

Inside the Clinician's Mind: Understanding the Counseling Process When Working with
Survivors of Domestic Violence

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Abstract

The present study examined helping professionals' perspectives concerning the issues of domestic violence in the counseling profession, including best practices for treating the population, the needs of the population, counselor training, difficulties in treating these clients, and counselor self-care. The rigorous nature of a counseling graduate program does not often allot extensive training in treating domestic violence victims. It is necessary to consider the perspectives of those clinicians who work directly with domestic violence when working with this population given that evidence-based practices are sparse. This qualitative study analyzed findings derived from individual, semi-structured interviews with ten clinicians. Findings produced several major domains including: the significant role of counselor as self, how the counselor lens impacts client work, and the degree to which clinicians are underprepared and to which clients are underserved. The findings of this study are salient in informing future research in domestic violence and the training required to treat this population.

Keywords: domestic violence, intimate partner violence, counseling, counselor education, self-care, evidence-based practices, and clinician perspectives

Introduction

The Centers for Disease Control and Prevention define intimate partner violence (IPV) as physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner (2016). Approximately 10 million men and women are physically abused by an intimate partner per year (National Coalition Against Domestic Violence, (2015). This results in about 20 people per minute who are physically abused by an intimate partner and more than 20,000 phone calls to domestic violence (DV) hotlines nationwide per day (National Coalition Against Domestic Violence, 2015). If untreated, victims of domestic violence may suffer from adverse effects, including post traumatic stress disorder (PTSD), substance use disorders, anxiety disorders, and similar disorders (Orzeck, 2010; Hogan, Hegarty, Ward, & Dodd, 2012). Current research explores the mind of the IPV and DV survivor and their experiences of traumatization; however, there is little research on clinician experience in working with these populations (Ben-Porat, & Itzhaky, 2009). The research that does exist suggests that in treating this population, clinicians are likely to experience secondary or vicarious traumatization, which refers to the behavioral and emotional consequences of exposure to traumatic events, such as stress (Ben-Porat, & Itzhaky, 2009, p.507). Secondary and vicarious traumatization can result in negative effects for the counselor, including countertransference; over-identification; and a sense of helplessness, inundation, and despair (Ben-Porat, & Itzhaky, 2009). While counselor educators emphasize self-care, counselors and mental health professionals working with this population may not have the resources or established self-care practices necessary to avoid secondary and vicarious traumatization.

In addition to limited research, there is also a lack of training and evidence-based practices. Kress, Protivnak, and Sadlak (2008) conducted a study in which 50% of American

Mental Health Counselor Association members reported no training for treating IPV or DV populations within their graduate programs, while 78% of those who did receive training reported it as inadequate. Further, there is outdated research on evidence-based practices (EBP's) for treating those within the populations, other than recent studies on advocacy, empowerment, government involvement, and trauma-based interventions (Song, 2015; Hughes, & Rasmussen, 2010; Kress et al., 2008; Harris 2006). As IPV and DV remain prevalent, it is essential that mental health professionals understand appropriate treatment options available to them. Additionally, they must be able to receive training regarding said treatment options as well as proper self-care techniques. The present study provides a unique perspective and seeks to explore better practice and preparation for working with IPV and DV populations and the appropriate self-care methods for clinicians doing so.

DV and IPV

The research on DV and IPV does provide practitioners and counselor educators with information on the unique needs of the population and the importance of serving this population. According to Orzeck, Rokach, and Chin (2010), the “traumas of human design,” i.e. intentional malicious acts as opposed to external forces (e.g. natural disasters), can have extreme psychological effects on the victim or survivor of the trauma, including characteristics such as low self-esteem, anxiety, self-blame, and denial” (p.168). Studies have identified psychological, relationship, and societal influences on a woman’s decision to stay in an abusive relationship, including financial reasons, lack of empowerment, pressure from the family, and more (Hays, Green, Orr, & Flowers, 2007; McDonough, 2010; Orozco, Nievar, & Middlemiss, 2012; Song, 2015). McDonough’s (2010) quantitative study investigated the decision-making processes for both women in an abusive relationship and those who were not. The study indicated that women

who were battered and those who had not been battered both claimed that they would not stay in an abusive relationship, which McDonough concluded to be due to both groups of women being “thrust into an intellectual exercise” (p.180) rather than put into the actual situation of being battered. It is assumed that most women would self-report this as it is “socially desirable” (p.181) to leave a relationship should it become violent; however, previous research suggests discrepancies between self-reporting and actual behavior. Those who have been battered and abused are more likely to develop a substance abuse disorder, PTSD, anxiety, depression, and other similar disorders, with likelihood increasing over time (Alani & Stroink, 2015; Hogan, Hegarty, Ward, & Dodd, 2012; Orzeck et al., 2010; Godfrey, 2007; Hays, Green, Orr, & Flowers, 2007). These individuals are also apt to feeling shame, guilt, self-blame, isolation, loss of self-esteem, insomnia, dissociative features, and denial; these symptoms can evolve into depression, anxiety, and PTSD (Hogan et al., 2012; Orzeck et al., 2010; Hays et al., 2007). These issues are enough to decrease self-esteem and make one believe that they will be alone if they exit the relationship, thus, increasing not only the likelihood of the battered remaining in the relationship but also the risk of long-term psychological effects. Because battered women often do experience feelings of denial, they may not view their relationship as abusive.

Commonly, the word “victim” may arise from admitting to the abuse that one is experiencing. This frequently causes the public image of the woman to shift from that of a whole and functional person to a “tainted” (p.6), modification of a whole person instead (Dunn, 2005). When a woman does choose to confront the idea of being a victim of abuse, the options for treatment are often limited. A woman might enter a shelter, where she can receive legal, housing, and other services. However, after leaving the shelter, where does a woman go to recover from the trauma this relationship has caused? It is essential that counselors be adequately equipped to

treat a client who has disclosed abuse in a current or past relationship. Contextual factors must be considered in treating those within the population, including religion, culture, family values or familism, socioeconomic status, and geographical context (Orozco, Nievar, & Middlemiss, 2012).

There is little research on best practices that target violent relationships specifically, however, studies have shown that group therapy, cognitive behavioral therapy, advocacy counseling (empowerment strategies), motivational interviewing, and other intervention programs are useful in treating victims within shelters, in the relationship, and out of the relationship (Hays et al., 2007; Lawson & Brossart, 2009; Hughes, & Rasmussen, 2010; Lothstein, 2010; Johnson & Zlotnick, 2011; Binkley, 2013; Graham-Bermann & Miller, 2013; Hansen, Erikson, & Elklit, 2014; Song, 2015). In a qualitative study conducted by Godfrey (2007), four steps in treating a client were identified by a counselor working with IPV. The research indicated that counselors must first affirm the client's feelings and experiences; assess what type of abuse is occurring, how severe, etc.; document each step that is taken by the counselor and the client; and, if one is unable to effectively treat the client, they must refer to someone who can.

The present study fills a much-needed gap in the literature by examining helping professionals' experiences with treating, training, and self-care. In a graduate training program, the focus of training is on general practice; while training in areas of specialty (e.g. domestic violence) is not extensive (Henriksen, Nelson, & Watts, 2010). Counselors who wish to specialize in treating domestic violence issues are often not prepared to treat these issues directly out of their graduate program, therefore, it is necessary to receive additional training (Henriksen, Nelson, & Watts, 2010). Further, those who are perceived as being prepared by other

practitioners have received specialized training, which is not readily available to all counseling professionals. Counselors who do not receive training in treating DV and IPV and continue to treat this population brings up ethical considerations, as these counselors are practicing outside of their professional expertise (Council for Accreditation of Counseling and Related Educational Programs, 2014). This becomes an issue as all clients should receive treatment that is relevant and effective for the concerns they are presenting with. In Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited programs, for example, counselors in training must receive training outside of the core courses, including chemical dependency, crisis intervention, and more (Council for Accreditation of Counseling and Related Educational Programs, 2014).

Henriksen et al. (2010) surveyed program directors and department chairs from 20 CACREP accredited counseling programs, which train students to become licensed professional counselors. Results showed that domestic violence coursework was only offered in one program, in which it was required to receive education on treating victims, survivors, and batterers (Henrikson et al., 2010). Thirteen of the programs said that domestic violence was addressed in other courses; however, six of the universities reported that they were adding courses to address sexuality issues and domestic violence. Though this was based on a small sample in one state, it could suggest that counselors in training are being only minimally exposed to issues that they will likely encounter with future clients. Those universities that recognize this lax in training are attempting to fill this gap for their students, but it is unknown if other programs of similarity are as well. Counselors may lack knowledge of community resources, detection of abuse, dynamics, effects, and relevant clinical skills due to minimal training (Henrikson et al., 2010; Hays, Green, Orr, & Flowers, 2007).

Furthermore, there has not been extensive research conducted on the impact that working with DV and IPV victims may have on the counseling professional (Hogan, et. al, 2012). Studies that have addressed this impact have concluded that counselors may suffer from vicarious trauma, burnout, and changes in cognitive schemas regarding their safety, world-view, and gender power issues. Hogan et. al (2012) studied counselors' experiences in working with male victims of female-perpetrated violence, which resulted in several themes relevant to the present study, including: "I needed my supervision to help me stay upright," "keeping yourself safe," and "I rely much more on experience" (p.6). These three themes discuss supervision for internalized values, coping strategies to avoid burnout, and the helpfulness of training and experience. Counselor self-care is also an issue that is addressed in counselor training programs. However, it remains an area that can easily be expanded upon when educating future counselors.

Theoretical Framework

This study utilizes a phenomenological qualitative approach to explore clinicians' experiences in working with clients who experience domestic violence and intimate partner violence. For the purposes of this study, clinicians are defined as professionals providing direct counseling services to clients (mental health counselors, social workers, and psychologists). A phenomenological study involves conducting interviews with participants who have experienced a similar phenomenon in order to capture individual experiences related to the phenomena, and to identify themes (Carpenter, 2016). Interviews were recorded, transcribed, and then analyzed for emergent themes. Rerouting from a traditional phenomenological approach involving analysis without theoretical constraint, emergent themes were compared to one another for overarching themes (Carpenter, 2016).

Trustworthiness

The researchers began by discussing preconceived assumptions about the population in order to bracket these perceptions and approach the topic with a clear mind (Moustakas, 1994). To ensure credibility of data, several precautions were taken during the collection and analysis process. Prior to analyzing research, participants were given the opportunity to review the transcript from their interview to make certain that there were no mistakes, and that the transcriptions matched what they stated. Next, participant's statements were analyzed and assigned codes that closely represented their statements, from which all data was coded. Coding was double checked by two non-participants within the counseling profession, including a professor of counseling and a clinical mental health counselor. Upon completing coding and analysis of emergent and overarching themes, an outside party (a mental health counselor and doctoral student) as well as the researcher reviewed data for consistency.

Methods

The study included ten participants recruited through snowball sampling. Appendix A includes relevant demographic information on the participants. The participants were working in two different states in the Northeast. Nine participants were female, one participant was male, and all participants identified as White. Five participants were licensed professional counselors, three were licensed clinical social workers, and two were licensed psychologists. All participants were sent an informed consent by the researchers, including a list of 15 questions (see Appendix B) that would be asked during the interview. Once informed consent was signed, all participants were interviewed in person or over the phone using an audio recording app called TapeACall. Interviews were semi-structured individual interviews, in which participants were asked the 15 questions included with the informed consent, as well as any follow-up questions that came up as

relevant during the interview. All interviews were recorded, during which participants gave verbal recorded consent for recording, and then were verbatim transcribed. The researcher then sent final transcriptions to participants to confirm that transcriptions were accurate and to give participants an opportunity to add material.

Data Analysis

Transcriptions were reviewed using qualitative analysis. First, the researcher conducted line-by-line coding. Transcriptions and initial codes were checked by two of the researcher's colleagues for consistency and accuracy. Initial codes were then clustered into categories, removing irrelevant statements and highlighting significant statements. Codes were kept in a separate document until the 3 major domains emerged, which include counselor as self, counselor lens, and underprepared and underserved. Data analysis concluded by determining major themes and subthemes, as outlined in the results section.

Findings

After careful review and analysis, three interrelated major domains were identified in this study: 1) Counselor as self (n=10); 2) Counselor lens (n=9); and 3) Underprepared and Underserved (n=10). The researcher identified subthemes within each major domain (as seen in Table 1. Findings: Domains and Subthemes). The counselor as self domain contains subthemes including a) self care while doing this work, and importance of resolution of past trauma prior to doing this work, and b) what the counselor brings as self, e.g. individual characteristics. Counselors lens domain contains a) assumptions about client drive and its impact on the treatment process, and b) direct intervention is essential. Underprepared and underserved includes a) lack of training/on the ground learning, and b) supervision as an essential.

Table 1. Findings: Domains and Subthemes		
Domain 1: <i>Counselor as self</i>	Domain 2: <i>Counselor lens</i>	Domain 3: <i>Underprepared and Underserved</i>
Subtheme A: <i>self care while doing this work, and importance of resolution of past trauma prior to doing this work</i>	Subtheme A: <i>assumptions about client drive and its impact on the treatment process</i>	Subtheme A: lack of training/on the ground learning
Subtheme B: <i>what the counselor brings as self</i>	Subtheme B: <i>direct intervention is essential</i>	Subtheme B: supervision is essential

The first domain, *counselor as self* can be defined as what the counselor brings, i.e., “I bring myself to this.” Counselor as self includes the individual characteristics of the counselor, the personal history of trauma and recovery, as well as the personal belief system. Participants discussed the element of self-care as a major component in treating this population (n=6). They expressed the need to resolve past trauma and the ability to balance their personal life with their professional life so as to avoid overlap and burnout. Trauma is perceived as being “cyclical” and the need to utilize one’s own counselor, prioritize their personal life, and to seek supervision was emphasized throughout these six participants’ responses. For example, Michael says, “I think that one of the most important things you can do is to make sure you work that stuff out.

Whatever it is. Because the nature of trauma is that it's often very cyclical. I think probably the most important thing is that your own mental health is in check." Participants who currently work at domestic violence shelters explained the requirements of workers in the shelter, e.g. Shannon says, "there's training for them so they can recognize when they've been traumatized and they can get the support that they need"; Jane explains, "if somebody wants to volunteer for us, we always say they have to have been out of a domestic abuse relationship, and out of treatment for it for a year." Others discuss the importance in balance and resolution for themselves: Michael – "being able to kind of decompose, hear a truly horrendous, awful story, and not have a breakdown about it is often some of the hardest stuff about this work... I think probably the most important thing is that your own mental health is in check."; Emma – "I have to know what's my max number. Otherwise, you know for me in a week is about 25 clients... no 2 trauma, serious patients in a row. More than that, I'm not at a good capacity to give the most I can give to them."; Nicole – "...even outside of all the clinical pieces, make sure you're seeing friends on the weekend or you're with your partner... you also need that time to have fun and be able to release everything. Otherwise it can weigh so heavy on you that eventually you need treatment... we never want anyone to get to that place."

The second subtheme in the counselor self domain is what the counselor brings as self. Participants offered the idea of their personal belief systems and personality as an important part of this work (n=5). Michael – "You've got to have a person who has the ability to make good clinical judgment and also be present, empathetic, be able to hold the space and the feelings... I truly believe that to some degree it is about the person as much as it is about the education... What I can't reinforce enough is the relationship piece and I strongly note that every time I

forget this I am happily reminded by a client that above all else, and there is research to demonstrate it, it is the relationship that heals.”

Others expressed the belief that the type of licensure has little to do with success in treating this population. Counselors, social workers, and psychologists have different types of training; however, treatment success is based more on the individual, how interested they were in working with the population, and their history of personal abuse. Jen, a counselor in a domestic violence shelter, says, “I think that a lot of people that are drawn to the field of domestic violence have been touched by it in some way... domestic violence is one of those things that you don't just go to work and you're in a factory, you have to really believe in the principles, the philosophies, and you have to believe in having healthy relationships and respect,” she continues, “You really have to walk the walk and be able to practice what you preach.” Each participant discussed their personal beliefs on why people abuse and what the clients who are abused need in treatment. These opinions are impacted not only by education and training, but also by personal experience. One can conclude that the counselor's personal experiences and who they are as a person can impact success in treatment. The ability to form a healthy relationship with a client who may otherwise not know how is an essential piece of treatment that must be demonstrated to the client. This process allows the client to observe the formation of a healthy relationship and grow to trust and exercise their own ability to form healthy relationships outside of the client-counselor interaction.

The second domain, *the counselor lens* (n=10) is the way in which the counselor perceives the situation, the client and their abuse, and what is important in treatment. One way to view this domain is by conceptualizing the counselor as the expert on what is happening (i.e. insight), and knowing what is best for the client in treatment. There are different perspectives on

why people abuse, which can be impacted by the counselor's training and what they are bringing to the table as an individual. Participants discussed their assumptions about clients' beliefs, which impacts the process of treatment (n=5). Essentially, several ideas are pieced together, the first being the beliefs about the development of abusive behavior: Mary - "they are struggling with controlling their internal stressors, which means they easily blame their victims"; Shannon - "all batterers just want to go back to sleep, not look at it, not face it... these patterns take a really long time to develop, they usually come when people come out of a trauma background"; Emma - "I've had kids who have been sexually molested and then, themselves begin to go through puberty and feel urges... so some I've found it runs back as far as childhood, being told they were never good enough"; Sue - "this is coming from a deep well of insecurity... they're trying to manage their outer environment because their insides can't handle it."

Commonly, counseling professionals believe that abusers are intelligent and often "cherry-pick" (Emma) their victims and that these women do not establish a "walk away point" (Mary, Michael) at the beginning of the relationship, which is essential in ending the abusive relationship. Nicole says, "The abusers are also very smart... They look purposely for people with low self-esteem. They'll alienate people from their families and they'll do it little by little so that at first, the victim doesn't even realize that it's going on and then by the time they're sort of ensnared in the web, it's sort of too late to get out." Shannon says, "Perpetrators are at the necks of being both abusers and trauma survivors and almost every single one of them is a survivor of trauma, not every one but many." She believes the cure to violence is treating not only the victims, but also the abusers, as abusers are often victims themselves: "Because who are they? Why did they become like this? How did they get so distorted and how were they wounded? You

know, this is not how people should be..." This type of trauma is cyclical, not only within the counselor to client relationship but within the abuser and the victim.

Why do you stay? What are you afraid of? The answers to these questions may vary from client to client, however, there are several ideas that all of the participants agreed upon. The client's fears may vary depending on the levels of abuse within the relationship, anywhere from "I am afraid that he will kill me," to "I am afraid of being alone." Shannon envelops most of these fears in her explanation:

There are so many reasons why it's hard for victims to leave an abusive relationship and that they really hold onto hope. Or they feel like it's wrong to break up the relationship or they have religious beliefs or there's children or there's financial dependency. She's afraid that if she leaves, what will people think of her? She's afraid if she leaves, she's breaking up her family, she'll damage her children, you know she's gonna disappoint everybody. She's afraid if she leaves, he'll stalk her, he'll never leave her alone, and he'll come after her. She's afraid if she leaves, he'll kill her. 'I'm afraid of being alone, I'm afraid no one will ever love me, I'm afraid that I'm a failure, I'm afraid that I'm unlovable, I'm afraid I won't survive, I won't have enough money.

The aforementioned fears are ones that all participants claimed to have encountered (n=10). In considering the various fears mentioned above, a counselor might tailor their treatment to provide insight, empowerment, and resources to the client. A counselor must also consider the client's beliefs about their control in the relationship: Does the client believe they can change their partner? Do they believe they have no control at all and they are "resigned" to the control of the abuser? Conversely, these counseling professionals have stated that they believe the client's sense of control is actually a "false sense of control" that originates from the

client's self-blame. They believe they can control the abuse because they believe it is their fault.

Participants discussed their perceptions of the client's control in the relationship (n=9); Gina

says:

It's one thing to work with somebody that sees it for what it is and even if they're scared, they want to leave. It's a whole nother story when she's still minimizing and doesn't see it the way we see it, so those are two totally different clients to work with. So I think it's as far as some women know they're being controlled and some people just don't identify it as that, they see it as something completely different, it's at their own level of minimization. It's almost like being in a cult, you know, where this guy is able to manipulate and have such an extensive level of power and control that they're able to convince them of whatever it is that they want to and then you throw in all those elements of fear and everything else that's going on in the relationship that the victim sees the situation very differently than how we might see it and as the counselor or the person potentially intervening it's a delicate dance.

These beliefs on self-blame and control inform the counselor's process in treatment, which ties into the second subtheme: direct intervention is essential (n=9). Direct intervention will be described as the use of directive counseling techniques such as insight treatment, safety planning, and teaching. Participants discuss the need to provide insight to victims. However, in providing insight, one must understand the facets of the abusive relationship through training and education. The clinician has the ability to act as the expert in treatment, and participants discuss the importance of safety planning as a first step (n=5). Mary discusses the idea of insight and safety planning in a combined manner, while emphasizing the importance of knowledge on the topic within the third domain:

I thought the woman was paranoid. She's telling me my house is bugged, my car is bugged, I know he's following me. Well, when he was deposed as part of the divorce proceedings, he was under oath, so he had to admit to all of it. It was all true. Treating the victims, it's getting them to look at the pattern of behavior that got them to where they were. So that then they can make the decisions that make the most sense and helping them to understand the importance of a safety plan so that because we had developed a safety plan, she was able to activate her safety plan and get herself and her children out of the house. Had she not had the safety plan, she would've been missing the money she needed, the place to go, the evidence of the abuse would've still been in the house rather than in the hands of a friend in another state. But because we had developed a safety plan, she was able to implement it.

The third major domain, *underprepared and underserved*, is the central idea that these professionals felt as though they were not prepared to treat this population after recently completing their graduate programs. This was true across participants, regardless of licensure, while many participants claimed that licensure is not as important as experience and the individual. The first subtheme is lack of training and on the ground learning. Participating clinicians responded in regards to training within their graduate program and overall preparedness without further training on domestic violence treatment (n=8). Shannon says, "I mean, you do your best, you know you do as much as you can. I don't think any graduate program, no matter how good, can, I mean, you just get your foundation and then the most important thing is doing the work and having good supervision it's like that is like essential." Here, she also mentions the importance of supervision. Supervision is essential (n=5). Supervision and consultation were a cornerstone of these participants' training experiences, as

those who were more experienced in the field seemed to 'have the answers' when new clinicians did not. "I think until you can actually get out and start working with clients and understand that this is the population you want to work with and you have to go to more training and do more research and have great supervision. I don't think people are prepared coming out of school for this...even when you're done with supervision, you still stay in contact with your supervisor, have other colleagues in the practice for consultation that you can talk to," says Nicole, a clinical mental health counselor who owns her own practice. The information given within these three major domains may be helpful to counseling students, counseling professionals, as well as counselor educators.

Discussion

The foregoing three major domains and six subthemes include: 1) **Counselor as self** (n=10): a) self care while doing this work, and importance of resolution of past trauma prior to doing this work, b) what the counselor brings as self; 2) **Counselor lens** (n=9): a) assumptions about client drive and its impact on the treatment process, b) direct intervention is essential; and 3) **Underprepared and Underserved** (n=10): a) lack of training/on the ground learning, b) supervision is essential. As mentioned previously, these major domains and their subthemes are interrelated. For example, if a counselor has experienced domestic violence in the past, resolved or otherwise, they may view the clients' issues differently than a counselor who has not experienced domestic violence first hand.

Limitations of this study include gender of participants, ethnicity and race, and the use of snowball sampling. While nine out of ten participants were female, the male perspective was much different than the female. Michael described his gender as being advantageous in some respects while treating this population, i.e. clients are able to understand that it is possible to

form a meaningful and healthy relationship with a male. Further exploration of gender roles within the counseling relationship may shed light on meaningful differences in the clinician's experiences. Ethnicity and race of participants are a major limitation, as culturally diverse clinicians may have different, and vital, experiences and perceptions when working with this population. Furthermore, as with other qualitative studies, the number of participants serves to give us an in-depth look at emergent themes, but it may not serve well to generalize to a larger population. The above limitations should be explored in future study to further expose the struggles of clients and clinicians in treatment for domestic violence.

All participants discussed a lack of training and even knowledge on the topic of domestic violence. As a prominent issue, it is essential that counseling professionals are equipped with fundamental knowledge and understanding of these clients' experiences, perceptions, and options, rather than being thrown into a "sink or swim" condition. These types of conditions combined with lack of knowledge and training can put a client at risk for further harm than they are already experiencing. A participant claimed that they took an optional course on treating the population during their counselor-training program (n=1), while the other participants had minimal exposure to information about the issue as well as methods of treating clients (n=9). Counselor training programs may begin to take necessary steps in providing professional development opportunities for students to expand their knowledge in treating specific issues and populations.

This study shed light on the significant lack of evidence-based practices and interventions in treating this population as well as the use of a counselor's personal belief system to guide their work (i.e., how the therapist thinks insight will occur). Counseling professionals agreed on insight as treatment as well as the use of safety planning; however, there were a variety of

practices being used, none of which have been proven to work best in targeting the population's problem specific issues. The American Counseling Association Code of Ethics requires counselors to practice "only within the boundaries of their competence, based on their education, training, supervised experience, and appropriate professional experience"; "counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience" (American Counseling Association, 2014, p.8). Thus, counselors in training and counseling professionals should seek domestic violence training if there is a desire to work with this population. Further, it is necessary that interventions be researched in future studies to provide clients with evidence-based practices that will be more likely to ensure their success in treatment.

Practitioners in this field experience secondary trauma even more so than with other client populations. In treating this population, they are exposed to accounts of trauma they would otherwise never encounter. This exposure has potential to cause a number of reactions that adversely impact their well-being and subsequently their work. There is a common thread of self-care throughout participants' discussions of secondary trauma. Participants recommended setting boundaries such as limiting trauma caseload, taking steps to preserve one's social and family life, staying active and healthy. Self-care is emphasized in counselor training programs; however, it is important for professionals to not only acknowledge the importance of self-care but practice it regularly. This may occur with appropriate supervision and training. If practitioners are not exposed to necessary information for treating this population during a graduate program, it may be necessary to seek out information and training elsewhere. Several of the participants received such training independently.

Clients within this particular population are already at risk for a number of injurious experiences. When not properly informed of or trained in regards to domestic violence, counselors risk creating additional distressing experiences for this population. These implications, like the major domains, are also interrelated. A client may have difficulties returning to or developing a healthy lifestyle if the counselor is not in a healthy mental or physical state due to lack of self care, knowledge, and supervision. It is suggested that counseling programs take action in training future counselors in treatment of domestic violence victims and that counseling professionals maintain their own mental and physical health so that clients are receiving optimal care.

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Table 1. Findings: Domains and Subthemes		
Domain 1: <i>Counselor as self</i>	Domain 2: <i>Counselor lens</i>	Domain 3: <i>Underprepared and Underserved</i>
Subtheme A: <i>self care while doing this work, and importance of resolution of past trauma prior to doing this work</i>	Subtheme A: <i>assumptions about client drive and its impact on the treatment process</i>	Subtheme A: lack of training/on the ground learning
Subtheme B: <i>what the counselor brings as self</i>	Subtheme B: <i>direct intervention is essential</i>	Subtheme B: supervision is essential

Appendix A

Participant Demographics

Name	Gender	Years of Experience	Race	Ethnicity	Occupation
Mary	Female	30+	White	Caucasian	Psychologist
Michael	Male	4	White	Caucasian	LPC
Shannon	Female	20+	White	Caucasian	LCSW
Jane	Female	16	White	Caucasian	LCSW
Emma	Female	7	White	Caucasian	LPC
Sue	Female	20	White	Caucasian	LCSW
Brenda	Female	6	White	Caucasian	Psychologist
Nicole	Female	8	White	Caucasian	LPC
Gina	Female	10	White	Caucasian	LPC
Jen	Female	20	White	Caucasian	LPC

Appendix B

Interview Questions

Background question: Can you tell me about your educational and professional background?

What brought you to pursue your current position?

What interested you in this population?

Please give me a general overview of your client population.

What are the needs of this population?

What is the most challenging part of your work? On a personal level? In treating clients?

Are there specific theories or skills that work best in treating this group?

Based on your experience, do you think that counselors are adequately prepared for treating these clients and do others perceive counselors as being prepared? Please expand.

OR

Based on your experience, are licensed professional counselors adequately prepared in comparison to social workers in working with this population? Psychologists?

What have you noticed about hiring potential in working with this population based on competition with others in the mental health profession?

How are you uniquely able to serve this population, as a licensed professional counselor?

How and where did you receive training for treating those in this population?

From your perspective – as the counselor – what do you think clients think about their control over the abuser?

From your perspective – as the counselor – what do you think clients are most afraid of in DV and IPV relationships?