

**What helps, what hinders when counselling women who have
experienced intimate partner violence?**

by

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THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

in the
Counselling Psychology Program of the
Faculty of Education

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SIMON FRASER UNIVERSITY

Fall 2011

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Abstract

The critical incident technique was used to investigate the helpful and hindering counselling events for women who had experienced intimate partner violence (IPV). Given the ubiquitous nature of IPV, ongoing research in this area is essential to understand ways to best promote healing for women who have experienced abuse. This study focuses on women who have experienced IPV and who have attended counselling regarding the impact of this abuse. The main question in the study explores what counselling experiences helped or hindered women in the process of healing from an IPV situation. Seventy percent of critical incidents were identified as helpful and thirty percent hindering. Key findings show the tension between participants' feelings of empowerment and feelings of shame within a counselling relationship. Safety was participants' primary foundational need, as counselling relationship experiences can parallel those of the IPV relationship.

Keywords: intimate partner violence; domestic violence; counselling and abuse; trauma; helpful and hindering counselling interventions; counselling psychology

Acknowledgements

Deepest thanks to all of my family and friends—you helped me make this project happen. Thank you to Patrice Keats for providing me with wonderful direction and support and Coral Payne for your excellent coaching.

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Chapter I.

Introduction

Intimate partner violence is an issue that crosses cultural, economic, international, educational, and social delineations (World Health Organization, 2005). Given the ubiquitous nature of intimate partner violence (IPV), ongoing research in this area is essential to understand ways to best promote healing for women who have experienced abuse. This study focused on women who experienced intimate partner violence and who had attended counselling regarding the impact of this abuse. In accordance with feminist counselling approaches a methodology that minimally imposed on the participants and viewed the woman's perspective as the source of information was used. The main question in the study explored what counselling experiences helped or hindered women in the process of healing from an IPV situation.

The aim of this study was to explore what women who have experienced violence in intimate relationships view as relevant and helpful within a counselling relationship. The applicability of this study to counsellors working with women who are identified as having experienced intimate partner abuse is quite direct. The findings of this study may influence therapeutic techniques currently in use and be included in IPV counsellor training information. This research may also contribute to the understanding of what is helpful and relevant when counselling women who have experienced IPV and add to the body of research on IPV clients' views of counselling.

In recent decades there has been an increase in the body of literature regarding the social and personal impact of IPV (Hampton & Gerrard, 2006; Haskell, 2003; Herman, 1992; Mann, 2000; Sanderson, 2008, World Health Organization, 2005). Given the considerable health risks associated with IPV, programs have been developed to provide refuge, shelter, and health services for women. Programs and policies that are intended to address this issue have been developed and implemented by government

and non-profit agencies. One such program is the Stopping the Violence (STV) counselling program in British Columbia, which provides counselling services to women who have experienced abuse. This program also provides training and support for STV counsellors.

Given that IPV impacts the physical, social, psychological and financial well-being of women, counsellors working with women who have experienced abuse are often faced with multiple and complex client issues (Sanderson, 2008). Women who have experienced IPV are vulnerable to retraumatization (due to difficulties accessing resources), as well as impairments in interpersonal relationships (Sanderson, 2008). Garnering information about what is helpful in the counselling process is an important endeavour and may inform the use of effective and sensitive therapeutic techniques with this client population. Research suggests that the factors that are thought to be helpful for women healing from intimate partner violence include: the presence of the therapeutic alliance; transparency regarding inherent power imbalance; therapists modeling appropriate boundaries; learning about the importance of boundaries; and the counsellor's expression of hope and belief in the clients healing (Ziegler & McEvoy, 2006).

The clients' perception of the counselling experience is an area of research that has the potential to illuminate various aspects of effective therapy practices (Manthei, 2007a). Client feedback can provide useful information for therapists in terms of guiding both the process and the content of therapy, as well as recognizing client agency in the counselling experience (Llewelyn & Hardy, 2004). Asking clients for their descriptions of instances in therapy that they deem as either helpful or hindering honours the client's experience of counselling as a valuable source of information. The emphasis on valuing the clients experience is congruent with feminist approaches that view the woman as the expert of her own experience. Given that this research project focused on women who have experienced abuse and have seen a counsellor trained from a feminist theoretical approach, the use of this methodology is an appropriate choice.

Feminist therapy approaches acknowledge the importance of including the woman's experience as essential in guiding both effective counselling practice and research (Brown, 1991). This is particularly salient when considering women who have

experienced a loss of power, agency, or visibility due to intimate partner violence. Indeed, “most women will enter therapy expecting their relationship with the therapist, and its inherent power imbalance, will carry similar dangers of powerlessness, dismissiveness, or dependency as those that existed in the relationship with their abuser” (Haskell, 2003, p. 82). Given that the women who have participated in this study are clients who have seen a counsellor employed for an agency that espouses feminist therapy; it was considered essential to use a methodology that echoed the central tenets of this approach.

Feminist therapy is thought to use a co-expert model of differing expertise. The therapist is the expert in processes of change and empowerment, while the client is the therapeutic knower of her own experience and chooses change processes that are compatible with her needs. Given that feminist therapy strives to both acknowledge the inherent imbalances in the therapeutic relationship and work toward the goal of equality, asking the client’s view of the counselling experience is clearly aligned with a feminist approach. Asking the client’s view is also in line with the design of research methods, used in this project (Brown, 2000).

Critical Incident Technique

In alignment with feminist theory, the Critical Incident Technique (Flanagan, 1954) was the method used in this study. The Critical Incident Technique (CIT) is a method for gathering significant information about behaviour in a specified context. The CIT method employs a set of guidelines to direct data collection and analysis that are flexible enough to be adapted to a diversity of activities being studied (Flanagan, 1954). Initially developed during the Second World War to study pilot performance, the CIT has since been widely used in the social science disciplines (Butterfield, Borgen, Amundson, & Maglio, 2005). The applicability of the CIT method to the field of counselling was asserted by Woolsey (1986) in her instructional article outlining the merits of this approach when exploring counselling-specific issues. Woolsey noted that the CIT method is useful for exploratory and foundational research work, helping to clarify and define key activities for further research. Beyond the taxonomical utility of the CIT, Woolsey states that it is useful for criterion development and theory building. Further, she suggests, that the use of the CIT method by the counselling discipline may contribute to the development of a unique methodology (Woolsey, 1986). Related to this study, the CIT method has been used to explore the counselling experiences of women with a history of child sexual abuse (Koehn, 2007); however, a review of the current literature does not reveal a study using the CIT for research into intimate partner violence specifically. Consequently, this study adds to the field of research by using the CIT with clients who have experienced intimate partner violence.

The CIT procedure involves gathering information about incidents deemed to be *critical* by the participant. The term *critical* refers to events that are significant or revelatory, and are chosen by the participant as representative of the defined criteria of interest in the study and centre on the activity being explored. Unlike other methods, the CIT is not a rigid set of rules, but rather a flexible set of guidelines that directs the researcher and participant in the acquisition and categorization of data. For example,

once the incidents are gathered, the content of the assessments are categorized into clusters and then a thematic analysis is conducted.

Research on the perspectives of women attending abuse counselling are often embedded in stories of their survival and have focused on events that facilitated or impaired their decision to leave the abuser (Dziegielewski, Campbell & Turnage, 2005). This study attempts to broaden this knowledge base by inquiring about the women's views of significant events in their counselling experiences by using the CIT method.

Chapter II

Literature Review

Researchers and practitioners have sought to understand why counselling is effective. Given that efficacy rates are comparable despite theoretical orientation (Hubble, Duncan, & Miller, 1999), researchers have turned to investigating process variables to enlighten our understanding of what works. Process research is the study of the interaction between the client and the counsellor within a counselling session, and the mechanisms of client change (Duncan, Miller & Sparks, 2004; Llewelyn & Hardy, 2001). One means of understanding therapeutic processes is by asking the clients' view of the counselling experience (e.g., Critical Incident Technique; Flanagan, 1954; Session Rating Scale; Duncan, Miller, Sparks, Claud, Reynolds, Brown, Johns, 2003). The feminist counselling approach uses client feedback as one source of information to guide practice and theoretical developments (Brown, 2000). Women who have experienced intimate partner violence are often referred for counselling with a feminist therapist and as such their views on the counselling experience are an important source of information. The focus of the current chapter is to review the relevant literature regarding the use of a client focused inquiry into counselling efficacy for women who have experienced intimate partner violence and have attended feminist counselling.

Defining Intimate Partner Violence

Defining intimate partner violence (IPV) has been difficult for those in the field (Sanderson, 2008). The way IPV is defined is important because it can have an impact on the reported prevalence rates of the problem. For example, researchers using narrow definitions (often based on criminal law criteria) to study IPV generate low prevalence rates that may not accurately reflect actual rates or the severity of the phenomenon (DeKeseredy & Schwartz 2001, Edleson, & Bergen, 2001). Broader definitions that go beyond criminal law criteria to include behaviours that have impacted

the woman's physical and psychological well-being have been accused of being too general to be sufficiently descriptive (DeKeseredy & Schwartz, 2001; Edleson, & Bergen, 2001). Others have argued that using terms such as 'domestic violence' or 'family violence' obscures the gender based aspects of the phenomenon (Whalen, 1996).

In Canada, societal definitions of IPV have not kept a pace with the accounts of front line shelter workers (Tutty, 2006 in Hampton & Gerrard). However, the 1999 General Social Survey (Statistics Canada, 1999) included a victimization questionnaire which asked general questions regarding crime and other justice related information as well as those aimed at accounts of violence in intimate relationships. The IPV related questions queried not only the physical impact of abuse but also psychological and emotional aspects. Other Canadian researchers, such as those involved with RESOLVE (a network of prairie-based anti-violence researchers) have sought to understand some of the unique aspects of IPV for women living in rural communities and to impact policy change (Hampton & Gerrard, 2006).

In 2005, the World Health Organization (WHO) conducted a multi-country study of women's health and domestic violence in which they replaced the term 'domestic violence' with 'intimate partner violence.' The study found that prevalence rate of violence against women within an intimate relationship ranged from 13% in Japan to 61% in Peru. The study also found strong associations between IPV and the physical and mental ill-health of women. Findings of the WHO study reveal that intimate relationships pose the greatest risk of violence to women and that in many cultures this behaviour is considered normal.

The WHO report made several categories of recommendations for those involved in anti-violence against women work, namely; (a) strengthening national commitment and action, (b) promoting primary prevention, (c) involving the education sector, (d) strengthening the health sector response, (e) supporting women living with violence, (f) sensitizing criminal justice systems, and (g) supporting research and collaboration. In accord with these findings, the proposed study seeks to understand the perspectives of women who have experienced IPV and who have worked with a counsellor(s) within the health sector. The present study uses the terminology 'intimate partner violence',

because it best describes behaviours that are physically, emotionally, psychologically, socially, financially, sexually, and spiritually abusive to women in intimate relationships.

Research on Intimate Partner Violence

Despite over three decades of research and advocacy, intimate partner violence continues to affect women at alarming rates and in a multitude of ways. According to a Statistics Canada report on Family Violence (Statistics Canada, 1993), 51% of all women age 16 and older report at least one incident of physical or sexual violence in their adult lives. Intimate partner violence is a gender-based occurrence, disproportionately affecting women regardless of socio-economic factors (Hampton & Gerrard, 2006). Although research has revealed that males are victims of intimate partner violence (15%), women continue to be overrepresented in this area (85%) (National Clearinghouse on Family Violence, 2004). For women, violence is more likely to occur from within an intimate relationship than from an unknown assailant (WHO, 2005). Research into this area is important because women are twice as likely to be injured, and are reported to be three times more likely to be the victims of ten or more acts of violence from their partners than their male counterparts (Brzozowski, 2005).

Theoretical Explanations of IPV

Efforts to understand intimate partner violence (IPV) have paralleled the changing status and stature of women in society (Renzetti, Edleson, & Bergen 2001). Since the mobilization of women supporting feminist perspectives in the 1970s, the issue of gender equality has become a social and legal concern, as well as a legitimate domain of academic inquiry (Hampton & Gerrard, 2006). Associated with this has been an evolution in the way IPV has been conceptualized, understood, and addressed. This evolution is marked by a shift from a position that sanctioned male privilege, to one that places responsibility for abusive behaviour on the abuser. Theoretical explanations of intimate partner violence can be characterised as focusing either on individual or societal factors, or some combination of both.

Individual Theories

A major explanation for IPV focuses on individual pathological factors such as psychopathology or mental illness. Early research in this area focused on victim characteristics, often resulting in blaming the victim (Jasinski, 2001). More recently, data from men who have been identified as batterers has been used to develop typologies and psychological profiles (Dutton, 1995). This approach underscores the presence of violence, disinhibiting mental illnesses and personality disorders (e.g., borderline personality disorder, anti-social personality disorder) in men who have committed IPV (Greene, Coles, & Johnson, 1994). Violence against women is viewed as a deviation from normal behaviour and as such an individual problem rather than a collective or social issue. Some proponents of this approach acknowledge the role that social factors may play a role in violence, though they tend to focus treatment and amelioration efforts on the individual perpetrator as a more manageable target for change. Critics of this framework cite the tendency to minimize personal responsibility for abuse in favour of pathological explanations, as well as minimizing the role of the social structure on violence (Yllo & Bograd, 1988).

Biological theories of IPV include those focusing on genetic factors (Wilson & Daly, 1996), and head injury (Rosenbaum, Hoge, Adelma, Warnken, Fletcher, Kane, 1994) as plausible explanations for violence. From this perspective IPV is thought to occur due to some physical ailment or more controversially a predisposition of males to behave violently toward women. Animal research has provided the primary source of data for this approach, (given the ethical limitations inherent in human genetic studies) and as such the findings offer limited generalizability. Other explanations of IPV have looked at the strong link between alcohol and violence. Alcohol is thought to be involved in intimate assaults with estimates ranging from 6% to 85% (Jasinski, 2001). Although alcohol may be a contributing factor, it is not sufficient as a causal explanation in the commission of IPV.

Social learning theory suggests that violence is a learned problem solving behaviour (Bandura, 1977). From this perspective, an individual perpetrates violence because they have observed another person behaving violently. Learning that violence is an appropriate means of interacting with others is thought to occur when modeled and

reinforced by people who an individual values. When applied to intimate partner violence, the term *intergenerational transmission* of violence is often used to describe violent behaviours that are learned within a family context (Cappell & Heiner, 1990). A limitation of this approach is that not all those who experience or witnessed violence become perpetrators. Some critics of this approach note that the rate of intergenerational transmission of violence is only 30% (Kaufman & Kiegler, 1987) and others have found that witnessing abuse is not a robust predictor of future violence (Arias & O'Leary, 2001). Further, some researchers have forwarded the idea that being the victim of violent behaviour, or observing violence and being the victim of violence are better predictors of future violent behaviour (Hotaling & Sugarman, 1986).

The idea of learned helplessness (Abramson, Seligman & Teasdale, 1975) was initially used to describe the behavioural state of animals that were unable to escape environmental constraints. This concept, when applied to IPV, has been used to examine how the interaction between the perpetrator and the victim affect the continuance of violence. Walker (1984) used the terminology "learned helplessness" to describe why women stayed in an abusive relationship, positing that a woman's inability to control or change the abusive behaviour resulted in a state of apathy. Although intended to illuminate the nature of abusive relationships, the approach is thought to have fuelled the "why does she stay" line of inquiry of attributing responsibility onto the women rather than the perpetrator of the abuse. Other limitations of this approach are the minimization of the influence of the social structure on a woman's ability to leave an abusive partner, as well as failing to explain why many women do leave abusive relationships.

Social Theories

Contrasting with theories focusing on individual factors, social theories of IPV include the influence of cultural and social factors. Feminist theories view intimate partner violence as the product of a patriarchal system that oppresses women (Dobash, Dobash, Wilson, & Daly, 1992). This is a central tenet regardless of the diverse viewpoints and political affiliations amongst feminists (Brown, 2000). Feminist theories maintain that male dominance is institutionally legitimized (Gill, 2006), is maintained by gender specific socialization practices (Pagelow, 1984; Smith, 1990) including the

mechanism of traditional marriage (Yllo & Straus, 1990). Sexual violence from this point of view is thought to occur as a means of domination and control rather than for the purposes of sexual gratification (Ellis, 1989). Critics of this analysis of violence have argued that the explanation is overly simplistic, ignores the fact that the majority of men do not use violence in intimate relationships (Dutton, 1995), and does not explain violence perpetrated by women (Coleman, 1994).

Emerging from the feminist approach, the cycle of violence and the power and control wheel (see appendix A) are widely used explanatory models of IPV. Walker (1984; 1993) developed a tri-phasic model of violence describing the tension building, acting out and honeymoon stages. Some practitioners have adapted this model by integrating information garnered from batterers and have replaced the “honeymoon” stage with a “justification” stage (Nielsen & Dewhurst, 2006). The power and control wheel depicts male domination as central to all forms of violence. Both descriptive models are used widely in treatment programs for men who have abused and within counselling for women who have experienced abuse. I have included an adapted model of the power and control wheel that I have used in my counselling work (see appendix B).

Systems theories focus on the role of interpersonal factors in the commission of violence. This approach views violence as more likely to recur in a family system that rewards such behaviour by not imposing sanctions on the aggressor (Cunningham, et al, 1998). Treatment approaches from a systems perspective often involve couple and family therapies, and as such are controversial given that responsibility for the abusive behaviour is implied to be shared by all family members (including victims). Further, critics have highlighted the inherent safety concerns of conducting conjoint therapy when abuse has occurred (Hansen, 1993). Some jurisdictions prohibit couples counselling altogether (Healy et al., 1998), while others recommend it for carefully screened clients (Goldner, 1998). Some jurisdictions require a violence free period and the completion of a treatment program for the batterer before couples counselling can begin, while others require other measures of behavioural change (see Austin & Dankwort, 1999 for a review of batterer programs). Critics of this approach have focused on the inherent victim-blaming in this explanation as a fundamental flaw of this explanation of violence. While proponents of this approach cite *family conflict* statistics that suggest that women

equally perpetrate assault, and therefore, viewing the family unit as a target for intervention and investigation is a legitimate position (Straus, 2005). This assertion has been contested by feminists, arguing that the overly simple and context free data collection techniques used do not reflect information drawn from hospitals, police reports and shelters which indicate that women are the victims in the vast majority of cases. Kurz (2007) provides an excellent overview of the research that has examined victimization rates in North America over the past three decades, supporting the position that IPV is a gender based occurrence.

Despite the models and theories above and the limitations of the feminists approach, this study adheres to the view that IPV exists in the context of a patriarchal culture. Although individual factors may elevate or moderate risk, a cultural context based on the oppression of women must be considered central in the occurrence of violence against women.

Impact of Intimate Partner Violence

Research into intimate partner violence (IPV) is important because violence impacts many aspects of women's lives. IPV has been found to have profound effects on the acute and chronic physical and mental health of women, as well as their interpersonal functioning. Women who experience abuse are also reported to have low self-esteem, depression, anxiety, suicidal ideation and substance abuse issues (Campbell, 2002; Fowler, 2007; The Stella Project, 2005; WHO Report, 2005). They are disproportionately represented among rape victims, homeless women, women who have attempted suicide, alcoholics and drug users, mothers of abused children, psychiatric patients, and women with Human Immunodeficiency Virus (HIV) (Cohen et al., 2000). These health issues are best interpreted as a result of living with intimate partner violence, rather than mental disorders or dispositional factors.

The impact of intimate partner violence has been conceptualized from a trauma approach wherein posttraumatic stress disorder symptoms (PTSD) are thought to capture the presenting behaviours of women who have been physically or psychologically abused by their partners (Haskell, 2003; Herman, 1992; Walker, 1994). The adoption of the trauma conceptualization has generated a point of tension, as feminist theories view

the use of diagnostic labels as pathologizing and perpetuating oppression, while trauma clinicians see the applicability of conceptualizing and working from a PTSD approach (APA, 2000). Some feminist practitioners have bridged this gap by using the terms 'response' rather than 'disorder,' 'adaptations' rather than 'symptoms,' 'clients' rather than 'patients,' and 'survivors' rather than 'victims' (Haskell, 2003). Others have contributed to the understanding of the impact of IPV by focusing on the somatic aspects of trauma and seeing this focus as the most efficacious therapeutic approach to address the links between physiological responses and psychological experiences (Levine, 2005; Rothschild, 2000).

Given the impact of IPV on the health of women, the quest for effective responses is essential. Investigating what helps women recover and heal from the impact of IPV will enhance our response and counselling approaches with this population. It is important that counsellors are aware of the things that work for women who have experienced abuse in order to integrate this information into practice.

Counselling Programs for Women Who Have Experienced Abuse in British Columbia

Counselling programs for women who have experienced IPV are often affiliated with women's shelters and other agencies that provide protective or refuge services. Generally speaking, the goals of working with abused women have focused on validating and defining the woman's experience as abuse, providing abuse awareness information (cycle of abuse, power and control wheel, community resources), acknowledging feelings of shame and humiliation, and advocating for client safety (Deaton & Hertica, 2001). Initially, therapeutic interventions were a response by grassroots feminists, and were often delivered in the form of peer support. Many programs have since grown to include agencies employing professional counsellors to work with women who have IPV experiences (Leavitt, 2007).

In the province of British Columbia, Canada, counselling programs for women who have experienced IPV are organized as the Stopping the Violence programs (STV). Because females are disproportionately victimised (Hampton & Gerrard, 2006; National Clearinghouse on Family Violence, 2004), the STV counselling programs are designed

to meet the needs of female clients. The STV programs are an example of a program characterized by the shift toward a more professionalized model of counselling, integrating grass root initiatives with empirically based counselling approaches.

Research on Client Perspectives

Agreement between clients and therapists regarding the counselling experience remains elusive. Research has shown that counsellors and clients disagree on the expected duration of counselling (Horvath, Marx, & Kamann, 1990; Klein, Stone, Hicks & Pritchard, 2003), the role and intention of the therapist (Horvath, 1995) the impact of sessions (Caskey, Barker & Elliot, 1984; Dill-Standiford, Stiles & Rorer 1988) and the identification of important events (Cummings, Martin, Hallberg & Slemon, 1992). Other studies have found that counsellors' perceptions are quite accurate when viewing clients as a group (generalized information); however, this accuracy is diminished when counsellors are asked to predict the thoughts and reactions of specific clients (Manthei, 2007a).

The alliance between the client and the counsellor is a well-researched aspect of counselling (Horvath, 1995; Horvath, Del Re, Fluckiger, & Symonds, 2011; Horvath & Greenberg 1989; Martin, Garske, Davis, 2000) and is considered to be central to its success. The client's assessment of the strength of the therapeutic alliance has been shown to be positively correlated with effective counselling outcomes (Horvath & Bedi, 2002). However, a study exploring the client's view of alliance formation found that the clients did not identify factors typically theorized as characteristic in the development of therapeutic alliance (Bedi, Davis, & Williams, 2005).

Given that opinions about what is effective in counselling often differ among counsellors and their clients, it behooves researchers to use client views to inform counselling theory and practice. Seligman (1995) highlighted the need for client opinion in addition to controlled efficacy studies to understand how psychotherapy is useful. Others report that client perceptions of relationship factors account for almost a third of the positive outcomes of counselling (Duncan, Miller, & Sparks, 2004).

The use of descriptive methods to research the counselling experience is considered to be an appropriate means of capturing information that may elude other

methods. Researchers have used observation and interviews as a means of gathering information about the clients counselling experiences (Llewelyn & Hardy, 2001). Techniques that use an 'events paradigm' to gather information about events or interactions that are deemed significant are one means of garnering clients' views on counselling. From this paradigm, data is organized by conceptual similarity, with the inference that those deemed more significant will be most linked to therapeutic change. An example of an event focused approach is the Interpersonal Process Recall (Elliott, 1986), where participants' assessments of significant counselling events are quantitatively analyzed. The Session Rating Scale (Johnson, Miller, & Duncan, 2003) is another example of a means of tracking clients' perception of alliance factors. The Critical Incident Technique method used in this study is another example of an events approach but uses a qualitative approach to analyzing the data.

What Do We Know from Women Who Have Experienced Abuse?

Feminist theorists have explored women's experiences while working towards improving women's social conditions by recognizing inequalities, discrimination, social control, and oppression. Through the analysis of the experiences of abusive relationships, feminist researchers are seeking an understanding of violence against women (Brown, 2004). Investigating the experiences of women who have experienced abuse is one way to better understand IPV and effective ways of responding.

A study by Koehn (2007) looked at women's perspectives of helpful or hindering events when receiving counselling for sexual abuse issues. Women reported that helpful events were focused on the theme of power and control. Specifically helpful events were identified by clients as: feeling in control of the direction and pace of the therapy; sensing counsellor flexibility in terms of the treatment agenda; feeling treated as an equal; and having their criticisms met with openness and self-examination. Hindering events were found to be those that emulated the initial experience of violation (helplessness, intense anger, or inadequacy) and were specifically identified as times when the counsellor was perceived as controlling or pushing. The Koehn study outlines the importance of counsellors responding to the client's needs in order to foster therapeutic progress. This is particularly salient when working with women who have experienced abuse.

Researchers have also explored the views of women who have experienced IPV within the context of their interactions with medical professionals. Dienemann, Glass, and Hyman (2005), found that women preferred an active response to their disclosures of IPV that was respectful, protective and immediate. A similar study found that women reported wanting interventions that provided information and individual counselling rather than those that imposed police reporting (Chang et al., 2005). Along with including information from forensic psychology research, professionals working in the anti-violence field consulted with women (who have experienced IPV) regarding the development of a risk management framework (Nielsen & Dewhurst, 2006) and then reworked the cycle of abuse model.

Other studies have explored the narratives of women whose partners used a weapon during an assault, looking at issues related to the genesis of abuse, explanations of partners' abusive behaviour, abuse throughout the relationship, as well as the impact of abuse (Tutty, 2006). Another study asked women to identify the factors that helped or hindered their ability to leave an abusive relationship (Dziegielewski, Campbell & Turnage, 2005), while others have explored the meaning of shame for women who had experienced intimate partner violence (Buchbinder & Eisikovits, 2003). I was unable to find any studies where researchers asked women who have experienced IPV what worked in the counselling session. My research aligns with the previously mentioned research in terms of using the woman's perspective as the source of expertise. But it further expands on the research by inquiring into what is helpful or hindering in terms of their counselling experiences.

Investigations into what works in counselling sessions are also important because it is the women who have experienced intimate partner violence who are often financially vulnerable and have few resources and many barriers to accessing resources (Dobash, Dobash, Vavanagh & Lewis, 2000). In a recent discussion paper, Haskell (2010) outlines how the often co-occurring issues of violence, mental health concerns, and substance use serve as barriers for women accessing services for IPV issues. The profound effects on the physical and mental health of women who have experienced IPV, and the limited resources available to them, highlights the importance of research efforts geared toward illuminating ways of reducing these barriers. In light of the importance of increasing the accessibility of counselling services for women who have

experience abuse, it is imperative that we as counsellors know how best to use the time and discover what works.

This study contributes to the current literature by exploring the perspectives of women who have experienced intimate partner violence regarding their assessment of helpful and hindering events to promote healing in their counselling experience.

Chapter III.

Method

Critical Incident technique

The critical incident technique (CIT) (Flanagan, 1954; Woolsey, 1986) was used to collect and analyze the data for this study. This exploratory method uses an events paradigm to capture and analyze information. The CIT procedure involves gathering information about incidents deemed to be *critical* (significant or revelatory) by the participant. It is used by a wide variety of disciplines (Butterfield, Borgen, Amundson, & Maglio, 2005) and is considered to provide both reliable and valid information (Andersson & Nilsson, 1964). Initially developed to identify job requirements critical for successful performance, the CIT has since become a frequently used method in a diverse range of disciplines. In 2005, Butterfield et al. published a review article citing over 125 studies using the critical incident technique. These authors note that Flanagan's 1954 paper on the CIT method is an oft-cited source by industrial and organizational psychologists, and has been utilized by a variety of other fields such as nursing, education, counselling, and social work.

Woolsey (1986) provided an overview of the critical incident technique and its applicability to the counselling discipline. She identified the method's flexibility to study a wide range of phenomena, its' usefulness as an exploratory tool, and it's potential as a counselling specific methodology as important reasons to use the CIT in counselling research. Examples of counselling research using the CIT include those which have examined clients' perspectives of forming counselling alliance (Bedi, Davis, & Arvay, 2005; Bedi, Davis, & Williams, 2005), First Nations people's views on healing (McCormick, 1994), women's perceptions of sexual abuse counselling (Koehn, 2007), outplacement counselling (Butterfield & Borgen, 2005), and graduate student accounts of ethical transgressions (Fly, van Bark, Weinman, Kitchener, & Lang, 1997).

The CIT is thought to be advantageous to other methods in that it allows for a focused discussion about the interviewee assessment of critical or important events and can reveal contextual information that illuminates the frame of reference. Although interviews can generate similar information, the focus of CIT method allows for the interviewer to 'follow the thread' of the response, and as such, elicit a richness of information. Further, the CIT is useful for comparative work in that themes across individual cases can become patterns used to inform policy and practice.

Participants

Ten female participants were recruited through notices (see Appendices C and D) distributed to counsellors inviting them to suggest participation to their clients and by notices posted in counselling agencies in the Metro Vancouver area working within the auspices of the Ending Violence Organization of British Columbia specifically those providing services to women who have experienced abuse. Inclusion criteria included: (a) adult females (19 years and older at the time of data collection) who had experienced intimate partner violence and;(b) who had attended one or more individual counselling sessions with a STV counsellor; (c) who had not misused alcohol or substances within the past three months; (d) who had not been hospitalized for self-harm concerns within the past year; (e) who were currently not in care; and (f) who were not currently involved in an abusive relationship. The inclusion criteria were designed to select participants who presented as low risk from harm to self as well as from others. Participants were asked to provide retrospective verbal descriptions of events they deemed as helpful and hindering in terms of meeting the aim of the counselling goal.

Participants ranged in age from 31 to 52 years with a mean age of 42.7 years and a median age of 44 years. Eight participants were Caucasian, one was Aboriginal, and one was Black. The number of counselling sessions(individual and group) participants had attended ranged from 6 to 175, with four (40%) of the participants reporting attending 50 sessions, and three (30%) having attended over 100 sessions. Two (20%) participants were involved in counselling for less than one year; four (40%)participants for more than one year but less than five; one (10%) participant for seven years, one (10%) participant for 10 years, and two (20%) participants reported that they were involved in counselling for more than 20 years. Six (60%) participants

had attended counselling with two therapists; three participants (30%) with three therapists; and one (10%) participant had seen nine different therapists. The referral source for four (40%) participants was a health professional (i.e., psychiatrist, psychologist, or physician), for three (30%) participants were referral by a social service agency, two (20%) participants were referred by a friend or family member, and one (1%) participant was referred by an employee assistance program. Participants' reasons for initially seeking counselling included emotional abuse in relationship ($n=4$; 40%), childhood sexual abuse and family of origin issues ($n=3$; 30%), depression ($n=2$; 20%), and following a suicide attempt ($n=1$; 10%). All participants sought counselling for IPV occurring within a heterosexual relationship.

Specifications

The critical incident method requires that the researcher determine the aim of the activity to be studied, who will be observed, and what behaviours will be reported.

Aim of the activity. The general aim of the activity being studied is the counselling experience for women who have experienced intimate partner violence. As per the recommendations of Flanagan (1954) and Woolsey (1986), a review of the empirical literature was conducted as well as consultation with experts currently working in the field of stopping violence against women. The aims of counselling were determined to be empowerment women to make healthy decisions about their lives, and the acquisition of skills that enhanced women's safety and well-being.

Who was observed. Reports of counsellor behaviours, participants' feelings, thoughts, and attitudes, as well as any other events that occurred during the participants' time in the counselling process that they perceived as either helpful or hinder were included.

Which behaviours and experiences will be reported. Participants reported on their perception of events occurring in counselling that were either helpful or not helpful. Incidents were regarded as "critical" if they were defined by participants as being important to their healing by means of influencing their behaviour, thoughts, feelings or attitudes; and if they were described in significant detail by participants.

Procedure

Participants contacted the researcher by telephone, in person, or via email as per the instructions in the invitation for participation notice (see appendices C and D). During this initial contact, participant suitability was determined, and the scope of the study was clarified including the interview questions. On the day of the interview, the researcher read aloud the description of the study (see appendix F) and gave participants an opportunity to ask any questions. The description of the study included information concerning the type of questions asked, the process of data collection and analyses, as well as information regarding counselling support if they should become emotionally activated during the interview. If they agreed to participate, the researcher read aloud the Consent to Participate form, and then the participant signed the form (see appendix E). The researcher interviewed each participant for a period of approximately one hour; the author conducted all interviews. Although the interview was guided by the research protocol (see appendix F), the semi-structured format allowed the researcher to be responsive to additional information presented by the participant. As a counsellor working with women who experience IPV my experience has afforded me the opportunity to become well acquainted with the issues women face. My proximity to this particular client population and IPV issues may have resulted in me entering the interview with some expectations about what the participants would say.

The interviews were digitally recorded and transcribed in preparation for a CIT categorical thematic analysis. There were three parts of the interview, the first section inquired about the participants' counselling history, including questions about length of time in counselling; number of counsellors seen; and reasons for attending counselling. In addition to gathering information, these questions were included as a way to build rapport with the participant. The second part of the interview was focused on the research questions whilst the final part offered an opportunity to debrief the interview experience. The key interview questions were as follows:

Think back over your time working with your last STV counsellor. Remember a specific event or incident that you believe either helped or made it harder for you to meet your counselling goals.

1. Tell me what it was about the event that made it helpful (or hindering)? How did you know?
2. What meaning did this particular incident hold for you?
3. What went on before/after?
4. How did it turn out?
5. Tell me more about that?

Participants were invited to elaborate on their responses as needed, in order to obtain as much information as possible about critical incidents in counselling. Given that the interview questions were focused on abuse related counselling events, ethical approval included a provision for a list of additional resources to be given to the participants. The consent form also clearly stated that the participant could stop the interview at any time and this was verbally reiterated at the beginning of the interview. In one interview a participant expressed some distress, and was invited to terminate the interview, although she declined. She was provided with the list of additional supports at that time, rather than at the end of the interview, and was encouraged to consult with a mental health service provider.

At the end of the interview, participants were asked if they wanted to add any further information to the interview. They were also asked if they could offer any recommendations to counsellors and clients involved in STV counselling. Finally, they were also provided with community resource information at the conclusion of the interview.

Data Analysis

All interviews were audiotaped and transcribed by a professional transcription service who signed a confidentiality contract. Transcriptions were standardized in terms of language in that “umms”, “ahs”, word repetition and other non-formal spoken language were translated into readable text while maintaining the integrity of the speakers’ voice. Critical incidents were independently extracted from the transcripts by

the researcher and a clinical psychologist. The lists of critical incidents were compared for similarities and differences. In cases where there was disagreement a process of discussion and consensus was used to reach agreement. The final list of critical incidents was entered into a spreadsheet in order to analyze the patterns of repetition. An additional rater (Ph.D. psychologist) reviewed the incidents and each rater generated a list of categories and subcategories and consensus was achieved through a process of discussion or consultation.

Chapter IV.

Results

A total of 590 critical incidents from the 10 participants were used for analyses. Of the total incidents, 414 (70 %) were deemed *helpful*, and 176 (30%) were deemed as *hindering*. There were 12 helpful categories (42 subcategories), and 8 hindering categories (27 subcategories). As I describe the subcategories specifically, I include quotations from participants in instances where an understanding of the subcategory maybe better demonstrated through the participants' own words; thus, some subcategories remain only descriptive without a participant quotation.

Helpful Categories

Table 1 provides an overview of the categories of helpful critical incidents and the corresponding number of participants who identified incidents within this category. Categories are displayed in descending order of the percentage of total incidents they represent.

Table 1. Incidents that Participants Found Helpful in IPV Counselling

| Category of incident | Number of incidents (percentage of total) | Number of participants (percentage of total) |
|--|--|---|
| Positive Counsellor Characteristics | 75 (18%) | 9 (90%) |
| Having a Good Alliance with Counsellor | 55 (13%) | 10 (100%) |
| Appropriate Counselling Tasks Accomplished | 47 (11%) | 9 (90%) |
| Good Access to Information | 35 (8%) | 7 (70%) |
| Appropriate Additional Support | 33 (8%) | 8 (80%) |
| Client Agency Supported | 33 (8%) | 8 (80%) |
| Client Validation | 33 (8%) | 7 (70%) |

| | | |
|---|---------|---------|
| Helpful Skills Learnt | 29 (7%) | 9 (90%) |
| Counsellor Sets Good Boundaries | 24 (6%) | 6 (60%) |
| Positive Emotional Work | 22 (5%) | 6 (60%) |
| Counsellor is Listening | 17 (4%) | 6 (60%) |
| Having Continued Care After Counselling | 11 (3%) | 6 (60%) |

Category 1: Positive Counsellor Characteristics(75 incidents/9 participants)

This category refers to the counsellor’s characteristics perceived by participants as positive and represents the largest number of incidents elicited by 90% of the participants. Participants’ critical incidents describe aspects of counsellors’ demeanor, independent of approach, or techniques counsellors used. Four subcategories emerged: general positive characteristics; counsellor attentiveness; counsellor skillfulness; and counsellors’ positive directiveness. This category reflects the variety of positive counsellor characteristics identified as helpful by the participants.

Counsellor attentiveness (42 incidents/9participants). This subcategory refers to how attentive the counsellor appeared to participants. Critical incidents in this subcategory included descriptions of physical acts of attentiveness “*she used to bring me water at the beginning of every session. And very seldom would she ever forget that, and that helped.*” This subcategory also captures descriptions of counsellor authenticity and openness, as well as participants’ perceptions of counsellor candor and humility. Further, descriptions of attentiveness in the form of empathic responding were included. One participant described her experience by saying:

There was one time in particular that I was telling a really sad story, you know, and I can hardly remember the story that I was telling. I don’t remember the story but I remember her eye, she, a tear, and she never did that but she actually, you could just see that. And I remember thinking that was a real powerful moment for me, that she felt, that I really felt like she got it, like she understood. And that, and not that she cared but that she really, she understood, like she empathized with my situation and she really kind of felt my pain, I guess you could say, right.

This account offers a poignant example of the positive impact the counsellor's attentiveness had on the participant. Interestingly, the participant did not recall the content of the story but rather the salience of the counsellor's empathic response. The counsellor's ability to remain present and emotionally in tune with the participant appears to have resulted in a significantly healing therapeutic event for the participant. Counsellors who were seen as soft-spoken, gentle, calm and non-blaming were valued by participants as well as those seen to be transparent and open to dealing with client complaints.

Counsellor skillfulness (16 incidents/8 participants). Critical incidents in this subcategory describe the participants' perceptions of the level of skill the counsellor used. Responses referred to more general skills such as "asking the right question" as well as more specific skills related to abuse issues. For example, one participant explained:

I think it was probably because she didn't bullshit me ever. She said in the group one day, one thing she liked about herself was that she was honest. And she was. Like, there was times that she just—like, I remember asking her some question and it was kind of a rhetorical question, and she just looked at me straight in the eye, and I remember it was about abuse, and she looked at me, and she said, 'it really was that bad. It was very, very bad.'

In this description, the participant identified her counsellors' verbal acknowledgments of the abuse but also her ability to look her directly in the eye. This directness on part of the counsellor to confront the issue of abuse was viewed as evidence of her skill and willingness to deal with issues in a forthright manner. Other counsellor skills that participants reported, were when or how they inquired about relationship dynamics and abuse as well as counsellors appearing to be knowledgeable about abuse issues.

General positive counsellor characteristics (14 incidents/7 participants). This subcategory refers to features of the counsellor that participants perceived as helpful or positive. Descriptions of "good fit" with counsellor and being of a "similar age" were included in this category. Additionally, friendliness, counsellor consistency, and sense of humour were included in this subcategory. One participant describes her experience of when a counsellor used humour in session when she stated:

She was—she reminded me of a female—reminds me of a female Woody Allen. She's hilarious, and she's—I don't know if she is Jewish, but she's like a little Jewish woman. And she just was funny. Like funny and real . .

Participants appeared to feel positively about the counselling process when counsellors showed authenticity and were seen as approachable and open to participants. Further, counsellors who provided a sense of hope and calmness were viewed positively and were thought to contribute to the helpful aspects of the counselling experience.

Counsellor's positive directiveness (3 incidents/2 participants). This subcategory refers to incidents describing counsellors using a solution focused approach and being responsive to the participants requests for direction. Participants saw it as helpful when counsellors were able to offer direction when they asked for it, and when they appeared to be focused on directing the client toward solutions.

Category 2: Having a Good Alliance with Counsellor (55 incidents/10 participants)

This category is comprised of the second most often occurring critical incidents in the data set. Critical incidents describing the positive therapeutic relationship between the participant and the counsellor are included. Incidents in this category refer to relationship variables such as 'feeling connected,' 'understood,' or 'comfortable' with the counsellor. Feelings of trust, safety, and acceptance were core aspects of the events included in this category. The 55 incidents were further categorized into five subcategories as a means of better illuminating the data: feeling safe with the counsellor, establishing trust, feeling aligned with the counsellor, feeling accepted by counsellor and having positive perceptions of the counsellor.

Feeling safe with counsellor (17 incidents/6 participants). This subcategory includes descriptions of participants' feeling safe in terms of being able to be honest, authentic, comfortable, or unpressured. One woman explains:

She just listened to me and I think she was in tune with what my needs were. And when I think about the work, like, with her, there was a calming presence with her, she wasn't overbearing, she didn't share a lot of

information. Like, she didn't share, I don't think, really any personal information. She, when I think about what it felt like to sit and to talk with her it was just a really accepting feeling, not a judging feeling.

This participant's description offers a view into her perception of the counsellor's behaviours and her ability in facilitating a feeling of safety and trust. Counsellors were valued if they were seen as creating a therapeutic atmosphere that encouraged participants to be honest and authentic. One participant spoke of having positive transference toward her counsellor and how this fostered a feeling of safety allowing her to be open and honest.

Establishing trust (12 incidents/5 participants). This subcategory refers to events that were indicative of building trust within the counselling relationship. One woman spoke of a specific trust exercise that facilitated the development of trust with her counsellor. Another woman described being positively received by the receptionist as helpful because, consequently, it helped her in establishing trust with her counsellor. Another woman describes her experience with a counsellor holding her hand and how it helped to build trust with the counsellor in the following way:

. . . I knew [touching my hand], probably wasn't allowed so she was kind of doing something . . . she was showing me trust. That she could actually work outside the guidelines. Just the fact that she was doing something that maybe she shouldn't be doing. So it showed trust in me, so I could have maybe trust in return.

The exchange of a trusting moment in this description seems to have provided the participant with a sense of confidence in the counsellor. Counsellors were viewed positively if they were seen as willing to persist with a client despite an initial difficulty with trusting the counsellor.

Feeling aligned with counsellor (12 incidents/6 participants). This subcategory is comprised of critical incidents where participant describe feeling "connected" with the counsellor. Half of the incidents in this subcategory refer to "internalizing the counsellor's voice" as a helpful experience. One participant explained:

I was at a funeral and I remember looking around. [My counsellor] would always say 'what's the emotion underneath that anger? Anger is just a

result. What's underneath it?' And it just kind of didn't hit me, I didn't get it. But when I was at this funeral I'm looking around and like the person was loved very much, and I just really saw the sadness in around, like it was so sad that this person was gone. He was just a wonderful person. And it hit me. I could hear my[counsellor's] voice, 'what's the emotion underneath?' Okay, I get it, [counsellor]. I get it now. What's the emotion under my anger? My sadness.

This account reveals the retention of the counsellor's words outside of the counselling setting. Further, this subcategory included the participants' perceptions that the counsellor was not only aligned with the client, but was not aligned with the abuser. Participants who perceived counsellors as being connected with them, and on the same side of the abuse issue as they were, thought the counsellor's action were helpful in the healing process.

Feeling accepted by counsellor (8 incidents/5 participants). This subcategory refers to critical incidents where participants described feeling "honoured" and "known" by the counsellor. This participant describes her feelings when the counsellor addressed the abuse issues in her family of origin:

Yeah, and she honoured me in it, and I was really touched by that. Like I was –I remember feeling really angry when she first said it and started to defend my mum. And she just pressed with it.

For this participant it appears that the counsellor's willingness to recognize the details of her story and to identify the abuse within the story was viewed as honouring her experience. Other women spoke of feeling as though the counsellor "knows who I am" and "she accepts me" and that this perception was a valued aspect of the counselling experience.

Having positive perceptions of the counsellor (6 incidents/4 participants). This subcategory refers to reports of clients seeing their counsellor as a positive role model or mentor. One woman described the impact of accessing her counsellor when she was thinking of going back to school:

Yeah, and I was able to connect with her and she was totally, and even after that because she did that [helping] work, she didn't make me feel like, "Oh you're too screwed up to do that, what are you doing even

thinking about that?” And she was supportive, like if I had questions later I think when I was looking into my studies and she met with me on a different, like she was [*in a senior position*] or supervisor, I don’t know what it was. But, she’d changed her position there and she was more than happy to meet with me and answer questions.

In this example, the relationship with the counsellor has shifted to more of a mentor or role model, and was positively received by the participant. Other participants’ accounts in this subcategory describe the benefits of knowing something about the counsellor outside of the counselling context; for example, knowing that the counsellor was a mother or lived in their same community. In one instance, a participant reported the positive aspects of seeing her counsellor in her community.

Category 3: Appropriate Counselling Tasks Accomplished (47 incidents/9 participants).

This category refers to critical incidents that describe the benefits of specific tasks accomplished in counselling. Incidents were included where participants describe the helpfulness of counselling that was purposive and focused. Five subcategories emerged from this category as a means of better illuminating the nuances of the responses: specific counselling session focus/techniques, using non-verbal techniques; using techniques that incorporate visualization, using techniques focused on thought process, and counsellor as a supportive witness.

Specific counselling session focus/techniques (24 incidents/8 participants). This subcategory refers to incidents where participants describe the benefit of counselling sessions where counsellors use specific techniques or had a specific focus. For example, this subcategory includes sessions focused on grief work, inner child work, or dealing with perfectionism. Other helpful aspects were reported to as participant inclusion in creating a treatment or counselling plan, or setting counselling goals and discussing the counselling framework and expectations. Further, the mode of counselling used to achieve participants counselling goals, (e.g., processing issues, group setting) were also included in this subcategory.

Using non-verbal techniques (13 incidents/5 participants). This subcategory describes critical incidents where counsellors’ use of techniques did not rely solely on

speaking between the participant and counsellor. More than half of the incidents (i.e., eight) in this subcategory described Eye Movement Desensitization and Reprocessing (EMDR) techniques. One participant explains:

It was very odd, there's no doubt about it. I remember, you know, sitting back and kind of, you know, back in my chair as far as—'Are you sure about this?' I felt really, you know, a little bit of an oddball. But, you know, just trying it a number of times. And we would try it, like actually go into the—to the moment, to the feelings of the anger, and then she would say, 'Okay,' and she'd start tapping. She wouldn't even say anything. She's start tapping, and I could hear it. And I'm, like, 'Darn,' and I'd start tapping, too. But it worked. Right?

This account describes her initial skepticism to the EMDR technique and then surprise by the ultimate benefits she experienced. Other non-verbal techniques such as dance therapy, art therapy, and journaling were included in this subcategory.

Using techniques that incorporate visualization (5 incidents/ 2 participants). This subcategory is differentiated from the previous category in that only techniques describing images or visualizations were included. One participant described the use of a Gestalt two-chair technique as helpful for her healing:

She did some interesting stuff with me, because she did this one exercise where I had to sit in a chair and talk to myself and then move to the other chair and move to the other—and I thought, this is stupid. But oh my God, I had some massive breakthrough around my mom and some other issue and I was, like, holy shit. That was amazing.

From this account it is evident that the participant viewed the use of the visualization technique as quite positive. Additionally, another participant spoke of the benefit of visualization in terms of increasing her feelings of strength and coping.

Using techniques focused on thought process (3 incidents/2 participants). Incidents in this subcategory were focused on participants' descriptions of techniques that counsellors aimed at altering participants' cognitions. One participant described how her counsellor would "question her beliefs" and "reframed" her thoughts. Participants acknowledged that the use of techniques focused on thinking were helpful.

Counsellor as a supportive witness (2 incidents/2 participants). This subcategory describes participant reports about the helpful benefits of telling a stranger (a counsellor) their abuse stories (including a specific value in speaking about the details of their abuse experiences). Participants viewed it as helpful to be able to share their story with someone who they viewed as impartial.

Category 4: Good Access to Information (35 incidents/7 participants).

This category refers to incidents where participants describe the availability of specific information to them as clients. In particular, participants valued it when their counsellor provided them with information about abuse issues, their community resources, and the counselling process. There were three subcategories that emerged from the data: given information about intimate partner abuse, having access to general information and resources, and given information about counselling.

Given information about intimate partner abuse (20 incident/6 participants). This subcategory refers to incidents when the counsellor shared abuse specific information with participants. One participant describes her experience as follows:

She was just a very—seemed like a caring person . . . very educated, of course. She seemed like she actually, like, knew the abuse cycle, you know, so like—which is—just made sense to me.

In this example, it appears that when a counsellor has information about the dynamics of abuse and shared it with the participant, she found it beneficial. Another participant described the benefits of her counsellors querying her about her experience of abuse:

Well, and even looking at it with the other counsellor too, you know, she said, “How tall are you? How much did you weigh? How tall was he? How much did he weigh?” He was trained, he was trained to hurt people, to be able to hurt people . . .

It seems as though the benefit for this participant was in the practical information shared by the counsellor regarding the physical dominance of the abuser relative to her. Also as helpful, participants saw when counsellors provided information about general human

rights, abuse prevention, the impacts on women of childhood sexual abuse, and the impacts of intimate partner violence in general.

Having access to general information and resources (9 incidents/3 participants).

This subcategory describes critical incidents when participants described the benefits of gaining general information and specific information regarding resources. Participants described critical incidents related to the benefit of having access to parenting information, and community resources. One participant describes the impact for her of gaining information about community resources:

She knows in the community where to go, what to do, who to talk to. Go and ask, like, you know, I have no idea of income assistance. Or I have no idea of the Ministry of Children. And I have no—and so terrified. I remember my ex-husband telling me all the times that, I mean, ‘If you call 911, the Ministry of Children’s going to come, and they going to put the children in a foster house.’ So I was always—I was always freaking out to do anything . . . I cannot ask, the police is bad, you know, it’s just not—it’s just going to take my children away. And so I was so—and then I realize with[my counsellor] that, no way, I mean, the Ministry of Children is our helpers. And the police is a big helper. And so through her—I actually have in my phone the cell phone of two police officers that I met through [the agency]...that help me to get my children back. And they been involve twice—three times, in strong incidents with him. So without that, I would be crazy.

This incident exemplifies the benefits of being given information about helpful community resources that could enhance the participant’s safety. Participants viewed connecting clients to external resources as a key aspect of the healing process.

Given information about counselling (6 incidents/4 participants). This subcategory refers to critical incidents where participants described the benefit of counsellors explaining their counselling style, or telling about the counselling process in more general terms. Participants perceived this type of information as helpful and added to their positive perceptions about the specific counselling agency to which they were involved.

Category 5: Appropriate Additional Support (33 incidents/8 participants).

This category refers to participant descriptions of critical incidents which they deemed as supportive, and thus, helpful to the healing process. These four subcategories emerged to better illuminate the data: counsellor support, family and child care support, practical support and medical support.

Counsellor Support (14 incidents/6 participants). This subcategory describes counsellor actions that participants deemed supportive. One participant describes her experience of support as follows:

She was really-well, she was very supportive and she was very—she gave me a lot of room.

This is an example of a counsellor behaving in a supportive way regarding the use of counselling time and supporting a client's chosen direction. Other examples of counsellor support were seen in participants' descriptions of the benefit of counsellors 'supportive words, and participants' accounts of feeling nurtured or taken care of by the counsellor.

Family and child care support (8 incidents/4 participants). This subcategory refers to participants' descriptions of the benefit of having helpful services available for children or other family members. Critical incidents that participants mentioned related to counselling services, childcare services, and support groups or other assistance for family members were included in this subcategory.

Practical support (4 incidents/3 participants). This subcategory captures participants' views of supportive actions by the counselling agency that was geared toward practical concerns such as providing food. One participant describes her experience as follows:

Like, last week, well I got laid—well, not laid off—laid off now, but was on stress leave—stress leave, sorry—and a little low on food, and my counsellor went downstairs [and] helped me get some food, so that was helpful too.

The benefits of this type of support are clear and straightforward. Other examples of practical support included critical incidents where the counsellor extended sessions despite a late start to the session. The participants viewed these practical actions as helpful.

Medical support (3 incidents/2 participants). This subcategory refers to participants' reports of the benefits of having adjunctive care from medical professionals while they were attending counselling. Participants described the care as helpful, especially when they were able to access medication and other types of physical therapies during the course of their counselling.

Category 6: Client Agency Supported (33 incidents/8 participants).

This category describes critical incidents that promoted participants' sense of active participation and involvement in the counselling experience. It was considered helpful when clients perceived that their counsellor supported a sense of agency and self-direction in terms of their counselling and healing processes. This category includes the following three subcategories: client choice of counsellor and session focus, client allowed self-discovery, and client viewed as expert of her own life.

Client choice of counsellor and session focus (17 incidents/6 participants). This subcategory refers to critical incidents where participants describe the helpfulness of being able to change their counsellors if there is not a match with their initial counsellor. Additionally, participants viewed it as helpful when they were able to direct the focus of the sessions, and when they saw their counselling as individualized to their specific needs.

Client allowed self-discovery (8 incidents/ 4 participants). This subcategory captures critical incidents that participants described where they worked through an issue in congruence with their own style rather than feeling like they had to comply with a counsellor's interpretations. One participant describes the process of finding her own answers:

I think that the fact that they don't tell you what to do, that they find a way through questions or techniques to allow you to find your answers yourself, and that's how I think you learn.

Participants found counsellors who encouraged them to draw their own conclusions about their issues as helpful. Additionally, counsellors who promoted client self-discovery were also viewed by participants as helpful.

Client viewed as expert of her own life (8 incidents/5 participants). This subcategory refers to critical incidents where counsellors viewed the participant as the expert of their own experiences, and acknowledged their own choices and direction in life. One participant explains her experience in the following way:

I felt a trust with her because I did feel like I was being treated as an individual who did have power and did know what she needed for her life, but just couldn't see it, couldn't see what that was. And [my counsellor] kind of helped me see that, without telling me.

This incident captures the benefit of when the counsellor treated the participant as a capable person who could understand her own needs. The importance of participants feeling knowledgeable and competent about their own lives was evident in all critical incident responses in this subcategory.

Category 7: Client Validation (33 incidents/7 participants).

This category consists of critical incidents where participants describe their counsellor's behaviours that validated their abuse experience and instilled the counsellor's acknowledgement of belief about the clients' account of abuse events. One participant's description of this type of validation was as follows:

And so when you get somebody who actually sits down and looks at you straight in the eye and says what nobody else will, and who believes what it is you're saying—[that's important] . . .

In this participant's account, the counsellor seems to have a unique role in the participant's life where she was willing to address the abuse issues that no one else was willing to do. They valued counsellors who recognized and acknowledged their abuse experiences.

Counsellor normalizing clients' experience (13 incidents/4 participants). This subcategory of critical incidents describes participants' statements about counsellor behaviours that they perceived as removing the stigma attached to the participants' abuse or to their symptoms of abuse. One woman explains an incident with her counsellor as follows:

I was sitting there as a person with my [education], you know, it can be kind of, and she acknowledged, like I think for me, when I think about those two things, she didn't take that away. Like, it was like, I could still be this skilled person and still have some difficulties; she gave me that, right? Whereas I was thinking, 'how can these two things go together?'

Having the counsellor normalize her experience was viewed by this participant as helpful and allowed her to view herself as more than a victim of abuse. Other participants spoke of counsellors who permitted them to have needs, and consequently to consider their own needs in their decisions. Other participants' accounts focused on the benefits of not feeling crazy or abnormal as survivors of IPV.

Client feeling empowered (12 incidents/6 participants). This subcategory refers to counselling events that elicited participants' feelings of empowerment and equality. One participant describes a critical incident with her counsellor:

It's that imbalance of power that I really don't do well with, and if I feel that I'm in that kind of a situation, that shuts me down. And [my counsellor] didn't do that. I didn't ever feel like she was better than me or I was better than her. You know, that's key right there. I always felt like I was an equal to her as a human being. Even though she knew more education-wise and kind of counselling-wise, we were still equal. And she was willing to share that knowledge so that I could bring my knowledge and it would benefit me.

Other critical incidents in this subcategory referred to participants' experiences of having the counsellor view them as more than just a victim of abuse, as this participant explains:

You're what it's about. So it wasn't about something bad that happened to me, or that my whole life is bad. It's that okay, that's what brought you here, that's great, and let's talk about you. And who you are and what—what you want in your life and where you're at. So it was—it became—the counselling was about me, not me being abused.

This incident highlights the importance of participants being seen by the counsellor as more than just the presenting issues, or as this woman describes “a victim,” and then having the benefit of seeing themselves beyond the abuse issue. Other critical incidents in this subcategory reflected the value of participants feeling important, empowered, and believed by the counsellor.

Feeling Validated (8 incidents/3 participants). This subcategory refers to participants’ more general experiences of feeling validated. For example, one participant describes an experience in the following way:

One [helper] is actually a [psychiatric nurse], and she, for the first I think eight sessions with [a psychiatrist], she went in with me to validate my situation, which amazes me because the [psychiatrist] calls me a very honest person. I have never, ever been called honest by anyone that cared about me before.

In this example the participant described the benefits of a psychiatric professional validating her in the presence of another more trained psychiatric professional and the positive feeling she had when a psychiatrist called her honest. Other helpful critical incidents in this subcategory included those where counsellors promoted participants’ feelings of being validate.

Category 8: Helpful Skills Learnt (29 incidents/9 participants).

This category captures those critical incidents that participants described as beneficial in terms of acquiring new skills that promote participants’ healing and counselling gains. Acquiring general skills, as well as specific skills such as those related to interpersonal relationships and self-awareness comprised this category. The critical incidents in this category were divided into three subcategories to capture the nuances of the responses: client learning new skills, helpful self-acceptance skills, and client having increased awareness.

Client learning new skills (15 incidents/6 participants). This subcategory consists of participants’ descriptions of critical incidents related to acquiring general skills. Critical incidents focus on the helpful aspect of gaining skills that impact participants

'perspective of themselves or their situation. For example one participant describes her skill learning experience in the following way:

Yes, so I could get clarity on his treatment of me through a roundabout way because I was focusing on what she was saying, and it allowed me to step outside of the marriage and take a better look. So that's what helped me a lot, yes.

Her account of describes her new ability to take a different view of her relationship as a result of her counselling. Other critical incidents that participants described focused on acquiring new ways of seeing IPV that challenged their thinking patterns and perspective taking.

Helpful self-acceptance skills (7 incidents/ 3 participants). This subcategory consists of critical incidents that highlight participants' learning about how to be gentle with themselves, gain self-acceptance, and acquire forgiveness of themselves. For example, one participant says:

And so when she said to me, "Do you think that maybe you need to forgive yourself?" It was—it's one of those moments where everything falls into place. And you do the really ugly cry and you realize that, yeah, you know, no matter how bad you feel, no matter how guilty you feel, no matter how many times you question that you could have done something different, and maybe there would have been a different outcome. So—but that did help, and through that process of forgiving myself and realizing that, you know, things do happen and it's not always what you want, right. But it—I think it made me a lot more open to coming into myself and looking into myself and who I was and who I wanted to be.

Counselling interventions that promoted self-forgiveness and self-acceptance for this participant appears to have helped her healing process.

Client having increased awareness (5 incidents/4 participants). This subcategory refers to critical events where participants describe gaining insight or new understandings of themselves and others. One participant described gaining a new awareness of her family of origin dynamics. Another participant's account spoke of having awareness about the benefits of generalizing the information gained in group therapy to other situations. Finally, another participant described her awareness of the positive aspects of feeling productive in counselling.

Category 9: Counsellor Sets Good Boundaries (24 incidents/6 participants)

This category captures participants' critical incidents that refer to counsellor actions that set healthy limits or boundaries regarding the counsellor's behaviour, the clients' behaviour, or the counseling setting. The three subcategories that are included in this category are: counsellor modeling/maintaining their own boundaries, teaching boundary skills and counsellor's strong actions related to setting boundaries.

Counsellor modeling/maintaining their own boundaries (13 incidents/4 participants). This subcategory refers to participants' accounts of when a counsellor demonstrates good boundaries. One participant explains her experience when she said:

I think that she helped me a lot in terms of role modeling around professionalism and the work. Like, how to be a counsellor or a good counsellor or whatever—you know, a support counsellor, all that kind of stuff. And just be professional, have good boundaries. Like I said, she had very good boundaries.

In addition to this participant's account of seeing good general boundaries, other participants found that counsellors who refrained from disclosing personal information or were unapologetic for strict office hours viewed those actions as helpful boundary-making. Participants valued professionalism and the maintenance of boundaries within the therapeutic relationship.

Teaching boundary skills (10 incidents/4 participants). This subcategory consists of helpful incidents where participants were taught about the concept of boundaries, or how to set or maintain them in their lives. One participant describes her learning when she said:

Well, every session was a step up on—in an aha moment. And it—I think the real beginning was when I said to my counsellor, 'My family does not believe me. They have never had my back. I am alone in the world.' And she helped me to build walls so that they became boundaries, which I had never learned how to set. And we worked on setting boundaries, to the point where I could say, 'This far and no farther.'

The benefits of acquiring the knowledge and skills needed to set boundaries with others are evident in this participant's account. Other critical incidents for participants reflected the value of learning safety concerns when setting boundaries, specifically the potential safety concerns when using boundary setting skills with abusive partners.

Counsellor's strong actions related to setting boundaries (1 incident/1 participant). This subcategory consists of a single critical incident where a participant describes how her counsellor terminated her involvement in a therapy group. Although this was an unusual incident, the participant perceived it as a helpful boundary for her and a model of how to set a strong boundary.

Category 10: Positive Emotional Work (22 incidents/6 participants).

This category describes participants' accounts of the benefit of having emotional content happening in counselling sessions. The category includes references to the helpful aspects of participants' expressing emotions, and counsellor actions that encouraged safe emotional work. The three subcategories of this category were identified as: counsellor facilitating emotional work, client becoming more aware of emotions, and expressing emotion in session.

Counsellor facilitating emotional work (6 incidents/3 participants). This subcategory refers to participants' critical incidents related to when a counsellor used skills and techniques that specifically encouraged emotional expression, or deeper exploration of participants' feelings. One participant described her experience when she said:

I think that is the time period that the actual time spent with the counsellor was most beneficial. Right? I can go and tell my story to—I mean, there's lots of people out there, right? To make best benefit of my time with that counsellor, it's not necessarily about the whole story. It's about the emotions that need healing, that need to actually be addressed or need to be heard, that need to be—whatever it is that we're doing, whether it's, you know, shaping, coddling, whatever.

This participant's description of the counsellor facilitating her emotional work as beneficial was echoed in other participants' accounts of how counsellors encouraged

emotional expression, or were seen to have help participants fully explore their emotions.

Client becoming more aware of emotions (5 incidents/2 participants). This subcategory consists of participants' accounts of critical incidents where they benefited from connecting their feelings to past memories, and in turn, were able to integrate their stories into a life narrative on a deeper level. One participant offered her views when she stated:

I think it was very good because when you marry up the memories with this stuff that [the counsellor] has given me, it provides acknowledgement to things that kind of feel almost like a lie. And when you have not been able to discuss them ever, or nobody's willing to hear them, when you talk about reactions or response to things, and they mirror what you're feeling, it just kind of fills it. I don't even know how to explain it. It's—it sort of takes it out of a fictional situation and sort of allows you to attach yourself to the—because when you pull it out, you feel emotion toward the information.

This critical incident exemplifies the participant's perceptions of the importance of linking emotions to the content of the abuse story and a way of enriching the participant's understanding of the abusive events and herself.

Expressing emotion in session (4 incidents/3 participants). This subcategory refers to the participants' perceptions of the helpful effect of expressing emotion in the counselling session. For example, one participant makes this assertion:

But if you just need to go in and cry, then that's all you need to do. And that you should have the room to do that, but you should also have the room within yourself to do that. And then whatever comes up in that crying, that's the gift because that's the work you get to do.

In addition to the positive aspects of crying, other critical incidents focused specifically on the benefits of expressing anger in the counselling session. It appears as though participants who were able to express strong emotions in a safe counselling setting found this opportunity to be very helpful.

Category 11: Counsellor is Listening (17 incidents/6 participants).

This category is comprised of critical incidents where participants describe the general benefits of having someone to listen to their story, and in addition having a more specific experience of feeling “heard” by the counsellor. Descriptions of participants feeling heard by a counsellor include descriptions of deeper listening skills and attentiveness. The two subcategories included in this category are: client felt counsellor listened and client recognized active listening skills.

Client felt counsellor listened (9 incidents/6 participants). This subcategory refers to participants’ perceptions of being listened to by a counsellor, and feelings about the counsellor having truly heard what they were saying. The link between feelings of safety and acceptance, and feeling heard and listened to were expressed by this participant when she said:

Yeah, and just being accepted, being heard, being listened to, being—all of those things that sort of encourage that level of safety, to be able to, you know, to feel that it’s okay to actually delve into those painful subjects.

This incident emphasizes the value placed on feeling heard and listened to by the counsellor and how important it is in light of IPV and the distrust that can arise because of it.

Client recognized active listening skills (8 incidents/4 participants). This subcategory refers to participants’ recognition of counsellors’ use of specific skills that facilitate deeper listening. Critical incidents related to instances where participants recognized when a counsellor used rephrasing, clarifying, and attending skills. For example, one participant states:

He really listens and I can tell he’s listening because he’ll sort of say back, like he’ll not say back word-for-word, but he’ll try and capture what I’ve said, he’ll check in with me about that. So, he’ll laugh every once in awhile, right, with me.

This incident highlights how attentive IPV clients can be to what the counsellor is doing and the importance of the counsellor to clarify and rephrase the client's words. Participants viewed counsellors who used these types of active listening techniques positively.

Category 12: Having Continued Care After Counselling (11 incidents/6 participants).

This category is comprised of critical incidents in which some form of after care or follow-up service was provided or offered to participants. The two subcategories in this category include: clients could contact counsellor or support person and clients received literature or written information.

Clients could contact counsellor or support person (8 incidents/5 participants).

This subcategory describes the benefit of ongoing counsellor contact and other support services for clients. One participant explains by stating:

Well, it's actually never totally ended. I'm not in counselling anymore, but we still keep in contact through email, and I just give her updates on how I'm doing. And—just because it's really important for me to be able to keep one continuous relationship in my life because I've never really had one.

Other examples in this subcategory include participants describing being able to have phone contact or having access to a crisis line affiliated with the agency.

Clients received literature or written information (3 incidents/2 participants). This subcategory consists of participants describing helpful reports of being given useful written materials in conjunction with one-on-one counselling sessions.

Hindering Categories

Table 2 provides an overview of the 8 categories of hindering critical incidents in IPV counselling and the corresponding number of participants who identified incidents within this category. Categories are displayed in descending order of the percentage of total incidents they represent.

Table 2. Incidents that Participants Found Hindering in IPV Counselling

| Category of incident | Number of incidents (percentage of total) | Number of participants (percentage of total) |
|--|--|---|
| Lack of Client Agency | 31 (18%) | 8 (80%) |
| Lack of Information | 31 (18%) | 6 (60%) |
| Lack of Alliance | 29 (17%) | 8 (80%) |
| Negative Counsellor Characteristics | 27 (15%) | 6 (60%) |
| Poor Counselling Techniques Used | 22 (12%) | 7 (70%) |
| Poor Service Provision | 15 (8%) | 5 (50%) |
| Inappropriate and Devaluing Use of Power | 11 (6%) | 6 (60%) |
| Client Felt Blamed | 10 (6%) | 4 (40%) |

Category 1: Lack of Client Agency (31 incidents/8 participants).

Critical incidents in this category refer to occurrences when participants did not feel in control of their counselling experience. Some of the participants spoke of feeling unable to influence the course of their counselling experience, while others remarked on the negative impact of the counsellor directing the content and topics of counselling sessions. Three subcategories emerged from the analysis and include: counsellor directs focus of counselling, counsellor directs actions too little or too much, and unexpected termination.

Counsellor directs focus of counselling (16 incidents/6 participants). This subcategory refers to critical incidents describing the negative aspects on participants of having a counsellor direct the focus of the counselling session. Participants considered it unhelpful when counsellors chose to focus on historical rather than current issues, despite their need for present-day safety planning. Further, participants thought it hindering when counsellors appeared inflexible with regards to the counselling plan. One participant describes her experience saying:

Yeah, and we would talk about family. We would talk about the suicide attempt. We would talk about how I was feeling, you know. Sort of what precipitated the whole event. But then the next appointment, you know, it would be back to childhood. And I don't know if that was the thinking in

that time in psychiatry, that it had to be, because it's like everything else. It sort of goes in waves of treatment.

This participant's response reflected her dissatisfaction with the counsellor returning to historical issues, and specifically focusing on childhood events. The hindering aspect of focusing on historical events was reported by another participant regarding being repeatedly asked her history. She said:

. . . they asked me all these questions to get my history, and next appointment, the assistant hadn't given the doctor my history, so I gave it again. And then the third one, same thing happened again.... I'm doing all I can. Like, I'm doing all I can, and I'm getting nowhere.

From this participant's account it appears that when there is a lack of appreciation by a mental health professional for the potential revictimization that may occur with client's repeatedly telling a traumatic history it can result in a negative experience for the client. Additionally, participants found it hindering when counsellors did not focus on their current issues and needs, or were seen by the participants as being inflexible with regards to the direction and focus of counselling sessions.

Counsellor directs clients' actions too little or too much (13 incidents/4 participants). This subcategory refers to critical instances where a counsellor was perceived to be telling the participant what to do, rather than allowing her to determine her own direction. For example, one participant says:

And having counsellors along the way who would tell me what to do did not help me. It just increased that frustration of not being heard, of not being supported and not being accepted for who I am and that I can actually figure it out with the right supports.

From this participant's response, it is apparent that the counsellor's actions were perceived negatively and had a detrimental effect on her feelings of being validated and accepted. Conversely, other incidents in this subcategory reflect times when participants were seeking direction and the counsellor did not adequately provide it.

Unexpected termination (2 incidents/2 participants). This subcategory refers to two critical incidents where the participants were asked to change counsellors due to a conflict of interest or when they were asked to leave a group counselling setting. These

participants found this unexpected ending as having a hindering effect on their therapeutic efforts.

Category 2: Lack of Information (31 incidents/6 participants).

This category captures hindering incidents where participants describe the negative impact of not being given information by their counsellor. Critical incidents were further categorized into three subcategories: lack of information about counselling, a counsellor lacking information about the client, and about lacking information about community resources. Counsellors who were perceived as not providing sufficient information to participants were viewed negatively by them.

Counsellor lacked knowledge about counselling (16 incidents/5 participants).

This subcategory describes the participants' perceptions of counsellors appearing to lack sufficient knowledge about general counselling issues such as termination, transference, or therapy roles. Participants reported unhelpful counsellor actions related to not being offered information regarding the end of a counselling relationship, or information about the roles of the client and counsellor within a therapeutic framework. Further, participants described critical incidents where counsellors did not provide any (or inadequate) information about abuse dynamics or safety needs within an IPV relationship. For example, one participant states:

I also think if people would have asked me specific questions [about abuse] like even you just did a little, you know, like a specific question checklist. And nobody ever did a safety plan with me, like, around any of that, right.

From this participant's response it appears she would have benefited from having direct questions asked by a counsellor about her safety rather than not having the issue addressed at all. Other participants found it detrimental when their counsellor did not appear to know how to manage symptoms and responses associated with abuse, or when their counsellor appeared not to know what to do in the course of counselling. Participants saw counsellors they viewed as incompetent or unwilling to address presenting abuse issues as hindering the counselling process.

Counsellor lacked information about client (9 incidents/3 participants). This subcategory refers to the participants' perceptions of counsellors who knew little about them or conducted minimal (if any) forms of assessment about their specific presenting issues. As an example, one participant describes the problem with a lack of assessment when she states:

So, definitely assessment of the level of, of, of what's actually going on. And, like, I think, when I think back to where I was at, I think it would have to be quite specific questions, like, as specific as you can get without being totally intrusive, right. But, at the same time – because I didn't have any idea what was really going on for me, you know, and I think about that loss and I think about the lacking direction – I think there needed to be some assessment to really help me see where I was and what I was experiencing.

This participant's account highlights the negative impact of not conducting an assessment of her needs and safety risks. Further, counsellors were hindering when participants' perceived them as being closed to hearing a client's story, or did not inquire about relationship abuse.

Counsellor lacked knowledge about resources (6 incidents/2 participants). This subcategory is comprised of participants' critical incidents that showed a hindering effect when counsellors had an inadequate knowledge of community resources. For example, one participant said:

I think that if I had a better counsellor I will—that has more knowledge about the community and—I mean, I probably could have made better choices at the time, that were less painful and less hard to go through.

This participant's comments emphasize a negative impact when a counsellor does not providing sufficient information about what is available in the community. Other participants describe critical incidents that reflect a failure to offer any written information, useful safety checklists, or informative handouts.

Category 3: Lack of Alliance (29 incidents/8 participants).

This category refers to participants' perceptions about the therapeutic alliance between a client and counsellor that was inadequate, and thus, hindering in terms of

fostering a healing counselling environment. Critical incidents in this category are reflected in three subcategories: perceptions of counsellor negativity, a lack of fit between client and the counsellor, and participants' feelings of disconnection with the counsellor.

Client's perception of negativity (13 incidents/4 participants). This subcategory includes critical incidents where participants perceived the counsellor as cold or aloof, patronizing, impatient or bored with the client, or (in some cases) frustrated with the clients' lack of therapeutic progress or with her decision to stay with the abusive partner. This participant's excerpt highlights one her experience. She says:

See, that's a tough one, because I know that—I don't know—I believe that client-counsellor conversation is to be geared to the client. However, if I had been able to say, like, 'I feel'—which I didn't—I feel that you're running out of patience with me because I haven't left him yet.' Right? If I had felt the courage and the strength to be able to say that, we probably could have worked through it. Right? But I just didn't feel—I didn't feel accepted enough to be able to be on that—

From this participant's account it is evident that she felt hindered in her healing process because of her perception of the counsellor's impatience when she stayed with her abusive partner. Other participants saw counsellors as hindering when they responded negatively to the participant, or were viewed by the participant as uncaring or frustrated.

Lack of fit (13 incidents/4 participants). This subcategory refers to the mismatch between the counsellor and participant due to physical variables (i.e., age, gender), the counselling approach (e.g., wanting to prescribe medication, viewed as "old school"), or the participants' perceptions that counsellors' style in session was not a good fit. For example, one participant explains a mismatch between her and a counsellor:

He wasn't—I didn't ever feel any sort of connection to—that he was listening to me. That he understood. He was kind of stuffy. I don't know, like, I was in my 20s and he was an older man. And talking to a man about it too was difficult, right? I probably could have talked to someone else that, you know, would have been more comfortable. But he wore the tweed jacket and—I'm surprised he didn't have a pipe, but he just never really was engaged. And he would ask these really open-ended questions that I really didn't—I wasn't sure.

In this participant's account several variables are seen as not being a good fit: gender, age, fashion sense, aloofness, and counselling techniques. The lack of fit between her and the counsellor impeded the benefits of being in therapy.

Disconnect to counsellor (3 incidents/3 participants). This subcategory captures participants' descriptions of not feeling connected to the counsellor. One woman describes her experience of disconnection when she said:

And that coupled with the fact that I—obviously was not a good fit either. And probably partly because I had those feelings in the sessions. I didn't really open up a great deal either. So maybe the lack of connection could have been partly—you know, he just was, like, 'I don't' know what to say to her.'

This participant's account emphasizes the importance of the client feeling a connection to the counsellor in session. Further, this participant remarks on her perception with the counsellor not seeming to connect to her either, and noticed the mutuality of the sense of disconnection. Other critical incidents participants mentioned in this subcategory included accounts of not feeling accepted by the counsellor, and in one case, not feeling accepted by the other members in group counselling.

Category 4: Negative Counsellor Characteristics (27 incidents/6 participants).

This category refers to participants' perceptions of negative characteristics associated with the counsellor. These critical incidents focused specifically on counsellor behaviours that participants saw as detrimental and hindering to their healing process. The three subcategories include: a lack of professionalism displayed by counsellors, a lack of appropriate boundaries, and counsellors over-disclosing personal information about themselves.

Lack of professionalism (14 incidents/3 participants). This subcategory refers to the participants' perceptions that counsellors were not behaving in a sufficiently professional manner. Hindering critical incidents included descriptions of counsellors being late for sessions or missing appointments, and not having a clear policy regarding

expected client behaviors. For example, one participant described an incident when her counsellor fell asleep during the counselling session. She said:

And at one point—in session, she fell asleep, almost fell asleep and I could see, I was, like—and I—you know, her eyes are shut—and I looked at her, I’m looking at her and I’m thinking, ‘wake up.’ And part of me felt like I didn’t even need her to be awake, it doesn’t matter because I [was doing] EMDR.

In addition to reports of counsellors falling asleep in session, some participants spoke of the negative impact of when counsellors were promoting themselves. For example, one participant states:

I could sense that kind of—she was very—she was an entrepreneur and she’s hungry, right. I could sense that with her, and she was—and part of her bragging was, that was her sales pitch.

In addition to the negative view of counsellor self-promotion, other participants referred to the counsellor as being unavailable to discuss conflict or how they responded defensively to participant complaints. Further, participants also saw counsellors who delayed their response to participant phone calls negatively.

Lack of boundaries (8 incidents/3 participants). This subcategory refers to the hindering effect on participants when counsellors either did not deal with boundary issues that participants presented, created a dependency for the participant on them, or were not consistent or clear with their professional boundaries. For example, one participant described her counsellor as overly friendly and she perceived that as hindering her counselling progress. Another participant offered this critical incident around counselling boundaries:

Yeah, and she just, you know, was allowing it, and I think that’s also where we started—the boundaries did start to blur because we’d been together for so long. And I think I had—and then I had a couple of appointments and I cancelled them, and it wasn’t her. I just knew that it was time to do something—like, time to take a break and then it was time to find someone new if I was going to continue with the counselling.

This lack of clear boundaries disrupted a possible appropriate termination experience for this participant and negatively impacted her progress. Other critical incidents for

participants showed their dissatisfaction when they noticed that they were wanting to please the counsellor, or finding themselves feeling dependent on the counsellor.

Counsellor over-disclosure (5 incidents/3 participants). This subcategory captures critical incidents where participants describe times when counsellors disclosed personal information with them. For example, one participant said:

She, I think, there were times I'm pretty certain, that she was telling me what to do, even directly, like yeah. And then talking about her and her husband all the time, I just, and her garden, I don't know what she was talking about. Probably more, you know, like all the time. A lot, blah-blah-blah-blah-blah-blah.

From this incident, it is apparent that the counsellor lacked focus on the participant's issues. Thus, participants viewed the use of inappropriate self-disclosure as hindering to the counselling process. Other critical incidents cited by participants included their feelings of dissatisfaction with counsellors who were using over-disclosure to brag or talk excessively about themselves.

Category 5: Poor Counselling Techniques Used (22 incidents/7 participants).

This category is comprised of participant accounts that discuss counsellors' use of techniques or interventions that were not effective for them. Critical incidents in this category show participants' dissatisfaction when their counsellors used methods that did not fit within their comfort level, lacked any positive outcome, or most frequently when there was a negative power imbalance. Therefore, the subcategories are: counsellor techniques indicative of negative power imbalance, techniques did not fit with the client, client did not experience results from counselling, inappropriate emotional work, and repeated techniques used.

Counsellor techniques indicative of negative power imbalance (8 incidents/4 participants). This subcategory shows critical incidents where participants noted an imbalance in power dynamics within the counselling relationship. The essence of this subcategory is that participant perceived the counsellor as using methods were overpowering for the participant, such as using an intimidating or confrontational

approach or by making assumptions about the participant's needs. One participant described her experience in the following way:

Oh, there was one item that I had to add, and I need to spit this out now, because it was so important. I made a call looking for help. Now, this is, gosh, I don't know, fifteen years already, I've already been in counselling. And I made a call, because it had been—it had been some time. And it was very poorly received, and again, I was directed. Okay? 'You don't need counselling, you need medication.' Right? And I looked at the phone, and I was like, 'Well, that would be great, if I did medication. Thanks for your help.' Click. And that was so unhelpful. I think that especially on the telephone, we should never, ever make assumptions, direct, dictate, nothing. That was—that was really hard. It was hard to come back, because I have since returned—sometime later, albeit—I had to get over that little hurdle, but in the initial phases, very upset and very angry. How dare you take my inventory. You don't even know me, and medication is not an option. If I can go through a broken back without narcotics, I certainly don't need them now. So I was very, very offended.

This participant's account exemplifies the detrimental impact of counsellors making assumptions about client needs; this incident shows the significant impact of a fractured initial contact for therapeutic assistance. Other ineffective techniques that participants noted were related to when counsellors lectured them, scrutinized them, and tried to exert pressure on them for particular changes. These types of incidents were considered by participants as having hindering effects through power imbalances.

Techniques did not fit with client (5 incidents/4 participants). The essence of this subcategory is the counsellors' use of techniques that do not match the style or counselling needs of participants. Examples include the counsellors' use of open-ended questions, complex language, or (in one instance) the use of mirroring the participant's words. She describes her experience, saying:

Yeah, she would mirror back to me what I said. That did not work for me at all . . . It felt very patronizing. It felt like she was just confirming exactly how I felt, and it just pissed me off even more. Because she would say to me—she would repeat what I said. When he made me feel like shit, she would repeat what I said, and it just felt like she was speaking the same words he was. And it just got me so frustrated and it did not work.

From this participant's account, it is clear that this technique did not fit her needs and frustrated her because it was a reminder of how her abuser behaved. Indeed, counsellors using this technique should be aware of its possible hindering effects.

Client did not experience results from counselling (4 incidents/2 participants).

This subcategory refers to participant reports when counselling did not produce the types of results or outcomes that participants' desired. Participants who did not feel helped or did not see any change in their symptoms had a negative view of techniques or interventions used by counsellors.

Inappropriate Emotional Work (3 incidents/3 participants). This subcategory consists of critical incidents regarding the hindering aspect of counsellors doing inappropriate emotional work. Here, participants described critical incidents where they felt too emotionally triggered to do effective counselling work. For example, one participant spoke of the negative effect of dissociating in a group counselling setting due to high emotional arousal. Other critical incidents outlined participants' difficulties in coping with feeling emotionally activated in one-on-one sessions with counsellors.

Repeated techniques used (2 incidents/1 participants). This subcategory is comprised of critical incidents where participants described the lack of variety in the counselling techniques used by their counsellor. For example, one participant explained this type of situation in the following way:

. . . because she wasn't trying anything new, and that had been a big thing, right. And so it was just not effective, and it was getting redundant and we could both feel it. And I think we just didn't want to let go because we had been together for a long time.

It seems as though the perception of recycling techniques and not using novel methods hindered the counselling process for this participant.

Category 6: Poor Service Provision (15 incidents/5 participants).

This category captured participant accounts of the hindering impact of contextual factors affecting their healing processes. The essence of this category refers to the situational conditions that participant saw as negatively influencing their process of

healing. There were two key subcategories: difficult counselling context and counselling duration either too long or too short.

Difficult counselling context (11 incidents/3 participants). This subcategory describes critical incidents that participants referred to as hindering contextual circumstances. Examples of critical incidents include: the negative impact of the counselling setting (i.e., in a hospital, group counselling), the impact of funding cuts, and participants feeling deserted by government agencies. Specifically, participants had concerns about the hindering effects of peer-lead groups, and groups that required significant disclosure or use of overly confrontational methods.

Counselling duration either too long or too short (4 incidents/3 participants). This subcategory refers to critical incidents where participants thought that counselling had gone on for too long, or conversely, when counselling was perceived as not sufficiently long enough in duration for significant personal changes to take place.

Category 7: Inappropriate and Devaluing Use of Power (11 incidents/6 participants).

This category describes critical incidents where participants saw power in the counselling relationship as being used by the counsellor in a negative manner. Perceptions of the misuse of power by the counsellor, as well as incidents describing the lack of safety and equality were included in this category. Four subcategories emerged: counsellor perceived as powerful and controlling, client not feeling safe, counsellor perceived as a negative authority, and client lost in counselling process.

Counsellor perceived as powerful and controlling (4 incidents/2 participants). This subcategory refers to critical incidents that highlight the power imbalance between the counsellor and participant. One participant describes her experience of a misuse of power in the following way:

He was older. He was smarter. He knew all the answers, and I felt like I was under a microscope and that I wasn't answering correctly. And I couldn't verbalize, no, no, no, this is—I want to know this--to him I couldn't—I guess I was really intimidated by him too, yeah. But it never felt like we were communicating about the same thing.

From this description the participant's feeling of subordination is evident and it hindered her progress. Other participants spoke of feeling overpowered or controlled by the counsellor, and in one instance, a participant spoke about feeling unsure of what specific information her counsellor shared with others about her. Participants negatively viewed counsellors who they saw as too powerful.

Client not feeling safe (3 incidents/2 participants). This subcategory refers to critical incidents where participants expressed the negative impact of feeling unsafe with a counsellor. One participant describes her experience as follows:

But it would have been more helpful if that had been part of the conversation to work through it, to help that, you know. I just felt abandoned. Or, like, she—yeah, and it hurt. I felt hurt, and I felt abandoned. And then over time I got very resentful about that. And I remember, I think it was towards the last couple of times where it happened again, and I didn't feel like I could assert—I didn't feel safe enough to assert myself. And that's where it became the big sister, little sister thing and I—and that was my own stuff around my siblings. Like, you know, where I always felt like I didn't want to rock the boat and didn't want to assert myself and say, like, I don't like that you didn't—don't return my calls.

From this example, it is apparent that a lack of safety impeded the participant's ability to assert herself with the counsellor and it consequently had a negative impact on her counselling experience. Other instances within this subcategory included participants' perceptions that it was unsafe to be honest with their counsellor. Participants who did not feel safe in counselling sessions connected it to being hindered and unhelped.

Client lost in counselling process (2 incidents/2 participants). This subcategory describes critical incidents where participants described their feelings of confusion about the expectations of the counsellor, or their uncertainty about how to “do” counselling (i.e., not knowing how to respond to questions or feeling as though they were not doing counselling “right”).

Counsellor perceived as negative authority (2 incidents/1 participant). This subcategory refers to one participant's perceptions that her counsellor used authority that created a negative impact on her and left her with a sense of powerlessness. She states:

Absolutely, with a person who—my own perception, my own belief, with a person who is going through abusive situations or traumatic situations, a lot of times they're being told what to do and their power of control is so out of balance that they're controlled. So they don't need a counsellor that's going to come along and control even more because then they'd create that anxiety for the client. Even though this is a good person, it's still that piece of lack of self-control.

This participant's account links to the importance of clients feeling in control in the counselling setting, especially for women who have experienced IPV abuse.

Category 8: Client Felt Blamed (10 incidents/4 participants).

This category refers to critical incidents where participants feel blamed by the counsellor for being abused. This perception of being blamed was based on participants' interpretation of why counsellors might avoid discussing abuse issues, how they choose the questions they ask, or why they did not validate the participant's experience. Thus, the subcategories for this category include: counsellor not validating clients' concerns, counsellor left abuse issues unaddressed, and counsellor blaming the client for abuse.

Counsellor not validating clients' concerns (5 incidents/3 participants). This subcategory refers to participants' descriptions of feeling unheard by counsellors, or when a counsellor did not believe their abuse story, or when they felt "shut down" by a counsellor. Incidents in this subcategory reflect the hindering impact of the counsellors' lack of validation for their clients' experience.

Counsellor left abuse issues unaddressed (3 incidents/1 participants). This subcategory refers to critical incidents where the client thought the counsellor avoided or did not adequately attend to abuse issues. A participant's sense of the counsellor's collusion with her abusive partner is exemplified in this excerpt. She states:

So it was even more confusing for me because I didn't know him as an equal partner ever. And when we went to the first counselling session *he* was able to charm her, totally charm her, and she never really—seen the issues. Yeah, she basically bought everything he said. And I don't remember exactly what he said, but I just know I walked away from that and she was almost like chummy with him. And it was like okay, this isn't going to work because I again, have no voice . . . She was just really—she was friendly with him. Like, he—when he was around people he

wanted to impress, he could charm them, and he would charm them. Somehow, I don't know how he did it. But I don't remember. I just remember walking out of there and thinking no, she was fooled by him too.

This incident highlights how hindering it can be for the participant when she saw her counsellor siding with the abuser. More importantly, the participant could not trust that the counsellor could help her because the counsellor was blinded in a similar way to the abuser's charms and so was susceptible to the abuser's manipulation or influence.

Counsellor blaming the client for abuse (2 incidents/2 participants). This subcategory captures critical incidents that participants considered to be hindering related to how a counsellor might hold the participant responsible for the IPV abuse. One participant describes her experience in the following way:

The most unhelpful thing was the first one, you know, family, family, family, family, because it made me feel like something that happened to me made it okay for him. It must have been something about what I was doing, or what I had experienced, that made me the victim for him.

This participant's response offers an insight into her view of how the counsellor focused on her childhood experience (reflected her assessment) as the cause of her experience of IPV abuse rather than on the abuser's actions of violence.

Chapter V.

Discussion

The objective of this study was to examine female survivors' of intimate partner violence (IPV) perceptions of helpful and hindering counselling events. As an IPV counsellor, my experience working with women has afforded me the opportunity of having an insider's perspective and as such has prompted me to want to investigate the best practices for this client population from their perspective. Using a critical incident method, information gained from interviews comprised the data set, and the findings were presented in Chapter IV. Critical incidents were identified as either helpful or hindering and then organized into categories and subcategories. Counsellor characteristics emerged as the major preoccupation of participants when looking at helpful and hindering counselling events. As well, the content of their responses resulted in the identification of three key themes that emerged from the data: safety, empowerment, and shame. This chapter presents the conclusions of the findings, as well as discussing the limitations of the study and recommendations for future research.

Summary of Results

The thematic analysis of the critical incidents resulted in six categories having both helpful and hindering events. These categories were related to counsellor characteristics, therapeutic alliance, counselling tasks/techniques, access to information, validation, and client agency. Categories that were unique to the helpful incidents included: having additional appropriate support, counsellors who set good boundaries, positive emotional work, learning helpful skills, having continued after care, and a counsellor who listened well. Categories that were unique to the hindering incidents included counsellors' inappropriate and devaluing use of power.

Participants most often cited counsellor characteristics (whether helpful or hindering) as being important. It may be that a counsellor's specific characteristics are most strongly impacting because they can be most significantly shaming or nurturing (e.g., used as a model for how to act in difficult situations). Other explanations for this may be that participant perceptions of counsellor characteristics are preliminary to, or a component of the strength or weakness, and safety or danger in a therapeutic relationship.

On the positive side of the scale, participants cited incidents that described the quality of counsellor characteristics that facilitated the development or quality of the alliance between the client and the counsellor (e.g., attentiveness, good listening). Therapeutic alliance is a well-researched aspect of counselling and researchers see it as a robust predictor of positive counselling outcomes (Duncan, Miller, & Sparks, 2003; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Thus, the characteristics that participants noted in this study are consistent with previous literature.

On the negative side of the scale, participants in this study note those counsellor characteristics that hindered and impeded their progress. Critical incidents included accounts of counsellors not having clear boundaries, lacking professionalism, or misusing personal self-disclosure. Clear boundaries within the counselling relationship are thought to be of central importance when counsellors are working with women who have experienced IPV abuse and trauma (Herman, 1997). For example, a counselling contract is essential to both the client and counsellor in explicitly stating their roles and expectations during counselling work. This is one of the components that can assist creating clear boundaries that define the work and clarify the nature of the therapy relationship. In essence, it provides essential protection for both the client and counsellor during the IPV work. This is especially true when working with female survivors of abuse. As Sanderson (2008) notes, some female counsellors may become over identified with their clients (i.e., enmeshed), which reduces the client's autonomy and control of her own life.

Counsellor self-disclosure from a feminist perspective is thought to reduce the power differential between the counsellor and the client, empower the client, offer options to the client, and increase the counsellor's solidarity with the client (Simi &

Mahalik, 1997). However, findings from this study did not concur with this assertion. Counsellors who used self-disclosure were seen as hindering the clients healing process by focusing the session away from client concerns. The use of self-disclosure was thought to reveal the counsellor as self-interested or self-promoting and as such not client-focused. While there is less research on what clients find to be hindering in counselling, a study by Manthei (2007b) found that excessive counsellor self-disclosure, the use of ineffective or poor techniques, and poor counsellor listening skills were detrimental to the counselling process. The findings of this study also show similar hindering counselling incidents to those in Manthei's research.

Unique Findings

In this present study, three key themes are identified: safety, empowerment, and issues related to shame. Trauma theorists and feminists see the importance of safety, empowerment, and reducing shame as essential issues in trauma work with women (Brown, 1994; Haskell, 2000; Herman, 1997). I outline these three aspects below as related to the critical incidents reported by participants in this study. Appendix I depicts the relative importance of the three themes as well as the categories that were directly linked to each theme.

Safety. In this study the following helpful categories captured aspects of safety: positive counsellor characteristics, having a good alliance with counsellor, counsellor sets good boundaries, additional support, and having continued care after counselling. Participants emphasized the importance of safety as a major helpful aspect in their counselling experiences. Safety in the counselling relationship meant that the women were able to feel comfortable enough to share their stories and safe enough to trust the counsellor as a collaborator in their healing process. They typically viewed their counsellors as attentive, consistent, and willing to explicitly address their experiences of abuse and their safety needs. Further, safety meant that counsellors were open to discussion regarding the direction, pace, and tasks of counselling. They also noted how counsellors had modeled appropriate boundaries or boundary-making, and demonstrated empathy and gentleness. For the women in this study, safety meant that they felt accepted, understood, and supported by their counsellors.

The primacy of safety in trauma therapy has been well established by traumatologists (Haskell, 2003, Herman, 1992, Levine, 2005, Rothschild, 2000). In fact Rothschild notes, “no trauma therapy can or should take place in the absence of a developed and secure relationship between the client and the therapist” (p. 88). This was echoed in my findings by the value the participants placed on their positive perceptions of their counsellors and their feelings of alliance with the counsellor. Participants in this study valued counsellors who set good boundaries and fostered feelings of safety. The importance of boundaries in the therapeutic relationship is fundamental, as good boundaries will allow for clients and counsellor to negotiate any conflict that may arise and set the course for resolution.

Given the interpersonal history of women who have experience IPV, there is a potential for dependency on their counsellor to develop. Dependency is viewed as compromising safety for clients by emulating the imbalance in abusive relationships (Haskell, 2003). Links to this are found in the categories of appropriate support and after-care, in which client-counsellor contact was maintained but not in overly-dependent ways and, as such, enhanced feelings of safety for women.

On the other hand, participants saw that the absence of safety meant counsellors were patronizing, uncaring, impatient, and disconnected from them. The categories that were seen to hinder safety were: negative counsellor characteristics, lack of alliance, and experiencing the poor techniques counsellors used. Counsellors demonstrating poor boundaries, a lack of professionalism, or using techniques that were viewed as interrogative or as colluding with the abuser, were seen by participants as impeding or thwarting their feelings of safety. As previously noted, safety in trauma therapy is predicated on a secure and well developed therapeutic relationship. Therefore, it stands to reason that counsellors who are perceived negatively or in instances where there is a lack of alliance between the counsellor and the client are thought to be unsafe. Regarding the poor use therapeutic techniques, it is thought the introduction of trauma therapy techniques too soon in the counselling process can impede the therapeutic relationship (Rothschild, 2000). It may be the case that the timing and readiness of the client is an important nuance to explore when considering the use of specific therapeutic techniques.

These findings are consistent with the broader literature, which asserts that issues of trust and safety in the counselling setting are paramount for IPV survivors given their exposure to violence and psychological manipulation in relationships. Indeed, the establishment of safety is thought to be the necessary first stage of recovery for trauma survivors (Haskell, 2003; Herman, 1992). Herman(1997) notes the need for counsellors to demonstrate technical neutrality rather than moral neutrality in order to promote the therapeutic relationship and enhance clients' feelings of safety.

Empowerment. Participants also identified the importance of empowerment in terms of fostering their healing process. In this study the following helpful categories captured aspects of empowerment: client agency supported, appropriated counselling tasks accomplished, helpful skills learned, and having good access to information. The theme of empowerment is an oft-cited issue for feminist therapy and is seen as key in the development of feminist consciousness (Brown, 1994; Herman, 1997). For the women in this study, empowerment meant that the counsellor supported their sense of volition and agency, respected their expertise about their own experience, and approached counselling in a way that was tailored and responsive to their personal needs. Additionally, empowerment involved their acquisition of skills and knowledge about such aspects of the experience as abuse dynamics, access to community resources, and disclosure about the processes in counselling. Also, women perceived the tasks of counselling as relevant and meaningful. Conversely, when empowerment was absent or unsupported it often meant that women perceived the counsellor as too authoritative, controlling, and overpowering.

Participants also saw empowerment as connected to the counsellor's knowledge about their history and experiences of abuse. Hindering categories in this study that reflect difficulties with empowerment in the counselling setting are: lack of client agency, poor service provision, and lack of information. Counsellors who did not conduct assessments that included queries about relationship abuse and violence, or who did not provide information about abuse dynamics or safety concerns were seen by participants as lacking sufficient skills and knowledge regarding abuse. This missed opportunity for counsellors to provide information, and in turn empower their clients was viewed by participants as hindering their healing process. Counselling techniques that were ill suited to client needs, focused on counsellor desires rather than client needs, and did

not result in any positive changes for the client contributed to the sense of disempowerment.

Shame. Being a victim of violence is often laden with shame, both in terms of an individual woman's personal feelings about self, and the general social stigma directed at women who have experienced intimate partner violence (Herman, 2007). Herman states that, "shame is one's own vicarious experience of the other's scorn," (Lewis, 1987, p.15, as cited by Herman, 2007) which reflects both the intra- and interpersonal aspects of shame. Given the interpersonal setting of counselling therapy, and the intrapersonal focus of counselling content (e.g., self-perceptions), it is not surprising that the issue of shame can arise if there is a potential power imbalance in a counsellor-client relationship (Herman, 2007). This was evident in participants' critical incidents that highlighted the significance of feeling supported and accepted, rather than shamed in counselling therapy. Feelings of acceptance typically occurred when clients felt believed and validated by their counsellors, and they were able to have their experience witnessed and validated by a supportive professional. Further, participants reported feeling accepted and having a sense of belonging when a counsellor acknowledged their emotions. This allowed them to then learn skills that could assist them in recognizing, identifying, regulating, and managing their emotional arousal.

Participants also placed value on counsellors who named abuse issues and held abusers responsible for their actions. The power of naming violent and abusive experiences is a key aspect of feminist approaches to counselling (Brown, 1994). Brown asserts that by making these experiences visible and with non-pathologizing language is elementary to an egalitarian therapy relationship. When their symptoms were normalized and recognized as being the result of living within a trauma context, women saw this as helpful to their healing process. In this study, the helpful categories of validation, positive emotional work, and the counsellor listening all captured the value participants placed on not feeling shamed within the counselling environment.

Conversely, participants felt shamed when counsellors blamed them for having an abuse experience, aligned with the abuser, disbelieved their accounts of abuse, or failed to acknowledge their evidence of being abused. Specifically, the hindering categories were: clients' feeling blamed and the inappropriate and devaluing use of

power. Shame meant that participants felt unheard, invalidated, or shut down by the counsellor. Further, aspects of the counselling experience that tended to elicit shame for women included repeatedly telling their story and feeling unheard by the counsellor, or feeling stigmatized or dismissed either by the counsellor or by the agency's initial contact person (e.g., receptionist).

The identification of these three key themes is consistent with the literature regarding counselling trauma and IPV survivors. Safety is seen to be fundamental for trauma survivors (Herman, 1997) and as such the necessary first and ongoing task of the counselling process. Empowerment is a central concept in feminist counselling as is the reduction of power imbalances. The hindering aspects of shame within the counselling context for IPV survivors are consistent with research investigating the social aspects of the experience of shame (Herman, 2007).

Possible Explanations for Counsellors' Hindering Actions

A fundamental principle for counsellors is *non-maleficence* or to 'do no harm;' however, findings of this study indicate that in 30% of the reported incidents, counsellor actions were considered hindering and at times harmful to clients. Explanations for this incongruence may be due to counsellors' adverse reactions to clients' traumatic information. Vicarious trauma and secondary traumatic stress responses are thought to be occupational hazards for those working with trauma survivors (Munroe, 1999). These reactions are similar to the symptoms of posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000) and can manifest in counsellors' re-experiencing images of client's traumatic events, facing other physical responses such as heart palpitations, sweating, and persistent arousal or sleep disturbances (Figley, 1999).

Given the nature of IPV, counsellors working with survivors are often exposed to descriptions of abuse involving acts of physical and sexual violence that require skill to manage. For example, IPV counsellors are also required to assist women in high-risk situations to create a safety plan and to liaise with community resources regarding their safety needs. Further, IPV counsellors are often working in environments with varying degrees of supervision support and training opportunities for skill development. The

impact of these factors can result in reactions that may impact the efficacy of counsellors in their therapeutic work.

In a recent study, Slattery and Goodman (2009) investigated the factors that contributed to secondary traumatic stress in a sample of domestic violence advocates. Recommendations of their study indicated that to foster emotional well-being in domestic violence advocates, work environments should be supportive and collaborative. Further, these authors assert that IPV counsellors' benefit from respectful clinical supervision that is characterized by a sense of safety and trust; and promotes discussion of secondary traumatic stress symptoms. A study by Baird and Jenkins (2003) found that counsellors with more education reported less vicarious trauma than those with less education. It may be that poor supervision or lack of appropriate counsellor training may have impacted counsellors hindering actions.

Implications for Counselling Practice

Attention to general safety in the therapeutic relationship. The importance of safety for women who have experienced IPV cannot be overstated, particularly safety within relationships. The abusive nature of their intimate relationships necessitates ongoing assessments of the client's perception of safety. Counsellors essentially recreated an unsafe intimate relationship for participants when participants viewed them as negative authorities, disbelieving of their accounts of abuse, or not explicitly stating the expectations and limitations of counselling. From the findings in this study, survivors of IPV tended to respond to unsafe counselling relationships in similar or parallel ways that mirrored their response to their abusive relationships. For example, participants said that they found themselves acquiescing, becoming silent, non-participatory, or reluctantly compliant to counsellor demands. In this regard, counsellors must take significant care in tending to the safety needs of IPV clients by working in a collaborative, non-threatening, non-coercive, and attentive manner. Further, it is recommended that issues of safety (both within and beyond the counselling setting) be an ongoing topic for review within counselling sessions and among professionals working with IPV survivors. The equality wheel (Appendix G) created by the Duluth Domestic Abuse Project provides a useful model for working from a respectful, collaborative, and safe approach with women who have experienced IPV.

Ongoing attention to power dynamics within the counselling relationship. Given that both IPV and counselling occurs within an intimate relationship, counsellors need to be sensitive to and be aware of the power dynamics of abusive relationships and the potential for revictimization. Although counselling relationships are intimate in different ways than partner relationships, there remain issues of trust and confidentiality that may be particularly acute for women who have experienced long-term repeated violence within intimate relationships. The repetitive nature of abuse impacts self-structures such as identity, attachment, and a sense of meaning about their lives and the world (Herman, 1997). Counsellors need to be aware of client responses that may mirror their responses to IPV, especially related to their feelings of shame, loss of control, being silenced through counsellor's misbelief, and counsellors demanding obedience to forms or formats that may be unsuitable to clients due to their life orientation or culture. The power and control wheel (Appendix A) created by the Duluth Domestic Abuse Project depicts the types of abusive behaviour perpetrators use to exert power and control over people. Specifically, the use of coercion and threats, intimidation, minimizing or denying abuse, and blaming the victim for the abuse are some of the tactics described. Given the abusive context IPV survivors come from, it is important that counsellors are mindful of these types of power and control issues and their possible presence in the counselling relationship. Counsellors must attend to the impact of their responses on clients, especially related to how they may react to clients' accounts of abuse.

Counselling professionals' discussions about IPV clients. Counsellors working with women who have experienced IPV are often required to participate in case conferences with other professionals. Conversations with other counsellors working for the same agency, or those working in other social service settings are a frequent occurrence. Further, counsellors are often called to communicate with other medical professionals (i.e., mental health workers, psychiatrists, physicians) as well as social workers, teachers, housing providers, and police. These types of interagency or multiagency communications may be beyond the scope of many counsellors training and therefore require additional training and supervision to manage the complexities of this task (McBride, 2010).

Due to the findings in this study related to concerns women have about shame, empowerment, and safety I agree with McBride's (2010) recommendations to encourage

counsellors to have written informed consent from their clients concerning the nature and the parties involved in any discussion. Client consent is empowering especially when they know that they are entitled to, and are within their rights to refuse consent. In the end, they can give consent freely and fully understand why. Since shame is a key issue for women, I also agree with McBride that only the most relevant information be shared and then documented accordingly. Further, this protection can be enhanced by assuring clients that no confidential information leaves the counselling site. In terms of safety, I agree with McBride's recommendation that any outcome of advocacy work with clients be shared and counsellors trained in the best practices in how to do it.

McBride's recommendations are echoed in the reports of the women in this study. Participants who expressed the most satisfaction with counselling felt honoured and valued by their counsellor and were collaborators in their counselling process. While participants who expressed the most dissatisfaction were those who felt overpowered by their counsellor or perceived their counsellor as misaligned or disconnect to them. This finding emphasizes the importance of professionals guarding against any professional conversations that may reflect societal biases about IPV, including victim blaming and minimizing the severity or impacts of abuse. Indeed, counsellors must be the best advocates for their clients.

On the basis of the information above, I make the following recommendations for counsellors working in the area of IPV to ensure the most helpful services:

- (a) Use counselling contracts that explicitly state the expectations, limitations and role of the counsellor and the client. Include information about the complaint process.
- (b) Provide information about policies regarding telephone, email, and social network communication between the counsellor and client.
- (c) Provide information about the process of sharing client information with other agencies or professionals.
- (d) Assess the safety needs of the client in every session and modify safety plans accordingly.
- (e) Give clients safety checklists and make these available in public waiting room areas.
- (f) Have a list of community resources available for clients.

- (g) Have regular clinical supervision that offers a safe environment to explore vicarious trauma and compassion fatigue issues.
- (h) Counsellor training programs should include a course regarding working with trauma and intimate partner violence.

These recommendations will be helpful to clients by enhancing their safety both within and beyond the counselling setting and for counsellors by helping to support their work with clients.

Future Research

Future research directions could build on the findings of this exploratory research by investigating these findings with the use of other kinds of research methods. Video analysis, audio diaries, and client session assessment could be used to investigate the perspectives of clients more thoroughly. Further the themes of safety, empowerment, and shame could be explored in more depth by examining these aspects more directly through individual accounts, in specific contexts, or related to a variety of cultures. Further research might explore counsellor's perceptions of these themes in their counselling practice and compare them with client perceptions. Also, expanding the investigation to include counsellors with different theoretical orientations would also expand the research. Finally, it may also be interesting to investigate the differences between sub-groups of clients; for example, comparisons based on the number of sessions or types of sessions (groups or individual) may yield findings that could shed light on the efficacy of specific counselling modalities.

Limitations

This study used a qualitative exploratory CIT design and as such no statistical inferences or hypothesis testing was conducted. Thus, these findings are not predictive of how all women receiving counselling services for IPV will experience counselling; however, the data could be used to refine questions in the next level of investigations.

This study used retrospective interviewing where participants were asked to recall significant events and as such their answers and identified critical incidents may be subject to forgetting, misremembering, or unusual interpretation. In this regard, future

research methods could include more immediate assessments of client perspectives or ongoing assessment and evaluation of the counselling process with clients. The use of video analysis or session ratings may enhance the recall of critical or revelatory incidents.

Other limitations could include the biases of the interviewer. Although a single interviewer can enhance the consistency of the interview process, it is also possible that interviewer bias may be present. In this regard, the use of a semi-structured interview guide helped to minimize the potential influence of interviewer bias. Further, given that I was the interviewer in this study and that I am an IPV counsellor, it is possible that my experience biased my expectations regarding the participants' responses. Although my experience may have enhanced my sensitivity to the issues facing the participants it may be that during the interview, my follow-up questions to participants' responses were influenced by my bias, and in turn subtly directed the focus of the responses.

The sample size (n=10) while generating a considerable number of critical incidents (CI's=509) has limited generalizability. Although the sample size was limited, the CIT method is considered to be useful in terms of foundational research and as such the findings in this study may serve to expand on the research question with a larger sample size (Woolsey, 1986).

In this study there were a considerable number of categories (20) and subcategories (42) used in to represent the data. This type of conceptualization has the disadvantage of diluting the thematic impact of the incidents. However, the strength of multiple categorizations is that the representations of the incidents were more closely linked to voices of the women. Given the exploratory nature of this study I chose to keep the emphasis of the findings on the women's accounts of helpful and hindering events in more detail in order to capture their meaning more directly.

Final Words

In conclusion, the findings from this study have impacted me in my work as an IPV counsellor. Specifically, I plan to incorporate ongoing assessment of client perspectives and views of their counselling processes so that I can be more responsive to the unique needs of each client. Further, I am motivated to have an increased

awareness of the power differential between the counsellor and the client and to use techniques and methods that are seen by the client as empowering. Adding to this awareness, I have more insight into the impact of shame on women who experience IPV and how parallel process can take place in counselling sessions in terms of my counselling style and how I plan counselling treatments. Finally, I intend to respectfully advocate for my clients with other professionals in ways that I have not done in the past.

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Appendices

Appendix A.

Power and Control Wheel



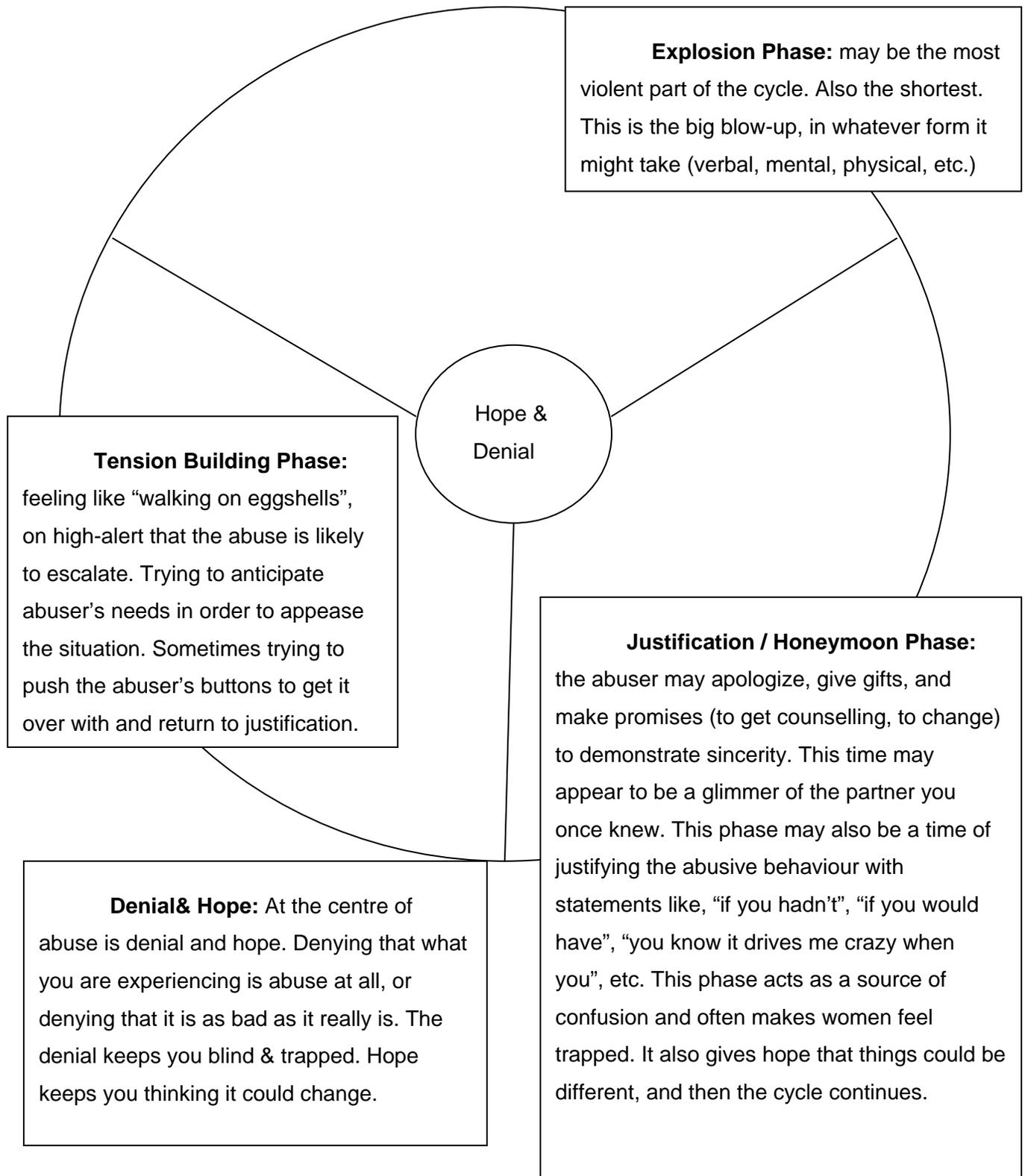
DOMESTIC ABUSE INTERVENTION PROJECT

202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.duluth-model.org

Appendix B.

Cycle of Abuse

The Cycle of Abuse



Appendix C.

Call for Participants

Faculty of Education
Counselling Psychology Program
Simon Fraser University
8888 University Drive
Burnaby, BC V5A 1S6

CALL FOR PARTICIPANTS
Women's Experiences in Abuse Counselling

Investigator: Dr. Patrice Keats, PhD
Collaborator: Lori McHattie, BA
Simon Fraser University

You are invited to participate in a research study to discuss your counselling experience. Our interest in this project is to understand what was helpful for your recovery from the impact of domestic abuse.

In this regard, we intend to answer the following questions:

How do women who have experienced domestic abuse describe their counselling experiences?

What counselling events are considered helpful or not helpful?

Why these events were considered helpful or not helpful?

Our key purposes of this project are to learn more about women's experiences of counselling. Thus, the three main objectives are:

- (a) To better understand what was helpful for women who attended counselling for issues related to experiencing domestic abuse*
- (b) To examine the ways in which women describe why these events were helpful or not helpful*
- (c) To learn more about their counselling experiences from women who have experienced domestic abuse*

Suggested criteria for participation may include:

- *Women (19 years and older) who have had at least one experience of abuse within an intimate relationship*
- *Women who have attended at least one counselling session to deal with the impact of their experiences of abuse*
- *Women who have not misused alcohol or substances within the past three months*
- *Women who have not been hospitalized for self-harm concerns within the past year*
- *Women who are currently not in a residential care facility*
- *Women who are not currently involved in an abusive relationship*

The *total time commitment* for this research interview is approximately 1.5-2 hours. This time will involve a personal interview in-person at a location that will ensure confidentiality. All information will remain *strictly confidential* and will be used only for the purposes of this study.

If you are interested in participating or would like more information, please contact:

Lori McHattie (SFU) at 778-782-8479 or by email mclori@shaw.ca

Appendix D.

Call out for Participants Poster

Participants

Are you a woman who has experienced abuse in a relationship?

Have you attended at least one counselling session for issues related to your experiences of abuse?

Are you currently not misusing substances and are not in an abusive relationship?

Would you like to participate in a confidential interview to talk about what has been helpful for you?

If you are interested in participating or would like more information, please contact:

Lori McHattie, BA or

Patrice Keats, PhD

Simon Fraser University – Faculty of Education, Counselling Psychology Program

778-782-8479

mclori@shaw.ca

Counselling Experiences
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Appendix E.

Consent to Participate Form



Faculty of Education
Counselling Psychology Program
Simon Fraser University
8888 University Drive
Burnaby, BC V5A 1S6

Consent To Participate

Project Title: What Helps, What Hinders When Counselling Women Who Have Experienced Intimate Partner Violence?

Ethics Application # 2010s0589

Investigator:

Dr. Patrice A. Keats
Simon Fraser University--Faculty of Education
Phone: 778-782-7604
Email pkeats@sfu.ca

Collaborator:

Lori McHattie, BA
Simon Fraser University--Faculty of Education
Phone: 604-813-1728
Email mclori@shaw.ca

Research Purpose:

I am interested in listening to women who have experienced intimate partner violence, describe their experiences when they attended counselling. I am hoping that the women will recall their experiences that were both helpful and hindering in terms of their process of healing and empowerment.

In this regard, I intend to answer the following questions:

- What events are deemed helpful to promoting healing ?*
- What events are considered to hinder the healing process?*
- What events are neither helpful or hindering?*

My key purposes of this project are to learn more about the experiences of women who attended counselling for issues related to domestic abuse.

Thus, my three main objectives are:

- (a) To understand what is helpful when counselling women who have experienced intimate partner violence?*
- (b) To examine the events that women deem as either helpful or hindering to their healing process*
- (c) To learn more about the subjective experiences of women who have experienced abuse and who have attended counselling.*

Study Procedures:

By signing this *Consent to Participate* form, you have agreed to participate in a study where a personal interview will be conducted. This activity will entail:

A. Personal Interview

1. You will meet with the investigator at Simon Fraser University or another location, to participate in an audio-taped interview. The interview will last from 1½ to 2 hours, during which time you will be asked questions that will encourage you to describe the experience of your subjective feelings about your counselling experience. You always have a right to decline answering questions that make you feel uncomfortable during the interview process. You also have the right to withdraw from the study at any stage of the research.
2. During the interview you will be giving demographic information and discussing your experiences of counselling.
3. We may contact you after the interview for your comments about our findings related to your interview material. You have the right to decline to participate in further interviews at any time.
4. You may choose to receive a transcribed copy of your interview or the research findings if you are interested.

Risks

You may experience some psychological stress during the interview as you recall, verbalize and share potentially very painful memories. As a precaution to any stress continuing after the interview is over, you may be offered a referral for ongoing counselling in a community agency if needed. Similarly, the interview will be conducted by an upper level Counselling Psychology student who is trained in empathic listening and containing strong emotions.

Benefits

Some potential benefits to you may include: the cathartic release of telling your story, using the pain of your experience towards a greater good, being part of a larger connection of women, and having a chance to work through the experience of telling your story. In addition, perhaps participation in this research project will provide the catalyst for you to connect with agencies offering services for women who have experienced intimate partner violence.

Confidentiality:

Any information that is obtained during this study will be kept confidential to the full extent under the law. The law requires that any disclosure of past or current harm to a child, intention of harm to another person, or imminent harm to yourself will need to be reported to the appropriate authorities. Other than these limits, knowledge of your identity is not required. You will not be required to write your name or any other identifying information on research materials with the exception of this confidential consent form. Materials (i.e., audio tapes, transcriptions of interview) will be maintained in a locked filing cabinet. You will not be identified by name in any reports of the completed study; rather code names will be used. Only the investigator and her supervisor will have access to the audio-tapes and files.

Contact:

If you have any questions or desire further information with respect to this study, you may contact (Lori McHattie) at 778-782-8479 or email (mlori@shaw.ca) or Dr. Patrice Keats at 778-782-7604 or pkeats@sfu.ca

Consent:

Having volunteered to participate in the research study named above, I certify that I have read the procedures specified in this document describing the study. I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time. I understand the procedures to be used in this study and the personal risks to me in taking part in the study as described above.

I consent to participate in the following optional research activities.

I understand that I may withdraw my participation at any time. I also understand that I may register any complaint with the researchers named above to the Director of Research Ethics as shown below:

Director of Research Ethics--Dr. Hal Weinberg, hal_weinberg@sfu.ca, 778-782-6593

I may obtain the results of this study, upon its completion by contacting:

(Lori McHattie); 604 813-1728 mclori@shaw.ca

Dr. Patrice Keats; 778-782-7604; pkeats@sfu.ca

I have been informed that the research will be confidential.

I have received a copy of this consent form for my own records.

I understand the risks and contributions of my participation in this study and agree to participate in the activities above:

Participant _____
Last Name First name

Contact Information (Address, phone, email)

Participant Signature Witness Signature

Date

Appendix F.

Interview Guide and Question Protocol

PROCEDURE

INTERVIEW GUIDE AND QUESTION PROTOCOL

Potential participants who respond to the call are contacted by phone to confirm that they meet the inclusion criteria and to make the arrangement to meet.

Introduction:

Participants will be oriented to the interview using the following script:

Thank you for agreeing to meet with me. I am interested in hearing what you have to say about what helps and hinders your healing process in your counselling sessions. These incidents might be something the therapist said or did, the type of activities you experienced, or anything else that might impact your experience of recovering from intimate partner violence. I am hoping that this information will assist us in learning better about what helps to promote healing when counselling women who have experienced intimate partner abuse.

Before we begin, I want to remind you briefly about the process of the interview, some issues that we need to discuss so that you feel as comfortable as possible, and then read over a consent for your participation so that you can fully understand all the aspects of the purpose and process of the study, what will happen during the interview, and how the information that you give me today will be protected.

First, during the interview, I will ask you to describe in detail specific incidents that stand out for you during your one-on-one sessions with your counsellor in the STV program. To be sure I understand exactly what you are saying, I may ask you some clarifying questions as we talk. Second, I want to remind you that the interview will be taped so it can be transcribed and studied in detail. All identifying information will be removed from the transcript. Once I have studied and analysed the text, I will draw some conclusions about what you and other participants have told me, and will then make a written report about the findings. Third, I want to let you know that some people may become emotionally aroused when discussing more difficult aspects of counselling. If you find you are having an uncomfortable emotional response, let me know and I will pause the interview to check in with you. We may need to give you a break or stop the interview if you feel strongly that you cannot continue. If you feel

emotionally aroused, I will give you a number you can call with 24-hour crisis counselling, and a list of names of agencies with therapists that can help you for low or no cost.

Do you have any questions? We will now read the consent, and if you agree to the process and conditions, then we will sign it and start the interview.

INTERVIEW PROTOCOL

Questions About Counselling History

1. How did you hear about your STV counsellor/agency and how did you make contact?
2. How long have you been involved in counselling about your IPV situation?
3. How many therapists have you seen related to this issue?
4. How many individual counselling sessions have you attended?
5. What was your main goal in counselling? What were you hoping to gain from the experience?
6. Briefly describe the reason(s) that brought you to counselling?

Main Question

Think back over your time working with your last STV counsellor. Remember a specific event or incident that you believe either helped or made it harder for you to meet your counselling goals.

1. Tell me what it was about the event that made it helpful (or hindering)? “How did you know?”
2. What meaning did this particular incident hold for you?
3. “What went on before/after?”
4. “How did it turn out?”
5. “Tell me more about that?”

Debriefing Guide

At the end of the interview, two final questions will be put to the participants. They are designed to assist them in summing up their thoughts and ideas and will help give closure to the interview:

1. "What advice or suggestions would you give to counsellors working with women who have experienced intimate partner abuse?"
2. "What advice would you give to someone in the process of attending counselling?"

POST-INTERVIEW

After the participant has completed the interview, I will ask the following:

"How are you doing now that we are at the end of the interview?"

If the participant indicates being emotionally aroused, I will ask if she would like to speak with a therapist or needs a 24-hour crisis line number to call to receive crisis counselling services if something arises for her in the next few days. The list of organizations that have qualified therapists who can assist the participant for no cost or low cost will be given as a standard procedure. Participants will also be directed to speak with their own therapist if they are currently working with someone.

CRISIS LINES

Safer: 604 872-9251

Women Against Violence Against Women: 604 255-6344

NO or LOW COST COUNSELLING

Stopping the Violence Programs

Atria Women's Resource Society 604 331-1407

Battered Women's Support Services 604 687-1867

Burnaby Family Life Institute 604 659-2200

Chimo Crisis Centre 604 279-7077

Dixon Transition Society

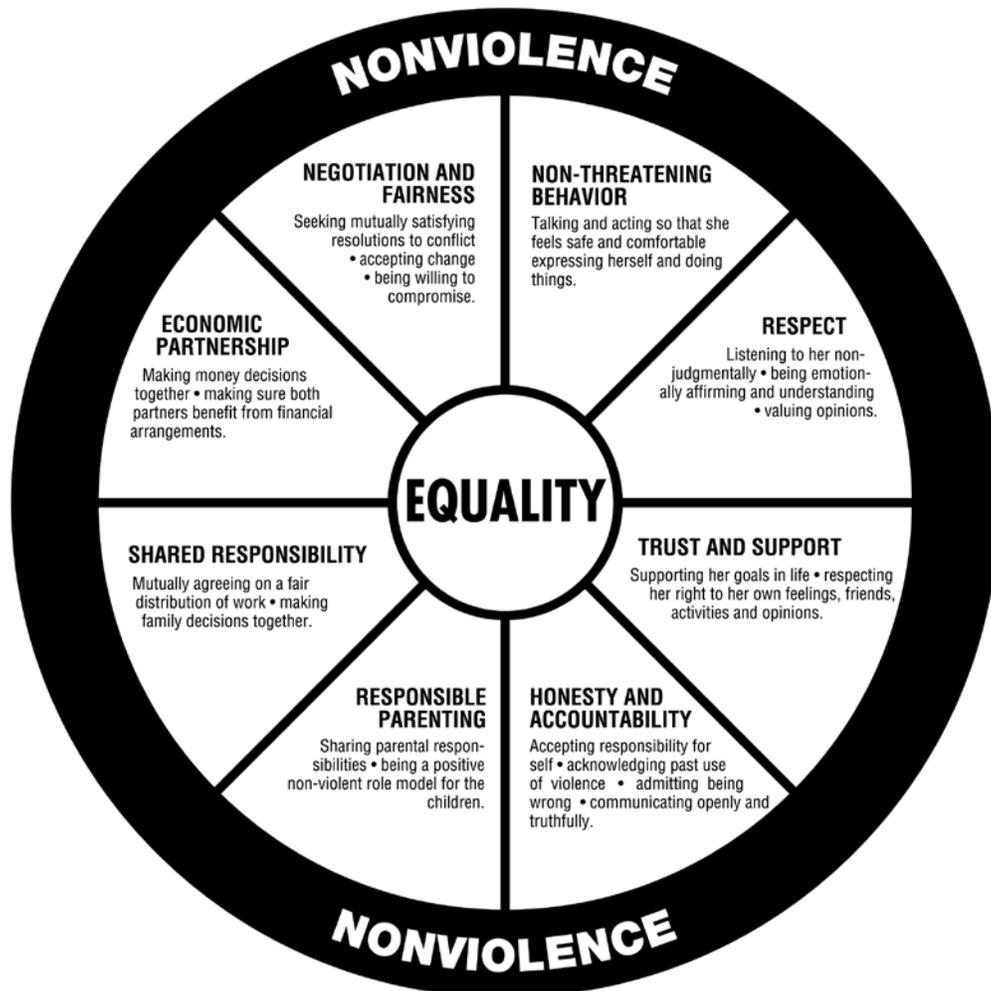
Family Services of Vancouver 604 874-2938

Family Services of the North Shore 604 988-5281

Mosaic 604 254-9626

Appendix G.

The Equality Wheel



DOMESTIC ABUSE INTERVENTION PROJECT

202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
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Appendix H.

Ethics Approval



OFFICE OF
RESEARCH ETHICS

street address
Simon Fraser University
Multi-Tenant Facility
Room 230, 8900 Nelson Way
Burnaby, B.C. Canada
V5A 4W9

October 19, 2010

mailing address
8888 University Drive
Multi-Tenant Facility
Burnaby, B.C. Canada
V4A 1S6

Dr. Patrice Keats
Faculty of Education
Simon Fraser University

Dear Dr. Keats:

**Re: WHAT HELPS, WHAT HINDERS WHEN
COUNSELLING WOMEN WHO HAVE EXPERIENCED
INTIMATE PARTNER VIOLENCE? - Appl. #: 2010s0589**

I am pleased to inform you that the above referenced Request for Ethical Approval of Research has been approved by the Research Ethics Board. This approval is in effect until the end date October 18, 2014, or for the term of your faculty appointment at SFU, whichever comes first.

The Office of Research Ethics must be notified of any changes in the approved protocol. Request for amendments to the protocol may be requested by email to dore@sfu.ca. In all correspondence relating to this application, please reference the application number shown on this letter and all email.

Your application has been categorized as "minimal risk" and approved by the Research Ethics Board in accordance with University policy R20.01, <http://www.sfu.ca/policies/research/r20-01.htm>.

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RESEARCH ETHICS

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“Minimal risk” occurs when potential participants can reasonably be expected to regard the probability and magnitude of possible harms.

Please note that it is the responsibility of the researcher, or the responsibility of the Student Supervisor if the researcher is a graduate student or undergraduate student, to maintain written or other forms of documented consent for a period of 1 year after the research has been completed.

If there is an adverse event, the principal investigator must notify the Office of Research Ethics within five (5) days. An Adverse Events form is available electronically by contacting dore@sfu.ca.

All correspondence with regards to this application will be sent to your SFU email address.

Please notify the Office of Research Ethics at dore@sfu.ca once you have completed the data collection portion of your project so that we can close this file.

Best wishes for success in this research.

Sincerely,

A handwritten signature in blue ink, consisting of a series of loops and strokes.

Appendix I.

Key Themes and Categories

