EJQRP (2023) Vol. 13, 153-167 ISSN: 1756-7599

European Journal for Qualitative Research in Psychotherapy
www.EJQRP.org
European Association for Integrative Psychotherapy

Literature review applying therapeutic theory and practice in the field of domestic abuse and coercive control

Ruth Smith

Private practice, South Wales, UK *Email*: ruthsmiththerapy@outlook.com

Abstract: This literature review introduces the issue of domestic abuse and coercive control to psychotherapists and considers how to work therapeutically with survivors. It will provide a definition of domestic abuse and coercive control, including discussion about post-separation abuse and domestic homicide. Drawing on my own experience of working with survivors of domestic abuse and sexual violence as a psychotherapist, combined with the work of notable figures in the field of trauma therapy, I will outline the recommended therapeutic approach to working with survivors. It is hoped this article will contribute to the field of psychotherapy and the call for mental health professionals to be aware of domestic abuse. Finally, this article supports the stance that domestic abuse is a human rights violation and positions psychotherapy with survivors as an act of social justice.

Keywords: Domestic abuse, coercive control, trauma, psychotherapy, survivors, social justice

This article aims to introduce the issue of domestic abuse and coercive control for psychotherapists in order to provide a foundational understanding of this topic to enable practitioners to work effectively with survivors. To do this, I will define what constitutes as domestic abuse and then focus on coercive control because at the centre of domestic abuse are the "multiple types of control [that] interweave to form what can feel like an inescapable web" (Monckton-Smith, 2021, p. 118).

The motivation for writing this article draws from my past experience of working as a refuge support worker for women and children fleeing domestic abuse, my recent experience of working as a VAWDASV (Violence Against Women, Domestic Abuse and Sexual Violence) trainer for Welsh Women's Aid, and my long term and ongoing work as a psychotherapist working with survivors of domestic abuse, domestic violence and sexual violence including sex trafficking and rape as a weapon of war.

To be transparent, it is important to present my theoretical orientation. I am a trained integrative psychotherapist, and my personal practice is informed by both feminist therapy and social justice therapy. Feminist psychotherapy has the core principles of valuing women's experiences, recognising that informed consent is a right and acknowledging the socio-cultural aspect of what clients bring to therapy (Ross & Lovrod, 2010). It places emphasis on the empowerment of women and other disenfranchised groups (Sesan & Katzman, 1998). It is based on socio-political philosophies that identify oppressions as the cause of psychological and emotional distress (McLellan, 1999). However, as it is recognised that traditionally feminism has been understood from a white, middle-class perspective (Phipps, 2020), I take an intersectional feminist approach. Crenshaw (1989) introduced the term "intersectionality" to describe the multi-dimensional way black women are

discriminated against in the justice system by being discriminated for both race and gender. Intersectionality relates to social inequality and how power is organised and shaped "not by a single axis of social division, be it race, gender or class, but by many axes that work together and influence one another" (Hill Collins & Bilge, 2016, p. 2). Indeed, it states that feminist therapists need to understand each survivors' "unique social and economic location" and that feminist therapists "particularly but not exclusively those who are from the dominant groups (i.e., white, middle-class, heterosexual) can miss or ignore issues of upmost importance to women's ongoing safety and healing" (Senn, 2010, p. 83). Therefore, feminist therapy needs to acknowledge intersectional oppressions, and I argue one way of achieving this is an awareness of social justice. Social justice psychotherapy is motivated by social justice and human rights and has feminist and multicultural theory at its core (Chung & Bemak, 2012). It considers "how inequality, discrimination, oppression and other societal-level forces contribute to mental illness at the individual level" (Rogers-Sirin, 2017, p. 55). While my undergraduate and postgraduate degrees are in counselling and psychotherapy, my PhD is in Social Justice, meaning that incorporating feminist and social justice principles into my therapeutic practice complement my personal and educational perspectives.

Throughout this article, I will use the term "survivor" to describe those who have both experienced and are living with domestic abuse, taking the position that those who are living with domestic abuse are literally surviving every day. However, the word "victim" will be used when reproducing direct quotations from research and literature.

It has been argued that "mental health professionals should be identifying, preventing, and responding to violence against women more effectively" (Oram et al., 2017, p. 159); it is hoped that this article will contribute to this aim.

Defining domestic abuse

Domestic abuse is defined as:

> an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer. It is very common. In the vast majority of cases, it is experienced by women and is perpetrated by men. (Womens Aid, 2022)

The Welsh Government (2021) state that "violence against women is a violation of human rights … and a manifestation of historically unequal power relationships". However, the myth that violence is the only form of domestic abuse is one that persists, but it is now recognised that it can take various forms. The Domestic Abuse Act 2021 (HM Government, 2021) understands abusive behaviour encompasses: "physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional or other abuse". Other abuse can include harassment and stalking, online abuse, female genital mutilation, forced marriage and so-called honour-based violence (Welsh Women's Aid, 2023). Therefore, it is important for psychotherapists to be aware that domestic abuse is multifaceted, with forms of abuse overlapping making it challenging for survivors to recognise that what they are experiencing is abuse. For example, in a relationship that may involve economic abuse, it may seem "normal" and even caring for one person to have control over spending, income, grocery shopping etc., but if the other person's life is constricted and limited by the other person's financial control, including access to bank accounts and employment, it is abusive. Indeed, one in six women have experienced economic abuse (Surviving Economic Abuse, 2023) indicting that it is not a rare occurrence. A useful tool, and one frequently used in VAWDASV training, is the Duluth Power and Control Wheel (The Duluth Model, 2017) which shows that physical violence is just one form of domestic abuse, and that intimate-partner control is at the root of all abuse.

Prevalence

Although the most recent data from March 2021 to March 2022 shows an estimated 2.4 million adults aged 16 to 59 years experienced domestic abuse in England and Wales (ONS, 2022a), this is not necessarily an accurate number as there are many unreported cases, meaning the number is likely to be much higher. While not infallible, statistics do indicate that the number of domestic abuse-related crimes has continued to increase in recent years (ONS, 2022a). One in five people experience domestic abuse during their lifetime, with one in four survivors being women and one in six-to-seven survivors being men: Most perpetrators are men (National Centre for Domestic Violence, ND).

Given these statistics, domestic abuse is a gendered crime but one that permeates across geographical regions, age, educational levels, culture and social class (ONS, 2022b). The majority of domestic abuse survivors are women, "13.8% of men and 27.4% of women aged 16 to 74 have experienced some form of domestic abuse since the age of 16 (2019/20)" while gay and bi-sexual men are more likely to experience domestic abuse than heterosexual men (Mankind Initiative, 2021, pp 1-2). Nonetheless, "women and girls are disproportionately the victims" (The Welsh Government,

2021), a claim that is reaffirmed by a recent Home Office domestic homicide review for the period of 2020-2021 which found "113 victims (of which 15 were, or appeared to be, victims of domestic abuse who died by suicide)" and "77 percent of the victims were female and 23% were male. For perpetrators, 89% were male and 10% female" (Home Office, 2022, p. 1). Given these statistics, as psychotherapists, we must be conscious to the prevalence of domestic abuse and be prepared for it be present within our therapy rooms.

Coercive control

Coercive control underpins all forms of domestic abuse and therefore, it isn't a "new" form of domestic abuse. However, the conceptualisation of a set of behaviours as "coercive control" and its incorporation into the Domestic Abuse Act 2021 (HM Government, 2021) enables both psychotherapists and survivors to have a clarity over what can be a seemingly intangible form of abuse. As a psychotherapist, it is important to be vigilant to the indicators of coercive control and if suspected, gently bring these to the attention of the client. This process may be challenging for the client who while feeling unhappy, stressed, or uncomfortable with their relationship may not realise that their partner's behaviour is abusive. However, this does pose an ethical dilemma: as therapists we do not tell clients what to do and we must be sensitive and sure before we open a dialogue about potential abusive behaviour. At the same time, we follow ethical frameworks which state principles such as "respecting human rights and dignity, alleviating symptoms of personal distress and suffering, enhancing people's wellbeing and capabilities" and "protecting the safety of clients" (BACP, 2018, p. 8).

One way to negotiate this ethical conundrum is to gently offer psychoeducation about domestic abuse and to explore with the client whether it resonates with their personal experience; the aim is to offer and not enforce information. However, if there are concerns about a risk of domestic homicide, this is further complicated and potentially necessitates breaching confidentiality; in this instance I would always endeavour to speak about this with the client before taking such a step. The significant role psychoeducation can have in therapeutic work with survivors of domestic abuse and coercive control and a discussion of domestic homicide is presented below.

Stark (2007) coined the term "coercive control" and defines coercion as "the use of force or threats to compel or dispel a particular response" (2007, p. 228), and control as "structural forms of deprivation, exploitation, and command that compel obedience indirectly" (2007, p. 229). When coercion and control happen simultaneously, it is understood to be *entrapment*. Although coercive control can be appear in variable ways, there does appear to be consistent indicators of its presence, those experiencing coercive control can be deprived of "money, food, access to communication and transportation and other survival resources even as they are cut off from family, friends and other supports" (Stark, 2007, p. 6). It also includes, but is not limited to, gaslighting, humiliation, tracking movements and monitoring behaviour (Welsh Women's Aid, 2023b).

In 1979, Walker argued that while coercive tactics used by abusers were unique for each individual, the tactics shared similarities. Although it is possible to identify certain behaviours as constituting as coercive control, it is important to recognise that they can evolve. For example, when Walker (1979) undertook her research, she could not have anticipated what is now referred to as "technology facilitated domestic violence" or "digital coercive control" (Woodlock et al., 2020) which refers perpetrators' use social media as well as tracking devices, drones, spyware and cameras to monitor and control the survivor (Australian Government, 2021). In addition, emerging research is showing a connection between animal abuse and domestic abuse and coercive control (such as: Taylor and Fraser, 2019; Wakeham, 2021; Links Group, 2023), suggesting that psychotherapists need to be aware of developments in the field of domestic abuse to help them identify "red flags" that may appear during therapy.

Isolation of the survivor from their support networks is arguably a cornerstone of coercive control and can occur early in an abusive relationship (Monckton-Smith, 2018; 2021). Therefore, psychotherapy may be a way for survivors to reconnect with others outside of their abuser's control, this is particularly significant if the survivor has accessed psychotherapy of their own volition and chosen you to be their therapist (rather than been allocated their therapist by a statutory or third sector service). This decision is a step toward survivor autonomy and as a psychotherapist, one should recognise the courage taken by their survivor client in initiating contact and attending therapy. In fact, Herman (2001, p. 159) encourages the therapist to "state this view explicitly and in detail to address feeling of shame and defeat" the client may feel in attending therapy. It is important for the therapist to be aware that in abusive relationships the perpetrator's coercive control seeks to erode a survivors' autonomy, for example controlling what the survivor wears, eats, who they speak to, where they go etc. Even if the abusive relationship has ended before the therapy commences, the therapist needs to be cognisant of the significance of the survivor-client deciding to come to therapy and in choosing you to be their therapist as this may be a first step toward them regaining the confidence in their autonomous decision-making skills. If the client is still in a relationship with the perpetrator, and/or digital coercive control is an aspect of the abuse, psychotherapists need to be mindful of how they communicate with their survivor client

lest the perpetrator intercepts communications sent between therapist and client. In this instance, ongoing verbal agreement about the safest way to communicate is important (this could be session-by-session) because the safest method of contact may change if the perpetrator changes their controlling tactics.

Another form of coercive control that survivors may not be prepared for and psychotherapists need to be aware of is post-separation abuse. This refers to the continuation of coercive controlling behaviour from the perpetrator toward the survivor even though their relationship may have ended and is the:

> ongoing, wilful pattern of intimidation of a former intimate partner including legal abuse, economic abuse, threats and endangerment to children, isolation and discrediting and harassment and stalking. It is common for perpetrators to persist in their abuse usually through children such as undermining her parenting, and finances. (Spearman et al., 2022, p. 1).

It has been referred to as "devastating" form of coercive control (Sharp-Jefferies, 2021) and in April 2023 it became a criminal offence in England and Wales. Therefore, it is vital that psychotherapists are cognisant that while their client's relationship may have ended, it does not necessarily follow that the abuse has ended.

Indeed, the client's decision to leave, and perhaps guilt or shame at not having left earlier, can form a part of the therapy. It is important to normalise for clients that leaving is not a simple act, indeed research has found that "leaving was a process, not an event" (Storer et al., 2021), which is an essential reminder that leaving an abusive relationship is both complicated and dangerous. Therefore, while the psychotherapist may feel a sense of urgency for their client to leave their abusive relationship, it is important to remember that due to the psychological effects of domestic abuse making such a decision is a challenging one, let alone organising practical arrangements such as finances and housing.

Domestic homicide

In fact, leaving an abusive relationship is the most dangerous time for a woman: 8% of women killed by their ex-partner from 2009 to 2018 were killed within the first month of separation and 89% in the first year, (National Centre for Domestic Violence, ND). Professor Jane Monckton-Smith has developed the homicide timeline, which presents eight escalating stages of domestic abuse culminating in domestic homicide (Monckton-Smith, 2021; University of Gloucestershire, 2019) – see Table 1.

Stage	Description of perpetrator behaviour
One: A history of control or stalking	A pre-relationship history of stalking or abuse by the perpetrator.
Two: The commitment whirlwind	The relationship develops quickly into a serious relationship, e.g., early cohabitation and pregnancy, jealous and possessive etc.
Three: Living with control	The relationship becoming dominated by coercive control e.g., isolation from family and friends, violence, threats of suicide, threats to children/pets, sexual aggression etc.
Four: Trigger	A trigger threatens the perpetrator's control, e.g., the relationship ends, financial difficulties, physical/mental health deterioration etc.
Five: Escalation	An increase in the intensity or frequency of the partner's control tactics.
Six: A change in thinking	Feelings of revenge/injustice/humiliation motivates perpetrator to resolve situation by moving on, revenge or homicide.
Seven: Planning	The perpetrator might buy weapons or seek opportunities to get the victim alone, threats to children, stalking behaviour, choosing to move on, either through revenge or by homicide.
Eight: Homicide and/or suicide after homicide	Homicide - the perpetrator kills his or her partner, and possibly hurts others such as the victim's children and may complete suicide.

(*Adapted from* Monckton-Smith, 2018; 2021)
Table 1: Summary of the eight stages of the homicide timeline

Awareness of the stages of domestic homicide can be a useful tool for psychotherapists working with survivors of abuse to identify the risk posed to their client as the client may not be aware of the severity of their circumstances. While it is not the intention of presenting Monckton-Smith's (2021) 8-stages to alarm practitioners, it is critical that we understand the potentially fatal consequences of coercive control to dispel the misconception that only domestic violence is a precursor to domestic homicide. In fact, research has highlighted the

nature of abuse in domestic homicides was more likely to emotional/psychological abuse and coercive control than physical abuse (Femicide Census, 2020). Therefore, I argue awareness of coercive control and the associated risks is central when working with survivors.

Working therapeutically with survivors

A recent report by Women's Aid (2023a) has shown that "28.7% [of survivors] reported having a disability and, of these, 56.0% had a mental health disability and 22.3% had a physical disability". Consequently, the psychological impact of domestic abuse cannot be underestimated and lasts beyond the duration of the relationship. This is compounded by post-separation abuse where coercive control can still be perpetuated via children, finances, housing, and pets. This is further complicated by the practical challenges of leaving an abusive relationship, due to the fact that in recent years access to women's refuges has become harder as due to national and local government funding cuts for domestic abuse services including refuge spaces (Grierson, 2018; Welsh Women's Aid, 2023b). Despite their advocation that mental health professionals need to be aware of domestic abuse, there is also recognition that there is a lack of research "on how to improve identification and treatment of victims and perpetrators in contact with mental health services" (Oram et al., 2017, p. 159).

People who experience domestic abuse have experienced trauma, with PTSD (Post-traumatic Stress Disorder) being a frequent consequence of abuse. It has been found that PTSD is experienced by 51% to 75% of women who have experienced domestic abuse in comparison to an average of 10.4% of women in the general population (PTSD UK, 2023). The symptoms of PTSD can include flashbacks; nightmares; repetitive and distressing images or sensations; physical sensations, such as pain, sweating, feeling sick or trembling and in a state of hyperarousal (NHS, 2022a). Survivors of domestic abuse can experience complex-PTSD (also called C-PTSD) which includes the symptoms of PTSD in addition to problems with managing emotions and interpersonal relationship issues as well as feelings of worthlessness, shame and guilt (NHS, 2022b). A recent article in *The Lancet* has also stated that childhood abuse and domestic abuse can cause complex-PTSD, potentially effecting emotion regulation, identity, and relationships (Maercker et al., 2022). Therefore, psychotherapists who are working with survivors must take trauma approaches into consideration and helping survivors feel in control (of their minds, lives and trauma symptoms) is an important part of the therapeutic process.

It has been suggested that in order for therapy to be ethical, it needs to be guided by research (Blease et al., 2016). The Cochrane Collaboration (2023) provides a repository for evidence-based research and is useful resource to psychotherapists looking to support their practice with research findings. A systemic review of psychological therapies for chronic PTSD found that sample sizes of research tended to be small, with limited follow-up data to show long-term efficacy (Bisson et al., 2013). This study supports the argument made elsewhere that "there is inconsistent evidence to support trauma informed interventions as an effective approach for psychological outcomes" and that the definition of trauma should be expanded to include racism and discrimination (Han et al., 2021, p. 1).

Therapist awareness and integration of intersectional feminism (Crenshaw, 1989; Hill Collins & Bilge, 2016) can be one way to recognise the trauma of intersectional oppressions. For example, a lesbian victim-survivor of domestic abuse will have experienced gender-based and heteronormative discrimination; therapist awareness of this can help the client to feel seen, heard and accepted. Hameed et al. (2020) undertook a systemic review of psychological therapies for women who experience intimate partner violence (IPV). They found that while psychological therapy may help to reduce depression and anxiety:

> there is limited available evidence of whether psychological therapies improve general mental health symptoms, quality of life, social support, uptake of healthcare and IPV services and safety planning, or reduce PTSD and re-exposure to any form of IPV. Overall, we did not find evidence that psychological therapies had a negative or harmful effect (Hameed et al., 2020, p. 29)

While Hameed et al did not find definitive evidence of the best therapeutic practice with victim-survivors of domestic abuse, they did suggest that the type of therapeutic intervention, the setting (i.e., healthcare, refuge etc.) and the therapist made little difference to therapeutic outcomes, but five or more sessions "showed a probable beneficial effect in reducing depression" (Hameed et al., 2020, p. 29). However, the American Psychological Association (APA) has issued guidelines recommending Prolonged Exposure Therapy, Cognitive Processing Therapy and trauma-focused Cognitive Behavioural Therapy when working with PTSD (APA, 2017; Watkins et al., 2018).

Prolonged Exposure Therapy (PE) aims to alter fear structures, i.e., fear stimuli and fear responses and the meanings attached to those stimuli and responses. Cognitive Processing Therapy

(CPT) proposes that traumatic events lead to "cognitive distortions" in how the survivor sees themselves, others, and the world and CPT aims to shift those distortions to "accommodate" new learning, e.g., from "it was all my fault" to "I was not responsible for others' actions." Trauma-focused Cognitive Behavioural Therapy (TF-CBT) uses traditional CBT theories and utilises other theories including PE and CPT (Watkins et al., 2018). It should be noted that this APA recommendation is based on military veterans and is not without controversy, with petitions being organised against the APA guidelines (Henrlques, 2018) and the critique that such approaches may be overwhelming to clients with complex trauma - and therefore potentially harmful - and that they fail to consider the clients personal and cultural needs and the therapist's self-care (Henning & Brand, 2019). From a feminist perspective, I suggest these approaches may unintentionally replicate patriarchal systems of power where there is an "expert" who "knows" the correct approach leading to unequal power dynamics that do not consider intersectional oppressions, socio-cultural context or the importance of the therapeutic relationship.

Consequently, it is difficult to ascertain the best approach to working with trauma and, more specifically, the best therapeutic approach to working with victim-survivors of domestic abuse and coercive control. It is evident that further research is needed in this area. Although they discuss medicine rather that psychotherapy, Greenhalgh et al. (2014) caution that evidence-based practice can be problematic if it is applied mechanically, and Box 1 lays out their recommendations. In order to ensure effective evidence-based medicine, they say, practitioners should:

- **Make the ethical care of the patient its top priority.**
- **Demand individualised evidence in a format that clinicians and patients can understand.**
- **Is characterised by expert judgment rather than mechanical rule following.**
- **Share decisions with patients through meaningful conversations.**
- **Build on a strong clinician-patient relationship and the human aspects of care.**
- **Apply these principles at community level for evidence based public health.**

(Greenhalgh et al., 2014, p. 4)
Box 1: What is real evidence-based medicine and how do we achieve it?

The research indicates that there is no clear approach to working with psychological trauma and with victim-survivors, but as more evidence-based research becomes available psychotherapists need to maintain the primacy of the therapeutic relationship over recommended techniques and theories.

The maxim upon which I base my practice is the assertion that "recovery can take place only within the context of relationships; it cannot occur in isolation" (Herman, 2001, p. 133). Simply put, the role of a mutually respectful, ethical and boundaried therapeutic relationship has in the client's healing after they have experienced an abusive relationship should not be underestimated. The reason for the profound effect these can have upon the therapeutic relationship is because those elements of respect, ethics and boundaries are not present in abusive relationships and their presence in therapy indicates to the survivor that they are worthy of these core values and enables them to recognise what a healthy relationship looks and feels like.

In alignment with the connection between domestic abuse and psychological trauma, my own therapeutic approach is based on the work of Herman (2001) and Rothschild (2000; 2011; 2017). Herman (2001) outlines three stages of trauma recovery: safety, remembrance and mourning and reconnection. However, she also notes that these stages may not be as linear or as simple as they may appear, meaning a degree to flexibility is required but the safety stage is fundamental to recovery.

Rothschild (2017) believes that trauma recovery is possible without trauma memory resolution, meaning that recovery from the symptoms of trauma, such as flashbacks, can be sufficiently healing for the client thus negating the need for exploration of traumatic memories. The efficacy of psychological debriefing has long been questioned (van Emmerick et al., 2002; Choe, 2005; Vignaud et al., 2022). This is supported by research conducted post 9/11, which found that critical incident debriefings to discuss the event had little impact on those who participated in it (Harmon, 2011; Pandya, 2013). This assertion that it is not necessary to intensively examine traumatic memories is one that can come as a surprise to therapists, dispelling the myth that debriefing is a necessary step of trauma recovery. The knowledge that trauma memory exploration is not necessary can come as relief to survivors who may not want to delve into the specific experiences of domestic abuse. It is for this reason that I will focus on safety stage of therapy with survivors of domestic abuse and coercive control.

In my experience, I have found that when therapy sessions were time-limited (such as when I worked for a charity) working on the here-and-now, i.e., normalising and managing trauma symptoms, establishing a safe therapeutic relationship and exploring present emotions were, in and of themselves, healing. However, if the therapy is open-ended it may be possible (but not always necessary) to work toward "remembrance and mourning" and "reconnection" (Herman, 2001). In either scenario, it is important to go at a pace that is right for the client. If therapy proceeds too quickly it may lead to the client experiencing retraumatisation (Rothschild, 2000; 2017), when the "recollections of a past traumatic event are elicited in a manner that continually escalates fear and helplessness rather than promotes new learning about safety" (Zayfert & Black Becker, 2020, p. 60).

Consequently, Herman's (2001) safety stage may be the whole of the therapeutic process and essential in reducing the risk of retraumatisation. As she notes, trauma deprives the survivor of power, and control and restoration of power and control is the "guiding principle" of recovery and that:

> The first task of recovery is to establish the survivor's safety. The task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured. No other therapeutic work should even be attempted until a reasonable degree of safety has been achieved. (Herman, 2001, pp. 159-160)

This stage of recovery can last between weeks or years depending upon the client and their trauma history; therefore, it is important to reiterate that particularly in time-limited therapy the safety stage may be the whole of the therapy. The stage can also be integrated into different therapeutic theories and modalities (Sanderson, 2013). In my personal experience of working with survivors of various form of abuse and violence, establishing a sense of safety is essential. In practice, this means establishing what "safety" means and feels to clients, as some may not remember ever feeling safe. Together we explore what they hope safety will be for them and for others. In this process, they may be able to connect with past experiences of feeling safe and remember what that feels like emotionally, physically, and psychologically.

In either scenario, safety begins with reducing hyperarousal, which refers to the autonomic nervous system (ANS) being in a state of "chronic activation" leading to "anxiety, panic, weakness, exhaustion, muscle stiffness, concentration problem and sleep disturbance" (Rothschild, 2000, p. 47). There are two branches of the ANS, the sympathetic (SNS) and the parasympathetic (PNS). During hyperarousal, the SNS is particularly activated and the PNS is suppressed. Rothschild (2017; Norton Mental Health, 2018) has provided a useful table that outlines the physiological symptoms of different stages of hyperarousal, such as heart rate, respiration, pupils' dilatation, skin tone changes as well as the emotional indicators. As psychotherapists working with survivors of trauma, we need to be cognisant of any physiological changes in the client and check frequently how their body is reacting to what they are talking about in the moment (in my experience, different clients will connect to different bodily sensations such as temperature, heart rate, nausea etc.). This may mean a more directive approach than some psychotherapists' may feel initially comfortable with, but gently bringing the client to an awareness about the physiological signs of their trauma response can be an important step in the safety stage as it allows therapy to progress safely, reducing the risk to retraumatisation, and allows them to intervene early when they experience a flashback, dissociation or panic. Consequently, it can allow the survivor to regain a sense of control over their body and mind - something that was absent in the abusive relationship.

If the client experiences hyperarousal during the session, the use of grounding techniques is helpful in reducing this; these can take various forms from observations of their present environment to breathing exercises. Clients may need to try a few to see what is right for them. A technique that I find particularly useful is to ask the client to look around our therapy room and slowly describe five objects they can see and always describe at least two objects myself to show what I am asking them to do. If grounding techniques are used, it is important to explain to the client the reason why you asked them to do it and ask them to check-in with their heart rate/temperature/nausea etc., to see if it feels better, worse or the same. Again, it is about explaining to them that you want to ensure that they feel as safe as possible, and for them to learn how recognise and stop trauma responses.

In doing so, another important aspect of the safety stage is brought into the therapy room: the role that psychoeducation. It has been suggested that it allows survivors to "normalise their reactions and begin to take more control rather than be embedded in or flooded emotions" (Sanderson, 201, p. 77). In my practice, this often takes the form of explaining in uncomplicated terms to the client the neurobiological reasons for PTSD and complex-PTSD, as well as the symptoms of hyperarousal, including flashbacks, and the different forms of abuse. I also share what are known as the "5 F's" of trauma response, emphasising that a trauma response is instinctual, and we do not consciously decide how to react to trauma – see Table 2:

Trauma response	Description
Fight	Physically fighting, pushing, struggling, and fighting verbally e.g., saying 'no'.
Flight	Putting distance between you and danger, including running, hiding or backing away.
Freeze	Going tense, still and silent. Freezing is not giving consent; it is an instinctive survival response. Animals often freeze to avoid fights and potential further harm, or to 'play dead' and so avoid being seen and eaten by predators.
Flop	Similar to freezing, but muscles become loose, and body goes floppy, reducing the physical pain of the traumatic experience. The brain can also shut down to protect itself.
Friend	Calling a 'friend' or bystander for help, and/or 'befriending' the person who is dangerous, by placating, negotiating, bribing or pleading with them.

(*Adapted from* Rape Crisis England and Wales, ND)
Table 2: Summary of the "5 F's" of trauma responses

Physiological psychoeducation can help the client to understand that what they are experiencing is not their fault, nor is it a sign of weakness or something to feel ashamed of. Likewise, sharing with the client the different forms of abuse can help dispel any misconceptions and challenge gaslighting tactics by the perpetrator that they are overreacting or that the perpetrators behaviour is/was expressions of love. This is particularly relevant in cases where physical and/or sexual abuse may not have been present in the relationship but coercive control was. I have often witnessed the moment when the client has an "a-ha" moment when I am explaining the different forms of abuse and they realise that it wasn't "all in their mind", that physical violence is not the only form of domestic abuse and that what they experienced *was* indeed abuse. It cannot be understated the profound effect that this can have.

The feminist philosopher Miranda Fricker conceptualised the theory of "epistemic injustice" (in philosophy, epistemology refers to how we understand our reality). Fricker's theory (2007) which considers how a person's knowledge can be discredited in two ways: testimonially and hermeneutically. *Testimonial injustice* refers to a rejection of the knower's experience or knowledge due to prejudice based on their identity (e.g., because they are a woman or because they are a person of colour). *Hermeneutical injustice* refers to someone not having access to the conceptual and structural resources needed to understand their experiences. Therefore, psychotherapy is giving the client testimonial justice because we hear, believe and bear witness to their experience of domestic abuse and psychoeducation gives the client hermeneutical justice as we are providing them the conceptual resources to understand their experience of domestic abuse and their trauma symptoms.

Roddy (2023a, pp. 20-21) has presented eight key elements to working with clients – see Table 3:

Element	Summary
1	Engage with and help the client with whatever they bring which can build the foundations for future work.
2	Understand domestic abuse, its affects and how it can be perpetrated.
3	The combination of high-level empathy and psychoeducation on domestic abuse helps the client understand their situation.
4	Be genuine and consistent in session helps the client to feel safe.
5	Work within your competence as this will help you feel confident and the client feel safe.
6	Provide positive support and feedback by recognising that the client has been trying their best to manage a challenging relationship.
7	Always work from the clients perspective, bringing challenge when needed.
8	Review your client work regularly through supervision to facilitate better understanding of client work and self-care.

Table 3: Key elements of working with clients of domestic abuse

These key elements have emphasised the importance of the therapeutic relationship, of which psychoeducation is one aspect of the therapy but not the focus. As Roddy argues, "building a therapeutic relationship based on trust, hope and understanding is a key foundation to future exploration" (Roddy, 2023a, p. 20). I will explore the centrality of the therapeutic relationship in my own practice below.

Another core component of psychotherapy is supervision. In a BACP commissioned systemic review on the impact of supervision, it was found that while the quality of the available research was variable, there were indications that supervision can help to enhance the self-efficacy and skills of the supervisee and a can have a beneficial effect on the client and the outcome of therapy (Wheeler & Richards, 2007). The BACP (2022) state that working with a domestic abuse informed supervisor is important, and that ethical considerations of working with victim-survivors include asking oneself whether additional supervision and support is needed and whether it is appropriate to refer the client to another practitioner or

organisation with more expertise. Vetere (2017) suggests that, for supervision in cases of domestic violence, the supervisor and supervisee do not need to share a theoretical orientation but that the supervisor should take a directive approach in discussing the safety of the client and the supervisee and allow space for the supervisee's doubts, concerns and self-reflection within a safe and trusting supervisory relationship. For therapists working with trauma, it is important to have a trauma-informed supervisor who can not only support client work but can also support the therapist with issues of vicarious trauma and self-care (Jordan, 2017). I have written previously about my own experience of vicarious trauma (Smith, 2021) and I believe that supervisory relationship where one feels able to honestly share the challenges and complexities of trauma work is an act of self-care in itself.

Virtue and Fouché (2010) present a model of supervision they term "multiple holding" which refers to:

> the processes practitioners can use to enable them to remain working in the field of trauma and abuse and includes relational supervision, knowledge and skills and the use of resources outside the supervision relationship (Virtue & Fouché, 2010, p. 64).

They define relational supervision as including "warmth, acceptance, validation of the supervisee's felt experiences and being open, curious and undefended in the supervisory role" (Virtue & Fouché, 2010, p. 68), with outside resources including spirituality, personal therapy, collegiality with others working with trauma and trauma training. The "multiple holding" model takes a more holistic approach to supervision, acknowledging that relational supervision is essential, but it needs to be combined with support from other sources which enables the supervisee to feel sustained to continue working with victim-survivors of trauma and abuse. Significantly, this model consciously recognises the effect of feminist principles on supervision, particularly in regard to the social context of interpersonal violence and traditional medical approaches to trauma which neglect gender and power dynamics (Virtue & Fouché, 2010). In this way, relational and feminist supervision that understands trauma and abuse in its socio-cultural context and fosters a safe and non-judgemental space mirrors the therapeutic relationship with victim-survivors which similarly needs to be safe, non-judgemental and understand domestic abuse and coercive control through a feminist lens. Further discussion about the role of the therapeutic relationship is discussed in the next section.

In essence, psychotherapy with survivors requires the client re-establishing a sense of physiological, psychological, and physical safety with psychoeducation providing hermeneutical justice to the survivor. Importantly, it is a process that should not be rushed and establishing safety may be entirety of the therapeutic work. It seems that supervision for therapists working with domestic abuse and coercive control may be more effective if it is relational, trauma-informed, considers the socio-cultural context and is situated alongside other resources such as collegiate support and further training.

Reflections on my therapeutic practice with victim-survivors

There can be confusion as to what the purpose of domestic abuse therapy is; whether it is to reduce depressive and/or trauma symptoms, enhance decision making skills or to increase overall safety (Roddy, 2023b, p. 3). Arguably, the purpose is dependent upon the circumstances in which the therapy is taking place, e.g., time-limited or ongoing sessions, whether it's in private practice, the public sector or a charity. It is my intention to offer some clarity to this confusion by presenting my reflections of my own therapeutic practice with victim-survivors of domestic abuse and coercive control, while acknowledging that this is not the only therapeutic approach.

When working with complex-PTSD, which can include survivors of domestic abuse, it has been recommended that:

> multicomponent therapies start with a focus on safety, psychoeducation, and patient-provider collaboration, and treatment components that include self-regulatory strategies and trauma-focused interventions (Maercker et al., 2022, p. 60)

Similarly, my own personal therapeutic approach when working with victim-survivors is to provide safety, psychoeducation, and collaboration. I understand "collaboration", to mean the therapeutic relationship. As outlined previously, the maxim upon which I base my practice is the assertion that "recovery can take place only within the context of relationships; it cannot occur in isolation" (Herman, 2001, p. 133). Relational integrative psychotherapy understands that the "challenge" of the therapeutic relationship "is to embody ways of 'being' and 'being-with' (as opposed to just 'doing') naturally and effortlessly, rather than being led by some intellectual principle" (Finlay, 2015, p. 3).

Therefore, the importance of the therapist authentically embodying safety, respect and boundaries should not be underestimated when working with victim-survivors of abuse as a safety, respect and healthy boundaries are not present in abusive relationships. Learning to feel safe in a relational dynamic may be whole of the therapy.

While "safety" can feel an ambiguous term, in my own practice I initially establish safety in the first session when I explain to the client that they do not need to tell me anything that are not ready to, that it is not necessary for me to know every detail of what happened to them unless they choose to tell me, and that we will go at the right pace for them. At that first session, I also gently remind the client that it is okay to disagree with me, for example if I misinterpret an emotion; this is especially powerful when the victim-survivor has been gaslit and feels uncertain of their own emotional or mental state and has faced harmful repercussions if/when they questioned their abuser's perspective. While it can take time for a client to disagree with me, it is a moment that can signify a breakthrough as it indicates that the client (a) has become confident in knowing their own emotions and (b) feels safe enough in the therapeutic relationship to disagree and trusts that there will not be negative consequences. In this way, I am not 'doing' safety, I am *'being'* safe.

Providing a therapeutic safe space that is free from judgment is important in any therapeutic relationship, and it is particularly vital when working with victim-survivors of domestic abuse and coercive control. These women are often met with the question "why didn't you just leave?", and this compounds feelings of guilt and shame. I find it useful to communicate to the client that abusers tend to increase the "temperature" of the abuse slowly at first, so the victim-survivor does not always notice the rising temperature until many of their resources (friends, family, finances, self-esteem etc.,) have been stripped away. This means that "just" leaving may not feel mentally, emotionally and practically possible. As mentioned previously in this article, domestic homicide is a real possibility when women do decide to leave (National Centre for Domestic Violence, ND; Monckton-Smith, 2021; University of Gloucestershire, 2019; Femicide Census, 2020). As the poet Rupi Kaur (2020, p. 55) wrote:

> "don't ask me why i didn't leave
> he made my world so small
> i couldn't see the exit
> - i'm surprised i got out at all"

It is important for the therapist to recognise that stripped of all resources, the victim-survivor may not be able to see the exits and if they have already left, the courage and risk they took for them to leave. I often verbalise this recognition to counter any self-blame the client may feel in staying and acknowledge the dangerous process of leaving.

Further complicating the client's emotions is that there may be times when the abuser was nice, funny or generous leaving them feeling disorientated as to what they feel/felt for their abuser. Here it is important to acknowledge that there were probably happy times in the relationship and this is part of the "love bombing" stage of abuse, i.e., over-the-top displays of affection and attention, but that those moments of apparent kindness do not excuse the abuse.

Victim-blaming, which includes the questioning of survivors of crimes as to what they could have done to prevent the crime, is often applied to women who have experienced domestic abuse and sexual assault (Roberts, 2016). It is therefore important to provide a therapeutic space that is free from victim-blaming. Understanding the complexities of both being in and leaving an abusive relationship can support the client to understand their experience with greater insight and self-compassion.

If the centre of my therapeutic practice is the therapeutic relationship, then feminist psychotherapeutic principles are the foundation. Specifically, intersectional and trans-inclusive feminism. Feminist therapy emerged as a critique of the traditional psychoanalytic approach to therapy and focused on three areas: (a) the mechanism of control, (b) the failure to acknowledge the impact of context on individual lives, and (c) the androcentrism of psychological theories that underly psychotherapy (Evans et al., 2010, p. 8). In relation to domestic abuse and coercive control these areas can be applied in three ways: (a) the therapist recognises by whom and how the client is being controlled, (b) the therapist identifies the contextual circumstances of the client and how this may be impacting their experience of domestic abuse., i.e., socio-economic status, gender identity, sexual orientation, race, culture and disability; and (c) the therapist embraces and embodies feminist principles. The latter can include awareness of intersectional oppressions, honouring and celebrating women's voices, consciousness of power imbalances in both the therapeutic dyad and societally, and a commitment to social justice. Hilary Clinton said at the United Nations conference in 1995, "women's rights are human rights" (Blackmore, 2020) and the Welsh Government (2021) recognises domestic abuse as a human rights violation.

It has been suggested that psychology needs to move away from individualistic understanding of human rights which can separate the personal and the political (Gemignani & Hernández-Albújar, 2019). I argue that feminist psychotherapy provides a framework to understand and work with victim-survivors of domestic abuse and does so in a way that seeks to empower women of the rights they have been denied by their abuser.

The role of supervision in my practice is also essential in maintaining my therapeutic work, especially as I have previously experienced vicarious trauma (Smith, 2021; McCann & Pearlmann, 1990; Branson, 2018). I believe that in

order for supervision to be effective there needs to be a relational supervisory approach where the supervisor creates a safe and non-judgemental space, is trauma-informed, respects and/or shares my feminist principles. It is important, too, I am completely honest with myself and my supervisor about my work. Being self-reflective between supervision sessions is also necessary to ensure that I take time to "check-in" with myself and appraise the impact that the therapeutic work is having on my emotional and physical health (I have Myalgic Encephalomyelitis). In my own practice, this means that I have 30-minute spaces between clients and work 3-4 days a week. I also take the time to incorporate other interests including writing about psychotherapy. I see writing about psychotherapy as participating in the "multiple holding" process (Virtue & Fouché, 2010) by forging collegiate alliances and contributing to the field of trauma therapy, to the VAWDASV sector, and feminist psychotherapy.

Returning to the confusion as to the purpose of domestic abuse therapy (Roddy, 2023b), my personal stance is that the purpose of domestic abuse therapy is to create a space where the victim-survivor feels literally and emotionally safe, where they are understood, where psychoeducation is offered in uncomplicated terms, and where support with trauma symptoms can found. It is my hope that from these VAWDASV core conditions, victim-survivors can develop a sense of self-esteem, (re)connect with their autonomy and feel empowered.

Concluding Thoughts

While this article gives a brief introduction to domestic abuse, I hope that it has raised awareness of this prevalent, multifaceted and growing issue and provided a foundational knowledge base for psychotherapists working with survivors of domestic abuse.

It is also important to emphasise that although this specific field of psychotherapy can be challenging, it is also incredibly rewarding. Personally, I believe that it is an honour to be invited to witness someone's path to healing, to be trusted to listen to their stories and provide psychoeducation on domestic abuse and trauma, gently supporting the client to understand the various forms of abuse and trauma symptoms. It is vital that women learn they are not to blame for what has happened to them. As a feminist and a human rights advocate, I view my work with female and female identifying victim-survivors of domestic abuse, coercive control, and sexual violence as being connected to the history of feminism and situated in the historical legacy of female emancipation and empowerment. However, therapy does not happen in a vacuum and trauma-informed supervision, awareness of developments in both the VAWDASV sector and in feminist theory provides the support needed to work in this area and can help mitigate the challenges of working with trauma.

For psychotherapists working therapeutically with survivors of domestic abuse, a trauma-based approach is recommended with the safety stage of therapy being prioritised and psychoeducation incorporated into therapy as a means to facilitate hermeneutical justice. Working therapeutically with survivors of domestic abuse and coercive control can be a significant step toward recovery and empowerment for the survivor. The point that domestic abuse and coercive control is a human rights violation and awareness of this and the reality that coercive control can result in domestic homicide (Monckton-Smith, 2021), means that psychotherapy as a profession has a responsibility to be aware of this prevalent issue. However, as professionals, we are well placed to support survivors by offering a safe and respectful therapeutic relationship where they will be heard, valued and believed allowing them to regain power and control over their own bodies, minds and lives. Thus, psychotherapy with survivors of domestic abuse has the potential to be both psychologically healing and an act of social justice.

Support Services

Live Fear Free: Helpline: 0808 80 10 800 /Text: 07860 077333/Email info@livefearfreehelpline.wales

Mankind Initiative: Helpline: 01823 334244/Website: https://www.mankind.org.uk/

Refuge: Helpline: 0808 2000 247 /Website: Home - Refuge

Welsh Women's Aid: Home: Welsh Women's Aid (welshwomensaid.org.uk)

Women's Aid: Home - Women's Aid (womensaid.org.uk)

Women's Aid Ireland: Women's Aid - Listening. Believing. Supporting. Empowering. (womensaid.ie) / 24h National Freephone Helpline 1800 341 900

Women's Aid Federation Northern Ireland: Women's Aid Federation Northern Ireland (womensaidni.org) /24hr Domestic & Sexual Abuse Helpline, managed by Nexus NI on 0808 802 1414

Scotland's Domestic Abuse & Forced Marriage Helpline: 0800 027 1234/Email: helpline@sdafmh.org.uk

Scottish Women's Aid: Scottish Women's Aid | Changing attitudes, changing lives. (womensaid.scot)

References

American Psychological Association (2017). *Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults*. https://www.apa.org/ptsd-guideline/ptsd.pdf

Australian Government (2021). *Calling out technological tethers in coercive control.* https://www.esafety.gov.au/newsroom/blogs/calling-out-technological-tethers-coercive-control

BACP (2018). *Ethical framework for the counselling professions*. bacp-ethical-framework-for-the-counselling-professions-2018.pdf

BACP (2022). *Working with domestic abuse within the counselling profession.* https://www.bacp.co.uk/media/15492/bacp-working-with-domestic-abuse-fs-gpia116-jun22.pdf

Bisson, J. I., Roberts N. P., Andrew M., Cooper R., & Lewis C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews* 2013, Issue 12. Art. No.: CD003388. https://doi.org/10.1002/14651858.CD003388.pub4

Blackmore, E. (2020). *'Women's rights are human rights,' 25 years on*. www.nationalgeographic.com/history/article/womens-rights-human-rights-25-years-later

Blease, C. R, Lilienfeld, S. O., & Kelley, J. M. (2016). Evidence-based practice and psychological treatments: The imperatives of informed consent. *Frontiers in Psychology*, *7*(1170), 1–5. https://doi.org/10.3389/fpsyg.2016.01170

Branson, D. C. (2019). Vicarious trauma, themes in research, and terminology: A review of literature. *Traumatology*, *25*(1), 2–10. https://doi.org/10.1037/trm0000161

Choe, I. (2005). The debate over psychological debriefing for PTSD. *The New School Psychology Bulletin*, *3*(2), 71–82. https://doi.org/10.1037/e741582011-005

Chung, R. C.-Y., & Bemak, F. P. (2012). *Social justice counselling: The next steps beyond multiculturalism*. Sage.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of anti-discrimination doctrine, feminist theory and anti-racist politics. *The University of Chicago Legal Forum, 140*, 139–167.

Evans, K. M., Kincade, E. A., & Seem, S. R. (2010). *Introduction to feminist therapy: Strategies for social and individual change*. Sage.

Femicide Census (2020). *Femicide census 2020*. 010998-2020-Femicide-Report_V2.pdf (femicidecensus.org)

Finlay, L. (2015). *Relational integrative psychotherapy: Engaging process and theory in practice*. Wiley.

Fricker, M. (2007). *Epistemic injustice: Power & the ethics of knowing*. Oxford University Press.

Gemignani, M., & Hernández-Albújar, Y. (2019). Critical reflexivity and intersectionality in human rights: Toward relational and process-based conceptualizations and practices in psychology. *European Psychologist, 24*(2), 136–145. https://doi.org/10.1027/1016-9040/a000367

Greenhalgh T., Howick J., & Maskrey N. (2014). Evidence based medicine renaissance group. Evidence based medicine: A movement in crisis? *British Medical Journal*, *13*(348), 1–7. https://doi.org/10.1136/bmj.g3725

Grierson, J. (2018, March 23). Council funding for women's refuges cut by nearly £7m since 2010. https://www.theguardian.com/society/2018/mar/23/council-funding-womens-refuges-cut-since-2010-england-wales-scotland

Hameed, M., O'Doherty, L., Gilchrist, G., Tirado-Muñoz, J., Taft, A., Chondros, P., Feder G., Tan, M., & Hegarty, K. (2020). Psychological therapies for women who experience intimate partner violence. *Cochrane Database of Systematic Reviews, 7*(CD013017). https://doi.org/10.1002/14651858.CD013017.pub2

Han, H. R., Miller, H. N., Nkimbeng, M., Budhathoki, C., Mikhael, T., Rivers, E., Gray, J., Trimble, K., Chow, S., & Wilson, P. (2021). Trauma informed interventions: A systematic review. *PLoS One*, *16*(6),e0252747. https://doi.org/10.1371/journal.pone.0252747

Harmon, K. (2011). *The changing mental health aftermath of 9/11--psychological "First Aid" gains favor over debriefings.* https://www.scientificamerican.com/article/the-changing-mental-health/

Hemming, J., & Brand, B. L. (2019). Implications of the American Psychological Association's posttraumatic stress disorder treatment guideline for trauma education and training. *Psychotherapy Theory Research Practice Training*, *56*(3), 422–430. http://dx.doi.org/10.1037/pst0000237

Henrlques, G. (2018). *Debate about PTSD treatment guidelines: The APA is in conflict over PTSD treatment guidelines*. https://www.psychologytoday.com/us/blog/theory-knowledge/201802/debate-about-ptsd-treatment-guidelines

Hill-Collins, P., & Bilge, S. (2016). *Intersectionality*. Polity Press.

HM Government (2021). *The Domestic Abuse Act 2021.* https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

Herman, J. L. (2001). *Trauma and recovery: From domestic abuse to political terror.* Pandora.

Home Office (2022). *Domestic homicide reviews: Quantitative analysis of domestic homicide reviews October 2020 – September 2021*. Annex_A_DHRs_Review_Report_2020-2021.pdf (publishing.service.gov.uk)

Jordan, K. (2018). Trauma-informed counseling supervision: Something every counselor should know about. *Asia*

Pacific Journal of Counselling and Psychotherapy, *9*(2), 127–142. https://doi.org/10.1080/21507686.2018.1450274

Kaschack, E. (2016). Feminist psychotherapy. In A. Wong, M. Wickramasinghe, R. Hoogland, & N. A. Naples (Eds.), *The Wiley Blackwell encyclopedia of gender and sexuality Studies*. https://doi.org/10.1002/9781118663219.wbegss395

Kaur, R. (2020). *Home Body*. Simon & Schuster.

Links Group (2023). *About us.* https://thelinksgroup.org.uk/about-us

Mankind Initiative (2021). *Male victims of domestic abuse and partner abuse: 55 key facts.* https://www.mankind.org.uk/wp-content/uploads/2021/04/55-Key-Facts-about-Male-Victims-of-Domestic-Abuse-and-Partner-Abuse-Final-Published-April-2021.pdf

Maercker, A., Cloitre, M., Bachem, R., Schlumpf, Y. R., Khoury, B., Hitchcock, C., & Bohus, M. (2022). Complex post-traumatic stress disorder. *The Lancet*, *400*(10345), 60–72. https://doi.org/10.1016/S0140-6736(22)00821-2

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*, 131–149.

McLellan, B. (1999). The prostitution of psychotherapy: A feminist critique. *British Journal of Guidance and Counselling*, *27*(3), 325–337.

Monckton-Smith, J. (2018). *Intimate partner femicide timeline. In: UN day opposing violence against women seminar and launch of the femicide watch 2018*, 23 November 2018, Dublin. Microsoft PowerPoint - Jane Monckton Smith Powerpoint 2018 [Compatibility Mode] (glos.ac.uk)

Monckton-Smith, J. (2021). *Control: Dangerous relationships and how they end in murder.* Bloomsbury.

National Centre for Domestic Violence (ND). *Domestic abuse statistics UK*. https://www.ncdv.org.uk/domestic-abuse-statistics-uk/

NHS (2022a). *Symptoms: Post-traumatic stress disorder*. https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/symptoms/

NHS (2022b). *Complex PTSD - Post-traumatic stress disorder*. https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/complex/

Norton Mental Health (2018). *Babette Rothschild explains her new autonomic nervous system table*. https://www.youtube.com/watch?v=FfNN_DNgfng

ONS (2022a). *Domestic abuse prevalence and trends, England and Wales: Year ending March 2022*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2022#main-points

ONS (2022b). *Domestic abuse prevalence and victim characteristics*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseprevalenceandvictimcharacteristicsappendixtables

Oram, S., Khalifeh, H., & Howard, L. M (2017). Violence against women and mental health. *The Lancet Psychiatry*, *4*(2), 159–170. https://doi.org/10.1016/S2215-0366(16)30261-9

Pandya, A. (2013). A review and retrospective analysis of mental health services provided after the September 11 attacks. *The Canadian Journal of Psychiatry*, *58*(3), 128–134.

Phipps, A. (2020). *Me not you: The trouble with mainstream feminism*. Manchester University Press.

PTSD UK (2023). *Causes of PTSD: Domestic Abuse*. https://www.ptsduk.org/what-is-ptsd/causes-of-ptsd/domestic-abuse/

Rape Crisis England & Wales (ND). *The 5 Fs: Fight, flight, freeze, flop and friend*. https://rapecrisis.org.uk/get-help/tools-for-victims-and-survivors/understanding-your-response/fight-or-flight/

Roberts, K. (2016). *The psychology of victim blaming*. https://www.theatlantic.com/science/archive/2016/10/the-psychology-of-victim-blaming/502661/

Roddy, J. (2023a). Introduction. In J. Roddy (Ed.), *Working with client experiences of domestic abuse: A handbook for counsellors, psychotherapists, and other mental health professionals* (pp. 1–6). Routledge.

Roddy, J. (2023b). A model of therapeutic practice. In J. Roddy (Ed.). *Working with client experiences of domestic abuse: A handbook for counsellors, psychotherapists, and other mental health professionals* (pp. 7–21). Routledge.

Rogers-Sirin, L. (2017). Psychotherapy from the margins: How the pressure to adopt evidence-based treatments conflicts with social justice orientated practice. *Journal for Social Justice Action in Counselling and Psychology*, *9*(1), 55–78. https://doi.org/10.33043/JSACP.9.1.55-78

Ross, L. R., & Lovrod, M. (2010). Negotiating social complexities in counselling practice. In L. R. Ross (Ed.), *Feminist counselling: Theory, issues and practice* (pp. 1–21). Women's Press.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* W. W. Norton & Company.

Rothschild, B., & Rand, M. (2006). *Help for the helper: Self-care strategies for managing burnout and stress.* W. W. Norton & Company.

Rothschild, B. (2011). *Trauma essentials: The go-to guide.* W. W. Norton and Company.

Rothschild, B. (2017). *The body remembers volume 2: Revolutionizing trauma treatment.* W. W. Norton & Company.

Sanderson, C. (2013). *Counselling skills for working with trauma: Healing from child sexual abuse, sexual violence and domestic abuse*. Jessica Kingsley Publishers.

Senn, C. Y. (2010). Male violence against women and girls: What counsellors need to know to begin their work with women. In L. R. Ross (Ed.), *Feminist counselling: Theory, issues and practice* (pp. 77–100). Women's Press.

Sesan, R., & Katzman, M. (1998). Empowerment and the eating-disordered client. In I. B. Seu & M. C. Heenan (Eds.), *Feminism & psychotherapy: Reflections on contemporary practices* (pp. 78–76). Sage.

Sharp-Jefferies, N. (2021). *New laws to protect victims added to Domestic Abuse Bill.* https://www.gov.uk/government/news/new-laws-to-protect-victims-added-to-domestic-abuse-bill

Smith, R. (2021). The emotional impact of research: A reflexive account of a counsellor-turned-PhD researcher's experience of vicarious trauma and its impact on the research process. *European Journal for Qualitative Research in Psychotherapy*, *11*, 22–32.

Spearman, K. J., Hardesty, J. L., & Campbell, J. (2022). Post-separation abuse: A concept analysis. *Journal of Advanced Nursing*, *00*, 1–22. https://doi.org/10.1111/jan.15310

Stark, E. (2007). *Coercive control: How men entrap women in personal life*. Oxford University Press.

Storer, H. L., Rodriguez, M., & Franklin, R. (2021). "Leaving was a process, not an event": The lived experience of dating and domestic violence in 140 characters. *Journal of Interpersonal Violence*, *36*(11–12), NP6553–NP6580. https://doi.org/10.1177/0886260518816325

Surviving Economic Abuse (2023). *What is economic abuse?* https://survivingeconomicabuse.org/what-is-economic-abuse/

Taylor, N., & Fraser, H. (2019). *Companion animals and domestic violence: Rescuing me, rescuing you.* Palgrave Macmillan.

The Duluth Model (2017). *Wheel information center*. https://www.theduluthmodel.org/wheels/

The Cochrane Collaboration (2023). *About us.* https://www.cochrane.org/

The Welsh Government (2021). V*iolence against women, domestic abuse and sexual violence: National advisers annual plan 2021 to 2022*. https://www.gov.wales/sites/default/files/pdf-versions/2021/1/1/1610972790/violence-against-women-domestic-abuse-and-sexual-violence-national-advisers-annual-plan-2021-2022.pdf

University of Gloucestershire (2019). *Homicide timeline: 8 stages.* https://www.youtube.com/watch?v=lPF_p3ZwLh8

van Emmerick, A. A. P., Kamphuis, J. H., Hulsbosch, A. M., & Emmelkamp, P. M. G. (2002). Single session debriefing after psychological trauma: A meta-analysis. *The Lancet*, *360*(9335), 766–771. https://doi.org/10.1016/S0140-6736(02)09897-5

Vetere, A. (2017). Supervision and domestic violence: Therapy with individuals, couples and families. In A. Vetere, & J. Sheehan (Eds.), *Supervision of family therapy and systemic practice* (pp. 163–172). Springer International Publishing.

Vignaud, P., Lavallé, L., Brunelin, J., & Prieto, N. (2022). Are psychological debriefing groups after a potential traumatic event suitable to prevent the symptoms of PTSD? *Psychiatry Research, 311*(114503). https://doi.org/10.1016/j.psychres.2022.114503

Virtue, C., & Fouché, C. (2009). Multiple holding: A model for supervision in the context of trauma and abuse. *Aotearoa New Zealand Social Work*, *21*(4), 64–72. https://doi.org/10.11157/anzswj-vol21iss4id262

Wakeham, M. (2021). *Animal abuse as a strategy of coercive control.* [Doctoral Thesis, University of Bristol] https://research-information.bris.ac.uk/en/studentTheses/animal-abuse-as-a-strategy-of-coercive-control

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

Watkins, L. E, Sprang, K. R, & Rothbaum, B. O. (2018). Treating PTSD: A review of evidence-based psychotherapy interventions. *Frontiers in Behavioral Neuroscience*, *12*, 258. https://doi.org/10.3389/fnbeh.2018.00258

Welsh Women's Aid (2023a). *What is domestic abuse?* https://welshwomensaid.org.uk/information-support/what-is-domestic-abuse/

Welsh Women's Aid (2023b). *What is coercive control?* https://welshwomensaid.org.uk/information-support/what-is-coercive-control/

Wheeler, S., & Richards, K. (2007). *The impact of clinical supervision on counsellors and therapists, their practice and their clients.* https://www.bacp.co.uk/media/1982/bacp-impact-clinical-supervision-on-counsellors-therapists-practice-and-clients-systematic-review.pdf

Woodlock, D., McKenzie, M., Western, D., & Harris, B. (2020). Technology as a weapon in domestic violence: Responding to digital coercive control. *Australian Social Work*, *73*(3), 368–380. https://doi.org/10.1080/0312407X.2019.1607510

Women's Aid (2022). *What is domestic abuse?* https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/

Women's Aid (2023a). *The domestic abuse report 2023: The annual audit*. Annual-Audit-2023-Briefing-FINAL-1.pdf (womensaid.org.uk)

Women's Aid (2023b). *The domestic abuse report 2023: The annual audit*. The-Domestic-Abuse-Report-2023-The-Annual-Audit-FINAL.pdf (womensaid.org.uk)

Zayfert, C., & Black Becker, C. (2020). *Cognitive behavioural therapy for PTSD: A case study formulation* (2nd ed.). The Guilford Press.

About the Author

Dr Ruth Smith lives in South Wales and has undergraduate and postgraduate degrees in counselling and psychotherapy and a PhD in Social Justice. Her PhD research focused on white trainee counsellors' racial cognisance. Ruth's research interests are socio-politics and social justice, particularly how these intersect with counselling and psychotherapy. Ruth has worked as a therapist with survivors of trauma, including survivors of war, torture and human trafficking. She now works in private practice, specialising in working with survivors of domestic abuse, coercive control and sexual violence. She has published articles relating to: the socio-politics of therapy, feminism and self-care, her original concept of "The myth of the good white counsellor," book reviews and a reflexive exploration of vicarious traumatisation. Ruth can be contacted via her website: dr-ruthsmith.co.uk.