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To cite this article: Ellen R. Gutowski, Anisha Jahagirdar, Mikayla Lisi, Aïda Retta & Mina Pichtikova (19 Oct 2026): “By the Time You Get to That Trust Part, Your Sessions Are Done”: Women Intimate Partner Violence (IPV) Survivors’ Experiences with Counseling and Psychotherapy Services, *Women & Therapy*, DOI: [10.1080/02703149.2026.2742297](https://doi.org/10.1080/02703149.2026.2742297)

To link to this article: <https://doi.org/10.1080/02703149.2026.2742297>



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“By the Time You Get to That Trust Part, Your Sessions Are Done”: Women Intimate Partner Violence (IPV) Survivors’ Experiences with Counseling and Psychotherapy Services

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ABSTRACT

This study investigated the counseling and psychotherapy experiences of women intimate partner violence (IPV) survivors. With input from co-researchers with lived experience, we interviewed 25 ethnically diverse women who sought counseling and psychotherapy services following IPV. Analyses revealed barriers to engaging in therapy as well as encounters with therapists that participants described as healing, harmful or ineffective. Participants reported both positive and negative long-term outcomes and identified unmet needs. They offered several recommendations for improving counseling and psychotherapy services for survivors of IPV. Findings highlight the urgent need to expand access to quality mental healthcare for this underserved population.

KEYWORDS

Domestic violence; intimate partner violence; psychotherapy; trauma

Intimate partner violence (IPV) is a prevalent global public health issue. While IPV affects all genders, rates among gender minority adults (Peitzmeier et al., 2020) and cisgender women are particularly high (White et al., 2024). In Canada, women make up the majority of IPV survivors and nearly 44% of Canadian women report experiencing IPV during their lifetime (Cotter, 2021). Moreover, compared with men, women report higher rates of severe and sexual violence and are twice as likely to report that IPV has disrupted their mental health (Conroy, 2021; Cotter, 2021). Research on the mental health of women survivors indicates that IPV is associated with mental health concerns including depression, post-traumatic stress disorder (PTSD), and suicidality (White et al., 2024). Therefore, many survivors access mental health support such as therapy¹ to cope with distress, improve mental health, and increase functioning.

For those who access care, establishing an alliance with one’s therapist is considered one of the most critical factors that contributes to positive

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 Supplemental data for this article can be accessed online at <https://doi.org/10.1080/02703149.2026.2742297>.

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outcomes (Wampold, 2015). While there is a vast body of literature on the value of the therapy relationship, relatively little research focuses on the experiences – positive or negative – of IPV survivors with this relationship. This is a significant gap. IPV entails harm in a relationship where one expects safety, and it is possible that this betrayal makes it difficult for survivors to trust therapists or increases their vulnerability to retraumatization. Alternatively, an effective therapy relationship may offer a corrective experience following IPV. Given these possibilities for harm and for healing, research is needed to explore survivors' views of therapy, their relationships with their therapists, and the long-term consequences of their engagement in therapy for their mental health. We sought to fill this gap by exploring women survivors' experiences accessing therapy. We focus on participants' perceptions of engaging in therapy, the extent to which therapy relationships were contexts for healing or harm as well as the long-term consequences of these experiences. Next, we review literature on therapy for IPV and extant research on survivors' perspectives.

Therapy for Intimate Partner Violence (IPV)

To cope with the psychological consequences of IPV, many survivors seek formal support (Tutty, 2024). For example, one study using Canadian General Social Survey data (a sample of 19,422 Canadian adults) reports that approximately 32% of women IPV survivor survey participants sought help from a counselor or psychologist (Barrett et al., 2020). Literature on therapy for IPV demonstrates that numerous therapeutic approaches may be valuable for survivors including cognitive-behavioral (see Arroyo et al., 2017 for review and meta-analysis), dialectical-behavioral (Iverson et al., 2009), present-centered (i.e., problem-focused, supportive therapy; Johnson et al., 2020), feminist, psychoanalytic (Herman, 1997), strengths and empowerment-based (Iverson et al., 2011, 2021; Johnson et al., 2020) as well as models based on client perspectives (Roddy, 2023). Therapy interventions are associated with reductions in PTSD and depressive symptoms as well as increases in empowerment, self-esteem, self-efficacy, and emotional well-being (Arroyo et al., 2017; Iverson et al., 2011; Johnson et al., 2020). Many who experience symptom reduction also report less revictimization (Johnson et al., 2020).

While many models have shown promise with IPV survivor-clients, interventions tailored for IPV have been found to be especially valuable for survivors as opposed to general interventions (Arroyo et al., 2017). Specifically, empowerment is central to both feminist therapy (Brown, 2018) and the anti-violence movement as it is a natural target for those who have been abused by a partner (Cattaneo & Goodman, 2015). Adapting interventions for IPV survivors thus often involves risk assessment and

safety-planning as well as focusing on strengths, power-sharing, and empowerment (Iverson et al., 2021).

Therapist Perspectives on Working with Survivors

Despite the existence of promising intervention models, many therapists report feeling underprepared to work with IPV (Burns et al., 2022; Sutton et al., 2021). Indeed, some therapists report that they lack knowledge about IPV and face challenges establishing and maintaining therapeutic relationships with survivors (Gutowski et al., 2025; Sutton et al., 2021). In one study, when presented with a clinical vignette, therapists failed to recognize IPV, failed to accurately assess risk of lethality, or suggested interventions that were likely to increase the survivor's risk of injury or danger (Raphael Dudley et al., 2008). A scoping review of 21 qualitative studies on counselor and therapist perspectives on working with IPV survivors highlights the use of diverse conceptual frameworks for understanding IPV, some of which are victim-blaming (e.g., therapists reported believing that IPV survivors contribute to the abuse because they tolerate it or have low self-esteem; Gutowski et al., 2025). Survivors may be harmed by victim-blaming perceptions. Therapist assertions that survivors are to blame for the abusive relationship are correlated with a weakened therapeutic alliance and with clients perceiving the therapy as less helpful (Leedom et al., 2019). Many therapists also use interventions that are highly directive (Gutowski et al., 2025) which may take power away from survivor-clients.

In essence, while some therapists express experiencing fulfillment through their work and skillfully apply tailored interventions, many report feeling unprepared, unsupported, and under-resourced (Gutowski et al., 2025). Gaps in training and supervision combined with inadequate resources and session limits influence some to question their competency as well as the effectiveness of therapy as an intervention for IPV (Gutowski et al., 2025). Watson and colleagues' (2017) qualitative study captured the experience of "therapeutic helplessness" noting how therapists can feel ineffective in their work. For some, this feeling can be pronounced when serving survivors who are still in abusive relationships or facing multiple, intersecting obstacles to recovery (Gutowski et al., 2025). Ultimately, therapists commonly report stress, vicarious trauma, and burnout due to the challenge of addressing traumatic content in addition to the barriers to effectively serving this population (Gutowski et al., 2025).

Survivor Perspectives on Therapy

Existing research that focuses on survivors' experiences accessing mental healthcare indicates mixed experiences (Marsden et al., 2024; Örmon et al.,

2014; Rose et al., 2011; Sorrentino et al., 2021; Trevillion et al., 2014; Tutty, 2024). Among positive experiences, one secondary analysis of open-response survey data from 660 women survivors on their experiences accessing counseling services reveals participants' views of the benefits of receiving medication or a diagnosis, getting support with IPV and sexual abuse, and accessing resources through counseling (Tutty, 2024). Interview-based qualitative studies provide descriptive information about the experiences of survivors with mental healthcare and much of this research focuses specifically on service users' experiences with assessment and disclosure of IPV in generalist psychiatric and mental health settings (Örmon et al., 2014; Rose et al., 2011; Trevillion et al., 2014). Such studies reveal the importance of having one's IPV experiences appropriately assessed, experiencing a supportive provider-client relationship as a context for disclosure, and having one's trauma acknowledged and treated sensitively (Örmon et al., 2014; Rose et al., 2011; Trevillion et al., 2014). While most of the existing research is not specific to individual counseling and psychotherapy or focuses narrowly on survivor experiences with IPV disclosure, some research has also sought to examine what survivors desire from mental health services. For example, one study based on qualitative interviews with 50 survivors seeking care through the Veterans Affairs Administration reveals these participants' perceptions of provider flexibility, support for self-determination, and help with seeking safety and accessing resources as core to client-centered mental healthcare for IPV (Sorrentino et al., 2021). Roddy's (2023) provider-oriented book on domestic violence counseling inspired by interviews with 20 survivors emphasizes the value of counselors being nonjudgmental and consistent as well as having a thorough understanding of IPV and its effects so they can build trust. In an Australian study of 20 women IPV survivors focusing on what survivors want from their psychologists, participants report the value of psychologists who fully "see" survivor-clients, honor their expertise, and do not impose provider-driven agendas (Marsden et al., 2024).

In addition to this research that highlights elements of beneficial mental healthcare for survivors, survivors also describe challenges and harm. Studies on IPV disclosure in mental health settings document many survivors' experiences with stigma and fears of negative consequences of disclosure including child protection proceedings, worsening of violence, and not being believed (Rose et al., 2011; Trevillion et al., 2014). Some survivors also report lack of screening for IPV and failure of mental health providers to recognize and validate their disclosures (Marsden et al., 2024; Trevillion et al., 2014). These studies report survivors' interactions with providers who have limited knowledge of IPV (Tutty, 2024), focus only on psychiatric symptoms, pathologize their responses to trauma, and misdiagnose their concerns (Trevillion et al., 2014). In Marsden and colleagues'

(2021) qualitative research with 20 Australian women survivors, participants described experiences of being blamed, silenced, and disbelieved by their psychologists. However, Marsden's prior research focuses exclusively on survivors' experiences with psychologists and does not attend to the diversity of counseling and psychotherapy services (Marsden et al., 2021, 2024). Furthermore, participants in these studies reported on experiences that occurred once they were already receiving services, leaving the process of seeking and engaging in care unexamined. This is a significant gap as available research suggests that amidst stigma and fears associated with disclosure, establishing a supportive therapy relationship may be critical for survivors from the very beginning of their help-seeking processes (Rose et al., 2011; Trevillion et al., 2014). Moreover, women who experience IPV hold diverse identities and commonly report structural violence (Wathen & Mantler, 2022) which may be echoed during the process of seeking counseling and psychotherapy services. Yet, research on this topic has paid limited attention to this diversity.

To fill these gaps, we sought to explore how a diverse group of women survivors perceive their experiences of engaging in counseling and psychotherapy services. We explored their perceptions of forming relationships with their therapists from the very first steps of accessing services, how therapy relationships facilitate healing or harm in the context of prior trauma, and how these encounters may lead to long-term consequences for survivors' lives. Finally, we sought to understand survivors' recommendations for how to improve counseling and psychotherapy services for those who have experienced IPV.

Theoretical Framework

Existing clinical and trauma-informed frameworks indicate that individuals who have survived violence may experience a replication of traumatic experiences when seeking support (Harris & Fallot, 2001; Herman, 1997; Wathen & Mantler, 2022). For IPV survivors, therapists without specialized training may unintentionally reenact harmful dynamics (Courtois & Ford, 2013). For example, therapists may speak with authority, require survivors to enter an enclosed space, and ask intrusive questions – interactions that can feel reminiscent of prior interpersonal trauma. Further, inadequate access to care, rigid policies such as mandated reporting and routine screening, as well as inattention to social context may lead to an enactment of oppression and structural harm (Wathen & Mantler, 2022). Alternatively, perspectives on recovery from traumatic stress propose that relationships are paramount to healing (Herman, 1997). Indeed, effective therapy may offer a corrective experience (Alberti, 2018) or a distinct shift that fosters new understandings or affective experiences within the

context of the therapy relationship, leading clients to be transformed both personally and relationally (Knox et al., 2012).

Thus, survivors seeking help from a therapist – an act that requires trust and safety – may encounter the very harmful dynamics that occurred with an abusive partner or within broader society. Alternatively, they may experience a healing, corrective experience. Yet, little research has explored these dynamics from survivors' perspectives. Therapy may serve as a setting for such powerful interactions as it involves an ongoing relationship with a therapist on whom clients depend for their recovery.

Current Study

This study explores the experiences of women who accessed counseling and psychotherapy services following IPV. Using qualitative description (Sandelowski, 2000, 2010) with consultation from those with lived experience, we asked the following exploratory research questions: 1) How do participants perceive their experiences accessing and engaging in counseling and psychotherapy services? 2) How does the therapy relationship serve as a context for healing or harm following an IPV experience? 3) What are the consequences – positive and negative – of participants' experiences in counseling and psychotherapy services? 4) What recommendations do participants have for how to improve counseling and psychotherapy services for IPV survivors?

Method

Co-Research

Consistent with calls to include the voices of those with lived experience of IPV in mental health research (Oram et al., 2022), this study uses co-research (Moghimi & Hilton, 2025). Co-research involves equitable and collaborative partnerships with IPV survivors (Moghimi & Hilton, 2025). It is critical in mental health research, given the history of excluding the voices of women with experiences of IPV (Goodman & Epstein, 2008). Two women who sought therapy following IPV were recruited by a community-based partner organization. Community partners advertised the role to their networks, conducted interviews with potential co-researchers, and then invited the two selected co-researchers to join the project. Co-researchers participated in monthly meetings, sharing perspectives on data collection and analysis as well as interpretation and dissemination of findings. They received ongoing support and training from community partners as well as compensation for their time.

Participants

Participants included 25 ethnically diverse cisgender women who sought counseling and/or psychotherapy services in Ontario, Canada after IPV. Participants' ages ranged from 31 to 69 years. Most identified as straight (72%) and single or separated/divorced (60%) (See Table 1). Most sought counseling or psychotherapy services from a social worker (56%) and many from a clinical psychologist (40%) or master's-level psychotherapist (40%). Therapy durations ranged from 3 to 6 months to 10 years (See Table 2).

Data Collection

This study is part of a larger project focusing on the experiences of cisgender women, nonbinary, and transgender survivors accessing counseling and psychotherapy services following IPV in Ontario, Canada. We report procedures and findings related to the cisgender women sample as data

Table 1. Participant demographics.

Demographic characteristic*	<i>n</i> (%)
Race/Ethnicity	
White/Caucasian/European	8 (32%)
Latina	6 (24%)
Black/African-descended	4 (16%)
Asian/South Asian	2 (8%)
Middle-Eastern	1 (4%)
Other/Did not disclose	3 (12%)
Sexual Orientation	
Straight/Heterosexual	18 (72%)
Bisexual	3 (12%)
Questioning	1 (4%)
Other/Did not disclose	3 (12%)
Income	
Unemployed/Receiving Government Assistance	8 (32%)
\$12,000 - \$25,000	5 (20%)
\$32,000 - \$65,000	7 (28%)
\$80,000+	3 (12%)
Other/Did not disclose	2 (8%)
Religion	
Christian	10 (40%)
Spiritual	4 (16%)
Hindu	2 (8%)
Muslim	2 (8%)
Atheist	2 (8%)
Other/Did not disclose	5 (20%)
Relationship Status	
Single	8 (32%)
Divorced/Separated	7 (28%)
Married/Common Law	4 (16%)
In a relationship	4 (16%)
Widowed	1 (4%)
Other/Did not disclose	1 (4%)

Note. Demographic information was missing for one participant.

*Multiple terms are used as participants were invited to share identities in response to open-response questions. More general categories were used in place of specific country or religious sect names to protect participant confidentiality.

Table 2. Psychotherapy and/or counseling accessed by participants.

Experience with provider services	n (%)
Service Accessed	
Community Organization	14 (56%)
Private Practice	12 (48%)
Other* (e.g., EAP, community clinic, shelter, retreat)	12 (48%)
Victim Services Agency	10 (40%)
Hospital	9 (36%)
Clinic	8 (32%)
Accessed more than one service	17 (68%)
Provider Credentials	
Social Worker	14 (56%)
Psychotherapist (Masters Level)	10 (40%)
Clinical/Counseling Psychologist (Doctoral Level)	10 (40%)
Other** (e.g., psychiatrist; college counselor; retreat facilitator)	10 (40%)
Masters in Counseling	3 (12%)
Psychological Associate (Masters Level)	2 (8%)
I don't know/remember	10 (40%)
Accessed more than one type of professional	16 (64%)
Therapy Modality	
Cognitive Behavioral Therapy (CBT)	8 (32%)
Emotion Focused Therapy (EFT)	5 (20%)
Dialectical Behavioral Therapy (DBT)	4 (16%)
Psychodynamic Therapy	2 (8%)
Feminist Therapy	2 (8%)
Eye Movement Desensitization and Reprocessing (EMDR)	2 (8%)
Cognitive Processing Therapy (CPT)	2 (8%)
Other (e.g. mindfulness, "talk therapy," narrative, relational)	9 (36%)
I don't know	8 (32%)
Barriers to Accessing Therapy	
Cost	13 (52%)
Waitlist too long	11 (44%)
Provider not a good fit	10 (40%)
Transportation challenges	6 (24%)
Work schedule	5 (20%)
Childcare schedule	4 (16%)
Other (e.g., abuse; legal case; no woman providers, COVID)	7 (28%)
N/A	3 (12%)

*All participants who responded with "Other" accessed multiple services.

**All but one participant who responded with "Other" accessed multiple providers.

from participants who identify as nonbinary and/or transgender were analyzed separately. After receiving approval from the Research Ethics Board at University of Toronto, recruitment was conducted in collaboration with a partner organization that works with anti-violence organizations and survivors. Flyers were distributed to partner networks and interested participants connected with the research team to confirm eligibility. Eligible participants had the choice of participating in person, virtually, or by phone.

Eligibility criteria for this study included: 1) being 18 years or older, 2) English-speaking, 3) identifying as a woman, 4) having been afraid of an intimate partner, and 5) having sought individual counseling or psychotherapy services in Ontario afterward. No restrictions were placed on the length of time since participants' IPV or counseling and psychotherapy experiences occurred or whether their primary presenting concern was IPV. This decision was made in order to be inclusive of those who may not have identified their experiences as IPV at the time of accessing

services as well as those who had concerns (e.g., insomnia, depressed mood, relationship concerns) that may have been connected to an earlier IPV experience even if IPV was not presented as an initial focus of therapy. Moreover, eligible participants sought counseling or psychotherapy services from a diversity of agencies including both IPV specialist organizations and generalist mental health agencies. Including those who sought care from a range of settings allowed us to shed light on the array of experiences that survivors have when seeking support for their mental health given that many see multiple practitioners over time. It also reflected a core aim of the study which was to understand participants' full experiences of engaging in care from the initial stages of this process.

Participants were recruited using purposive sampling (Robinson, 2014). We sought a sample size large enough to achieve saturation, but small enough for case-oriented analysis (Onwuegbuzie & Leech, 2007). Our sample size is consistent with recommendations for studies using similar methods (Creswell, 2013). The research team met throughout data collection to determine whether saturation had been reached, meaning that no new themes were identified and data collection could be terminated (Onwuegbuzie & Leech, 2007).

Interviews

After eligibility was confirmed and consent was provided, participants completed an interview and questionnaire. All interviewers (the first, fourth, and fifth authors) had a background in providing mental health services. We used feminist interviewing which aims to reduce power differentials, create a supportive, empathic environment, and offer information and resources (Campbell et al., 2010). Participants received a \$65 CAD gift card for their time.

Fraud Protection

To prevent data fraud, consistent with recommendations (Sefcik et al., 2023), we asked virtual participants to turn cameras on and screened them prior to participation. We attended to red flags during emails (e.g., duplicate, brief, non-personalized messages) and interviews (e.g., muffled audio, inconsistent responses). Interviewers were careful to differentiate reactions to traumatic content with suspected fraud and sought consultation as needed. Twenty individuals were screened out due to fraud (17 prior to the interview, one during the virtual interview, and two after the interview was completed) and one was unable to participate in English.

Measures

Survey

The survey collected information on demographics (e.g., age, income) and services accessed (e.g., duration of therapy, therapeutic modality).

Interview Protocol

The study team drafted an interview protocol which was revised based on feedback from community partners and from project co-researchers. Questions related to engaging in counseling and psychotherapy services, the therapy relationship, and the outcomes of therapy (e.g., “Could you tell me about your relationship with your therapist?” and “Did your relationship experiences with your ex-partner affect how you worked with your therapist?”).

Data Analysis

We used qualitative description (Sandelowski, 2000, 2010) which permits deep exploration of participants’ subjective experiences. Based on the tenets of naturalistic inquiry, qualitative description privileges participant words rather than researcher interpretations (Sandelowski, 2010). Three team members (the first, fourth, and fifth authors) drafted a codebook by reading one interview line-by-line and noting themes. The second and third authors and a research assistant then coded interviews using NVivo after a thorough training process that entailed reading about qualitative description and several group coding sessions. This codebook was refined using constant comparison, adapted from grounded theory (Boeije, 2002). The team met weekly to seek consensus on coding decisions by discussing themes and closely reading interviews. This process led to a finalized codebook with three levels (see [Appendix A](#)).

Reflexivity

The research team included researchers, mental health professionals, and students working in gender-based violence who bring understandings of this work shaped by both lived experience and professional practice. The first author is a White, Polish-American woman living in Canada who is a doctoral-level psychologist and educator, has provided psychotherapy to survivors of IPV, and conducts research on systems-level responses to this form of traumatic stress. The second author is a South Asian-Canadian woman and doctoral student in clinical and counseling psychology who has provided psychotherapy to survivors of IPV. The third author is a White, Italian-Canadian woman who holds a Master’s degree in developmental psychology and has contributed to research on the experiences of

survivors of IPV. The fourth author is a Black, second-generation Ethiopian-Canadian woman who holds a Master's degree in counseling psychology and at the time of the study, was a psychotherapist in training and had worked in transitional housing and supportive counseling programs serving women fleeing IPV. The fifth author is a White, Bulgarian-Canadian, first-generation immigrant woman and doctoral candidate in clinical and counseling psychology whose research and clinical training have focused on trauma, psychotherapy, and IPV.

Collectively, research team members were at varied career stages, all had some experience either conducting research on IPV and/or providing counseling and psychotherapy to survivors, and some team members also had personal experiences with IPV including experiences of supporting loved ones who were affected. Authors engaged in critical reflexivity as a form of perspective management during data collection and analysis (Levitt et al., 2021). Authors wrote and processed reflections on their experiences and biases related to study themes, such as their expectations of study results (e.g., professional therapists expected results to reveal gaps in practitioner competencies) (Levitt et al., 2021). Throughout our discussions, we consistently emphasized going back to participants' words to prioritize participant perspectives.

Member Checking

Member checking was used to enhance the credibility of findings (Levitt et al., 2021). Seven participants who consented to member checking and responded to follow-up confirmed that findings resonated and some provided additional information or context. The study team also presented results to co-researchers who agreed with the project's main findings.

Results

Data analysis revealed five clusters. Each cluster is under a separate heading with themes in subheadings and codes italicized. We use pseudonyms to protect participant identities.

Survivors Faced Complexities and Barriers When Engaging in Therapy

In response to the first research question regarding how participants viewed their experiences accessing and engaging in counseling and psychotherapy services, participants explained that seeking and engaging in therapy involved a process of becoming ready. Once they were ready to seek help, they reported multidimensional barriers to accessing services.

Survivors Described the Process of Becoming Ready to Engage in Therapy

Participants described the process of becoming ready to engage in therapy. Five participants were *not ready to engage in therapy initially*. They described concerns about whether therapy would help, whether the abuse warranted support, and how others would perceive them. Amira questioned whether therapy would benefit her: “My impression was, “how am I going to disclose [the abuse] and what help I will receive?” [I wondered,] “is it a waste of time or are they really going to help me out?”” Liya explained her concerns about disclosure, “I was ashamed to tell people because they knew me to be this intelligent person, good job [...] I didn’t think I fit the profile.” For eight participants, *third-party involvement* played a critical role in recognizing abuse and accessing support. After Janelle confided in a coworker, “[My coworker] actually called [an IPV-specialist agency] because of my safety concern.” Janelle then received a call from an IPV professional which ultimately influenced her to connect to services: “I got an anonymous call. [...] I didn’t contact anybody. I didn’t want to contact [any]body because I didn’t know I had a problem.” Some participants were referred to counseling and psychotherapy services by medical or legal professionals. For Liya, “[my] doctor advised that I needed psychotherapy and a trauma informed therapist and needed a psychiatrist... before that, I had no idea. I just thought it was a normal thing that everyone faced in marriage like conflict.” While some participants sought therapy prior to identifying their experiences as abuse, 11 participants *engaged in therapy after recognizing that the abuse was a cause for concern*. This recognition evolved over time: some developed concerns about the abuse or its effects while they were still in the relationship, and others, during the process of leaving or after separating. Lily accessed therapy prior to leaving her relationship with the person who harmed with hopes of promoting healthy relationships in her family, “this partner and I had a high conflict relationship ... we decided to have a child together and I just thought therapy was the answer, that it was the most essential thing to help us.” Gabriela decided to seek support when the abuse increased in severity: “[At the time I had decided], “I’m gonna leave him. He’s gonna kill me...I need help and I can’t do this alone. I can’t, so, I need help.” For Alice, “coming to understand IPV, intimate partner violence, [is] something that happened over a time span. [...] The way that I engaged with services was reflective of that awareness within myself.”

Survivors Experienced Barriers to Engaging in Therapy

Once they sought services, participants faced multidimensional barriers to engaging in therapy. Some participants described ways in which the harming partner influenced their engagement in mental healthcare. Five participants reported *barriers to engaging in therapy due to a partner or*

ex-partner's interference or potential retaliation. Liya's ex-partner convinced her to stop attending sessions: "I didn't do therapy anymore because [my ex-partner] told me he wasn't comfortable, that I was going to become mad and insane if I kept seeing all these psychiatrists and doctors." Isabella detailed her fear of retaliation, which influenced her to refrain from help-seeking, "you get punished if you tell the wrong person [about the abuse] [...] you can't always be telling everyone what you're going through, because then there'll be repercussions for that." Sakina feared her ex's use of information disclosed in sessions against her in legal proceedings: "I was afraid to share...Can he subpoena? Can he look at these things and twist them around and make me look like the crazy person?"

Many also faced substantial financial and resource-related barriers. Nine participants *experienced barriers to engaging in therapy due to the cost*. Financial constraints limited access to therapy as well as to adequately trained and qualified therapists. Romina, who came to Canada as a refugee, explained, "my money was very limited. So, I started looking online. The therapies were extremely expensive. Completely out of my budget." She further shared that due to the financial impacts of abuse, "having the luxury of speaking with a psychotherapist. And paying - I don't know, \$200 per session - It's just out of the question." Isabella who was able to eventually pay for a private therapist reported that she "started healing" only once she "made enough money to pay for my own therapist." Seven participants *experienced barriers to engaging in long-term or regular therapy*. Sakina described how having to wait extended periods of time, often three weeks or more, in between sessions led to "re-explaining" and "not really being able to dive in too, too much in the session." Alice disclosed that being unable to afford "an ongoing [therapeutic] relationship" led to "short-term therapeutic environments" in which "it takes a long time to build trust [...]. And by the time you get to that trust part, your sessions are done." Eight participants faced *barriers to engaging in therapy due to long wait times*. Sakina explained: "You're waiting so long, and [...] [by the time services are available] you have to reopen the wounds because you just put them away." Antonia explained how waitlists were long for those with financial constraints, "if you're low income, in order to get therapy, there's a huge waiting list. Minimum two years. Probably more." Three participants reported *barriers to engaging in therapy due to travel*. For Lara, "[commuting for services] was difficult while trying to find a job and [...] single-parenting." Living in a rural setting meant Clarissa had to commute for an hour each way to appointments.

Systemic barriers further complicated access. Participants described the harmful nature of inflexible policies and concerns about mandated reporting. Two participants expressed concerns about *engaging in care due to the potential for mandated reporting or child welfare involvement*. Nicole

expressed, “[The therapist] could sense hesitancy about things that they would recommend [...] I have to be careful because I could lose my child over this.” After a negative experience with a therapist who filed a mandated report, Camila described taking precautions when interacting with subsequent therapists: “I have to hold my tongue because I never know what they will take from what I share.” Seven participants described *barriers to engaging in therapy due to institutional processes*, explaining how institutions could mirror the abuse with misleading advice, unkept promises, unanswered phone calls, and a lack of genuine care. Alice felt institutions that “have a mandate to help” were “undependable.” She shared, “there’s no calling back. Like I’m calling. I’m leaving messages, and they just disappear into the ether.” This failure to support and respond was “triggering because the very same behaviors [you’re seeking to escape] when you’re looking for help are being echoed in systems we are turning to help for.” Sonya “was told: [...] “Monday [the shelter] would have social workers. [They would have] counseling...they had none of those things.””

Finally, three participants faced *barriers to engaging in therapy due to negative past help-seeking experiences*. For example, after a “very traumatic” therapy experience, Camila took “years to overcome my fear to go to a therapist again.” After being bounced around to several therapists with no success, Emily felt, “I didn’t want to call back again and then explain myself over and over again that that’s what happened to me.”

Survivors Described Therapy as Healing

Responding to the second research question, regarding how the therapy relationship may offer a context for healing, participants described the value of therapeutic relationships characterized by a genuine connection and responsiveness with practitioners who had expertise in IPV, as well as shared identities and cultural values and/or the ability to foster safety for clients’ identity-based and cultural experiences. When effective, these relationships offered a contrast to harmful personal relationships including with the partner who abused them.

Survivors Valued Therapy Relationships Built on Genuine Connection

When relationships with therapists were built on a genuine connection, participants felt able to share their experiences of abuse, express their authentic emotions, and internalize an experience of being valued and treated as equal. Eighteen *participants valued being understood*. Participants described how feeling understood stemmed from moments in which they felt deeply and authentically heard in sessions. In Marina’s first session,

“I just cry and cry. [I could] barely talk.” She described how her therapist responded from the very beginning:

It felt like she gave me a hug [even though] we were over the phone the first time... She heard me. She heard me. She heard me. Whatever I say to her could be a mess. Could [make] no sense, [but] she really listen[ed].

Clarissa described how a previous therapist also communicated understanding, “She listened. And she was so gentle. So gentle and she dealt with trauma. She just knew [what to do].” During emotional moments in therapy, Clarissa detailed how her therapist cried, and she felt moved by her therapist’s tears. Fifteen participants *valued safety*. These participants felt able to express a range of emotions and experiences without receiving a judgmental or negative reaction. Isabella expressed, “[after being] victimized for so long, you should be able to express your freaking emotions, scream or hit something or box something, you know, get that anger out.” Serena explained, “I can just trust [my therapist] and say anything to her without feeling like she’s gonna judge me... she just really allows me to be me.” Thirteen participants *valued therapists communicating they are worthy*. This communication involved therapists conveying that they were proud of their clients, that they believed in their clients and saw their strengths, and that they viewed their clients as deserving of care. Emily’s counselor made her feel “like I was important and it mattered, and that was a very important feeling for me.” This counselor communicated investment in Emily’s well-being: “She would say things like, “oh, I was thinking about you yesterday” [...] like, “wow, she’s thinking of me even when she’s not talking to me.”

Eight participants *valued experiencing a sense of equality* with their therapists; they had therapists who were honest with them and shared a sense of partnership and mutual respect. Antonia described one counselor’s acknowledgment of her expertise: “I’ve been through a lot, so sometimes I’m intimidating...[Like,] “How the hell is this woman alive? She knows more than me.” [Counselor] wasn’t afraid to say that. If I recommended a book, she’d read it. That’s partnership. That’s equal.” Nine participants *valued having a therapist who was like “a friend”*: present, caring, and reliable. Marina’s therapist felt “like a friend” because “she’s not just doing her job,” but is “working with [her] heart” and truly cares: “she really focuses and you can see her feelings, her dedication, her intentions to help.” Camila’s therapist showed care by extending a session because Camila “wasn’t ready to step out on the street at that moment.” Camila explained how she felt, ““OK, I’m not alone. I have someone walking beside me and holding my hand because that’s what I needed.”” Participants explained that it was critical to have this sense of connection to their therapists given the social isolation they experienced from the abuse. At

the same time, participants were clear that therapists were not friends, and that attention to ethics and boundaries mattered alongside these qualities.

Survivors Valued Responsive Therapy Relationships

Participants valued responsive relationships with therapists who offered referrals, structured services to meet their needs, and addressed social context by taking actions outside of sessions to support them with the multifaceted consequences of IPV. For 12 participants, therapists offered *referrals to resources* including housing, legal support, employment centers, and other mental health or support services. Participants valued therapists who knew resources that were available and who – in Christina’s words – “fought tooth and nail” to get them access to supports such as housing. Anya’s therapist was “inclined to help me in every direction and go way out of the way.” She described how her therapist referred her to an employment resource center. Faced with the economic impacts of abuse, she found it meaningful to have support from employment counselors who “wanted my success.” Five participants felt the *structure of services* was responsive. Participants expressed the importance of having long-term support, consistency, and regularity. Uma described waiting all week to have therapy and knowing she could depend on sessions on the “same day, same time.” She shared the significance of receiving a phone call when she missed one week as it showed her therapist cared. Emily described the value of continuous, long-term support from her counselors with whom she worked for years: “They were able to convey this...reassurance that they’re always there for me.” Thirteen participants *valued therapist actions outside of sessions* such as advocacy, phone and text communication, and support navigating systems such as court. Ariana, whose therapist was “like my family,” described a time when she emailed her therapist for support between sessions and received a call back within minutes. She valued knowing her therapist was there “all the time.”

Survivors Valued Therapists’ Experiences (Personal and Professional) with Abuse

In addition to receiving tools and strategies to address trauma, participants appreciated therapist competence with IPV, specifically. Nine participants *valued therapist knowledge of abuse*. Anya felt “validated and supported” after learning about the cycle of violence in therapy:

[My therapist] educated me on what I was going through. I was in such a state of bewilderment and perhaps denial, and she helped illuminate me. I just could tell that she had a lot of experience. [...] There was actually hope for the future by her teaching me this and supporting me.

Four participants *valued therapist experiences working with other survivors*. Amira gained trust in her therapist after learning that her experience was not unique and that there are others who “have gone through this [and] were successful. They’re living their lives successfully now, happily.” Two participants valued working with therapists who themselves had *lived experience with IPV*. Lived experience expertise was valuable – in addition to skilled, professional support – when supporters were managing personal trauma so that they could effectively offer care. Liya valued having a survivor-counselor: “She being a survivor, her perspective was very real. [...] I find I felt more sane when I was speaking to that particular woman, because she was telling me how she dealt with her [experience].” For Antonia:

It’s a whole different experience when you’re working with a survivor. [...] They’ve been through many of the challenges. They’ve been through the reasons to be afraid; they’ve been through all of the different things that happen when you’re trying [...] to recover or become alive. And they’re probably the least judgmental of all counselors.

Survivors Valued Therapists’ Identities and Ability to Respect Identity

Participants emphasized the importance of either having shared identities with their therapists or having therapists who understood their identity-based experiences. Six participants *valued having a woman therapist*. Having a woman therapist made it possible for many to discuss the abuse. Romina felt speaking to a man “wouldn’t be safe.” Six participants *valued respect for their cultures and identities* including their religions, genders, identities as mothers, and as survivors. Liya found it meaningful to receive permission to end harmful relationships from a counselor who understood the importance of culture:

[The counselor] was Indian, different culture, but culture was big for her, as well. [...] [In India] you don’t [cut out] family members. You don’t delete or block people’s numbers regardless of what [they do]. She gave me permission to delete those numbers without guilt. I felt guilty. But after a while I was over it.

Five participants *valued having a therapist with shared identities and cultural values*. Camila sought a “psychologist, a mother, an immigrant” from her home country. “All those layers that could really see me where I was at. [My therapist] fit all those layers that I was looking for and that was [...] very important.” Two participants *valued communicating with their therapist in their first language*, stating they accessed emotions differently. Antonia explained:

My counseling was offered in Spanish, which is my first language, and it’s also the language that my relationship with my ex was in. So, it was very helpful for me. It’s really helpful to have counseling in the language that you first began to speak in. Because that’s [...] our emotional language [...] I still connect feelings with Spanish.

Survivors Valued Therapy Relationships That Contrasted Harmful Personal Relationships

Therapy relationships could offer healing by countering harmful experiences in family, friend, and partner relationships. Ten participants *valued that their therapy relationships provided a supportive contrast to family and friend relationships*. Participants described the value of being validated as well as having space to speak about their experiences when family and friends either did not believe them or were unable to support them. Liya faced a discrepancy between responses from her informal supports and those from her therapist:

I was happy that [my therapist] was advocating for me for the first time, 'cause all the people I told before then were either telling me: 'Call the cops, leave the marriage, [or] go to shelter.' My mom would hit me and say, 'Here's your punishment for speaking ill about your husband.' Nobody had ever told me, 'Your fears are valid and you shouldn't be treated this way.'

Four participants *valued that therapy relationships provided a healthy contrast to their relationships with their ex-partner(s)*. They appreciated therapists who respected their autonomy, validated them, affirmed their decisions, and perceived their strengths. Camila explained:

And that [was] the beauty behind this relationship because I didn't feel oppressed, I didn't feel pushed. [...] I am the one who is in charge, so [my therapist] helped me to regain my power and my self-esteem, my confidence. Having that feeling of someone watching over me all the time. And I don't have the freedom to even, you know, move my body properly. [But] with her I felt like I [could] start to...recognize my potential [...] because until then, I was getting oppressed.

Lily's therapist made her feel: "finally I had this other person who was validating my experiences, whereas my partner would just gaslight me continuously when we were home alone and it made me afraid." In the context of these experiences with gaslighting, Lily valued having a therapist who "believed in me and trusted me. [She] affirmed my actions...as a mother who's doing everything in her capability to keep her child safe." Eleven participants valued their *therapist modeling genuine caring and healthy relating*. This involved being honest, giving the survivor space to be themselves, and offering attention and care, experiences that translated into relationships outside of sessions. For Camila:

[My therapist] gave me time and space to work on myself to have access to my inner feelings, my inner child and try to be honest to myself as much as I can right now. [...] the consequence is also being honest with others. [Using] honest and clear communication. [...] Because I can talk with [my therapist], I can go [in] to the world and talk with others, too.

Survivors Reported Therapy Was Harmful or Ineffective

Addressing the second research question, regarding how therapy relationships may enable harm, participants described harmful encounters with therapists who made them feel unsafe based on IPV, identity-based, or cultural experiences, missed and minimized the abuse, and were not attuned to their needs or to relational dynamics in sessions.

Survivors Reported Therapy Relationships Lacked Safety for IPV, Identity, and Culture

Participants detailed encounters with therapists who failed to foster safety for their IPV experiences, their identity-based or cultural experiences, or the intersection of IPV, identity, and culture. Eight participants felt unsafe with therapists who conveyed *attitudes about IPV that reinforced feelings of victimhood*. Participants described therapists who adopted patronizing or dominant stances and made them feel judged, disempowered, or mistreated. Isabella's counselor was "gentle, but [tip] toeing." She described how this counselor's stance made her feel like a victim, "It's hard enough to accept that you're a victim. So, to have another person [who] kind of victimizes you... like, "Are you OK?"" Antonia felt abuse dynamics were enacted with her counselor due to the counselor's own unresolved trauma. She described: "Some counselors seem to think they're above the clients [...] It was a control and abuse situation, [...] It was like it was my job and I had to do my job. If I wanted a therapist... I had to do her job for me for her." When she sought to terminate the appointments, the counselor called her repeatedly to ask for "closure," which felt inappropriate. Three participants felt unsafe with therapists who *lacked cultural understanding about IPV and/or relationships*. These therapists failed to understand how ending relationships was perceived in participants' cultures, the cultural significance of relationships, as well as cultural norms about marital relationship dynamics. Liya explained:

[The therapist is] White, so, there's some things that she didn't understand. [Such as] why I was holding onto people who she felt were so toxic. I didn't know how to explain to her why I was still enabling them. Because I technically didn't want to lose them completely.

Liya further explained that culturally, she could not cut off relationships immediately and needed "a gradual process." Three participants felt unsafe due to *therapist assumptions about their identity-based, cultural, or religious experiences*. These participants described therapists who made microaggressions toward them, assumed that they held particular religious or

cultural values based on how they appeared ethnically, or lacked attention to power and privilege. Liya recounted a microaggression by a provider:

He said, ‘I don’t know if culture has to play with this, but I’ve seen a lot of people who look like you who are going through abuse and choose not to do anything, and their health just gets worse.’ [...] It really scared me because I thought he was going to tell me things would get better.

Survivors Reported Therapists Neglected or Minimized Abuse

Participants also described therapists who either missed the presence of IPV or invalidated their experiences. Four participants had therapists who *did not identify or address IPV*, leaving them without support or safety planning. For Alice, multiple therapists failed to name her experiences as abuse: “[My experiences] were violent and abusive [...] psychologically, emotionally, sexually, physically, economically. [...] I really question why somebody didn’t reflect that back to me and say, “hey, you know, you are in an abusive relationship.”” Six participants described therapists who were *not knowledgeable about abuse or trauma-informed*. They described therapists who did not understand how to support them with ongoing post-separation abuse and therapists who were unable to establish therapeutic relationships in the context of trauma and abuse. Antonia, who had training as an entry-level mental health worker, felt, “This is what a lot of the counselors don’t get, is that actually it’s worse after you leave.” She explained, “It’s quite frightening when you’re seeking support and you’re realizing, “Wow, I’m more trained than the people who are trying to help me.”” Seven participants had therapists who were *dismissive or invalidating of trauma*, minimizing the impact of abuse or oversimplifying the situation or its resolution. Emily recounted being “basically told to take a bubble bath. To go meditate, go for a walk” without the therapist wanting “to know anything about my background, why I was calling, what I’m going through.” This left her feeling unheard. Antonia highlighted how some counselors relied on standardized approaches that failed to address complexity: “A lot of counselors just send information to you [...] Do this, do that, safety card, and everything will be OK. It’s not OK.”

Survivors Reported Therapists Were Not Attuned to Relational Needs and Dynamics

Participants described harmful relationships with therapists who failed to foster a genuine connection, were overbearing, or neglected attention to boundaries. Eight participants were *unable to address IPV due to a lack of personal connection* with their therapists. Participants described relationships that felt distant, transactional, and impersonal. Janelle lacked a

personal connection with her therapist. She explained, “[my therapist] looked at me like I was a dollar sign or another invoice to her. There was no personal connect[ion].” Ultimately, Janelle terminated with this therapist after four sessions, concluding, “This is a waste of my time. I’m not getting what I need for me mentally [and] it’s very frustrating to not get to talk [...] about [the abuse].” Four participants *reported therapists used intrusive or invasive questioning*. Often this involved lengthy questioning without any warning or rationale provided or continued questioning after the participant had indicated they did not want to answer. When Emily called to get connected to services, the therapist “asked so many questions, but she went way back into my childhood. She asked questions about my mother, my father, my aunt [...] for an hour.” She described her reactions, “I just didn’t want to delve into all of this, you know? I get it. It’s all sort of interrelated, but at that moment I just needed, you know, help a lot for my PTSD.” Four participants described therapists who *imposed their perspectives or treatment plans* without considering the survivor’s preferences or readiness. Antonia’s prior therapist “told me what my experience was. You can’t tell someone, ‘Okay, this has happened to you. This is how you must be feeling.’” Antonia further described how this type of intervention put the therapist in the role of “expert” when truly “the person who owns the body and owns the experience is the expert.” Two participants described therapists who *pressured them to leave an abusive relationship*. Christina’s prior therapist “was frustrated that I was still with him [...] and I started sensing that [...] I started to have this mantra in my mind: ‘I can’t be the client that she needs.’” Christina’s therapist’s frustration changed the focus of the therapy in a way that was countertherapeutic:

I think that’s really a sad place and that’s really horrific for a client [...] to actually think bad about their therapist. It’s a micro violence done to the client because you know what? We’re not there to make the therapist feel OK.

Nicole articulated that therapists are too often not fully aware of what survivors experience when considering leaving an abusive relationship: “it can be a little bit frustrating because [...] what [therapists are] saying makes sense but [...] there’s all this work to get your mind there.” She felt that “[therapists] don’t take into consideration... it wasn’t bad all the time [...] there are moments where [my ex-partner] was kind.” For three participants, therapists made *boundary violations*. Antonia’s counselor sought a personal relationship, revealing her own trauma history in the process: “She ended up sharing. I know more about her than she knows about my experience. I ended up having to support her.” As a result of this experience, when Antonia had to go to counseling, she felt, “I have to protect myself.”

Survivors Experienced Positive and Negative Consequences of Therapy

In response to the third research question about the consequences of therapy, most participants described positive long-term outcomes, while some also faced unaddressed needs and harm. While participants benefited from naming the abuse, feeling empowered, and experiencing changes in their outlooks or relationships, some faced unmet needs, declines in their mental health, challenges in relationships, or hesitation to seek help again. It was common for participants to connect with multiple services and providers over the course of their recovery journeys as their needs and access changed over time. Thus, they presented varied pictures of help-seeking involving a mix of positive, negative, and unresolved outcomes.

Survivors Experienced Positive Consequences of Therapy

Nineteen participants described positive long-term consequences of therapy. Participants expressed that positive outcomes could be long-lasting and “lifesaving.” Among these, eight participants *felt able to name the abuse* through therapy. Liya explained:

I didn't know manipulation and mental abuse was a thing [before therapy]. I only started thinking I was in danger when I was being physically abused...it was years after during counseling that I realized that all through the relationship there was one form of abuse or another. I just didn't have language for it.

Eight participants *felt empowered or uplifted*. They described therapists who helped them gain a sense of hope and power over time. Anya expressed, “[Therapist] gave me a second life, I should say. [...] they give me an injection of determination, motivation to get up for yourself and to change this situation.” Fifteen participants *felt their outlook or mental state improved*. Participants spoke of having increased self-awareness, engagement with life, and reduced trauma symptoms following therapy. While some emphasized that they were still “a work in progress,” therapy could be transformative. Janelle felt:

There's so much growth that I've done...My job has changed. My outlook has changed. I'm doing things that I wasn't doing before in terms of heal[ing] my health. So, mentally, I think I am in a better position than I was years ago.

Nine participants felt their *lives and relationships improved*. Sakina explained how therapy helped her relationships:

With [...] my family, and with my kids, especially my kids. I just feel more connected to them. Because honestly for a while I just felt so numb. I think it's just like a survival thing for so long that ...the only way you can make it through these things is just shut off internally. So, [therapy] helped me to rediscover myself again.

Six participants expressed feeling *open to accessing therapy again* if needed. Melissa reported going back to her previous therapist for support: “I’ve recently seen her again...I’ve spoken to her half a dozen times... [because] I realized the value that that entire umbrella of services has provided to me for years.”

Survivors Experienced Unmet Needs and Negative Consequences of Therapy

In addition to positive consequences, participants described unmet needs and negative consequences. Six participants reported that their *needs as IPV survivors were unmet*. Many described how they could not find providers with adequate IPV or trauma intervention expertise who could support them in their recovery, address safety concerns, or help them feel comfortable being vulnerable. Some described being referred to multiple therapists in a row without success, leaving concerns unresolved. Emily was told that nobody at her employee assistance program (EAP) could work with her: “They asked me, ‘What is your issue?’ and I said, ‘I’ve dealt with a lot of domestic violence, I was assaulted at work.’ They were like, ‘I don’t know if we have somebody that can deal with those complex things but let me try to find somebody.’ And that’s when they gave me the next one, the next one, the next one.” Four participants articulated how *having needs go unmet could be harmful* as safety or mental health concerns were unaddressed and participants received the message that they were – in Clarissa’s words – “a lost cause.”

Two participants reported that a *negative experience in therapy led to harmful consequences* including disruptions to their mental health and relationships. Clarissa expressed, “you can get some wonderful experiences [in the mental health system], and you can get some really horrible ones.” She described a rupture she had with a counselor whom she initially trusted and liked. This counselor spoke about Clarissa to another provider without Clarissa’s knowledge or consent, leading her to feel, “there goes the trust with her.” Clarissa ultimately felt “Betrayed. Horrified. Angry. Hurt. [...] Trust is a really big issue for me...I won’t get into a relationship again simply because of that. It wouldn’t be fair. Because I don’t think I could ever trust anybody on that level again and that’s not fair.”

Survivors Provided Recommendations for Improved Services

In response to the fourth research question, seven participants emphasized the need for *expanded accessibility of therapy services* for survivors of IPV, particularly in times of crisis. They called for reduced wait times, longer-term treatment options, and an end to impersonal, automated systems. Sakina noted: “[The period when one accesses services is] such a crucial time...some people might do something drastic or go back to these

relationships.” Sixteen participants highlighted the need for *improved competency for therapists working with IPV*. This meant seeking to understand and not blame survivor-clients as well as being sensitive to their trauma histories. Romina called for therapists to “Believe your clients. [...] Believe them. [...] Take it really seriously. Take it really seriously.” Participants emphasized the importance of individually tailored, trauma-informed, IPV-competent care. Alice called for specific competence in identifying intimate partner and gender-based violence. Melissa highlighted the need for therapists to approach survivor-clients from an “empathetic place”:

[Survivors] have already been minimized...abused...dismissed...not valued. [Therapists should] deviate slightly from the paper and the check boxes and just ask a question that comes from inside [...] so it doesn't feel like it's just a box being checked [...] I believe that hearing is a gift [...] that's a gift that you give someone else to hear them or make them feel heard.

Seven participants recommended *interdisciplinary collaboration* to support trauma survivors. Many asserted the need to address survivors' holistic needs including the economic impacts of IPV. They also highlighted the need for integrating therapy, legal resources, and peer support given that – in Isabella's words – “violence has different ramifications.”

Discussion

This qualitative study explored women IPV survivors' experiences of counseling and psychotherapy services following IPV. We asked four exploratory research questions. First, we asked how participants perceived their experiences accessing and engaging in these services. Consistent with help-seeking models for IPV, recognizing that abuse was a concern and seeking formal mental health services was a process that took time (Liang et al., 2005). Unfortunately, when participants did seek care – often when the abuse worsened – they faced an under-resourced system with long wait lists, high costs, and infrequent or short-term sessions. Participants described the distress of referrals that went nowhere. For some, this unresponsiveness echoed the devaluation they experienced in abusive relationships. As one co-researcher explained, the message, “no one can help you” leads to a profound loss of hope.

Second, we examined how the therapy relationship may be a context for healing or harm following IPV. Corroborating research from survivor (Marsden et al., 2021, 2024) and therapist (Gutowski et al., 2025) perspectives, participants reported both healing and harmful encounters with therapists who were inconsistent in their approaches to addressing IPV. Effective therapists understood IPV and skillfully helped participants recognize abuse. Participants valued therapists with IPV knowledge or lived experience. They described the power of building genuine connections

with therapists who were responsive to their needs and made them feel valued and hopeful. These findings align with broader psychotherapy literature supporting the therapeutic alliance as one of the most potent healing ingredients in therapy (Wampold, 2015; Wampold & Flückiger, 2023). When survivors described why this aspect of therapy was healing, many expressed how therapy countered isolation and prior relational harm by providing a new way of being in relation to another that offered validation and empowerment – meaningful experiences after the manipulation, coercion, and devaluation characteristic of IPV.

Participants also detailed harmful encounters with therapists who did not address IPV, invalidated them, or lacked sensitivity to their trauma. Participant reports are consistent with global calls to reform mental health systems to improve responses to those affected by IPV (Oram et al., 2022). Without IPV training, mental health providers risk relying on frameworks that over-emphasize survivors' "pathology" and downplay the role of social oppression in their distress (Goodman & Epstein, 2008). As Goodman and Epstein (2008) highlight, psychological models often neglect the social conditions that sustain IPV and thus fail to fully address survivors' needs. This lack of attention to the external realities of survivors' lives came through in participant accounts of therapists who pressured them to leave abusive relationships without attention to the risks and complexities involved and made assumptions about their identity-based and cultural experiences.

The third research question explored the long-term consequences of participants' experiences engaging in counseling and psychotherapy services. While participants emphasized that their healing was ongoing, most communicated powerful - at times lifesaving - shifts from effective interventions including recognizing abuse, feeling empowered, and experiencing improvements in their outlooks and relationships. However, adding to the literature on IPV survivors' experiences in mental healthcare, a smaller number of participants also articulated how they experienced retraumatization when prior relational trauma was echoed throughout these therapeutic encounters. Therapists' disingenuity, detachment, invalidation, or dominance could feel like a repetition of abuse. Some participants even described their therapy relationships as involving "micro-violence" or "power and control" dynamics. Indeed, therapy may be a perfect context for institutional betrayal as survivors place trust in their therapists who may instead exacerbate harm (Smith & Freyd, 2014). Many assume that counseling and psychotherapy providers have the requisite expertise to address IPV and thus take risks and invest resources to engage in care. Yet, when therapists fail to address survivors' needs, the betrayal that results may lead to worsened mental health (Smith & Freyd, 2014). One project co-researcher described a therapist as a "trusted source." Years of

enduring manipulation and isolation can significantly compromise trust, and some survivors turn to therapy hoping for a safe bond with their therapists. When instead they encounter a therapist who lacks IPV knowledge or is unattuned to relational dynamics, harm can result.

The fourth research question addressed participants' recommendations for improving counseling and psychotherapy services for IPV survivors. Participants emphasized the need for increased access to care, competency among therapists addressing IPV, and interdisciplinary collaboration. Such recommendations are consistent with longstanding calls to improve the responses of mental health systems to those affected by IPV (Goodman & Epstein, 2008).

Limitations

Limitations of this study include that recruitment practices may have left out potential participants. For example, those in crisis as well as those who faced significant mental health concerns, housing instability, or poverty may have found participating in a virtual interview at a set time challenging, thus making it difficult to connect and follow through with the study team. Moreover, we relied on participants' reports of the credentials of their therapists and did not collect data on how long ago these encounters occurred. As a result, it is possible that for some participants, difficulties with recall or a lack of awareness about therapist credentials affected the information collected. While prioritizing the lived experiences of survivors of IPV is crucial to improving services, using data that rely on retrospective accounts constitutes a limitation of this study as participants' recollections of their experiences in therapy could have been influenced by subsequent reappraisal of their experiences. Moreover, because we did not collect data on the duration, severity, or recency of participants' experiences of IPV, we cannot determine whether our findings generalize to the diverse range of IPV experiences that clients bring to therapy. Additionally, while a strength of this study is participants' racial, ethnic, and cultural diversity, most identified as straight. Finally, this qualitative research relays in-depth perspectives of cisgender women survivors, yet findings cannot be generalized to all IPV survivors seeking mental health support. Importantly, these data do not capture the experiences of survivors who are diverse in terms of sexuality and gender identity.

Implications for Research

This study provides an important step in uncovering survivors' experiences of counseling and psychotherapy services. However, more applied research in this domain is needed to transform systems and foster

meaningful change that centers survivor perspectives (Goodman & Epstein, 2008; Moghimi & Hilton, 2025). Co-research is an important direction to improve the quality of care for this population and prevent harm (Moghimi & Hilton, 2025). While this project focused on the perceptions of cisgender women survivors, more research is needed with survivors who have diverse gender identities and have been underrepresented in existing literature. A co-research design with survivors who are diverse in gender, sexuality, culture, and geographic location can be used to capture a range of perspectives. Moreover, while this qualitative study provides rich, descriptive information on participants' subjective experiences, other study designs (e.g., quantitative, longitudinal) are needed to ascertain dimensions of the therapeutic relationship that are healing or harmful over time. In addition to centering survivor perspectives, future research should incorporate a range of methodologies to understand specific practices that lead to specific outcomes. Moreover, while this study focused on individual counseling and psychotherapy services, future research may explore survivor experiences with other forms of mental healthcare and support.

Implications for Practice and Policy

Enhanced training and supervision support for therapists who serve IPV survivors is essential (Gutowski et al., 2025). Without such preparation and support, IPV may go unidentified, which can be invalidating, prolong suffering, or fail to prevent ongoing abuse and related harm. Identifying IPV requires understanding the role of systems of oppression in sustaining it. Thus, competency for therapists involves recognizing the social realities that survivor-clients face. Participants valued responsive therapists who understood the multidimensional effects of IPV and operated outside of the boundaries of traditional therapy when appropriate. Such an approach is aligned with frameworks that attend to how structural violence both perpetuates and intersects with IPV to affect mental health (Goodman & Epstein, 2008; Wathen & Mantler, 2022).

Beyond upholding a contextual understanding of IPV and knowing how to identify it, therapists need to be attuned to the process of establishing and maintaining relationships with survivors. Professional competency involves vigilance about not recreating experiences of disempowerment or dismissal, consistent with feminist perspectives (Brown, 2018). It entails genuine caring and healthy relating. Therapists can thus adopt survivor-defined and feminist practices that build services around survivors' choices, center partnerships, and emphasize sensitivity to survivors' needs and contexts (Goodman et al., 2016). Relatedly, therapist competency necessitates intersectional awareness and cultural responsiveness (Gutowski et al., 2025). Corroborating accounts of help-seeking experiences of survivors

with marginalized identities (Robinson et al., 2021), participants spoke of therapists who made them feel unsafe based on their identity-based or cultural experiences. These findings highlight the urgent need for therapists to be responsive to culture and social context in their practices with IPV survivors.

Lastly, participants indicated that quality care was difficult to access. They called for an increase in mental healthcare options for IPV survivors. The shortage of accessible mental healthcare for this population requires a call to the profession and to policymakers to increase efforts and funding to fill this gap.

Conclusion

Counseling and psychotherapy services can provide crucial opportunities for recovery and growth for women who have survived IPV. Yet, attempts to seek care may result in unmet needs or harm when survivors are faced with an under-resourced mental health system and therapists who lack competency to work with those affected by this social problem. Thus, there is a clear need to expand access to mental healthcare for IPV survivors. Further, when therapists are not attuned to dynamics within the therapy relationship with women survivor-clients, therapy can echo prior interpersonal and structural harm. Thus, when working with women survivors, therapists must not only be knowledgeable about IPV and intersecting experiences of structural harm but also be sensitive to how these experiences affect the process of forming relationships and engaging in services. When therapists are competent to work with women IPV survivors, counseling and psychotherapy services have the potential to offer a powerful context for healing.

Note

1. In this paper, the terms 'therapy' and 'therapist' are used to refer to individual counseling and psychotherapy services offered by providers who have a range of credentials including counselors, psychotherapists, social workers and psychologists. This term was chosen to align with the language used by participants themselves. However, it is important to note that some professionals described may be part of a professional group practicing the controlled act of psychotherapy and some professionals described may offer services that fall outside of this classification.

Acknowledgements

We would like to thank Priya Shastri, Premila Chellapermal, WomanACT, the project advisors whose wisdom helped to guide this project, Sharan Sagoo for her research assistance, and the participants who shared their experiences with the hope of helping someone else.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Social Sciences and Humanities Research Council (SSHRC) under Grant: # 892-2022-3040.

Use of AI

Claude, Fable 5 was used to verify formatting of references and to proofread for minor typos and grammatical errors in select sections of this manuscript. All content was written and verified by the authors.

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