Chapter 4 – Enhancing therapeutic skills

Authors:

Jeannette Roddy, Leigh Gardner and Linda Dubrow-Marshall

Chapter Authors:

Jeannette Roddy

https://orcid.org/0000-0001-9757-2539

Leigh Gardner

https://orcid.org/0000-0002-0642-3974

Linda Dubrow-Marshall

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

Abstract

Creating the right environment for counselling to take place is vital for any therapy to progress. The nature of domestic abuse, such that it is a relational abuse, requires very strong and clear therapeutic relationships to be built. As counselling trainers, we assessed the level of skills required and concluded this was above the standard of skills normally required in final assessments during counselling training.

This chapter identifies the main skills required to work well with someone who has experienced domestic abuse. It also invites you to reflect on your competency level regarding these skills and to consider how these could be improved (if necessary). This chapter will also discuss the important issues of building trust and hope, as well as how to respond to difficult client disclosures during therapy, in the context of ethics and safeguarding.

Learning objectives

1. To understand the importance of advanced counselling skills in creating trust and working with clients who have experienced domestic abuse
2. To recognise how and when advanced skills can be used
3. To assess current competency levels for advanced skills and create a plan to address any gaps or upskilling required
4. To recognise the context of client material brought to session and how to respond, particularly in the context of ethics and safeguarding

Context

Domestic abuse is complex. The relationship that began in love and commitment begins to unravel and becomes uncertain and difficult or harsh. As discussed in chapter 3, the behaviour of a domestically abusive partner can lead to isolation and shame, a heightened sensitivity to meeting the needs of their partner, and a lack of self-belief, self-esteem, and trust in others, for the other

partner. Silence can become a frightening experience, as it has previously resulted in more abuse from their partner and needs to be considered therapeutically. The relational aspect of counselling is key to recovery, as the individual must build at least one safe, secure relationship which is helpful to them, to begin to trust in others again. Yet there may be uncertainty from the client about engaging with the counsellor. Building the therapeutic relationship requires high levels of counselling skills, building on the counsellor's own significant personal development, to ensure a trustworthy, consistent, and understanding presence as the client recounts their story.

In this chapter, we discuss the different ways to develop the therapeutic relationship and what additional levels of skill may be required.

Building Trust

Building trust with the client is an essential part of the early sessions in DA work. Clients who have experienced domestic abuse can often find it difficult to trust anyone completely. In part, this is due to the emotional or psychological abuse they have experienced, as it may have become difficult to believe what was being said and/or to decide who can or cannot be trusted. This lack of relational certainty can then undermine other relationships outside of the abusive relationship, even those with individuals or organisations who are trying to help.

The therapeutic relationship offers an opportunity for clients to test out trust in a safe space, which can then have very positive outcomes for the client outside of the counselling room. This was put very well by one previous research participant:

> Lucy (pseudonym): "The sense to be able to trust somebody again, because in trusting the counsellor and informing that relationship where everything that was said there was just between the pair of us, I actually began to trust other people more" (Roddy, 2015, p. 82).

However, it is important to recognise that building trust can begin before entering the counselling room. In many therapeutic contexts today, a person within the organisation is the first point of contact for the individual. This initial contact is frequently followed by an assessment session with a second person before an offer of counselling by a therapist, yet another person to meet. This means that the client may have already met 2 or 3 different people in the organisation as they begin therapy. Hence, when we talk about building trust, we must build trust in the organisation as well as in the therapist. See stage 2 in the process model in chapter 2 to understand more about this part of the work.

Developing organisational trust to the extent that someone may be prepared to take a risk (Mayer et al., 1995) such as a client who is uncertain about what to disclose, requires the following elements:

1. Ability – the client must believe that the organisation is competent enough to deliver the service they require. This is not just about the website or the client contract, but a sense of whether each of the individuals they meet understands their situation and needs.
2. Benevolence – there is a feeling that the organisation wants to and is motivated to help the client and is not seeing the client only because they have been paid or mandated to do so.
3. Integrity – the client understands the principles of the organisation and sees that there is a match between words and action over time. For example, communication is clear, consistent and any issues are properly and reasonably addressed. In this way the reputation of the service in the community and of the therapist that they see, can both assist trust in the therapeutic process even before therapy has started.

Reflection: When you think about the client journey into your organisation, what could you do to ensure that a potential client will see these characteristics at each stage of their journey? What might be useful to consider or change in the way that you assess clients to make it easier for them to engage?

As counsellors, it is easy to see that these defined ideas for organisations to build trust (ability, benevolence, and integrity) map nicely onto the three core elements of good therapeutic practice: empathy, positive regard, and congruence.

As therapists, we must understand our clients to build their trust in us, as therapists. This client group may have difficulty voicing the depth of their experience or understanding what might have happened. A therapist who can tentatively offer some insight into what might have happened to the client can help trust to build. This provision of a different context for the client, that of surviving and/or having normal responses to experiencing abuse (see also chapter 8), can feel supportive and caring to the client, and hugely beneficial (Roddy, 2014). Whilst we can help the client to see what they have achieved in face of enormous difficulty, we can also witness and help the client to process the feelings that they have about their experiences. Focusing too soon on client strengths may negate the client's experience of abuse, leading to early termination of therapy. Focusing too much on the terror of the situation may be overwhelming for the client (see also chapter 8), also leading to early termination. The therapist skill is to balance these too aspects of the work, through acknowledging the extent of the abuse as well as the client's strengths and resilience, providing positive regard for them and valuing and caring for them, as well as holding hope for the future. Balance and honesty in holding each of these positions are key aspects of the work, providing a relationship which can be trusted and is not overwhelming.

Seeing this positive therapeutic stance may be challenging for clients who have been living with an abuser who undermined and put them down. Sharing a space with someone who wants the best for them and sees the potential for positive change can be both welcome and a little scary, as they may wonder about the therapist's motivations. People living with abuse can become very good at reading people, at looking for signs that all is not well, or that something else is happening under the surface. Clients often test a therapist's reaction by offering something relatively small about their experiences first and then checking the therapist's response to this before offering anything bigger. Here, congruence is important, so that the client can see that they have been understood and received by the counsellor. In the past, picking up dissent from the abuser and shifting their position to align with the abuser helps to keep them safe. If they sense dissent from the counsellor, then this shift may happen in the therapy room and trust is lost.

From a counselling perspective, it is therefore important that you bring your open and honest, whole self into the counselling session. If you are saying one thing and thinking another, it is likely that the client will pick this up and change their story to suit what they feel you want to hear, to ensure that they maintain the relationship. If this continues, it will be difficult for the client to bring what they need to bring and it is likely that therapy will stop. Hence, congruence with the client is at least as important as empathy. If this is something you find particularly difficult, then working with this client group may not be for you. The section on congruence below will help you to determine your own levels of congruence and how comfortable you may feel with clients.

Reflection: When you think about how you practice empathy, positive regard, and congruence, how would you currently rate your skills? Which

one of these do you feel would need most development prior to working with this client group?

There are, of course, some difficult aspects of working with this client group whilst building and maintaining trust. For example, should you self-disclose your own experiences of abuse or not? The short answer is only when it is in service of the client, that is, it can be very helpful to client to hear what you have to say, but anything said should be brief and focused on helping the client, not providing an opportunity to discuss your experience. Another example is what to do if there is, as sometimes happens, evidence of harm to self or harm to others (including children). This is a very important ethical issue, which we will discuss in chapters 12 and 14, and requires a consistent and open discussion with the client about the organisation's protocols in the event of such disclosures. The key here is that when the disclosure is passed on, it is done with and alongside the client transparently, and not excluding the client.

In building trust, high levels of empathy, congruence and positive regard are important elements of therapeutic practice. Each of the elements are discussed in more detail below.

Advanced Empathy

> 'We think we listen but very rarely do we listen with real understanding, true empathy. Yet listening of this very special kind, is one of the most potent forces for change that I know'. (Rogers 1995 p134).

Advanced skills are an essential part of training for working with this client group to facilitate clients to form a deeper and longer lasting, life changing relationship with themselves and subsequently, others. These skills are extremely challenging for some and need to be modelled as part of the therapeutic relationship to establish trust and to allow depth to grow in the therapeutic relationship. This developing depth and trust helps the client to move through the model of practice from Stage 1 to Stage 2 (see chapter 2).

Elliott, Bohart, Watcho and Murphy (2018) note the many and varied definitions of empathy and, when discussing Rogers' 'seeing through the client's eyes, to adopt his frame of reference' (Rogers 1980, p85), describe this aspect as 'higher-order process'. This matches well with Kohut's 'a higher form of empathy' (Lohut 1959 in Natiello, 2001, p10) which talks of taking the empathy from beyond the 'formulaic empathic responses' (McLeod (1999, p386) into something different, ' the process of weaving together the fragments and threads of the client's experiences over a period of time' (Lohut in Natiello, 2001, p10). This way of listening and being allows the therapist to hear 'the music behind the words' (Tolan and Wilkins, 2011 p.105). It is through this deep understanding and willingness to be alongside, that the client will start to feel heard in a different and more compassionate way, will start to feel that they can open up more to the therapist, and also feel that the therapist will be able to tolerate anything that they are going to tell them, without judging or responding from their own frame of reference. This kind of 'hearing', being truly seen in all aspects of themselves when they have previously spent time trying to hide from the abuser and others, can be overpowering for a client. Hence the therapist must determine the extent of using this skill, whilst establishing a trusted relationship (see above).

Knowing as the therapist when to offer deeper empathy is a necessary part of working with DA – it is essential that we work within the client's window of tolerance and work at the client's pace (see

Chapters 2 and 8) to continue to build a healthy and trusting relationship. Deep empathy is touching on an edge of awareness (Gendlin, 1984) and an inexperienced therapist may want to join the dots. Yet this work needs to be done by the client, at their own pace, to make meaningful understanding it must come from them, rather than the counsellor. Working with DA clients can be slow, gentle work, what can be described as putting out the breadcrumbs for the client to pick up when they are ready. This may include general psychoeducation around DA or stories of how DA can be, to facilitate the client understanding more about their own process, without being told.

Part of providing empathy is being with the client and both client and therapist taking in the nonverbal clues such as body language, eye contact (empathy can be shared with no words but through eye contact, see exercise in Appendix 1). Using the telephone for counselling may mean no face to face contact or screen to aid in visual clues, but the therapist can listen for breathing, changes to breathing, catches of the breath, cracks in the voice; there is an incredible intimacy to working on the telephone that can lend itself well to deep empathy creating therapeutic depth as both client and therapist are focused on the client's disclosure. Of course, any over sharing as noted by the disinhibition factor (Suler, 2004) needs to be noted and discussed with the client prior to the end of the session.

> Reflection: what is your experience of providing advanced empathy? What do you find easier and what more challenging? What would be the signs from the client that they have had 'too much' empathy? How could you deal with this with the client in the moment?

Deep empathy may also include working with similes and metaphors, eg, 'it sounds like you are on a roller coaster with moments of exhilaration then moments of sheer terror and just wanting it to stop'. Often clients will offer their own metaphors eg' I am stuck in room with no windows and I can't get out and there is no air coming in'. When a client offers images in this way, it is important to pick them up and work with them to explore their meaning and really show empathy. A therapist may be tempted to change the metaphor to something that they were imagining, but the client is giving a wonderful insight into their world through metaphor, so use it and work with it. This develops the sense of the client feeling understood, to impart what Bozarth calls 'idiosyncratic' empathy (Bozarth, 1984, p.74 in McLeod 1999 p.386). For more information on how to work with metaphor, see chapter 8.

Congruence

When Carl Rogers (1957) developed person-centred therapy, he conceived of clients as being in a state of incongruence based on their earlier experiences where they were not free to express themselves fully and instead learned to behave in ways that were rewarded rather than being loyal to their own beliefs and feelings. This incongruence was perceived as leading to the distress that the clients felt as it produced anxiety and avoidance of uncomfortable feelings. Rogers postulated that it was very important therefore for the therapist to be congruent within themselves and with their clients so that they established a safe place for the clients to become attuned to their true selves. Through the role-modelling of the therapist's inner congruence in session, and the interpersonal experience of congruence that is felt by the client within the therapeutic relationship, the client would be able to recover. Kolden et al (2018, p. 425) describe congruence as meaning that "both therapists and patients are accessible, approachable, and sincere rather than obscured behind stereotypical roles or hidden behind protective facades". Congruence, which is often also described as genuineness, works alongside the other core conditions of empathy and unconditional positive

regard to set the stage for clients to recover and to be able to express themselves congruently to their inner states, thereby reducing their symptoms of distress.

Whatever the client's childhood experiences may have been, it can be assumed that in having been in an intimate relationship where they experienced domestic abuse that they certainly will have learned to be incongruent as a means of survival. A barrier to accessing help by victims of domestic abuse is listed in the Statutory Guidance for the Domestic Abuse Act (Home Office, 2021, updated 2022, p. 58) as "Shame and stigma – including fear of not being believed, feeling shame around disclosing abuse". This would certainly be an inhibiting factor in congruent expression in the psychotherapy room. The Statutory Guidance furthermore makes the point that "the abuse may make the victim feel isolated, worthless, to feel they are to blame for the abuse and/or be convinced they cannot look after themselves" (p. 57). It would be only natural for the client to want to avoid a genuine expression of such painful feelings.

It follows that the challenge for the domestic abuse counsellor is to demonstrate through words and non-verbal expressiveness that they believe the accounts of abuse by the client and that they see the actions of the perpetrator, not the victim, leading to the abuse. Furthermore, they genuinely believe in the client's ability to recover from abuse and go on to have a better life, both through the support of therapy as well as other resources. In clinical practice, countertransference may make it difficult for the therapist to always genuinely believe this when there may be so many serious obstacles to the client's recovery even after the person has left the relationship (see chapter 5 for more on countertransference). This might include continued threats by the perpetrator to life and safety, and post-separation legal abuse including motions to obtain custody of the children. If the therapist becomes traumatised by disclosed or subsequent events, their genuine response to working with other victims might include feelings of fear and powerlessness, in tandem with how victims feel (see also chapter 14).

Kolden et al (2018, p. 425) state that: "The therapy process promotes congruence, that is, the development of the capacity to approach, recognise, and reflect upon problematic mind states with openness and authenticity rather than fear and avoidance". This is an aspirational goal and for it to occur, both the therapist and client would move away from fear and avoidance, even though these may be powerful feelings to acknowledge when the danger that clients are experiencing is present. It is important for therapists to openly acknowledge their own painful feelings in relation to domestic abuse so that they can be more genuine when working with clients, and supervision is the perfect place to work on this. Personal therapy may also be indicated, especially for therapists who have personally experienced or witnessed domestic abuse. Peer supervision can also be invaluable in helping counsellors working with domestic abuse survivors as painful feelings can be validated by others who are feeling similarly and furthermore hope can be instilled by sharing accounts of clients who are successfully recovering from abuse. See also chapter 14 for more on self-care.

> Reflection: How do you manage congruence when you are feeling revolted by the story of violence that the client has presented? How would you respond to a client when their timeline of events does not seem to add up?

Unconditional Positive Regard

The third 'necessary and sufficient condition for therapeutic change' postulated by Rogers (1957) is unconditional positive regard, another aspirational goal within the therapeutic relationship. This core condition in client-centred therapy has been widely valued by other psychotherapeutic approaches who share the assumptions that positive regard, caring, respect for the client, accepting

them and trying to understand them no matter what they may reveal about themselves, are key elements of the psychotherapeutic relationship.

In a meta-analysis of the relationship between positive regard and therapeutic outcome, Farber, Suzuki, and Lynch (2018) reported a positive correlation between these two variables and suggested the need for further research to determine the role of non-verbal communication in expressing positive regard. Norcross and Lambert (2018) reviewed psychotherapy outcome research and characterised positive regard and empathy as effective, together with collaboration, therapeutic alliance, and goal consensus.

Goal consensus can present challenges within client-centred counselling generally as well as specifically with survivors of domestic abuse. Client-centred counselling allows the client to direct the content of the session, in contrast with more directive approaches used in cognitive-behavioural and solution-focused therapy approaches. An example of when goal-setting and unconditional positive regard can clash is when the client in a violent relationship presents that they believe that their partner wants to change and that they wish to remain in the relationship whereas the therapist recognises signs that the perpetrator is unlikely to change and interprets the situation as representing that the couple are in the 'honeymoon stage' which precedes the eruption of violence (Walker, 1979). A reflective model of how to consider this tension in the therapeutic relationship may come from approaches in client-centred therapy offered by occupational therapists and dilemmas they experience when clients set goals that involve physical activity that is unsafe for them. Kessler et al. (2019) noted that therapists would 'override' goals set by clients that were unsafe and suggested that they reflect on the power imbalances of the relationship and propose ways to deal with their concerns while continuing to support the client's goals. They cautioned: "While therapists were able to listen for and adopt many client-suggested goals, this study highlights the ongoing need for therapists to be keenly attuned to the balance of power during goal setting conversations as well as to their underlying, perhaps professionally engrained, values and beliefs around risk and attainability of goals. Conscious effort may be needed to actively listen, clarify meaning attached to goals and respect client choice" (p.324).

A further complicating factor in working with survivors of domestic abuse is the competing obligation of the psychotherapist to assess risk and safeguarding issues on a regular basis, and to uphold a commitment to the ethical value of 'protecting the safety of clients' (BACP, 2018). A principle of good practice from the BACP Ethical Framework (2018) is: "We will give careful consideration to how we manage situations when protecting clients or others from serious harm or when compliance with the law may require overriding a client's explicit wishes or breaching their confidentiality" (p.14). These tensions between supporting client goals that the therapist has safeguarding concerns about and wanting the best for the client (which the therapist believes is a different course of action) can challenge the therapeutic alliance and therapist aspirations to feel unconditional positive regard toward the client. Feelings of frustration and anger towards the client for making what is perceived as 'poor' decisions can pull apart empathy for the client's point of view and make it difficult to truly listen to the client's perceptions.

Keeping in mind that clients benefit from unconditional positive regard which facilitates more in-depth therapeutic work, if the counsellor begins to feel disapproval toward the client, they should consider the client's point of view more carefully and remember that the person is coming to therapy to try to improve their situation. It is also worth considering what the therapist respects, admires or likes about the client, to counter-act these mainly negative feelings. Such feelings should be discussed in supervision to determine whether they are experiencing 'compassion fatigue' which is interfering with their work (see also chapter 14). If they are feeling dissociated and distant from

the client, they may want to seek personal therapy to determine if client stories are affecting them or bringing up past experiences.

> Reflection: Have you experienced dislike toward clients when they expressed positive feelings toward their abusive partner? Have you been angry at clients for making poor decisions or returning to an abusive partner after having left? How did you restore your feelings of unconditional positive regard?

Working with Silence

Silence in therapy can be an important processing place. In a busy world, where we are connected to phones, computers, the internet/social media, we are not often able to sit and really experience silence. We are conditioned as children to 'take turns' to speak and not to interrupt and, when in conversation, there is a tendency to follow on quite quickly to keep the dialogue moving. Hence, silence may be a concept that neither client nor trainee therapist may be overly comfortable with, yet is something that can develop as part of a growing relationship. In silence there is opportunity for something to happen… There can be something highly spiritual about silence – many religious orders use the Great Silence, as a time to pray, contemplate and meditate to gain insight and awareness both within and universally without:

> 'As with prayer, there are many different levels of silence. At one end of the spectrum it can be felt as isolation and, at the other, silence offers the deepest connection to life and an opening to a unifying movement towards the greatest truths.' (McNeilage 2015.)

Silence though, can also be a charged and threatening place- used for holding power over someone – probably most connected to being a child and told to 'be quiet' and, in terms of abuse, a huge connection to being forced into silence and secrecy. How then as therapists do we use silence in the counselling room in a beneficial way? Classic client centred therapists are most likely to maintain that silence needs to be broken by a client, the space is theirs, they need to lead. However, when working with vulnerable clients, especially DA, this may not always be useful and could feel intimidating and scary – as if they are doing something wrong or someone hasn't quite explained the rules to them. There are many types of silence – a comfortable one, an uncomfortable one - a battle of who breaks the silence first perhaps? And each person in the relationship may be, and probably is, experiencing it differently. There may be an expectation that it will be the client that breaks the silence, yet the client has not been trained in what the silence may be there for or that it is part of the process. This may show a misbalance of power (Proctor, 2002) where the therapist may be 'expecting' the client to speak. This is not to dismiss silence in any way – it is an important part of learning, growing and changing in therapy but the point here is that it has to be beneficial to the client. It has to be an 'active' part of the dialogical encounter:

> 'Humans do not only substantially rely on dialogue they are dialogue. Therapy does not only substantially rely on dialogue, therapy is dialogue.' (Schmidt,2006, p251)

and:

> 'True dialogue is not transmission of information; it is participation in the being of the other which is only possible if it includes metacommunication (Schmid 2006 p246; Rennie,1998)

This metacommunication or 'talking about communication' is an essential part of looking at being in relationship and working in relationship during therapy. This allows clarity, congruence and

complete non-judgement in noting what is happening in the encounter between therapist and client, bringing into awareness some essential learning:

> ‘we have to realise that there is dialogue regardless of whether we are aware of it or not’ (Schmid, 2006 p250).

Silence is therefore about being and not doing but this ‘being’ is in the presence of another. It is important that psychological contact is kept throughout any silences in order to maintain the therapeutic relationship and the six necessary and sufficient conditions (Rogers, 1957, 1995). It may be that silences are much fewer earlier on in the therapy to allow the client to settle and the relationship to develop. Establishing ways of working with a client is very important for the use of silence in therapy – clients may need to know that there could be silences and to have explained how these could be useful – thus sharing therapist power in sharing knowledge. A part of contracting may be explaining this way of working, especially if contracting to work over the phone or internet where it may be useful to work out between client and therapist what may be needed if there is a silence, for example, a reassurance that both parties are still there and that the connection is not lost or a check-in to see where the client is in their process.

> Reflection: What is your own relationship with silence? How long could you hold a silence with a client comfortably? How do you know that the silence is also comfortable for the client? How do you know that you still have psychological contact with the client during silence?

This collaborative way of working is encouraged through the use of empathy, unconditional positive regard and congruence at deep levels, thus enabling relational depth (Mearns and Cooper, 2020) and providing what Winnicott called ‘a holding environment’ (Winnicott 2018).

Working with Hope

Many studies of counselling have seen hope pushed into the category of ‘placebo’ rather than an ‘active’ ingredient (Wampold & Imel, 2015) and the debate around the nature of hope and methodological integrity of measuring the effect within psychotherapy continues. In this model of practice, we consider that the common factors of therapy are the important underpinning aspects of the work and that hope, which is highlighted in this work, plays an important part (Frank & Frank, 1991; Lambert, 1992).

The concept of hope has divided opinion for centuries, with Ancient Greeks considering it unhelpful to hope for things as there was no way of knowing whether what was hoped for would be delivered (Menninger, 1959). On the other hand, world religions have encouraged hope that the next life will be better than the current one. Within DA relationships, there are some signs that hope is a very strong element of staying in the relationship, that in some way, if the right combination of behaviours or actions can be determined, that the relationship will revert to the positive experience of early courtship. Of course, this is not part of the abuser’s plan as perpetrating abuse ensures their needs are met. This state of believing that the relationship can be improved has been described as wishful thinking, but perhaps the term ‘unrealistic hope’(O’Hara, 2011) is a better term, as if the hope experienced is heartfelt rather than fanciful. When individuals finally recognise that the relationship will not improve and that all their efforts have been in vain, this can lead to a feeling of hopelessness (Roddy, 2012) which can be linked with higher levels of suicidal ideation (Beck et al., 1974). This also appeared to be the point where the individual finally began to reach out for help as they no longer believed they had the resources required to solve their problems. The situation they

found themselves in seems very appropriately described by a Bennett and Bennett (1984) quotation cited in Frank and Frank (1991):

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

The movement from unrealistic hope through hopelessness to realistic hope has been previously documented (O'Hara, 2011). The journey that we take with a client of abuse through hopelessness, and existential crises (Beck et al., 1974) can be challenging for therapists. However, we can hold onto the possibility of a new and different life for the client. We may not know what that life will be as we start the work, but we can hold hope for the future of the client, when the client has lost hope themselves.

There have been various authors who have examined what can create hope within a therapeutic relationship and these papers will provide you with many ideas of what you might do in practice (Larsen & Stege, 2010a, 2010b, 2012; O'Hara & O'Hara, 2012; O'Hara, 2013). Examples of ways to prompt hope in clients include: witnessing the stories of abuse openly and with care and compassion; highlighting client resources (what they can do rather than what they cannot); separating the client from the problem (understanding the impact of the abuse on an individual irrespective of who they are); or using metaphor and creative work to create a different perspective or new insight (see chapters 8 and 13). If you are interested in more details around working with hope, please do access these papers as they provide a valuable resource for therapists.

In summary, it is important for counsellors to have hope *for* the client, *in* the client, *in* the counselling process and *in* life in general. Maintaining an optimistic view of the world, despite the presentation of abuse, is a gift for the therapist as well as for the client (see also chapters 10 and 14).

> Reflection: What is your own relationship with hope as a person, as a therapist, and from your experience of therapy? How might these views impact on your counselling practice?

Understanding Abuse Narratives

Whilst we have talked about hope as a means of maintaining therapeutic presence when the client is sharing deeply distressing memories or feelings, it seems appropriate to share some of the ways that clients will tell, or not tell but imply, what has happened. The title of this section, understanding abuse narratives, is not about the stories that the clients tell, it is about understanding the way that stories are told and why that might be the case.

Often the extent of the abuse or any injuries sustained will be minimised. There are many reasons for this, such as:

1. The abuser will have explained in detail why the client was at fault or responsible for what happened: the story has become one of guilt and shame that they could have behaved in such a way making it hard to disclose the whole story (see also chapter 6).
2. The abuser may have claimed that the abuse was 'nothing' with the threat that there could be a lot worse to come: the client is now unsure that they can trust themselves to judge the seriousness of incidents and are reluctant to share for fear of misrepresenting the facts and being 'caught out' by the counsellor.

3. The client may still feel traumatised by the events and may not be able to go anywhere near the story as they may feel too distressed to do so (see also chapter 8).
4. There may be cultural issues associated with the abuse, for example religious beliefs or sexuality, which may bring conflict and confusion within the client not only about their experience but in their sense of themselves and their life (see also chapter 11).
5. There may be historical issues, for example, if they grew up in a domestically violent family and/or have had friends who have been in particularly violent relationships not identified as domestic abuse (see also chapter 3), they may consider that what has happened to them is not as bad as for others and hence minimise based on their own judgement and experience (intergenerational transmission of abuse).

When listening to the client, it is important to look out for signs that there is more to the story than is being told. A very matter of fact presentation of the story, despite some gruesome aspects, may suggest either that they have already repeated the story many times to other professional services or that they have disengaged with the material and are not prepared to feel the enormity of what happened. A gentle enquiry about some aspect of the story will usually provide evidence of the client situation and what might be behind the reticence.

It is important when listening to stories of the client's life today and in the past to be able to hear the dismissing of things, the passing over things quickly, and the elements that are missing, such as the emotional content. It is not just what is being said, but what is not being said. Using highly attuned empathic skills, together with your own understanding of what you have heard/noticed, allows you to speak for the client in situations where they want to tell you something but cannot find the words.

> Reflection: How comfortable do you feel in 'guessing' what might be going on for the client and sharing your thoughts about this with them? What might be difficult about doing this? How can you share this with the client without 'telling' them what happened?

Summary

Working with clients who have experienced domestic abuse is complex, not just due to the issues that can potentially be brought, but also due to the relational complexity that working with a survivor of abuse brings. A simple summary is to suggest that a relational abuse requires a relational approach for healing. In this chapter, we have explored the need for trust and outlined some ways to develop trust with the client. Within this, key elements of person-centred work presented as vital to working with the client, specifically high levels of empathy, beyond those normally required for standard counselling training, high levels of congruence, beyond those generally required for client work, and positive regard for the client and the ability to accept and respond appropriately to whatever the client might bring.

These core counselling skills are also used to bring gentle challenge to perceptions about the abuse and help with client understanding about what might have happened. Silence and hope within therapy can provide both positive and difficult experiences with clients and learning how to use them in the context of the client is useful for this work. Understanding why stories may have been presented in particular ways can help with exploration, particularly in noticing any missing gaps and supporting the client to tell the whole story.

Issues which come up for therapists as a result of hearing client stories or remembering their past history as a result of client work need to be dealt with in supervision and/or personal therapy.

Key learning points

1. Building trust in the therapeutic relationship is the foundation upon which counselling is built. This may need particular attention and skill with this client group due to their past experiences.
2. Advanced empathy, where the counsellor can understand and share what is going on for the client without specific narrative, is extremely helpful in working with and facilitating the client.
3. Therapists need to very comfortable with themselves, their skills and their process to ensure that present a competent, confidence and consistent presence in the counselling room.
4. At times, the client may opt for courses of action that the therapist may judge unhelpful, yet they must also continue to offer positive regard to the client as such issues are worked through.
5. Silence in therapy can be difficult for some clients, particularly if the abuser was silent before an attack. It is important to have strategies to both manage and explain silences for the benefit of the client.
6. Hope within therapy can have positive effects on both the client and counsellor during the work and can usefully be brought into the therapy room as appropriate.
7. Learning how to hear stories of abuse and quickly understand the hidden and underlying meanings of what has been told can help to facilitate a more helpful telling of the abuse narrative.

References

Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology*, *42*(6), 861-865. https://doi.org/10.1037/h0037562

British Association for Counselling and Psychotherapy (BACP). (2018). *Ethical framework for the counselling professions.* BACP.

Elliott, R., Bohart, A.C., Watson, J.C., & Murphy, D. (2018). Therapist Empathy and Client Outcome: An Updated Meta-analysis. *Psychotherapy*, 55 (4), 399-410. American Psychological Association.

Farber, B., Suzuki, J., & Lynch, D. (2018). Positive regard and psychotherapeutic outcome: a meta-analytic review. *Psychotherapy,* 55 (4), 411-423. American Psychological Association.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy (3rd ed.)*. Johns Hopkins University Press. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1991-97489-000&site=ehost-live

Gendlin, E.T. (1984). The client's client: The edge of awareness. In R.L. Levant & J.M. Shlien (Eds.), *Client-centered therapy and the person-centered approach. New directions in theory, research and practice*, pp. 76-107. New York: Praeger. From http://previous.focusing.org/gendlin/docs/gol_2149.html

Home Office (2021, updated 2022). Domestic abuse act statutory guidance. Domestic Abuse Act statutory guidance - GOV.UK (www.gov.uk)

Kessler, D., Walker, I., Sauve-Schenk, K., & Egan, M. (2019). Goal setting dynamics that facilitate or impede a client-centred approach. *Scandinavian Journal of Occupational Therapy.* 26 (5), 315-324. DOI: 10.1080/11038128.2018.1465119.

Kolden, G., Wang, C., Ausin, S., Fraser, S., Chang, Y., and Klein, M. (2018). Congruence/Genuineness: a meta-analysis. *Psychotherapy,* 55 (4), 424-433. http://dx.doi.org/10.1037/pst0000162

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectical therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration.* (pp. 94-129). Basic Books. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1992-98710-003&site=ehost-live

Larsen, D. J., & Stege, R. (2010a). Hope-focused practices during early psychotherapy sessions: Part I: Implicit approaches. *Journal of Psychotherapy Integration*, *20*(3), 271-292. https://doi.org/10.1037/a0020820

Larsen, D. J., & Stege, R. (2010b). Hope-focused practices during early psychotherapy sessions: Part II: Explicit approaches. *Journal of Psychotherapy Integration*, *20*(3), 293-311. https://doi.org/10.1037/a0020821

Larsen, D. J., & Stege, R. (2012). Client accounts of hope in early counseling sessions: A qualitative study. *Journal of Counseling & Development*, *90*(1), 45-54. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2012-02486-006&site=ehost-live

McNeilage. A. (2015). *The heart of silence.* https://www.bacp.co.uk/bacp-journals/thresholds/winter-2015/the-heart-of-silence/ accessed 20/12/21

Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995). An Integrative Model Of Organizational Trust [Article]. *Academy of Management Review*, *20*(3), 709-734. https://doi.org/10.5465/amr.1995.9508080335

Mearns.D. and Cooper. M. 2020. *Working at relational depth in counselling and psychotherapy.* London: SAGE Publications Ltd.

Menninger, K. (1959). The academic lecture: Hope. *The American Journal of Psychiatry*, *116*, 481-491. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1960-06192-001&site=ehost-live

Natiello. P. 2001. *The person-centred approach:A passionate presence.* Ross-on-Wye: PCCS Books

Norcross, J., & Lambert, M. (2018). Psychotherapy relationships that work III. *Psychotherapy*, 55 (4), 303-315. American Psychological Association.

O'Hara, D. J., & O'Hara, E. F. (2012). Towards a grounded theory of therapist hope. *Counselling Psychology Review*, *27*(4), 42-55.

http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2013-04085-005&site=ehost-live&scope=site

O'Hara, D. J. (2011). Psychotherapy and the dialectics of hope and despair. *Counselling Psychology Quarterly*, *24*(4), 323-329. https://doi.org/10.1080/09515070.2011.623542

O'Hara, D. J. (2013). *Hope in Counselling and Psychotherapy*. Sage. Proctor. G. 2017. The dynamics of power in counselling and psychotherapy: Ethics, politics and practice. PCCS Books: Hay-on-Wye.

Rennie. D.L. 1998. *Person centred counselling: an experiential approach.* London: SAGE Publications Ltd.

Roddy, J. (2012). *Hope, Belief and Compassion: Values for the Therapist, Researcher and Client* 2012 Value and Virtue in Practice-based Research Conference, York St. John University.

Roddy, J. K. (2014). *A Client Informed View of Domestic Violence Counselling* [PhD, University of Leeds]. Leeds.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95–103. https://doi.org/10.1037/h0045357

Rogers. C. 1995. *A way of being.* Houghton: Miffin Harcourt.

Peter F. Schmid (2006) The Challenge of the Other: Towards dialogical person-centered psychotherapy and counselling. *PersonCentered & Experiential Psychotherapies,* 5:4, 240-254, DOI: 10.1080/14779757.2006.9688416

Suler (2004) *The Online Disinhibition Effect.* Cyberpsychology & behavior: the impact of the Internet, multimedia and virtual reality on behavior and society 7(3):321-6 DOI: 10.1089/1094931041291295

Tolan. J. and Wilkins. P. 2011. *Client issues in counselling and psychotherapy.* London: Sage.

Truax CB and Carkhuff RR. 1967. *Toward effective counselling and psychotherapy.* Chicago: Aldline.

Walker, Lenore. 1979. *The battered woman.* Harper Collins.

Wampold, B. E., & Imel, Z. E. (2015). *The Great Psychotherapy Debate* (2nd ed.). Routledge.Rogers, C. R. (1942). *Counseling and psychotherapy; newer concepts in practice.* Boston: Houghton Mifflin.

Winnicott. D.W. 2018. *Holding and interpretation, fragment of an analysis.* Abingdon, Oxon: Routledge.