A sanctuary of tranquillity in a ruptured world: Evaluating long-term counselling at a women's community health centre

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Ethnicity	
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African Nigerian	1
American	3
British	28
European	7
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Indian	1
Irish	4
Israeli	1
Mixed heritage	11
Taiwanese	1
Sexuality	
Asexual	1
Bisexual	5
Heterosexual	44
Lesbian	4
Not clear	5
Employment status	
FT employment	8
PT employment	14
Unemployed	34
Retired	3
Qualifications	
Undergraduate degree or above	33
A level	10
O level/GCSE	6
None	10

Table 2: Abuse, self-harm and psychiatric history of participants

	n	%
Personal history		
Physical abuse as adult	17	28.8%
Physical abuse as child	20	33.9%
Sexual abuse as adult	10	16.9%
Sexual abuse as child	23	38.9%
Emotional abuse as adult	28	47.5%
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Psychiatric medication	29	49.2%
Psychiatric in-patient	12	20.3%
Suicidal ideation	29	49.2%
Self-harm	32	54.2%

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Article

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Keywords

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Introduction

Around 25% of the UK population is estimated to have mental health problems (Swift, Cyhlarova, Goldie, & O'Sullivan, 2014), with 21% of women reporting that they have anxiety or depression (Beaumont & Lofts, 2013). Women have the highest representation in most mental health diagnostic categories, including the highest rates of admission to psychiatric in-patient units (Williams, Scott, & Waterhouse, 2001). Approximately 75% of those diagnosed with 'borderline personality disorder' are

women, and the diagnosis is strongly associated with a history of childhood abuse (National Collaborating Centre for Mental Health, 2009). Mental health issues also affect around 14% of new mothers (Turjanski, 2010).

Some researchers emphasise the effects of biological factors such as menstruation, pregnancy and childbirth on women's mental health (Astbury, 2001). However, there are also clear correlations between social factors and women's mental health. Women are commonly required to carry out multiple roles, are generally the principal carers of children and relatives, may often be isolated working at home, and feature predominantly in low-income low-status jobs. Women who are lone parents and older women are especially likely to live in poverty (Groh, 2007). Depression and other mental health issues have been found to reduce women's likelihood to be in paid work, and to increase the risk of their children suffering from mental illnesses (Lennon, Blome, & English, 2001). Gender differences in mental health are likely to have multiple causes: for instance, girls are more likely to develop self-critical attitudes about their appearance, develop eating disorders, and experience pressure to conform to conventional 'feminine' behaviour (Cromby, Harper, & Reavey, 2013). Clinicians and statutory services have inadequately addressed women's gendered experiences, such as when they become mothers after a history of abuse (Alldred, Crowley, & Rupal, 2001). The United Nations and the World Health Organisation cite gendered violence as the greatest overall health risk to women throughout the world (World Health Organisation, 2005).

Poverty is also one of the most serious risk factors for mental illness for women worldwide (Belle & Doucet, 2003). Factors affecting women on low incomes include

poor social support, living in disadvantaged neighbourhoods, physical and psychosocial comorbidities (Payne, Ciclitira, Starr, Marzano, & Brunswick, 2015), reduced access to educational and employment opportunities, and problems with housing (Groh, 2007). While studies have been published on the mental health issues of women in low income groups (e.g. Belle & Doucet, 2003; Goodman, Glenn, Bohlig, Banyard, & Borges, 2008; Miranda, et al., 2006; Peden, Rayens, & Hall, 2005), relatively little research has been conducted on their responses to counselling and even less on such women undergoing long-term counselling and psychotherapy.

Service provision: short-term and long-term counselling

Vanheule (2009) notes that the emphasis on research into short- rather than long-term therapy is driven by financial concerns and the desire to contrast psychotherapy with pharmaceutical treatments. For example, investment in the Improving Access to Psychological Therapies programme (IAPT) in the UK, with its emphasis on short-term cognitive behavioural therapy (CBT), compounds this imbalance; relatively little research has evaluated longer-term counselling, and mainly with small samples (e.g. Perren, Godfrey, & Rowland, 2009).

The National Institute for Health and Care Excellence guidelines on depression (2009) are limited by the paucity of evidence about the long-term effects of psychological interventions. Studies that have examined the impact of long-term therapy have used different criteria and outcome measures. However, in-depth international studies of psychoanalytic therapy (Beutel, Rasting, Stuhr, Rüger, & Leuzinger-Bohleber, 2004), and a randomised controlled trial in the UK (Fonagy, et al., 2015) suggest that long-term therapy can result in lasting changes in mental and

social functioning, which may ultimately be more cost-effective than short-term therapy. A meta-analysis of 23 studies involving 1053 patients (Leichsenring & Klein, 2014), and a systematic review of 27 outcome studies with 5,063 patients (De Maat, De Jonghe, Schoevers, & Dekker, 2009) found that the efficacy effect sizes for long-term psychotherapy were not only significantly higher than those for short-term therapies, but that they continued to increase from termination of treatment to long-term follow-up, especially in cases of severe and complex mental illnesses.

Women-only services

In the UK, the Department of Health (2002) acknowledges the vital need for women-only mental health services. Women's organisations report that their services empower women to gain more independence and control over their lives, enabling them to take more active roles in their communities. In a study with 1,000 women, 78% thought women seeking professional help should have the choice of a woman clinician, and 97% stated that women who have been sexually assaulted should have access to women-only services (Corry, Dhami, Hudson, Moor, & Pouwhare, 2007). Given the current pressure on public finances, women-only services have been found to deliver economic, social and environmental value. Economic savings include improving women's job opportunities, preventing re-victimisation (e.g. domestic violence), or health problems arising or worsening. Women's services can fill gaps in statutory provision and support hard-to-reach groups (Women's Resource Centre, 2011).

In summary, while their complex psychological issues may be challenging to treat, research suggests that women on low incomes benefit from, and generally prefer

counselling in a women-only service. Given the demand, and the fact that few suitable services exist, it is important to evaluate the effectiveness of such services.

The main aim of this study was to explore how service users make sense of long-term counselling in a women-only service in the context of their gendered experiences and complex needs.

Method

This article describes a longitudinal study of the counselling services at a women's community centre, using semi-structured interviews to explore the views and experiences of 59 women service users. This centre was established by women in 1986, in central London. The Centre prioritises women who are marginalised and on low incomes; it provides low-cost counselling, a wide range of complementary and alternative medicine (CAM), travelling therapies, classes, groups, and has a crèche. The Centre's stated mission is 'to create an integrated complementary and alternative healthcare service responsive to the needs of women, while encouraging and facilitating a broader awareness of women's health issues and promoting innovative ways of approaching healthcare'.

Local women on a low income applying for counselling are clinically assessed by the Centre's counselling co-ordinator (an experienced attachment oriented psychoanalytic psychotherapist). Individual psychological needs, preferences, sexual orientation and counsellor expertise are taken into account to allocate applicants to an appropriate counsellor. At the time of this study the Centre provided long-term, low-fee

counselling (approximately 90 sessions over two years), with 39 female counsellors, primarily unpaid volunteers, and one-third of these were trainees. All counsellors were required to have counselling experience, were expected to be in personal therapy until accredited, to embrace the ethos of the Centre, and to attend regular supervision and the Centre's workshops. Counsellors were required to offer a minimum of four hours a week for two years, and were trained in diverse theoretical orientations, including attachment, existential, Gestalt, integrative, person centred and psychoanalytic approaches.

Sample

All 550 women who were provided counselling during 2003-2010 were sent a leaflet about the larger study, in which they were offered an interview pre- and post-counselling (for details of the larger study see: Payne et al., 2015; Ciclitira, Starr, Marzano, Brunswick, & Costa, 2012; Starr, Ciclitira, Brunswick, Costa, & Marzano, 2012). In total 59 of these participants ranging from 23 to 67 years were interviewed between 2004-2011. Sample characteristics are described in Table 1.

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African Ghanaian	1
African Nigerian	1
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Filipina	1
Indian	1
Irish	4
Israeli	1
Mixed heritage	11
Taiwanese	1

Sexuality	
Asexual	1
Bisexual	5
Heterosexual	44
Lesbian	4
Not clear	5
Employment status	
FT employment	8
PT employment	14
Unemployed	34
Retired	3
Qualifications	
Undergraduate degree or above	33
A level	10
O level/GCSE	6
None	10

33 participants were interviewed pre-counselling only (following their clinical assessment and before they started their counselling), 19 were interviewed post-counselling only, and a further seven were interviewed both pre-counselling and post-counselling.

Sample characteristics (in relation to history of abuse, psychiatric medication, hospitalisation, suicidal ideation and self-harm) are described in Table 2.

Table 2: Abuse, self-harm and psychiatric history of participants

	n	%
Personal history		
Physical abuse as adult	17	28.8%
Physical abuse as child	20	33.9%
Sexual abuse as adult	10	16.9%
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The semi-structured interview guide assessed participants' demographics, medical and psychological histories, incidences of self-harm, and any sexual, emotional and physical abuse. Questions also focussed on individuals' developmental and sociocultural history, and significant relationships throughout their lives. In the pre-counselling interviews women were asked about their reasons for seeking counselling at the centre, and their expectations with regard to their counselling. The post-counselling interview guide repeated some of these questions and also explored how participants reflected on their lives and relationships, as well as whether they had noticed any psychological and health changes. Questions also explored participants' experiences of their counsellor, the counselling process, and various aspects of the Centre. The interviews were carried out by three of the article's authors, were audio-recorded, and lasted between 30 and 83 minutes.

Ethics

The researchers' university's ethics committee gave approval for the research. Researchers informed participants that the researchers worked at a university and not for the Centre, that the interviews would be confidential and that only anonymous excerpts would be published. All participants signed consent forms, and were assured they were not obliged to participate in the research. Interviewers informed participants

that counsellors would not have access to data, and that lack of participation would not affect their counselling. Debriefing involved extensive discussions, and participants were able to contact their interviewer with any concerns. The researchers were aware that many of the participants had suffered trauma and were at increased risk of harm due to research participation (Griffin, Resick, Waldrop, & Mechanic, 2003). All participants were offered the opportunity to amend their interview transcript. All identifying details were anonymised in the transcripts.

Reflexivity and theoretical positioning

As researchers we acknowledge the interplay between ourselves and the participants (Bury, Raval, & Lyon, 2007). Two of the research team are clinicians, interested in the efficacy of long-term therapies, and the other researchers are academics. We recognise the differences between counselling and research, whilst acknowledging the similarities and the fluidity between them. As feminists we aimed to ensure that this study included an examination of power: we were committed to provide a platform from which this marginalised group of women could be heard, to respect participants' autonomy, and to be transparent, including engaging in dialogue with participants which included appropriate self-disclosure (Etherington, 2007). Care was taken to ensure interviewees felt comfortable and that they were viewed as the experts about their experiences; however, the researchers were aware that they too are often positioned exclusively as the 'experts' (see Ciclitira, Marzano, Brunswick, Starr, & Berger, 2004).

Only seven participants were available to be interviewed both pre- and post-counselling. Due to the dropout rate, it was difficult to decide when to end the data

collection; more pre-counselling participants were interviewed, as fewer were available for interview post-counselling. A large sample can increase validity by providing more data and can also give more women a voice (Lumsden, 2013), but after eight years of collecting data with limited resources it was felt necessary to end. There are various possible reasons for the dropout rate. While waiting to start counselling some may have viewed an interview as an opportunity to share their painful experiences, which became less necessary post-counselling. Furthermore, those coping with difficult social circumstances may not have conceived the research as relevant; and perceived communication difficulties between middle-class researchers and participants may have been a factor (McLeod, Johnston, & Griffin, 2000).

Feminist and attachment theories

The research was informed by feminist theory, with the aim of privileging women's voices, promoting social justice, and exploring alternative way of understanding the world through women's experiences (Harding, 2007). The interviews were designed to explore socially constructed barriers, drawing on feminist theory, and recognising that medicalising psychological distress and pathologising femininity can produce an individualising, apolitical and biological form of understanding which neglects social inequalities (Alldred, et al., 2001; Bondi & Burman, 2001; Ussher, 2013). The research was also informed by attachment theory (Bowlby, 1969). Thus the interviews explored participants' significant child and adult attachments, experiences of abuse, self-harm, separation and loss, as well as external environment and socioeconomic circumstances as covered in recent attachment research (Bifulco & Thomas, 2013).

It is acknowledged that there are tensions involved in combining attachment theory and feminist theory. Some feminists have criticised attachment theory for being essentialising, individualising, ahistorical and decontextualising (e.g. Bliwise, 1999; Burman, 2008; Clearly, 1999; Franzblau, 1999). However, social policies and clinical practices are increasingly influenced by attachment approaches, and some feminists accept that they are useful, as long as applications of attachment theory are considered through a critical lens (Buchanan, 2013). Neither attachment theory nor feminist theory are unitary theories, some versions of either are more compatible than others. Previous research has successfully drawn on both theories to focus on gender differences, mental distress and relational themes (e.g. Chittenden, 2015; Orbach, 2003). In addition, there is a move away by attachment theorists and clinicians from a narrow focus that held mothers responsible for their children's social and emotional lives, towards a recognition of systemic perspectives and attachment narratives within cultural and social structures (Dallos & Vetere 2009, 2012) across the whole life span (Holmes & Farnfield, 2014; Mikulincer & Shaver, 2016).

Participants in this study were deliberately not classified into specific attachment categories as used in some research (e.g. George, Kaplan, & Main, 1985), as classifications were viewed as potentially pathologising and too similar to medical diagnosis (Slade, 2008). Attachment quantitative research instruments which only frame mental distress within an individualised perspective were viewed as positivist, and were not considered as suitable for a gendered and feminist analysis (Buchanan, 2013). Pitfalls of previous attachment research were also avoided, such as assumptions about 'biological' mothering, focusing on mothering in isolation from context, and advocating that women should be children's sole carers.

Analysis

The researchers took a critical realist approach, acknowledging the way individuals make meaning of their experience, and how the social context impinges on those meanings, while retaining a focus on material factors (Ussher, 2010). The interviews were transcribed verbatim (Jefferson, 2004). After reading through all of the transcripts the researchers agreed that to address the research aim it would not be useful to separate pre- and post-counselling interview transcripts for analysis, as many of the issues concerned all participants (e.g. women's gendered experiences, their complex needs and views about the NHS (National Health Service), their expectations, and reasons for attending a women's service). In this respect pre-counselling interviews were of as much interest as those post-counselling. However, issues related to women's experiences of long-term counselling necessarily arose only from the post-counselling interviews. Data excerpts were labelled pre- and post-counselling to contextualise them (not for the sake of comparison).

Participants' data were analysed thematically (Braun & Clarke, 2013). The analysis considered attachment theory (Bowlby, 1969), and feminist theory (Harding, 2007). This involved considering women's attachment and relationships throughout their lives and not viewing their childhoods in isolation. Drawing on feminist theory involved considering broader social structures in the context of women's lives. A qualitative method was used to obtain rich and meaningful data, with an aim to both acknowledge the social context of women's lives, and to consider women's actual words and experiences.

Transcripts were coded line-by-line, and text was amalgamated into categories. A coding frame was developed from codes and grounded in the data content. The 'keyness' of a theme was dependent on whether it captured something important in relation to the research question, and represented a level of patterned response or meaning within the data (Braun & Clarke, 2006). Themes were refined so they were specific enough to be discrete, and broad enough to encapsulate the ideas contained in text segments (Attride-Stirling, 2001). NVivo (computer software) assisted in systematically looking at prevalence, patterns and links between codes and themes. This involved on- and off-computerised analysis to avoid abstracting data and attaching too much importance to the frequency of codes (Joffe, 2012).

The analysis focussed on themes that were common across the interviews, i.e. the dominant themes that were the specific interest of this study, whilst also considering exceptions and contradictions. Criteria for selection were not intended to attribute greater overall explanatory value to themes on a quantitative basis, but simply to focus attention on commonalities. Another analysis (e.g. with a focus on individual narratives) could have employed different criteria for selection (see Attride-Stirling, 2001).

Findings

The four main themes all relate to the study's aim to explore how participants make sense of long-term counselling in a women's service in the context of their gendered experiences and complex needs. The first theme explores participants' traumatic histories and broken attachments, i.e. 'violence and loss in the context of female oppression', with sub-themes: 'the permeating losses of migration' and 'life blown

apart: the impact of childhood abuse'. The second theme explores 'a sanctuary for women', with sub-themes: 'an oasis of tranquillity' and the gendered dimensions of distress'. The third theme explores 'non-medicalised long-term counselling in a safe setting' in which participants discuss their experiences of the NHS. The fourth theme 'benefits of the long view' includes the sub-themes 'it takes time to do the work' and 'healing the ruptures: psychological and physical wellbeing' (the fourth theme arose only from post-counselling interviews).

1. Violence and loss in the context of female oppression

It was considered important to have some understanding of the context of women's complex lives before focussing on their experiences of counselling. Participants discussed how their early significant attachments had been disrupted. Two sub-themes were identified: 'the permeating losses of migration', and 'life blown apart: the impact of childhood abuse'.

The permeating losses of migration

Twenty-eight of the participants had experienced forced migration, and reported negative effects which included separation from family and communities, violence, lack of social support, racism, loss of country, language, culture, and low socioeconomic status. Jennifer was born in Asia during a civil war; one of her sisters was tortured and another died, and her father was in prison. She was sent to England alone aged seven:

> The trauma is about my, the guardians…never listened, because they were very, very religious so they did things that they believed that God wanted them to do. (Pre-counselling)

Anne described traumatic events after she was sent by her father to a war-torn country at three years old:

> Mum and I were captured…I had guns to my head…since then I've had a lot of problems. I got expelled from school because I was just crapping myself…and my mum was very abusive…and would burn me. (Post-counselling)

Mothers can be left with the tragic choice of separating from their young children, not only due to poverty, but also for safety. Elizabeth's mother abandoned her in Asia when she was 13 years to work in the UK. Elizabeth reported severe anxiety that was affecting her eating and sleeping. Since she started counselling she reported that her anxiety had considerably reduced and that she was dealing better with relationships:

> It is relationships and it is intimacy, and it is I suppose liking myself and accepting myself. Because I never, I didn't really ever get that from my parents, so it's, and that's what I have kind of discovered through the therapy. So it's not, I am not mad, I just have trust issues…I haven't had one (panic attack) for a very, very long time. (Post-counselling)

Life blown apart: The impact of childhood abuse

Katarina was sexually abused, and reported that when she started hearing voices 'telling me to kill myself' she decided to have counselling at a women's service:

> Like somebody put a hand-grenade in the middle of my life and just blown it all a part, and my life is just all these bits that you know I couldn't put back together again and that's when I needed help...I lost my job because I got really ill. (Pre-counselling)

Most participants reported a life-long history of multiple abuses. Melinda reported that her violent father sexually abused her; she subsequently took an overdose, and at 14 she was raped. Melinda felt that long-term counselling had enabled her to deal with life better:

> When you start feeling better about yourself you start thinking things differently which the counselling can help. It alters your mind. (Post-counselling)

2. *A sanctuary for women*

Findings highlighted the importance of a safe and calm counselling environment. The majority of the participants had complex histories of abuse, and stressed the importance of having their counselling in a women-only centre, in the sub-themes 'an oasis of tranquillity' and 'the gendered nature of mental distress'.

An oasis of tranquillity

Mandy reported being in violent relationships with men most of her adult life. She said 'It's really great to have a women only centre':

> A totally different environment…Not just because I've had all these violent relationships with men…It's an oasis of tranquillity…There are lots of women that wouldn't come…if it was mixed. (Post-counselling)

Katarina, who was severely abused in childhood explained:

> It feels very safe there and it's very friendly and laid back...It doesn't feel intimidating or anything like that…There should be more places like that around, (the Centre) is like a little jewel…if men were here I wouldn't feel so safe. And I think it would change the atmosphere. Women and men create different energy. (Pre-counselling)

Elspeth said 'it helps so much':

> I owe so much to the Centre because it's a sanctuary for women, and it's a place to just become a woman…a safe place. (Post-counselling)

The gendered dimensions of mental distress

Sandra said that the reasons for her distress were at least in part gendered in nature, and emphasised the importance of having counselling at a women's centre:

> I was attacked a few years ago...It's nice that it's women only…Men can be just out for one thing and make you feel uncomfortable, so you don't have to worry about that. (Pre-counselling)

In contrast to her experience at a women-only service, Miranda described how detrimental it was to have counselling with a man elsewhere:

> It felt like he had a scalpel and he just pick, pick, pick...he didn't even worry about closing me up. A lot of it was around the sexual abuse as a child...explaining to him that for a woman having her virginity taken against her will is really different to a man…I said I needed a woman counsellor…He would leave me in absolute pieces and what he did was he unpicked all these wounds, and I was walking out of there devastated…it did more harm than good…I ended up drinking more. (Pre-counselling)

3. Non-medicalised long-term counselling in a safe setting

Participants discussed having long-term counselling in this safe community setting and their preference for having counselling outside of the NHS. Melinda said:

> You have got nicer counsellors here than they have at the NHS…People that want to work here are the type of people that want to help, not just to make money…more intimate and most of the people are nice. You feel that there is an internal warmness, and they are not just being nice for the sake of being nice. (Post-counselling)

Voluntary organisations like this Centre are generally not bound by structures of the kind that prevail in the NHS. Katarina said:

> It's a safe place. And for me it's really important because it's not in the mental health system…because in the mental health system everything is centralised and everything you say is put on a central computer and you know it makes you feel really vulnerable. (Post-counselling)

Many of the participants reported negative experiences of being on psychiatric medications and encountering male clinicians. Carol, a woman in her late 20s, had been on anti-depressants for more than ten years:

> Some of them (anti-depressants) obviously didn't work, and I had one really bad doctor and he actually said to me 'oh you are not suffering from depression because otherwise they would work'…You are so vulnerable you don't have the strength to say anything. (Pre-counselling)

Miranda described how she was sectioned and felt pathologised for having been raped:

> My 18th birthday, I had seven months in a lock, being surrounded by very, very poorly people and nobody allowing me to say 'listen, my step-father is an evil bastard who has been beating us, raping me, beating my mother'…They wouldn't discharge me, and they would perceive that as me being ill…They gave me lithium, which I swelled up…I've got the scars of the effect that drug had on me. (Pre-counselling)

4. Benefits of the long view

Many participants appreciated the opportunity to have long-term counselling and to have the time to think about their lives.

It takes time to do the work

Participants gave various reasons for the value of having time. Joanna said:

> I am terribly impressed that it [the Centre] offers two years counselling. If you get counselling from your GP it's something like six sessions, which it takes you that before you even start talking…Over a two year period you can really relax, and not think oh my god there are only another few sessions…It was an accumulative effect, it did stop me feeling suicidal. (Post-counselling)

Linda explained:

> What I like about (the Centre) is that it is on-going. So it allows…much more exploration of whatever and six weeks (in the NHS) is nothing, so it's really a big difference…(discussing) the same things but with different layers and you know, maybe I might think 'oh this is the reason I am doing it' or 'this is the reason why I am like that. (Post-counselling)

Lorraine said that she needed time to understand the links between her childhood and her abusive adult relationships:

> Slowly, slowly I've been able to make understanding between things that happened quite a long time ago and things that are happening to me now…I've

> got more understanding about the reason why all this has happened. (Post-counselling)

Elizabeth reported that she had suicidal feelings before she started counselling, and that it took time for her to explore these:

> It took quite a long time for me to completely open up to her as well, because I had never really done it with anyone before so that was initially quite hard. But I think our relationship is good…You just get into the habit about feeling bad about yourself and dealing with everything on your own…It was good…to realise it was alright to feel the way I felt. (Post-counselling)

Alison had six weeks of NHS therapy, which 'wasn't sufficient', and she described the benefits of her long-term work with her 'very receptive and very warm' female counsellor:

> She helps me to go through all these feelings and…helps me with some interpretations, and she is very patient. It doesn't seem to matter that we go over the same ground again and again…It's very helpful. (Post-counselling)

Three participants talked about how difficult counselling could be at times. Katarina described how painstaking, although helpful, counselling has been:

> I've started dipping my toes in the water, very slowly, it's not something I feel very comfortable about…I am starting to be more open about things over the

> last couple of years. More out of desperation really because I just realise how much help that I need to kind of sort myself out…It was quite hard work but…I could see the value…being able to stop and look at yourself…the mirroring all the way through the rest of life…get a little bit more distance from the crisis situation and bit more perspective on it all. (Post-counselling)

Elizabeth said:

> There were times when I just didn't want to go, it was a real struggle for me to go, I just thought 'I can't bear it, I can't bear it, I can't bear it, dread, dread, dread'…It's only…six months that I have really gone how bloody lucky am I to have this, like to go and talk about myself. And I think it's fabulous now…going over what we've done in the last year or so, and making it more kind of concrete…a bit more automatic and natural. (Post-counselling)

Healing the ruptures: psychological and physical wellbeing

All of the 26 participants interviewed post-counselling reported positive changes which they attributed to their long-term counselling. Most said they had gained greater insight into their lives and behaviour. The reported effects of counselling included being 'able to cope' with difficult feelings, having a better understanding of their lives which 'removed self-blame', and in some cases no longer feeling suicidal.

Most of the participants had suffered various illnesses before their counselling, and some had used excessive alcohol and drugs. Participants reported various health-related benefits from counselling, and six reported positive physical changes.

Catherine said that due to her counselling she had been able to come off sedatives, face her difficulties, and engage in life:

> It was certainly a really important part of my being able to sort out mental health issues…it basically saved my life…I had a life which frankly wasn't worth having…trying to run away from myself…(the Centre) was quite instrumental in getting me to a place where I want to be present and to take part in life…I used to smoke a lot of weed and I used to drink really heavily, so I don't smoke at all…my diet is more healthy. (Post-counselling)

Mary described how long-term counselling had helped her:

> Without having had counselling…I would have been really stressed out. I might have turned to drink and drugs, or I might have beaten my children…I've felt really desperate and stressed, and I feel that having counselling has helped me to manage myself better and my feelings better and to process…To physically…move on as well...Your emotional wellbeing transpires onto your physical wellbeing I suppose, I've slept a lot better for it. (Post-counselling)

Seven participants reported that they believed that psychological changes, which they attributed to their counselling, had facilitated them to feel more confident and capable of being employed or embarking on training. For example, Belinda said:

> Counselling has sort of led me into a different place, which I think then made the job feasible…I feel very emotionally strong. (Post-counselling)

Mary believed that being able to process her emotions over time in counselling had enabled her to take better care of herself:

> Processing what my feelings are...I really do feel like I have moved on…I've got a really good relationship with myself…I'm much happier and more confident in myself. I'm really happy about my job…I can continue to make changes in my life, I've been more assertive, I've made a plan, it really had a really positive impact…There are things that are within control I can change them. I am off (State) benefits, which I'm really pleased about. (Post-counselling)

Mary reported that developing her emotional intelligence had improved her relationships and helped her children:

> I've got a better understanding of myself, and of other people…I value my emotional intelligence…I kind of developed it. And that's all developed in my children as well and they've got much better. (Post-counselling)

Discussion

The analysis in this study identified four broad themes. The first theme 'violence and loss in the context of female oppression' outlines the extreme distress and trauma reported by most of the participants, and the fact that almost half of the sample had experienced forced migration. In the second theme 'a sanctuary for women' the participants described the importance of being able to attend a women's centre, and highlighted how valuable it is for those who had suffered violent abuse perpetrated by men (no participants objected to it being a women-only centre). The third theme 'non-medicalised long-term counselling in a safe setting' explored why all of these participants chose to have long-term counselling at this centre rather than in the NHS. In the fourth theme 'benefits of the long view' post-counselling participants discussed why they found long-term as opposed to short-term counselling helpful. In the sub-theme 'it takes time to do the work' participants described the necessity of having time to understand their issues, to make links to their childhood, and to help them avoid repeating destructive patterns. In the sub-theme 'healing the ruptures: psychological and physical wellbeing' post-counselling participants' described various psychological and physical benefits they attributed to their counselling.

Most of the women in this study had suffered extreme ruptures in their emotional and physical lives through extensive abuse and deprivation. Poor parenting, stress, lack of other support, and a history of abuse all affect individuals' relationships, wellbeing and ability to reflect and mentalise (Holmes & Farnfield, 2014). However, as found in this study, women can find that being able to describe their experiences of abuse gives them a sense of relief and a feeling of solidarity with other survivors (Phillips & Daniluk, 2004). Furthermore, women who have suffered violations of trust with their caregivers can have difficulties with attachments throughout their lives (Bifulco &

Thomas, 2013), which emphasises the importance of these women being able to have low-fee counselling in a women's centre where they feel safe. Those who have experienced forced migration are in particular need of such services as they are reported to have around ten times higher levels of mental and psychological illnesses, (particularly post-traumatic stress), than the general population of developed host countries (Schouler-Ocak, 2015).

As in previous research (e.g. McLeod, et al., 2000; Winter, Archer, Spearman, Costello, Quaite, & Metcalfe, 2003), participants with a low socio-economic status reported various benefits from counselling, including being able to explore and better understand their life histories in an environment they perceived as 'safe', 'warm' and 'friendly', and to make positive changes in their lives. These changes also included reduced anxiety, depression and suicidal ideation, finding employment, and improved health. Significant personal gains included being better able to look after themselves, being able to improve their relationships (including with their children), not repeating negative patterns as mothers, and being able to leave an abusive partner. As Catherine poignantly put it, counselling had 'saved her life'.

The ability to develop a relationship with a counsellor over longer-term counselling appeared to be particularly significant. Participants said that they needed *time* in counselling to understand the nature of their difficulties and that this enabled them to recognise that these stemmed from their traumatic childhoods and complex adult lives. This process was noted by some participants as painstaking work that required them to go over their issues again and again. As well as being able to have counselling in a women-only environment, the changes that participants reported could also be

attributed to three overlapping concepts of attachment theory and psychoanalytic practice which are viewed as key concepts for effective therapy: the therapeutic relationship, meaning making, and promoting change (Holmes, 2009).

Women in this study also explained why it was important for them to receive long-term counselling in a women-only supportive environment compared to the NHS, which largely provides short-term CBT in a medicalised environment. Psychiatrists tend to use a disease model of diagnosis, with virtually no basis for the diagnostic categories or evidence of neurobiological malfunction, prescribing medication with side effects, and some times with limited interest in terminating prescriptions (Gergen, 2015; Lafrance & McKenzie-Mohr, 2013; Saibil, 2005). In a medical context women's narratives are often presented in a way which can invalidate personal distress in favour of the 'expert' health professionals, and pathologises social issues and abuse such as domestic violence and rape, as noted by the participant Miranda who was sectioned after having being raped by her step-father (Lavis, Horrocks, Kelly & Barker, 2005; Tosh, 2011).

However, McLeod and Wright (2009: 128) argue that although psy-based knowledge and practice – what they call a therapeutic ethos - regulate subjectivity and conduct, they can also open up transformative and productive possibilities for women, providing a sense of competence in socially difficult and damaging circumstances. Women not only want women-only services but they are also cost-effective, as they are inexpensive to run and create savings for health provision (Corry, et al., 2007). Furthermore better support for mothers can improve mental health outcomes for women and for their children (Department of Health, 2014).

Limitations and strengths

This naturalistic study necessarily has limitations. This is partly due to lack of resources. In the current economic climate funding in the UK is mainly allocated to randomised control studies (RCTs) of 'evidence-based practices' such as CBT and its descendants, e.g. Acceptance and Commitment Therapy, Dialectical Behaviour Therapy and Mindfulness. Consequently, the voices of service users and the complexity of their lives are largely absent from clinical studies. The expense and complexity of such research mean that most clinical research is conducted in medicalised, government funded, high profile establishments (unlike this one), and therefore rarely focus on types of therapy not generally represented e.g. feminist, gay, lesbian, bisexual and transgender (LGBT), long-term relational therapy, and multicultural therapy. Unlike most quantitative RCTs, a qualitative evaluation like in this study, accepts ambiguity in outcomes rather than adopting a 'horse race' mentality in which the therapy with the highest score is the winner (McLeod, 2011: 262).

Practice implications

In the climate of concern for cost-effectiveness, the findings from this study offer another contribution to the growing body of support for the benefits of long-term therapies. Whilst it is argued that short-term therapies provide rapid cost-effective benefits, long-term therapies can provide more intense and longer-lasting change (Lindfors, Knekt, Heinonen, Härkänen, & Virtala 2015). This suggests the need for a cultural shift to expand government service provision beyond CBT to further include longer-term therapies (Loewenthal & House, 2010).

Whilst there are relatively few overtly attachment-based therapies, attachment theory has much to say about the procedural and relational aspects of all therapies. Attachment ideas constitute a meta-position from which to view therapeutic practice (Holmes, 2009; Slade, 2008). Categorisation of 'attachment types' to understand distress, however, is largely reductionist and minimises complex lived experiences. With the increased popularity of attachment theory, the cause of domestic violence and 'mental illness' is often situated as a product of an individual's insecure early attachment relationships (see Buchanan, 2013). Psychological therapists of all orientations should engage in a critical analysis of their individualising therapeutic models including attachment theory, and consider broader relational, sociocultural contexts and dominant sociocultural discourses surrounding oppressed groups, including women. Gender and its related power imbalances should not be rendered invisible by clinicians and theorists (McPhail, Busch, Kulkarni, & Rice, 2007). Smail (2005) argues that it is not possible to understand the phenomena of psychological distress without consideration of how power is distributed and exercised within society. A raised awareness of these issues would reduce the drive to pathologise human experience (Dillon & Hornstein, 2013), and hopefully improve the therapeutic experience and outcomes for service users.

Future research

Future research could focus on evaluating services suitable for female survivors of violence, including migrants and refugees. Forced migration, which is on the increase worldwide, is stressful and increases the risk of poor health (Schouler-Ocak, 2015). Women are at particular risk of gender-based discrimination and violence such as rape

(Quilted Sightings, 2008). Clinical research should further consider factors such as ethnicity, sexual orientation, disability and gender, which could lead to better treatment and outcomes (Killin & Della Sala, 2015).

Research could also consider the benefits of the complementary and alternative medicine (CAM) being offered by this and similar services. Individuals with diagnosed serious mental illnesses have been found to perceive CAM as providing a wide range of benefits (Russinova, Cash, & Wewiorski, 2009).

Further research into the experience and effectiveness of long-term therapy is essential. The impact of long-term therapies is under-researched (Perren, Godfrey, & Rowland, 2009), and individuals such as those in this study with complex mental issues have been found to benefit from long-term therapy (Leichsenring & Rabung, 2011). Women on low incomes report levels of mental health difficulties that are much higher than the norm (e.g. McLeod et al., 2000); and in this study long-term counselling appeared to be effective regardless of the level of initial severity (see Payne et al., 2015). In the UK, given that IAPT services offer mainly short-term CBT or self-help to approximately just 15% of those with diagnosed mental illnesses (NHS, 2015), there is clearly a need for rigorously evaluated long-term mental health services both in the public and voluntary sectors.

In conclusion, this study aimed to consider how female participants' make sense of long-term counselling in the context of their gendered experiences, relationships and the complex sociocultural and economic contexts of their lives. Women-only centres established by women aim to support those suffering from social inequalities and

diagnosed with mental 'illnesses' and to help them find ways of dealing with their distress and histories of abuse (Williams, Scott, & Waterhouse, 2001). Women can develop confidence, independence, feel less marginalised, more listened to and more able to express themselves when using women-only services (Corry, et al., 2007). This is clearly supported in this study, yet in 2015 this long-term service was suspended after losing Government funding.

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