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PROFESSIONAL VALUES OF CRISIS CENTER STAFF

This article examines the professional values of crisis center staff providing support to survivors of domestic violence. The aim of the study is to identify the key professional values of crisis center workers, analyze the typical ethical dilemmas arising in the process of supporting survivors, and determine the organizational and systemic factors influencing the implementation of professional principles in everyday practice. The study is based on a qualitative research design. The empirical data were collected through in-depth semi-structured interviews with seven crisis center professionals from Almaty and Karaganda. The data were analyzed using thematic analysis with a coding framework structured around four analytical domains: professional values, ethical dilemmas, support practices, and systemic barriers.

The findings demonstrate that ensuring the safety of clients and children serves as the central professional orientation of crisis center staff. Core values consistently reflected in professional practice include a trauma-informed and non-blaming approach, respect for client autonomy, confidentiality, maintenance of professional boundaries, teamwork, and supervision. The value of the study lies in its empirical description of how professional values are enacted in everyday crisis intervention practices and how organizational environments influence the quality of professional decision-making. The study contributes to the development of research on professional ethics, crisis intervention, and social work in the field of domestic violence prevention and response. The practical significance of the findings lies in their potential application to the development of professional training programs for crisis center staff, improvement of service delivery standards, implementation of supervision systems, and strengthening of interagency support mechanisms for survivors of violence.

Keywords: domestic violence, crisis centers, professional values, ethical dilemmas, safety, confidentiality.

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Дағдарыс орталықтары қызметкерлерінің кәсіби құндылықтары

Мақала тұрмыстық зорлық-зомбылықтан зардап шеккен адамдарға көмек көрсететін дағдарыс орталықтары қызметкерлерінің кәсіби құндылықтарын зерттеуге арналған. Зерттеудің мақсаты – дағдарыс орталықтары қызметкерлерінің негізгі кәсіби құндылықтарын анықтау, жәбірленушілерді сүйемелдеу тәжірибесінде туындайтын типтік этикалық дилеммаларды талдау, сондай-ақ кәсіби қағидалардың күнделікті қызметте жүзеге асуына әсер ететін ұйымдық және жүйелік факторларды айқындау. Зерттеудің әдіснамалық негізін сапалық зерттеу дизайны құрады. Эмпирикалық база Алматы және Қарағанды қалаларындағы дағдарыс орталықтарының жеті маманымен жүргізілген тереңдетілген жартылай құрылымданған сұхбаттарды қамтиды. Деректерді талдау кәсіби құндылықтар, этикалық дилеммалар, көмек көрсету тәжірибелері және жүйелік кедергілер сияқты төрт аналитикалық блок бойынша кодтауға негізделген тақырыптық талдау әдісі арқылы жүзеге асырылды.

Зерттеу нәтижелері дағдарыс орталықтары қызметкерлерінің негізгі кәсіби бағдары клиенттер мен балалардың қауіпсіздігін қамтамасыз ету екенін көрсетті. Кәсіби тәжірибеде травмаға сезімтал және айыптамаушы емес тәсіл, клиент автономиясын құрметтеу, құпиялылықты сақтау, кәсіби шекараларды ұстану, командалық өзара әрекеттестік пен супервизия сияқты құндылықтардың тұрақты көрініс табатыны анықталды. Зерттеудің құндылығы кәсіби құндылықтардың дағдарыстық көмек көрсету тәжірибесінде қалай жүзеге асатынын және ұйымдық ортаның кәсіби шешімдердің сапасына қалай әсер ететінін эмпирикалық тұрғыдан сипаттауында жатыр. Жұмыс кәсіби этика, дағдарыстық интервенция және тұрмыстық зорлық-

алу саласындағы әлеуметтік жұмыс зерттеулерінің дамуына үлес қосады. Нәтижелердің практикалық маңызы оларды дағдарыс орталықтары қызметкерлерінің біліктілігін арттыру бағдарламаларын әзірлеуде, көмек көрсету стандарттарын жетілдіруде, супервизиялық қолдау жүйесін енгізуде және зорлық-зомбылықтан зардап шеккендерді ведомствоаралық сүйемелдеудің неғұрлым тұрақты моделін қалыптастыруда қолдану мүмкіндігімен анықталады.

Түйін сөздер: тұрмыстық зорлық-зомбылық, дағдарыс орталықтары, кәсіби құндылықтар, этикалық дилеммалар, қауіпсіздік, құпиялылық.

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Профессиональные ценности работников кризисных центров

Статья посвящена исследованию профессиональных ценностей работников кризисных центров, оказывающих помощь пострадавшим от бытового насилия. Цель исследования заключается в выявлении ключевых профессиональных ценностей работников кризисных центров, анализе типичных этических дилемм, возникающих в практике сопровождения пострадавших, а также определении организационных и системных факторов, влияющих на реализацию профессиональных принципов в повседневной деятельности. Методологическую основу исследования составил качественный исследовательский дизайн. Эмпирическая база включает глубинные полуструктурированные интервью с семью специалистами кризисных центров Алматы и Караганды. Анализ данных проводился методом тематического анализа с использованием системы кодирования по четырем аналитическим блокам: профессиональные ценности, этические дилеммы, практики помощи и системные барьеры.

Результаты исследования показали, что центральным профессиональным ориентиром работников кризисных центров выступает обеспечение безопасности клиентов и детей. В профессиональной практике устойчиво проявляются такие ценности, как травма-информированный и не обвиняющий подход, уважение автономии клиента, соблюдение конфиденциальности, поддержание профессиональных границ, командное взаимодействие и супервизия. Ценность проведенного исследования заключается в эмпирическом описании того, каким образом профессиональные ценности реализуются в реальных практиках кризисной помощи и как организационная среда влияет на качество профессиональных решений. Работа вносит вклад в развитие исследований профессиональной этики, кризисной интервенции и социальной работы в сфере противодействия бытовому насилию. Практическое значение результатов состоит в возможности их применения при разработке программ повышения квалификации сотрудников кризисных центров, совершенствовании стандартов оказания помощи, внедрении супервизионной поддержки и формировании более устойчивой системы межведомственного сопровождения пострадавших от насилия.

Ключевые слова: бытовое насилие, кризисные центры, профессиональные ценности, этические дилеммы, безопасность, конфиденциальность.

Introduction

Domestic violence remains one of the most complex social problems because it is not only an individual incident within a family but also a persistent social mechanism that affects survivors' safety, health, economic independence and social participation (WHO, 2024; World Health Organization, 2013). In everyday practice, crisis centers function as key "first-contact" institutions providing emergency support. They are the point where immediate protection needs, legal pathways, psychological stabilization and risk-sensitive case management intersect (Sullivan, 2018; Goodman et al., 2016).

The professional work of crisis-center staff is inherently value-laden. Decisions are made under uncertainty, resource scarcity and constant time pressure, often in situations of heightened danger (stalking, escalation risks, and children's safety). Therefore, service quality depends not only on formal protocols but also on professionals' stable "value core": which principles are non-negotiable, how responsibility boundaries are drawn, how the balance between client autonomy and risk communication is understood, and how confidentiality and its limits are interpreted.

Empirical findings from the present study indicate that the most consistent themes in practitioners'

accounts include: safety as the primary decision filter; a non-blaming, trauma-informed approach; respect for client autonomy combined with the center's duty to inform about risks; confidentiality as a component of safety with clearly recognized limits; professional boundaries; teamwork and supervision; and systemic constraints (SAMHSA, 2014; WHO, 2013; Sullivan, 2018).

Importantly, safety operates as a meta-value rather than a declarative principle: it structures practical steps from initial risk screening and 24–72-hour safety planning to careful handling of sensitive information and pacing of legal actions.

This also generates a central ethical dilemma "safety vs client autonomy"-where practitioners must respect clients' choices while ensuring a minimum safety package and explicit risk communication.

The study further highlights structural barriers that complicate the implementation of values in practice: weak interagency coordination, social normalization of violence and stigma, family pressure, clients' economic dependence, and the emotional risks of the profession, including burnout under high moral load and limited resources.

The aim of this article is to identify and describe crisis-center workers' professional values in the context of domestic violence, and to demonstrate how these values are enacted through typical dilemmas, support practices and perceived barriers. The empirical basis consists of in-depth interviews with staff from crisis centers in Almaty and Karaganda, with participants anonymized as R1–R7 in the materials. The analytical strategy relies on thematic analysis with four coding blocks – values, dilemmas, practices and barriers – linking micro-level professional decision-making to organizational and systemic conditions (Braun & Clarke, 2006; Tong et al., 2007). The article is structured as follows: methodology and sample; results of the thematic analysis, including core values, dilemmas, practices and barriers; discussion of organizational implications; and conclusions with practical recommendations for strengthening standards, supervision and interagency collaboration.

Literature review

Domestic violence most commonly discussed in the international literature under the term *intimate partner violence* (IPV), i.e., violence perpetrated by an intimate partner is widely recognized as a major public health problem, a violation of human rights, and a direct threat to survivors' physical, mental, and social well-being. According to World Health Organization estimates, approximately 30% of women globally experience physical and/or sexual violence by a partner or sexual violence by a non-partner over the course of their lifetime, with a substantial share of cases attributable specifically to partner violence (WHO, 2024). This framing is essential for research on the professional values of crisis-center practitioners, whose everyday decisions are shaped not only by personal convictions but also by the ongoing necessity to assess the risk of repeat violence, threats and stalking, and the impacts of violence on children.

At the level of service provision, crisis centers, shelters, and specialized NGOs constitute critical access points to safety, initial psychological support, legal navigation, and social referral pathways. Research on victim-support services emphasizes that effectiveness depends not only on the range of services offered, but also on *how* those services are delivered respectfully, safely, without coercion, and in ways that account for trauma histories and the practical constraints of the system (Sullivan, 2018).

In Kazakhstan, the relevance of this topic is amplified by the concurrent institutional development of support systems and the continuing "latency" of the problem. Quantitative studies in Kazakhstan note that violence often remains hidden due to social norms, distrust, and barriers to help-seeking, which reduces the likelihood of formal reporting and complicates access to protection (Kainazarova et al., 2025). Public materials from governmental bodies also indicate an expansion of crisis-support infrastructure: official information reports that approximately 74 crisis centers operate nationwide, a significant proportion of which include shelters for women and children (Government of Kazakhstan, 2025). At the same time, analytical reports point to regional disparities in service availability and to workload pressures related to the financing and organization of specialized social services delivered through crisis centers.

Within sociological and social work perspectives, "professional values" are understood as stable normative orientations that define standards of what is acceptable and unacceptable in helping practice and delineate the boundaries of professional intervention. Core values typically include respect for human dignity, self-determination (autonomy), non-discrimination, confidentiality, competence, and accountability to clients and society. These orientations are codified both in international ethical prin-

ciples for social work (IFSW, 2018) and in professional codes that explicitly emphasize clients' rights to self-determination and the obligation to protect confidentiality within the bounds of law and ethics (NASW, 2021).

In the context of domestic and partner violence, this framework requires further specification: the value of client autonomy must be balanced with practitioners' responsibility to communicate risk, support safety, and avoid actions that may inadvertently increase danger. Accordingly, research on services for survivors highlights that values are enacted through "micro-decisions" in practice what to document, how to discuss risks, how to build rapport without pressure, how to maintain confidentiality, and where the limits of confidentiality lie (WHO, 2013).

One of the most widely endorsed approaches in contemporary support systems is the *trauma-informed approach*. It assumes that traumatic experiences are prevalent and shape behavior, decision-making, and the capacity to seek help; therefore, an organization's task is to prevent retraumatization and embed an understanding of trauma into procedures and interactions. In SAMHSA's formulation, a trauma-informed approach entails recognizing the widespread impact of trauma, identifying its signs in clients and staff, integrating trauma knowledge into policies and practices, and actively resisting retraumatization (SAMHSA, 2014). At the level of guiding principles, SAMHSA emphasizes safety; transparency and trust; peer support; collaboration; empowerment and choice (voice); and attention to cultural, historical, and gender factors (SAMHSA, 2014).

In IPV response, these principles align closely with survivor-centered (or women-centered) practice: minimizing blaming interpretations (e.g., "why didn't you leave earlier"), acknowledging the cyclical nature of violence and the possibility of returning to abusive partners, respecting the survivor's pace, and avoiding practices that intensify shame and isolation (WHO, 2013). International guidance consistently stresses that even an initial professional response must be supportive, safe, and respectful in order to preserve trust and avoid increasing the risk of further violence (WHO, 2013).

Increasingly, contemporary service models are described as supporting *empowerment* and restoring control over one's life, rather than directive "rescue." Conceptual models of crisis-service practice suggest that sustained improvements in well-being are linked to the extent to which services help survivors regain a sense of safety, access resources, strengthen social support, and make decisions under conditions of risk (Sullivan, 2018). Empirical research also underscores the role of the helping relationship (the practitioner–survivor "alliance"): the quality of the relationship with an advocate or support professional can operate as an important mechanism associated with increased perceived agency and improved psychological well-being (Goodman et al., 2016). Thus, the professional value of autonomy does not imply "non-intervention"; rather, it involves active work to provide information, clarify alternatives, support choice, and strengthen safety while respecting the client's right to decide (WHO, 2013).

Confidentiality in services for survivors of violence serves a dual function: (1) it builds trust in the practitioner and the service, and (2) it is a direct component of safety, because information leaks may lead to stalking, retaliation, or coercive return. WHO clinical and policy recommendations stress the need to conduct consultations in private settings and to maintain confidentiality while explicitly explaining its limits in advance (e.g., mandatory reporting requirements or imminent threats to life) (WHO, 2013). This establishes a central ethical dilemma for crisis-center practitioners: balancing protection of trust with obligations to respond when the life or safety of children or other persons is at risk.

Research on support services also highlights that the "safety of space" in shelters and crisis centers requires strict communication rules, careful control of location disclosure, and caution in interagency coordination to avoid creating risks for all residents (WHO, 2013).

Professional values in crisis-center work also necessarily include *boundaries* both as an ethical principle and as a mechanism for preventing burnout. Working with traumatic narratives, threats, and crisis situations increases the risk of secondary traumatic stress and other forms of professional exhaustion. Studies of social workers indicate that a substantial proportion experience symptoms of secondary traumatic stress, and some may develop clinically significant levels of symptomatology (Bride, 2007).

For professionals supporting survivors of domestic violence, emotional strain is particularly pronounced due to the combination of "real, ongoing danger" to the client and a high degree of empathic engagement. A study of domestic violence advocates found that key protective factors include collegial support and high-quality clinical supervision;

protection is also strengthened by an organizational environment characterized by shared responsibility and "shared power" (respect, reciprocity, and aligned decision-making), rather than a rigidly hierarchical model (Slattery & Goodman, 2009). In the Kazakhstani context, studies of organizations working on violence against women additionally document structural stressors surges in demand during crisis periods, resource constraints, the need to adapt service formats, and organizational pressure all of which intensify risks of staff overload (Karabay et al., 2024).

Even when teams share a coherent value base, service effectiveness depends on interagency coordination (police, health care, education, courts, and social services). International recommendations emphasize the need for coordinated systems, adequate funding, and staff training to ensure appropriate initial responses and referral pathways (WHO, 2013). In practice, however, "systemic barriers" (limited shelter capacity, uneven accessibility, bureaucratic procedures) can turn values into an arena of continual dilemmas and compromises. In Kazakhstan, analytical materials similarly note challenges related to crisis-center accessibility and the regulatory provision of specialized social services, which shapes a persistent constraint environment for practitioners.

Overall, contemporary literature identifies several "nodal" foundations of crisis-center practitioners' professional values: safety as a primary criterion; non-blaming, trauma-informed engagement; support for autonomy and empowerment; confidentiality and management of its boundaries; professional boundaries and team sustainability; and interagency coordination under conditions of systemic constraint (SAMHSA, 2014; WHO, 2013; Sullivan, 2018; Slattery & Goodman, 2009).

At the same time, in Kazakhstan there remains a need for empirical studies that examine how these values are articulated and enacted by crisis-center professionals in everyday decisions, dilemmas, and practices at the intersection of professional ethics and the structural constraints of service provision (Kainazarova et al., 2025; Karabay et al., 2024).

Materials and methods

Study Design

This study was conducted within a qualitative paradigm and has an exploratory design. The empirical basis comprises in-depth semi-structured interviews with crisis-center staff working with survivors of domestic violence. Data were interpreted using thematic analysis as a strategy for identifying recurrent meanings and practices in participants' professional experience (Braun & Clarke, 2006).

The reporting logic follows principles of transparency in qualitative research particularly regarding the description of the sample, procedures, analytic steps, and the use of illustrative quotations consistent with the COREQ recommendations (Tong et al., 2007).

Sampling Strategy and Participants

The sample was formed using purposive sampling with an emphasis on capturing diversity of functional roles within crisis services, including: initial intake and risk assessment; shelter operations; child-focused practice; legal navigation and referral; coordination of complex cases and supervisory functions; outreach and partnerships; and training and standards of practice.

Participants included seven crisis-center workers from Almaty and Karaganda (six women and one man). Participants ranged in age from 27 to 59 years (27, 33, 35, 42, 46, 51, and 59). To ensure confidentiality, anonymized identifiers (P1–P7) are used throughout the text, and no specific organizations or other identifying details are reported.

Data Collection

Interviews were organized around thematic blocks designed to elicit professional reflection and the "internal logic" of crisis work: (1) professional trajectory and work context; (2) understandings of professional values and principles; (3) values in action (examples of decisions/cases); (4) ethical and legal boundaries; and (5) organizational culture, support, and practitioner sustainability (burnout).

Data Analysis

Analysis was conducted as an iterative, code-based thematic analysis with progressive refinement of codes and higher-order meaning-making (Braun & Clarke, 2006). The analytic framework operationalized coding across four interrelated dimensions of professional experience: (1) values, (2) dilemmas, (3) practices, and (4) barriers. The analytic output included a codebook indicating code coverage (i.e., how many participants articulated each code), as well as a synthesis of cross-cutting emphases and integrative themes.

Ethical Considerations

The study adhered to principles of informed consent, voluntary participation, and confidentiality. Notably, participants' reflections on the boundaries and exceptions of confidentiality as a professional norm constitute part of the study's empirical material.

Results and discussion

Sample characteristics

Seven crisis-center professionals from two cities in Kazakhstan (Almaty and Karaganda) participated in the study (six women, one man). Participants' ages ranged from 27 to 59 years (M = 41.9; Me = 42).

Table 1
Socio-demographic characteristics of participants (n = 7)

Indicator	Value
Total participants	7
Women	6
Men	1
Age (M)	41.9
Age (Me)	42
Age (min–max)	27–59

Participants represented a range of functional roles across the crisis-service continuum: initial intake and risk assessment; shelter-based support; child-centered work; legal navigation; complex case coordination and supervision; outreach and access pathway development; and staff training and standardization. Typical cases included repeat help-seeking, nighttime arrivals without documents, threats/stalking, complex presentations (violence + addiction + children + housing instability), and strong social normalization of violence in clients' environments.

Cross-cutting core meanings

Across interviews, a stable core of professional meanings was identified: (1) safety as the primary decision filter; (2) a non-blaming stance grounded in recognition of survivors' lived experience; (3) client autonomy paired with the duty to communicate risk; (4) confidentiality as a safety mechanism, with explicit boundaries (risk to life, child safety); (5) professional boundaries and rejection of "rescuing"; (6) teamwork and supervision as infrastructure for quality; and (7) a persistent context of systemic constraints (capacity, staffing, interagency coordination, reporting and accountability demands).

Respondents commonly described a shift from expectations of a "quick exit" toward understanding support as a longer, non-linear process marked by returns. In this framing, keeping "the door open" and ensuring a "minimum safety package" were viewed as critical practice commitments (translated from the original interviews).

Value codes

Value codes show the densest normative core around safety, trauma-informed non-blaming engagement, autonomy, confidentiality, and professional boundaries.

Table 2
Coverage of value codes (n = 7) (n = number of respondents explicitly articulating the value; % = proportion of the sample)

Code	Value	n	%
V1	Safety first	7	100
V2	Non-blaming / trauma-informed approach	7	100
V3	Autonomy and voluntariness of decisions	7	100
V4	Confidentiality as protection	7	100
V5	Professional honesty / realism	6	86
V6	Priority of children's well-being	4	57
V7	Professional boundaries (anti-heroism)	7	100
V8	Teamwork and supervision	6	86
V9	Non-discrimination and accessibility of support	3	43

V1. Safety first (7/7). Safety of the client, children, and shelter space was positioned as the primary decision criterion, operationalized through safety planning, escalation prevention, and controlled disclosure of identifying information. Safety was repeatedly framed as collective: a single error may compromise the entire shelter's location.

V2. Non-blaming, trauma-informed engagement (7/7). Participants emphasized avoiding shame

and moralizing, arguing that blame disrupts trust and reduces subsequent help-seeking.

V3. Autonomy and voluntary decision-making (7/7). "We do not decide for the person" encapsulated the approach: staff provide risk information and options while recognizing the client's right to make imperfect choices, especially in scenarios of returning to the perpetrator or declining to file a report.

V4. Confidentiality as protection (7/7). Confidentiality was construed as both trust-building and safety-critical, with a strong emphasis on proactively explaining exceptions in advance, particularly when life-threatening risk or child safety concerns emerge.

V5. Professional honesty/realism (6/7). A recurring value was avoiding unrealistic promises regarding timelines, placement availability, and legal procedures; respondents framed realism as essential to ethical practice.

V6. Priority of children's well-being (4/7). Children were treated as an independent subject of safety and care; respondents emphasized that children should not be instrumentalized in adult conflicts.

V7. Professional boundaries and rejection of "heroism" (7/7). Boundaries were described as an ethical norm and a prerequisite for sustainability, including limits on availability and avoidance of shifting professional support into personal relationships.

V8. Teamwork and supervision (6/7). Team-based discussion and supervision were positioned as mechanisms of quality assurance and psychological containment for complex cases.

V9. Non-discrimination and accessibility (3/7). Respondents highlighted plain language, barrier reduction, and safe modes of contact (including anonymous approaches) to support equitable access.

Ethical dilemmas

Ethical dilemmas clustered around recurrent decision nodes in crisis practice. The most universal were "safety vs. autonomy" and "empathy vs. professional distance."

Table 3
Coverage of ethical dilemma codes (n = 7)

Code	Dilemma	n	%
D1	Safety vs. client autonomy	7	100
D2	Confidentiality vs. duty to intervene	6	86
D3	Justice/punishment vs. escalation prevention	4	57
D4	Speed of support vs. bureaucracy	5	71
D5	Client needs vs. shelter safety	3	43
D6	Empathy vs. professional distance	7	100
D7	Resource scarcity and triage ethics	2	29
D8	Client/family values vs. center values	6	86

D1. Safety vs. autonomy (7/7). The most frequent scenario involved client choices perceived as higher-risk (returning to the perpetrator, refusing to report, maintaining contact). The dominant practice logic combined respect for choice with explicit risk communication and a minimum safety plan.

D2. Confidentiality vs. duty to intervene (6/7). This dilemma emerged when risks to life or child safety required interagency action, potentially undermining trust. Participants emphasized anticipatory clarification of confidentiality limits.

D3. Justice/punishment vs. escalation prevention (4/7). Respondents noted that rapid punitive action can intensify threats, especially in stalking contexts and when children are involved; caution was framed as risk management.

D4. Speed vs. bureaucracy (5/7). Participants described a persistent mismatch between the urgency of crisis and slow procedural requirements (documentation, queues, approvals), experienced as "the system moving slower than the crisis".

D5. Client needs vs. shelter safety (3/7). Tension arose between individual preferences (contacts, calls, meetings) and collective safety rules; strict shelter protocols were justified by the shared-risk environment.

D6. Empathy vs. distance (7/7). Emotional engagement was recognized as necessary, while "res-

cuer" dynamics were framed as risky for both client and practitioner.

D7. Triage ethics under scarcity (2/7). Limited capacity produced ethically burdensome decisions regarding who could be accommodated, with harm-minimization as the guiding rationale.

D8. Client/family values vs. center values (6/7). Social normalization of violence ("this is how it is," "for the children") conflicted with the center's norm that violence is unacceptable. A common strategy was to avoid direct confrontation and instead re-anchor discussion in safety, consequences, and available choices.

Practice codes

Practice codes captured how values were enacted in routine work from initial risk assessment to practitioner sustainability.

Table 4

Coverage of practice codes (n = 7)

Code	Practice	n	%
P1	Risk assessment and safety planning	7	100
P2	Minimizing secondary traumatization	6	86
P3	Stepwise support and a "minimum package"	7	100
P4	Multidisciplinary collaboration	6	86
P5	Referral navigation and interagency coordination	5	71
P6	Shelter protocols / safety of space	3	43
P7	Child-centered practices	4	57
P8	Outreach and "safe channels"	2	29
P9	Professional hygiene/resilience and team practices	7	100

P1. Risk assessment and safety planning (7/7). Initial risk screening, a 24–72-hour plan, code words, document preparation, and contact control functioned as the operational core of safety work and a key response to the autonomy–safety dilemma.

P2. Minimizing secondary traumatization (6/7). Respondents emphasized "not interrogating," avoiding repeated detailed recounting, respecting pace, and documenting carefully.

P3. Stepwise support and a minimum package (7/7). Even when clients declined an "ideal" pathway, staff-maintained engagement and offered minimum safety, information, and options consistent with the "door stays open" commitment.

P4. Multidisciplinary collaboration (6/7). Involving psychologists, lawyers, and social workers supported role clarity and reduced error risk in complex cases.

P5. Navigation and interagency coordination (5/7). Participants described coordinated work with police, courts, healthcare, and educational institutions, often via formal referrals and accompaniment. This practice was repeatedly constrained by systemic coordination barriers.

P6. Shelter protocols and safety of space (3/7). Rules governing communications, address protection, and risk management for other residents were framed as necessary for collective safety.

P7. Child-centered practices (4/7). Practices included assessing children's needs, liaising with schools/kindergartens, and supporting caregivers' understanding of stress-related child responses.

P8. Outreach and safe channels (2/7). Neutral communication and minimization of digital/interactional traces were used to reduce the likelihood of escalating risk.

P9. Professional hygiene and sustainability (7/7). Supervision/intervision, end-of-shift closure routines, leave, and boundaries on availability were treated as ethical prerequisites for maintaining service quality and mitigating burnout risk.

Barrier codes

Barriers constituted the structural background against which values had to be continuously operationalized through compromise.

Table 5
Coverage of barrier codes (n = 7)

Code	Barrier	n	%
B1	Shortage of shelter places/resources	5	71
B2	Staffing shortages and overload	5	71
B3	Reporting requirements and bureaucracy	4	57
B4	Weak interagency coordination	6	86
B5	Normalization of violence and stigma	6	86
B6	Client economic dependence	3	43
B7	Limited child/trauma competencies in the wider system	2	29
B8	Emotional risks of the profession: burnout	7	100

B1. Shelter capacity/resource scarcity (5/7). Respondents described situations in which women with children could not be accommodated at the point of crisis; scarcity intensified triage pressures.

B2. Staffing shortages and overload (5/7). Turnover and fatigue were described as risks to quality and as factors exacerbating vulnerability to burnout.

B3. Bureaucracy and reporting demands (4/7). Participants described tension between human-centered support and paperwork/metrics, with high time costs and the risk of dehumanizing service delivery.

B4. Weak interagency coordination (6/7). The dominant formulation was that "the system moves slower than the crisis"; inconsistent understandings of violence across partner agencies disrupted pathways of protection and support.

B5. Normalization of violence and stigma (6/7). Family pressure and norms discouraging disclosure delayed help-seeking and increased returns, complicating efforts to maintain the service's non-violence framework.

B6. Economic dependence (3/7). Housing and financial constraints frequently drove returns, reinforcing the long-term, non-linear character of support trajectories.

B7. Limited child/trauma competencies (2/7). Shortages of specialized professionals and accessible services constrained child-centered components of support.

B8. Burnout and emotional risk (7/7). Participants reported markers such as cynicism, irritability, diminished empathy, and somatic symptoms, and explicitly framed sustainability as part of ethical helping practice.

The findings indicate that the "normative core" of crisis-center professionals' values is organized around the meta-value of safety and sustained through an interconnected set of orientations non-blaming practice, client autonomy, confidentiality, professional boundaries, and teamwork/supervision operating under persistent systemic pressure (resource scarcity, interagency gaps, bureaucracy, and reporting demands). In the thematic analysis, these elements were reproduced across nearly all participants and formed a stable practice logic: support is conceptualized not as "rescue," but as ongoing accompaniment that anticipates possible returns, where the key outcome becomes a minimum safety package and continuity of contact ("the door remains open").

Domestic violence as a crisis type generates a distinct professional rationality: "safety first" functions not as one value among others, but as the primary decision filter shaping legal pathways, the scope and form of documentation, shelter rules, and even the tone and timing of communication. This aligns with international clinical and programmatic guidance emphasizing safety orientation and the avoidance of practices that increase escalation risk, including uncontrolled disclosure of information and "accelerating" action without risk assessment (World Health Organization [WHO], 2013).

In interviews, the safety logic was expressed both as the organization of space (confidential shelter address, rules governing contact and disclosure) and as the organization of process (safety planning, stepwise support, follow-up checkpoints, and discouraging actions likely to heighten risk). Practically, these accounts correspond to victim-defined advocacy, where safety is interpreted broadly extending beyond physical risk to include basic needs that shape vulnerability (housing, income, access to services) and where safety planning is framed as collaborative work rather than top-down instruction (Davies, 2011).

Non-blaming and trauma-informed practice as a condition for trust and service engagement. A cross-

cutting motif in the data is the rejection of survivor-blaming and the recognition of survivors lived experience as a foundational professional norm. For crisis centers, this stance is not only ethical but also pragmatic: a non-blaming posture reduces barriers to help-seeking and supports continuity of engagement, especially in contexts of repeated help-seeking and returns to relationships captured in the analysis as a shift from "saving" to "accompanying." This aligns with the principles of a trauma-informed approach, where safety, trustworthiness, collaboration, and empowerment are treated as organizing features of work with trauma (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Importantly, in crisis-center settings trauma-informed practice is not limited to "careful communication"; it also involves organizational discipline (protocols, supervision, clear boundaries) that prevents secondary traumatization of both clients and practitioners.

Client autonomy and the "safety vs. autonomy" dilemma. Across all interviews, client autonomy was articulated as a core principle ("we do not decide for the person"), alongside the center's responsibility to communicate risks and offer minimally safer options. This produces the key ethical dilemma identified as central in the dataset (D1): clients may choose "non-ideal" or higher-risk options, and practitioners must maintain a balance between respect for choice and harm prevention.

Such balancing is also emphasized in contemporary survivor advocacy, particularly when relationship exit is not feasible or may increase danger and when safety planning must be developed "in contact" (Davies, 2011). In this regard, the practices identified in the study stepwise support and the "minimum package" (contacts, scenarios, code words, checkpoints) operate as professional mechanisms that preserve autonomy without abandoning responsibility.

Confidentiality: trust, safety, and the boundaries of intervention. In the data, confidentiality functions simultaneously as a value (V4) and as a recurrent tension point (D2) due to intervention boundaries in cases involving life-threatening risk and/or child safety. This reflects international guidance: confidentiality is critical for access to support, yet exceptions related to safety and legal duties of protection are structurally embedded in violence-response systems (WHO, 2013).

From a sociological perspective, it is notable that confidentiality is interpreted not as "absolute silence," but as a technology of safety (minimizing traces, controlling access to data, careful documentation). This shifts ethics toward the procedural level: values are enacted through routines and safeguards rather than through declarative principles alone.

Professional boundaries, teamwork, and sustainability as an "infrastructure of ethics". A distinct contribution of these findings is the emphasis that values are "performable" only when supported by organizational infrastructure: supervision, team-based case discussion, workload distribution, clear rules, and rejection of "heroic" expectations. These results align with research on occupational well-being among IPV-support practitioners: supervision quality, collegial support, and a culture of shared power reduce secondary traumatic stress among domestic violence advocates (Slattery & Goodman, 2009).

Respondents described boundaries as a form of professional maturity: not being available 24/7, avoiding rescuer dynamics, and not remaining alone with severe cases. This resonates with broader models of burnout conceptualized as a syndrome emerging from chronic mismatches between job demands and resources, control, recognition, and value alignment (Maslach & Leiter, 2016). Crucially, burnout in these accounts is not merely "fatigue" but changes in the moral–emotional fabric of professional work (cynicism, emotional numbing, irritability), which directly threatens service quality.

Systemic barriers and moral load: bureaucracy, scarcity, and interagency gaps. At the structural level, the study documents a stable set of barriers: shortage of shelter places and resources, staffing overload, reporting pressure, weak interagency coordination, normalization of violence, clients' economic dependence, and universal exposure to burnout risk. These barriers do not merely complicate service delivery; they generate dilemmas (e.g., triage under scarcity, trade-offs between speed and quality) that intensify practitioners' moral load.

From the sociology of organizations, these dynamics can be interpreted through street-level bureaucracy: front-line staff translate abstract policies into case-level decisions under high workload and limited resources, resulting in routine rationing strategies and reduced predictability of assistance (Lipsky, 2010). In professional–ethical terms, such conditions increase the risk of moral distress, when practitioners know what would be "right" but institutional constraints make it difficult to enact. Research within IPV/SV service sectors shows that scarcity, operating above capacity, role shifts, and communication failures are common sources of moral distress with negative impacts on staff, orga-

nizations, and clients (Voth Schrag et al., 2023). In this study, that logic appears in continuous compromise and an explicit orientation toward "minimizing harm" when an ideal support trajectory cannot be secured.

Practical and managerial implications

Positioning the findings against the relevant literature suggests several service-development directions that follow directly from the identified values and barriers: Institutionalize safety as a cross-cutting standard: implement unified protocols for risk assessment, safety planning, and responses to stalking/threats; train staff to conduct risk review without pressuring clients (WHO, 2013; Davies, 2011). Build a trauma-informed organizational environment: embed trust, collaboration, and empowerment not only in client interaction but also in workforce management (supervision, psychological support, rejection of "heroic" culture), thereby reducing secondary stress and improving service quality (SAMHSA, 2014; Slattery & Goodman, 2009). Strengthen interagency pathways: given the repeated barrier of systemic "slowness" and coordination gaps, formalize referral routes (MOUs, designated contacts, rapid communication channels) to reduce reliance on individual staff effort. Interagency coordination must operate within a safety logic and prevent information leakage (WHO, 2013). Prevent moral distress: introduce regular ethical case reviews, collective triage decision mechanisms under scarcity, and transparent workload allocation rules to reduce the internalization of "personal guilt" for systemic limitations (Voth Schrag et al., 2023).

Study limitations and directions for future research

Interpretation should consider the qualitative design and small sample (seven professionals from two cities). First, the data reflect professional self-report and may be influenced by social desirability. Second, variation in organizational models (NGO vs. state-led formats, shelter presence, staffing levels) likely shapes how values and dilemmas are articulated, but such differentiation is analytically limited in a small sample. Future research may expand geography (including smaller cities), triangulate sources (interviews + observation + document/protocol analysis), and incorporate clients' perspectives to compare "declared" versus "experienced" standards of support. WHO also highlights the need for context-sensitive research and implementation evaluation of recommendations across settings (WHO, 2013).

Overall, the discussion supports the conclusion that crisis-center professionals' values function simultaneously as an ethical compass and a practical risk-management tool; however, their enactment depends directly on organizational and systemic conditions. Where resource scarcity and interagency fragmentation become normalized, moral load and exhaustion risks increase; conversely, supervision, teamwork, and clear protocols translate values into sustainable practice.

Conclusion

This qualitative study suggests that, in the context of domestic violence, crisis-center professionals' values operate as a practical decision-making "compass" that helps balance survivor support with risk reduction. The core value structure comprises safety as the primary action criterion; non-blaming, trauma-informed engagement; client autonomy paired with mandatory risk communication; confidentiality as a component of safety; professional boundaries and rejection of rescuer dynamics; and teamwork/supervision as quality infrastructure.

At the level of dilemmas, the main tensions revolve around "safety vs. autonomy," "confidentiality vs. duty to intervene," and compromises produced by limited resources and slow interagency coordination. These tensions intensify burnout risk (7/7), suggesting that sustainability practices (supervision, workload distribution, clear regulations) should be treated as elements of ethics and quality rather than optional "add-ons."

The practical contribution of the study lies in the operationalization potential of the identified values into staff training standards and crisis-support protocols: a basic safety package, careful (non-retraumatizing) interviewing, transparent confidentiality rules, and stable team mechanisms for decision-making. At the level of social policy, the findings point to the need to strengthen shelter resource capacity, improve interagency coordination, and expand child-focused and trauma-therapy competencies in the support system because systemic constraints are precisely what transform professional values into ongoing labor of moral compromise and triage.

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