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Ciclitira, Karen ORCID: <https://orcid.org/0000-0001-7222-0334>, Starr, Fiona, Payne, Nicola ORCID: <https://orcid.org/0000-0001-5885-9801>, Clarke, Lisa and Marzano, Lisa ORCID: <https://orcid.org/0000-0001-9735-3512> (2017) A sanctuary of tranquillity in a ruptured world: evaluating long-term counselling at a women's community health centre. *Feminism & Psychology*, 27 (4) . pp. 530-552. ISSN 0959-3535 [Article] (doi:10.1177/0959353516685344)

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

Journal:	<i>Feminism &amp; Psychology</i>
Manuscript ID	FAP-15-5370.R3
Manuscript Type:	Article
Keywords:	abuse, attachment, long-term counselling, low income, women-only, qualitative, feminist, women's centre, thematic analysis, mental health
Abstract:	<p>The longitudinal study described in this article evaluated long-term counselling provided at a women’s health centre in the UK for service users on low incomes. The article focuses on the qualitative aspect of the study in which 59 women were interviewed individually before and/or after their counselling. The interviews explored how women make sense of long-term counselling in the context of their gendered experiences and complex needs. The data were analysed using thematic analysis informed by a feminist orientation and attachment theory. Four main themes emerged: ‘violence and loss in the context of female oppression’, ‘a sanctuary for women’, ‘non-medicalised long-term counselling in a safe setting’, and ‘benefits of the long view’. Participants attributed various benefits to receiving long-term counselling in a women-only environment. These included gaining employment; reduced suicidal ideation, anxiety and depression; improved physical health, improved confidence and being able to make positive changes in their relationships. The women interviewed post-counselling valued long term-counselling in this context, in contrast to short-term therapy in a medicalised environment. Wider implications with regards to clinical practice and research are discussed.</p>

**Abstract**

The longitudinal study described in this article evaluated long-term counselling provided at a women's health centre in the UK for service users on low incomes. The article focuses on the qualitative aspect of the study in which 59 women were interviewed individually before and/or after their counselling. The interviews explored how women make sense of long-term counselling in the context of their gendered experiences and complex needs. The data were analysed using thematic analysis informed by a feminist orientation and attachment theory. Four main themes emerged: 'violence and loss in the context of female oppression', 'a sanctuary for women', 'non-medicalised long-term counselling in a safe setting', and 'benefits of the long view'. Participants attributed various benefits to receiving long-term counselling in a women-only environment. These included gaining employment; reduced suicidal ideation, anxiety and depression; improved physical health, improved confidence and being able to make positive changes in their relationships. The women interviewed post-counselling valued long term-counselling in this context, in contrast to short-term therapy in a medicalised environment. Wider implications with regards to clinical practice and research are discussed.

Table 1: Participants' characteristics (n=59)

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<b><i>Ethnicity</i></b>	
African Ghanaian	1
African Nigerian	1
American	3
British	28
European	7
Filipina	1
Indian	1
Irish	4
Israeli	1
Mixed heritage	11
Taiwanese	1
<b><i>Sexuality</i></b>	
Asexual	1
Bisexual	5
Heterosexual	44
Lesbian	4
Not clear	5
<b><i>Employment status</i></b>	
FT employment	8
PT employment	14
Unemployed	34
Retired	3
<b><i>Qualifications</i></b>	
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	%
<b><i>Personal history</i></b>		
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%
Emotional abuse as child	33	55.9%
<b><i>Psychiatric medication</i></b>	29	49.2%
<b><i>Psychiatric in-patient</i></b>	12	20.3%
<b><i>Suicidal ideation</i></b>	29	49.2%
<b><i>Self-harm</i></b>	32	54.2%

### Acknowledgements

We would like to thank all the women who participated in this study and their generosity for being so willing to share intimate details about their lives. We are also grateful to Sue Berger for her support, as well as to Clare Lewis, Nicky Brunswick and Ana Costa.

For Peer Review

### Author biographies

Karen Ciclitira is an Associate Professor in the Department of Psychology at Middlesex University. Dr Ciclitira is also a practising psychoanalytic psychotherapist. Her scholarly interests include mental health, women's health, diversity, gender, and sexuality.

Nicky Payne is a Health Psychologist and Associate Professor in the Department of Psychology at Middlesex University. Her primary research interests are work-life balance, gender and diversity in the workplace, and stress and health behaviour change.

Lisa Marzano is an Associate Professor in the Department of Psychology at Middlesex University, specialising in mental health and suicide research.

Fiona Starr is a practising clinical psychologist, family therapist and an Associate Professor in the Department of Psychology at Middlesex University. Her research interests centre on aspects of clinical practice, supervision, and child and family mental health.

Lisa Clarke is a lecturer in the Social Policy Research Centre at Middlesex University. Her research interests include: knowledge transfer, ethnicity, migration, diversity and equality, and qualitative research.

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

(Department of Psychology), Middlesex University, UK

**Fiona Starr**

(Department of Psychology), Middlesex University, UK

**Nicky Payne**

(Department of Psychology), Middlesex University, UK

**Lisa Clarke**

(Department of Social Policy), Middlesex University, UK

**Lisa Marzano**

(Department of Psychology), Middlesex University, UK

**Abstract**

The longitudinal study described in this article evaluated long-term counselling provided at a women's health centre in the UK for service users on low incomes. The article focuses on the qualitative aspect of the study in which 59 women were interviewed individually before and/or after their counselling. The interviews explored how women make sense of long-term counselling in the context of their gendered experiences and complex needs. The data were analysed using thematic analysis informed by a feminist orientation and attachment theory. Four main themes emerged: 'violence and loss in the context of female oppression', 'a sanctuary for



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### **Keywords**

Abuse, attachment, feminist, long-term counselling, low income, mental health, qualitative, thematic analysis, women's centre, women-only

### **Corresponding author:**

Karen Ciclitira, Department of Psychology, Middlesex University, The Burroughs,  
London NW4 4BT, UK

Email: k.ciclitira@mdx.ac.uk

### **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

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3 women, and the diagnosis is strongly associated with a history of childhood abuse  
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5 (National Collaborating Centre for Mental Health, 2009). Mental health issues also  
6  
7 affect around 14% of new mothers (Turjanski, 2010).  
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12 Some researchers emphasise the effects of biological factors such as menstruation,  
13  
14 pregnancy and childbirth on women's mental health (Astbury, 2001). However, there  
15  
16 are also clear correlations between social factors and women's mental health. Women  
17  
18 are commonly required to carry out multiple roles, are generally the principal carers  
19  
20 of children and relatives, may often be isolated working at home, and feature  
21  
22 predominantly in low-income low-status jobs. Women who are lone parents and older  
23  
24 women are especially likely to live in poverty (Groh, 2007). Depression and other  
25  
26 mental health issues have been found to reduce women's likelihood to be in paid work,  
27  
28 and to increase the risk of their children suffering from mental illnesses (Lennon,  
29  
30 Blome, & English, 2001). Gender differences in mental health are likely to have  
31  
32 multiple causes: for instance, girls are more likely to develop self-critical attitudes  
33  
34 about their appearance, develop eating disorders, and experience pressure to conform  
35  
36 to conventional 'feminine' behaviour (Cromby, Harper, & Reavey, 2013). Clinicians  
37  
38 and statutory services have inadequately addressed women's gendered experiences,  
39  
40 such as when they become mothers after a history of abuse (Alldred, Crowley, &  
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42 Rupal, 2001). The United Nations and the World Health Organisation cite gendered  
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44 violence as the greatest overall health risk to women throughout the world (World  
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46 Health Organisation, 2005).  
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55 Poverty is also one of the most serious risk factors for mental illness for women  
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57 worldwide (Belle & Doucet, 2003). Factors affecting women on low incomes include  
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3 poor social support, living in disadvantaged neighbourhoods, physical and  
4 psychosocial comorbidities (Payne, Ciclitira, Starr, Marzano, & Brunswick, 2015),  
5 reduced access to educational and employment opportunities, and problems with  
6 housing (Groh, 2007). While studies have been published on the mental health issues  
7 of women in low income groups (e.g. Belle & Doucet, 2003; Goodman, Glenn,  
8 Bohlig, Banyard, & Borges, 2008; Miranda, et al., 2006; Peden, Rayens, & Hall,  
9 2005), relatively little research has been conducted on their responses to counselling  
10 and even less on such women undergoing long-term counselling and psychotherapy.  
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24 *Service provision: short-term and long-term counselling*

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26 Vanheule (2009) notes that the emphasis on research into short- rather than long-  
27 term therapy is driven by financial concerns and the desire to contrast psychotherapy  
28 with pharmaceutical treatments. For example, investment in the Improving Access to  
29 Psychological Therapies programme (IAPT) in the UK, with its emphasis on short-  
30 term cognitive behavioural therapy (CBT), compounds this imbalance; relatively  
31 little research has evaluated longer-term counselling, and mainly with small samples  
32 (e.g. Perren, Godfrey, & Rowland, 2009).  
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44 The National Institute for Health and Care Excellence guidelines on depression  
45 (2009) are limited by the paucity of evidence about the long-term effects of  
46 psychological interventions. Studies that have examined the impact of long-term  
47 therapy have used different criteria and outcome measures. However, in-depth  
48 international studies of psychoanalytic therapy (Beutel, Rasting, Stuhr, Rüger, &  
49 Leuzinger-Bohleber, 2004), and a randomised controlled trial in the UK (Fonagy, et  
50 al., 2015) suggest that long-term therapy can result in lasting changes in mental and  
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3 social functioning, which may ultimately be more cost-effective than short-term  
4 therapy. A meta-analysis of 23 studies involving 1053 patients (Leichsenring &  
5 Klein, 2014), and a systematic review of 27 outcome studies with 5,063 patients (De  
6 Maat, De Jonghe, Schoevers, & Dekker, 2009) found that the efficacy effect sizes for  
7 long-term psychotherapy were not only significantly higher than those for short-term  
8 therapies, but that they continued to increase from termination of treatment to long-  
9 term follow-up, especially in cases of severe and complex mental illnesses.  
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### 20 *Women-only services*

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22 In the UK, the Department of Health (2002) acknowledges the vital need for women-  
23 only mental health services. Women's organisations report that their services  
24 empower women to gain more independence and control over their lives, enabling  
25 them to take more active roles in their communities. In a study with 1,000 women, 78%  
26 thought women seeking professional help should have the choice of a woman  
27 clinician, and 97% stated that women who have been sexually assaulted should have  
28 access to women-only services (Corry, Dhimi, Hudson, Moor, & Pouwhare, 2007).  
29  
30 Given the current pressure on public finances, women-only services have been found  
31 to deliver economic, social and environmental value. Economic savings include  
32 improving women's job opportunities, preventing re-victimisation (e.g. domestic  
33 violence), or health problems arising or worsening. Women's services can fill gaps in  
34 statutory provision and support hard-to-reach groups (Women's Resource Centre,  
35 2011).  
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54 In summary, while their complex psychological issues may be challenging to treat,  
55 research suggests that women on low incomes benefit from, and generally prefer  
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3 counselling in a women-only service. Given the demand, and the fact that few  
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5 suitable services exist, it is important to evaluate the effectiveness of such services.  
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10 The main aim of this study was to explore how service users make sense of long-term  
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12 counselling in a women-only service in the context of their gendered experiences and  
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14 complex needs.  
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### 17 18 19 20 **Method**

21  
22 This article describes a longitudinal study of the counselling services at a women's  
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24 community centre, using semi-structured interviews to explore the views and  
25  
26 experiences of 59 women service users. This centre was established by women in  
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28 1986, in central London. The Centre prioritises women who are marginalised and on  
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30 low incomes; it provides low-cost counselling, a wide range of complementary and  
31  
32 alternative medicine (CAM), travelling therapies, classes, groups, and has a crèche.  
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34 The Centre's stated mission is 'to create an integrated complementary and alternative  
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36 healthcare service responsive to the needs of women, while encouraging and  
37  
38 facilitating a broader awareness of women's health issues and promoting innovative  
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40 ways of approaching healthcare'.  
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47 Local women on a low income applying for counselling are clinically assessed by the  
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49 Centre's counselling co-ordinator (an experienced attachment oriented psychoanalytic  
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51 psychotherapist). Individual psychological needs, preferences, sexual orientation and  
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53 counsellor expertise are taken into account to allocate applicants to an appropriate  
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55 counsellor. At the time of this study the Centre provided long-term, low-fee  
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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.

Table 1: Participants' characteristics (n=59)

	n
<b><i>Ethnicity</i></b>	
African Ghanaian	1
African Nigerian	1
American	3
British	28
European	7
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	%
<b>Personal history</b>		
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%

Emotional abuse as child	33	55.9%
<i>Psychiatric medication</i>	29	49.2%
<i>Psychiatric in-patient</i>	12	20.3%
<i>Suicidal ideation</i>	29	49.2%
<i>Self-harm</i>	32	54.2%

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



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2  
3 that counsellors would not have access to data, and that lack of participation would  
4 not affect their counselling. Debriefing involved extensive discussions, and  
5 participants were able to contact their interviewer with any concerns. The researchers  
6 were aware that many of the participants had suffered trauma and were at increased  
7 risk of harm due to research participation (Griffin, Resick, Waldrop, & Mechanic,  
8 2003). All participants were offered the opportunity to amend their interview  
9 transcript. All identifying details were anonymised in the transcripts.  
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### 20 21 *Reflexivity and theoretical positioning*

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23 As researchers we acknowledge the interplay between ourselves and the participants  
24 (Bury, Raval, & Lyon, 2007). Two of the research team are clinicians, interested in  
25 the efficacy of long-term therapies, and the other researchers are academics. We  
26 recognise the differences between counselling and research, whilst acknowledging the  
27 similarities and the fluidity between them. As feminists we aimed to ensure that this  
28 study included an examination of power: we were committed to provide a platform  
29 from which this marginalised group of women could be heard, to respect participants'  
30 autonomy, and to be transparent, including engaging in dialogue with participants  
31 which included appropriate self-disclosure (Etherington, 2007). Care was taken to  
32 ensure interviewees felt comfortable and that they were viewed as the experts about  
33 their experiences; however, the researchers were aware that they too are often  
34 positioned exclusively as the 'experts' (see Ciclitira, Marzano, Brunswick, Starr, &  
35 Berger, 2004).  
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54 Only seven participants were available to be interviewed both pre- and post-  
55 counselling. Due to the dropout rate, it was difficult to decide when to end the data  
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3 collection; more pre-counselling participants were interviewed, as fewer were  
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5 available for interview post-counselling. A large sample can increase validity by  
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7 providing more data and can also give more women a voice (Lumsden, 2013), but  
8  
9 after eight years of collecting data with limited resources it was felt necessary to end.  
10  
11 There are various possible reasons for the dropout rate. While waiting to start  
12  
13 counselling some may have viewed an interview as an opportunity to share their  
14  
15 painful experiences, which became less necessary post-counselling. Furthermore,  
16  
17 those coping with difficult social circumstances may not have conceived the research  
18  
19 as relevant; and perceived communication difficulties between middle-class  
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21 researchers and participants may have been a factor (McLeod, Johnston, & Griffin,  
22  
23 2000).  
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### 29 *Feminist and attachment theories*

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31 The research was informed by feminist theory, with the aim of privileging women's  
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33 voices, promoting social justice, and exploring alternative way of understanding the  
34  
35 world through women's experiences (Harding, 2007). The interviews were designed  
36  
37 to explore socially constructed barriers, drawing on feminist theory, and recognising  
38  
39 that medicalising psychological distress and pathologising femininity can produce an  
40  
41 individualising, apolitical and biological form of understanding which neglects social  
42  
43 inequalities (Alldred, et al., 2001; Bondi & Burman, 2001; Ussher, 2013). The  
44  
45 research was also informed by attachment theory (Bowlby, 1969). Thus the interviews  
46  
47 explored participants' significant child and adult attachments, experiences of abuse,  
48  
49 self-harm, separation and loss, as well as external environment and socioeconomic  
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51 circumstances as covered in recent attachment research (Bifulco & Thomas, 2013).  
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3 It is acknowledged that there are tensions involved in combining attachment theory  
4 and feminist theory. Some feminists have criticised attachment theory for being  
5 essentialising, individualising, ahistorical and decontextualising (e.g. Bliwise, 1999;  
6 Burman, 2008; Clearly, 1999; Franzblau, 1999). However, social policies and clinical  
7 practices are increasingly influenced by attachment approaches, and some feminists  
8 accept that they are useful, as long as applications of attachment theory are considered  
9 through a critical lens (Buchanan, 2013). Neither attachment theory nor feminist  
10 theory are unitary theories, some versions of either are more compatible than others.  
11 Previous research has successfully drawn on both theories to focus on gender  
12 differences, mental distress and relational themes (e.g. Chittenden, 2015; Orbach,  
13 2003). In addition, there is a move away by attachment theorists and clinicians from a  
14 narrow focus that held mothers responsible for their children's social and emotional  
15 lives, towards a recognition of systemic perspectives and attachment narratives within  
16 cultural and social structures (Dallos & Vetere 2009, 2012) across the whole life span  
17 (Holmes & Farnfield, 2014; Mikulincer & Shaver, 2016).

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39 Participants in this study were deliberately not classified into specific attachment  
40 categories as used in some research (e.g. George, Kaplan, & Main, 1985), as  
41 classifications were viewed as potentially pathologising and too similar to medical  
42 diagnosis (Slade, 2008). Attachment quantitative research instruments which only  
43 frame mental distress within an individualised perspective were viewed as positivist,  
44 and were not considered as suitable for a gendered and feminist analysis (Buchanan,  
45 2013). Pitfalls of previous attachment research were also avoided, such as  
46 assumptions about 'biological' mothering, focusing on mothering in isolation from  
47 context, and advocating that women should be children's sole carers.  
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### *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.

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3 Transcripts were coded line-by-line, and text was amalgamated into categories. A  
4  
5 coding frame was developed from codes and grounded in the data content. The  
6  
7 'keyness' of a theme was dependent on whether it captured something important in  
8  
9 relation to the research question, and represented a level of patterned response or  
10  
11 meaning within the data (Braun & Clarke, 2006). Themes were refined so they were  
12  
13 specific enough to be discrete, and broad enough to encapsulate the ideas contained  
14  
15 in text segments (Attride-Stirling, 2001). NVivo (computer software) assisted in  
16  
17 systematically looking at prevalence, patterns and links between codes and themes.  
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19 This involved on- and off-computerised analysis to avoid abstracting data and  
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21 attaching too much importance to the frequency of codes (Joffe, 2012).  
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27 The analysis focussed on themes that were common across the interviews, i.e. the  
28  
29 dominant themes that were the specific interest of this study, whilst also considering  
30  
31 exceptions and contradictions. Criteria for selection were not intended to attribute  
32  
33 greater overall explanatory value to themes on a quantitative basis, but simply to  
34  
35 focus attention on commonalities. Another analysis (e.g. with a focus on individual  
36  
37 narratives) could have employed different criteria for selection (see Attride-Stirling,  
38  
39 2001).  
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### 45 **Findings**

46  
47 The four main themes all relate to the study's aim to explore how participants make  
48  
49 sense of long-term counselling in a women's service in the context of their gendered  
50  
51 experiences and complex needs. The first theme explores participants' traumatic  
52  
53 histories and broken attachments, i.e. 'violence and loss in the context of female  
54  
55 oppression', with sub-themes: 'the permeating losses of migration' and 'life blown  
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3 apart: the impact of childhood abuse'. The second theme explores 'a sanctuary for  
4  
5 women', with sub-themes: 'an oasis of tranquillity' and the gendered dimensions of  
6  
7 distress'. The third theme explores 'non-medicalised long-term counselling in a safe  
8  
9 setting' in which participants discuss their experiences of the NHS. The fourth theme  
10  
11 'benefits of the long view' includes the sub-themes 'it takes time to do the work' and  
12  
13 'healing the ruptures: psychological and physical wellbeing' (the fourth theme arose  
14  
15 only from post-counselling interviews).  
16  
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### 20 21 *1. Violence and loss in the context of female oppression*

22  
23 It was considered important to have some understanding of the context of women's  
24  
25 complex lives before focussing on their experiences of counselling. Participants  
26  
27 discussed how their early significant attachments had been disrupted. Two sub-themes  
28  
29 were identified: 'the permeating losses of migration', and 'life blown apart: the  
30  
31 impact of childhood abuse'.  
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#### 36 37 *The permeating losses of migration*

38  
39 Twenty-eight of the participants had experienced forced migration, and reported  
40  
41 negative effects which included separation from family and communities, violence,  
42  
43 lack of social support, racism, loss of country, language, culture, and low  
44  
45 socioeconomic status. Jennifer was born in Asia during a civil war; one of her sisters  
46  
47 was tortured and another died, and her father was in prison. She was sent to England  
48  
49 alone aged seven:  
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3 The trauma is about my, the guardians...never listened, because they were  
4  
5 very, very religious so they did things that they believed that God wanted them  
6  
7 to do. (Pre-counselling)  
8  
9

10  
11  
12 Anne described traumatic events after she was sent by her father to a war-torn country  
13  
14 at three years old:  
15

16  
17  
18 Mum and I were captured...I had guns to my head...since then I've had a lot of  
19  
20 problems. I got expelled from school because I was just crapping myself...and  
21  
22 my mum was very abusive...and would burn me. (Post-counselling)  
23  
24  
25

26  
27 Mothers can be left with the tragic choice of separating from their young children, not  
28  
29 only due to poverty, but also for safety. Elizabeth's mother abandoned her in Asia  
30  
31 when she was 13 years to work in the UK. Elizabeth reported severe anxiety that was  
32  
33 affecting her eating and sleeping. Since she started counselling she reported that her  
34  
35 anxiety had considerably reduced and that she was dealing better with relationships:  
36  
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38

39  
40 It is relationships and it is intimacy, and it is I suppose liking myself and  
41  
42 accepting myself. Because I never, I didn't really ever get that from my parents,  
43  
44 so it's, and that's what I have kind of discovered through the therapy. So it's not,  
45  
46 I am not mad, I just have trust issues...I haven't had one (panic attack) for a  
47  
48 very, very long time. (Post-counselling)  
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53  
54 *Life blown apart: The impact of childhood abuse*  
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3 Katarina was sexually abused, and reported that when she started hearing voices  
4  
5 ‘telling me to kill myself’ she decided to have counselling at a women’s service:  
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9  
10 Like somebody put a hand-grenade in the middle of my life and just blown it all  
11  
12 a part, and my life is just all these bits that you know I couldn’t put back  
13  
14 together again and that’s when I needed help...I lost my job because I got really  
15  
16 ill. (Pre-counselling)  
17

18  
19  
20 Most participants reported a life-long history of multiple abuses. Melinda reported  
21  
22 that her violent father sexually abused her; she subsequently took an overdose, and at  
23  
24 14 she was raped. Melinda felt that long-term counselling had enabled her to deal  
25  
26 with life better:  
27  
28

29  
30  
31  
32 When you start feeling better about yourself you start thinking things differently  
33  
34 which the counselling can help. It alters your mind. (Post-counselling)  
35  
36  
37

## 38 2. *A sanctuary for women*

39  
40 Findings highlighted the importance of a safe and calm counselling environment. The  
41  
42 majority of the participants had complex histories of abuse, and stressed the  
43  
44 importance of having their counselling in a women-only centre, in the sub-themes ‘an  
45  
46 oasis of tranquillity’ and ‘the gendered nature of mental distress’.  
47  
48

### 49 *An oasis of tranquillity*

50  
51  
52 Mandy reported being in violent relationships with men most of her adult life. She  
53  
54 said ‘It’s really great to have a women only centre’:  
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5 A totally different environment...Not just because I've had all these violent  
6 relationships with men...It's an oasis of tranquillity...There are lots of women  
7 that wouldn't come...if it was mixed. (Post-counselling)  
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13  
14 Katarina, who was severely abused in childhood explained:  
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17  
18 It feels very safe there and it's very friendly and laid back...It doesn't feel  
19 intimidating or anything like that...There should be more places like that around,  
20 (the Centre) is like a little jewel...if men were here I wouldn't feel so safe. And  
21 I think it would change the atmosphere. Women and men create different energy.  
22  
23 (Pre-counselling)  
24  
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32 Elspeth said 'it helps so much':  
33  
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36 I owe so much to the Centre because it's a sanctuary for women, and it's a place  
37 to just become a woman...a safe place. (Post-counselling)  
38  
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43 *The gendered dimensions of mental distress*  
44

45 Sandra said that the reasons for her distress were at least in part gendered in nature,  
46 and emphasised the importance of having counselling at a women's centre:  
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51 I was attacked a few years ago...It's nice that it's women only...Men can be just  
52 out for one thing and make you feel uncomfortable, so you don't have to worry  
53 about that. (Pre-counselling)  
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5 In contrast to her experience at a women-only service, Miranda described how  
6  
7 detrimental it was to have counselling with a man elsewhere:  
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10  
11 It felt like he had a scalpel and he just pick, pick, pick...he didn't even worry  
12 about closing me up. A lot of it was around the sexual abuse as a  
13 child...explaining to him that for a woman having her virginity taken against  
14 her will is really different to a man...I said I needed a woman counsellor...He  
15 would leave me in absolute pieces and what he did was he unpicked all these  
16 wounds, and I was walking out of there devastated...it did more harm than  
17 good...I ended up drinking more. (Pre-counselling)  
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### 30 *3. Non-medicalised long-term counselling in a safe setting*

31  
32 Participants discussed having long-term counselling in this safe community setting  
33 and their preference for having counselling outside of the NHS. Melinda said:  
34  
35  
36  
37

38 You have got nicer counsellors here than they have at the NHS...People that  
39 want to work here are the type of people that want to help, not just to make  
40 money...more intimate and most of the people are nice. You feel that there is an  
41 internal warmth, and they are not just being nice for the sake of being nice.  
42  
43  
44  
45  
46  
47 (Post-counselling)  
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51  
52 Voluntary organisations like this Centre are generally not bound by structures of the  
53 kind that prevail in the NHS. Katarina said:  
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3 It's a safe place. And for me it's really important because it's not in the mental  
4 health system...because in the mental health system everything is centralised  
5 and everything you say is put on a central computer and you know it makes you  
6 feel really vulnerable. (Post-counselling)  
7  
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14 Many of the participants reported negative experiences of being on psychiatric  
15 medications and encountering male clinicians. Carol, a woman in her late 20s, had  
16 been on anti-depressants for more than ten years:  
17  
18  
19

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21  
22 Some of them (anti-depressants) obviously didn't work, and I had one really bad  
23 doctor and he actually said to me 'oh you are not suffering from depression  
24 because otherwise they would work'...You are so vulnerable you don't have the  
25 strength to say anything. (Pre-counselling)  
26  
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34 Miranda described how she was sectioned and felt pathologised for having been raped:  
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38 My 18<sup>th</sup> birthday, I had seven months in a lock, being surrounded by very,  
39 very poorly people and nobody allowing me to say 'listen, my step-father is an  
40 evil bastard who has been beating us, raping me, beating my mother'...They  
41 wouldn't discharge me, and they would perceive that as me being ill...They  
42 gave me lithium, which I swelled up...I've got the scars of the effect that drug  
43 had on me. (Pre-counselling)  
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54 *4. Benefits of the long view*  
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3 Many participants appreciated the opportunity to have long-term counselling and to  
4  
5 have the time to think about their lives.  
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10 *It takes time to do the work*

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

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13  
14  
15  
16 I am terribly impressed that it [the Centre] offers two years counselling. If you  
17  
18 get counselling from your GP it's something like six sessions, which it takes  
19  
20 you that before you even start talking...Over a two year period you can really  
21  
22 relax, and not think oh my god there are only another few sessions...It was an  
23  
24 accumulative effect, it did stop me feeling suicidal. (Post-counselling)  
25  
26  
27

28  
29  
30 Linda explained:

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33  
34 What I like about (the Centre) is that it is on-going. So it allows...much more  
35  
36 exploration of whatever and six weeks (in the NHS) is nothing, so it's really a  
37  
38 big difference...(discussing) the same things but with different layers and you  
39  
40 know, maybe I might think 'oh this is the reason I am doing it' or 'this is the  
41  
42 reason why I am like that. (Post-counselling)  
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48 Lorraine said that she needed time to understand the links between her childhood and  
49  
50 her abusive adult relationships:

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53  
54 Slowly, slowly I've been able to make understanding between things that  
55  
56 happened quite a long time ago and things that are happening to me now...I've  
57  
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3 got more understanding about the reason why all this has happened. (Post-  
4 counselling)  
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9 Elizabeth reported that she had suicidal feelings before she started counselling, and  
10 that it took time for her to explore these:  
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16 It took quite a long time for me to completely open up to her as well, because I  
17 had never really done it with anyone before so that was initially quite hard. But  
18 I think our relationship is good...You just get into the habit about feeling bad  
19 about yourself and dealing with everything on your own...It was good...to  
20 realise it was alright to feel the way I felt. (Post-counselling)  
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29 Alison had six weeks of NHS therapy, which 'wasn't sufficient', and she described  
30 the benefits of her long-term work with her 'very receptive and very warm' female  
31 counsellor:  
32  
33  
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36  
37

38 She helps me to go through all these feelings and...helps me with some  
39 interpretations, and she is very patient. It doesn't seem to matter that we go over  
40 the same ground again and again...It's very helpful. (Post-counselling)  
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47 Three participants talked about how difficult counselling could be at times. Katarina  
48 described how painstaking, although helpful, counselling has been:  
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53 I've started dipping my toes in the water, very slowly, it's not something I feel  
54 very comfortable about...I am starting to be more open about things over the  
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3 last couple of years. More out of desperation really because I just realise how  
4  
5 much help that I need to kind of sort myself out...It was quite hard work but...I  
6  
7 could see the value...being able to stop and look at yourself...the mirroring all  
8  
9 the way through the rest of life...get a little bit more distance from the crisis  
10  
11 situation and bit more perspective on it all. (Post-counselling)  
12  
13

14  
15  
16 Elizabeth said:  
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20 There were times when I just didn't want to go, it was a real struggle for me to  
21  
22 go, I just thought 'I can't bear it, I can't bear it, I can't bear it, dread, dread,  
23  
24 dread'...It's only...six months that I have really gone how bloody lucky am I to  
25  
26 have this, like to go and talk about myself. And I think it's fabulous  
27  
28 now...going over what we've done in the last year or so, and making it more  
29  
30 kind of concrete...a bit more automatic and natural. (Post-counselling)  
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35  
36 *Healing the ruptures: psychological and physical wellbeing*  
37

38 All of the 26 participants interviewed post-counselling reported positive changes  
39  
40 which they attributed to their long-term counselling. Most said they had gained  
41  
42 greater insight into their lives and behaviour. The reported effects of counselling  
43  
44 included being 'able to cope' with difficult feelings, having a better understanding of  
45  
46 their lives which 'removed self-blame', and in some cases no longer feeling suicidal.  
47  
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49

50  
51  
52 Most of the participants had suffered various illnesses before their counselling, and  
53  
54 some had used excessive alcohol and drugs. Participants reported various health-  
55  
56 related benefits from counselling, and six reported positive physical changes.  
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3 Catherine said that due to her counselling she had been able to come off sedatives,  
4  
5 face her difficulties, and engage in life:  
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10 It was certainly a really important part of my being able to sort out mental  
11 health issues...it basically saved my life...I had a life which frankly wasn't  
12 worth having...trying to run away from myself...(the Centre) was quite  
13 instrumental in getting me to a place where I want to be present and to take part  
14 in life...I used to smoke a lot of weed and I used to drink really heavily, so I  
15 don't smoke at all...my diet is more healthy. (Post-counselling)  
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25 Mary described how long-term counselling had helped her:  
26  
27  
28

29 Without having had counselling...I would have been really stressed out. I might  
30 have turned to drink and drugs, or I might have beaten my children...I've felt  
31 really desperate and stressed, and I feel that having counselling has helped me  
32 to manage myself better and my feelings better and to process...To  
33 physically...move on as well...Your emotional wellbeing transpires onto your  
34 physical wellbeing I suppose, I've slept a lot better for it. (Post-counselling)  
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47 Seven participants reported that they believed that psychological changes, which they  
48 attributed to their counselling, had facilitated them to feel more confident and capable  
49 of being employed or embarking on training. For example, Belinda said:  
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3 Counselling has sort of led me into a different place, which I think then made  
4  
5 the job feasible...I feel very emotionally strong. (Post-counselling)  
6  
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9  
10 Mary believed that being able to process her emotions over time in counselling had  
11  
12 enabled her to take better care of herself:  
13

14  
15  
16 Processing what my feelings are...I really do feel like I have moved on...I've  
17  
18 got a really good relationship with myself...I'm much happier and more  
19  
20 confident in myself. I'm really happy about my job...I can continue to make  
21  
22 changes in my life, I've been more assertive, I've made a plan, it really had a  
23  
24 really positive impact...There are things that are within control I can change  
25  
26 them. I am off (State) benefits, which I'm really pleased about. (Post-  
27  
28 counselling)  
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34 Mary reported that developing her emotional intelligence had improved her  
35  
36 relationships and helped her children:  
37  
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39  
40 I've got a better understanding of myself, and of other people...I value my  
41  
42 emotional intelligence...I kind of developed it. And that's all developed in my  
43  
44 children as well and they've got much better. (Post-counselling)  
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## 54 Discussion

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

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2  
3 Thomas, 2013), which emphasises the importance of these women being able to have  
4  
5 low-fee counselling in a women's centre where they feel safe. Those who have  
6  
7 experienced forced migration are in particular need of such services as they are  
8  
9 reported to have around ten times higher levels of mental and psychological illnesses,  
10  
11 (particularly post-traumatic stress), than the general population of developed host  
12  
13 countries (Schouler-Ocak, 2015).  
14  
15

16  
17  
18 As in previous research (e.g. McLeod, et al., 2000; Winter, Archer, Spearman,  
19  
20 Costello, Quaitte, & Metcalfe, 2003), participants with a low socio-economic status  
21  
22 reported various benefits from counselling, including being able to explore and better  
23  
24 understand their life histories in an environment they perceived as 'safe', 'warm' and  
25  
26 'friendly', and to make positive changes in their lives. These changes also included  
27  
28 reduced anxiety, depression and suicidal ideation, finding employment, and improved  
29  
30 health. Significant personal gains included being better able to look after themselves,  
31  
32 being able to improve their relationships (including with their children), not repeating  
33  
34 negative patterns as mothers, and being able to leave an abusive partner. As Catherine  
35  
36 poignantly put it, counselling had 'saved her life'.  
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44  
45 The ability to develop a relationship with a counsellor over longer-term counselling  
46  
47 appeared to be particularly significant. Participants said that they needed *time* in  
48  
49 counselling to understand the nature of their difficulties and that this enabled them to  
50  
51 recognise that these stemmed from their traumatic childhoods and complex adult lives.  
52  
53 This process was noted by some participants as painstaking work that required them  
54  
55 to go over their issues again and again. As well as being able to have counselling in a  
56  
57 women-only environment, the changes that participants reported could also be  
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2  
3 attributed to three overlapping concepts of attachment theory and psychoanalytic  
4  
5 practice which are viewed as key concepts for effective therapy: the therapeutic  
6  
7 relationship, meaning making, and promoting change (Holmes, 2009).  
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12 Women in this study also explained why it was important for them to receive long-  
13  
14 term counselling in a women-only supportive environment compared to the NHS,  
15  
16 which largely provides short-term CBT in a medicalised environment. Psychiatrists  
17  
18 tend to use a disease model of diagnosis, with virtually no basis for the diagnostic  
19  
20 categories or evidence of neurobiological malfunction, prescribing medication with  
21  
22 side effects, and some times with limited interest in terminating prescriptions (Gergen,  
23  
24 2015; Lafrance & McKenzie-Mohr, 2013; Saibil, 2005). In a medical context  
25  
26 women's narratives are often presented in a way which can invalidate personal  
27  
28 distress in favour of the 'expert' health professionals, and pathologises social issues  
29  
30 and abuse such as domestic violence and rape, as noted by the participant Miranda  
31  
32 who was sectioned after having being raped by her step-father (Lavis, Horrocks, Kelly  
33  
34 & Barker, 2005; Tosh, 2011).  
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41 However, McLeod and Wright (2009: 128) argue that although psy-based knowledge  
42  
43 and practice – what they call a therapeutic ethos - regulate subjectivity and conduct,  
44  
45 they can also open up transformative and productive possibilities for women,  
46  
47 providing a sense of competence in socially difficult and damaging circumstances.  
48  
49 Women not only want women-only services but they are also cost-effective, as they  
50  
51 are inexpensive to run and create savings for health provision (Corry, et al., 2007).  
52  
53 Furthermore better support for mothers can improve mental health outcomes for  
54  
55 women and for their children (Department of Health, 2014).  
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### *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).

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4  
5 Whilst there are relatively few overtly attachment-based therapies, attachment theory  
6  
7 has much to say about the procedural and relational aspects of all therapies.  
8  
9 Attachment ideas constitute a meta-position from which to view therapeutic practice  
10  
11 (Holmes, 2009; Slade, 2008). Categorisation of 'attachment types' to understand  
12  
13 distress, however, is largely reductionist and minimises complex lived experiences.  
14  
15 With the increased popularity of attachment theory, the cause of domestic violence  
16  
17 and 'mental illness' is often situated as a product of an individual's insecure early  
18  
19 attachment relationships (see Buchanan, 2013). Psychological therapists of all  
20  
21 orientations should engage in a critical analysis of their individualising therapeutic  
22  
23 models including attachment theory, and consider broader relational, sociocultural  
24  
25 contexts and dominant sociocultural discourses surrounding oppressed groups,  
26  
27 including women. Gender and its related power imbalances should not be rendered  
28  
29 invisible by clinicians and theorists (McPhail, Busch, Kulkarni, & Rice, 2007). Smail  
30  
31 (2005) argues that it is not possible to understand the phenomena of psychological  
32  
33 distress without consideration of how power is distributed and exercised within  
34  
35 society. A raised awareness of these issues would reduce the drive to pathologise  
36  
37 human experience (Dillon & Hornstein, 2013), and hopefully improve the therapeutic  
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39 experience and outcomes for service users.  
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#### 47 *Future research*

48  
49 Future research could focus on evaluating services suitable for female survivors of  
50  
51 violence, including migrants and refugees. Forced migration, which is on the increase  
52  
53 worldwide, is stressful and increases the risk of poor health (Schouler-Ocak, 2015).  
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55 Women are at particular risk of gender-based discrimination and violence such as rape  
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3 (Quilted Sightings, 2008). Clinical research should further consider factors such as  
4  
5 ethnicity, sexual orientation, disability and gender, which could lead to better  
6  
7 treatment and outcomes (Killin & Della Sala, 2015).  
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11  
12 Research could also consider the benefits of the complementary and alternative  
13  
14 medicine (CAM) being offered by this and similar services. Individuals with  
15  
16 diagnosed serious mental illnesses have been found to perceive CAM as providing a  
17  
18 wide range of benefits (Rusinova, Cash, & Wewiorski, 2009).  
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23  
24 Further research into the experience and effectiveness of long-term therapy is  
25  
26 essential. The impact of long-term therapies is under-researched (Perren, Godfrey, &  
27  
28 Rowland, 2009), and individuals such as those in this study with complex mental  
29  
30 issues have been found to benefit from long-term therapy (Leichsenring & Rabung,  
31  
32 2011). Women on low incomes report levels of mental health difficulties that are  
33  
34 much higher than the norm (e.g. McLeod et al., 2000); and in this study long-term  
35  
36 counselling appeared to be effective regardless of the level of initial severity (see  
37  
38 Payne et al., 2015). In the UK, given that IAPT services offer mainly short-term CBT  
39  
40 or self-help to approximately just 15% of those with diagnosed mental illnesses (NHS,  
41  
42 2015), there is clearly a need for rigorously evaluated long-term mental health  
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44 services both in the public and voluntary sectors.  
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50 In conclusion, this study aimed to consider how female participants' make sense of  
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52 long-term counselling in the context of their gendered experiences, relationships and  
53  
54 the complex sociocultural and economic contexts of their lives. Women-only centres  
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56 established by women aim to support those suffering from social inequalities and  
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3 diagnosed with mental 'illnesses' and to help them find ways of dealing with their  
4  
5 distress and histories of abuse (Williams, Scott, & Waterhouse, 2001). Women can  
6  
7 develop confidence, independence, feel less marginalised, more listened to and more  
8  
9 able to express themselves when using women-only services (Corry, et al., 2007).  
10  
11 This is clearly supported in this study, yet in 2015 this long-term service was  
12  
13 suspended after losing Government funding.  
14  
15

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28  
29

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34  
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36  
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38  
39

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### 49 50 51 **References** 52

53  
54 Allred, P., Crowley, H., & Rupal, R. (2001). Women and mental health: A feminist  
55  
56 review. *Feminist Review*, 68, 1-5.  
57  
58

- 1  
2  
3 Astbury, J. (2001). *Gender disparities in mental health. In mental health: A call for*  
4 *action by world health ministers*. Geneva, Switzerland: World Health  
5 Organisation.  
6  
7  
8  
9  
10 Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative  
11 research. *Qualitative Research, 1*, 385-405.  
12  
13  
14 Beaumont, J., & Loftis, H. (2013). *Measuring Well-being – Health, 2013*. London,  
15 UK: Office for National Statistics.  
16  
17  
18 Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of  
19 depression among US women. *Psychology of Women Quarterly, 27*, 101-113.  
20  
21  
22 Beutel, M. E., Rasting, M., Stuhr, U., Rüger, B., & Leuzinger-Bohleber, M. (2004).  
23 Assessing the impact of psychoanalysis and long-term psychoanalytic therapies  
24 on health care utilization and costs. *Psychotherapy Research, 14*(2), 146-160.  
25  
26  
27  
28  
29 Bifulco, A., & Thomas, G. (2013). *Understanding adult attachment in family*  
30 *relationships*. London, UK: Routledge.  
31  
32  
33  
34 Bliwise, N, G. (1999). IV. Securing attachment theory's potential. *Feminism &*  
35 *Psychology 9*. 49-52. Bondi, L., & Burman, E. (2001). Women and mental health:  
36 A feminist review. *Feminist Review 68*, 6-33.  
37  
38  
39  
40  
41 Bowlby, J. (1969). *Attachment. Attachment and loss, vol. I. Loss*. New York, US:  
42 Basic Books.  
43  
44  
45  
46 Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative*  
47 *Research in Psychology, 3*, 77-101.  
48  
49  
50 Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide*  
51 *for beginners*. London, UK: Sage.  
52  
53  
54  
55 Buchanan, F. (2013). A critical analysis of the use of attachment theory in cases of  
56 domestic violence. *Critical Social Work, 14*(2), 19-31.  
57  
58  
59  
60



- 1  
2  
3 Burman, E. (2008). *Deconstructing developmental psychology* (2<sup>nd</sup> Ed.). London, UK:  
4  
5 Routledge.  
6  
7 Bury, C., Raval, H., & Lyon, L. (2007). Young people's experiences of individual  
8  
9 psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*,  
10  
11 *80(1)*, 79-96.  
12  
13 Chittenden, C. (2015). *Attachment feminism: Attachment parenting from a feminist*  
14  
15 *perspective*. Laverge, TN, US: Create Space.  
16  
17 Ciclitira, K., Marzano, L., Brunswick, N., Starr, F., & Berger, S. (2004). Theoretical  
18  
19 and ethical issues in conducting research at a women's health centre. *Psychology*  
20  
21 *of Women Section Review*, *6*, 1, 60-69.  
22  
23 Ciclitira, K., Starr, F., Marzano, L., Brunswick, N., & Costa A. (2012). Women  
24  
25 Counsellor's experiences of personal therapy: A thematic analysis. *Counselling*  
26  
27 *and Psychotherapy Research*, *12*, 2, 136-145.  
28  
29 Clearly, R. J. (1999). *III. Bowlby's theory of attachment and loss: A feminist*  
30  
31 *reconsideration*, *Feminism & Psychology*, *9*, 32-42.  
32  
33 Corry, D., Dhimi, K., Hudson, I., Moore, K., & Pouwhare, T. (2007). *Why women-*  
34  
35 *only: The value and benefits of by women, for women services*. London, UK:  
36  
37 Women's Resource Centre.  
38  
39 Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress*.  
40  
41 Basingstoke, UK: Palgrave Macmillan.  
42  
43 Dallos, R., & Vetere, A. (2009). *Systemic therapy and attachment narratives:*  
44  
45 *Applications in a range of clinical settings*. London, UK: Routledge.  
46  
47 Dallos, R., & Vetere, A. (2012). Systems theory, family attachments and processes of  
48  
49 triangulation: Does the concept of triangulation offer a useful bridge? *Journal of*  
50  
51 *Family Therapy*, *34(2)*, 117-137.  
52  
53  
54  
55  
56  
57  
58  
59  
60

- 1  
2  
3 De Maat, S., De Jonghe, F., Schoevers, R., & Dekker, J. (2009). The Effectiveness  
4 of long-term psychoanalytic therapy: A systematic review of empirical studies.  
5  
6 *Harvard Review of Psychiatry*, 17(1), 1-23.  
7  
8  
9  
10 Department of Health. (2002). *Women's mental health: Into the mainstream.*  
11 *Strategic development of mental health care for women.* London, UK:  
12 Department of Health.  
13  
14  
15  
16 Department of Health. (2014). *Closing the gap: Priorities for essential change in*  
17 *mental health.* London, UK: Department of Health.  
18  
19  
20  
21 Dillon, J., & Hornstein, G. A. (2013). Hearing voices peer support groups: A  
22 powerful alternative for people in distress. *Psychosis*, 5(3), 286-295.  
23  
24  
25 Etherington, K. (2007). Ethical research in reflexive relationships. *Qualitative*  
26 *Inquiry*, 13, 599-616.  
27  
28  
29  
30 Fonagy, P., Rost, F., Carlyle, J., McPherson, S. McPherson, Thomas, R., Pasco  
31 Fearon, R. M.,...Taylor, D. (2015). Pragmatic randomized controlled trial of  
32 long-term psychoanalytic psychotherapy for treatment-resistant depression: The  
33 Tavistock adult depression study. *World Psychiatry*, 14, 312-321.  
34  
35  
36  
37  
38 Franzblau, S. H. (1999). II. Historicizing attachment theory: Binding the ties that  
39 bind. *Feminism & Psychology*, 9, 22-31.  
40  
41  
42  
43 George, C., Kaplan, N., & Main, M. (1985). *The adult attachment interview.*  
44 Unpublished manuscript, University of California, Berkeley.  
45  
46  
47  
48 Gergen, K. J. (2015). The limits of neuroscience. *Therapy Today*, 26(6), 12-117.  
49  
50  
51 Goodman, L. A., Glenn, C., Bohlig, A., Banyard, V., & Borges, A. (2008).  
52 Feminist relational advocacy. Processes and outcomes from the perspective of  
53 low-income women with depression. *The Counseling Psychologist*, 37, 6, 848-  
54  
55  
56  
57  
58  
59  
60

- 1  
2  
3 Griffin, M. G., Resick, P. A., Waldrop, A. E., & Mechanic, M. B. (2003).  
4  
5 Participation in trauma research: Is there evidence of harm? *Journal of*  
6  
7 *Traumatic Stress, 16*(3), 221-227.  
8  
9  
10 Groh, C. J. (2007). Poverty, mental health, and women: Implications for psychiatric  
11  
12 nurses in primary care settings. *Journal of American Psychiatric Nurses*  
13  
14 *Association, 13*(5), 267-274.  
15  
16  
17 Harding, S. G. (2007). Feminist standpoints. In N. S. Hesse-Biber (Ed.), *Handbook*  
18  
19 *of feminist research: Theory and praxis* (pp. 45-70). Thousand Oaks, US: Sage  
20  
21 Publications.  
22  
23  
24 Holmes, J. (2009). *Exploring in security: Towards an attachment-informed*  
25  
26 *psychoanalytic psychotherapy*. London, UK: Routledge.  
27  
28  
29 Holmes, P., & Farnfield S. (Eds.). (2014). *The Routledge handbook of attachment:*  
30  
31 *Implications and interventions*. London, UK: Routledge.  
32  
33  
34 Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H.  
35  
36 Lerner (Ed.), *Conversational analysis: Studies from the first generation* (pp.13-  
37  
38 31). Amsterdam, Holland: John Benjamin.  
39  
40  
41 Joffe, H. (2012). Thematic analysis. In D. Harper & A. Thompson (Eds.),  
42  
43 *Qualitative research methods in mental health and psychotherapy* (pp. 209-223).  
44  
45 Chichester, UK: Wiley Blackwell.  
46  
47  
48 Killin, L., & Della Sala, S. (2015). Seeing though the double blind. *Psychologist, 28*,  
49  
50 4, 288-291.  
51  
52  
53 Lafrance, M. N., & McKenzie-Mohr, S. (2013). The DSM and its lure of legitimacy.  
54  
55  
56  
57  
58  
59  
60

- 1  
2  
3 Lavis, V., Horrocks, C., Kelly, N., & Barker, V. (2005). Domestic violence and  
4 health care: Opening Pandora's box – challenges and dilemmas. *Feminism &*  
5 *Psychology, 12*, 441-460.  
6  
7  
8  
9  
10 Leichsenring, F., & Klein, S. (2014). Evidence for psychodynamic psychotherapy in  
11 specific mental disorders: A systematic review. *Psychoanalytic Psychotherapy,*  
12 *28*(1), 4-32.  
13  
14  
15  
16 Leichsenring, F., & Rabung, S. (2011). Long-term psychodynamic psychotherapy in  
17 complex mental disorders: Update of a meta-analysis. *The British Journal of*  
18 *Psychiatry, 199*(1), 15-22.  
19  
20  
21  
22  
23 Lennon, M. C., Blome, J., & English, K. (2001). Depression and low-income women:  
24 Challenges for TANF and welfare-to-work policies and programs. Research  
25 forum on children, families and the new federalism. New York, US: National  
26 Center for Children in Poverty.  
27  
28  
29  
30  
31  
32 Lindfors, O., Knekt, P., Heinonen, E., Härkänen, T., & Virtala, E. (2015). The  
33 effectiveness of short- and long-term psychotherapy on personality functioning  
34 during a 5-year follow-up. *Journal of Affective Disorder, 1*(173), 31-38.  
35  
36  
37  
38  
39 Loewenthal, D., & House, R. (Eds.) (2010). *Critically engaging CBT*. Maidenhead,  
40 UK: McGraw-Hill Education.  
41  
42  
43 Lumsden, K. (2013). You are what you research: Research partisanship and the  
44 sociology of the underdog. *Qualitative Research, 12*(1), 3-18.  
45  
46  
47  
48 McLeod, J. (2011). *Qualitative research in counselling and psychotherapy* (2nd Ed.).  
49 London, UK: Sage.  
50  
51  
52 McLeod, J., Johnston, J., & Griffin, J. (2000). A naturalistic study of the  
53 effectiveness of time-limited counselling with low-income clients. *European*  
54 *Journal of Psychotherapy, Counselling & Health, 3*(2), 263-277.  
55  
56  
57  
58  
59  
60

- 1  
2  
3 McLeod J., & Wright, K. (2009). The talking cure in everyday life: Gender  
4 generations and friendship. *Sociology*, 333(1), 122-139.  
5  
6  
7 McPhail, B. A., Busch, N. B., Kulkarni, S., & Rice, G. (2007). An integrative  
8 feminist model: The evolving perspective on intimate partner violence. *Violence*  
9 *Against Women*, 13(8), 817-841.  
10  
11  
12 Mikulincer, M., & Shaver, P. R. (2016). *Attachment in Adulthood. Structure,*  
13 *dynamics and change.* London: Guilford Press.  
14  
15  
16  
17  
18 Miranda, J., Green, B. L., Krupnick, J. L., Chung, J., Siddique, J., Belin, T., &  
19 Revicki, D. (2006). One-year outcomes of a randomized clinical trial treating  
20 depression in low-income minority women. *Journal of Consulting and Clinical*  
21 *Psychology*, 74(1), 99-111.  
22  
23  
24  
25  
26  
27 National Collaborating Centre for Mental Health. (2009). *Borderline personality*  
28 *disorder: Treatment and management.* Leicester and London, UK: the British  
29 Psychological Society and the Royal College of Psychiatrists.  
30  
31  
32  
33  
34 National Health Service. (2015). *Improving Access to Psychological therapies*  
35 *waiting times guidance and FAQ's.* London, UK: NHS.  
36  
37  
38  
39 National Institute for Health and Care Excellence (NICE), (2009). Depression in  
40 adults: Recognition and management. London, UK: NICE.  
41  
42  
43 Orbach, S. (2003). The body in clinical practice. In K. White, (Ed.), *Touch*  
44 *attachment and the body* (17-47). London, UK: Karnac.  
45  
46  
47 Payne, N., Ciclitira, K., Starr, F., Marzano, L., & Brunswick, N. (2015). Evaluation  
48 of long-term counselling at a community health service for women who are on  
49 low income. *Counselling and Psychotherapy Research*, 15, 2, 79-87.  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

- 1  
2  
3 Peden, A. R., Rayens, M. K., & Hall, L. A. (2005). A community-based depression  
4 prevention intervention with low-income single mothers. *Journal of the*  
5 *American Psychiatric Nurses Association, 11*, 18-25.  
6  
7  
8  
9  
10 Perren, S., Godfrey, M., & Rowland, N. (2009). The long-term effects of counselling:  
11 The process and mechanisms that contribute to on-going change from a user  
12 perspective. *Counselling and Psychotherapy Research, 9*(4), 241-249.  
13  
14  
15  
16 Phillips, A., & Daniluk, J. C. (2004). Beyond “survivor”: How childhood sexual  
17 abuse informs the identity of adult women at the end of the therapeutic process.  
18 *Journal of Counseling and Development, 8*(2), 177-184.  
19  
20  
21  
22  
23 Quilted Sightings (2008). *A women and gender studies reader*. Miriam College, US:  
24 Women and Gender Institute.  
25  
26  
27  
28 Russinova, Z., Cash, D., & Wewiorski, N. J. (2009). Toward understanding the  
29 usefulness of complementary and alternative medicine for individuals with  
30 serious mental illnesses. *The Journal of Nervous and Mental Disease, 197*, 69-  
31 73.  
32  
33  
34  
35  
36  
37 Saibil, D. (2005). *The marketization of depression: The prescribing of SSRI*  
38 *antidepressants to women*. Toronto, Canada: Women and Health Protection.  
39  
40  
41  
42 Schouler-Ocak, M. (2015). *Trauma and migration. Cultural factors in the diagnosis*  
43 *and treatment of traumatised immigrants*. Basel, Switzerland: Springer.  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

- 1  
2  
3 Starr, F., Ciclitira, K., Brunswick, N., Costa, A., & Marzano, L. (2012). Comfort and  
4  
5 challenge: A qualitative analysis of counsellor's experiences of supervision.  
6  
7 *Psychology and Psychotherapy: Theory Research and Practice*, 86, 3, 334-351.  
8  
9  
10 Swift, P., Cyhlarova, E., Goldie, I., & O'Sullivan, C. (2014). *Living with anxiety*.  
11  
12 London, UK: Mental Health Foundation.  
13  
14 Tosh J. (2011). The medicalisation of rape: A discursive analysis of 'paraphilic  
15  
16 coercive disorder' and the psychiatrisation of sexuality. *Psychology of Women*  
17  
18 *Section Review*, 13(2), 2-12.  
19  
20  
21 Turjanski, N. (2010). 'Postnatal depression'. In D. Kohen (Ed.), *Oxford textbook of*  
22  
23 *women and mental health* (pp. 169-178). Oxford, UK: Oxford University Press.  
24  
25  
26 Ussher, J. M. (2010). Are we medicalizing women's misery? A critical review of  
27  
28 women's higher rates of reported depression. *Feminism & Psychology*, 20(1), 9-  
29  
30 35.  
31  
32 Ussher, J. M. (2013). Diagnosing difficult women and pathologising femininity:  
33  
34 Gender bias in psychiatric nosology. *Feminism & Psychology*, 23(1), 63-69.  
35  
36  
37 Vanheule, S. (2009). Psychotherapy and research: A relation that needs to be  
38  
39 reinvented. *British Journal of Psychotherapy*, 25, 91-109.  
40  
41  
42 Williams, J., Scott, S., & Waterhouse, S. (2001). Mental health services for "difficult"  
43  
44 women'. *Feminist Review* 68, 89-104.  
45  
46  
47 Winter, D., Archer, R., Spearman, P., Costello, M., Quait, A., & Metcalfe, C.,  
48  
49 (2003). Explorations of the effectiveness of a voluntary sector psychodynamic  
50  
51 counselling service. *Counselling and Psychotherapy Research*, 3(4), 261-269.  
52  
53  
54 World Health Organisation (WHO). (2005). WHO multi-country study on women's  
55  
56 health and domestic violence against women: Initial results of prevalence, health  
57  
58 outcomes and women's responses. Geneva, Switzerland: WHO.  
59  
60

1  
2  
3 Women's Resource Centre. (2011). Hidden value: Demonstrating the extraordinary  
4  
5 impact of women's voluntary and community organisations. London, UK: WRC.  
6  
7  
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### 9 10 **Author Biographies**

11 Karen Ciclitira is an Associate Professor in the Department of Psychology at  
12  
13 Middlesex University. Dr Ciclitira is also a practising psychoanalytic psychotherapist.  
14  
15 Her scholarly interests include mental health, women's health, diversity, gender, and  
16  
17 sexuality.  
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20  
21  
22  
23 Fiona Starr is a practising clinical psychologist, family therapist and an Associate  
24  
25 Professor in the Department of Psychology at Middlesex University. Her research  
26  
27 interests centre on aspects of clinical practice, supervision, and child and family  
28  
29 mental health.  
30  
31

32  
33  
34 Nicky Payne is a Health Psychologist and Associate Professor in the Department of  
35  
36 Psychology at Middlesex University. Her primary research interests are work-life  
37  
38 balance, gender and diversity in the workplace, and stress and health behaviour  
39  
40 change.  
41  
42

43  
44  
45 Lisa Clarke is a lecturer in the Social Policy Research Centre at Middlesex  
46  
47 University. Her research interests include: knowledge transfer, ethnicity, migration,  
48  
49

50  
51  
52 Lisa Marzano is an Associate Professor in the department of Psychology at Middlesex  
53  
54 University, specialising in mental health and suicide research, diversity and equality,  
55  
56 and qualitative research.  
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