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Peer reviewed version

Link to published version (if available):
10.1111/hsc.12699

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'We're all wounded healers': A qualitative study to explore the wellbeing and needs of helpline workers supporting survivors of domestic violence and abuse

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Main Document

Abstract

Domestic violence and abuse (DVA) can include physical, psychological, sexual, emotional, or financial abuses, and is a globally widespread problem across all age groups, cultures and socioeconomic groups. Alongside the impacts of DVA experienced by survivors, there is a growing recognition that other people, who form the support network of survivors, may also be affected by the situation. Domestic violence organisations such as helplines are important third sector services supporting survivors. However, there has been little research into the impact on those providing the support. This qualitative study of domestic violence helpline workers explored their needs and wellbeing. We used qualitative methodology, conducting interviews with staff recruited from a selection of different helplines who all undertook direct client-focused work. The interviews used a semi-structured format and followed a topic guide covering the training received before commencing work, self-care strategies, the impact of work on their daily life, and support offered by their employer. Ten helpline staff were interviewed, all female. Following analysis of the qualitative data, a number of themes emerged. Participants disclosed numerous ways in which their work challenged their wellbeing, including burnout, impact on personal relationships, and lack of training and support at work. Participants used some self-care strategies in order to 'switch off' from work, but they also wanted clinical supervision to support them with the difficulties they experienced at work. This study suggests that helpline staff should receive more education about trauma triggers, and ongoing support to reduce the impact on their home and social life, thus improving mental wellbeing and job satisfaction. This work begins the debate on the wellbeing needs of frontline helpline workers, and whether better meeting these needs can facilitate the provision of better support.

What is known about this topic:

- Compassion fatigue and vicarious trauma have been identified in professionals working

  with traumatised people

- The Helplines Standard states that organisations must ensure that measures are

  implemented to support the mental and physical health and safety of all staff and volunteers

What this paper adds:

- Domestic violence helpline staff should receive more education about potential trauma

  triggers, as well as training on handling the emotional impact of helpline work

- Helpline service commissioners should consider enforcing a minimum standard policy to

  ensure that staff across all helpline services have an equal opportunity to access support

  and supervision, which may reduce the personal impact on helpline workers' home and

  social life

Introduction

Domestic violence and abuse (DVA) can include physical, psychological, sexual, emotional, or financial abuses, and is a globally widespread problem across all age groups, cultures and socioeconomic groups (Garcia-Moreno 2005). The Office for National Statistics (ONS) in England and Wales stated that women are most likely to be a victim of domestic violence (ONS 2017). During 2016/17 there were 1.2million female victims of DVA in England and Wales, and the annual risk for women was 7.5%, with the highest risk to those aged between 16 and 29 years (ONS 2017). The estimated lifetime prevalence ranges from 21 percent to 55 percent of women (Hegarty 2006). Walby (Walby 2015), in a paper using a new methodology for calculating domestic violence statistics, found that the rate of domestic violent crime against women has been increasing by 17.9% every year after 2009.

Experiencing DVA impacts significantly on physical and mental health. It contributes to the development of anxiety, depression, post-traumatic stress disorder, and drug and alcohol misuse. Survivors may develop physical symptoms such as chronic pelvic pain or medically unexplained symptoms, be at risk of more sexually transmitted infections, or have poorly controlled long-term conditions such as asthma or diabetes (Ellsberg 2008, Trevillion 2012). Two women are killed by a partner or ex-partner each week (Home Office 2005, ONS 2017). The estimated costs of DVA to the UK economy, including health services, loss of economic output and emotional costs, are £16billion annually (Walby 2009).

Alongside the impacts of DVA experienced by survivors, there is a growing recognition that other people, who form the support network of survivors, may also be affected by the abuse. Third sector services include safe houses or refuges, advocacy, outreach support, counselling, helplines, and signposting between services.

Within the UK, there is now a network of DVA helplines. This includes: the National Domestic Violence Helpline (England), which is run in partnership between Women's Aid and Refuge[1]; similar specialist national domestic violence helplines run in Scotland[2], Northern Ireland[3] and Wales[4]; the men's advice line for male victims of DVA run by Respect[5]; the Respect helpline is specifically for perpetrators of DVA who are concerned by their behaviour[6]; Rape Crisis, who provide support and signposting to victims of sexual violence[7]; and Broken Rainbow, a helpline for LGBT victims and survivors of abuse[8]. There are also helplines that specialise in support for those facing forced marriage, so-called honour crimes[9], and FGM[10]. In addition to these national helplines, there are helplines provided by local services and at local authority level.

There is some recognition that working in this field can impact on professionals. The Helplines Standard states that organisations must ensure that measures are implemented to support the mental and physical health and safety of all staff and volunteers. Suggestions include making sources of support and supervision available for all helpline staff, and encouraging regular breaks and reflective practice (Helplines Partnership 2014).

However, despite the recognition of the value of domestic violence support services, austerity across the public sector has resulted in significant cuts to these essential services, and as a result there is increased pressure on those services that remain (Women's Aid 2018). Local authorities and commissioners have fewer resources, and therefore DVA services need to operate with the smallest possible budget in order to be re-commissioned and sustainable.

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[1] http://www.nationaldomesticviolencehelpline.org.uk
[2] http://www.scottishwomensaid.org.uk
[3] http://www.womensaidni.org/24-hour-domestic-sexual-violence-helpline/
[4] http://livefearfree.gov.wales/?skip=1&lang=en
[5] http://www.mensadviceline.org.uk
[6] http://www.respectphoneline.org.uk
[7] http://rapecrisis.org.uk
[8] http://www.brokenrainbow.org.uk/help/helpline
[9] http://www.karmanirvana.org.uk
[10] https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/).

This can lead to shortcuts and limitations in training, supervision, and continued professional development for staff, which may impact on their wellbeing.

Despite the importance of professionals' ongoing capacity to engage with individuals who have experienced trauma, there is limited literature examining the impact that offering support in the context of DVA has, particularly in relation to those working for helplines.

We undertook a qualitative research study to explore the experiences of DVA helpline workers: the training they received, the impact of their work on their personal lives, and their support needs in order to maintain their role. This work should be seen as a pilot study and precursor to larger studies with more participants across a wider area.

Methods

This paper reports a qualitative study in which semi-structured interviews were conducted with helpline workers working for domestic violence helplines. Semi-structured interviews allowed an informal approach while ensuring all topic areas were covered, and enabled participants to speak more about the areas they felt were most important without restriction (Bryman 2004, Gilbert 2008).

Recruitment.

A purposive sampling technique was used, which is a convenient method of finding information-rich participants in a limited-resource situation (Patton 2002). Participants were recruited from a selection of different helplines in the South West of England, and all undertook direct client-focused work. Helpline managers were approached at the start of the study and informed of the research questions. They were given the opportunity to ask

questions and advised that all participants would remain anonymous. All helpline managers

agreed to organisational access and introduced the research team to the helpline staff.

Participants.

Participants were eligible if they were aged 18 or over, were fluent in English, and had at least

six months' experience of working or volunteering for a DVA helpline. In order to protect the

anonymity of participants, neither the helplines they worked for, nor the individual participants,

are named in this paper.

Data collection.

Interviews with helpline staff were conducted on the telephone between July and September

2015, and participants completed a 'consent to interview' form prior to interview. The

interviews lasted between 20 and 60 minutes and were audio recorded. The interviews used a

semi-structured format and followed a topic guide (an outline of which is included in Appendix

A). The topic guide was employed flexibly, and the interviewer used open questions while

ensuring the necessary topics were covered. Topics included training, self-care, and

organisational support. Participants received a £10 gift voucher to thank them, and were also

offered a list of support organisations if they felt they needed it.

Data analysis.

Audio recordings were transcribed verbatim by a transcription company with which the

University has a Personal Data Processing Agreement. Sample size was guided by data

saturation, the point at which no new themes were emerging from the transcripts. After initial

familiarisation with the data, analysis was conducted thematically using techniques derived

from framework analysis (Pope 2000, Braun 2006, Gale 2013). The framework was initially

based on the questions in the topic guide. The researchers (AKT and AG) independently read

through the interview transcripts and generated potential codes, honing these to develop themes. As interviews continued, the emergent interview data were coded under each theme and relevant quotes were added to the framework. This enabled the identification of similarities and differences between transcripts, and the noting of deviant cases. There was little difference in coding between researchers. A group effect was predicted due to the close working relationship of some of the participants. The participants' perspectives and the context of any statements were taken into account when using quotes.

Ethical issues.

Ethical approval for this study was granted in May 2015 by the Faculty of Medicine and Dentistry Research Ethics Committee at the University (Reference 19961). Audio recordings were encrypted, password protected, and stored with the anonymised interview transcriptions on a password-protected secure server. Consent forms were stored in a locked cabinet, and the researcher (AKT) followed a confidentiality protocol. Participants were aware that they could withdraw their consent to participate in the study at any time.

Findings

We interviewed ten helpline staff, all female. Participants ranged in age from 22 to 54 years old. All but one were white British, and the number of years they had worked in their current helpline role ranged from one year to seven years. Several had additional occupations such as working as a counsellor or as an advocate in the DVA sector. One had a post-graduate diploma in counselling.

A number of themes emerged from the data: the emotional impact of helpline work, its impact on relationships with family and friends, the support provided by their organisation and whether they felt this was sufficient for their needs, support that helpline workers identified as

important, and self-care strategies already utilised. Illustrative quotes are presented for each theme; the participant number is preceded by the study code (STSB).

Emotional impact

Participants described a significant emotional impact from their helpline work. This was usually due to the volume and the content of calls they received, and for some people the cumulative emotional stress resulted in burnout. All the participants commented that they knew colleagues who had left the sector due to this.

We listen to some awful things. I've spoken to some colleagues in the helpline and some people just get burned out… Even though they love the sector, they just can't do it anymore mentally, and I find that really sad. (STSB11)

The pluses don't outweigh the minuses really. And everyone talks about it being a job with a shelf life but that really, that's because your emotions have a limit. (STSB01)

We're told to only do as much as you can do, but it does feel like a big stressor, so instead of delivering a really good service and looking after ourselves, we're just banging out calls and that emotionally… they are my worst days because it's just too much. (STSB03)

Some participants commented that certain types of shift, such as working overnight or working from home, were more stressful and difficult to recover from than other shifts. Although remote working enabled them to take calls in a familiar environment, this sometimes left them isolated. Participants who did overnight shifts felt that these calls tended to be more emotionally difficult.

When you do an overnight shift you do it at home on your own… You finish it at 8am

and you do a two-minute phone handover and then you're not in the office for two days

because you need to rest, but also you have all those calls in the night when you're

sleep deprived and alone. You are the whole helpline… It changes my week, really.

(STSB01)

Impact on relationships

Participants described a range of positive and negative effects on their relationships with partners, friends and family. Some women felt that their work had hindered them from starting a relationship.

It just puts me off dating because of all the things I'm hearing and that might be

something really unhealthy, because I might be losing out on opportunities to meet

really generally good men, but I'm just not in the right frame of mind. (STSB11)

I like men less, generally. Because of how prevalent it is I'm immediately able to look at

a situation like it might be abusive. I don't feel like it's made me paranoid, it's just that

I'm now incapable of closing my eyes to something… I do worry about it when I'm not

at work. (STSB01)

One woman noted that she found it very difficult to enjoy a sexual relationship with her husband due to being affected by what she had heard at work.

I think that it affects our sex life, massively. I hear stuff about rape, sexual abuse,

hideous stuff, and it really affects that side of it… (STSB05)

In contrast, relationships with friends and parents were often improved by the experience of working on the helpline.

> *[The helpline is] a feminist environment so it's definitely helped me improve my relationships with other women.* (STSB03)

> *I really get what happened with my dad [mum was abusive] so I do try and talk to him about it. It's made it better.* (STSB06)

Support at work

Even in the early stages of their helpline work, most participants described having received little training focusing on the emotional impact of work.

> *Kind of got told that if it gets too much you can take a break, talk to other people, talk to the manager, but that was it, really.* (STSB06)

> *I guess they … they only took people on who'd had some experience of a kind of a relevant area, so I suppose they made some assumptions about our robustness based on that. But yeah, nothing kind of specific about that … that self-care side of things, no.* (STSB09)

Participants reflected on a lack of regular support that would have enabled them to manage the high volume of distressing calls they received.

We're supposed to have supervision every month, but it doesn't quite work out as every four weeks, and we can talk about calls there, but our supervisors aren't trained in any kind of recognizing trauma or burnout or triggers and how to cope with those. (STSB05)

Most participants wanted regular one-on-one clinical supervision from a counsellor who was not affiliated with or linked to the helpline.

Definitely clinical supervision… It should be at least fortnightly. Someone coming in, preferably with counselling experience. From outside, not affiliated with [the helpline] in any way. And one-on-one. (STSB03)

Some felt that they would not be comfortable with group supervision, but other participants stated that, if facilitated appropriately to ensure all the participants felt able to talk, group supervision might be helpful.

I've had group process, so if you have a good enough leader who can support that and make sure needs are met, it would hold securely. (STSB06)

There's something really special about the support that can be offered from that group environment, that group dynamic, and especially from your peers, but I think it should be as well as, not instead of, one to one supervision. (STSB13)

A perceived lack of support from the organisations running the helplines appeared to cause a circular problem in which burnout worsened and participants felt more disempowered.

Self-care strategies and 'switching off'

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Participants talked about different methods of looking after themselves. These included physical activity, social connectedness through relationships with family and friends, and regular hobbies.

I enjoy swimming, I enjoy walking, I enjoy socialising, I enjoy er, cinema, theatre, listening to music, um, yeah, lots of variety like that really. And visiting my family, seeing friends, yeah… (STSB07)

I try and keep up with exercise outside of work, so that's running, jogging, yoga, um, just… doing things that make me happy, things I enjoy. (STSB13)

I do a drama group, look after my kids, see friends. (STSB05)

However, they often struggled to separate their helpline work from their life at home.

I can see [DVA] everywhere now, it's like a little window's been opened… I won't deal with it on my own time unless it's a really close friend, but I'd still try and get them to a DV worker. But I'm seeing it everywhere, and I'm just despairing at our world where women are second-class citizens. (STSB06)

I'm an introvert anyway, but [after a shift] I really don't want to socialize, I don't want to be around people because I need to process it myself and feel really drained, so I've probably become a bit more anti-social. (STSB03)

Discussion

Summary of findings

The women interviewed disclosed a number of ways in which working on a helpline resulted in challenges to their wellbeing, commonly affecting their personal lives, their relationships, and their ability to cope at work. Poor training on the emotional impact of their work, and often little ongoing support, meant that they considered themselves at risk of burnout. Participants wanted their workplace to offer regular clinical supervision to support them, and expressed a variety of opinions about the form in which this could most usefully be delivered.

Strengths and limitations

This is the first study to explore the wellbeing and needs of DVA helpline workers and therefore a key strength of the research is the novelty of the topic. In addition, using qualitative methods with semi-structured interviews enabled participants to discuss issues that were important to them, and to speak freely about what they felt their needs were and how they should be met.

The size of the study is the main limitation. Although we reached data saturation, it is possible that we did not speak with women who had a more positive or a more negative experience of working on the different helplines, so caution should be exercised in transferring the findings to other settings.

Additionally, we did not speak to managers or policymakers, so we may not have captured the full context of what support systems are in place.

Implications

Compassion fatigue and vicarious trauma have been identified in professionals working with traumatised people (Baird 2003, Conrad 2011, Figley 2002). Compassion fatigue is the diminished capacity to experience distress when hearing about or witnessing others' suffering,

while vicarious trauma is a general description of negative transformative processes experienced by professionals when working with traumatised individuals. In addition, occupational burnout has been described as a state of physical, emotional and mental exhaustion brought on by a work environment that is stressful and does not provide support to its employees to help them maintain energy and capacity (Schaufeli & Greenglass 2001).

Figley's model of compassion fatigue describes the exposure to and concern for clients combined with an empathic ability to contribute to the therapeutic response (Figley 2001). This then leads to increased residual stress and then compassion fatigue if there is little emotional support, prolonged exposure to clients, and traumatic memories or new life stressors. It could be inferred that participants working on domestic violence helplines have significant empathic concern and ability driving their work, and our participants discussed regular and often prolonged exposure to the suffering of clients, which is a feature of Figley's model (2001). Participants in our study clearly identified that burnout was a significant problem among helpline staff. It is also possible that vicarious trauma underpins compassion fatigue, such as exposure to suffering resulting in later emotional detachment, and that vicarious trauma makes one more likely to experience compassion fatigue (or vice versa). Baird (2003) has shown both compassion fatigue and vicarious trauma to be relevant for sexual assault and domestic violence staff, although the literature on reducing risk is sparse. This model may be helpful in understanding the experience of our participants, and has implications for how we offer support in order to reduce the risk of vicarious trauma and compassion fatigue.

Listening to the voices of the participants suggests that before beginning this type of work, DVA helpline staff should receive more education about potential trauma triggers, and training on handling the emotional impact of helpline work. Continuing professional development opportunities should be available to ensure that workers are able to cope with the distressing

issues that are disclosed to them, and to reduce the risk of burnout and vicarious trauma (Baird 2003, Conrad 2011).   In its current format, the Helplines Standard (Helplines Partnership 2014) is a voluntary accreditation, but helpline service commissioners should consider enforcing a minimum standard policy to ensure that all staff across all helpline services have an equal opportunity to access support and supervision, and to encourage regular breaks and reflective practice. Helpline staff could also be supported to undertake further education in counselling and/or social work in order to give them tools to improve their own resilience.

Support at work may reduce the personal impact on helpline workers' home and social life, reducing vicarious trauma and burnout and improving wellbeing (Ludick & Figley 2016). This in turn could reduce helpline worker turnover, and greater consistency in staff presence could improve group cohesion and job satisfaction (Hudgins 2016). Additionally, this research has illustrated how helpline workers would welcome greater acknowledgement by the organisations they work for of the impact of the work, and provision of increased opportunities for support.

Supervision is an essential part of supporting the mental health of helpline staff. Limited financial resources may prevent the employment of a qualified counsellor; however, trainee counsellors could volunteer their skills to helpline staff in exchange for counselling experience. Therefore, perceived financial burden should not be a limiting factor in the ability to provide supervision. It is important to note that the cost of employing an independent counsellor may be outweighed by the costs of burnout, sickness pay, understaffing and recruitment of new staff after current workers leave.

Austerity and cuts to DVA services, along with increased pressure on those surviving, may be contributing to the impact on helpline staff. However, failing to address the concerns raised in this paper may lead to poorer quality service provision for survivors and third parties accessing the service. Positive responses and reinforcement from supporters such as helpline staff may reduce the effects of abuse on survivors' physical and mental health (Coker 2003, Plazaola-Castano 2008) and act as a protective factor against future abuse (Goodman 2005). Therefore, meeting the resilience and wellbeing needs of frontline helpline workers may facilitate the provision of better support to survivors.

Conclusion

This study suggests that helpline staff should receive more education about trauma triggers, and ongoing support to reduce the impact on their home and social life, thus improving mental wellbeing and job satisfaction. This paper has begun a debate about the needs of DVA helpline workers by ascertaining the perspectives of staff on the impacts they face in the course of their work. Further research, including larger qualitative studies and anonymous surveys, should be undertaken to explore in greater depth the wellbeing of staff working for a range of gender-based violence helplines, and how burnout and staff turnover differ at helplines where different levels and modes of supervision and support are provided. It is also important to explore the perspective of other staff working for helplines, including managers and policymakers.

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Appendix A

Why did you start working at the helpline?

>*Previous experience of DVA or friend/family experience?*

>*Previous experience working on another helpline?*

>*Altruistic*

What training did you receive before starting work?

>*Yes/No*

>*How many hours?*

>*What did it cover? Physical/emotional impact, where to go to for support*

How do you take care of yourself?

>*What do you do in your spare time?*

>*What do you do to help you relax?*

>*Any particular things after a difficult shift?*

How has your work at the helpline impacted your own relationships?

>*Husband/wife/partner?*

>*Children? Do you use your experiences at the helpline as a teaching tool?*

>*Parents?*

Do you get ongoing support from the service?

>*If you had a difficult shift, would you know who to go to for help?*

>*Who would that be?*

>*Would you feel comfortable approaching them?*

>*Is the support you get sufficient for your needs?*

>*What other support do you think you might need?*