Research Article
Open Access

Female domestic violence counsellors/ psychotherapists: attitudes towards addiction. An interpretative phenomenological analysis

Abstract

Many counsellors/psychotherapists working with victims of domestic violence (DV) encounter substance use disorders (SUDs), whether directly or indirectly, and yet an understanding of how to address these co-occurring issues in practice appears lacking. A qualitative design using semi-structured interviews and IPA captured the individual experiences and perceptions of 6 female BACP registered counsellors/ psychotherapists who counsel victims of DV based in DV 'specific' organisations. Four super-ordinate themes emerged and included a 'feminist perspective', 'addiction: symptom of trauma', 'skills development in substance misuse' and 'feelings of exclusion in the workplace'. This study offers an initial understanding of how DV counsellors view SUDs and the impact this had in their practice. It further provided insight into how supported and involved they felt in their workplace when counselling this group. These findings are discussed in terms of strategy development and training aimed at improving the experience of counsellors/psychotherapists working in DV counselling organisations when they encounter SUDs in order to support counsellors and service-users well-being.

Keywords: counselling, IPA, substance use, domestic violence, feminism

Volume 5 Issue 3 - 2018

Nina Fricker, Samantha Banbury, Amanda Visick

School of Psychology, London Metropolitan University, UK

Correspondence: Samantha Banbury, School of Psychology, London Metropolitan University, 166-220 Holloway Road, London, N78DB, UK, Email s.banbury1@londonmet.ac.uk

Received: May 28, 2018 | **Published:** June 13, 2018

Abbreviations: DV, domestic violence; SUDs, substance use disorders; BACP, british association of counsellors and psychotherapists; AVA, against violence and abuse; CPD, continuing professional development; IAPT, improving access to psychological therapies

Introduction

Domestic Violence refers to physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion,[1] and affects approximately 1 in 4 women and 1 in 6 men in their lifetimes.[1] Women appear to be more adversely affected by male perpetration than men are from female perpetration.[2] However, much of the data has been derived from self-report measures. Indeed, Kimmel,[3] asserts that methodology is flawed in assessment of gender violence by omitting to mention discrepancies between conflict-motivated aggression and control motivation. Without this distinction, gender symmetry can be assumed.[4]

Substance Use Disorders occur when the recurrent use of alcohol and/or drugs causes clinical and functionally significant impairment.[5] The link between SUD and DV appears to be non-discriminatory as victims and perpetrators alike are at increased risk of having SUDs.[6] Certainly, women who have experienced DV are 5.5 times more likely to be diagnosed with a SUD during their lifetime.[7] With reference to the self-medicating hypothesis, Khantzian,[8] postulates that drugs and alcohol use may contribute to a numbing effect on an individual's perceptions of experiencing DV. In addition to the anesthetising effects alcohol and drugs may have on emotional trauma, they may also block the level of physical pain experienced during DV.[9] Drugs and alcohol may be used to control an individual,[10] whether the substance is being forcefully administered or withheld as an instrument of abuse.[11]

Treatments that are available to this population are focused on either the DV or the SUD, despite NICE guidelines,[12] and a 2010 Drug Strategy,[13] calling for integrated healthcare. It is recognised that women experiencing DV who have complex needs, such as SUDs, find it difficult to access services.[14] This may be due to cultural factors, child protection/social services involvement, financial insecurity, fear, shame, physical dependence, chaotic lifestyle and so forth.[15] Research shows that these complex service users experience a lack of support, that they face discrimination, and even premature death.[16] Although speculative, Garcia-Moreno et al.,[16] suggests that services may be focusing on those who are more likely to exhibit signs of recovery, excluding complex service users with diverse needs.[17]

The discrepancy between different counsellors'/psychotherapists' personal stances seems to influence the counsellors'/psychotherapists' attitudes towards service user complexity and attitudes towards working with various presenting issues.[18] In complex trauma work the therapeutic approach seems to be secondary to the inter-personal relationship of counsellors connecting uniquely to each individual service user.[19] There is however a consensus among counsellors and psychotherapists that deep issues should not be addressed whilst life is uncertain and unsafe.[20] Further, counsellors/psychotherapists new to trauma work can experience psychological difficulties and exhibit signs of changing personal schema including in terms of safety and world view, gendered power issues and a sense of isolation and helplessness.[21] Limited research has looked at the experiences and attitudes of counsellors/psychotherapists working with domestic violence and substance users. Indeed, this has only been explored as peripheral to other research. Therefore, the proposed study qualitatively explored how female domestic violence counsellors viewed working with SUDs.

Method

Design

A qualitative IPA design was selected to explore the individual experiences of a small group of DV counsellors/psychotherapists and their phenomenological perspective towards substance use. IPA is concerned with the examination of the lived human experience.[22] From this information IPA facilitated representative themes of the cohort to be developed without losing complexity.

Participants

Participants were accredited by the British Association of Counsellors and Psychotherapists (BACP); this was to ensure a level of professionalism and experience. In addition, all participants were required to have been practicing in DV specific organisations as a counsellor for at least one year prior to the interview so that they were able to draw on this involvement. Services for female DV victims are run by women for women therefore men were exempted by default. No restrictions were placed on theoretical background, age or ethnicity. Six therapists participated in the research, all were female, aged between 43 and 67 and British. All had received specialist training in their role as DV counsellors to work with the service user group of those who had prior histories of DV.

Ethics and procedure

Ethical approval was secured by a universities ethics review panel. The research was designed in accordance with British Psychological Society ethical guidelines,[23] and complied with BACP ethical framework for researching counselling and psychotherapy.[23] Participants were sourced via the Against Violence and Abuse (AVA) organisation which is an independent charity which works to improve services and towards ending gender-based violence through policy, research and prevention.[24] Six counsellors/psychotherapists to attend individual 50-minute semi-structured interviews. Each gave written consent for their data to be used. Participants were ensured confidentiality and reminded they could withdraw from the study at any point up to a given date. Debriefing took place following the interview.

Data analysis

The analytic process was guided by Smith, et al.[22] Each interview was transcribed from audio recordings where the initial themes were identified. This process was repeated several times such that themes - accurate interpretative representation of each individual's subjective experience – were developed into clusters. The clusters of sub-themes were further refined into super-ordinate themes and this was followed by the integration of themes for all participants. These represented the findings.

Findings

Super-ordinate theme: feminist perspective

The superordinate theme 'feminist perspective' embodied the counsellors' perspectives of working - as women - therapeutically with female DV service users. This reflection and sense of connection appeared to be based on personal values as opposed to theoretical orientation. Orientation presented as secondary to the therapeutic relationship.

Identification

Counsellors or psychotherapists who had not experienced DV, or did not disclose, had also expressed achieving relational depth; they described a sense of identification with some of the feelings around female oppression that the service users presented.

"I relate to the women on that level that there is other people watching you and wanting to be a certain way and needing you to be a certain way and often manipulation to get you to be what they want you to be".

Feeling connected

All of the therapists had what they described as strong feminist principles. They were all vocal about their sense of societal patriarchy and how they considered this an insidious abuse of power towards women. This seemed to be incorporated into counselling practice.

"Working from a feminist perspective allows me to understand where they are coming from".

Work as meaningful

The relational connection between the counsellor/psychotherapist and service user was described as meaningful. The work of DV counselling was expressed in terms of a vocation, which enriched and added depth and purpose to the counsellor's life.

"For me it creates, it gives me a sense of meaning and purpose in my life. I think that in my existence it is important, you know, and I guess it is a privilege to witness it. To be a part of it".

Super-ordinate theme: addiction: symptom of trauma

Whilst blocking emotional pain was seen as primary, there was also awareness that women who experience DV may also self-medicate for the physical symptoms of DV and trauma.

Self-medicating for emotional pain

Self-medication was viewed by participants as a way to numb the anguish and distress of having experienced trauma. The opinion of all of the counsellors was that happy and well-functioning individuals do not behave in a maladaptive manner around substances.

"When I'm aware that somebody is addicted to whatever substance, I see pain… that's what I see".

Intrinsic link: DV and SUD

All participants remarked on the relationship and overlap between DV and SUD. When DV and substance use were combined it was considered that the problems were greatly enmeshed.

"If you are drinking to block the pain, and the pain is related to the current situation you are in or a past situation you were in or there is a kind of symbiotic relationship going on with you and your partner around alcohol, just to separate the substance use out, it's not going to work is it"?

Perpetrating stigma

It was considered by the participants that the DV organisations where the counselling was practiced actively excluded DV victims and survivors who were active in addiction. Further, it was expressed that this matter of considered exclusion of SUD service users was a diversity issue. It was felt that this aided the perpetration of isolation

and shame on a group of women who were doubly stigmatised by DV and SUD.

"I don't think I've ever heard them say: How do we make this service more accessible to women who use substances"?

Super-ordinate theme: skill development in substance misuse

All participants felt that they were well equipped in terms of training, continuing professional development (CPD), and organisational support to work therapeutically with female 'victims and survivors' of DV. However, there was not enough acknowledgement of co-occurring complex needs such as SUD by the agencies.

Recognising the gap in training

Counsellors and psychotherapists reported ignorance about the effects and consequences of substance use. They wondered about ethical considerations of working with issues that they did not fully understand. Counsellors further reflected that training in SUD within the DV service would assist them in understanding contextual factors of the clients' experience of abuse if perpetrators used substances.

"I felt it was a gap, but the biggest question was how can we support these women".

Lack of a combined DV and SUD 'counselling' model

Participants came from varied professional and personal backgrounds. This was reflected in their knowledge of addiction and substance use. None of the participants had ever heard of any DV counselling/psychotherapeutic training that incorporated working with substance use.

"I think it would work better for clients for them [SUD and DV] not to be separated, because one makes the other worse, they are both so fused really".

Limited flexibility in practice

It was felt that all therapeutic emphasis had to be placed on DV or trauma symptom management. Counsellors described feeling unequipped with the necessary skills and training to work with DV service-users presenting with complex issues such as SUD. Participants believed that organisationally there was a rigidity and lack of acceptance of the complexities that some service users present with.

"If I had gone to supervision and said…well actually my client turned up and she'd had a couple of cans of Special Brew, they would have been outraged. So I never said, because that's what she does day in day out, that's how she is".

Super-ordinate theme: feelings of exclusion in the workplace

There was a sense of the organisation as a separate domain, as opposed to something that the therapists could feel a part of. Participants described feeling on the outside. Despite being sure of the intrinsic importance of their roles as counsellors and psychotherapists within DV services, they did not feel valued or included in structural decisions by the organisations.

Not feeling supported in work place

The lack of emotional containment that the counsellors reported was considered to be partly linked to working in isolated venues away from the hubs of the services.

"I just don't feel supported and held, I don't think it's generalised throughout the organisation. I just feel outside of the organisation".

Negative hierarchy

The organisations were viewed negatively as top-down hierarchical structures. It was felt that such weight was given to proving positive outcomes and the acquisition of funding that the people who work providing the counselling were not prioritised by the organisation.

"There isn't a kind of structure that enables it to be expressed that we are valued, no, I think it's more than that. I don't think it's embedded in the culture. It's the hierarchy, it's the structure".

Parallel abuse

A sense of parallel 'abuse' was conveyed by participants. They all noticed and commented upon the incongruity of working with abused service users when the consensus was that the organisations were 'abusing' the counsellors/psychotherapists with a punitive and non-compassionate attitude towards their therapists.

"It's obviously so ironic that they can be so insensitive and controlling in that way that is so familiar from the models that people are working with and have experienced".

Discussion

This study aimed to explore the experiences and perceptions of counsellors working with DV and SUDs. Using an IPA approach, the analysis yielded 4 superordinate themes based on the insights of six BACP registered counsellors/psychotherapists. The super-ordinate themes were 'feminist perspective', 'addiction: symptom of trauma', 'skills development in substance misuse' and 'feelings of exclusion in the workplace.

Edell, Brown & Tolman,[25] describe feminist counselling as definable by how the counsellor 'thinks' about what she does.[26] This definition could be considered appealing for its flexibility and capacity to accommodate a plethora of orientations and techniques. However, there are unanswered questions as to what exactly feminist values and ways of thinking are.[27] Certainly participants in this study expressed that they considered themselves feminists, for example, by promoting female empowerment and challenging societal patriarchal oppression.[28] Their feminist principles reflected those as described by Goddard E, et al.,[29] including the ongoing self-exploration of the counsellor, having an equal power dynamic, supporting the raising of consciousness, enhancing client strengths and leaving clients with the tools for social change.

Identification was recognised and utilised by the participants in this study as an inherent part of the therapeutic process and means of relating. Research looking at identification has demonstrated that counsellors who have themselves experienced trauma are more likely to experience vicarious trauma.[30,31] Whilst Rønnestad & Skovholt,[19] found that personal life experience enhances a therapist's counselling capacity, this could be considered during training in order to guard against vicarious trauma of counsellors/psychotherapists with personal experience in domestic or sexual violence.[32] When looking at identification and motivation, participants drew reference to the empathy-altruism hypothesis which is characterised by the ability to adopt another's perspective and have the experience of sympathy and compassion for another with the ultimate goal of improving the others welfare.[33]

Lack of training around addiction does not seem to be limited to the DV field. Improving Access to Psychological Therapies (IAPT) services do not provide therapies which specialise in substance use disorders,[34] which implies a lack of SUD training. Participants commented on their having received no skills development to work in this capacity with service users presenting with substance issues. How any discrete SUD knowledge was implemented into practice was not explored in this research. However, as already mentioned, research does show that counsellors' attitudes to SUD do impact on their DV specific counselling practice,[35] so it is likely that discrete knowledge would have some impact. Empirically evidenced counselling training for DV counsellors and psychotherapists when working with service users who present with SUDs appears limited. To develop new models of DV counselling with co-occurring complexities, may require clinical sub-groups of violence,[36] and addictions,[37] to be categorised. These differing clinical distinctions may need to be addressed with specific types of interventions.

Hierarchy and a 'top down approach' within the organisations was viewed by participants as negative in such complex and sensitive work. The counsellors/psychotherapists felt that they were not valued, which was felt to be hypocritical and against the supposed feminist ethos of the services.[38] All indicated they would prefer a 'bottom up' approach and services to be user-led;[39] though user-led organisations do tend to be smaller,[40] and user involvement can be as low as 0-16% in some community-based services.[41] Participants also commented on feelings of isolation which were social and/or professional.[42] Indeed, in private practice, isolation might be a risk due to the counsellor/psychotherapist co-ordinating their own case load and practice.[43] However, participants in this study commented on the sense of isolation they experienced despite all practicing in organisations. In fact, Steel suggested that counsellors in the NHS found the workload and lack of autonomy in their counselling roles emotionally exhausting.

Ishkanian,[43] argues that funding cuts are affecting the independence and ability of women's organisations to engage in positive policy shaping as so many are being shut down. Women's organisations and refuges could be planned and funded as national services but hosted locally,[44] with service user and worker perspective input.[39] This could then funnel up – through research – into policy shaping. The present study had a number of limitations. Qualitative research, in particular IPA, can be considered highly subjective,[45] due the interpretation of the data being so reliant on the researcher.[21] Certainly, the accounts of six Caucasian women working with DV and SUD could not be considered generalisable to a wider socio-culturally diverse populace. Further, participants were aged between 44 and 67; younger participants may have given alternative perspectives.[46] However, the findings do offer a starting point to generate ideas and recommendations for future quantitative research.[47]

Conclusion

Women who experience DV with interrelated SUD are undoubtedly a special population whose needs are seldom met specifically.[48] DV counsellors/psychotherapists who work 'accidentally' with the complexity of possible addiction issues have experienced this subject matter as indisputably neglected. Participants in this study highlighted the need for addiction awareness amongst counsellors to be incorporated into DV counselling training. Focusing on the experiences those DV counsellors who encounter the complexity of addiction in their practice highlighted the role of feminism as an intrinsic factor. This adds to existing studies on feminist counselling, discussing how therapists relate to their service-users and importantly the 'feminist empathy'[49] that seems to motivate the DV counselling work.

Organisational support was highlighted both in the findings and in literature as an area for improvement. The literature notes that not all counselling organisations are viewed as negligent towards therapists;[40] it is possible that the counsellors' described sense of 'abuse' is actually a parallel process, rather than the reality of an autocratic organisation.[50] It may be that the counsellors are recreating or paralleling the service-users' emotional difficulties as a transferal reactional way of relating to the organisation.[51] Boundaries between therapy and supervision can be ambiguous and especially in such work where personal and professional developments are easily entwined.[51] However, a lack of funding seems to play a role in the resources provided for the wellbeing of counsellors/psychotherapists.[52]

Compliance with ethical standards

Informed consent was obtained from all service users and all ethical guidelines were in accordance with the British Psychological Society (BPS, 2009) code of ethics and conduct.

Acknowledgements

None.

Conflict of interest

Nina Fricker, Samantha Banbury and Amanda Visick, declare no conflict of interest.

References

1. *Intimate personal violence and partner abuse*. USA, Office for National Statistics, Focus on Violent Crime and Sexual Offences; 2016.
2. Whitaker DJ, Haileyesus T, Swahn M, et al. Differences in frequency of violence and reported injury between relationships with reciprocal and nonreciprocal intimate partner violence. *Am J Public Health*. 2007;97(5):941–947.
3. Kimmel MS. "Gender symmetry" in domestic violence: A substantive and methodological research review. *Violence against women*. 2002;8(11);1332–1363.
4. Chan KL. Gender differences in self-reports of intimate partner violence: A review. *Aggression and Violent Behavior*. 2011;16(2):167–175.
5. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. American Psychiatric Association; 2013.
6. Crane CA, Oberleitner LM, Devine S, et al. Substance use disorders and intimate partner violence perpetration among male and female offenders. *Psychol Violence*. 2014;4(3):322–333.
7. Gans M. Psychological Injuries: Forensic Assessment, Treatment, and Law. *Psychiatric Services*. 2006;57(11):1663–1664.
8. Khantzian EJ. The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harv Rev Psychiatry*. 1997;4(5):231-244.
9. George O, Koob GF. Individual differences in the neuropsychopathology of addiction. *Dialogues Clin Neurosci*. 2017;19(3):217–229.
10. Walsh SD. Sex Trafficking and the State: Applying Domestic Abuse Interventions to Serve Victims of Sex Trafficking. *Human Rights Review*. 2016;17(2):221–245.
11. Weaver TL, Gilbert L, El-Bassel N, et al. Identifying and intervening with substance-using women exposed to intimate partner violence:

phenomenology, comorbidities, and integrated approaches within primary care and other agency settings. *J Womens Health (Larchmt)*. 2015;24(1):51–56.

12. *"Domestic Violence and Abuse." Guidance and Guidelines*. UK, NICE guidelines; 2014.
13. HM Governement. *Drug Strategy 2010 'A Balanced Approach' Third Annual Review*. UK; 2015:1–32.
14. Rivera PM, Fincham F. Forgiveness as a mediator of the intergenerational transmission of violence. *J Interpers Violence*. 2015;30(6):895–910.
15. Hegarty KL, O'Doherty LJ, Chondros P, et al. Effect of type and severity of intimate partner violence on women's health and service use: findings from a primary care trial of women afraid of their partners. *J Interpers Violence*. 2013;28(2):273–294.
16. García-Moreno C, Zimmerman C, Morris-Gehring A, et al. Addressing violence against women: a call to action. *Lancet*. 2015;385(9978):1685–1695.
17. Eckhardt CI, Murphy C, Black D, et al. Intervention programs for perpetrators of intimate partner violence: conclusions from a clinical research perspective. *Public Health Rep*. 2006;121(4):369–381.
18. Century G, Leavey G, Payne H. The experience of working with refugees: counsellors in primary care. *British Journal of Guidance & Counselling*. 2007;35(1):23–40.
19. Rønnestad MH, Skovholt TM. The journey of the counselor and therapist: Research findings and perspectives on professional development. Journal of career development. 2003;30(1):5–44.
20. Smith JA, Flowers P, Larkin M. Interpretative phenomenological analysis: Theory, method, and research. UK, London, *Sage Publishing*; 2013:232 p.
21. *Code of Ethics and Conduct. uidance published by the Ethics Committee of the British Psychological Society*. UK, St Andrews House, The British Psychological Society; 2009:1–31.
22. Smith JA, Osborn M. Interpretative phenomenological analysis. *Qualitative Psychology: A Practical Guide to Methods*. 2nd ed. UK, London: Sage; 2007:53–80.
23. Bond T. *Standards and ethics for counselling in action*. 4th edition. USA, Los Angeles, Sage Publishing; 2015. 352 p.
24. *A leading UK charity committed to ending gender based violence and abuse*. AVA. 2017.
25. Edell D, Brown LM, Tolman D. Embodying sexualisation: When theory meets practice in intergenerational feminist activism. *Feminist Theory*. 2013;14(3):275–284.
26. Chester A, Bretherton D. What makes feminist counselling feminist? *Feminism & Psychology*. 2001;11(4):527–545.
27. Enns C. Feminist Approaches to Counseling. *In The Oxford Handbook of Counseling Psychology*. USA, Oxford University Press; 2018.
28. Cohen K, Collens P. The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy*. 2013;5(6):570–580.
29. Goddard E, Wingrove J, Moran P. The impact of comorbid personality difficulties on response to IAPT treatment for depression and anxiety. *Behav Res Ther*. 2015;73:1–7.
30. Cieslak R, Shoji K, Douglas A, et al. A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychol Serv*. 2014;11(1):75–86.
31. Brockhouse R, Msetfi RM, Cohen K, et al. Vicarious exposure to trauma and growth in therapists: the moderating effects of sense of coherence, organizational support, and empathy. *J Trauma Stress*. 2011;24(6):735–742.
32. Batson CD. *The altruism question: Toward a social-psychological answer*. UK, London, Psychology Press; 2014.
33. Shinebourne P, Adams M. Therapists' understandings and experiences of working with clients with problems of addiction: A pilot study using Q methodology. *Counselling and Psychotherapy Research*. 2007;7(4):211–219.
34. Huss M, Langhinrichsen-Rohling J. Assessing the generalization of psychopathy in a clinical sample of domestic violence perpetrators. Law Hum Behav. 2006;30(5):571–586.
35. Capuzzi D, Stauffer MD. *Counseling and psychotherapy: Theories and interventions*. 6th edn. USA, John Wiley & Sons: Alexandria, VA American Counseling Association; 2016:497 p.
36. Skovholt TM. *The resilient practitioner: burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. 3rd edn. New York/London: Routledge; 2016.
37. McCarry M, Larkins C, Radford L, et al. The potential for co-production in developing Violence against women services in Wales. *Social Policy and Society*. 2018;17(2):193–208.
38. Omeni E, Barnes M, MacDonald D, et al. Service user involvement: impact and participation: a survey of service user and staff perspectives. BMC Health Serv Res. 2014;14(1):491.
39. Schulte S, Moring J, Meier PS, et al. User involvement and desired service developments in drug treatment: Service user and provider views. *Drugs: education, prevention and policy*. 2007;14(3):277–287.
40. Mcleod J, Machin L. The context of counselling: A neglected dimension of trainings research and practice. *British Journal of Guidance & Counselling*. 1998;26(3):325–336.
41. BACP - *British Association for Counselling & Psychotherapy*. 2017.
42. *Quality psychotherapy services in the NHS: summary findings from the UKCP and BPC members' survey*. UKCP/BPC; 2016:1–6.
43. Ishkanian A. Neoliberalism and violence: The Big Society and the changing politics of domestic violence in England. *Critical Social Policy*. 2014;34(3):333-353.
44. Bowstead JC. Why women's domestic violence refuges are not local services. *Critical Social Policy*. 2015;35(3):327–349.
45. Ragin CC. *The comparative method: Moving beyond qualitative and quantitative strategies*. California, Oakland, Univ of California Press; 2013.
46. Reed AE, Carstensen LL. The theory behind the age-related positivity effect. *Front Psychol*. 2012;3:339.
47. Creswell JW. *Research design: Qualitative, quantitative, and mixed methods approaches*. UK, London: Sage publications; 2013:330 p.
48. Thomas N, Bull M. Representations of women and drug use in policy: A critical policy analysis. *Int J Drug Policy*. 2018;56:30–39.
49. Brown LS. Empathy, genuineness--And the dynamics of power: A feminist responds to Rogers. *Psychotherapy (chic)*. 2007;44(3):257–259.
50. St Arnaud KO. Encountering the Wounded Healer: Parallel Process and Supervision. *Canadian Journal of Counselling and Psychotherapy (Online)*. 2017;51(2):131.
51. Talbot A. The importance of parallel process in debriefing crisis counsellors. *Journal of Traumatic Stress*. 1990;3(2):265–277.
52. Cameron A, Lart R, Bostock L, et al. Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature. *Health Soc Care Community*. 2014;22(3):225–233.