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A competency framework for domestic violence counselling

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A competency framework for domestic violence counselling

Abstract

Domestic violence (DV) affects around 20% of the population globally and is linked with complex mental health conditions and difficulties in client therapeutic engagement. Developing therapeutic competency to meet the standards for independent, professional practice is a significant part of counsellor training. A competency framework for DV is a useful addition to the literature. This framework has been systematically developed from a client informed DV counselling model (grounded theory) and integrates well with existing international publications. It highlights high level and wide-ranging counselling skills, specialist knowledge and specific personal characteristics for working with this client group, beyond the level required for independent practice. This framework could be used as a basis for pre- and post-qualification counsellor training, recruitment and assessment.

Key words: *domestic violence, counsellor competencies, counselling training curriculum, counselling skills, counsellor characteristics*

A competency framework for domestic violence counselling

Introduction

Research into the causes, prevalence and impact of domestic violence (DV) has been undertaken globally over the last 50 years and has provided a significant body of literature highlighting the potential for physical violence to cause serious physical or emotional harm, or death (at the hands of the abuser or by suicide) (Walker, 1979; Dutton, 1992; McLaughlin, O'Carroll & O'Connor, 2012; Hines & Douglas, 2015). More recently, the UK government's definition of DV (Home Office, 2012) has been widened to include psychological and emotional abuse, and coercive and controlling behaviours. These types of abuse have been shown to be a risk to mental health by researchers across the world, with symptoms of severe depression, suicidal ideation and post-traumatic stress disorder identified (Blasco-Ros, Sanchez-Lorente & Martinez 2010; McLaughlin, O'Carroll & O'Connor, 2012; Hines & Douglas, 2015). In the UK, with estimates of 1 in 5 of the population experiencing DV to some extent during their lifetime (Office for National Statistics, 2016) and around 30% of mental health in-patients showing a history of domestic abuse (Oram et al., 2013), it is likely that most counsellors and psychotherapists will see DV clients at some time in their career, whatever their specialism.

One of the difficulties of working in this area is the identification of emotional and psychological abuse, as it is easier during a psychological assessment to diagnose the symptoms of mental illness, rather than to identify factors relating to the experience of DV. Such symptoms lend themselves (in a western mental health system) to treatment plans based on diagnosis, and yet qualitative studies worldwide have suggested that this approach can be unhelpful (Walker, 1979; Seeley and Plunkett, 2002; Farmer et al., 2013). For example, the stress of being dominated through coercive control (now included in the UK definition of

domestic abuse (Home Office, 2012)) may result in difficulties focusing on thoughts, sleep problems, poor appetite, feelings of worthlessness and/or a sense of hopelessness perhaps with suicidal ideation which could result in a diagnosis of depression (American Psychiatric Association, 2013). Treatment through prescribed medication may alleviate some of the symptoms but will not change day to day life. Herman (1993) was the first to acknowledge DV as like living in a war-zone and the need for clients/patients to process the trauma they had experienced. Clients/patients agree (Seeley and Plunkett, 2002; Farmer et al., 2013; Roddy, 2014), stating that they value and gain more from processing and understanding the difficulties (trauma) of their home environment and the impact that has had on them, than from taking actions to relieve their symptoms.

Internationally, practitioners have responded by sharing methods of working based on their own successful psychotherapy practices (Walker, 1994; Sanderson, 2008; Agnew-Davis, 2013), each highlighting the difficulties and complexities of this work, together with proposed solutions. Such models of practice have been further developed and successfully delivered by specialist DV agencies, including those in the UK (BACP, 2011), for women referred into these agencies. However, not all areas of the UK offer such a specialist counselling service to women (Coy, Kelly & Foord, 2009) and there are few specialist counselling services available for men (Roddy, 2015). Even where these services have been available, UK agencies, like those in the USA and Australia, have historically relied on government grants and external funding to support victims of domestic abuse. Reductions in government spending and implementation of austerity measures means the funding pool for such services has diminished (Hirst & Rinne, 2012) and many UK counselling services have been closed or are offering a reduced and more limited service. Consequently, people who have experienced DV and seek help for psychological difficulties are now more likely to be

seen by mental health practitioners in the public, private or voluntary sectors who have a general, rather than specialist, counselling training.

The difficulties of working with a therapist who does not understand what it may mean to have experienced DV have been highlighted through qualitative research studies (Seeley and Plunkett, 2002; Roddy, 2014). Seeley and Plunkett's (stet.) Australian study highlighted that working with a counsellor who appeared to minimise their relationship difficulties, was unaware of the potential risks to them and/or focused only on their responsibility and actions (and not those of their partner) is problematic. Trust, which is developed through the counsellor's understanding and valuing of the individual and their situation, fails to build in such situations and can result in early termination of counselling sessions (Roddy, 2014).

Working beyond common factors

It may be difficult for general practitioners, looking from the outside, to understand why this client group does not respond well to counselling. Counsellors generally believe that all clients can benefit to some extent through implementing principles of good therapeutic practice (Frank, 1963; Hubble, Duncan & Miller, 1999; Lambert & Ogles, 2014) irrespective of a practitioner's core training. These elements, which include empathy, congruence, and positive regard, have been shown to create the trusting environment required for a successful conclusion to therapeutic work (Cooper, 2008).

These factors are identified in other existing competency frameworks for counselling: for example, the framework for humanistic counselling developed by Roth, Hill and Pilling (2009). This work was used as the basis for the Counselling for Depression intervention approved by NICE (National Collaborating Centre for Mental Health, 2009), used within the NHS Improving Access to Psychological Therapies service in the UK. The development of

such specialist frameworks supports the idea that there may be specific needs for particular client groups. In the case of DV, for example, practitioners globally have identified the need for counsellors to have specific knowledge and techniques to address likely problem areas arising from the experience of domestic abuse (Dutton, 1992; Walker, 1994; Sanderson, 2008). This aspect has also been included in the recently published NICE guidance for health professionals working with DV (National Institute for Health and Clinical Excellence, 2014).

However, there are potential differences in what constitutes good therapeutic practice for DV counselling compared with general counselling. For example: someone who stays safe by focusing on the needs of their partner and diverting attention away from themselves, may find an environment focused on themselves unsafe or frightening; an individual who has not been allowed to make any decisions may find a collaborative, objective setting process for therapy challenging and may simply agree with therapist ideas. A competency framework can help to identify gaps in knowledge or skills for practitioners when working with this client group, yet an examination of the literature suggests that such a framework has yet to be defined. Whilst those actively working with DV clients may implicitly understand therapeutic requirements, it would be helpful for other practitioners to have explicit resources, in the form of a suggested practice framework, to reflect upon.

Counsellor training in the UK

Counsellor training in the UK is not as developed as in Canada and the USA (Robertson & Borgen, 2016), and currently offers a confusing range of core and post-experience training programmes available to students and counselling practitioners. In part, this is a result of counselling being outside the current statutorily regulated helping professions such as counselling psychology, occupational therapy and nursing, which have recognised educational and professional development routes (Aldridge, 2014). Nevertheless, bodies

such as the British Association for Counselling and Psychotherapy (BACP) and the United Kingdom Council for Psychotherapy (UKCP), are beginning to identify scopes of practice, career pathways and core training requirements for counsellors and psychotherapists. An enhanced voluntary registration for the profession via approved registers held by UK Professional Standards Authority is now in place. Trainee counsellors and psychotherapists can access foundation, honours and postgraduate degree level training through higher education, further education and the private sector (Aldridge, 2014), with each focused on the establishment of a base level of knowledge and skills. Despite this, there remains a confusing array of training options for qualified practitioners' post-graduation.

Trained counsellors will develop specialist skills through working with clients or patients within specific areas and contexts, as well as undertaking additional specialist training. Historically, research into successful counselling has focussed upon facilitating the client's access to, and engagement with, therapy and the therapist (see for example reviews by Cooper (2008)). This has influenced the development of the profession's dominant focus upon core therapist skills and behaviours, with less attention to specialist client needs from therapy (Aldridge, 2014).

More recently, research involving counselling and psychotherapy professionals has shown that there may be significant differences in the outcomes for clients or patients, which are implicit in the therapist (Del Re et al., 2012). Responding to this, curricula have been developed to specifically highlight the characteristics required for therapists to work with specific client groups, such as individuals with depression (Sanders & Hill, 2014), resulting in a specialist Counselling for Depression training for experienced practitioners. It is envisaged that other frameworks will be developed or endorsed by professional bodies such

as BACP or UKCP to provide a structure for post-qualification training and assessment to enhance the outcomes for client work.

The complexity of DV work lends weight to the argument for evidence-based counselling training programmes and therapy interventions (see for example Minton, Morris & Yaites, 2014; Petersen, Hall & Buser, 2016). What is advocated here, in the form of a DV competency framework, is the basis for a post-qualification training programme, building upon commonly reported factors from client based-work around the world (Walker, 1979; Seeley and Plunkett, 2002; Farmer et al., 2013; Roddy, 2014). This will allow formal- and self-assessment of the practitioner aptitude, specialist skills and knowledge required when working with those traumatised by violence or abuse. In providing this additional training to general practitioners, it is hoped that the client experience of counselling, wherever that is received, will be improved.

Developing a Competency Framework for Domestic Violence (DV) Counselling

The competency framework is based upon a model of practice developed from a qualitative research study approved by the ethics committee at York St John University. Semi-structured interviews were conducted with 14 women and 6 men who had received counselling after experiencing domestic violence. Participants were recruited through four domestic violence agencies in England and Eire and each had ended counselling at least 3 months prior to the interview. Semi-structured interviews were analysed using adapted grounded theory (based on Glaser and Strauss (1967) and Charmaz (2006)) within a constructivist philosophy (Roddy, 2014). The findings were confirmed by the 4 female and 2 male participants, who had expressed interest in reviewing the findings, as an accurate representation of their experiences. The model shown in Figure 1 was developed from female participant interviews, with step 3 describing the beginning, steps 4 and 5 the middle, and steps 6 and 7 the ending

of counselling (Roddy, 2014). These steps reflect the same processes reported by practitioners working with women who have experienced DV (Dutton, 1994; Sanderson, 2008). Steps 1-2 and 8 are specifically related to the client experience and occur outside of the counselling room, whilst informing aspects of the counselling process. Step 6 is an internal client process uniquely articulated by participants in the study (Roddy, 2014).

The male participant experience of counselling (in the context of preferred counsellor knowledge, skills and characteristics) was similar, although the middle stage (steps 4 and 5 in Figure 1) was much shorter (Roddy, 2014). The women had been offered open-ended therapy and could work through issues in depth before leaving, but the time-limited counselling offered to men meant that they re-accessed therapy several times to process additional material as it came to the surface. Nevertheless, the therapeutic requirements for each stage, in general rather than gender specific terms, were similar to those identified by the women. There are currently no other published studies for male victims available for comparison.

Counselling competencies were identified using the data from this study by three professional counsellors: two had experience of working within the domestic violence field and two had significant experience of counsellor training within Higher Education. Each of the identified terms was discussed by the team and wording agreed based on a common understanding. Categorisation of the competencies was based on the frameworks developed by the British Association for Counselling and Psychotherapy on knowledge and skills identified in UK competencies (Roth, Hill and Pilling, 2009). A third category of important counsellor characteristics appeared, representing the view of the client, something often missing from practitioner led work.

Finally, the competencies identified were compared with those contained within existing competency frameworks and literature (Hill, Roth & Cooper, 2014; Sanders & Hill, 2014) to

identify any missing categories, which would have a therapist, rather than client, perspective. This added knowledge-based items on client safety and personal characteristics relating to counsellor self-care. The combination of expert client and professional opinion, together with extensive literature review aligns well with the competency framework process identified by Roth and Pilling (2008) (which is endorsed by the British Association for Counselling and Psychotherapy and used by NICE (National Collaborating Centre for Mental Health, 2009)).

A full list of the knowledge, skills and personal characteristics identified is provided in Table 1. Any noted areas of gender difference in the requirements from therapy of men and women have been highlighted within the table. Each table entry plays an important role in delivering a counselling service that will both help and engage clients who have experienced DV and brings together helpful factors reported in the DV literature over many years. In addition, it defines the characteristics required of a counsellor seeking to work in this area, recognising that the work is not only skills and knowledge, but also the characteristics required for self-care and resilience. A full list of definitions for these terms is available from the corresponding author.

Implications for Practitioners

The proposed DV framework offers a unique tool, including sector specific knowledge as well as specific counselling skills and characteristics required to provide the necessary environment for the DV client. Much of this knowledge is likely to be implicit in existing, specialist DV services, yet this framework provides an explicit representation. In addition, it highlights the complexity of the counselling process associated with DV, in dealing with the range of different life experiences and the potential impact of those on client mental health.

Many of the topics presented by clients are not unique to the experience of DV but may be more likely to be present. These issues can be challenging and may include: high number of clients experiencing suicidal ideation (McLauchlin, O'Carroll & O'Connor, 2012); parental anxiety associated with the assessment and monitoring of children by statutory bodies or health professionals (Keeling & van Wormer, 2012); witnessing multiple stories of extreme abuse. Such experiences are known to have an impact on the health and well-being of counsellors themselves (Iliffe & Steed, 2000) unless care is taken. This need for care is reflected in practitioner guidance (Roddy, 2015) and suggests additional areas of competence be considered including: the ability to transform appropriate knowledge and research into clinical practice; the capacity to judiciously identify and use relevant skills and approaches for each unique client; the capacity to self-care and the willingness to articulate experiences, perceptions and anxieties within a supervisory context.

The competency framework is flexible to meet these needs in therapeutic practice. Aspects of DV work are likely to combine knowledge, skills and/or personal characteristics and is represented pictorially in Figure 1. For example, a counsellor deciding to access additional supervisory support may use a combination of knowledge of secondary trauma and a characteristic desire to take preventative action.

The skill levels identified are also higher than generally expected. For example, the empathy required in DV work is not simply to be able to understand and respond to what the client has said, but to understand what the client has *not* said and to verbalise these unspoken thoughts and feelings on their behalf. This can be helpful if a client's actions or behaviours, perhaps in response to or in realisation of the extent of their abuse, are experienced as shameful, or when stopping mid-sentence whilst reliving traumatic events due to reconnecting with emotions which had been dissociated (Sanderson, 2008). Clients can experience their therapist being

able to ‘guess’ their unfinished story, through their knowledge of DV and the client, very positively (Roddy, 2014) interpreting it as understanding, lack of judgement and honesty.

Depending on the trainees’ theoretical orientation, these skills may or may not have been a focus of their core training. Sometimes practitioners can struggle with non-judgement and providing a congruent response when hearing of the abuse experienced by an individual and/or their response to that abuse. It can also be difficult to build the therapeutic alliance with someone who has learned over a long period of time not to trust, disclose or become close to anyone. This aspect of therapeutic work can be challenging, requiring a high level of counsellor skill and commitment. It is important to consider not only the presence of the skill, but also the current level of development.

It is anticipated that counsellors will have a qualification at least at level 5 (equivalent to HE Diploma level in England, Wales and Northern Ireland). This identifies the basic level of training against which these additional competencies can be compared. Within the framework, there is an acknowledged need for additional subject specialist knowledge, as highlighted above. Equally, the delivery of core competencies, such as empathy and authenticity, is at a higher skill level than would be required to pass level 5 counselling in the UK. Meeting such standards may require further post-qualification personal and professional development of the counsellor.

The competency framework in practice

DV counselling is a complex process, which goes through recognisable stages (Walker, 1994; Sanderson, 2008; Roddy, 2014). The examples of work-based competencies proposed in Table 2 highlights the potential to combine different skills, knowledge and counsellor characteristics at different stages of the counselling process.

Living with an abuser can elicit reduced confidence in oneself and others, as the abuser manipulates situations to their advantage (Sanderson, 2008). This can result in a lack of trust and an enhanced sense of wariness for the victim, possibly questioning the reasons for someone being helpful or pleasant to them, perhaps suspecting an alternative agenda. In these cases, it can be difficult for the person to share perceived shameful or embarrassing aspects of their abuse, as their experience may suggest that such disclosure will be used against them. The client may take up to 8 sessions to develop the level of trust and confidence in the counsellor required to share these experiences (Roddy, 2013). As the client's confidence in the counsellor grows, a strong, safe and contained therapeutic relationship can develop. If a referral to other services or practitioners is required after this beginning phase, there is a risk that the client could feel rejected having finally risked confiding in someone, that their disclosure has been used against them. As this may preclude future therapeutic engagement, it is important that any referral is handled sensitively. A client working with a counsellor trained to address the whole DV recovery process reduces this risk.

All counselling training considers processes of counselling, that is, the beginning, middle and end phases. This work goes further, suggesting specific elements of work in each of these stages to assist the client in moving through to recovery. Each stage utilises different aspects of the counsellor characteristics, knowledge and skills. Accepting that not all clients and therapists are the same, this framework provides guidance on what may be required within each therapeutic stage.

The beginning is focused on establishing the relationship and addressing current issues, as well as responding appropriately to initial client disclosures of their experiences. As the relationship builds, the level of disclosure will usually increase until the client is ready to tell the counsellor the details of their domestic abuse experiences and perceptions.

Once the therapeutic relationship is established, the counselling moves on to the middle stage, to consider trauma that may have been experienced at a younger age (such as physical, emotional or sexual abuse), as well as any disclosed adult experiences. Not all clients will need extensive exploration of past experiences or trauma, but many will. The length of this stage is dependent upon the number and seriousness of their previous abuse experiences and could range from 4-8 sessions over 2-3 months to perhaps 60-70 sessions over a period of 24 months. As this material is processed, the client begins to consider the possibility of ending the counselling as they feel more self-confident, self-reliant and positive about life.

The final stage, the ending phase, is very important to the client, as it allows them to make and feel comfortable with the decision to leave, an important element in the growth of self-efficacy following a controlling relationship. The client may have been thinking about leaving for a few weeks, but the actual ending with the counsellor may only be one or two sessions.

In reflecting on what is happening between the client and counsellor during these stages, it seems the skills, knowledge and personal characteristics identified in Table 1 are important at different stages of the counselling process. Table 3 shows how the previously identified elements in Table 1 can be utilised in each stage of the process. For a more detailed explanation of the stages and client needs in counselling (both male and female) see Roddy (2015).

Discussion

Numerous research projects have measured the effectiveness of counselling as a helpful intervention following DV (see, for example, Kubany et al., 2004; McNamara, Tamanini & Pelletier-Walker, 2008) however, the counsellor profile given here suggests that future

projects should give some attention to assessing the therapists involved in the research, as well as the therapeutic outcomes. Equally, there have been calls for a better understanding of the DV counselling process (Howard et al., 2003; Ramsay et al., 2005) so that services could be more clearly developed and structured. It is possible that this framework could provide a starting point for that work.

Relational skills, a solution focus and exploration of the client's experiences present and past are important. Arguably, the skill is not simply about understanding the client's words and phrases, but also includes the context of their experience and its implications for their mental health. As can be seen from Table 3, the counsellor needs to adapt to the differing needs of the client throughout the counselling. Yet, the learning to enable this adaptation is unlikely to come from a didactic training course on how DV occurs, which is the most commonly adopted training provision in organisations. Rather, it is important for the counsellor to learn how to understand the dynamic between two people: the psychology behind the abuse; the likely behaviour patterns of the abuser; and the impact that is likely to have on the survivor's relationship with the therapist. Experiential/role-playing training sessions can be very helpful in understanding emotionally charged and difficult material (Hobbs, 1992).

The framework offers an alternative counselling approach that could be used in a variety of ways, such as:

1. a training tool for counsellors who would like to work in DV.
2. an aid to recruitment for DV agencies.
3. identification of training and development needs for counsellors already working in the DV sector, either in supervision or through self-assessment.
4. further professional development for counselling professionals who have successfully completed their core training.

5. training and/or assessing counsellors in a general counselling organisation receiving referrals from a specialist (non-counselling) DV agency.
6. skills training for organisations and counsellors who see other client groups who find it difficult to engage with the therapeutic process due to trust and/or attachment difficulties.

It is important for organisations to remember that the impact upon the counsellor of working with violence and abuse can be significant and intense. Counsellors working in DV need regular supervision, support from their employer and a range of coping strategies to contain and respond to the multiple examples of extreme abuse shared by clients (Iliffe & Steed, 2000). Valued counsellor characteristics identified in the framework such as being calm, confident, compassionate, consistent, hopeful and resilient are those characteristics which are most likely to suffer if a counsellor starts to experience compassion fatigue, vicarious trauma, secondary traumatic stress or burnout (Bush, 2009). Ensuring the therapeutic relationship is consistent throughout the counselling, is not simply a matter of recruitment and training, but also of counsellor support and management.

Future work

This framework is presented as a tool built on client-informed research. Future work is planned to explore counsellors' views about areas where practitioner and client experiences of DV counselling converge and differ. This will inform further refinements to this DV framework and identify key areas for development in counsellor training.

The framework is currently being used within the York St John University *Counselling and Mental Health Clinic* and in the University of Salford's *Counselling Therapeutic Centre*. Its evaluation will be part of both clinics' research programmes.

Limitations

This client-based view of what is important was initially based on a grounded theory qualitative study involving 20 participants (14 women and 6 men) across 4 service providers and may not be representative. The framework which emerged aligns well with information and theories on DV counselling practice from around the world, developed over the last 30 years. This would nevertheless benefit from further evaluation and professional comment regarding its usefulness, robustness and applicability more generally.

Conclusions

This framework of competencies provides a guide for counselling professionals working with individuals who have experienced domestic abuse, based on qualitative research drawing on the experiences of clients. It provides an overview of the skills, knowledge and characteristics needed by counsellors working with clients at each stage of DV counselling and can be used in training counsellors to work with DV clients.

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Tables

Table 1: Counsellor skills, knowledge and characteristics for working with clients who have experienced domestic abuse

Counselling Skills	**Counsellor Knowledge**	**Counsellor Characteristics**
Building and maintaining trust	Ethical framework	Be able to respond appropriately to disclosures
Working with dissociation	Confidentiality limits (particularly with inter-agency working)	Hold hope for the client, the process and themselves
Working with anxiety	DV – types, perpetration, effects, "traditional" and "non-traditional relationships"	Confident in their own ability and knows when to access support
Client led sessions	Understanding warning signs of abuse through client narrative	Being able to work with the client's emotional response
Building the therapeutic alliance at the client's pace	Safeguarding and how it is carried out in the workplace	Authentic
Being able to contain/hold client when experiencing difficult emotions	Understanding of different forms of abuse related to culture or sexuality	Compassionate
Working with silence	Understanding the mental health difficulties associated with abuse	Empathic
Managing boundaries	Good understanding of working with CBT, person centred and psychodynamic theories	Calm
Working with disclosure	The therapeutic implications of working with someone who has experienced childhood abuse	Warm
Advanced empathy	The differences in gendered experiences of domestic abuse	Non-judgemental and accepting
Facilitating the client to make change	Transference and counter-transference	High levels of self-care and self-compassion
Managing endings appropriately	Attachment and how to work with insecure attachment	Creative
Knowing when to access supervision	How to work with trauma	

Table 2: Examples of competencies required for each stage of the DV counselling process

Beginning	Middle	End
Collaborative relationship	Offering genuine care and compassion	Support the decision of the client to end
Clear limits on confidentiality	Informed consent for any trauma interventions	Ensure any unplanned endings are managed as well as possible
Calm, supportive and respectful environment	Working with and processing traumatic memories and feelings	Ensure that the client is aware that they can come back again, if needed, in the future
Normalising client experiences in the context of domestic abuse	Work with and help client regulate their emotions	
Working with client led issues and goals	Challenge negative assumptions or beliefs of client self-concept	
Client led solutions for day to day issues	Promote/facilitate client's social (re)connection	
Careful pacing of any client disclosures to avoid re-traumatisation		
Providing a rationale for any interventions made		
Establish and maintain appropriate boundaries		
Check-in regularly with client to pro-actively resolve any issues		

Table 3: Skills, knowledge and characteristics required of a counsellor at different stages of the counselling process

	Beginning	**Middle**	**End**
Counselling Skills			
Building and maintaining trust	**	**	*
Working with dissociation	*	*	
Working with anxiety	*	*	
Client led sessions	**	*	*
Building the therapeutic alliance at the client's pace	*	*	
Being able to contain/hold client when experiencing difficult emotions	*	**	
Working with silence	**	**	
Managing boundaries	*	*	
Working with disclosure	**	*	
Using advanced empathy	**	*	
Facilitating the client to make change	*	**	*
Managing endings appropriately			*
Knowing when to access supervision	*	*	
Counsellor Knowledge			
The ethical framework	**	**	
Confidentiality limits (particularly with inter-agency working)	**	*	
Knowledge of DV – types, perpetration, effects, "traditional" and "non-traditional relationships"	**	*	
Understanding warning signs of abuse through client narrative	**	*	
Safeguarding and how it is carried out in the workplace	*	*	

Understanding of different forms of abuse related to culture or sexuality	**	*	
Understanding the mental health difficulties associated with abuse	**	*	
Good understanding of working with CBT, person centred and psychodynamic theories	*	*	*
The therapeutic implications of working with someone who has experienced childhood abuse	*	**	*
The differences in gendered experiences of domestic abuse	**	*	
Transference and counter-transference	**	*	*
Attachment and how to work with insecure attachment	**	*	*
How to work with trauma	*	**	
Counsellor Characteristics			
Be able to respond appropriately to disclosures	**	*	
Hold hope for the client, the process and themselves	**	*	**
Be confident in their own ability and know when to access support	**	*	*
Being able to work with the client's emotional response	**	*	*
Authentic	**	*	*
Compassionate	*	**	*
Empathic	**	*	*
Calm	*	*	*
Warm	**	*	*
Non-judgemental and accepting	**	**	*
High levels of self-care and self-compassion	*	**	*
Creative	**	*	*

Note: This table uses one star to indicate where the factor identified is more likely to be used and two stars where this may also require higher levels of technical competence from the counsellor, or where the client has indicated it is particularly important and therefore may require a higher level of competence. We are not ascribing greater significance to those competencies from a counsellor perspective. The absence of stars does not mean this factor will be missing. For example, there will be a need for working within the ethical framework at all times, but there are specific times in the counselling process where complex ethical considerations may be more likely.

Figure 1: Pictorial representation of a client informed model of counselling practice (Roddy, 2014)

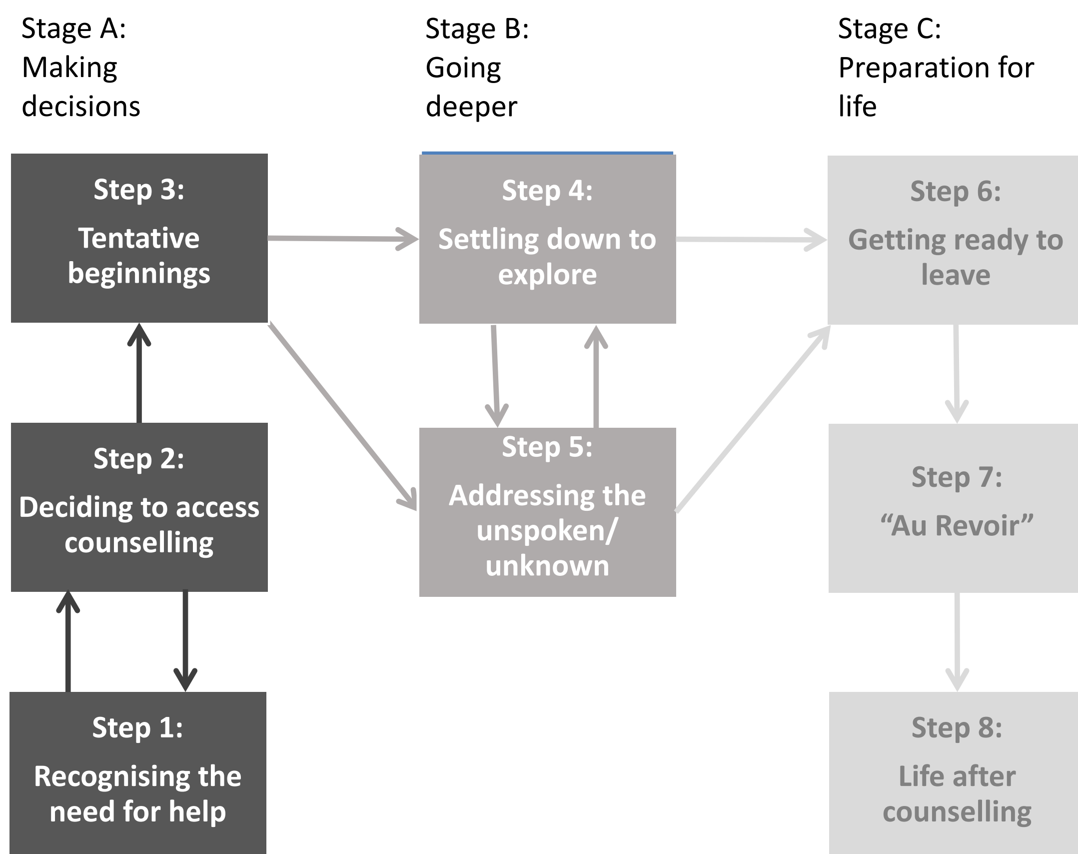

Figure 2: Pictorial representation of the Competency Framework for DV Counselling