completely different will be a lie. There is change but honestly speaking it is insignificant. What does future mean? I dare not to think about my future. I don’t make plans, nor develop strategies.’ (BG06)
IT:- The future was now faced, not being passive and compliant, rather in making things happen in a way respondents were looking for. They were aware of difficulties ahead but felt stronger and competent in dealing with them, and in improving their living circumstances.

‘I look at the future in a different way… I have taken many steps but I still feel very intimidated… I know I will receive a minimum pension and my son isn’t self-sufficient. Sometimes I feel exhausted, but I feel like I have recovered strength which has been away for a long time, trying to understand him and to complain, but I would grin and bear it. Now I complain less, I roll up the sleeves and I go forward.’ (IT08)

But there were also ambivalent thoughts about the future when compared with past experiences. Sometimes respondents doubted their motherhood ability due to violence towards by them and their children.

‘Before I didn’t even see the future, there were some times in which I said: “If there were no future, it would be better”, but now I see it long in front of me and I am desolate also … I always think about my daughters and I asked myself if I have been a good mother in the difficult times.’ (IT06)

NL:- The outcome of therapy was seen as important in women’s ability of imagining the future; it brought new skills which made them feel very different.

‘In so many ways, I am a new person, which can say NO, which I could not before.’ (NL03)

3.3.7 UNDERSTANDING DOMESTIC VIOLENCE

UK:- Respondents were clear on how they now understood domestic violence. Counselling had taught them that experiencing violence and abuse in what is meant to be a loving relationship between two people is not the norm, that it is not a natural way of being. Myths about rape within marriage had been challenged and accepted as wrong. For many years, respondents had accepted violence, blaming themselves, although they now recognised they were not to blame. There used to be a perception that counsellors did not take victims of domestic violence as clients (possibly related to feelings of self-blame).

‘Yes, it raised my mind to a lot because I wasn’t aware that I was in an abusive relationship until I got out of it… So it was through therapy that I was able to unpack it all and figure out different aspects of his behaviour and how I reacted to those.’ (UK10)

One respondent did not think her perception of domestic violence had changed as a result of counselling, as she already worked for the domestic violence support service so had good understanding of the field, but her feelings of empathy towards victims had been strengthened.

LT-S:- Respondents recognised that previously they accepted violence directed towards them and, in some cases, did not recognise it as violence at all.

‘Yes. There were many things that I did not see as violence at all. I was used to it. If one is badly beaten, then yes, it is violence, but even then one gets used to it, accepts it. I was used to accept things that I did not like, that were painful. But that happens. It is not pleasant, but it takes place. Like hail outside – not pleasant, but it happens. Now I look at it differently. I never thought before that violence is like a dragon not with one, but seven, even thousand heads. That it comes in so different forms. I do not think anymore that the victim in one way or another is guilty herself.’ (LT-S02)

Others had recovered to the point they considered it distantly and objectively. They also understood that conflict can be resolved peacefully within a healthy relationship, and it was this ability to recognise healthy and unhealthy relationships that was important. They recognised the cycle of violence and the effect it had on their lives, and knew it was unacceptable; they also recognised physical and emotional abuse.

‘I kind of new the theory, about the cycles and the like, I knew it could be awful, but I probably gained more from those real and different experiences. And how important it is what and how much you allow. How others treat you. For me the most important was to understand...’
that the victim is not helpless. That one can always find some kind of solution. And now I tell my friends the same." (LT-S03)

Respondents had all changed their perception of violence as normal to understanding how to leave an abusive relationship and not engage in future destructive relationships.

**LT-M**: Some respondents were better able to gain perspective on domestic violence, although opinions and perspectives of others were still in developmental stages, but there was a perception this will come with time.

‘Yes, definitely. It is often difficult to acknowledge to yourself that it is happening in your family. I am ashamed to talk about it.’ (LT-M11)

Clarity was a concept that appeared often, in that respondents were better able to understand past incidents that led up to violent relationships. Respondents were better able to assess their situations retrospectively and currently. They recognised they were an integral member of their family.

‘Before I felt that something is wrong in our family, but I was close to my husband and I said to myself that in no family there are ideal relationships. I even could not define to myself that I am suffering from emotional violence.’ (LT-M05)

Mothers whose children had been exposed to violence had new awareness of the lasting effects that trauma can have on their children, and the need to prevent the cycle of violence. As such, they were better able to avoid violent relationships in future and attain some closure.

**BG**: Respondents now had more knowledge and understanding of the different forms domestic violence may take, when before they would not have recognised what it was and that it was happening to them. Many had not previously suspected how gradually they had been isolated, lost all social positions, and allowed themselves to be controlled and manipulated. Some said it was disappointing their relatives were unable to learn more about domestic violence so they would be better able to support them.

‘So many years I have been treated like that without realising this is a form of domestic violence. Psychological violence, financial, economical dependence I haven’t even thought of.’ (BG03)

‘It seems to me that I was illuminated…everything becomes clear. Our society is not prepared, and many people don’t understand what is being spoken of, many people undergo domestic violence and remain silent. Therefore, more information is needed.’ (BG06)

**IT**: Psychological support contributed to changing the way respondents understood domestic violence. They developed awareness of two main aspects: although there was awareness that domestic violence exists, they realised it affects a large number of women and children; and violence does not always mean physical brutality, but also psychological abuse.

‘Now I have more consciousness because things happen to you, they are more direct, and it’s not just the hearsay or having compassion for someone who suffers. You really realize that it’s something real, you don’t hear it just on television. It is actually a matter more common than you think. I realized that there is a lot of hidden violence.’ (IT01)

They also realised who bore responsibility for the violence - now they knew it was not their fault, but rather the person who had been aggressive. Respondents also learned to protect themselves and be safe.

‘Now I see several things with another perspective … I feel safer.’ (IT05)

However, one respondent was still quite critical of men’s attitudes and did not believe there was anything that could be done to change the gender dimension of domestic violence.

**NL**: The way in which respondents understood domestic violence underwent significant change, as did feelings of guilt.

‘I thought before that only physical violence was domestic violence.’ (NL02)

‘Yes first I thought it was my fault, but now I know better.’ (NL03)

Not only as a result of psychological intervention, but separation from the violent relationship opened new perspectives and awareness of the phenomenon. One respondent also became involved in a support group.
Summary: The way respondents came to better understand the dynamics of domestic violence was significant across all countries. However, respondents in LT-M were still in early stages of therapy and were still learning. This newfound understanding led to dissolution of self-blame for some respondents in the UK, IT, and NL. Many respondents in the UK and LT-S could now more fully understand the dynamics of a healthy non-violent relationship.

3.3.8 NEGATIVE OUTCOMES AND AREAS FOR IMPROVEMENT

UK:- The data showed no negative outcomes of counselling.

LT-S:- Overall, there were no negative outcomes. Three respondents thought counselling should have been longer, whilst another still had difficulties with her children who perhaps also needed therapy.

‘There was everything that I needed. Only possible disadvantage is the lack of time. I had a feeling that those two hours limited us. Sometimes it felt that the meetings could have been longer. That we might not be able to discuss something and it will be forgotten.’ (LT-S05)

In terms of their social lives, some had lost friends, but the loss was seen more as a shedding of negativity and abuse which respondents welcomed. Of the respondents who claimed counselling could have been longer, one said she felt afraid to manage new situations without the support of her counsellor, although this feeling was perceived as natural after receiving counselling after a long period of abuse and starting a new life.

LT-M:- Only one respondent had experienced a negative outcome of therapy; the unforeseen and deep attachment to the counsellor. Loneliness can be a side-effect of ending abusive relationships as the woman is now on her own and not dependent on someone else. Since the therapist acts as supporter, confidante, and alternate perspective for the woman being counselled, a reliance on the specialist greater than expected may manifest itself. Although specialists warn of this, it presented a new challenge for one respondent who may have to learn to do without the very thing that helped her escape her situation in the first place.

‘The negative results could be such that a person after such big losses in personal life becomes close to the specialist. I did not solve problems anymore, but I knew that here is a place where I can come and talk about the problem. But the specialist warned me that it can happen. The positive is that without this support I would have been broken.’ (LT-M05)

BG:- Most respondents experienced no negative outcomes of counselling. One respondent still cannot cope with every situation she experienced by her abuser. However, this was not a negative outcome for her, rather the abuse is constant and she is regularly abused.

‘I came here with serious psycho-somatic problems and I underwent great progress. I cough when I am angry, now the situation is well in hand. When I talk on emotional level, I feel arousal, but I can talk about my feelings now. It is one year for now, and I encountered great improvement.’ (BG04)

Whilst one respondent maintained low self-esteem (she still did not consider her opinions valid), one respondent described clearly how her whole life had positively changed as an outcome of counselling.

‘I am happy that I am alive; mostly I am happy because of my daughter and the fact she is with me and loves me. The positive is that I am more courageous in my decisions and make changes in our lives; now I will look for a job as well – until now I was concerned with that school, that I have to be constantly with her, but when I myself am calmer, everything sets in order. I took another general decision – I won’t wait to be manipulated by my ex, instead I will undertake definite preventive measures, I will determine visiting schedule myself.’ (BG11)

IT:- Respondents could not identify any negative outcomes from counselling; they only mentioned some difficulties female survivors can experience, or difficulties re-constructioning their life.

‘And then to find a way to invent a new method, a new way to spend holidays, Christmas. Times when I would say that the conviviality was so strong, here is where we have been more touched because basically we stayed alone and this is strong, yes… at some point it is very harsh. In the everyday life no, but when there are holidays, this becomes a problem.’ (IT02)

NL - In general, respondents revealed more positive aspects than negative, for example, becoming aware of
the need to change, independency, talking about feelings towards each other in the family, and self-expression.

**Summary:** Generally, there were no definitive negative impacts of counselling, although some respondents in LT-S and LT-M had been caught in the unfortunate situation of becoming attached to their counsellor due to feeling lonely and being unable to manage new situations without their counsellor’s support.

### 3.3.9 SUGGESTIONS FOR IMPROVEMENTS TO SPECIALIST COUNSELLING SUPPORT

**UK:** The question of how specialist counselling for victims of domestic violence could be improved elicited anguish from many respondents who felt desperate to have the recently-closed counselling service reinstated. However, a number of themes emerged regarding service improvement including: more specialist counselling services for victims of domestic violence are needed; more publicity and public awareness; increased referrals to specialist counselling; financial issues should be lower priority than safety and wellbeing of women and children; and specialist training courses should be available to enable generic counsellors to become specialist domestic violence counsellors.

**LT-M:** The use of a good theoretical model (for those who recognised their therapeutic intervention) and the accessibility of counselling at the most appropriate time for the victim were important suggestions for improvement of counselling initiatives for victims of domestic violence. The referral process following disclosure was important so that clients are directed to the right place quickly and do not waste time seeking unsatisfying therapy.

‘I had to wait too long until it was my turn (for counselling). I came ready to work, but I had to wait for half a year.’ (LT-M06)

It was also stated that services must be free of charge since unemployed women may demonstrate difficulties in finding help, they may be slow to seek help, or may not try at all.

‘The help must be accessible at the right time. It has to be free of charge in this economic situation. But I do not know anyone who is as lucky as me.’ (LT-M02)

The most damaging outcome would be for women to stay in an abusive situation simply because they do not have the funds to get out of it. In that case, if clients must pay, then an assessment of the individual economic situation should be taken into account when determining the amount required for payment. Furthermore, the waiting list for free services was long, so women who became very motivated to work on their issues were forced to remain in their situations even longer until they could receive the counselling they needed.

**BG:** There should be more specialist counselling support centres for victims of domestic violence with greater information signposting victims; avenues for access should be broadened. One respondent indicated that counsellors could be more prescriptive. Support work should be more educational to enable better understanding of domestic violence and how its effects manifest.

‘There have to be more projects like this one because they make a big difference to lives not only to the victims, but their society too. Unfortunately more and more cases of domestic violence emerge due to many reasons, most times happen to be complex.’ (BG01)

**IT:** Respondents suggested more information about support services for victims of domestic violence to be made available to the general public, and better dissemination strategies within statutory settings (such as the police) in order to reach women in crisis situations; consider implementing on a larger scale group therapies or self-help groups alongside individual counselling; networking around cases; and free access to lawyers. Respondents also voiced suggestions framed according to professional areas, such as the courts and judges. In that respect, women felt the need for more awareness-raising of the gender perspective of domestic violence within the criminal justice system.

‘Well, I think what is lacking is a sensitisation and awareness of judges and tribunals, and also of the lawyers. In my opinion, it would be useful working in this direction, more than on women. It is important to work on these people that unfortunately have full powers and they are not accountable to anyone.’ (IT02)

Respondents also reinforced that multiagency work on domestic violence would empower and strengthen the work of each professional and, as a result, outcomes would be completely different in all areas of life.
Respondents expressed their feelings against injustices they faced due to lack of expertise on domestic violence of some professionals (from other knowledge domains that are not within support services). In that respect, lawyers and judges were particularly criticised for their poor quality of working and having a vast (often negative) impact on women and children’s lives.

‘We have arrived at the point that my daughter has supervised meetings, but we made two complaints at the juvenile court, I mean, a criminal complaint against him which is still open.’ (IT02)

NL:- Counselling for victims of domestic violence could be improved by more people knowing about services and breaking through the silence of violence: the more people talk about it, the more victims will gain. Services should have an intercultural approach and consider the health of the victim. Also, initiating self-help groups with survivors was suggested.

Summary: The most common recommendations for improvements to counselling support for victims of domestic violence were: more publicity and awareness of domestic violence counselling services (UK, BG, IT, NL); more specialist counselling and support centres for victims (UK, BG); counselling support should be accessed at the most appropriate time by increasing referral rates (LT-S, LT-M); financial issues should be lower priority than safety and wellbeing of women and children, so services should be free of charge (UK, LT-M); and self-help groups would be useful for domestic violence survivors (IT, NL). To a lesser frequency, UK respondents suggested specialist training courses should be available to enable generic councillors to become specialist domestic violence counsellors; LT-M respondents suggested waiting times should be reduced; BG respondents recommended support work should be more educational to facilitate better understanding of domestic violence and its effects; and NL respondents recommended an intercultural approach with due regards to health needs of victims.

3.3.10 CLIENTS’ ADVICE TO WOMEN IN RELATIONSHIPS OF ABUSE

UK:- Consensus showed that counselling should be available when the victim herself feels it is right for her.

‘I would say that if they feel that they need counselling, then have counselling. But I wouldn’t push counselling on them, if they weren’t in the place in their own head to want it… I wouldn’t push it on them if they weren’t ready, because if you’re not ready in your journey, then it isn’t for you.’ (UK02)

Counselling is only truly effective if there is a positive relationship between client and counsellor. The message was that if someone had a poor previous experience of counselling, this should not detract from sourcing alternative support until the right counsellor is found. There is no key ingredient for the right counsellor; the relationship needs to be built on mutual trust, respect, and understanding.

‘It helps to find the right counsellor because I’ve spoken to so many people who have been put with the wrong counsellor for their needs, and what I would say to anybody in that situation is ask for a referral. If you are with the wrong counsellor for your needs, see somebody else, not all counsellors are the same… My message would be, if it’s available to you, take the opportunity, and find the right one.’ (UK10)

Accepting that counselling is needed is difficult enough, but even more difficult is accepting that there is a need to talk about issues that are hurtful and which induce fear. Nevertheless, if victims of domestic violence are well prepared, then they will reap the rewards counselling can bring.

LT-S:- Respondents gave a great deal of advice. Some had advised close relatives who also suffered from violence to try counselling so that they can help themselves.

‘After completing the counselling myself, I already understand that it works, that it helps me. I have friends, acquaintances, relatives, whom I tell, “Go. Go and try. Try.” First I told my mother and sister this. I see that they live the way they’re used to, and they suffer. They’re stuck in the ground and just stand there. Don’t want to change anything in their lives. To be honest, it breaks my heart. They deserve better. Now I realize that I deserve better and so do they.’ (LT-S 01)

Furthermore, they said there is nothing to be ashamed of and they can receive effective therapy and a better life if they choose. Also, these issues should not remain hidden and victims of violence should find someone they can trust and express their feelings to.
COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING:
COUNSELLORS AND CLIENTS

‘You have nothing to be ashamed for, it is not your fault, you are normal. None of you should be a victim of violence! You should look for help. No one will judge you. Only will help you to find ways how to change your life.’ (LT-S 04)

The most important advice was for others to receive counselling. It was agreed that one has to understand they need help and not to surrender to hopelessness. They concurred that violence should never be tolerated, and that if there is an opportunity to access counselling, it should be taken. However, counselling should not be forced; it has to be by free will. There should be closer cooperation between counselling agencies and social services so that women feel comfortable seeking help sooner rather than later. Respondents were grateful for the opportunity to relate their experiences, and hoped their answers would help others.

**LT-M:-** The most predominant advice offered by respondents was not to allow problems to fester for a long time as issues of abuse do not resolve themselves.

‘If one has problems, one should solve them. One should not say that nothing happened. One must go and look for help.’ (LT-M01)

If a woman is in need of help, than she should go in search of it. In hindsight, respondents believed they should have sought help sooner. They said that victims need to be prepared to work hard if they want to achieve a positive change; the effort would be well worth it.

‘Dear women, you should not tolerate that. It is scary. I suffered for 20 years, even sexual violence, but you have to look for help.’ (LT-M04)

**BG:-** Advice from respondents was to make a stand, do not give in to violence, and seek out sources of support. Women in similar circumstances should not hesitate to seek help, rather they should act at the first sign of irregularity within the relationship; taking that first step is crucial to removing oneself from harm.

‘When they feel something is wrong in their relationship, seek support right away. They shouldn’t wait like me to be beaten and smacked around. When they perceive the smallest irregularity, call and seek support.’ (BG11)

Other advice was to talk about domestic violence and related problems to specialists; enlightenment and understanding leads to acceptance, which can lead to solutions.

‘To seek support from well prepared, in this area, specialists, now there are organisations like yours, towards which they can turn to.’ (BG07)

**IT:-** When asked if they wanted to leave a message to women surviving domestic violence, respondents immediately wanted to say something (although messages were not related to therapeutic support). They emphasised the need for every woman to believe in herself; the need to give the right attention to the first signs, and to understand it is not the woman’s fault; the need to seek professional help; and to speak about women’s experiences of domestic violence.

‘Certainly not to try to solve problems by themselves, we can’t do it because in those moments in which we suffer this kind of pressure from these filthy men that took from us everything, the freedom of thinking, of hearing, they humiliated us, they trampled us. We can’t do it alone to walk again, we see nothing anymore.’ (IT04)

‘Surely I would definitely recommend and say not to be ashamed to come to a place like this... even better, do it as soon as possible because it is really helpful. In fact, I suppose, this is one of the most important experiences that really helped me in my whole life. Therefore I know how difficult it is to contact here at the beginning, because you don’t know what is about and you feel bad as I did. But I would say not to delay because coming here it’s worth it.’ (IT09)

**NL:-** Although respondents presented various types of message, the main lesson revealed an incentive as to women’s involvement in their own lives and the willingness to be responsible for their situation. They clearly emphasised women’s right to remove themselves from a violent relationship and a need to break the silence by talking to friends and looking for ways to end the relationship.

‘Do not take all this suffering and look for help.’ (NL05)
‘Tell the relatives you trust or close friends.’ (NL06)
‘Get as much information as you can; there is a lot on the internet, identify support.’ (NL08)
COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING: COUNSELLORS AND CLIENTS

Summary: Advice to women in relationships of abuse included: there is nothing to be ashamed of (LT-S, IT); if there is an opportunity to access counselling, then it should be taken, and talk about domestic violence and related problems to specialists (LT-S, BG, IT); everyone has the right not to be abused and no-one should surrender to violence (LT-S, BG, NL); if victims are prepared to work hard in counselling, they will reap the rewards it can bring (UK, LT-M). It was suggested that victims of domestic violence should act at the first signs of violence or abuse (LT-S, LT-M, BG, IT), but this was modified by respondents in the UK who indicated counselling is something accessed when the victim feels it is right; this was supported by LT-S respondents who said counselling should be voluntary.

3.3.11 FINALLY...

Clients were asked whether there was anything else they would like to add that had not already been discussed during the interview.

UK: Respondents repeated key issues of how the counselling service had helped them put their lives back on track, but there should be more counselling services for children who can be deeply affected by abuse in the home. There was also sadness and despair because the service had recently closed due to lack of funds.

LT-M: The need for a place where women can gather and speak to one another was of great necessity. The financial support of the government was important to the plight of female victims of domestic violence and, by proxy, the organisations that support them. Respondents were thankful for the help and positive atmosphere provided by LT-M.

BG: There was concern over the cultural problem of domestic violence in BG, in that it seemed to be widespread and perceived as the normal pattern of relationships.

Summary: At the end of the interview, respondents highlighted a need for the continuity of counselling support; funding cuts or a decrease in funding was felt with sadness by clients (UK, LT-M). They also expressed the dynamic role counselling can have on the lives of women and children (UK, LT-M) and the need to overcome the cultural acceptance of domestic violence (BG).

4 FINDINGS: COUNSELLORS’ PERCEPTIONS OF DELIVERING DOMESTIC VIOLENCE COUNSELLING

4.1 COUNSELLORS’ BACKGROUND

Overview - This section of the comparative analysis assesses the educational, professional, and institutional background of counsellors involved in the research. It is important to know what experiences the counsellors have working as a counsellor and, specifically, as a counsellor for victims of domestic violence.

4.1.1 ADEQUACY OF TRAINING RECEIVED – BASIC AND SPECIALIST TRAINING ON DOMESTIC VIOLENCE

UK: The training received by counsellors up to Diploma standard was considered adequate, but learning ‘on the job’ was more important due to the varied experiences of clients. There was continual professional development depending on counsellors’ need and interest.

‘The on-going and different experiences you have means you are learning all the time. If I come across an issue, I will research it myself at a later date or discuss it in peer groups. It isn’t just about academic qualifications; these are just the foundation of knowledge. You learn on the job, and from clients’. (UK01)

LT-S: Two respondents indicated that training opportunities were inadequate and they have learned through experience and self-learning; they now feel fully qualified in their fields. Both respondents had Master’s level degrees in psychology, one respondent having obtained professional education in existential psychotherapy. Although both respondents were highly educated, they agreed training on the dynamics of domestic violence was lacking. As such, they were self-reliant in gaining in-depth knowledge of the subject so they can counsel effectively. One respondent noted there are many fields related to violence that are not addressed at university; courses focus mainly on psychological processes rather than practical application.
‘...inadequate, especially if it is only this one course at the university, because it focuses only on the psychological processes. But in the cases of violence there are many related areas, such as judicial and practical knowledge which is needed and that in the beginning is lacking. I think that I by now have adequate training for this work, because I have learned a lot by working here for the last ten years. I have had a lot of contact with lawyers, with social workers, read specialised literature. But that is my own initiative.’ (LT-S01)

There is need for supplementary education, for example training and seminars, to be provided by counselling centres and more extensive education provided by universities for those studying psychology.

**LT-M:**- One respondent had a Bachelor’s degree in psychology and certificate in systemic psychotherapy, and participated in seminars to increase her knowledge. The other had a Master’s degree in clinical psychology and had taken steps to upgrade her expertise when necessary.

‘Taking into consideration that I give my consultations within the borders of my specialisation (systemic family psychotherapy), I feel competent giving consultations to women who have suffered from violence. I constantly improve my knowledge through reading and professional trainings and seminars.’ (LT-M01)

Although respondents had degrees which qualified them to manage cases of domestic violence, what is clear is a need and desire for supplementary and on-going knowledge of domestic violence.

**BG:**- Training received in psycho-drama was considered adequate, yet even though many counselling training courses had been accessed, there was always more that could be learned. Within the focus group, the prime concern for counsellors was the necessity of appropriate qualification and education of counsellors in health and social care professions. However, more important was further training on domestic violence. Another concern was that counselling victims of domestic violence was better when outside of government institutions and social services; most optimal was when teams of non-government organisations work in close collaboration. In terms of specialist training for counselling victims of domestic violence, practice in the non-statutory domestic violence sector greatly augmented counsellors’ learning experience.

‘About the specialised trainings concerning victim of domestic violence, I would like to say that the work in the non-government sector enriched my experience’. (BG02)

**IT:**- Both counsellors had a degree in psychology, acted as Psychologists, and one was also a psychotherapist and expert in psycho-drama. Both received specialist training to become a counsellor of victims of domestic violence provided by their organisation which demands specialist training. One counsellor was a member of two professional counselling organisations, the Order of Psychologists of Tuscany, and the Italian Association for the Study of Traumatic Stress.

**NL:**- Both interview respondents had professional Social Work backgrounds, and one was also a teacher. Both said they had received specialist training to be a counsellor in the domestic violence field. One respondent had a degree in Social Services where counselling and coaching were covered, whilst the other did not identify the type of training received. Both considered their training appropriate to counsel victims of domestic violence.

**Summary:** Counsellors’ academic qualifications ranged from Diploma (UK), to Bachelor degree (LT-M) to Master’s level (LT-S, LT-M), and continuing professional development was undertaken by many (UK, LT-S, LT-M, IT). Respondents said they increased their own knowledge base (UK, LT-M, LT-S). A need for additional specialist training in domestic violence was articulated by respondents in LT-S, LT-M, and BG. Training was adequate for some respondents (UK, BG, NL), and inadequate by others (LT-S, LT-M). Respondents in BG reported that domestic violence counselling is optimum when NGOs work in close collaboration, and that practice in the non-statutory domestic violence sector greatly augmented counsellors’ learning experience.

**4.1.2 EXTENT OF EXPERIENCE OF COUNSELLING VICTIMS OF DOMESTIC VIOLENCE**

**LT-S:**- One respondent was a psychologist who had been providing counselling for family violence for 10 years and the other was a psychotherapist who had been working in the field for 14 years.

**BG:**– One respondent had delivered domestic violence counselling for one year, whilst the other had 10
years’ experience. Education was not perceived by respondents as enough, and years of experience can be far more helpful in this context. One respondent had applied puppet therapy, working therapeutically with groups of children who had experienced emotional and behavioural problems, and some who had learning disorders, some of whom had been victims of violence, and some of whom had mothers who were victims of violence. Her proposal as a psycho-dramatist was to compare a group of children with such problems with a control group to determine whether psycho-dramatic techniques were effective or not, indicative of continued learning. There had been visits by specialists who provided training on the dynamics of domestic violence and the necessity for complex interdisciplinary approaches. These included psychologists from institutes in NL, and Australia, who provided training in European standards for working in shelters with women and child victims of domestic violence.

**IT:** The oldest interview respondent had more working experience than the other both as a counsellor (34 and 12 years respectively), and as a domestic violence counsellor (17 and 12 years respectively). One was responsible for directive counselling training and the other for the management of groups, telephone operators, and compiling in-house statistics. Translation is often necessary, for which they resorted to volunteers in Italian, French, English, and Spanish. Both respondents considered intercultural competences were vital to their work for two reasons: cultural settings differed considerably; and people were not always aware of national legislation. Within the organisation, women with disabilities were not counselled but women in same sex relationships were. Counsellors frequently did not consult with or counsel children; they gathered information on the psychological and physical status of children through their mothers.

**Summary:** Length of experience as a specialist domestic violence counsellor was stated by respondents from three countries: two respondents in LT-S had 10 and 14 years’ experience; two from BG had one and 10 years’ experience; and two from IT had 12 and 17 years’ experience. It was felt by BG respondents that, although education was adequate, extensive experience is far more helpful in counselling victims of domestic violence. Intercultural competence was vital to the work of counsellors in IT, and continued professional development is strong in BG. Respondents in IT lack experience women with disabilities and children were not counselled.

**4.1.3 ORGANISATIONAL PROVISION OF CLINICAL AND MANAGERIAL SUPERVISION**

**UK:** Counsellors had regular supervision in proportion to the number of counselling hours worked. External clinical supervision occurred twice a month to relieve vicarious trauma, and managerial supervision occurred once a month. There was also opportunity for informal supervision or to talk over issues as they arose. Generally, counsellors elected their own supervisors.

**LT-S:** Due to lack of funding, one respondent’s team had no supervision while the other’s team had co-supervisors who handled the crisis telephone service with no determined length or frequency of supervision. Counsellors relied primarily on peer support.

‘At this moment, no, due to lack of funding. We would like to do that if the situation would allow it. Currently we have co-supervisions. The staff of the crisis telephone service have regular supervisions once a month, and that includes of course domestic violence, how often they are called about it. Psychologists and psychotherapists take care of themselves.’ (LT-S01)

**LT-M:** There was a monthly supervision process for their respective teams. Furthermore, they were led by professionals and supervision was maintained within their respective professions.

**BG:** There was frequent counselling supervision on a fixed number of sessions, with extra sessions in emergency cases. The tradition over many years had been that the team relied on professional supervision. Counsellors had the opportunity to discuss cases during individual supervision, for which each counsellor booked an appointment in the supervisor’s office hours. Group guidance was conducted once a month. Supervision occurred immediately after a difficult session and also at team meetings.

**NL:** In such demanding work as counselling victims of domestic violence (where multiple aspects are involved and are hard to manage) the counsellors' work was one of great intensity and often isolated. It was not uncommon for respondents to say that professional isolation sometimes made evolution of approaches and their adequacy to each context harder. Therefore, it was frequent to find services that shared cases between
counsellors within a supervision environment. Supervision was perceived to contribute to evolution of the counsellor, adding to knowledge the exchange of experiences. Whilst one respondent received supervision annually, for the other, although supervision had been used historically, there was no regular funding from the government to provide it now.

Summary: Regular clinical supervision was received by counsellors in the UK twice a month and in LT-M once a month, whilst group supervision was conducted once a month in BG. Informal supervision, group discussion, and peer support was provided in the UK, LT-S and BG. Lack of funding prevented regular clinical supervision in LT-S and NL.

4.2 THERAPEUTIC MODELS AND APPROACHES

Overview - This section of the comparative analysis assesses which models and approaches were usually applied by counsellors and main constraints that can arise. The way counsellors perceived domestic violence is also presented in this section.

4.2.1 MOST FREQUENT NEEDS PRESENTED BY VICTIMS OF DOMESTIC VIOLENCE

UK:- Counsellors said their clients need a place that provides practical and emotional safety, as this was important so that clients can disclose anything, work through the trauma, and build self-confidence and self-esteem. It was important that women and children who experience domestic violence should be listened to, not be told what to do, or judged. Clients need to be believed, as a counsellor might be the first person to whom they disclose and who actually listens to their problems. They need to know that their situation is affirmed.

LT-S:- Three areas of client need were expressed by respondents. The first was the need for clients to have confirmation that they have the right to seek help if they felt something was wrong in their relationship; furthermore, was the need for information, in that a woman who decides to end the violence needs to know where she can go and what she can do. Second, the clients needed understanding, support and a sympathetic ear from the counsellors so that the woman can become informed as to what is happening to her which may lead to a renewed sense of self-respect and empowerment so that she may change her circumstances. A final concern expressed was the mental and physical security of women while they seek help. As such, concerns were expressed regarding the ability of professionals from other services to co-operate effectively without creating additional trauma to clients. Currently, there is a greater need for more efficiency in communication between service professionals who assist women in crisis so that they can receive the necessary help without exacerbating trauma.

LT-M:- Respondents indicated the need for therapy to decrease the consequences of emotional traumas that women suffer as a consequence of domestic violence. This includes support and understanding on many levels including emotional, financial, medical, and so forth. In terms of moving forward, respondents emphasised the need for women to have access to tools and methods necessary to overcome past experiences and to avoid re-victimisation. This is not only important for women but also for the children of women in violent relationships who also suffer trauma. Women must learn how to help their children and maintain a healthy atmosphere. This was emphasised numerous times in counsellor interviews, demonstrating a deeper concern for the ongoing cycle of violence as it pertains not only to women but to their children who are also at risk of repeating violent or destructive behaviour. An important element was the need for women to have time for inward and outward reflection so they can become more informed about what is happening to them and to understand their world from different perspectives. Clients must be in a safe environment to learn to build healthy relationships. Afterwards, self-renewal can begin, enabling women to protect themselves and their children.

BG:- Victims present at times of crisis. Initially, problems appear as judicial matters then social issues become the prime concern. But the most serious concerns were clients’ emotional needs. There were also frequent problems for clients’ children; emotional and behavioural disorders and drug problems were the norm. Help was also sought to move house, or to enrol children in a new school.

IT:- Respondents clearly identified clients’ different needs at different times. When women first come to the counselling service, their needs are emotional; they want to be heard, to be listened to, and to be understood. This understanding is not trivial; they are looking for validation without being judged, which is
important at the beginning of building a relationship based on trust.

‘I think that basically there is the need to be listened to and heard, thinking that this is a safe place for them, but especially a place where you understand the problem of the violence. This aspect of understanding is fundamental... It is very important to understand the facts, not minimizing them, not justifying them, or just setting the problem in the right direction, the acknowledgement given to the woman as a feedback.’ (IT02)

Frequently, women also sought help to obtain information on legal aspects. But if this is, for some women, the reason to approach support services, within that service counsellors and other professionals know that women also need to be prepared to cope with all legal procedures and consequences. It was essential to prepare women for legal and judicial practices within the counselling process.

‘The main need, for sure, is that of the legal advice, with the fact of having to support in understanding why this is happening, if it is their fault or if there are behaviours which can stop or decrease violence, then realize what is happening, and at a the practical level... the legal advice.’ (IT01)

Women’s needs are two-fold: on one hand, they present practical needs whilst on the other they have emotional needs and seek emotional support to understand what had happened to them. They also demonstrated more practical needs so they could develop strategies to end sustained violence.

NL:- Emotional needs were more commonly mentioned. However, this could not be separated from practical needs such as the need for shelter, protection, and safety.

‘The counsellor would have to get through to her to break the shield she puts up for herself to protect herself.’ (NL02)

The practical issue of safety is one of the counsellors’ responsibilities.

**Summary:** The most frequent needs presented by victims of domestic violence were: emotional and practical safety (all countries); to be heard, listened to, and understood without being judged (UK, LT-S, LT-M, IT); information on services and other support (LT-S, BG, IT); tools and strategies to overcome and avoid future violence (LT-M, IT); and strategies to help their children (LT-M, BG).

### 4.2.2 FACTORS PERCEIVED TO INFLUENCE DOMESTIC VIOLENCE

**UK:-** Counsellors said that domestic violence may be more related to individual factors than social systems, although in some Asian cultures there is a sense that women should not earn money, or else should not earn as much money as the man. Although such issues affect family values, they have no impact on the counselling model used. The important thing is for the client to lead the process.

‘We have to work with the woman and her needs – if she wants to discuss culture, then we can, as this can be one of the reasons that she has decided to attend counselling.’ (UK01)

Many factors that contribute to domestic violence were discussed: stereotyping and gender issues, marketing and publicity, how women are portrayed in and by the media - they all stereotype women and women’s place in society. From this perspective, domestic violence is gender-based.

**LT-S:-** One respondent said the primary factor influencing domestic violence is the individual. After that come social and cultural influences. However, that being said, both respondents agreed that a woman’s family background is integral to deciphering what has happened to her and developing a suitable approach.

‘Without denying that violence is part of the social system and that this impact needs to be recognised, when working I put in the first place the individual factors and influence of the family. Because I believe that a person first grows up in a family and only afterwards is influenced by the wider society. The basis of the personality is put by the family. And the fact that a woman has gotten the role of the victim in the relationship with her partner is rarely the first violence in her life. Most often in one way or another, her childhood relationships in the family have been destructive. If the social and cultural system can be analysed and its influence understood, it cannot be changed by an individual, and such changes happen slowly. But changes on the personality level are possible. And that, of course, influences the way how I work with my patients.’ (LT-S02)

The emphasis on family background is because the family unit is the primary social contact that people have in early development, and important elements of personality and emotional development are determined by
early social development. Other social factors such and friends and culture then add other layers of complexity to psychological development that can act as a determinant for violent or healthy relationships.

**LT-M**: Responses were very similar to those of counsellors in LT-S.

‘From my professional experience I can conclude that family has a big role in whether or not a person gets into violent situations. In family they learn social skills and roles within the family (e.g. victim role). However, in every individual case each factor has a different impact. There are cases where individual factors and personal characteristics have a very important role.’ (LT-M01)

Therefore, it is important to take an in-depth look at the early childhood of women who are suffering from domestic violence and intertwine this with individual reflection so she can attain the necessary understanding of her situation. This will allow her to determine what events and feelings in her life may have led her into a violent situation and if not treated may lead her into future violent relationships.

**BG**: It was stated that everything is relative, and all factors are involved to some extent. However, social status can determine the type of violence perpetrated and how it is experienced.

‘Psychological and ‘refined’ violence is more typical for the intellectual circles. In other spheres, there is clear difference and there the physical violence is more distinct.’ (BG01)

In BG, there was historical acceptance and broad tolerance towards violence in the family, both between partners, but also by parents towards children. Another concern was the influence of patriarchal education throughout the country’s history, and especially historical social habits and conventions.

**Summary**: Perceptions of factors that influence domestic violence differ between countries. Counsellors in the UK assert that individual factors are important but there are also complex cultural differences; domestic violence was viewed as essentially gender-based. In LT-S and LT-M, although the primary influential factor was the individual, family background contributed significantly to how domestic violence was perpetrated and experienced. In BG society, domestic violence is a patriarchal system in which violence between intimate partners and their children is an accepted norm.

### 4.2.3 THERAPEUTIC MODELS AND GENDER INFLUENCES

**UK**: Generally, counsellors in the UK tended to specialise in particular models, but The Haven’s counsellors were integrative and used a feminist Egan model; this means that they adopted different models of therapy depending on the needs of the client. The Egan model was very good in demonstrating to a client where they are because there were a number of tools that can be used.

**LT-S**: Respondents stated that the perspectives of women in terms of gender were taken into consideration. They specified that gender was taken into account not in a discriminatory way, but a background factor. For example, professionals considered whether or not clients were of the gender equality or patriarchal perspective. This was important in understanding the clients’ viewpoints so they know how to work with them.

‘Gender roles in our society are still very pronounced. Although, in my opinion, there are two trends. There are women whose beliefs are strongly based on the gender equality model, and there are women whose beliefs are strongly based on the patriarchal model. And therefore it is important to see in which model the woman sees herself in, and on the basis of that, we work with her.’ (LT-S01)

**BG**: Within this organisation, psychodrama was an effective model although it requires time. One respondent stated that this approach is right for everybody and that the gender perspective is not considered. On the contrary, the other counsellor stated that the gender perspective is considered mandatorily, and that the team had undergone specialist training particularly concerned with matters of gender. The interdisciplinary nature of the work was highlighted by one respondent.

‘...directed towards more complex interdisciplinary approach. Domestic violence is a multi-faceted phenomenon and there should be an appropriate specialty for each problematic unit. The fact that in our organisation we work in a multidisciplinary team really helps me...I rely on the appraisal and inclusion of jurist, doctors, and psychologists.’ (BG02)
There were no significant differences in therapeutic outcomes in respect to ethnic group. However, age was seen to impact outcomes as domestic violence impacts differently within age groups, for example, between children and women over the age of 60 years. This being so, clients were often signposted towards specialists.

**IT:-** For counsellors, domestic violence was perceived as resulting from social factors or based on cultural systems. It was mainly a result of societies that accept gender-based violent behaviours; a client’s gender perspective was the basis of any therapeutic approach for victims of domestic violence.

**NL:-** The gender perspective was contemplated in the approach of both respondents. One respondent stated that this was achieved by discussing power struggles between victim and perpetrator.

**Summary:** There was consensus from the UK, LT-S, IT and NL that the gender perspective of domestic violence was addressed with clients, but there was disagreement between counsellors in BG.

### 4.2.4 FACTORS CONSIDERED IMPORTANT TO THE COUNSELLING PROCESS

**UK:-** A client’s personal characteristics were not said to influence counselling outcomes. Counsellors indicated that they first and foremost work with the needs of the women; this was the first and most important thing. Then goals and objectives were identified, articulated, and developed using the Egan model. The process was built around what will work for the woman.

> ‘How I work is always the same, I use the same approach regardless of age but dependent on the needs of the client, it’s really important to stress this.’ (UK01)

Generalisation should not be a requirement of counselling as to generalise can be counter-productive. A younger client, someone from an ethnic minority background, an older woman, or a lesbian client might perhaps need different things. But the one thing they are all looking for is to understand how they were in the situation of domestic violence; quite often they do not understand how they got there.

**LT-S:-** Respondents maintained that the most important factors in the counselling process were the client’s full consent to the needs and goals of therapy. Clients must be determined and motivated to attain the help and change they desire. One respondent maintained that women must be prepared to work hard and be patient with the process as it takes time for them to see improvement. The most important thing is to regain a sense of security, and this feeling facilitates greater openness thereby allowing the therapeutic process to progress.

> ‘I think trust and conviction that every person has a healthy core of personality, which wants to develop and realize itself. And it exists even if the experience has been very hard, if the experienced events have left a destructive attitude towards self and towards life. It is possible to return to oneself and to an appropriate life.’ (LT-S02)

In order for the therapy to have any chance of success, the woman must have a strong sense of conviction that she does not want to be in her current situation any longer.

**LT-M:-** Two themes were tolerance and agreement on therapeutic goals. It was important that client and counsellor agree when it comes to therapy and desired outcomes of the counselling process. This means that the therapy administered is at its most effective and the client feels safe and involved in the recovery process; the success of therapy depends mainly on her.

> ‘The agreement with the client about the therapy process is important as it includes client’s needs and goals of the therapy. My beliefs outside of my professional work have no influence on the therapy process. My obligation is to stay within professional borders.’ (LT-M01)

Furthermore, neutrality plays an important role in the counselling process, since a counsellor must make sure not to influence the client to make decisions based on the counsellor’s beliefs and opinions. If the client does not learn to make decisions on her own that are in her favour as opposed to the benefit of others, the likelihood of recidivism is higher. Therefore, when teaching clients the tools to move forward autonomously, the counsellor must be aware of her role so that she does not inadvertently overpower the client.

> ‘For me it is important to stay neutral and constantly grow tolerance towards any difference, and to avoid those situations when my beliefs have some influence on the help that I provide. Although I am not sure what is meant in this question with the word “belief”. My belief could be that I have to be neutral and non-judgmental, and I allow these beliefs to influence the counselling process.’ (LT-M02)
BG:- There was consensus that counsellors’ own beliefs were an important aspect related to the model and approach used in therapy. Their beliefs were in complete accord with the approach used and were reflected in the whole counselling process. Counsellors in the focus group shared unique and common experiences of medical and psychological approaches, crisis intervention, and family counselling, agreeing there was more than one effective model, although neither one nor the other was sufficient on its own. The holistic approach, psychodrama, and sociometry were also discussed, but the consensus was that there was no most effective approach. Everyone shared the opinion that the therapist’s personality, their professional and personal experiences, and the relationship they establish with their client are significantly more important.

IT:- Regardless of the uniqueness of the design of the counselling process, there were some aspects that have to be reflected upon within the counselling approach. Firstly, counsellors take into consideration their client’s safety (and that of her children), and then all aspects of the client’s life, in particular their emotions and emotional intelligence.

NL:- A counselling process generally comprises a first moment where space and time are given to the client to talk freely, the counsellor being an active listener. One counsellor tries to undo a feeling of isolation that the victim might feel by intimating that her case is not the only one. The attitude of searching for help was also valued. Another counsellor said that she tries, along with her clients, to find the problems in their intimate relationships. Sometimes, some women want more than this discovery process and to look for direct answers.

Summary: A crucial factor in the design of a counselling process is the involvement of the clients in the setting of personal goals for the process; this is clearly a step to take by counsellors and clients together - defining the goals and objectives and primarily considering the women’s needs. A reference to the design of specific individual-oriented approach is emphasised, avoiding the duplication of one-fits-all counselling process (UK, LT-S, IT); the need for counsellors to first hear their clients in a full and open manner (NL). The client and her children’s safety is important to counsellors (LT-S, IT). Women should engage in their own recovery; the will to change must come from women themselves as well as the motivation to pursue the change (LT-S, LT-M). Moreover, clients’ personal characteristics can be of no relevance to the design of the counselling process, but the relationship established between the counsellor and the client is determining (UK, BG); counsellors’ own beliefs and professional experience can interact in the counselling design (BG).

4.2.5 CLIENT-SPECIFIC ATTRIBUTES WHICH INFLUENCE COUNSELLING APPROACH

IT:- Victims’ particular characteristics significantly influenced the counselling approach used and on the main outcomes of counselling. For example, women’s age is an important aspect to take into consideration when designing a counselling process. Counsellors cannot expect similar outcomes for young and older women; younger women may perceive and more easily overcome the gendered construction of social relationships. Ethnicity should also be considered when designing a counselling program. Sometimes migrant women bring situations of closed social relations based on their nationalities, different social and gender cultures and no understanding of human rights. It is important to consider the person herself. According to the counsellors’ experiences, the counselling process involves a unique design targeting the woman and her peculiarities and it is also central to know the woman’s perception of herself.

NL:- The domestic violence phenomenon is linked, in a way, to individual factors, but mostly to sociocultural ones. One respondent recognised the possible impact of variables such as age, assuming that with younger women the counselling work tended to be easier. Cultural differences can have an important role and discussions take place with clients to determine the best method to apply.

Summary: Both in IT and the NL there are features that can influence the counselling approach, namely age and ethnicity. Younger women can more easily understand and overcome the gender aspect of social relations and cultural features within violent relationships.

4.2.6 THE PROCESS - STEPS TAKEN IN COUNSELLING VICTIMS OF DOMESTIC VIOLENCE

UK:- Respondents only referred to the first session of counselling, which was for practical issues regarding the counselling contract to be addressed; it was important to get that framework in place. If the client had been
referred to the service, introductions would be made, length of the sessions and number of weeks addressed, the client would be asked what her expectations were from counselling, and matters of confidentiality would be discussed. It was important for both parties to be satisfied they understood what was going to happen. The first session was groundwork, the foundation of what was to follow. The first session was often difficult due to circumstances outside the counsellor’s control.  

‘Lots of clients will actually leave the first session telling you the most significant thing just as they’re going out the door and there’s not a lot you can do about that. So you put it in your notes, record it and the next time you see the client, hopefully that’s something that you can bring in and address in the next session.’ (UK02)  

From a practical perspective, it was important to ensure that when a client comes for counselling, everything is done to ensure that session is as productive as possible, for example, appointment time, childcare provision, or scheduling a Saturday morning session because of weekly commitments.  

**LT-S:** Crisis intervention was often the first step taken by specialists since women are in a highly stressful and volatile situation. Professionals must determine the client’s immediate needs on arrival, especially when the case is high risk. Afterwards, it is necessary to gather as much information as possible to understand the client’s crisis. Once this information is obtained, clients’ individual needs are determined. Having done that, the client and specialist decide together if they share the same understanding of the problems and needs so that, together, goals can be created to help the client overcome her problems. In conjunction with these goals, counselling models are employed based on the needs of the client. Specialists often employ cognitive behavioural approaches, restructuring of thinking, and re-processing of emotions. This allows the client to discover issues that precede and thus facilitate violence.  

‘First of all, we try to collect enough information to find out the real situation, how safe she is. We try to discuss with her all those possibilities to ensure that she can continue with the counselling process, especially if it is a crisis situation. One of the fundamentals is to create a trusting atmosphere. In the beginning it is mostly work with emotions and the actual situation. Then the more practical questions arise, for which they need support.’ (LT-S01)  

Another method employed was family therapy, a method used to deal with issues stemming from childhood, to understand issues such as co-dependence. Group therapy is used to help clients gain a broader perspective on the violence they had experienced. Existential therapy draws from other models due to the various situations of clients. In the event that communication is more difficult for some clients, sand therapy is used when there are things that cannot be expressed in words. When creating a family and relationships in a sand box, it is easier to get closer to some issues and speak about them. In terms of developing tools for future social interaction, training and role play sessions were used so that clients have an opportunity to discover themselves from different perspectives. For instance, clients may do role play which involves job interviews. This is done so they learn to feel confident and efficient in new roles outside of the ones they are familiar with. This gives them a greater sense of independence and inclination to move forwards.  

**LT-M:** Both respondents indicated that understanding the client’s expectations and goals for the outcome of therapy are important. However, clients may have specific expectations when they come to the counselling centre, or they may have little or none at all. It is the counsellor’s role to assist the client in formulating goals based on the expectations she expresses regardless of whether or not they are long- or short-term. Throughout the process of counselling, specialists’ understanding is crucial to therapeutic success.  

‘First and most important is to understand the goals of the help that I provide – first of all, to find out the client’s expectations, and what the professional assessment is on why the client needs to receive psychological support. Also the opinion of the case leader on why the client needs the psychological support needs to be asked. In most cases the view of the client and the case leader is similar, because already before the consultation with the psychologist the client has met with the case leader, i.e. social worker. Sometimes the expectations of the client and the case leader differ; in such cases the whole team needs to meet to agree on the opinions and to have one common understanding on the direction of the case.’ (LT-M02)  

Not one specialist is accountable, but an entire team is instrumental in assessing the needs of clients and subsequent course of support. Thus co-operation as well as understanding is necessary. If specialists do not understand the needs of clients and work together effectively, they run the risk of adding to the client’s trauma by delivering inappropriate interventions. Counselling models are employed based on the specific needs of the client. Specialists often employ cognitive behavioural approaches.
BG:-- Collaboration with other organisations was essential to ensure maximum benefit to clients; it was necessary to be familiar with social structures in order to suggest appropriate resources. This relied on receiving optimal information from the client. There was consideration of which specialists are appropriate to be consulted, who will lead the case, and what was expected to happen in the first few months. This was discussed directly with the client and, after discussion and mutual agreement, an action plan was designed.

‘The prime focus of the plan falls on risk appraisal, therapeutic goals, and tasks, ways and approaches, which would lead towards fulfilment of these goals. There is a time boundary and we determine the frequency of the sessions.’ (BG02)

There was very little interagency collaboration and linkage for children in BG, and improvements were recommended.

IT:-- When a woman comes to a support service, counsellors began by assessing risk and defining a safety plan. Counsellors likewise always consider the children as they are an important subject to be included in the women’s counselling process.

‘When the woman arrives, in her crisis moment, you evaluate her needs and level of danger, then it starts a phase of support on the aspects of the path, with all the needs the woman can have: social needs, economic, jurisdiction, parenting problems, etc. The help given in parenting problems is an important need for a woman: at a certain point these children raise a priority for them, even if before they were not at the centre of their problems.’ (IT02)

Counsellors’ usual steps are assessing the level of danger; identifying women’s needs (psychological, social, economic, legal); and getting to know the children’s psychological state.

NL:-- Within the social counselling provided in NL, the first step was to give time and space for women to talk about their experiences of violence. Women are then positively reinforced for their capacity of looking for help to change. Counsellors address intimate relationships, problems, and their clients trusted friends. In some situations, women are just looking for help in resolving practical matters.

Summary: Crisis intervention is always the first action taken by counsellors in LT as most women present as very emotionally unstable; in those situations, problems are identified and needs are later discussed. The therapeutic model most used was the CBM, taking an approach to the restructuring of thoughts and feelings (LT-S, LT-M); other approaches were used such as family therapy, group therapy, existential therapy, and sand therapy (LT-S). A common aspect was the need for all processes to be validated by the clients; for instance, with establishment of the therapeutic contract in the first session, counsellors clarified all relevant issues that will guide therapy (UK). In IT and BG, action plans were developed with the involvement of clients and counsellors.

4.2.7 FACTORS INFLUENCING CHANGE OF COUNSELLING APPROACH FOR THE SAME CLIENT

UK:-- A PCA is often used at the beginning to build a therapeutic relationship, to build trust and to offer positive reinforcement and empathy. If the client talks about her beliefs, CBT can be used, but perhaps only for one session. In terms of applying other models, one counsellor stated that she might change her approach and model from the Egan and PCA, although she would like to see robust research evidence behind other approaches, and that such research had been conducted with the social model or in a way that the female research respondents were facilitated in the most appropriate way. The CBM would be applied if a client was having negative automatic thoughts. This enables clients to notice how they see themselves in a negative light which often contributed to them remaining a victim. The CBM is often employed when working long-term. It is very much about learning and ensuring clients understand where their thought processes come from.

‘Getting them to actually notice when they are putting themselves down, so that they can eventually say to you, I was going to say that…..then I thought about it and I changed what I was going to say.’ (UK Focus group)

Other approaches used in therapy include Gestalt techniques, transactional analysis, psychodynamic work, and art therapy. Gestalt techniques are humanistic and very direct; they cannot be applied unless the counsellor knows the client very well. The counsellor might ask the client to look at an empty chair, to talk to who they perceive is sitting in the empty chair, and tell them how they feel. Alternatively, maybe the perpetrator of the abuse is sitting in the chair, and the client moves in and sits in the chair to try and see where that other person is
coming from - this can be very powerful therefore demands significant experience and must be practiced with great care. Transactional analysis clearly defines roles of parent, adult, and child, and how interactions between the roles work in the context of behaviour. Psychodynamic work explores a client’s life history (their childhood, what happened then, and how that affects them in adulthood). But again, this requires time.

‘You need to have the time because you can’t open a box of history and then close it again quickly. You’ve got to be able to feel safe enough and have the time to use this process. With TA, you can use it in a session in the same way as CBT, but certainly with psychodynamic work, you need to be sure that you’ve got time to do that.’ (UK Focus group)

Stones and shells are used in psychodynamic therapy too, in which the client assigns roles to stones, using them as a tool in conversation. Art therapy is used often if clients are able to draw.

‘If they can draw their emotions, and even if they can’t draw, really it’s amazing what comes out on paper…and write poetry as well…..very much any kind of the artistic nature that you can draw from a person, it’s amazing how it helps in their therapeutic process because it’s about them and it’s theirs and they own it, it’s brilliant really.’ (UK Focus group)

The important issue for any creative work in counselling is that counsellors convey to clients how good their creative expression is. They may have a history in which nobody has ever told them they are good at anything, especially in a situation of control. Positive affirmation is one of the most important features.

**Summary:** The answers obtained in the UK suggest the initial use of a PCA in order to establish an empathic relationship with clients. CBM is used when the client presents negative thoughts and beliefs about herself, long-term. Other models are used, such as Gestalt, which is a model that requires a great deal of experience on the behalf of the person applying it and the need to be well acquainted with the client, since this model uses techniques that can be very strong. The Psychodynamic approach is also a possibility, albeit a longer one. Transactional Analysis and Art Therapy can also be used.

### 4.2.8 EFFECTIVENESS OF THERAPEUTIC MODELS

**IT:** It was not easy to identify and distinguish the type of therapeutic model counsellors used. Nevertheless, one counsellor stated she was using the humanistic model. Another counsellor referred to person-centred counselling, focusing therapy on the woman’s will and determination, whilst the rest used a model that they had been developing since 2000, based on a three-phase approach: risk assessment, support, and empowerment. This three-phase approach allowed counsellors to assess the risk, to provide psychological support particularly when women see that they are experiencing violence, and to build a life project.

**NL:** Respondents were not psychologists; responses therefore did not directly relate to psychological or therapeutic models or approaches. One respondent referred to empowerment as the preferred model to work with women victims of domestic violence. The other respondent reported using the systems-related model, then the client-centred model at the end of session.

**Summary:** The more effective therapeutic models were not clearly identified. The humanistic approach and the PCA were mentioned as being the most used in IT where the development of a three-stage victim-centred approach is mentioned - risk evaluation; psychological support and empowerment. The notion of empowerment is also present in NL’s answers as something to be achieved with the woman although the intervention model was not specified.

### 4.2.9 OPTIMUM TIME TO INITIATE COUNSELLING FOR VICTIMS OF DOMESTIC VIOLENCE

**UK:** Generally, counsellors indicated there is no optimum time during a violent relationship when counselling might be beneficial; the time is right when the woman herself decides the time is right.

‘I have seen situations where the professional organisation will tell the woman that she should go into counselling, that they have booked her in for it. But this will not work. The woman herself needs to be ready. This gives them the autonomy and choice.’ (UK01)

‘When the woman wants to make the change, that is the biggest driver. And the will to make the change.’ (UK02)

**LT-S:** Both respondents maintained that the best time to initiate counselling is when a woman becomes aware of her situation and made the decision to take action.
COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING: COUNSELLORS AND CLIENTS

‘If a woman is in an acutely violent situation, then during the crisis phase after the act of violence, that is also normally the moment that they come here. But generally I could say that it is the time when the client is ready and comes here. When she is ready, it is her choice to try doing something. That it is not a suggestion from a professional, that you have to come and do something, that there is no pressure from the outside to take this decision.’ (LT-S01)

**LT-M:** The best time to initiate counselling is when the crisis has been overcome and the client has asked for help from the police or social worker. Therapy should be made available directly after crisis intervention.

‘The best time to start therapy is when the crisis (violent act) has been overcome and the client has received crisis help, she is safe from repeated violence. Any aggravation, repeated violence, or crisis can have a negative impact on the therapy process, because the focus changes from the client’s long-term needs to her short-term needs.’ (LT-M01)

**BG:** Respondents were asked what they consider the best time in a client’s recovery to begin counselling and why. They were also asked how long the process of counselling can take on average based on their own experience. There appeared to be misunderstanding of these two questions as well as differences of opinion. One respondent stated counselling could take 14 years, whilst the other maintained that for cases of domestic violence sometimes two to three months are not enough: the complexity of each case requires flexibility.

‘When the situation is urgent and there is a need of intervention, sometimes a crisis intervention for a period of 4-6 months is enough. It depends on the client’s desires, moods, and expectations. These are sometimes determining factors in regard to continuation. There are cases in which systematic work is not enough. Maybe, 2-3 months is the optimum, but if necessary the period can be expanded to not more than 6 months.’ (BG02)

**IT:** The best time to begin counselling is when the woman is out of danger; that is the moment when women can start to think for themselves and by themselves.

‘When a person is out of danger, when she is out from it she can start to elaborate about what she is living.’ (IT01)

‘When the woman is no longer in danger, because you can’t work to rebuild or reconstruct when women are risking their lives.’ (IT02)

When there is no more danger is also when women can present their life histories framed in a narrative which is more coherent and based on a (re)arrangement of memories; safety is somehow guaranteed and it is time to move forward through change.

**Summary:** The best moment for a woman to start the therapeutic process is when she decides to do so (UK, LT-S, LT-M). Another position argues that the intervention must take place when the woman becomes aware of her situation and decides to do something about it. From IT’s perspective, the woman can think about herself when her safety needs have been met.

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4.2.10 DURATION OF COUNSELLING

**UK:** Domestic violence is not a one-off occurrence: often domestic violence is systematic over a long period of time, so if clients do not feel they have gained insight, then returning to the violence relationship is possible. Counsellors agreed that domestic violence counselling can take anything from 10 sessions to over 100 sessions; it depends on the issues a woman or child presents with and whether they are in a safe place to confront these issues. If the woman has been traumatised by one issue, counsellors can deal with this one issue. However, if trauma has occurred over 35 years, there may be many more issues to deal with. So non-trauma could be dealt with in a shorter period of time, about 6-10 sessions. However, there was scepticism regarding long-term counselling.

‘We are talking about counselling. We’re not talking about psychotherapy and medical intervention...I think if someone was coming into counselling for a very long period of time, that would say to me either the counsellor is not working in the best way for that client or that there is a greater need for that client and they should be signposted to other services.’ (UK02)

Counsellors said they review clients every six sessions, so the therapeutic approach can be amended if required, but the number of sessions clients can access is not limited.
IT:-- Counselling takes, on average, two to three years. Although this seems to be an adequate period for emotional healing, sometimes it does not run in parallel with all other processes women are involved with, namely judicial processes, thereby lengthening counselling.

'It is very much linked to the legal question and unfortunately times of justice are very long, therefore some paths continue because there are trials, it is a critical phase for a woman, it means to put into play what happened, this can be therapeutic too, because it gives them a way to open and realize what is still opened and then you can address and tackle it. (...) The path is concluded when the need of the woman has transformed or has concluded.' (IT02)

So, after the two to three years of counselling, women are (somewhat) transformed or changed.

NL:-- The duration of counselling is one year, although some cases would take two to four weeks.

Summary: The duration of therapy is flexible; it depends on each situation and the fact that many victims are in violent relationships for a long time and so may require more extensive intervention. As such, some situations may take six to 10 sessions, yet others significantly more. In IT, the average time is two to three years, while in NL therapy usually lasts one year or less.

4.2.11 LIKELY PROBLEMS FOR CLIENTS

UK:-- Generally, counsellors were concerned that clients may become stuck, perhaps because they cannot move onto more difficult aspects of talking about their deepest feelings. It is time, not the counselling model per se, that may be a limiting factor for clients. It is a clear and helpful process in many ways, but some clients who do not think in systematic ways might find counselling challenging. That is why counselling is reviewed at six weeks, so clients are aware that it has to remain a useful intervention.

'With CBT, women are already aware it will be about 10-12 sessions. Apart from if they are moved from one counsellor to another and the issues are not dealt with.' (UK01)

'The cyclical Egan process was said by counsellors to be quite a driven process. Everything is very clear and it may well be that when clients get to a certain position in that cycle, they find it difficult to go to the next level, facing those really difficult, traumatic feelings and experiences. And so they go into the cycle again and then you use different models and tools to try and enable them to get past that block.' (UK02)

LT:-- There were four specific problems identified by respondents, specifically, short-term care for clients, assessment of client need, group therapy, and the practice of taking personal responsibility. With regard to the first topic, short-term care was offered for problems that may require long-term therapy. In lieu of that it is important for clients to identify the necessity for long-term therapy. That said, specialists must stay within the parameters of short-term care in order to achieve the goals therein.

'There is a risk that the client misunderstands the short therapy as the long one. But it is important for the client to understand the borders, and identify this necessity for a long-term therapy. My task is to keep the borders and to remind them about the goals of the short therapy.' (LT-S01)

The task of assessing what type of help the client needs is based on the characteristics of the case and is a delicate procedure; care must be taken in order for the client to receive effective treatment with the short-term care provided. Therefore, if not done well, precious time may be lost within the short time frame of therapy if a client has to change therapies or chooses to leave therapy due to dissatisfaction with the process. The group therapy approach also comes with risks to the client’s wellbeing. If the client is a beginner to group therapy, extra attention must be paid by the counsellor to ensure she feels safe and welcome in an open environment. However, even if special attention is paid, it is still possible the client will leave the group.

'A problem in group work can be considered the fact that there are women who in the beginning feel too insecure to work in a group, and there is a risk that she will leave the support group. And therefore it is necessary to give them more attention in the beginning, to contact them before the group meetings, remind them about the group. Also during the group meetings they should be supported in their every attempt to get more involved in the group work, and therefore help them to be part of the group. But it also must be taken into account that the group process is not suitable to all. And then we have to look for alternatives, which is not easy.' (LT-S01)
Approaches employed all entailed the need for clients to take personal responsibility for their lives. This is in spite of shortcomings within the social system. This approach is a particular challenge for women who blame others for their current situation and who must come to terms with their effect on their environment in order to recover from trauma.

**LT-M:** Problems arise with regards to duration of counselling. It would be optimal for counsellors to treat patients for a longer period of time, but they are limited to approximately five consultations. They have to try hard to ensure they understand their client’s initial concerns and administer the right counselling model or else the chance to help the client may be lost or prolonged. It was also mentioned that access to affordable care is a barrier to treatment; victims may be financially dependent upon their partners and therefore may not get help.

**BG:** There were difficulties with clients’ disclosure and sharing. Victims of domestic violence feel shame and guilt, find difficulty talking about their problems, and only disclose and share their experiences gradually. Counsellors should avoid provoking inhibitory tendencies in clients, and the therapeutic dyad should display power balance. Often the difficulty resides in the core of the phenomenon itself – domestic violence.

**IT:** Sometimes women raise obstacles relating to their willingness to get treatment for, or of contacting, their violent partners. Some women still demonstrate a desire to involve men as part of problem solution. This is something that counsellors must carefully deconstruct; the right intention framed in incorrect sentences at the wrong time can trigger bad decisions.

**Summary:** One concern for UK counsellors was the possibility of clients becoming getting stuck, so had adopted a standard procedure of evaluating the process every six sessions. Another concern was with the time available to deliver therapy, which is often short, when sometimes a longer process was needed (LT). BG states a problem for clients is embarrassment making it hard for her to talk, and the therapist must enable free and open dialogue. Counsellors in IT warn that in some cases the woman wants to involve her partner as part of the solution to the problem, so the approach to this must be handled with care.

### 4.2.12 PROBLEMS EXPERIENCED BY COUNSELLORS

**UK:** One respondent stated there were no problems perceived or experienced with the model of practice, and any issues that did arise are dealt with in clinical or peer supervision. However, another respondent said she was frustrated with herself when her clients became stuck.

‘I think sometimes just the frustration because you can see clients getting to a certain stage and then ... I use the word frustration because you really want the best for the client and it’s not frustration at them, it’s probably more frustration with myself in relation to what else can I do?’ (UK02)

On many occasions, difficulties can arise for counsellors when a client is dealing with a situation of oppression, power, and control, and the same issues are experienced from professional organisations. Counselling women in refuge and counselling women in the community present different challenges. For example, there is a range of practical issues that clients want to deal with apart from domestic violence matters; therapeutic counselling can sometimes be overshadowed by practical issues. If there is someone living in refuge and they are dealing with many practical issues, counselling may not have the same impact as it might on someone who has been re-housed and is in a stable environment. Whilst the concept of being non-judgemental and valuing each client was paramount, it was important to know if counsellors’ belief systems can impact them within their role. Respondents said it was particularly difficult to leave their own values and beliefs outside of the counselling context. If issues arose within the counselling context that impacted on the counsellor’s belief system, then these issues were explored in supervision.

**BG:** One respondent stated that accelerating the process of psychodrama empowers clients to become more active which, in turn, is acknowledged by the perpetrator who intensifies aggression. This is a serious complication of therapy and counsellors were aware of the problem. They would like to work in a broader context by also working with offenders. Another concern was related to vicarious trauma, but this was dealt with by peer support, or redirecting the case towards people who can better manage it.

**IT:** Problems were found within the service provider – limited physical space, long breaks between counselling sessions, and counsellor burnout. The main problem was psychological fatigue which can emerge
from working with victims of domestic violence. However, it was also frequently mentioned that the lack of financial and human resources can also cause difficulties for counsellors.

**Summary:** One of the problems pointed out by the counsellors is the possibility of the professional getting frustrated when she realizes that therapy isn't making progress (UK). The therapists' professional exhaustion and vicarious trauma are other features that constrain counsellors (BG). In IT, organizational features are aspects that can harm counselling, namely the physical conditions of the provider organisation, the space between sessions, and the organizations' financial status.

### 4.2.13 COUNSELLING VICTIMS STILL LIVING WITH PERPETRATORS

**UK:** There was mixed response to whether it is possible to continue to counsel women and children whilst they are still living with their abuser. One respondent stated that if it is a male/female relationship, then it would not be possible to counsel the woman; it is generally not safe for her to go back to the situation. However, if the perpetrator is the woman’s child then it becomes more complicated, although it is generally possible to counsel a woman if her child is still in the house. So it depends where and who the perpetrator is. The problem appears to be that, during the counselling process, the client will change. Those changes might only be very small and insignificant, but may be something that the perpetrator might pick up on.

> ‘The perpetrator has got used to the partner being in a certain way with a certain mind-set and by supporting the client to view things from a different perspective or to help them consider their other options, that will enable the client to operate in a different way in the relationship. So I think it is possible to do it but I do think the client needs to be made aware of those impacts in relation to the perpetrator. The safety aspect is absolutely critical.’ (UK02)

This is explained to the client. If clients are living with the perpetrator, then counsellors mainly work with issues of safety, and not deal with trauma associated with violence. The client’s individual needs are taken into account, which reflects the approach used. None of the counsellors interviewed or in the focus group had counselled women who still lived with their abuser.

**LT-S:** Respondents stated primarily that it is possible to counsel women who still live with the perpetrator, the main benefit being that therapy has the potential to empower a woman, even within her violent situation, to make a choice and try and get the help she needs.

> ‘Yes, it is possible, and maybe even it’s necessary. Both in group and individual counselling the most important thing is to strengthen the woman, so that she can take her own decisions about what to do.’ (LT-S01)

**LT-M:** Neither respondent has any client still living with their abuser. However, one counsellor said that therapy may have to stop at some point since a woman still living with the perpetrator is at increased risk of violence and would therefore need the intervention of other specialists such as social workers in a crisis situation.

**BG:** Group work would not stop if clients were still living with the perpetrator; pressure on the woman is greater, but this was viewed neither positively nor negatively. One respondent acknowledged that it was difficult to work with the client if they lived with their abuser, as the risk for the woman increases because she changes within therapy.

> ‘The psychodrama makes them experience catharsis, to rehearse different behaviours, but the unhealthy environment with their abuser could prevent them from doing so.’ (BG01)

The other respondent perceived no problems whether the woman chooses to leave or stay in the aggressive environment; the approach used does not exacerbate the symptoms.

> ‘The greatest difficulty is not to show my personal subjective opinion, and to protect myself from suggesting and sometimes hastening/rushing.’ (BG02)

**IT:** Despite living with violent partners, women can receive counselling, but these situations impose different strategies in order to overcome risks and to protect women. In other words, women do not have to break their relationship in order to be supported; the violence is tackled through other means.

> ‘Sometimes it happens that there are women coming here not regularly or continuously,'
staying with their partner and coming here to help them to understand how to act, how to live and protect themselves in that situation... the way of working has the goal of going out from the violence.’ (IT01)

However, some situations require time and specific measures that can, sometimes, include an interruption in the counselling process.

‘There are several women who arrive here when they still are in the situation, the difficulty is to keep together different aspects, the most difficult thing is when the woman does not perceive the danger and she doesn’t protect herself; in these cases I see the risk of a direct path as being too severe and would lead nowhere so I stop the process, so I prefer to wait a bit of time with this woman if she is not ready to take certain steps, because I noticed that reports made when the woman is not ready are not effective, on the contrary they take to the withdrawal of the complaint... ’ (IT02)

But also counsellors think that therapy is not always possible; they advised against it when women are living with the perpetrators.

NL:- The consensus was that counselling becomes harder, although the use of the systematic model in some situations was felt best.

Summary: The general opinion working with a client victim when she is still living with the aggressor is difficult because the victim can assume a more active role in the relationship which can trigger increase in her abuser’s aggressiveness. It is argued that therapy can continue with different approaches in order to avoid bigger risks but it might have to be interrupted at some point. The therapist might consider that therapy must not occur and should warn the woman about that. In LT one opinion was that psychotherapy can be a positive factor in increasing the woman's sense of empowerment.

4.2.14 MAIN CONCERN WHEN WORKING WITH VICTIMS OF DOMESTIC VIOLENCE

UK:- Clients’ safety on both physical and emotional levels was the primary concern when counselling victims of domestic violence, as there is the potential risk of suicide. A second concern was whether counsellors have sufficient skill to enable clients as much as possible, and how long funding will last for the service to continue.

‘Physically, you have to work out if that person is now in a safe environment, i.e. at a hostel, at a refuge, if the perpetrator has been pulled away or is not part of that relationship anymore, and emotional safety to come and talk when they feel okay, and to be able to go home and feel okay.’ (UK Focus group)

Clients can also be referred to other sections of the organisation that work from a legal perspective. For high risk cases, non-molestation orders could be adopted. The counsellors can work alongside such support from an emotional perspective. For clients in crisis, counsellors enable clients to rationalise what is going on and enable them to take control. It is also about breathing and relaxation, being more focused about what is happening around the client so their anxiety is reduced and the counsellor can start to rationalise with them about what is going on. So crisis sessions are about bringing the anxiety level down to a place where the client can begin to rationalise. These sessions are not about trauma. If a woman came in and evidenced that she had harmed herself or tried to take her life, then the counsellor will completely change the way they work.

LT-S:- The security of clients, especially after crisis intervention, was paramount amongst all respondents. Furthermore, it was important to understand the framework of violence; for example, the characteristics of a violent person, characteristics of a victim, as well as the dynamics of a violent relationship and the power struggles that can ensue. Respondents were also concerned with a need for stronger legislation to reflect the needs of clients, such as a need for greater access to services and legal protection for women suffering and recovering from domestic violence.

‘Here the legislation does not say that the perpetrator is the one who has to do something, need to receive help, have to change something in his life. We here have an absurd situation – the victim is already in crisis, but she is the one who has to change her living conditions. (LT-S Focus group)

For example, women often do not call the police due to law enforcement’s inability to detain the perpetrator for an extended period of time, thus rendering the woman vulnerable to reprisal. There is no legal demand for
the perpetrator to seek assistance for their problems so there is no effective legal solution for clients. Internal resources are also another concern; clients are often financially dependent on their partners, thus they have a difficult time making the decision to leave. For instance, if a woman leaves her partner, she has to consider finding a new home, a new job, and sufficient care for her children. Thus, remaining in a partnership, albeit destructive, makes it easier to sustain basic needs, so it is difficult for women to become independent.

LT-M: Respondents emphasised that understanding the nature of violence (behaviours, manifestations) as well as power relationships is important in order for clients to gain a different, more empowered perspective of their situation as well as to avoid violent relationships in the future. It was also important that the client is able to help herself in the event of a future crisis situation. She must have the tools to be self-reliant and have greater confidence in herself as she relates to her family, friends, and culture.

'It is important to understand the anatomy of violence – the characteristics of a violent person, characteristics of a victim, as well as the dynamics of a violent relationship, for example the cycle of violence, as well as (especially within my professional competences) the system how the individual is influenced by his/her family and people around, society and culture.' (LT-M01)

BG: Respondents said it is important to determine whether violence is active, whether it is chronic, and when peak moments arise. It is also important to assess resources available to the client, within her environment and at her place of work. Every aspect of a client’s life can play a significant role in recovery if used effectively. Counsellors’ main concerns were that the woman should feel secure, and to trust the therapist to listen and hear her. It is also important not to be intrusive. Support after therapy ends was also a main consideration. In the focus group discussion, psychological and social needs of clients came to the fore, and a substantial problematic area was outlined regarding the children of domestic violence victims. Some discussants suggested it was important for children to be counselled individually. Moreover, different therapeutic strategies in counselling mothers and children should be co-ordinated. Therefore, work in teams between child and mother was preferable.

IT: Assessment of risk and danger was the most relevant aspect to consider in therapeutic work. This was one of the first steps taken when women arrived at the service but also continuously throughout the counselling process. Counsellors’ main concern was their clients’ safety. It is important to assess the level of danger in the living conditions of women experiencing violence. This assessment allows measurement of risks to life women are facing, and to get a first acquaintance with the women’s capacities, competences, and emotional and social resources.

'For sure the detection of danger, trying to understand where the woman is; the intervention can work only if the woman is at my level, because if she describes a violent action but then she asks how to help him, how to cure him, my danger indications are not useful, I absolutely have to find a point of contact with the woman. I am worried however, when services minimize or normalize violence, when they are not aware of the seriousness of the elements of danger. For me, it is worrying when there is violence and the woman normalizes this; it is very difficult to manage, because there is no point of contact, your risk of losing that woman if you stay too much on a level of reality, of meaning. What worries me the most is the effects on children – this worries me greatly.' (IT Focus group)

Children are also one of the main concerns of counsellors. It is necessary to evaluate the level of risk and to develop protection measures and strategies to be applied by children. On one hand, when women are experiencing violence within an intimate partnership, some women may lose control of their own competences as mothers. On the other hand, often children are also experiencing violence, either targeted towards them or watching their mother being attacked or abused.

‘My main concerns are related to children. I can try to understand what is going on and the effects of the violence suffered in relation to parenting, but not when women talk about how these children are exposed, and the incapacity of the mothers to protect them.’ (IT02)

However, counselling children requires specialist training and specific tools designed for children of different ages. This is something that not all counsellors or even support services for victims of domestic violence possess. Nevertheless, safety is the main concern of counsellors and having this in mind can mean that to protect children or women they can act towards the criminalisation of perpetrators without women’s agreement.

NL: The main concern was for victims who were so badly hurt that counsellors did not know if their counselling was sufficient for them. Other difficulties were related to the victim’s condition herself than to the
counsellors' training. In that sense, difficulties identified in some counselling processes were more connected to the existence of children which can add a sense of insecurity to women concerning their capacity of raising children without their partners, and many victims were not ready to be independent and wanted to go back to the familiarity of home, despite mistreatment.

**Summary:** One feature concerned the victim's security and the need to prevent suicide, whilst another was the counsellors' expertise and the service’s financial status (UK). In LT, worries with safety as well as comprehension of the situation, clarifying characteristics that relate to the situation of violence and the victim herself, were concerns. Legislation that protects the victims and grants them support is required (LT-S). In IT, evaluating the risk and identifying the victim's personal and social skills was highlighted. Intervention with children is very important, and a concern was the need for qualified professionals doing that work, which isn't always the case. NL draws attention to the fact that the children can be an inhibiting factor for women during decision-making; in some cases women cannot think of themselves as capable of taking care of the children when they are still dependent themselves. Crisis intervention and stabilization of victims was another aspect to take into consideration.

### 4.3 PERCEIVED OUTCOMES RELATED TO THERAPEUTIC MODEL USED

Overview - This section of the comparative analysis assesses outcomes of counselling and determines if and how counsellors perform evaluate outcomes. It is also important to know if clients are involved in the therapeutic process (if it is a shared process or not).

#### 4.3.1 DEFINITION OF GOALS PRIOR TO COUNSELLING – CLIENTS’ INVOLVEMENT

**UK:** Once the ground rules have been discussed and agreed with clients, counsellors move on to eliciting what women expect from the sessions, and how counsellors can facilitate that. One counsellor stated that she can often define the goals of counselling. It may not be structured, such as identifying specific goals, but may be a general goal such as to be happy. Mostly, those goals were very much dependent on the client’s needs. So if the client needs brief therapy for particular issues, it is not necessarily about their trauma, rather other issues. For instance, the Egan model asks ‘Where are you?’, ‘Where do you want to go?’ and ‘How do you want to get there?’ Counsellor and client then work towards achieving that together. Sometimes it might take a number of sessions before those goals are realised. However, clients can become confused as to what their goals might be.

‘Sometimes, rather than the Egan, I do spider graphs with the client, so they are in the middle and then all their issues kind of stem off from the cells, and what that means to them, and then I get them to scale it so it’s almost like prioritising their need...this is definitely a five.....and this is definitely a one....so this enables them identify themselves, what it is that means the most at the time, and gets them very much involved in their process and working towards something.’ (UK Focus group)

**LT-S:** Respondents were adamant that the client must be fully involved in the process of counselling in that she must set her own goals with the counsellor. Part of the counsellor’s role is to inform the woman about violence if she has no pre-existing knowledge.

‘I always ask what is a client’s goal for the counselling process, her own personal goal. That is the most important goal. For myself I determine as a goal both in the individual and group counselling to inform the woman about violence as such if she does not have such knowledge and information already. But the goal of the counselling is chosen by the client, what she wants to achieve.’ (LT-S01)

Goals of therapy can change as the client’s situation changes, therefore what was decided at outset should be flexible to provide effective therapy.

‘I should talk about two things here. First, the goal of the counselling which is being formulated together with the client. This goal can change; can be rephrased when the situation changes or the client needs it. But in parallel my goal as a therapist working with women who are victims of domestic violence, is to renew their feeling of security, self-esteem and belief in self. To renew the inner health and the integrity of the client.’ (LT-S02)

**LT-M:** When defining goals, therapists must take into account the clients’ needs. The client and counsellor should understand goals the same way. Involvement of the client is a prerequisite to their recovery. Co-
operation between client and therapist is important in that the client’s ability to take responsibility for her life and take decisions is encouraged. However, although co-operation is necessary, it is important for the client to define her own goals and those goals must be open to change over time. Thus, goals are defined and changed during the process of understanding and development.

‘It is important to define the goals of the therapy taking into account client’s needs, and make sure that the client understands these determined goals the same way as I do. Involvement of the client in this process is one of the prerequisites.’ (LT-M01)

BG:- All respondents agreed that goals of counselling were defined following the application interview, in which the client’s needs and expectations are determined and what topics should not be addressed. Limits and time boundaries are determined and goals of therapy are agreed together. This confirms unanimously the important and necessary involvement of the client.

‘Maybe not in advance, but during the first session, immediately after orientating in the situation – then yes. Of course, this is done together with the client. This takes place in the constant conversation, while trying to generalise and outline goals together, and to report improvement/progress on the case.’ (BG02)

IT:- All counsellors established individual goals for all counselling processes but this could only be done by involving women. It was fundamental for goals to be defined with the involvement of women themselves. The definition of goals requires several stages. First, counsellors and clients discuss the client’s life history, then several questions are posed regarding the definition of goals. But by doing so, counsellors put the client at the centre, so all is done in a collaborative way between the two persons involved.

‘In setting the goals and the path, I am very explicit when I ask questions to the woman, when I ask about the violence, I tell her that is necessary to understand how much she is in danger along with her children, and step by step we can share the projects. Sometimes the woman has a project different from ours and it is very important to make it explicit and to be explicit in our plan, discussing it with her, as she can feel free to say what she thinks and what she wants to do: together we can estimate the feasibility of her plan, you just need continuous dialogue, this is essential.’ (IT Focus group)

However, some aspects are very important, namely the women’s and children’s safety. Sometimes women themselves do not have full perception of the level of danger they or their children are in; this is clearly one of the main tasks of counsellors.

Summary: All counsellors considered involvement of clients as a basic feature in the definition of counselling goals, which are clearly dependent on the clients’ immediate and long term needs (UK), and must be adaptable to the client’s situation, reflecting change over time (LT-S, LT-M). Needs and goals should be defined in close collaboration between counsellor and client (UK, LT-M, BG, IT), and goals are a pre-requisite and good monitoring indicator of the recovery process (UK, LT-M). However, the client and her children’s safety is also a major goal, sometimes demanding action from the counsellor as not all clients perceive the risk they are facing (IT).

4.3.2 EXTENT OF CLIENT INVOLVEMENT IN THE COUNSELLING PROCESS

UK:- Client involvement in their development and future was considered top priority by counsellors. This was reflected within the Egan model; clients define their own problems, choose their own goals, and choose their preferred approach to problem resolution. There is reluctance to revisit trauma when clients are not prepared, and often, if there is a good therapeutic relationship, a client can become defensive and remain silent. At such times, the counsellor asks what the client would like to do. The therapist would then work in silence with craft materials. So although there is no therapeutic conversation, other beneficial work has taken place.

LT-S:- Respondents were adamant that clients are responsible for shaping their life; all specialists can do is provide the tools for clients to proceed with greater autonomy. Specialists aspire to teach the client and renew her ability to function socially on her own, for instance to find and use her own internal resources, as well as external resources. An end goal was that the client can go forward without the specialist’s support and she is able to manage her own life. It was very important to avoid situations where specialists make decisions in place of a client, or pressure clients into making decisions based solely on the therapist’s opinion.
The future is in their hands, and we talk together about the possible resources and solutions. What are the consequences for that solution, and what are for the other ones. What are her resources, and what she can do. We discuss variants A, B and C, but she has to take decisions in real life. We can help her to prepare the fishing line and teach her to fish, but it is her decision what type of fishes she will catch. (LT-S Focus group)

BG: - A judgement on clients’ involvement in the counselling process was a difficult matter for respondents to address. It was indicated that all clients develop individually, but they have learned family attitudes, so both personal and family circumstances are included.

IT: - In most situations, counsellors considered involvement of clients in designing their own life’s project.

‘Yes, immediately, because this begins from her and even if the request is in a dangerous situation, she should be the one to decide whether to leave or not.’ (IT01)

Nevertheless, counsellors assess case by case. Based on literature and their own professional experience, counsellors pre-establish therapeutic goals then discuss them with clients looking for consensus and commitment and, eventually, include goals brought by women. What sometimes happens is that counsellors need to change the goals; there are cases when the involvement of women is weighed considering, for instance, the children’s safety.

‘Obviously if there are minors, you have to do what is required from the law and you have to explain to her the seriousness of the situation if the children are at risk; after all it is always up to her to decide.’ (IT01)

But counsellors bear in mind they are dealing with women who in the course of the counselling process are able to accomplish their own immediate goals regardless of the difficult times they have experienced.

NL: - Concerning the design of their life project, women are definitely involved in it. Outcomes were monitored with clients whenever possible and as long as they were willing to collaborate. Another evaluation is made through the number of women who are willing to live their lives apart from their perpetrators.

Summary: Clients’ involvement in the counselling process is of major importance (UK, LT-S, NL, IT); they define problems, establish goals, and decide how to approach them (UK). Clients are the sculptors of their own lives and counsellors are the tools; the counselling process helps them to regain their abilities and social competencies and to make use of their internal and external resources (LT-S). Clients are not always prepared to talk about traumatic experiences, and counsellors should consider that and work with them in different ways (UK), avoiding making decisions, or pressuring clients to make decisions (LT-S) and consider personal and family circumstances (BG). At the end, most clients fulfil their goals (IT).

4.3.3 MEASUREMENT OF CLIENT OUTCOMES

UK: - In measuring outcomes, counsellors usually revert to the initial goals which they review with the client, if appropriate. Often clients can see for themselves the growth patterns over time. If the client does not see how much she has grown, there is still more work to do. If the client’s beliefs prevent her from seeing growth, then CBT would be employed to challenge those beliefs. It is impossible to identify generalised outcomes for all clients of the counselling service as their needs are very individual. However, organisational objectives are always considered as required outcomes.

‘We address these priority outcomes for the client, but as an organisation fundamentally opposed to domestic violence, through the process that information or some of that will be touched on with each and every client, at the most relevant and appropriate time.’ (UK02)

Also clients are asked to complete self-report evaluation forms, but the general feeling is that if clients do not need their counsellor anymore, then they have been successful. All the evaluation forms that have been received to date were all very positive. There have been no complaints of the service, and usually if a client is dissatisfied in some way because they have been challenged, that is usually resolved between counsellor and client; this is part of the process of change and growth. Some dissatisfaction is about projection of anger onto the counsellor; some of it is about transference; because it is a safe environment.

LT-S: - There was a system in place to measure the results of the counselling process, the use of
evaluation forms, client feedback at the end of the process, and a control meeting six months after the cessation of group therapy.

‘One way is through the above mentioned client evaluation forms. Second, is the feedback from the client at the end of the process – how the client sees the results. For group therapy, six months after the therapy we organise a control meeting that allows us to evaluate the achieved results in a longer time frame.’ (LT-S02)

A dependency test may be administered to clients to measure therapy success. In the case of minors, a questionnaire was given after the therapy ends to measure the effectiveness of treatment.

‘If children come from the social rehabilitation programme, I give them a questionnaire of trauma symptoms and a checklist at the beginning and at the end of the therapy. For adults in individual counselling I do not use any measurable tools.’ (LT-S Focus group)

**LT-M:** Respondents used evaluation forms, feedback sessions, and control meetings held six months after the cessation of therapy. In other instances, specialist and client together assess the results of therapy using a 10-point system related to goal attainment. However, self-assessment of the client was also very important.

**BG:** Two measures were reported, clients’ actual behaviour change, and self-reported client assessment of outcomes, although these can be very subjective. Most participants in the focus group reported that they measured results of therapy quantitatively at the end of the process through inquiries and specialist questionnaires.

‘I am a person who relies on practice. They change their behaviour, quality of life, better self-evaluation, they change their paternal behaviours, they start defending the child from the violator, they improve their sensations and start recognising cues of violence.’ (BG01)

‘Sometimes the results and effects of counselling are very subjective matters. These are not just numbers or quantities we could measure. For us, the feedback on part of the client is very important. We have special inquiries, which after each session our clients complete.’ (BG02)

**IT:** It seems somehow obvious that counselling women experiencing domestic violence is a complex process that is frequently constrained by time. Women look for help at key moments of their violent relationship and when women recover, counselling ends as does the contact between counsellor and client. So measuring outcomes implies assessment of immediate results.

‘There is not a test, you notice the results gradually, little by little, just talking through the interviews you see if what was defined in the talks has been achieved.’ (IT01)

However, assessing long-term outcomes was something that counsellors intend to work on in the near future.

‘I think we should start to work for measuring the results. Anyway, we can see results because a lot of women go out from the situation; in longer paths we can notice results step by step, but there is no control in the next period to prove the strength of the result. I think we lack an evaluation system that is more articulated, I would like to engage myself with this in the future, and we could find some objective indicators and indicators of change, to verify the women’s ability of mentalizing the change’. (IT Focus group)

**Summary:** The measurement of client outcomes is mostly done by a structured system, using self-report evaluation forms (UK), evaluation forms plus client feedback, feedback sessions, and control meeting six month afterwards (LT-S, LT-M), a 10-point system related to goal attainment (LT-M), and inquiries and specialized self-assessment questionnaires (BG, UK, LT-M, BG, IT). There are no general outcomes, as outcomes are a reflection of the successful work done on clients’ needs (UK); not all assess long-term outcomes (IT).

**4.3.4 CLIENT OUTCOMES OBSERVED BY COUNSELLORS**

**UK:** The key outcomes most frequently observed by counsellors were growth, determination, empowerment, autonomy, choice, and self-esteem. Being able to function normally in life and employing coping strategies learned within counselling are fundamental outcomes of specialist counselling for victims of domestic violence. When clients leave counselling, they should be in a place where they can function, where they have greater self-esteem, and where they understand their thought processes and feelings. Clients should
recognise they are being acknowledged and that somebody believes their story. Clients are then at a stage in their lives where they can cope and manage their lives more effectively.

**LT-S:** Achievements were measured by the outcome that the client gets out of her situation or has increased her control over it. In this way, clients learn how to adequately react in crisis situations and look for internal and external resources to overcome a crisis. They know their rights and leave with the tools to protect themselves.

**LT-M:** There were two categories of outcomes of counselling, namely visible and invisible. Visible ones are usually reduction of anxiety and fear, and increase in emotional stability to make practical decisions such as divorce. Furthermore, women become more social and build new relationships, but ultimately know that their happiness is not dependent on male companionship. The invisible ones included deeper insight into and belief in oneself. One counsellor measured her achievements when her clients are better able to handle crisis situations and know how to look for external resources.

**BG:** Clients’ recognition and articulation of violence is a key outcome of counselling, as is their change in reaction towards it. There is change not only in their view of the perpetrator, but also of themselves. Clients can also more easily recognise their own needs. Sometimes they learn how to counteract and even leave the violent relationship, although this usually takes some time to achieve. One respondent stated the most tangible outcome is reduced anxiety and other symptoms. It was noted in the focus group that, initially, outcomes are not the same across all counselling approaches. The psychodramatists stated that often the situation exacerbates and worsens, and violent episodes can occur. However, in most other approaches, colleagues reported improvement in clients’ emotional states, and better orientation towards decisions and behaviours preventing future violence. Colleagues using psychodrama stated that re-enactment and rehearsal of different behavioural models in the psychodrama group sometimes leads to prevention and decrease of violent episodes. Often clients rehearse how to prevent aggression, which provides insights that allow them to analyse what provokes the perpetrator, and where her limits of permeability are.

**IT:** The first outcome was unmistakably linked to awareness that domestic violence was more common than expected. This was of enormous importance as it means that the problem does not impact women individually but rather on women as a social category. So this is a double kind of outcome and awareness – women are not the ones responsible for the violence they experienced, and there are other women facing the same situation. This awareness has a direct impact on women’s self-esteem as when they see that they are not irrational it enables them to begin building on their own individuality, psychologically and physically. Another relevant outcome is ‘looking and thinking of me’. During the counselling process women begin to relocate themselves in their own framework of thinking; it is their thoughts, emotions, and impressions that are now relevant. And they start to feel themselves as active agents and in back-grounding the other’s figure. Being an active agent means taking control of their lives, of crossing the border from being a victim to being a survivor. Another outcome expressed by respondents was the formal breaking of the violent relationship.

**NL:** There is a distinction between counselling and therapy, clearly stated by one respondent. However, most responses were related with social work, not the therapeutic approach; when this kind of intervention is considered necessary, women are referred to other services. From the beginning, one respondent stressed as a positive thing the nonexistence of health problems, especially mental illness, as an outcome of counselling.

**Summary:** The most evident outcome observed by counsellors is client growth, determination, autonomy, and self-esteem (UK, LT-S, LT-M, BG, IT). Increased control over their own lives, coping strategies for dealing with crisis situations, being equipped with tools for self-protection (LT-S, LT-M, BG) and to manage life’s challenges (UK) are visible outcomes. Reduced anxiety and fear, more emotional stability (LT-M, IT), notably to ‘see’ and believe in themselves (BG, IT), and looking for external resources with regard to their human rights (LT-S, LT-M) were also observed outcomes.
4.3.5 FUNDING CONSTRAINTS

**UK:** If there had been no termination of funding, then the service would have been in a unique position. The service was free to clients with no difficulties in relation to constraining the number of times clients were seen. For some clients, having a restricted timeframe might not be the best way to work, but the process eventually has to come to an end, so there has to be a cut-off point.

**LT-S:** Respondents’ services already suffered from insufficient funding so, having 10 free consultations to offer was seen as optimal. They cannot ensure free-of-charge consultations for a longer period of time.

**LT-M:** Respondents stated that lack of funding affects their ability to administer treatment beyond a certain timeframe. They must deliver therapy that is both effective and free. The concern is that women who need long-term therapy are often unable to afford it themselves. A balance must be struck between choosing a therapy that is right for the client but also accessible. Due to financial constraints, some specialists cannot satisfy the client’s needs when their support requires more than five consultations.

**BG:** Funding constraints resulted in a reduction of the number of cases undertaken. When budget is limited, they try not to accept too many cases, rather direct people toward other services. However, the organisation strived to prevent funding issues from having a direct impact on its clients. It was recommended that funding for counselling for victims of domestic violence should become government policy.

**IT:** The lack of funding, or insufficient funding, has a strong impact on the quality of services an organisation can offer to female victims of domestic violence. It impacts directly on the counselling process, making it necessary to reduce the number of sessions per woman, or decreasing the number of women that can be helped.

**NL:** Funding this work seems to be a problem. All counselling work with a victim of domestic violence - from practical needs until the counselling process that allows a restructuring of the victim which facilitates her empowerment process and prevents relapses - is a process that in some cases can last longer and it must not be interrupted, adding to that the need for professionals to be highly trained. One respondent mentioned that the work carried out with victims is voluntary work, and although they tried to give as much time to all victims as possible, lack of government financial support often resulted in the use of volunteers’ personal money. In any case, the objectives of the work were always built with client participation. One other problem referred to as very serious, and actually worsened, was the continuous funding cuts to services and organisations. These cuts have had serious implications for work being carried out with victims. A greater financial capacity would allow reduction of waiting times in finding safe accommodation with the consequent benefits regarding victim safety. Only a few clients can escape this situation if they have private health insurance that supports the costs of specific therapeutic processes, but those cases are a minority, which means that specialist support is not available in some organisations, which can be a serious problem in recovery and prevention of relapse.

**Summary:** Funding constraints impact the number of sessions services can offer to clients regardless of their need for longer therapy (UK, LT-S, LT-M, IT), but not on the quality of the service provided (UK). It impacts on the timeframe of the counselling process, imposing on clients a waiting time not suitable to their immediate needs and sometimes referring clients to other services (BG, IT, NL). Lack of funding can put an end to specialist service provision (UK, IT).

4.3.6 CONSEQUENCES OF FUNDING CUTS TO THE COUNSELLING SERVICE

**UK:** Long-term impact of closure of the service was almost impossible to measure. The financial cost of closure can be measured, but the cost of emotional damage to women who had their counselling curtailed, and to society generally, is immeasurable. When the service had its funding cut there was a sense of loss and grief because current clients were nowhere near finishing counselling, and they had to be referred to other counselling services. But some clients did not want to switch counsellors. Counsellors were generally very concerned about the continued welfare of their clients.

'It’s ethically and morally wrong to open someone’s emotional boxes and then say to them: well, that’s it.’ (UK Focus group)

'I’m gutted that this is going to be taken away. One of our clients found the words for the
Moreover, there was no other similar specialist domestic violence counselling service offered free at the point of entry in the locality. The repercussions of service closure were that women and children living in the area would have no specialist counselling service that addressed domestic violence, rape, and sexual abuse.

‘There is no free service provision so if people did need counselling they will have to try and afford it, which in this economic climate, is not really easy or they can wait for a doctor which is going to take some time and also the sessions will be very limited. It wouldn’t be trauma therapy, it would usually be CBT.’ (UK Focus Group)

Within this highly specialist service, the boys’ counsellor was a very positive role model to young boys up to the age of seventeen, so to lose that role would be detrimental to the growth and development of this client group. There was generally a sense of despair at respondents’ perceptions of their clients’ thoughts and reactions to the closure of the service. Without this specialist counselling service, clients would not learn how to keep themselves safe, they would not learn how to change, they would not learn to identify domestic violence, and they would not accept they had been a victim of domestic violence. To some extent, some of the clients were in denial of service closure; they just did not believe it had happened.

LT-S:- Funding cuts have already taken place in LT. In the case of LT-S, funding has been postponed from 2013-2014 and therefore they must make do with money they already have which is not enough.

‘Although on the government level there is a programme against the violence in family, it is currently postponed until 2013 or 2014 due to lack of funds. Therefore there cannot even be talk about regular funding. The funds are as big as it is possible to get from the participation in projects or through donations. We do all that we can think of, but it is not enough. Therefore I could say that for our clients the situation would improve if the violence in family would be finally admitted as a national policy issue. But it should be admitted in practical help, by solving the financial issue, rather than just in words.’ (LT-S01)

It was important to understand the ramification of not being able to provide free counselling to victims of domestic violence.

‘They would not be able to afford it. It is particular that with the violence there is very often financial dependency. The oppressor has the wallet, and the woman is not able to pay even if she would like to work. And therefore to ask the oppressor for money ... Of course there are cases, when it is possible. But honestly, if the counselling is not free of charge it limits them very much.’ (LT-S Focus group)

Women may have to suffer even longer in a violent situation because they cannot afford to get the psychological and practical help they need. This can cause some women to lose hope or develop deep psychological trauma that may require long-term help that some centres may not be able to provide because their financial constraints force them to offer only short-term care. Experience often shows that receiving donations is effective not only in gaining funds but in educating members of the public who support the organisation. Co-payment is another method whereby clients give as much as they can for the service. Project funding is also a method employed to pay for services.

LT-M:- In the event of funding cuts, the task of social workers would be to find external resources from other organisations to provide therapy if necessary. It was also believed that if funding should be cut, clients would be unable to afford a psychologist, psychotherapist, or other specialist to stop the violence.

‘If the financing was fully cut, then victims of violence could be left without any help, because most of our clients cannot financially afford to pay for a psychologist, psychotherapist and other specialists in order to stop the violence they are suffering from.’ (LT-M02)

BG:- The consequence of funding cuts would be a reduction in the number of clients accepted into the service. In the focus group, special attention was directed towards different ways of financing, and it transpired that, in BG, there is no single government programme for victims of domestic violence, irrespective of whether they are children or women. Counsellors from different NGOs stated their work with clients occurred in different projects, all of which were financially unstable; often a decrease in the capacity of cases is necessary. Some counsellors stated that some NGOs have closed their services for victims of domestic violence. An example was given of the closing of shelter services in an organisation in Plovdiv two years previously.
IT:- Funding cuts, and the political orientation attached to what funding institutions considered being the main priorities, strongly impacts on service quality. In that sense, the priority in IT is to provide emergency services rather than continuous counselling services. Lack of funding would immediately impact on the quality of service provided, but could also implicate the end of the service.

‘I suppose that the repercussions on women would be serious because an historic point of reference would suddenly lack; it is almost 20 years that we are on the territory, we are well-known and the consequences of closing a centre to which women could not refer anymore would be absolutely tragic.’ (IT02)

**Summary:** The most devastating consequence of funding cuts to counselling services would be their closure; it would impact on the community but particularly clients who are currently undergoing counselling (UK). The closure of specialist services would have a devastating impact on women and children affected by domestic violence (UK, LT-S). Most clients cannot afford to pay for specialist treatment (LT-M), and funding cuts result in short-term treatments that do not always meet clients’ needs, and longer waiting lists which impact on client motivation (LT-S, IT). All services have already experienced funding cuts, but services now in place are insufficient and capacity is limited.

4.3.7 CLOSING REMARKS - ADDITIONAL INFORMATION PROVIDED BY COUNSELLORS

**UK:** Two issues were emphasised: the complexity of the approach and model used to counsel victims of domestic violence; and recommendations for the outcome of the research study, in terms of identifying the need for specialist counselling for victims of domestic violence. It was difficult to measure the outcomes of counselling in terms of prevention of future domestic violence. However, the approach to therapy should facilitate personal growth so clients should recognise and understand oppression, power, and control. As the client changes during therapy, this inevitably will impact the perpetrator if they are still in a relationship. It is possible that future violence may be averted when the client gets to a stage in the counselling process that domestic violence is recognised in all its shapes and forms. Clients can become more informed about their own needs so that if they were to identify violent or controlling behaviour within any relationship they should be able to walk away, because their self-esteem and valuation of self has increased.

**LT-S:** One respondent re-asserted the damage done by domestic violence to the body and soul. In order for the soul to regenerate there is a need for a smart support system.

**LT-M:** The struggles of women in violent situations are worldwide and all encompassing. Measures should be taken at policy level to ensure improved outcomes for women suffering domestic violence.

**IT:** Preventing new situations or episodes of domestic violence was one of the main objectives of counselling approaches, either in present or future intimate relationships. One group of counsellors went further in trying to know the impact of counselling for domestic violence and discovered that, whilst some women were still living in a violent relationship and others found themselves in new violent relationships, the majority were living in safety. However, counsellors mentioned that their knowledge in this matter was quite limited because they did not maintain contact with women who had completed counselling, therefore did not know how these women were living and with whom. There are still some situations that have a strong negative impact in preventing women to return to violent relationships: migration, long-term relationships, and emergency situations where women were taken into refuge but were not prepared to accept the change that leaving a violent relationship requires. Counsellors were quite critical of the way policies are defined and implemented, particularly in the area of domestic violence, since recent policies do not take into account the need for prevention. Violent behaviour, in particular gender-based violence, is deeply rooted in Italian society, and this is a matter that would need a more comprehensive approach and targeted gender interventions from a vast range of services.

**NL:** There was uncertainty in the use of any preventive measures regarding new situations of violence.
Summary: Counsellors expressed their difficulties in measuring the outcomes of counselling in terms of the prevention of future domestic violence (UK, IT, NL). However, counselling will certainly produce a change in the way clients perceive domestic violence, acting as a tool for recognition. Counselling allowed clients to grow, gain self-esteem and improved value of self (UK). Domestic violence causes damage to the victim’s body and soul (LT-S) and it is a worldwide phenomenon that requires political will, policies and initiatives to combat it; therefore, policies should have a more comprehensive and holistic approach, targeting the gender dimension of domestic violence (LT-M, IT).

5 COMPARATIVE ANALYSIS CONCLUSION

Having empirical research material that explores the same themes across different sample groups, it is useful to collate the data to present a clearer and wider picture of counselling approaches to female survivors of domestic violence. The comparative analysis conclusion presented here draws together diverse views and knowledge of experience in counselling survivors of domestic violence, from the professionals who practise it to the clients who experience it.

UNITED KINGDOM

Counsellors’ training and experience - Training received by counsellors to diploma standard was adequate, but in-house learning was significant to a thorough understanding of how to appropriately intervene to support victims of domestic violence. Regular supervision was received in relation to a number of counselling hours worked. External clinical supervision occurred twice a month with managerial supervision conducted once a month. Difficulties can arise for counsellors when a client is faced with oppression, power, and control concurrently by professional organisations and by the perpetrator.

Clients’ help seeking behaviour and service contact - Decisions to seek counselling derived from despair and hopelessness which triggered help-seeking behaviour as clients could not recover alone. Referrals were made primarily by refuge Support Workers, Community Teams, police, and support workers from other services. Years of abuse and suffering sparked by a specific incident culminated in relationship separation and self-referral. Being at a low point, needing pressure release, living a chaotic existence which allowed no time to think, and limited understanding led to partial expectations and responses are crucial in the counsellor’s response within a multicultural society. Waiting times were the only perceived barrier to access. This was the first counselling for domestic violence that clients and their children had received; previous experiences through other sources had been adverse or unhelpful. Although there was initially an element of apprehensiveness, respondents swiftly relaxed into the relationship and were soon able to talk confidently and openly. Respondents had been receiving counselling ranging from between four weeks and one and a half years.

Therapeutic models and approaches - Free counselling sessions were held once a week with a degree of flexibility yet tempered by the need for clients not to become dependent; counselling began weekly and was then reduced via a staged approach. Reviews were held every six sessions so the therapeutic approach could be tailored to the client’s requirements, but the number of sessions per client was not limited. Counsellors explained in detail the ethics and processes of counselling at the outset and, although goals were client-led, counsellors helped to articulate issues, so goals were jointly developed and agreed. The client’s involvement in her own development and future was considered top priority by counsellors. Counsellors were integrative in orientation and used a feminist Egan framework within which they applied different models of therapy depending on client need (CBT, Gestalt techniques, Transactional Analysis, Psychodynamic work, and Art Therapies). However, clients showed little understanding of the counselling model or approach. Counsellors worked primarily with the needs of their clients, whose physical and emotional safety was of primary concern as there was often the potential for suicide. Counsellors gave mixed responses as to whether it is possible to counsel women and children who still lived with their abuser. Clients valued reciprocal respect, and the truthfulness, honesty, and non-judgemental attitudes of counsellors who encouraged them to be independent. The work of the counsellor enabled relief from feelings of blame and shame. Suffering and anger were often interlaced with laughter and joking within the therapeutic relationship which had the capacity to normalise feelings and reduce anxiety. Children need connection on their own level to experience positive outcomes; empathy was exceedingly important in supporting children. Clients could become stuck within the process, perhaps because they could not move onto more difficult aspects or their deepest feelings when talking about domestic violence. It was time, not the model, which may be a limiter or facilitator for clients. Professional and personal empathic responses were crucial in building trust and respect. The friendship and listening skills of counsellors contributed to good therapeutic relationships and in some cases resulted in suicide prevention. The depth of reciprocal relationships improved over time and it was only with continuity and reliability that positive outcomes ensued.
**Perceived outcomes** - Clients were helped to better understand their experiences and themselves, to feel they were genuinely listened to, and to regain autonomy and move forward. Positive personal achievements included perceiving a future after feeling suicidal, increased confidence, generalisation of problem-solving skills, future planning, entering education, and improvement in children’s cognition and behaviour. Outward displays of emotion were reduced through the release of concealed and suppressed thoughts and emotions. Beliefs about domestic violence were now shared within the whole family. Some clients became sympathetic towards other victims of domestic violence, expressing a need to help them. The children’s counsellor was instrumental in helping children to better manage anger and solve problems peacefully. There was differential impact between clients living in refuge and those living in the community. The key outcomes most frequently observed by counsellors were growth, determination, empowerment, autonomy, choice, and self-esteem. Being able to function normally in life and employ coping strategies learned within counselling were fundamental outcomes. It was difficult to measure outcomes in prevention of future domestic violence. However, the approach to therapy should facilitate personal growth so clients will recognise and understand oppression, power, and control. Meeting organisational and funders’ objectives were required outcomes. Clients were generally asked to complete self-report evaluation forms. The data showed no negative outcomes of counselling.

**Recommendations for services and counsellors** - Continuity of counselling support is vital so more specialist counselling services (for women and children) are required with more publicity, public awareness, and increased referrals. More specialist training courses should be available to enable generic counsellors to upgrade in order to specialise in domestic violence. The long-term impact of service closure was impossible to measure; although the financial cost could be measured, the emotional health and wellbeing of clients and of society generally was immeasurable - counsellors were highly concerned about the continued welfare of their clients. Financial issues should be a lower priority than the safety and wellbeing of women and children.

**Recommendations for victims** - Counselling must only be undertaken if and when the domestic violence victim feels it is right for her, and it is only effective when there is a positive relationship built on mutual trust, respect, and understanding between client and counsellor. Counselling is not easy and clients should be motivated and determined in order to achieve sound outcomes.

**Bulgaria**

**Counsellors’ training and experience** - Counsellors operated within a multi-agency organisation including legal and medical services, which benefits clients with accompanying children. They worked to integrationist and crisis intervention models with humanist and narrative approaches. Gender-neutral psycho-drama was preferred and considered effective although time-expensive. Usually clients have one or two counsellors. Training courses were varied and accessible although years of experience enhanced education. Continued learning through action research in the non-statutory domestic violence sector greatly augmented learning experiences received in the statutory sector. Structured supervision with opportunities for crisis supervision ensured caseloads and counsellors were monitored. Collaboration with other organisations was fundamental to ensuring maximum client benefit; familiarity with social structures was required to enable signposting to appropriate resources. Bulgaria has little inter-agency collaboration for children.

**Clients’ help seeking behaviour and service contact** - Clients sought help via telephone helplines, the Internet, television programmes, word of mouth, and from child protection services. Triggers to access were escalating violence, children becoming affected, deteriorating health, and exhaustion. Expectations included practical advice from controlling violence to legal advice, someone to share with and to listen to them, and problem definition. Clients have limited knowledge and feel helpless. Few barriers to access included childcare, heavy workload, and service location. Clients presented at times of crisis, the most serious concerns being emotional needs although children’s behavioural disorders and drug problems were also important. Application interviews included determining needs and expectations, and together agreeing boundaries and goals of therapy. Clients’ recognition and articulation of violence and their change in reaction towards it were often key goals of therapy.

**Therapeutic models and approaches** - Clients showed different understandings of counselling approaches stating that the service also prescribed medicine, general advice, and prescriptive advice on responding to violence. All clients trusted their counsellors enough to disclose although initially some lacked confidence due to shame and guilt; understanding this requires a thorough theoretical grounding in the dynamics of domestic violence. Relationships between counsellors and clients were open, honest, genuine, and motivated; transparency rendered clients less embarrassed to reveal experiences in depth. Clients felt understood and supported by their counsellor, and clear boundaries led to no difficulties. Length of therapeutic support ranged from one to 12 months, the majority having been in therapy for four months. Counselling times were flexible in response to need. Initially, sessions were held once or twice weekly to provide reassurance and support although clients often...
preferred fortnightly sessions. Counsellors were respectful and non-judgemental of clients’ decisions. Counsellors encouraged clients to think and articulate their needs yet also advised how to reach their potential. The children of half of the sample had received support through specialist psychologists and the education sector. Counsellors were said to have honesty, trust, compassion, and integrity. Counsellors perceived no approach to therapy which was most effective; consensus indicated that personality, professional and personal experience, and counsellor-client relationship were more important.

**Perceived outcomes** - Clients’ perceived key outcomes included empowerment, confidence, inner strength, improved self-worth, self-validation, and awareness of domestic violence and its effects. Clients realised they had gradually lost their social positions and had allowed themselves to be controlled and manipulated. Clients appreciated that other women and children shared similar experiences, relationships and family bonding had improved, psychosomatic symptoms were overcome, and children’s development was positively impacted. Social structures and benefits became more familiar; women were no longer scared of their abuser, accepted the consequences of decisions, and had strength to meet future challenges. Thought processes had become more positive, and they were realistic and thorough in decision-making. Job searching was underway when once clients were suicidal. Clients perceived no negative outcomes of counselling, however counsellors identified problems through acceleration of the therapeutic process within psychodrama in which clients become empowered, and subsequently more active - this is recognised by perpetrators and aggression intensifies. This was a serious complication of therapy and counsellors wanted to work with offenders to better address this. Clients were at different stages; some were still on the journey to recovery, and older clients remained unsure of the future. No significant differences were perceived by counsellors in therapeutic outcome regarding ethnicity, but age was said to influence outcomes as domestic violence impacts differentially between age groups. For counsellors, the most tangible outcome of therapy was reduction in anxiety. Counsellors measure outcomes quantitatively at the end of therapy through questionnaires.

**Recommendations for services and counsellors** - All similar projects in BG are financially unstable which can result in reduced numbers of cases accepted and clients are signposted to other services. Some NGOs have closed their services for victims of domestic violence due to lack of funding. Funding for counselling for victims of domestic violence should become government policy. More specialist counselling and support centres for victims of domestic violence are required with greater signposting for those who need help. A team-based coordinated therapeutic strategy for counselling mothers and children was preferred. Every aspect of a client’s life can play a significant role in recovery and should be used effectively. Support after end of therapy is also required.

**Recommendations for victims** - Advice to others in similar situations was to not yield to violence but rather adopt a safety approach, and find sources of support at the first sign of irregularity within the relationship. Additional advice was to talk to specialists about violence and other related problems as understanding leads to acceptance which, once achieved, can lead to solutions.

**ITALY**

**Clients’ help seeking behaviour and service contact** - Clients from IT were older than the average age of clients in this type of service (average age of 53 years)\(^2\). Bearing this in mind, it is quite reasonable\(^3\) that most of them sought help via the police and other professionals from social and health care services. Triggers to service access were related to time – the significantly long time they had experienced violence, ranging from six to 25 years, and subsequent chronic feelings of despair and hopelessness. Their self-perception as victims of violence is something that took much time, as their age, gender, and generational perspective certainly had an influence. Their expectations were mostly related to security and safety, although they could not really explicitly articulate what they expected from services. From the counsellor’s perspective, clients’ expectations were related to a need to be heard and understood; the counselling work was mostly done on the emotional side. When contacting counselling services, clients encountered few but significant barriers, such as incompatible working schedules of the clients and of the service. Counsellors resort to different counselling approaches, basing their intervention on the client herself and working holistically. Safety is the first aspect guaranteed, and when out of danger is the best time to begin real counselling; clients start to recount their histories in a coherent narrative based on a (re)arrangement of their own memories.

**Therapeutic models and approaches** - Clients could not distinguish or name the counselling model or UK-based on emotions and feelings or self-reflection. Moreover, the assessment they made was optimistic.

\(^2\) Counsellors in IT did not answer questions on training and experience.

\(^3\) See Table 1: Comparative demography.

\(^4\) Ongoing research (Perista and Silva, forthcoming) shows that older women somehow tend to look for help from the police before contacting other types of support service.
Clients needed help as they were feeling alone, and counselling impacted on overcoming loneliness mostly through the listening capacity of counsellors. The relationship between client and counsellor was based on trust, empowerment, practical-oriented; clients felt emotional freedom, welcomed and accepted, enabling them to rethink their own opinions about many events and contexts. Counselling processes take time – clients were receiving support for more than one or two years, some once a week whilst for others the frequency changed over time (most frequent at the beginning, on a weekly basis, then monthly); counsellors said that effective counselling takes two to three years. Throughout the process, goals were redefined; this is related to the fact that the definition of goals must always involve women’s needs and capacities, something that is changeable throughout the counselling process. Counsellors respected clients’ life decisions, but also expressed reservations or concerns towards specific decisions, leading the path to self-reflection.

Perceived outcomes - A major outcome clients perceived was the capacity to see a different self and different others around them; counselling empowered them and contributed to putting aside feelings of shame. According to the counsellors’ perspective, clients first gain awareness that domestic violence is something more widespread than the average population expects; and this awareness impacts on women’s self-esteem. Clients recognised that through the counselling process they were able to conquer their fears and become stronger. Clients gain autonomy, capacity to make decisions, the right and will to say ‘no’, by having learned to protect themselves and to be safer. Clients then make think of ‘me’ and not of ‘him’, that is, they start to think that they have control over their own lives. However, counsellors judge this by assessing immediate results rather than long-term ones; this is something that worries counsellors in IT.

Recommendations for services and counsellors - Briefly, clients suggested more information about support services for victims of domestic violence made available to the public in general and better dissemination strategies within specific professional settings (such as the police); more available refuges or places in refuges; increasing the refuge’s capacity to accommodate women and children for longer periods of time; consider also implementing, in larger scales, group therapies or self-help groups alongside individual counselling; and professional networking around individual cases. Counsellors are preoccupied with funding cuts which impact the availability and quality of the service. Counsellors were also critical of the way policies are defined and implemented in the area of domestic violence since recent policies do not take into account the need for prevention. Violent behaviour, in particular gender-based violence, is deeply rooted in Italian society, and this is a matter that requires a more comprehensive approach and targeted gender interventions from a vast range of services.

Recommendations for victims - There is a need for every woman to believe in herself, and the need to give consideration to the first signs of domestic violence and to face it without shame. Women experiencing domestic violence should always seek professional help. This is the time for women to speak about their experiences of domestic violence.

THE NETHERLANDS

A preliminary note must be considered. It was challenging to establish any relations between the data provided by women survivors of domestic violence and the data provided by the counsellors interviewed in the project: the interviewed counsellors were not psychologists or therapists but social workers; women and counsellors did not come from the same organisations. Therefore, the comparative element of the analysis loses objectivity and is less effective.

Clients’ help seeking behaviour and service contact – Clients’ decisions to seek counselling were based on the weariness of a long-term intimate relationship lived in violence, on the escalation of violence and on the impact of violence on their children. The counsellors’ perspective was that the majority of women who reach their services come in a fragile emotional state, with difficulties in assuming control over their own lives and on defining an autonomous and secure life trajectory due to the violence they are experiencing. Counsellors also stated that sometimes children act as an obstacle since some of the victims reaching their services do not feel capable or sufficiently confident to bring up their children without their partners.

Therapeutic models and approaches - Clients stated that sharing intimate feelings and events is not an easy thing to do, therefore to establish a trustful therapeutic relation right at the beginning is crucial. Clients’ high expectations of counselling are mostly based on the level of trust acquired within the therapeutic process. Counsellors also said it is important that the first phase of the therapeutic process is based on good listening and allowing clients to express their feelings openly. It is possible to determine the need for a better understanding of procedures or an improve sharing of working methods. Assuring confidentiality and collaboratively design a plan are relevant features. However, some clients said they were not involved in the design of their own therapeutic process and some mentioned their lack of knowledge regarding the therapeutic model they were engaged in; however this was not felt important by clients. On the other hand, counsellors
highlighted that their work is always assessed by clients and built in close cooperation with them. Clients and counsellors in the NL come from different organisations which may account for the differences in opinion.

**Perceived outcomes** - Clients were unanimous affirming the benefits of the therapeutic process impacting on their own emotional autonomy, lowering stress levels, and raising their ability to see their future. In general, clients felt empowered by counselling.

**LATVIA (MARTA)**

**Counsellors’ training and experience** - Although respondents have degrees which qualify them to handle cases of domestic violence, what is clear is a need and desire for supplementary and on-going knowledge of domestic violence. This could imply gaps in education and training causing counsellors to use a more proactive approach to their careers in counselling victims of domestic violence. It could also be argued that these potential gaps in knowledge occur because domestic violence is complex and multi-faceted in that it manifests itself differently in individuals, relationships, and cultures and so as it evolves, training and knowledge must be upgraded so that the counselling provided remains relevant to the client’s specific needs. Monthly supervision is led by professionals, and supervision is maintained within their respective professions.

**Clients’ help seeking behaviour and service contact** - Some clients came to the service with the assistance of social workers, school psychologists, teachers, friends and even other counselling centres that specialize in domestic violence but recommended Marta to clients who cannot afford to pay for therapy. Others arrived at Marta on their own initiative after doing background research on the facility, and some women arrived seeking further information on services offered before deciding to get help.

**Therapeutic models and approaches** - Counsellors indicated the need for therapy to decrease the consequences of emotional trauma that women suffer as a consequence of domestic violence. This includes support and understanding on many levels including emotional, financial, medical, and various other means. Counsellors also emphasised the importance of counselling as it pertains to the welfare of children who are at a high risk of repeating the cycle of violence due to exposure. An important element emphasised by respondents was the need for women to have time for inward and outward reflection so that she can become more informed about what is happening to her and understand her world from different perspectives. Clients must be in a safe environment where they can learn to build healthy relationships. Family background was considered integral to determining factors that contributed to the client’s current violent situation. The gender perspective is only important in terms of how it affects a client’s personal viewpoints. The most important factors in the counselling process were the need for tolerance and agreement on the goals of therapy. Finally, counsellors indicated that understanding the client’s expectations and goals for the outcome of therapy are integral when counselling victims of domestic violence.

**Perceived outcomes** - The ability to communicate with loved ones and members of the outside world with a greater sense of security is one positive outcome of treatment. The loss of a sense of hopelessness in exchange for a rejuvenated sense of self-worth and willingness to live is accomplished. Seeing the world for all the positive things it has to offer instead of its potentially negative impacts is an important perspective gained by respondents. The ability to clearly ascertain who they are and what they need is another important outcome. In terms of moments of doubt and uncertainty, memories of counselling can act as a safeguard in reminding clients that they are not alone and that they have already discussed their major issues so they are more easily able to tackle tough issues as they come. Only one client had experienced a negative outcome of therapy, the unforeseen deep attachment to the counsellor that clients can sometimes experience during and after therapy.

**Recommendations for services and counsellors** - For clients, the use of a good counselling model and the accessibility of therapy at the right time were important suggestions for the improvement of future counselling strategies. The referral process is important so that clients are directed to the right place quickly and do not waste time seeking unsatisfying intervention. The service must be free of charge since women without work may demonstrate difficulties in finding help, slow to seek help, or may not try at all.

**Recommendations for victims** - Counsellors advised women to seek out help at the first instance of violence so that it does not have a chance to escalate.

**LATVIA (SKALBES)**

**Counsellors’ training and experience** - Training opportunities are inadequate and they have learned through experience and self-teaching and now feel fully qualified in their fields having practiced for more than a decade. Counsellors’ hold Masters level degrees in Psychology and Psychopathology. Although they are highly educated, both agreed that training on the dynamics of violence against women is deficient. As such, they have had to rely on themselves to gain more in-depth knowledge so they may counsel effectively.
Many issues related to violence are not addressed at university, as studies focus mainly on psychological processes and omit practical and juridical knowledge. There used to be broader supervision, but now due to lack of funding, some teams have no supervision whilst others have co-supervisors who handle the crisis telephone service with no determined length or frequency of supervision. Counsellors must rely primarily on themselves for supervision.

Clients’ help seeking behaviour and service contact - In some cases women had access to information about support groups from home and abroad which made it easier for them to access the service. The benefit of access to information is that it gives a greater sense of comfort and confidence in approaching the service because they have a solid foundation of information so they have a greater idea of what they are accessing. For some very distressed clients, their need for help is difficult to hide from the outside world. Many respondents received help from outsiders or acquaintances because their physical appearance or personality created cause for alarm.

Therapeutic models and approaches - Therapeutic models and processes are determined by the needs of clients, and counsellors described three specific needs. First, there is a need for clients to have confirmation that they have the right to seek help if they feel something is wrong in their relationship; there is a need for information, in that a woman needs to know where she can go and what she can do. Second, clients need understanding, support and a sympathetic ear from counsellors so that the woman can become informed as to what is happening to her which may lead to a renewed sense of self-respect and empowerment so that she may change her circumstances. Third, there was concern about the women’s need for mental and physical security while they seek help; this relates to the ability of professionals from other services to co-operate effectively without creating additional trauma. There was a great need for more efficiency in communication between service professionals so that women in crisis can receive the necessary help. Family background was the most important factor in helping determine the manifestation of violence in future relationships, as the family is the first phase of social interaction and learning.

Gender perspectives were taken into account only with regard to whether or not the client views her situation from a gender equality or patriarchal perspective. The most important factor in the counselling process was the client’s full consent to the goals of therapy; she must be determined and motivated to attain the change she desires. Specialists often employ cognitive behavioural approaches, restructuring of thinking, and processing of emotions. This process allows the client to discover things because there are issues that precede the violence and thus may facilitate it. Family and existential therapy may also be employed as well as training and role play sessions in order to prepare women for specific life scenarios for which they have no prior experience.

Clients maintained their counsellors were trustworthy and supportive. They felt confident they could speak openly about their feelings without fear of judgement, and the models used in the therapeutic process were effective in providing the help they need as well as building blocks for autonomy. In terms of frequency, treatments were once or twice a week, once every two weeks, then taper off to once a month as therapy progressed. The security of clients, especially after crisis intervention, was paramount for all counsellors.

Perceived outcomes - Negative outcomes of the process were that three respondents thought it should have been longer whilst another still had difficulties with her children who perhaps needed therapy too. In terms of their personal lives, some had lost friends, yet this loss was seen more as a shedding of negativity and abuse which the client seemed to welcome. Some felt afraid of managing new situations without the support of their counsellor. All clients felt more confident in their ability to control their lives and make decisions. They had a calmer more sensible approach and were able to put even the darkest of days into perspective. They were not worried about themselves anymore and were more able to focus on their children. They did not stress as much when it came to confrontation and can take an effective stance against aggression. Feelings of helplessness had dissipated and they no longer felt lost. The impulse to panic had gone and mentally they were able to analyse their situation, an ability lacking before but that developed through self-analysis, and reflection facilitated by therapy. As such, their feelings of helplessness had dissipated.

Recommendations for services and counsellors - The main concern for clients was the need for more counselling sessions. Some were dissatisfied at the amount of consultations they could have and although they learned valuable lessons and the tools to be free of abuse, they wanted to continue as they were unsure if they were ready to continue on their own.

Recommendations for victims - Counsellors emphasized seeking out help in time and not allowing the effects of domestic violence to fester.
6 RECOMMENDATIONS

The comparative analysis has revealed many issues consistent across countries and it is from these that general recommendations are made. Recommendations are directed at three target groups: specialist counselling services for female and child victims of domestic violence; funding bodies and commissioners of specialist counselling services for female and child victims of domestic violence; and policy-makers for supporting female and child victims of domestic violence.

R1 Many victims of domestic violence do not realise they are in a position of abuse and control, therefore are unable to access appropriate support. It is recommended that specialist support services deliver more publicity of their facilities and benefits to women and children, which can lead to increased public awareness of domestic violence and the impact it has on women and children. This is required at European level.

R2 The referral process following disclosure is important so that clients are directed to the right place quickly and do not waste time seeking unsatisfying therapy. It is recommended that clear pathways of care between statutory and NGO support services are in place to enable more appropriate and effective referrals.

R3 Victims of domestic violence need a highly experienced counsellor who fully understands their position within a violent relationship. This is particularly so for children’s counsellors. The data show that where theoretical models of approaches to counselling are concerned, most are satisfactory but no one approach is better than others: there is no ‘one size fits all’. It is recommended that for generic counsellors to become specialist domestic violence counsellors, it is essential they have access to specialist and dedicated training courses to learn the dynamics of domestic violence.

R4 The use of a good evidence-based theoretical model and approach to counselling for victims of domestic violence, although a requirement of funding and commissioning bodies, is in reality not a key ingredient of success and should be complemented with specific training on domestic violence dynamics. What is effective is the knowledge and experience of the counsellor in the dynamics of domestic violence, and the victim accessing specialist counselling when she is relatively low risk and when she decides it is the right action to take. It is recommended that specialist counselling services for victims of domestic violence use more imaginative yet robust measures of success that can better inform the decision-making of funding bodies. Further research on outcomes measures for female and child victims of domestic violence are required.

R5 It has been shown that psychodrama can enable clients to become empowered and more autonomous, which is a good outcome, although these changes can be acknowledged by the perpetrator who can then intensify the level of aggression or a change in abusive tactics. It is recommended that serious consideration is given to client characteristics and domestic context to enable those more at risk of violence escalation to be offered alternative models and approaches.

R6 Long waiting lists and reduced funding impact heavily on the ability of specialist domestic violence counselling to be overall effective, yet financial issues should not take priority over the safety and wellbeing of women and children. Notwithstanding reduced budgets, it is recommended that more NGO services for victims of domestic violence are developed throughout EU member states which replicating the positive outcomes seen in established services. It is further recommended that all member states observe Article 20 of Council of Europe Convention on preventing and combating violence against women and domestic violence:

1. Parties shall take the necessary legislative or other measures to ensure that victims have access to services facilitating their recovery from violence. These measures should include, when necessary, services such as legal and psychological counselling, financial assistance, housing, education, training and assistance in finding employment.

2. Parties shall take the necessary legislative or other measures to ensure that victims have access to health care and social services and that services are adequately resourced and professionals are trained to assist victims and refer them to the appropriate services.

R7 The most damaging outcome would be for women to stay in an abusive situation simply because they do not have the money to leave; unemployed women or those financially manipulated can demonstrate difficulty in finding help; they may be slow to seek help or they may not try at all. It is recommended strongly that services must be free of charge at the point of entry, and that marketing materials, also in different languages to reach migrant women, should state that counselling services are free to every woman and child.
R8 There is very little interagency collaboration and linkage for children in BG and, although improvements were recommended, there were no suggestions as to how multiagency working might be enhanced to improve the outcomes for child victims of domestic violence. *It is recommended* that research is needed to explore pathways of care for children experiencing domestic violence in BG and provide ways in which service strategies may be updated to reflect required changes or service reconfigurations enacted to enhance support for children.

R9 Counselling women and children who have been affected by domestic violence can save lives. Evidence within the data is unequivocal. *It is recommended* most strongly that efforts are made to strengthen the position of NGOs within the EU market place in providing specialist dedicated emotional and psychological support to women and child victims of domestic violence.

R10 To develop awareness among professionals of other sectors (educational practitioners, health care professionals, etc) in order to facilitate the recognition of signs of violence, to promote support and to increase referral from victims of domestic violence. *It is recommended* that schools, health care and front line professionals in social care settings should have basis domestic violence awareness training.

R11 It should be common practice for women survivors of domestic violence to have a ‘voice’ in the design and evaluation of service provision and in the policy debate concerning domestic violence prevention and combat. *It is recommended* that commissioners and funders of domestic violence services seek evidence of effective efforts made to involve women and children in the co-production of services and policy development.
APPENDIX 1

INTERVIEW SCHEDULE – CLIENTS

Interviews should be conducted by a senior counsellor or Counselling Coordinator. Only one person should conduct the interviews, for consistency and familiarity with the data.

Interviewer should have at hand:
- Informed consent form (3 copies: one to give to the participant, one to keep within the project files, one for Daphne project files)
- Social data form
- Tape recorder
- Something to drink
- Paper and pencil

INTRODUCTION
First of all, thanks a lot for agreeing to give an interview. I really appreciate that you have the time and the availability to share your experience with me. I would like to give you some information on this interview. This interview is part of a European project which we are carrying out together with colleagues from seven other European countries and our study is funded by the European Union through the Daphne programme. We know that survivors of domestic violence can turn to supporting services in order to be safe and to be able to make informed decisions about their lives. But we are interested to know more about the types of psychological support most services provide. The study looks at the need to support survivors of domestic violence and abuse through counselling and psychological therapies, and at the ways this support could be improved and better funded. The project aims to improve knowledge and awareness of non-governmental organisations’ (NGOs) counselling and psychological provision in EU countries for women and children affected by domestic violence and abuse in order to encourage effective investment and ensure longer term impact for victims. We welcome and acknowledge your willingness to participate in this study. This interview will be tape-recorded and transcribed in order to allow us to analyse in depth what you have told us. All the information will be used for study purposes only. We can assure you that everything you tell us will be treated confidentially – no one will know your name, the name of the city you live in and we will change every recognizable detail. After transcription, the tape will be destroyed. The interview will last around one hour, but whenever you want to have a break just tell me. If you want to talk longer, this will also be possible. You can stop or interrupt the tape-recording or the interview altogether at any point if you feel uncomfortable with the situation, and you can certainly decide not to answer specific questions. We have prepared an informed consent form. Your signature means that you understand and agree to be interviewed.

A HELP SEEKING BEHAVIOUR AND SERVICE OR INSTITUTIONAL CONTACT
Rationale: to get to know the woman’s help seeking behaviour and the circumstances that led her to seek help. It is important to know about her first contact with supporting services, how important this first contact was for her, and subsequent contacts
1. How did you come to this service? Prompt: Was it by referral, from whom?
2. When you decided to seek help, what triggered your decision to seek help? Prompt: For how long were you affected by violence? How long did it take from when you recognised the ‘symptoms’ to when you were able to receive support? Was it a planned decision?
3. When you came to this service, what were your expectations? Prompt: Did you have your family or friends’ support regarding your decision?
4. Did you perceive any barriers / problems in accessing the service? Please explain.
5. Was this your first contact with counselling for domestic violence?
6. Were you informed about your rights in relation to the counselling code of confidentiality?

B FEATURES OF THE THERAPEUTIC PROCESS
Rationale: to identify the self-perceived characteristics of the therapeutic process received and how the woman values it
1. Do you know what specific counselling model / approach was used that you engaged in? Prompt: What do you know about this, and other, approaches?
2. What do you think about the counselling process?
3. What do you think about your counsellor? **Prompt:** Did you have more than one counsellor? If yes, was it in the same service or within different organisations?

4. Do you feel confident enough with your counsellor to talk openly about your problems?

5. What can you share about the therapeutic relationship that developed between you and your counsellor? **Prompt:** Was this important for your progress?

6. Did you feel understood / supported by your counsellor? **Prompt:** Did you feel you had the opportunity to express your ideas freely?

7. For how long did you receive psychological / therapeutic support?

8. What was the frequency of the support sessions (weekly, monthly)? **Prompt:** Did the frequency change over time? If so, how? If not, do you know why? Did you feel that the frequency of the sessions was/is adequate?

9. In the beginning of the psychological / therapeutic support, were therapeutic goals defined? If so, by whom?

10. How would you describe the attitude of your counsellor towards your experience and your decision and attitude related to the life options you took?

11. Did / do you feel that your counsellor encourages you to speak about what you want for your life, or on the contrary, encourages you to choose what she/he thinks about your life?

12. Did your children get any kind of therapeutic support? If so, what kind?

13. Did you ever have difficulties in understanding your counsellor? **Prompt:** Have there ever been misunderstandings? Have they been clarified? How?

C **PSYCHOLOGICAL /THERAPEUTIC PROCESS’ OUTCOMES**

Rationale: to identify the self-perceived gains obtained by the psychological / therapeutic support and to know if and how the woman herself felt empowered by the psychological / therapeutic support

1. In what ways was the psychological / therapeutic support helpful to you at this stage of your life? **Prompt:** Can you explain what were the main results of the psychological / therapeutic support?

2. What do you consider to be the most positive outcomes of the psychological / therapeutic support? And the most negative ones (if any)? **Prompt:** Could anything have been different in the psychological / therapeutic support you received?

3. Did/do you feel free to make your own life choices? **Prompt:** Did/do you feel that your counsellor respects your own decisions?

4. Do you feel emotionally different now from when you started the psychological / therapeutic support? If so, in what way? **Prompt:** The way you look at yourself, now, is this different from the way you perceived yourself in the beginning of the psychological / therapeutic support? If so, how?

5. During and after the psychological / therapeutic support you received, do you think you’ve gained more autonomy for yourself and your life? **Prompt:** Do you think that the psychological / therapeutic support has helped you in making decisions about your life? How?

6. Do you feel more able to deal with problems in your life as a result of counselling? Please give one or two examples? **Prompt:** Did it help you with communication, presentation and other parts of your life?

7. Did the psychological / therapeutic support help you to view the future differently? **Prompt:** To what extent did your life change with the psychological / therapeutic support?

8. Did the psychological / therapeutic support change the way you see and understand domestic violence?

9. Would you like to leave any message to other victims of domestic violence regarding the therapeutic support / counselling?

10. How could counselling be improved for victims of domestic violence in the future?

11. Is there anything else you’d like to add that we haven’t already discussed?

THANK YOU VERY MUCH FOR THIS INTERVIEW
SOCIAL DATA FORM

1. How old are you? ............

2. What is your marital status? (married, cohabiting, divorced, widowed, single)
   ..............................................................................................................

3. Do you have children? ............

4. If yes, how many? ............

5. How old are your children? ...........................................................................................

6. Do you have any major health problems that affected the counselling process?
   ..............................................................................................................

7. Ethnicity ....................................................

8. Interview-Code (unique reference number): ____________
COMPARATIVE ANALYSIS OF PERCEPTIONS OF DOMESTIC VIOLENCE COUNSELLING:
COUNSELLORS AND CLIENTS
INTRODUCTION

First of all, thanks a lot for agreeing to give an interview. I really appreciate that you have the time and availability to share your expertise and knowledge with me. I would like to give you some information on this interview. This interview is part of a European project which we are carrying out together with colleagues from seven other European countries and our study is funded by the European Union through the Daphne programme. We know that survivors of domestic violence can turn to supporting services in order to feel safe and to be able to make informed decisions about their lives. But we know little about the type of emotional and psychological support most services provide. The study looks at the need to support survivors of domestic violence and abuse through counselling and psychological therapies, and at the ways this support could be improved and better funded. The project aims to improve knowledge and awareness of non-governmental organisations’ (NGOs) counselling and psychological provision in EU countries for women and children affected by domestic violence and abuse in order to encourage effective investment and ensure longer term impact for victims. Our main aim is to focus on your expertise and professional experience regarding counselling for victims of domestic violence in this service.

A YOUR BACKGROUND TRAINING ON COUNSELLING

1. Do you feel your training is adequate to the counselling work you perform? Prompt: If no, please explain why. If yes, how so?
2. Do you encounter any difficulties when counselling victims of domestic violence? Prompt: If so, what are they and how do you overcome those difficulties?
3. Does your organization provide supervision on a regular basis? Prompt: Please explain how and when this happens.

B THERAPEUTIC MODELS (MOST) USED

1. What do you perceive as the most frequent needs that victims of domestic violence present? Prompt: Do these needs revolve around practical or emotional issues?
2. Do you perceive that domestic violence is more related to individual factors, family or social and cultural systems? Prompt: Which of these factors do you consider to contribute the most to domestic violence and why?
3. What therapeutic model do you use when counselling victims of domestic violence? Prompt: Is it, in your opinion, the most effective one? Why? Do you ever resort to a different model for the same client? Which one? Why did you change?
4. Do differences relating to a victim’s particular characteristic influence the counselling outcome? Prompt: i.e. younger and older victims, women from ethnic cultural groups? If so, what are they? And how do you deal with them (what do you do differently)?
5. What do you consider important when designing a counselling process? Do your beliefs impact on the counselling model/approach you use?
6. Do you consider clients’ gender perspective in your therapeutic approaches? Prompt: How is this done and do you feel this is important?
7. What are the usual steps you take in the process of counselling victims of domestic violence?
8. What is the best time in the client’s recovery period to begin counselling? Why?
9. Could you tell me, on average and based on your own counselling experience, how long does the process of counselling take?
10. Do your funding constraints impact on the number of sessions that you have with a client? If so, what is the impact on the client?
11. What are the most likely problems to arise for the client with regard to the model/approach you use? Prompt: How do you overcome these problems?
12. What are the most likely problems to arise for you with regard to the model/approach you use? Prompt: How do you overcome these problems?
13. Is it possible to carry on with the counselling when the woman still lives with the perpetrator? Prompt: If so, what are the strengths of the counselling model/approach that facilitates this? If not,
why? Is there something about the counselling model/approach that renders it inappropriate for this client group?
14. How often do you counsel women that still live with their partner / perpetrator? What are the constraints you encounter while counselling this client group?
15. Are there some particular aspects to be taken into account in the therapeutic work that you do with your service users? What is it? And why?
16. What are your main concerns when working with victims of domestic violence?

C PERCEIVED OUTCOMES RELATED TO THE THERAPEUTIC MODEL (MOST) USED
1. Do you previously define the goals of the counselling process? When doing so, do you consider the client’s involvement? If so, how? If not, why not?
2. What are the outcomes more frequently observed in your counselling processes?
3. In your counselling processes, to what extent do you consider the victim’s involvement in her own life’s project?
4. Do you consider that the counselling approach you frequently carry out could prevent new situations / episodes of violence in (that) survivor’s life? Prompt: If so, to what extent? If not, why?
5. How do you measure client outcomes in your practice?
6. If your counselling practice had its funding cut (either slightly or severely), what would be the repercussions for your clients?
7. Lastly, is there anything else you would like to add that will help the study?

QUESTIONNAIRE TO COUNSELLORS

A PERSONAL AND INSTITUTIONAL BACKGROUND
1. What is your age?
2. Gender?
3. Ethnicity?
4. What is your educational background?
5. What is your professional background?
6. How many years of experience do you have working as a counsellor?
7. And as a domestic violence counsellor?
8. Taking into account the work you do in this organization, what are the main roles and responsibilities involved in your work?
9. Are intercultural competences relevant in your work?
10. If yes, in what sense do you need them? Are there misunderstandings that occur frequently?
11. Which languages are covered in your NGO?
12. Is translation needed sometimes?
13. If yes, how do you organise and finance it?
14. Do you counsel women with disabilities?
15. If yes, what kinds of disabilities are common and how do you get in contact with each other?
16. Do women in same sex relationships access your counselling?
17. If yes, is there anything special or remarkable about the counselling approaches you use with them?
18. Which role do children play in your counselling (either as potentially in need of counselling as well or as factors in the women’s recovery process or in her violence biography etc.)?

B YOUR BACKGROUND TRAINING ON COUNSELLING
1. Did you receive any specific training in order to become a counsellor for victims of domestic violence?
2. If yes, what was it?
3. Was the training given by this organization?
4. Does your organization demand specific training?
5. If not, how did you ‘train’ yourself? (For instance, literature review, received training in other organizations, schools, university)
6. Are you a member of a recognised professional counselling organisation?
7. If yes, which one and what is the status of your membership?

THANK YOU FOR YOUR CONTRIBUTION TO THIS RESEARCH
APPENDIX 3

FOCUS GROUP GUIDELINES - COUNSELLORS

Interviews should be conducted by the organisation’s project lead.

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