

**Therapist-Perceived Barriers to Mental Health Counselling for Survivors of Intimate
Partner Violence: Understanding the Challenges of the Therapeutic Relationship**

By

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Abstract

This capstone examines the perspectives of mental health practitioners on the challenges of building therapeutic alliances with survivors of intimate partner violence in mental health counselling and how these challenges influence the survivors' engagement in treatment. From a trauma-informed care framework, this manuscript aims to identify the specific challenges that mental health practitioners encounter when working with survivors, develop an understanding of how they impact treatment participation, and provide recommendations for practitioners to overcome such challenges. The methodology adopted is literature review synthesis and critical analysis. Studies were selected and compiled to determine numerous themes, including practitioner preparedness to work with intimate partner violence survivors, considerations for building therapeutic alliances, specific population considerations, and the influence of practitioner burnout. Trust was found to be one of the most critical factors required for building therapeutic alliances with survivors, and present in almost all themes. The findings of this capstone provide information for mental health practitioners on the challenges and implications of building therapeutic alliances, such that stronger alliances can support positive therapeutic results. Recommendations for building therapeutic alliances are provided, such as demonstrating empathy and empowering clients to contribute to building trust. Finally, this capstone lays the groundwork for future research that contributes to the limited body of literature specifically looking at the perspectives of mental health practitioners, along with quantitative studies to test the efficacy of strategies to build strong therapeutic alliances.

Keywords: Intimate Partner Violence (IPV), IPV Survivor, Mental Health Therapy, Therapeutic Alliance, Treatment Engagement

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Chapter 1: Introduction

Background and Context

In mental health counselling, providing a safe space for clients to discuss their concerns and difficulties is the mental health practitioner's highest priority (Canadian Psychological Association [CPA], 2017). The therapeutic alliance, which is defined as the relationship between the client and mental health practitioner (MHP), where both individuals work towards a common therapeutic goal, is paramount to the therapy process and shown to be essential for change in mental health counselling (Nienhuis et al., 2016). The therapeutic alliance becomes especially important when working with individuals who have experienced trauma and are experiencing significant mental health consequences, specifically with individuals who have experienced intimate partner violence (IPV) (Paphitis et al., 2022). Experiencing IPV may have physical and psychological consequences, which makes the development of a therapeutic relationship challenging, yet essential to establish safety within the context of therapy (Paphitis et al., 2022; Toccalino et al., 2023).

Remaining in and leaving relationships that are characterized as violent or abusive can lead to significant mental health concerns for the survivor, such as post-traumatic stress disorder (PTSD), depression, and anxiety, among other consequences, prompting survivors to seek out mental health services for support (Lee et al., 2021). The violence in each relationship is unique and specific to the individual couple, which presents MHPs with the task of providing mental health support that is individualized to their client (Kulkarni, 2019). There are challenges to developing therapeutic alliances with any client, and even more specific challenges when working with survivors of IPV that MHPs must consider, such as establishing trust and safety (Messing et al., 2022). Research must be completed to identify these challenges, promote awareness, and provide recommendations for overcoming them to support MHPs and clients as they navigate mental health counselling. This chapter will

discuss the background and prevalence of IPV, outlining the importance of research with IPV survivors and MHPs who work with them. Furthermore, I will discuss the research question, the framework for viewing the research, as well as identify the key terms that will be used throughout this capstone. Finally, this chapter will conclude with an in-depth look at my personal stance, identifying where efforts to mitigate bias will be required and included.

IPV is a broad term that encompasses any act of physical, sexual, or psychological violence from one partner to another in the context of an intimate relationship (World Health Organization [WHO], 2012). This may also include threats, coercion, stalking, financial abuse, and emotional abuse (Stewart et al., 2020). As a result of these behaviours, common consequences for survivors include, physical injuries, such as bruises, broken bones or worsened chronic health conditions, and psychological concerns, such as PTSD, depression, anxiety, reduced self-esteem, and substance abuse (Kahraman & Bell, 2017; Kulkarni, 2019; Lee et al., 2021; Paphitis et al., 2022). Lee et al. (2021) described violence within an intimate relationship as particularly traumatizing and damaging due to the level of betrayal involved in engaging in any form of violence towards one's partner. The authors described the intimate relationship as one built on trust and companionship, which is betrayed when one partner acts in physically, sexually, or psychologically violent ways, which increases the risk of psychological consequences. Furthermore, homicide and suicide are extreme, but significant risks associated with IPV (McLaughlin, 2017; Wilson et al., 2021), indicating the potential gravity of these situations due to the severity of IPV and the risk to survivors in these relationships.

In addition to the physical and psychological risks of experiencing IPV, survivors are often faced with a variety of social consequences as well. For example, leaving an abusive relationship can result in the dissolution of family relationships, the loss of access to children, and disconnection from the community (Messing et al., 2022). Anguzu et al. (2023) found

that individuals in Ugandan communities are less likely to report instances of IPV due to the risk of ostracization from their family and community. Furthermore, many survivors who leave abusive relationships are faced with financial hardships due to separating from their partner, who either supported them or contributed financially to the relationship (Wood et al., 2023). Wood et al. (2023) additionally noted that leaving relationships may come with the risk of losing their housing, with many survivors being required to seek refuge in shelters that support IPV survivors during times of transition. This demonstrates the significant consequences and additional stressors that may arise from IPV, indicating the diverse needs of IPV survivors.

IPV is an incredibly prevalent issue affecting various individuals in many diverse settings (Government of Canada, 2025). Statistics Canada (2024) reported that between 2018 and 2023, rates of IPV rose by 13%, with women and girls accounting for 78% of the survivors (Statistics Canada, 2024). It is additionally noted that in the same period, rates of IPV occurring against men saw a larger increase than the violence against women. While women are disproportionately affected by this issue, the rising occurrences of IPV for men and women in recent years indicate that this is an issue that goes beyond gender and is worth continuing to explore (WHO, 2022; Statistics Canada, 2024). Given the prevalence of IPV and the significant mental health implications, it is highly likely that mental health practitioners (MHPs) will encounter clients who have some experience with IPV (Kahraman & Bell, 2017; Lee et al., 2021). Whether clients have a history with IPV, are currently experiencing abuse, or have recently left a relationship, MHPs need to be prepared to offer support to clients in any of these situations.

The topic for the current research project is to examine the MHP's perspective of the challenges that they face in building a therapeutic alliance with IPV survivors during mental health counselling. This study aims to understand the MHP experiences and perspectives in

working with IPV survivors, how these contribute to building an effective therapeutic alliance, and how this may foster treatment engagement for survivors. In recent years, more research has been conducted to examine the IPV survivor's needs when attending mental health therapy; however, there is also research suggesting that MHPs and survivors may have different perspectives and goals in mental health therapy (Cardenas, 2024; Kulkarni, 2019). Similarly, Mengo et al. (2023) found that survivors and providers agreed on many areas of success; however, there were some areas where they had different ideas. The authors indicated that regarding the concept of recognizing abuse, the providers emphasized the importance of survivors learning about the impact of the violence; whereas, survivors were more likely to emphasize that success was characterized by feelings of persistence, strength, and courage in the face of abuse. The disconnected understanding of success may present challenges for MHPs who work with this population, such as forming a therapeutic alliance.

The current capstone project will critically examine current research on the MHP's perspective on the challenges of working with this population and outline the areas for improvement. Beginning to understand MHP perspectives will additionally create opportunities to examine the challenges of building a therapeutic alliance with IPV survivors in mental health counselling and how these challenges impact treatment engagement. This research is important due to the need for examining how MHPs view working with their clients, specifically those who have experienced IPV. Research has described the concerns that clinicians working with this population have and how these concerns may or may not align with the experience of the client (Cardenas, 2024; Kulkarni, 2019; Mengo et al., 2023).

The disconnect between the goals of clients and MHPs affects the MHP's ability to create safe environments for clients to feel safe disclosing their circumstances and abuse (Kennedy et al., 2024). Furthermore, Mallonee et al. (2022) found that treatment engagement

was higher for outpatient clients with severe mental health concerns when a stronger therapeutic alliance and higher levels of empathy from the MHP were in place. By understanding MHPs' perspectives on the challenges of building therapeutic alliances with and treatment engagement from clients who have experienced IPV, the findings of this project can be applied to clinical practice to improve the work MHPs do with their clients.

Research Problem Statement

Working with IPV survivors involves a variety of specific considerations due to the complexity of their circumstances and the trauma they have dealt with or continue to experience (Lee et al., 2021). There has been research examining the barriers and needs of survivors in mental health therapy (Sorrentino et al., 2021); however, there is room for a deeper understanding of the MHP-perceived challenges and the MHP perspectives (Wilson et al., 2021). This research gap limits MHPs from having a full understanding of the nuances of working with IPV survivors, further reducing the ability to prepare for the challenges of forming therapeutic alliances. Therefore, there is a need to examine the challenges that MHPs face in developing therapeutic alliances when working with IPV survivors in mental health therapy, and the influence these challenges have on the survivors' participation in treatment. The findings of this capstone will apply to MHPs' mental health practices and aim to provide MHPs working with this population with recommendations for overcoming these challenges.

In addition to identifying challenges and recommendations for overcoming them, I hope that this capstone will provide new insights for MHPs and perhaps validate the experience of MHPs who have encountered similar challenges. Consequences such as burnout may be more common for MHPs if they believe they are alone in facing specific challenges and lack support from others in the field (Duncan & Pond, 2024). Through validation and new insights into working with IPV survivors in therapy, this capstone will provide an understanding to mental health practitioners that many of the challenges they

encounter are shared with others in the field. I will also recommend strategies to address such challenges and improve the therapeutic experience for practitioners and clients. By learning ways to address the challenges of creating a strong therapeutic alliance and integrating ways to maintain them, MHPs will be better able to develop safety in session for clients, ultimately improving service delivery and creating meaningful sessions for clients.

MHPs have an ethical responsibility to their clients to remain up to date on research and the needs of their clients (Canadian Psychological Association [CPA], 2017). The CPA (2017) Code of Ethics additionally requires psychologists to promote inclusivity and incorporate awareness of diversity into their practice. This capstone will provide insights into working with the broad population of IPV survivors, as well as the diverse individuals within this group. This will ideally provide a deeper understanding of the unique clients who will present for mental health counselling. IPV survivors are not a uniform group who all share the same experiences, as many individuals experience compounding trauma due to other intersecting components of their identities, including race, culture, socioeconomic status, gender, or sexuality (Gutowski et al., 2022). Each client is unique with their own story, and presenting insights into these experiences will allow MHPs to create an individualized approach to mental health treatment with their clients that meets their specific needs.

Research question

As such, the research question I plan to answer in this capstone is: “What challenges do MHPs perceive in forming therapeutic alliances with IPV survivors, and how do these challenges impact treatment engagement?”

Rationale and Justification

IPV remains highly prevalent in Canada and all over the world (WHO, 2022); therefore, steps must be taken to improve the support that can be offered to survivors who seek mental health therapy. This capstone will investigate the current perspectives of MHPs

on the challenges of creating a therapeutic alliance with IPV survivors in mental health therapy. While some research has been conducted on this topic (Fogarty et al., 2022; Forsdike et al., 2019; Loncar & Scott, 2023; S. Taylor et al., 2024; Wilson et al., 2021), it appears to be an underexplored area, with much more room for future research (S. Taylor et al., 2024; Wilson et al., 2021).

Developing a strong therapeutic alliance with clients in mental health counselling can be challenging for a variety of reasons, such as taking time to establish trust, or client fears of judgment or discrimination (Kennedy et al., 2024; Robinson et al., 2021). A significant reason that IPV survivors may not disclose the violence they experience may be due to fear of the consequences of doing so for themselves, their partner, or others, such as children (Anguzu et al., 2023; Asante, 2024; Evans et al., 2024). Discrimination and stigma towards survivors are also common reactions to IPV, the risk of which has been shown to significantly reduce the likelihood of disclosure (Kennedy & Prock, 2018; Taccini & Mannarini, 2023). Therefore, building trust and developing safety are large hurdles for MHPs to overcome. Additional challenges include identifying and providing education about abuse in relationships for survivors, which must be done with the utmost sensitivity and requires the MHP to be able to discuss it with empathy (Kalra et al., 2021). Finally, cultural differences may create barriers in developing therapeutic rapport and require cultural awareness from the MHP to provide an inclusive and supportive environment (Asante, 2024; Cardenas, 2024; Green et al., 2024).

This research is important as the challenges faced by MHPs in building a therapeutic alliance can significantly impact the therapeutic experience for both clients and practitioners (Sorrentino et al., 2021). This manuscript will synthesize and clarify the areas where MHPs may require extra training and provide information for creating therapeutic alliances with clients in sessions. Delving further into these challenges and understanding how they affect

treatment engagement for IPV survivors will not only assist MHPs in their work with clients but will additionally impact the clients themselves and the organizations that work with them.

Additionally, this capstone will lay the groundwork for future researchers to study the barriers to forming therapeutic alliances with IPV survivors and the effects these specific barriers have on treatment progress. It will provide a starting point for qualitative studies to continue exploring MHP experiences. Furthermore, in Chapters Four and Five, I will provide recommendations for overcoming the challenges of building therapeutic alliances, which will create opportunities for future quantitative studies to test the effectiveness of the recommendations.

The findings of this capstone and any subsequent studies may assist MHPs in their practice, the clients who receive services, as well as the stakeholders and community agencies that serve them, through recommendations based on the challenges encountered by MHPs. Recommendations include moving at the client's preferred pace and taking time to develop trust, which are paramount in developing therapeutic alliances with IPV survivors (Messing et al., 2022). This allows for time to establish safety within the relationship and provides the MHP with opportunities to understand the specific client they are working with. Furthermore, building trust is essential to providing opportunities to discuss experiences with IPV, demonstrating to the client that they are in a non-judgmental space and safe to disclose their experiences with violence (Voth Schrag et al., 2021a). Finally, considering the client's cultural background is essential, particularly when working with IPV survivors, as clients with diverse experiences and beliefs will have different understandings of IPV and differing levels of willingness to discuss their experiences (Kennedy et al., 2024; Messing et al., 2022; S. Taylor et al., 2024). Building trust, allowing the client the freedom to discuss their experience with IPV, and cultural considerations are the primary recommendations that will

be discussed in depth throughout this manuscript, providing MHPs with an understanding of why these are essential for working with this population.

Significance

Research on the experiences of IPV survivors and their needs in mental health therapy is prominent and important; however, the perspectives of MHPs who work with this population are equally important, yet they remain understudied (S. Taylor et al., 2024; Wilson et al., 2021). It is additionally known that the role of the therapeutic alliance is important in the therapy process and influenced by the MHPs ability to be empathetic and genuine toward the client (Nienhuis et al., 2016). In reviewing the literature to justify the current research project, I found many articles identifying that MHPs report a lack of self-efficacy and experience doubt regarding their abilities to work with clients who experience or have experienced IPV (Alston et al., 2021; Sutton et al., 2021). This lack of confidence may lead to imparting further trauma on the survivors, such that they may avoid addressing trauma or circumstances related to IPV for fear of doing so incorrectly (Forsdike et al., 2019; Voth Schrag et al., 2021a). Furthermore, the MHP's understanding of their clients' treatment barriers influences the decisions they make regarding treatment planning (Trabold et al., 2020). This research project will clarify the challenges that MHPs perceive in working with IPV survivors and provide opportunities for insight into overcoming these challenges.

Aligning MHP perspectives with survivor needs will help them create treatment plans that prioritize and acknowledge the presence of trauma in the client's life, clarifying how this may contribute to the barriers they experience. The therapeutic alliance is essential when working with clients who have histories of trauma, and understanding how to form an effective therapeutic relationship with clients is required (Norcross & Wampold, 2019). With this in mind, this capstone will apply to professional practice as it will provide an understanding of how MHPs view their work with IPV survivors and outline where they may

need to make changes to improve rapport building, foster treatment engagement, and improve client outcomes.

IPV survivors are an important population to consider, given the trauma that occurs within abusive relationships, physically and mentally (Stewart et al., 2020). Many individuals within this population have not only experienced trauma through their relationship but, additionally, may have experienced systemic barriers or trauma related to factors such as gender, sexuality, race, or socioeconomic status, which necessitates additional considerations in building therapeutic alliances in mental health therapy (Messing et al., 2022; Reed et al., 2024; Stewart et al., 2020). Another significant barrier faced by many IPV survivors is access to appropriate care while living in IPV-specific shelters (Wood et al., 2023). Many survivors escaping IPV rely on shelters for services; however, a lack of funding or staff in shelters to provide such services may limit the mental health services available to the clients.

Additional barriers include the lack of cultural sensitivity and the lack of culturally relevant services, all of which make it difficult to obtain mental health support (Asante, 2024; Green et al., 2024; S. Taylor et al., 2024). Culturally insensitive or irrelevant counselling not only risks harm to the clients in therapy, but it also makes therapy inaccessible to individuals from non-dominant populations (CPA, 2017; Reed et al., 2024). By examining the challenges specific to diverse demographics within the IPV survivor population and how MHPs understand them, this capstone will provide insights for MHPs to tailor their services to their clients' needs based on the barriers they face, ultimately improving the chances of treatment continuation.

While understanding the challenges that MHPs perceive for IPV survivors in therapy is essential for improving practice, it is equally important to do so from a trauma-informed perspective. As noted, IPV survivors are likely to have experienced trauma within their relationship and outside of it as well (Williams et al., 2021). Awareness of the presence and

effects of trauma for clients is essential for MHPs to avoid contributing to traumatic experiences, as well as fostering therapeutic alliances (Paphitis et al., 2022; Voth Schrag et al., 2021a). Common perspectives in other research include Feminist Theory and Ecological Systems Theory, which have their own benefits; however, trauma has far-reaching effects, and it is essential to understand these effects as MHPs to support their clients through their journey of mental health therapy (Kulkarni, 2019).

Theoretical Framework

Attachment Theory

The theoretical framework that will be used to guide this capstone will be Attachment Theory. Attachment Theory, developed by Ainsworth & Bowlby (1991), explains how the relationships that children form with their early caregivers influence how individuals form and maintain relationships in adulthood. Bowlby (1969) suggested that the influence of these early relationships evolves throughout an individual's lifespan and can be attributed to relationships other than caregivers, with the other individuals becoming a new "attachment figure" (p. 255). This figure is someone who can meet the emotional and physical needs of the individual, and someone the individual will seek out in times of distress or difficulty. When the attachment figure is able to meet the child's needs, they are more likely to develop a secure attachment, characterized by a positive view of self and beliefs that others are trustworthy (Colombo & Milani, 2025). Whereas failure to meet those needs can result in an insecure attachment such as avoidant, where the individual is avoidant or fearful of emotional intimacy or relying on others for support, or anxious attachment, where the individual experiences a significant need for emotional support and experiences anxiety when attachment figures are not present (Condino et al., 2024). This demonstrates the longevity and significance of attachment relationships and is especially important when looking at IPV experiences.

This framework emphasizes the various roles that attachment figures and relationships have in an individual's life. Researchers have found that attachment style may be related to the experience of IPV, such that partners with insecure attachment styles are more likely to display aggression, anger, or jealousy toward their partner (Wright, 2017). Experiencing such behaviours within an intimate relationship can lead to what was defined by Freyd (1996) as betrayal trauma, where the attachment figure becomes a source of pain and abuse rather than the expected safety and support in the relationship. The closer the individual is to the survivor, the higher the degree of betrayal and subsequent trauma (Freyd, 1996). This interpersonal betrayal creates trauma for the survivor of the abuse and may have long-term effects on their ability to form relationships in the future (Lahav et al., 2025; st. Vil et al., 2018).

When IPV is experienced by the survivor, the impact of the trauma is damage to the individual's perceptions of what relationships should look like (st. Vil et al., 2018). St. Vil et al. (2018) additionally noted that this betrayal may result in consequences for forming relationships, such as withdrawing from social connections, not pursuing romantic relationships, or difficulty trusting others. When conflicts arise between what is expected from the attachment figure and what is provided by the attachment figure, stress, trauma, and fear can be significant results (Bowlby, 1969). This may also have implications for forming therapeutic alliances with IPV survivors in mental health therapy.

The current research will examine how MHPs develop therapeutic alliances with their clients and how this influences treatment engagement for such clients. IPV survivors are more likely to experience physical and mental health consequences requiring intervention from a healthcare professional (Trabold et al., 2020). Therefore, Attachment Theory is a pertinent framework for this research due to the importance of the therapeutic relationship and the histories these clients may have with trauma in relationships. Given that I am

examining MHP perspectives of challenges in forming therapeutic alliances, it is essential to consider whether these perspectives contribute to or minimize the risk of re-traumatization. The emphasis on relationship histories and the development of new attachment bonds included in Attachment Theory invites exploration of how these experiences inform MHP perspectives.

Definition of Key Terms

The following terms are significant to this study and are defined as follows.

Intimate Partner Violence (IPV). IPV is a prevalent issue in both Canada and the United States, affecting a wide range of individuals (American Centre for Disease Control [CDC], 2024; Government of Canada, 2025). The Government of Canada (2025) defines IPV as harm inflicted by one partner towards the other through a variety of methods, including but not limited to physical abuse, sexual abuse, emotional abuse, and financial abuse. The CDC (2024) identifies four types of IPV: physical violence, sexual violence, stalking, and psychological aggression. White et al. (2024) define IPV in a clinical sense as any behaviour of one partner within an intimate relationship to cause physical, sexual, or psychological harm. Psychological abuse occurs through manipulation and coercion to enact control over the other partner (Stewart et al., 2020). This can encompass verbal and non-verbal behaviours that create feelings of fear and dependency in the partner experiencing abuse. Financial abuse is an additional form of IPV, whereby one partner limits the other's access to finances, forces or manipulates them into building debt, or prevents access to or negatively influences their partner's employment (Johnson et al., 2022). These forms of financial abuse ultimately force one partner to rely on the other, limiting their options for ending or leaving the relationship. The definition of IPV that will be used throughout this manuscript is based on the WHO (2022) definition, which defines IPV as diverse behaviours and forms of violence inflicted by

one partner on another, past or present, with severe risks of mental and physical consequences.

Mental Health Practitioner (MHP). In this capstone, the term MPH in general will refer to any individual who works in the mental health field, and throughout this manuscript, I will be referring specifically to MHPs who work with IPV survivors. This may broadly refer to therapists, counsellors, mental health nurses, or social workers who work with IPV survivors in community support settings, who work to support this population (Berry et al., 2024). The term MHP is broad enough to incorporate a range of roles that are examined in research.

Therapeutic Alliance. A therapeutic alliance is defined as the relationship between an MHP and a client during their treatment sessions, with emphasis on the bond between the client and MHP, which is built to assist with reaching the client's therapeutic goals (Goodman et al., 2016). Furthermore, this relationship is based on trust, empathy, and mutual respect, allowing for progress to be made towards these goals. Strong therapeutic alliances are suggested to be linked to positive improvements for clients, and the development of such alliances depends on the individual factors of both the client and MHP (Barr et al., 2024).

Treatment Engagement. Treatment engagement refers to a client's level of involvement in and the likelihood of continuing services (Cardenas, 2024). In this capstone, treatment engagement will be further defined as the willingness to participate, continue, and work with MHPs in mental health therapy. Treatment engagement is a result of many factors and can be influenced by the therapeutic alliance and factors specific to the client and MHP (Berry et al., 2024).

Reflectivity and Positionality Statement

My motivation for choosing this topic comes from personal experience of working with IPV survivors in therapy during my internship placement. During my placement, I have worked at a second-stage women's shelter for women leaving abusive relationships. The

women living in this shelter had fled relationships, leaving with very few belongings, often with custody of their children, and have minimal options for housing. The residents are permitted to stay for one year and must engage in programming and group therapy while there, with the option of free individual mental health therapy provided.

When I began my internship, I took over the caseload from the previous intern in October 2024, and I immediately noticed that I was having difficulty maintaining it. I specifically noticed that clients were no longer interested in booking appointments, and those who booked appointments with me stopped attending their appointments. I started to wonder why this was happening, asking myself if there was something that I was doing to influence this behaviour change or if I was not meeting the needs of these clients. Additionally, knowing that IPV survivors experience a variety of barriers that influence their help-seeking behaviours, such as internalized stigma, fear of engaging with services, and difficulty trusting service providers (Kennedy & Prock, 2018; Kennedy et al., 2024; Mendoza & Rochford, 2024), I started to wonder if there were external reasons that may have been influencing this discontinuation in treatment. When it came time to decide on a topic for the current project, I was interested in looking into the factors of facilitating therapy engagement for IPV survivors, and when I discussed this with my capstone supervisor, examining the MHP's perspective on this issue stood out as the starting point for the project. I was curious about exploring if MHP perspectives align with those of clients and survivors, and how this impacts treatment progress and their ability to support clients during mental health treatment.

In preparation for this project, it is important to reflect on the biases I may hold concerning IPV survivors and working with them in therapy. Currently, my perspective is that IPV survivors face significant barriers, including access to stable housing, additional mental health and addiction concerns, and difficulty establishing trust with MHPs due to the sensitive nature of their concerns (Messing et al., 2022; Reed et al., 2024; Stewart et al.,

2020; Voth Schrag et al., 2021a; Wood et al., 2023). This is based on anecdotal experiences, as well as what I have read in literature thus far; however, being a 28-year-old, White, university-educated woman, my understanding of IPV survivors' perspectives may be limited by various aspects of my identity. This is important to consider, as the research that I reviewed was conducted outside of Edmonton. To mitigate this, it is important to provide space for additional viewpoints during this project and question if my perspective is biasing my understanding of the literature. Remaining objective and acknowledging where I may have limited knowledge of other cultures will provide opportunities for growth in this area as well. Using diverse resources and including sources that may not align with my perspective will also be essential. As I proceed with this project, it will be important to recognize where my own clinical skills can be developed and apply the knowledge from the research to improve my clients' wellbeing.

Capstone Chapter Overview

Chapter One introduced the topic of this capstone, which is to explore the challenges perceived by MHPs in creating therapeutic alliances with IPV survivors in mental health therapy and how this impacts client treatment engagement. This chapter discussed the relevance of IPV research due to the prevalence and diversity of individuals affected (WHO, 2022). From a TICF lens, this capstone will explore the challenges of building a therapeutic alliance while maintaining awareness of the role trauma plays in the experience of IPV survivors. I identified the topic of exploring MHP perspectives as an understudied area; therefore, this capstone will contribute to the field and provide knowledge and insights for MHPs working with this population.

Chapter Two is the methods chapter, where I will outline the process that I followed when conducting the research for this manuscript. This chapter will include the databases I

used, the inclusion and exclusion criteria, and the limitations of my chosen method. I will discuss the challenges encountered in my research and the strategies used to overcome them.

In Chapter Three, I will present the literature review. In this chapter, I will be examining the research on my chosen topic, analyzing the results and methodology of each study. I will explore the themes found in the research and the ethical considerations for each, allowing me to synthesize the information and answer the research question.

Chapter Four will detail how the literature review results may be helpful and relevant to professionals in the counselling field. I will outline how the results can be applied in counselling and provide recommendations for future MHPs. Given the challenges of building therapeutic alliances will be discussed in the preceding chapter, Chapter Four will include recommendations for overcoming such challenges to strengthen therapeutic alliances and improve the counselling experience for clients.

Finally, in Chapter Five, I will conclude my capstone by recommending directions for future research. These recommendations will be based on the remaining research gaps and will additionally include suggestions for methodology in future research. Following these recommendations, I will conclude by reflecting on the importance of continuing this research for MHPs and clients alike.

Chapter 2: Methods

The purpose of this manuscript is to examine the research is to examine the perspectives of mental health practitioners (MHPs) who work with IPV survivors in mental health therapy and how the strength of the therapeutic alliance influences survivor treatment engagement. Chapter two outlines the process and strategies used to complete the research for the literature review, which aims to answer the research question, “*What challenges do therapists perceive in forming therapeutic alliances with IPV survivors, and how do these challenges impact treatment engagement?*” In this chapter, I will outline the research design I used to search for and obtain research for the literature review, including article selection strategies, the inclusion and exclusion criteria, and process for data extraction. I will then discuss the methodological limitations of my research and the challenges I encountered while preparing this manuscript.

Research Design

The approach used for this capstone was the systematic literature review method. According to Siddaway et al. (2025), this method involves several stages and steps for completing a literature review. The first stage consists of planning various keywords for obtaining research articles, including specific inclusion and exclusion criteria, and tracking how research is collected. Both broad and specific keywords and inclusion and exclusion criteria were used to find sources (Creswell & Creswell, 2022), which will be detailed further later in this chapter. Furthermore, the second stage involves screening and identifying relevant articles, which is completed by searching multiple databases to search for and determine eligible sources based on the inclusion and exclusion criteria and reading the abstracts of potential sources (Creswell & Creswell, 2022). Finally, the theoretical framework, method, findings, applications, and limitations of each source were documented as the articles were reviewed. This approach allowed for the organization of the key

information in each article. Once the final articles were chosen, the next steps included reflecting on and organizing the data. For the purpose of this paper, a thematic framework was used, with the research being organized by the themes that emerge within the articles. Creswell & Creswell (2022) recommended using a literature map to manage the sources used in the literature review. I used a table to organize my research articles, which can be found at the conclusion of the chapter in Table 1.

Search Strategy and Study Selection Process

Several online databases were accessed for the literature review. The primary databases were PsycInfo & PsychArticles, the City University Library, and Google Scholar. Sage Journals was also accessed to obtain more specific sources related to the topic. Finally, SciteAI, an online artificial intelligence program designed for academic research, was used to search for additional sources, the titles of which were then accessed through the City University Library or Google Scholar. Using a variety of databases to access literature provided opportunities to find diverse sources on this topic.

Keyword selection is important to ensure that appropriate and relevant sources are obtained for the current review (Creswell & Creswell, 2022). Therefore, specific keywords such as *'therapist perspective,' 'IPV survivors,' 'intimate partner violence,' 'domestic violence survivors,' 'DV survivors,' 'therapeutic alliance,' 'therapeutic barriers,' 'treatment engagement'* were included for a narrow and focused search. Of note, acronyms for intimate partner violence (IPV) and domestic violence (DV) were also included in the searches. Broader terms such as *'therapist burnout,' 'therapeutic relationship,'* and *'IPV survivor therapy'* were additionally included in the searches to widen the available research. These terms were used in various combinations in online databases to build the research for this manuscript. When using Google Scholar and the City University library, several searches were conducted using specific phrases such as *"therapist perspectives of working with IPV*

survivors,” “developing a therapeutic alliance with IPV survivors,” “mental health therapy barriers for IPV survivors,” “therapist perceived barriers to developing rapport with IPV survivors,” and “effects of burnout on therapeutic relationships,” and “rapport challenges in therapy with IPV survivors.” Finally, searching the references in articles allowed me to find additional sources that were relevant to my topic. This strategy helped me find research that fit my topic when the original article that referenced it may not have been as appropriate.

Inclusion and Exclusion Criteria

Approximately 110 peer-reviewed sources were considered for the literature review, and 52 of the articles were included. The primary inclusion criteria for the articles chosen were that the articles were published between 2018 and 2025 and were peer-reviewed, qualitative or quantitative research articles, meta-analyses, or literature reviews. Articles were selected for review if their research topic was the experience of mental health professionals working with IPV survivors, examined both mental health professionals and survivors, or provided recommendations for therapists working with IPV survivors attending mental health treatment and survivor-specific IPV supports. An additional topic that was included was the experience of therapist burnout in working with IPV survivors, and five articles were included to examine the effects of burnout on the therapeutic relationship. Finally, one article from 2017 was included because the researchers examined the perspectives of professionals who work closely with IPV survivors.

Articles were excluded if they were published before 2017, as anything older than 2017 does not reflect current results, opinions, or perspectives. Sources were also excluded if they were not written in English, required a subscription or payment, were deemed grey literature, or were not peer-reviewed. Including peer-reviewed research was essential to ensure that the information being included in my literature review was valid. Finally, articles

with topics of IPV perpetrators or those solely outlining the experience of survivors were not included, as these perspectives were not relevant to the research question of this capstone.

Data Extraction

Data was extracted from the literature using a systematic literature review method. According to Siddaway et al. (2025), this method involves several stages and steps for completing a literature review. The first stage consists of planning various keywords for obtaining research articles, including specific inclusion and exclusion criteria, and tracking how research is collected. As noted above, specific keywords and inclusion and exclusion criteria were used to find sources. Furthermore, the second stage involves screening and identifying relevant articles (Siddaway et al., 2025), which is completed by searching multiple databases to search for and determine eligible sources based on the inclusion and exclusion criteria and reading the abstracts of potential sources. Finally, the theoretical framework, method, findings, applications, and limitations of each source were documented as the articles were reviewed. This approach allowed for the organization of the key information in each article. Once the final articles were chosen, reflecting on and organizing the data was essential.

Decisions and Limitations in Methodology

Numerous limitations in my research process led to limitations of the overall literature review. Specifically, some studies were excluded because they required payment to read and could not be accessed through the free online databases, such as the City University of Seattle library. Studies that were not written in English were additionally exempt from my review, which could have provided insight into the experience of individuals from additional demographics. Finally, while the date range between 2018 and 2025 was implemented to ensure I was using the most current research on the topic, there were relevant sources that were published before 2017, which may have allowed for a deeper understanding of the

experiences of therapists working with IPV survivors. Sources that fit these criteria were excluded to ensure only the most relevant research was included; however, this could have created limitations in the data presented in the literature review, potentially leaving out valuable information relevant to my topic. Despite the potential limitations of the exclusion criteria, this set of criteria assisted with managing bias throughout the process by maintaining objective reasons for excluding specific resources.

Researchers come into the research process with their own backgrounds, histories, and perspectives, which may influence how they approach and interpret the results of their studies (Creswell & Poth, 2024); therefore, mitigating bias was essential throughout this process to ensure a well-rounded review was created and there was no sole focus on any specific or favourable results. Going into this project, I had an idea of what the research might say based on personal experience, so I had to be aware of how my perspective might influence the articles I chose. It was important to ensure I prioritized diverse perspectives and did not only focus on articles that confirmed my viewpoint. This was made easier by the limited number of sources on this specific topic, such that after I chose most of the articles that specifically examined therapist perspectives, I was open to including any article I could find that was relevant to my topic and examined the experiences of mental health practitioners in general. This led to additional challenges, such as finding articles that were not only relevant but also demonstrated strong ethics and were methodologically sound.

Regarding the limitations of the articles included in my literature review, several articles had methodological limitations. The most common limitation was having a small sample size (Alston et al., 2021; Asante, 2024; Kozłowska, 2020; Periyasamy et al., 2024; st. Vil et al., 2021; S. Taylor et al., 2024; Vranda et al., 2022; Wilson et al., 2021). Small sample sizes are common in qualitative studies, and this was seen in many of the studies I included; however, small samples limit the generalizability of the results. Furthermore, many studies

took place in one location, either in one city or clinic (Asante, 2024; Fogarty et al., 2022; Vranda et al., 2022), which additionally limited generalizability as individuals working in different locations will have diverse challenges and ideas; whereas if the samples come from one area, they are more likely to share similar perspectives. Finally, few studies were completed in Alberta and Canada; therefore, the results of the studies cannot be generalized to the experience of practitioners in Alberta.

Challenges

One of the primary challenges of the literature search was finding enough sources for the literature review. There are copious amounts of sources exploring the perspectives of IPV survivors; however, there appears to be a gap in the literature for additional resources examining the perspectives of mental health professionals who work with IPV survivors. Although using “therapist” in the keywords was intended to narrow the search and provide more articles specific to the therapist experience, the lack of available research resulted in broader results. The search results often offered a small number of articles that specifically examined MHP perspectives, with the vast majority of articles looking at a variety of professionals who work with IPV survivors, including social workers, doctors, nurses, and individuals working at shelters for IPV survivors. Given the limited number of articles that specifically looked at MHPs, I needed to include articles that discussed the experiences of various professionals who work with IPV survivors to ensure I had enough research.

Chapter Summary

In Chapter Two, I outlined the methodological process I used to compile and present my research for this capstone. Using a variety of online databases and combinations of keywords and phrases, I was able to obtain diverse sources discussing the challenges perceived by mental health practitioners for developing therapeutic alliances with IPV survivors and how these challenges impact client treatment engagement. Given the number of

articles found for review, inclusion and exclusion criteria, such as limiting the research to the years between 2018 and 2025 and only including peer-reviewed articles, helped narrow the research to include. The limited number of articles specifically examining therapist perspectives demonstrated the gap that needs to be filled in the literature; however, it created challenges when selecting articles to include. Finally, it was essential to be cognizant of personal bias throughout this process and maintain awareness of how my personal views may have influenced the research I included.

In Chapter Three, I will present my literature review, critically examining the available research and subsequent emerging themes. The findings from the literature will build the base for Chapter Four, where I will discuss the practical implications of these findings. Finally, in Chapter Five, I will provide recommendations for therapists in the field to apply these results.

Chapter 3: Literature Review, Synthesis, Critical Analysis and Findings

The purpose of this review is to examine the current research of the perspectives of mental health practitioners (MHPs) who work with intimate partner violence (IPV) survivors in mental health therapy, to answer the research question: “What challenges do therapists perceive in forming therapeutic alliances with IPV survivors, and how do they impact treatment engagement?” The current literature review will discuss research relating to the research question about the challenges therapists encounter in establishing therapeutic alliances with IPV survivors and the effects these challenges have on the clients’ treatment engagement. Given that IPV is a prevalent and diverse form of violence, impacting approximately 44% of women and girls over age 15, with rates for men increasing annually (Government of Canada, 2025), this is an important research topic as it provides a deeper understanding of the experience of therapists and IPV survivors in therapy.

This chapter will examine literature on IPV, trauma-informed care, and the perspectives of MHPs who work with IPV survivors. In reviewing the research, several themes emerged, including trauma-informed care, therapist preparedness to support IPV survivors, developing a therapeutic relationship, challenges associated with specific events and populations, the effects of therapist burnout, and perspectives on client engagement, along with subthemes of trust and the impact of stigma and bias. These themes will be explored throughout the remainder of this chapter.

Intimate Partner Violence

IPV is a far-reaching issue that affects a diverse range of individuals across the globe, disproportionately affecting women (World Health Organization [WHO], 2022). According to the WHO (2019), 30% of women globally have experienced sexual or physical violence from a partner in the context of an intimate relationship, and 35% of women have experienced violence from an intimate partner or sexual violence in general. While IPV

overwhelmingly impacts women, it is not limited to the confines of gender, expanding further to race, sexuality, socioeconomic status, and religious or political beliefs (Government of Canada, 2025). With respect to demographics at risk, Lee et al. (2021) indicated that individuals are most likely to have their first experience with IPV in young adulthood, between the ages of 18 and 24. Furthermore, Indigenous women in Canada are more likely to experience IPV in general, along with more severe forms of IPV than non-Indigenous women (Stewart et al., 2020). Stewart et al. (2020) additionally reported that sexual and gender minorities are more likely to report IPV experiences than heterosexual individuals. Finally, the authors indicated that lower socioeconomic status, living with a physical or mental disability, and strong patriarchal beliefs and gender roles increase the risk of violence within relationships. These statistics suggest the increased risk of IPV behaviours among those from vulnerable, minority, and non-dominant demographics.

IPV additionally includes more than physical violence, with the Government of Canada (2025) indicating that psychological abuse, coercion or manipulation, stalking, harassment, economic abuse, sexual violence, or online violence additionally constitute IPV. The consequences of experiencing such behaviours can be severe for the survivors, including but not limited to psychological concerns such as Post-Traumatic Stress Disorder (PTSD), depression, anxiety, substance abuse, and severe mental health conditions (Chandan et al., 2020; Kahraman & Bell, 2017; McLaughlin, 2017). In their study, Chandan et al. (2020) found an association between exposure to IPV and the development of depression, anxiety, and severe mental illnesses such as schizophrenia and bipolar disorder. Through the online database used in the United Kingdom medical system, the authors accessed patient records to observe which patients were flagged for IPV exposure and their subsequent mental health concerns. The results indicated that individuals exposed to IPV at baseline were more likely to have received a diagnosis for a mental health disorder than those in the category of non-

exposure, additionally indicating that the risk of experiencing mental health concerns increased after experiencing IPV. While a significant limitation of this study is relying on doctors to accurately record this information, rather than researchers who are trained to recognize specific symptoms or experiences, the authors suggested that those with mental illnesses may be a vulnerable demographic to experiencing IPV.

In addition to the development of mental illnesses or disorders, suicidal ideations and behaviours are also psychological and physical risks to IPV survivors (Wilson et al., 2021). Further consequences of physical and sexual violence include broken bones, pregnancy, and homicide, demonstrating the seriousness of this phenomenon (Kahraman & Bell, 2017; McLaughlin, 2017). Despite the risks and consequences of IPV, it can be challenging for survivors to leave these relationships for a variety of reasons, such as the risk of retaliation or escalation in violent behaviours from their partner, the risks to their children, financial concerns, and lack of support or the presence of stigma (WHO, 2012). Barrios et al. (2021) conducted a qualitative study to examine the intersecting factors that contribute to a woman's decision to leave an abusive relationship, using multi-level analysis to analyze the interviews of 25 racially diverse research participants between the ages of 21 and 54 about their experiences. The authors found that overall cultural factors such as ethnicity, socioeconomic status, and race all intersect with gender to influence a woman's decision to leave, with women of colour and women from lower socioeconomic status taking more time to decide to leave. Furthermore, they indicated that a lack of social support, readiness to leave, access to resources and identity as a mother may increase the time it takes to decide to leave. Notably, a significant limitation of this study is that the authors analyzed interviews from an earlier study done by Khaw and Hardesty (2015) rather than conducting their own interviews. Similarly, using semi-structured interviews with 20 women, identifying as Black, Asian, or White recruited from shelters in the United Kingdom (UK), Heron et al. (2022) found that

women remain in abusive relationships due to their investment in the relationship, feeling isolated and financially dependent, cultural beliefs, internalized blame, inability to cope, and love for their partner. The authors additionally found that having social and professional support, fear of escalating violence or harm, and concern for the children were factors that contributed to decisions to leave. The limitation of this study includes the small sample size that was taken from participants in the UK, limiting generalizability as it cannot be assumed that individuals in other locations will have similar perspectives. However, the ethical considerations taken for confidentiality, informed consent, and participant well-being are important to note and emphasize the importance of prioritizing participant welfare.

Although MHPs are likely to encounter IPV survivors within the context of mental health therapy due to the pervasiveness of this issue, IPV survivors struggle to seek such services due to a variety of barriers, such as stigma from MHPs and marginalization and oppression in their communities (P. Taylor, 2019). Internalized shame and the belief that seeking help is a sign of weakness are additional barriers to seeking support following IPV (Thorvaldsdottir et al., 2022). It is important for MHPs to be aware of the prevalence, risks, and consequences of IPV to ensure they can appropriately support survivors who do seek services. Awareness of the trauma that may result from exposure to IPV is additionally essential for providing adequate services to those seeking mental health support (Gutowski et al., 2022; Kulkarni, 2019).

Trauma-Informed Care

Trauma-informed care is essential for working with survivors of trauma, as trauma is shown to affect numerous areas of an individual's life (Isobel et al., 2021). In their review of current practices in working with IPV survivors, Kulkarni (2019) noted that working from a trauma-informed approach emphasizes tailoring services to the client and acknowledging how trauma influences an individual's behaviours and actions. The authors further suggested

that an intersectional trauma-informed care approach involves prioritizing the client's autonomy and cultural influences, remaining authentic and offering genuine help, creating an individualized approach for each client, and advocating for clients within their community with challenges outside of therapy. Similarly, in the article by Gutowski et al. (2022) the authors summarized various approaches to trauma informed care, sharing recommendations for integrated trauma-informed care, some of which included creating safety through compassion, empathy, and honesty, being culturally responsive and competent, prioritizing the development of a strong therapeutic alliance with survivors, further allowing for collaboration within therapy, and responding to trauma with curiosity and compassion.

Gutowski et al. (2022) emphasized the importance of collaboration with IPV survivors in therapeutic settings, given the disempowerment and lack of autonomy within abusive relationships and the trauma that comes from it. Prioritizing client safety and autonomy throughout mental health therapy is an important component of trauma-informed care and can be emphasized through informed consent, providing opportunities to ask questions, and collaborating with clients in their treatment planning (Doyle et al., 2022). In the information article by Doyle et al. (2022), the authors noted that trauma-informed care with IPV survivors additionally includes considerations for client safety, such that the MHP should discuss the risks of sending literature home with the client or reaching out electronically to schedule appointments if the client remains in a relationship with their abuser. Safety planning promotes collaboration, emphasizes the MHP's investment in keeping their clients safe, while additionally empowering clients to seek safety when needed (Doyle et al., 2022).

Scheer and Poteat (2018) conducted a qualitative study, receiving surveys from 239 participants who identified as part of the LGBTQIA+ community and had experiences with IPV. The surveys inquired about the participants' experiences with TIC in therapy and the

subsequent outcomes, finding that while TIC was not associated with improved mental or physical health, it was related to increased feelings of empowerment, decreases in social withdrawal patterns, and improved emotional regulation. With respect to study limitations, the authors noted that some scales used in the survey provided issues with the answers and may have affected the interpretation of the answers. Furthermore, the mostly White sample, recruited through online servers, hindered the diversity of the answers as participants from other demographics may have differing perspectives. Overall, this study provided insight into the potential benefits of TIC and reinforced the importance of acknowledging and understanding the impact of trauma in mental health therapy.

These sources outline some of the important considerations to take when working from a trauma-informed stance with IPV survivors, emphasizing the importance of acknowledging the influence of trauma to build a strong therapeutic alliance and demonstrate safety to the survivors within the relationship (Doyle et al., 2022; Gutowski et al., 2022; Kulkarni, 2019; Scheer & Poteat, 2018). While these are helpful recommendations, some MHPs experience difficulty with fully incorporating these principles into their practice, whether from a lack of preparation to do so, bias, or other personal issues (Maghsoudi, 2018; Sutton et al., 2021; Vranda et al., 2022).

MHP Preparedness to Support IPV Survivors

IPV is a significant issue with rates that continue to increase annually and predominantly affect women and girls, with 30% of women over age 15 having experienced IPV (WHO, 2029; Statistics Canada, 2024); therefore, the chances of an MHP working with a client who has experienced IPV continue to increase. Receiving adequate training and experiencing feelings of self-efficacy significantly contribute to MHPs' perception of preparedness to work with IPV survivors (Burns et al., 2022; Vranda et al., 2022; Wilson et

al., 2021). Preparedness is defined as the level of confidence and readiness one feels in their ability to address certain issues (Alvarez et al., 2018; Forsdike et al., 2019; Taccini & Mannarini, 2023). For this capstone, preparedness refers to the readiness that MHPs perceive in their ability to work with IPV survivors in mental health therapy. This is often discussed in the literature as the knowledge MHPs have regarding IPV, their perceived ability to address the needs of IPV survivors, and their ability to assess risk (Alvarez et al., 2018; Burns et al., 2022; Forsdike et al., 2019). Preparedness has a significant impact on the therapeutic process and therapeutic alliance as it reflects the confidence that MHPs possess to work with these clients and contributes to comfort in having difficult, yet necessary, conversations with their clients (Vranda et al., 2022; Wilson et al., 2021).

In the qualitative study by Wilson et al. (2021). The authors interviewed 23 MHPs working at a mental health clinic in the United States (U.S.), inquiring about participants' perspectives on working with IPV survivors. The participants reported feeling self-doubt about their abilities to discuss IPV and suicide with survivors and to support them when such experiences were disclosed. Similar results were found by Burns et al. (2022), who surveyed 321 MHPs as part of a larger study, finding that only 53% of participants had reported receiving training specific to IPV. Vranda et al. (2022) found that 30 MHPs who received training in working with this population felt more prepared to do so after the training. The issue of generalizability was present in the quantitative study by Vranda et al. (2022), which was conducted at one location, and it cannot be assumed that the training interventions can be successfully applied to practitioners elsewhere without further research. Generalizability issues were additionally present in the study by Wilson et al. (2021) due to their small sample size, which also lacked cultural diversity. Despite these limitations, these studies together suggest the importance of having available training by noting that MHPs feel more prepared

to work with this population and address IPV-specific concerns in their clients when adequately trained.

MHPs are less likely to inquire about or discuss IPV experiences when they do not feel adequately trained to respond to disclosures of violence (Vranda et al., 2022). Furthermore, qualitative research with MHPs has demonstrated that clinicians who worry about offending clients and express feelings of discomfort about the topic of IPV are less likely to assess for such experiences with their clients (Forsdike et al., 2019). While MHPs are often concerned about retraumatizing clients by asking about past or current IPV-related experiences and do not feel prepared to respond to IPV disclosures, the research with IPV survivors indicates that many survivors want to discuss their experiences and rely on MHPs to broach the subject (Voth Schrag et al., 2021a). As such, when MHPs fail to openly communicate about this topic, they may inadvertently create more harm by implying that these behaviours and experiences should not be discussed, and contribute to the societal and internalized stigma that IPV survivors may experience (Forsdike et al., 2019; Voth Schrag et al., 2021a). Although MHPs appear to worry about negatively impacting their clients by asking about these experiences, survivors appear to believe that an MHP's ability to thoughtfully inquire and provide support with respect to their trauma history helps strengthen relationships and build trust (Sorrentino et al., 2021; Voth Schrag et al., 2021a). This indicates that when MHPs feel unprepared and lack knowledge about the experience of IPV survivors, it creates significant gaps in service delivery for meeting client needs (Forsdike et al., 2019).

Given the sensitive nature of IPV as a topic, MHPs are more likely to inquire about IPV experiences when they have higher confidence and self-efficacy for responding to disclosures of violence (Sutton et al., 2021). In the literature review by Sutton et al. (2021), the authors indicated that following IPV-specific training, MHPs reported feeling more

confident in their ability to conduct risk assessments and create safety plans with survivors. Learning about the specific experiences of IPV survivors and completing the training directly related to their needs created feelings of self-efficacy in therapists and subsequently improved their approach to their clients. Furthermore, Alvarez et al. (2018) conducted a qualitative study with 17 MHPs who work specifically with Latina IPV survivors, finding that the participants in their study were confident in inquiring about IPV and supporting the survivors; however, they were less prepared to conduct safety planning and risk assessment. Both studies demonstrated that a lack of confidence impacted MHPs' work with clients and that training and education in working with IPV survivors increased participants' feelings of preparedness to work with this population.

Building a Therapeutic Relationship

The development of a strong therapeutic alliance is essential when working with any client. Demonstrating acceptance of and empathy toward clients helps to develop a stronger connection with the client, further strengthening the therapeutic relationship (Zarzycka et al., 2022b). Special considerations should be taken when working with IPV survivors, as the experience of IPV may create attachment wounds, including fears of vulnerability, feelings of shame, and reduced self-esteem (st. Vil et al., 2021). This may create challenges in building therapeutic relationships with these clients and additionally demonstrates the importance of taking time to build a safe and supportive relationship with clients who have experienced trauma.

Trust

When working with IPV survivors, creating a safe environment where the client can trust that they can discuss traumatic experiences free of judgment is of the utmost importance (Voth Schrag et al., 2021a). In their qualitative meta-synthesis, Green et al. (2024) reviewed 38 studies, finding that clients from diverse cultures may struggle to build therapeutic

relationships with service providers due to a lack of trust in formal services. The authors indicated that this may be due to cultural differences between the provider and the client and a lack of understanding, as well as fear of consequences or judgment for reporting violence. Additionally, in a mixed-method study, Berry et al. (2024) found that from a service provider perspective, participants reported that client distrust of service providers was a significant barrier to seeking counselling or engaging with support services. Participants acknowledged the consequences that clients may expect to face when engaging with MHPs, such as disclosures of violence resulting in separation of the family and impacting the children. These studies demonstrated that MHPs view clients' fears of untrustworthy MHPs as a challenge that must be acknowledged and overcome when beginning therapy with their clients (Berry et al., 2024; Green et al., 2024).

Trust is one of the primary components of a therapeutic relationship and is essential for developing rapport and supporting clients in treatment, especially with IPV survivors (Messing et al., 2022). In their literature review analyzing 116 sources, Kennedy et al. (2024) determined that the three most common domains of trustworthiness that IPV survivors search for when determining the trustworthiness of an MHP are benevolence, fairness, and competence. MHPs who are deemed to be warm and caring, who provide accessible services, and who are competent to work with diverse demographics with a variety of modalities are more likely to be labelled as trustworthy by clients, who are then more likely to discuss their experience with IPV. Kennedy et al. (2024) further identified trauma-informed care as an essential component of benevolence that clients consider when assessing the trustworthiness of their MHP. Awareness of the trauma clients have experienced and the ability to develop a connection with the client through warmth and empathy are essential for creating a therapeutic relationship and building trust, as doing so communicates that the client is safe in the sessions with their MHP.

Institutional betrayal, which is defined by Smith and Freyd (2013) as an institution's failure to support survivors of a significant violation, such as sexual or physical violence, either directly or indirectly through policies, may influence a client's willingness to discuss or disclose IPV to an MHP (Kennedy et al., 2024; Lahav et al., 2025). Lahav et al. (2025) conducted surveys with 117 IPV survivors, finding that institutional betrayal has far-reaching effects, and those negative experiences may teach survivors that individuals in authoritative, power, or supportive positions are not safe to disclose their concerns to, nor will they receive help if they do disclose. While this study does not focus on MHPs, the findings of the effects of institutional betrayal demonstrate how barriers to trust are created and can be perceived by MHPs and survivors alike. Therefore, in their qualitative study with 57 participants, Messing et al. (2022) recommended starting slowly and assuring the clients that they are safe to discuss any of their needs without pressuring them to do so. The authors conducted 9 focus groups with the participants, finding that those interviewed consistently emphasized the importance of trust and creating a low-stakes environment to promote safety in discussing the clients' experiences. When trauma has occurred in some capacity for IPV survivors, either in personal relationships or within a larger environment, building trust takes time and must be approached with patience and care (Lahav et al., 2025; Messing et al., 2022).

Impact of Stigma and Bias

The presence of MHP stigma and bias is detrimental to any therapeutic relationship as it impedes the development of trust and safety (Maghsoudi, 2018). Stigma can be displayed through verbal and non-verbal behaviours and may be unintentional by the MHP; however, it is harmful when perceived by the client. In the literature review by Maghsoudi (2018), the author discussed the impact of MHP language, noting that placing blame or enacting judgment for returning to their partners can significantly hinder the therapeutic relationship. The authors found in their review that when MHPs fail to prioritize language that promotes

safety with their clients, the clients are more likely to feel judged or dismissed by their MHP. Using thematic analysis in their qualitative study with nine participants, Periyasamy et al. (2024) found that MHPs perceive judgement as a significant barrier for clients, noting that participants reported concerns that clients do not discuss or disclose their experiences with IPV due to worries about stigma or confidentiality.

Periyasamy et al. (2024)'s small sample size of nine MHPs is a significant limitation with respect to generalizability; however, the findings suggest the potential effect that worries about experiencing judgment from therapists have on IPV survivors when attending mental health therapy. An additional limitation to consider is that the research reviewed in the article by Maghsoudi (2018) was published as early as the year 2000, and it was not disclosed if the articles were peer-reviewed, suggesting that the literature included in this article may be outdated. Despite this, MHPs are often cautioned in literature that avoiding the topic of IPV out of fear of stigmatizing clients by inquiring about their experiences with IPV may cause further harm and perceptions of judgment by subliminally suggesting that IPV should not be discussed (Voth Schrag et al., 2021a). Therefore, MHPs need to be aware of their verbal and nonverbal communication to avoid contributing to these feelings of blame.

Although awareness of client self-blame and internalized stigma is essential, it is additionally important to consider the effects of societal stigma on IPV survivors (Kennedy & Prock, 2018). Cardenas (2024) additionally indicated that internalized stigma is influenced by the level of victim-blaming messages that clients are exposed to in their daily lives. The influence of stigma from larger, outside sources will impact a client's willingness to disclose or discuss IPV and may indicate the need for slow and intentional building of a therapeutic alliance. Awareness of such factors and cultural competency to work with clients from these backgrounds are important for building a therapeutic relationship, as failure to consider these

components may result in biased responses and stigma, preventing the development of trust and rapport (Kennedy et al., 2024; Maghsoudi, 2018).

Specific Challenges and Responsivity for Working with IPV Survivors

Population Considerations

Cultural competency is defined by Mollah et al. (2018) as valuing the diversity of clients who attend for mental health therapy and providing services that are culturally applicable to the clients who access them. The authors noted that culture influences mental and physical health, along with the steps clients take to address concerns that arise with their mental or physical health. In their qualitative study, the authors interviewed 20 MHPs from rural and urban settings on how they define cultural competency. Themes included acknowledging the influence of culture on beliefs and ideologies, such as gender roles and beliefs regarding mental health, as well as the effects language barriers have on services and the importance of having the ability to make such accommodations in the practice. While these ideas were seen as essential for creating therapeutic alliances with culturally diverse clients, limited funding or limited resources may present barriers for MHPs.

Asante (2024) used semi-structured interviews with 10 MHPs in Calgary, Alberta, to explore the experiences of those who work in a large Alberta city and work specifically with Black immigrant IPV survivors. Participants reported that while Calgary has numerous resources available for this population, many of the MHPs did not receive adequate training for supporting Black immigrant IPV survivors and many services are not tailored to the clients' specific needs. Specific concerns were noted regarding translation difficulties, with participants noting issues finding an interpreter, in addition to challenges with completing a therapy session through an interpreter. Despite the small sample from one city, the article illustrates the unique barriers that may be present for MHPs attempting to implement cultural competence into their practice. Furthermore, operational challenges are not the only

considerations for working with diverse clients, as differences in perspectives between MHPs and clients may also be challenges in building therapeutic alliances (Asante, 2024; Messing et al., 2022; Mollah et al., 2018).

Cultural beliefs and backgrounds have significant influences on how survivors view their own experiences with IPV and their engagement with MHPs (Cardenas, 2024). Messing et al. (2022) found in their qualitative study with 57 participants that some communities may hold beliefs that women are responsible for meeting specific standards in the home, and the male partner may be justified in engaging in violence when these expectations are not met. The authors noted that in societies where men hold power, women may face significant risks and consequences for reporting their IPV experience, such as retaliation from their male partner and his family, financial consequences, and the risk of separating the survivor from their children. These factors may prevent IPV disclosure and motivate clients to remain in these relationships; therefore, in such circumstances, MHPs express the importance of understanding their clients' cultural backgrounds and beliefs and approaching them in a culturally competent manner (S. Taylor et al., 2024). The results of the studies by Messing et al. (2022) and S. Taylor et al. (2024) emphasize the importance of learning about client perspectives to understand their specific cultural experiences. MHPs additionally expressed the importance of collaborating with available cultural resources, such as local newcomer community groups, to offer services tailored to clients (Asante, 2024; Mollah et al., 2018). While there may be logistical difficulties in providing culturally appropriate services in some communities, MHPs must listen to their clients' perspectives with curiosity rather than judgment to build rapport, create therapeutic alliances, and demonstrate that the client is safe to express their beliefs and values throughout the therapy process.

The primary limitation in many of the studies discussed in this section was the issue of generalizability, with many studies indicating low sample numbers, limited diversity

within their samples, or selecting participants from only one or two locations (Asante, 2024; Messing et al., 2022; S. Taylor et al., 2024). The sample from Messing et al. (2022), while large, was recruited through purposive sampling with intentional outreach to MHPs and potentially led to limited perspectives. S. Taylor et al. (2024) additionally recruited their sample several years before the study was completed from large cities in one American state. These limitations create issues with generalizability to a larger population, demonstrating the need for further research with more diverse population samples. To address this common limitation in their study, Mollah et al. (2018) used a diverse sample of 20 MHPs who work with diverse populations in their practice to examine the experiences of these MHPs. While this was a small sample, the diversity in the participants is a strength that provides a broader perspective.

In addition to cultural considerations, there are challenges specific to clients who are part of the LGBTQIA+ community that MHPs are aware of that impact the therapeutic process (Alston et al., 2021). Specifically, Alston et al. (2021) used a qualitative design and semi-structured interviews with 10 MHPs to explore their experiences working with the LGBTQIA+ community, finding that the compounding trauma related to the client's identity as part of the LGBTQIA+ community and previous negative encounters with service providers had a significant impact on help-seeking behaviours for this population. The authors additionally found that MHPs perceived systemic issues, such as a lack of LGBTQIA+-friendly or specific services, may influence a client's comfort in reaching out for mental health services. Similar results were seen in the qualitative study by Reed et al. (2024), where the MHP participants expressed concerns that some services do not appear to welcome LGBTQIA+ survivors who are not women or may not offer programming specifically for sexual and gender minority clients. Additional barriers noted by Alston et al. (2021) included the difficulty in identifying IPV in LGBTQIA+ relationships. This may

negatively impact the MHP's abilities to broach the subject of IPV due to heteronormative training and bias, possibly affecting the client's ability to identify IPV in their relationships as well.

Other findings by Reed et al. (2024) showed that MHPs are aware that some clients may not be open about their gender and sexual identity, which may influence their willingness to disclose IPV in their relationship for fear of being outed to the community. This may hinder rapport if clients do not believe that they are safe to discuss their identity and relationships and that their disclosures will remain confidential. This additionally indicates the need for MHPs to be open about their support for this community and partake in the appropriate training to be aware of the diverse needs and specific experiences of LGBTQIA+ individuals (Alston et al., 2021). While Alston et al. (2021) provided relevant recommendations based on their study, these results cannot be generalized to all MHPs who work with LGBTQIA+ clients due to the small sample size of 10, which was composed primarily of White female MHPs. Similar sample demographics were present in the Reed et al. (2024); therefore, it should be noted that additional barriers may be present for MHPs of colour, male, or those who are part of the LGBTQIA+ community themselves, that are not discussed in this article.

MHP concerns about working with IPV survivors are likely to be compounded by the challenges of working with clients who additionally have severe mental illnesses (Van Deinse et al., 2019). The participants in the qualitative study by Kozłowska (2020) expressed having difficulties with diagnosing Complex Post-Traumatic Stress Disorder (C-PTSD) and Post-Traumatic Stress Disorder (PTSD) in the survivors they were working with. Through semi-structured interviews with 6 participants, themes emerged that attributed this struggle to the lack of knowledge and training in recognizing how these disorders may manifest in the context of IPV. Having the appropriate knowledge and training is essential to working with

all clients, especially IPV survivors, to provide psychological support tailored to their individual experiences (Mengo et al., 2020).

Furthermore, MHPs interviewed in the qualitative study by Van Deinse et al. (2019) reported that they struggled to create therapeutic alliances with IPV survivors who additionally had mental health diagnoses due to the time it takes to establish trust with these clients. When screening IPV survivors for mental health conditions, service providers also reported concerns about labelling clients with a diagnosis and the risk of pathologizing normal trauma responses (Simmons et al., 2017). The risk of labelling and pathologizing client experiences may lead to perceptions of bias and stigma, ultimately rupturing the therapeutic relationship (Van Deinse et al., 2019) A recommendation from the study was for employers to provide specialized training to understand the nuances of working with this population. An individualized approach is also recommended when working with this population to determine the specific needs of each client, as the experience of mental health conditions may be a result of and affected by previous traumatic experiences or separate issues entirely (Toccalino et al., 2023; Van Deinse et al., 2019).

While the sample from the Kozłowska (2020) study limits the generalizability, the large sample of 62 MHPs in Mengo et al. (2020)'s qualitative study was selected from five different rural and urban agencies in one U.S. state, which is a substantial strength. Additionally, the qualitative study by Van Deinse et al. (2019) had numerous strengths, such as a relatively large sample of 28, selected from four different agencies and composed of various demographics. Together, these studies provide a comprehensive understanding of the challenges faced by MHPs who work with this demographic. MHPs seem to understand the barriers they face in making appropriate considerations or accommodations for clients, which are challenging to address regularly; however, these were further compounded by specific issues caused by the COVID-19 pandemic in 2020.

The Covid-19 Pandemic

The COVID-19 Pandemic created significant challenges for numerous sectors, especially how therapy is delivered and accessed (Williams et al., 2021). In their qualitative study, Williams et al. (2021) examined MHP experiences during the pandemic, and a significant challenge faced was the ability to form therapeutic relationships with IPV survivors through virtual appointments. The participants included 18 MHPs in Boston, Massachusetts, who reported difficulty building therapeutic alliances online, as well as concerns for client safety in their homes, and technological barriers for clients. Similar concerns were noted by the participants in the qualitative study by Fogarty et al. (2022), where the researchers conducted interviews with 5 clients and 14 MHPs. In their study, the MHPs reported that adaptations to building a therapeutic alliance included relying on tone of voice and facial expression rather than other non-verbal cues that may be more easily recognized in in-person appointments. As is common with qualitative studies, the small samples in these studies prevent generalization; however, do both suggest that while developing a therapeutic alliance may take longer through virtual sessions than in-person appointments, online services allow for greater accessibility for clients who may not have been able to attend in-person sessions (Fogarty et al., 2022; Williams et al., 2021).

Many MHPs expressed a desire to continue offering virtual sessions as an option for their clients post-pandemic, providing accessibility for those who may have difficulty accessing services due to transportation or funding (Williams et al., 2021). This flexibility may facilitate rapport building as it demonstrates a therapist's dedication to fairness and accessible services to clients (Kennedy et al., 2024); however, despite the flexibility of online formats, privacy concerns and issues regarding confidentiality were additionally noted by the MHPs in the study by Williams et al. (2021) as significant challenges when working with IPV survivors via virtual means. The lack of safe and confidential spaces, especially for IPV

survivors, may contribute to barriers such that the client may not feel safe to speak freely, and it becomes the MHP's responsibility to adequately safety plan and assess for risks to confidentiality during the session. Finally, Williams et al. (2021) found that the pandemic not only created changes in the therapy landscape for clients, but also the constant uncertainty and the influx of clients needing support added additional challenges with respect to strain and burnout for MHPs. While burnout is not a new phenomenon, MHPs reported experiencing it during the pandemic and impacted their ability to support their clients.

Burnout and Compassion Fatigue as Barriers for MHPs

Burnout is a significant issue experienced by MHPs and those in helping fields, characterized by emotional exhaustion, negative attitudes toward work, and low self-efficacy regarding their ability to make a difference (Yang & Hayes, 2020). Literature indicates that high workload demands and a lack of supervision or supervisor support contribute to the risk of burnout. In the literature review by Yang and Hayes (2020), the authors suggested that research on the effects of autonomy and control in one's job on the risk of burnout is mixed; however, they also noted this can be a result of different measures used between studies. They described limitations, such as including articles with conflicting results related to how clients progress in therapy when their MHP is burnt out, and additionally reported that one of the sources they included used questionable measures. This indicates that further qualitative research is required in this area to develop a more definitive understanding of the influence of MHP burnout on the therapeutic process with clients. While the development of burnout may vary depending on the research study and the participants, the effects of burnout have been shown to include feelings of helplessness and hopelessness in work, which may lead to the secondary experience of compassion fatigue (Lundy & Crawford, 2025; Voth Schrag et al., 2021b).

Compassion fatigue, defined as the reduced ability to support clients due to feelings of disengagement, is a common outcome when dealing with burnout (Voth Schrag et al., 2021b). This is significantly problematic when working with IPV survivors, such that compassion fatigue and burnout may lead to disengagement with the work and negatively impact client treatment outcomes (Delgadillo et al., 2018). It is suggested that disengagement leads to poorer treatment outcomes as it may impede an MHP's ability to demonstrate empathy to their clients and prevent the development of a positive therapeutic alliance (Delgadillo et al., 2018; Yang & Hayes, 2020). Delgadillo et al. (2018) conducted a qualitative study with 49 MHPs and clients, finding that lower MHP job satisfaction was associated with higher depression symptoms in clients, and suggested that MHPs who struggle at work may have impaired abilities to connect with their clients or fully engage with and support them during their treatment. The authors noted that they cannot infer causation due to the qualitative nature of the study, suggesting that poorer outcomes may influence MHP burnout rather than the other way around. They recommended future quantitative studies to determine causation, while additionally stating that burnout, although the effects of it remain inconclusive, is overall negative for the MHP.

Given the lack of concrete evidence of the impact of burnout on psychological progress for clients, more research is needed in this area. One conclusion that may be made is that burnout negatively impacts the experiences of MHPs at work, making it difficult to fully engage (Lundy & Crawford, 2025; Voth Schrag et al., 2021b; Yang & Hayes, 2020). While disengagement is not proven to cause negative effects for clients, the risk is that an MHP's inability to be present for their clients may impact the development of a therapeutic alliance. The absence of a therapeutic alliance will likely hinder the ability to develop trust, which is essential for IPV survivors (Kennedy et al., 2024). The risk of this occurring would be

detrimental to the clients and is worth taking steps to avoid for the sake of supporting clients in their therapeutic journey.

Client Treatment Engagement and Outcomes

MHP Perspectives on Survivor Treatment Engagement

MHPs indicated that successful outcomes from service engagement are more likely when services are tailored to the survivor's needs, providing information and prioritizing safety, along with empathic support and listening (Sullivan, 2018). In the qualitative study by Anderson and Overby (2020), the authors interviewed 19 MHPs who self-identified as survivors of sexual violence and work with IPV and sexual violence survivors, finding that minimizing barriers such as transportation, costs, and the need to take time off work supported their own engagement in services. The authors additionally found that fear of shame and retraumatization were significant barriers that could be mitigated through a trauma-informed approach. Despite the small sample size and participant selection from one city in the U.S., the inclusion of participants who worked as MHPs and were survivors themselves provided an in-depth look at both perspectives, demonstrating the fear of stigma, shame, and not being believed that is commonly experienced, even from individuals who work in a role of supporting survivors.

Using similar qualitative methods, Mengo et al. (2023) conducted a study to examine how both MHPs and IPV survivors determine successful therapeutic outcomes. Through semi-structured interviews with 53 survivors and 13 MHPs, the authors indicated that MHP answers mainly focused on the client's understanding of the impacts of abuse and recognizing when it is occurring, whereas, survivors primarily emphasized the development of personal strength and skills for coping with trauma. The authors noted that despite these differences, there were common themes of success that emerged from their semi-structured interviews with participants. The themes they found included acknowledging the journey,

establishing physical and psychological safety, being able to recognize abuse, positive outcomes such as improved mental health symptoms, coping skills, developing autonomy, personal achievement, and establishing hope and feelings of freedom. From an MHP perspective, clients face several barriers to participating in treatment. To address these barriers, they must collaborate with survivors to find an approach that meets their needs and supports ongoing treatment engagement (Anderson & Overby, 2020; Mengo et al., 2023; Sullivan, 2018). Furthermore, while MHP viewpoints are an essential component of this process, they can be supplemented by incorporating the perspectives of the survivors they aim to assist.

Survivor Perspectives on Treatment Engagement

From the perspective of IPV survivors in mental health counselling, Sorrentino et al. (2021) found that the primary aspects of therapy that created feelings of safety and a willingness to continue with treatment were MHPs who validated their experiences, listened with empathy, and tailored the treatment plans to meet their individual needs. Participants reported past negative experiences in therapy where they did not feel supported or understood by the MHP. In the qualitative study by Dichter et al. (2020), the authors used semi-structured interviews with 50 participants aged 45 and up, finding that trust was essential for IPV survivors to disclose their experiences to their MHP. Feelings of shame and embarrassment were also described as inhibitors to disclosing IPV; however, establishing a positive therapeutic alliance with an empathetic MHP made it easier to do so.

The use of sampling from two sites in the Veterans Health Administration (VHA) in the Sorrentino et al. (2021) and Dichter et al. (2020) studies may reduce the generalizability of the results due to the possibility of similar experiences and values from individuals engaging with these services. However, both studies had large sample sizes for qualitative studies, conducting semi-structured interviews with 50 participants, which is a strength that

improves the generalizability within that specific population. Based on these studies, IPV survivors who access care at the VHA need to believe that they are safe to tell their stories and feel that their MHP is attuned to their needs in order to build a therapeutic alliance and foster treatment engagement (Dichter et al., 2020; Sorrentino et al., 2021). This idea suggests that future research on this topic in diverse areas would be beneficial in determining survivor perspectives from various demographics.

Trust is a significant component of the therapeutic relationship from both the MHP and client perspectives (Dichter et al., 2020; Kennedy et al., 2024; Robinson et al., 2021). In their systematic review, Robinson et al. (2021) found a significant theme emerging in twelve of the articles they reviewed that distrust of MHPs due to fears of discrimination and worries of invalidation are significant barriers to treatment engagement for IPV survivors. IPV survivors are more likely to be willing to disclose and discuss their experience with violence when they believe their MHP genuinely cares about their well-being and believes their experiences (Dichter et al., 2020; Robinson et al., 2021). Furthermore, in the qualitative study by Voth Schrag et al. (2021a) the authors conducted interviews with 23 participants accessing services tailored to IPV survivors, who recommended that MHPs facilitate treatment engagement by listening to IPV disclosures, validating the clients and supporting them when they disclose, doing everything possible to ensure children remain with their parents, and providing information about IPV and IPV resources. Generalizability is again an issue in the Voth Schrag et al. (2021a) study, as the participants were selected from U.S. state; however, the diversity of the sample was otherwise beneficial. The articles discussed in this section reinforce that when MHPs take steps to meet their clients' needs, IPV survivors are more likely to continue with the therapeutic process.

While MHPs and survivors may have differing ideas of success in mental health therapy, the goal is to ensure the survivors can benefit from the treatment they are engaging

in (Sullivan, 2018). In the qualitative study by Skop et al. (2022), the authors interviewed 6 IPV survivors who participated in group art therapy, finding that participants reported their engagement in the group to be beneficial for forming connections, developing empowerment and resilience, and overall describing the treatment as an opportunity for healing.

Furthermore, Galovski et al. (2022) conducted a quantitative study, where the authors had participants who had previously been diagnosed with PTSD complete twelve sessions of Cognitive Processing Therapy in one week or over twelve weeks, finding that those in both interventions experienced reduced PTSD symptoms. Despite the limitation of small sample sizes for both studies, the results highlight the potential benefits of treatment engagement for clients and the need for MHPs to overcome the challenges they face in supporting them.

Ethics

Ethical considerations are of the utmost importance in research. The Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans [TCPS 2] (2022) outlined the expectations and principles when engaging in research. The first principle, respect for persons, describes the importance of participant autonomy through informed consent. This is additionally a component of the Canadian Psychological Association [CPA] (2017) Code of Ethics Principle I: Respect for the Dignity of Persons and Peoples. These principles specify the importance of researchers or MHPs taking steps to ensure participants and clients are aware of the process, risks, and benefits (CPA, 2017; TCPS 2, 2022). Many articles included information about their informed consent process, which included providing and discussing consent forms with information about the studies with participants (Anderson & Overby, 2020; Heron et al., 2022; Lundy & Crawford, 2025; Skop et al., 2022; st. Vil et al., 2021; Voth Schrag et al., 2021a). Other studies conducted an oral informed consent process, where the risks and benefits were discussed verbally (Berry et al., 2024; Messing et al., 2022).

Alternatively, some studies did not include information about their considerations of ethics or

how they maintained participant autonomy (Burns et al., 2022; Dichter et al., 2020; Mengo et al., 2023; Van Deirse et al., 2019), which raises questions about why this information was not included and reinforces the importance of discussing ethical procedures to minimize bias and clarify all steps taken in the studies.

Lundy and Crawford (2025) described significant ethics compliance, describing the approval from the university ethics review board and how the researchers remained neutral. The authors indicated that the researchers summarized interviews, which were then debriefed with peers, and a second researcher reviewed the transcripts. This provided opportunities to discover and mitigate biases. Kozłowska (2020) additionally included an in-depth description of ethical compliance, noting that the clinic supervisor provided approval before researchers began recruiting participants, and all researchers were briefed on the ethical obligations of MHPs to ensure these were upheld during the interviews. Bias is inherent when reviewing qualitative interviews; therefore, steps such as defining themes objectively and purposefully acknowledging where biases may exist may also assist in reducing the effects of bias (Alston et al., 2021). These approaches were beneficial and followed the TCPS 2(2022) principle of respect for persons, given that steps were taken to reduce bias and researchers were aware of ethical obligations before beginning their research with participants, thus ensuring all parties were given the relevant information before proceeding.

The second TCPS 2 (2022) principle, concern for welfare, outlines the importance of prioritizing the well-being of participants during the research process. Privacy and confidentiality are significant components of participant welfare and are essential for individuals participating in research. Many authors described the steps taken to ensure the confidentiality of participants, such as creating pseudonyms, assigning numbers to participants instead of names, collecting minimal identifying information, or not collecting identification information at all (Berry et al., 2024; Heron et al., 2022; Reed et al., 2024;

Sorrentino et al., 2021; Voth Schrag et al., 2021a). Given the participants in the discussed studies are MHPs who work with IPV survivors or IPV survivors themselves, privacy and confidentiality are especially important.

Participant welfare is particularly important when the research topic includes sensitive information, such as IPV. Awareness of the distress that may arise in discussing experiences of IPV or working with IPV is essential, and it is the researcher's responsibility to support participants if this occurs (TCPS 2, 2022). To do so, researchers provided opportunities to debrief the interviews with participants and provided information for mental health resources (st. Vil et al., 2021). Furthermore, other researchers recognized that barriers such as childcare may be present for participants and subsequently offered childcare to remove such barriers (Anderson & Overby, 2020). These practices align with CPA (2017) Principle II: Responsible Caring, which emphasizes maximizing benefits and minimizing harm to clients. The promotion of ethics and well-being in research additionally encourages the readers to follow similar practices when applying the findings to their personal practices (Forsdike et al., 2019; Periyasamy et al., 2024; Reed et al., 2024; S. Taylor et al., 2024).

The final TCPS 2(2022) core principle, justice, involves treating all individuals who are involved in the research process fairly. The TCPS 2 (2022) mentions a history of inequity in research through the exclusion of marginalized communities from research participation, which reduces the common knowledge that MHPs may have about working with these communities. Therefore, studies that examine the experience of communities such as immigrants, LGBTQIA+, and individuals from non-dominant cultural backgrounds (Alston et al., 2021; Messing et al., 2022; S. Taylor et al., 2024) are helpful for the development of an MHP's practice, providing them with information that may assist them in working with clients from these demographics.

Chapter Three reviewed the available literature on MHPs' understandings of the challenges of building therapeutic alliances with IPV survivors in mental health therapy and how this impacts the treatment process. A trauma-informed perspective was used to engage with the literature, incorporating the understanding of trauma experienced by IPV survivors and how this may influence the therapeutic alliance and subsequent treatment engagement. The literature review demonstrated that trauma and trust significantly impact the development of a therapeutic relationship, with significant impacts on a client's decision to disclose violence or continue with mental health treatment.

Despite the resources that were available on MHPs' perspectives of working with IPV survivors in therapy, there were far more available sources discussing the survivor perspectives on therapy and working with MHPs. While there was enough literature to review in the current chapter, this indicates there remains a gap to be filled regarding MHPs' perspectives on the challenges faced by IPV survivors in mental health therapy. Furthermore, numerous studies included small sample sizes with participants selected from a limited number of locations (Alston et al., 2021; Asante, 2024; Fogarty et al., 2022; Kozłowska, 2020; Periyasamy et al., 2024; st. Vil et al., 2021; S. Taylor et al., 2024; Vranda et al., 2022; Wilson et al., 2021). This indicates the need for larger studies to obtain a more generalized understanding of MHP perspectives or additional smaller studies to gain a deeper understanding of the experiences of MHPs from a wide variety of locations. Finally, only one study compared the perspectives of MHPs and IPV survivors to identify gaps or alignments in perspectives (Mengo et al., 2023), which demonstrates the need for additional studies to compare the perspectives and experiences.

Summary of Chapter 3

In this chapter, I have referred to a variety of sources that have addressed the perspectives of MHPs working with IPV survivors in mental health therapy, their perceived

challenges of creating therapeutic alliances with IPV survivors, and the subsequent effects on client treatment engagement. From the perspectives of MHPs and clients, building trust and rapport when working with IPV survivors is seen as the most important aspect of therapy (Kennedy et al., 2024; Messing et al., 2022). Despite this, therapists perceive several barriers in facilitating therapeutic alliances with IPV survivors due to fears of contributing to their trauma experiences, concerns about trust, and worries about stigmatizing the clients due to their experiences (Sutton et al., 2021). There are barriers they see as specific to certain communities, such as the understanding that individuals from diverse cultures may distrust MHPs, and concerns about the compounding trauma of IPV and the identity of being part of a marginalized community (Alston et al., 2021; Green et al., 2024; Reed et al., 2024). MHP-specific barriers, such as burnout and compassion fatigue, additionally function as barriers to forming a therapeutic relationship with clients, which may in some way affect the client's willingness to continue working with that provider (Delgadillo et al., 2018; Voth Schrag et al., 2021b; Yang & Hayes, 2020). Finally, MHPs have been shown to believe that working at a pace tailored to the individual client and demonstrating warmth and empathy is the best way to build a therapeutic relationship, which appears to align with the reported needs of survivors themselves (Anderson & Overby, 2020; Kennedy et al., 2024; Mengo et al., 2023; Robinson et al., 2021; Sullivan, 2018). Meeting the needs of feeling heard, understood, and supported appears to facilitate continued treatment engagement from the perspective of both MHPs and survivors.

In Chapter Four, I will discuss how MHPs can apply the findings of the current literature review in their clinical practice. I will review and summarize the themes discussed in Chapter Three to identify how they can be incorporated into practice and provide recommendations for MHPs to improve such practices. The discussion will additionally

include how a trauma-informed approach can be used to facilitate therapeutic alliances with IPV survivors in mental health therapy and support them in their mental health journey.

Chapter 4: Discussion and Application to Clinical Practices

The purpose of this study has been to examine the perspectives and experiences of MHPs who work with IPV survivors in mental health therapy and the challenges they experience with respect to building therapeutic alliances. In doing so, it was additionally important to question how these challenges influence the IPV survivor's continued involvement and progression in therapy. It was important to explore the perspectives of MHPs due to the lack of research specifically addressing their experiences and understanding of the complicated issue of IPV and working with those who have experienced it (Wilson et al., 2021). While a significant amount of research has been conducted on the perspectives of survivors, there has been a lack of research on those who work with them (S. Taylor et al., 2024). To address this, the research question that guided this capstone was "*What challenges do MHPs perceive in forming therapeutic alliances with IPV survivors, and how do these challenges impact treatment engagement?*" In this chapter, I will outline the key findings and answers found for the research question, analyze the results, discuss the applications of the findings, and provide recommendations for future practice.

Review of Research Findings

Emerging Themes

The literature reviewed in Chapter 3 identified five themes to answer the first component of the research question and explore the challenges that MHPs face in forming therapeutic alliances with IPV survivors: Trauma Informed Care, MHP preparedness, therapeutic alliances, specific challenges, and burnout and compassion fatigue in MHPs. These themes were discussed in further detail through four sub-themes: trust, the influence of stigma and bias, population considerations, and the challenges of the COVID-19 pandemic. The first theme of Trauma-Informed Care (TIC) examined the importance of considering trauma experiences when working with IPV survivors in mental health

therapy. TIC is described by Hopper et al. (20210) as a strengths-based approach that acknowledges the impact of trauma on clients and encourages providers to acknowledge how a client's behaviours and symptoms are manifestations of their trauma. This approach emphasizes empowering clients to move forward from their traumatic experiences while additionally creating psychological safety for both the client and the service provider. From this perspective, failure to recognize the presence of trauma in clients' lives may put the client at risk of retraumatization and limit their opportunities for progress in therapy (Isobel et al., 2021). Not only does trauma-informed care focus on the presence and effects of trauma, but it additionally emphasizes the importance of gender and cultural responsiveness, recognizing how a client's identity influences their experience in the world (Gutowski et al., 2022). Providing a safe space for clients to discuss their experiences is the most important job of a trauma informed MHP.

The theme of MHP preparedness explored MHP perceptions of their readiness to work with IPV survivors, with participants in many studies reporting they did not feel prepared to address concerns related to IPV (Burns et al., 2022; Forsdike et al., 2019; Vranda et al., 2022; Wilson et al., 2021). Disclosures of IPV are seen as daunting, as there are many considerations for the MHP, such as client safety, children's safety, and expectations to report or risk of future harm. The MHPs interviewed in several studies expressed a lack of knowledge about responding to such disclosures and a fear of handling them incorrectly, which subsequently damaged the therapeutic alliance with clients and prevented them from meeting the needs of the clients they served (Sutton et al., 2021; Vranda et al., 2022; Wilson et al., 2021). This theme demonstrated that preparing to work with IPV survivors is a challenge that many MHPs face, noting that the lack of preparedness creates barriers in forming therapeutic alliances with clients.

Throughout the literature on therapeutic alliances, trust was identified as a sub-theme and the foundation of a therapeutic alliance. Trust is deemed to be essential for a therapeutic alliance from both the perspectives of survivors and MHPs, with findings that indicated trust is paramount to survivors disclosing and discussing their experiences with IPV (Kennedy et al., 2024; Robinson et al., 2021; Sorrentino et al., 2021). Safety and trust are established in the therapeutic context through MHPs' displays of empathy, understanding, and support, which also help maintain treatment engagement (Kennedy et al., 2024). While trust was found to be essential for developing a therapeutic alliance, it was also determined that it is challenging to develop to IPV survivors' experiences with betrayal in their relationships and potential difficulties with other MHPs or services (Green et al., 2024; Lahav et al., 2025). If IPV survivors do not believe they can trust their MHP, they are unlikely to share their experiences and more likely to discontinue their therapeutic services.

Stigma and bias were identified as a sub-theme under the challenges of building therapeutic alliances, with some studies finding that the presence of such behaviours significantly hinders the therapeutic relationship (Maghsoudi, 2018; Periyasamy et al., 2024). Many authors described the experiences of IPV survivors experiencing judgment or having their concerns minimized by MHPs, or the worries of experiencing such issues (Cardenas, 2024; Kennedy & Prock, 2018; Voth Schrag et al., 2021a). Client fears of experiencing stigma or bias from their MHP are a hurdle for MHPs to overcome, such that it becomes the MHP's responsibility to demonstrate their objectivity and willingness to work with the client (Kennedy et al., 2024; Maghsoudi, 2018; Messing et al., 2022). Furthermore, as trust is established through MHP understanding and empathy, the client may be more willing to share their experiences with less fear of judgment (Berry et al., 2024; Kennedy et al., 2024).

An additional theme that arose included the responsibility considerations made for clients. Within this theme, the sub-themes of working with specific populations and how MHPs supported their clients throughout the COVID-19 pandemic emerged as well. The articles that developed these themes outlined the challenges that MHPs have reported with respect to working with individuals from marginalized communities, such as the lack of resources that prioritize cultural inclusivity and insufficient understanding of non-dominant cultures (Asante, 2024; Mollah et al., 2018). Furthermore, concerns for working with IPV survivors from the LGBTQIA+ community included the lack of help-seeking behaviours from individuals of this population due to histories of trauma with healthcare providers (Alston et al., 2021; Anderson & Overby, 2020; Reed et al., 2024). The underlying component of these considerations is the building of trust, which MHPs can strengthen through the understanding of client intersectionality and the various elements of their identities, along with providing adaptations to provide services such as online or telephone appointments, which were popularized during the pandemic (Fogarty et al., 2022; Williams et al., 2021). Acknowledging the trauma that accompanies association with marginalized communities and providing a safe space to discuss these experiences, along with their experiences of IPV, is crucial to creating trust and continuing to engage clients from these demographics (S. Taylor et al., 2024).

A final theme that emerged with respect to challenges was the experiences that MHPs have with burnout and compassion fatigue when working with IPV survivors. These challenges were specific to the MHP perspective as they arise when the MHP does not have adequate supports for their own mental health when working with vulnerable clients who have traumatic histories (Delgadillo et al., 2018; Lundy & Crawford, 2025). Burnout has a significant impact on the MHP's ability to provide support and therapeutic services to their clients; however, there appears to be room for additional research on how this

impacts the client experience and treatment engagement (Yang & Hayes, 2020). The impact of MHP burnout on client treatment engagement may be a direction for future researchers to explore, providing a more concrete understanding of this experience.

To answer the second component of the research question of how these challenges affect client treatment engagement, the research was separated into two themes: MHP perspectives and client perspectives. From the MHP perspective, success is defined as recognizing patterns of abuse and unhealthy relationships, while the client perspective describes success as empowerment, agency, and coping skills (Mengo et al., 2023). Despite these differences, both MHPs and survivors alike agree that trust must be established to form a therapeutic alliance (Kulkarni, 2019; Mengo et al., 2023). While MHPs and clients may have differing perspectives on the goals and success of mental health therapy, the research is consistent in indicating that progress is more likely from both perspectives if the previously discussed barriers are overcome (Maghsoudi, 2018; Mengo et al., 2023; Sullivan, 2018). MHPs have reported that when they are prepared, non-judgmental, and understanding of the clients' circumstances, the clients are more likely to engage in treatment (Sullivan, 2018). Finally, researchers who observed the benefits of attending mental health therapy found reductions in mental health symptoms such as anxiety, depression, or PTSD (Galovski et al., 2022; Skop et al., 2022), demonstrating the benefits of clients engaging with mental health treatment and the importance of building therapeutic alliances with clients.

Many of the studies reviewed in this manuscript were qualitative studies, which is beneficial as such methodologies provide a direct understanding of participant experiences through interviews and surveys; however, the small sample sizes used in qualitative studies prevent generalizing the results to the overall population (Creswell & Creswell, 2022). While some studies were conducted in locations such as Canada, India, Australia,

Africa, and England, most of the studies were conducted in the United States in one city or even at one clinic, which severely limits generalizability (Anguzu et al., 2023; Asante, 2024; Forsdike et al., 2019; Kozłowska, 2020; Lundy & Crawford, 2025; Vranda et al., 2022). This indicates the need for larger studies in diverse locations with larger, more diverse samples to gain a deeper understanding of the experiences of MHPs from various social locations. With more studies completed in a variety of locations, we can begin to gain an understanding of the general experience for MHPs working with IPV survivors and reduce biases that emerge from using samples with limited diversity.

Discussion of Research Findings Application to Practitioners

The topic of this capstone examines the challenges faced by MHPs in developing therapeutic alliances with IPV survivors and how these challenges impact survivor treatment continuation. As noted above, the most significant challenges for MHPs include establishing trust, client histories with stigma, bias, and trauma or considerations related to their identities, and MHP-specific challenges such as burnout (Alston et al., 2021; Berry et al., 2024; Cardenas, 2024; Messing et al., 2022; Reed et al., 2024; S. Taylor et al., 2024; Van Deirse et al., 2019; Yang & Hayes, 2020). Trust was shown to be necessary for building a strong therapeutic relationship with IPV survivors, which can be developed through MHP confidence to address client concerns and provide them with adequate resources following IPV disclosures (Kennedy et al., 2024). The development of trust was additionally reported to be hindered by the presence of stigma toward IPV survivors, with many articles indicating that MHPs have reported that IPV survivors are less likely to disclose their experiences if they perceive judgment from their MHP (Cardenas, 2024; Maghsoudi, 2018).

A surprising result related to MHP perceived challenges with IPV survivors was that participants in many studies expressed feeling unprepared to respond to disclosures of IPV, nor did they feel prepared to support IPV survivors due to the complex nature of IPV (Sutton

et al., 2021). Given that IPV continues to become more prevalent on an annual basis (Government of Canada, 2025; Statistics Canada, 2024), it is surprising that MHPs are not confident in their abilities to support survivors, especially those from marginalized communities. This challenge impacts treatment engagement, as IPV survivors in various studies reported they felt stigmatized and unsupported by MHPs who did not inquire about IPV experiences or provide opportunities to discuss their experiences, ultimately resulting in higher risks of discontinuing treatment (Dichter et al., 2020; Forsdike et al., 2019; Robinson et al., 2021; Voth Schrag et al., 2021a). This demonstrates the importance of offering MHPs appropriate education and training specifically related to supporting IPV survivors to increase their confidence, create feelings of empathy, and create a supportive therapeutic environment for these clients (Forsdike et al., 2019; Sutton et al., 2021; Voth Schrag et al., 2021a; Vranda et al., 2022; Wilson et al., 2021). Despite the issues with generalizability in the qualitative studies, many studies indicated that MHPs expressed similar concerns regarding preparedness, suggesting that this is an issue worth continuing to explore and mitigate by offering additional support for MHPs working with this population.

The results found in this study align with the concerns related to a Trauma-Informed Care (TIC) perspective. As discussed in Chapter 3, TIC is the practice of acknowledging how far-reaching the effects of trauma can be, specifically that many behaviours and thought patterns may be responses to trauma (Isobel et al., 2021). This perspective allows MHPs to develop a deeper understanding of their clients who have experienced IPV, such that their experiences with trauma within their relationships impact the formation of a therapeutic alliance and intersect with traumatic experiences in other areas of their lives, creating challenges that are specific to the individual client (Kulkarni, 2019). The results of this study demonstrated the importance of developing trust through empathy,

compassion, creating individualized treatment plans, and acknowledging the connection between trauma from IPV and group or cultural identification with mental health.

Recommendations for Practice

Building a therapeutic alliance is a process that takes time to develop and depends on the qualities of the MHP and the client (Zarzycka et al., 2022b). As discussed throughout this chapter, many factors contribute to a therapeutic alliance, such as trust, empathy, cultural considerations, and avoiding judgment. Trust is not earned in one session, and it may take time for clients to trust their MHP; therefore, the first recommendation for MHPs is to work at a pace that the client is comfortable with and to take the time to demonstrate their trustworthiness (Doyle et al., 2022; Kennedy et al., 2024; Messing et al., 2022). Individuals who have experienced violence within their relationships have experienced relationship trauma, which can affect the development of a therapeutic alliance and must be considered in the early stages of therapy (Lahav et al., 2025). Furthermore, given the diversity of clients presenting for mental health therapy, learning about their personal and cultural backgrounds will help develop trust, as doing so demonstrates the MHP's willingness to understand their clients and provides opportunities to build connections (Berry et al., 2024; Green et al., 2024; Messing et al., 2022). Additionally, acknowledging how these aspects of client identities come with separate trauma experiences will assist MHPs in creating a treatment plan specific to their clients' needs (Gutowski et al., 2022).

A significant challenge that was noted within the literature was MHPs' perceived lack of preparedness to work with IPV survivors and respond to IPV disclosures (Burns et al., 2022; Vranda et al., 2022; Wilson et al., 2021). This creates a significant issue in mental health therapy as MHPs are less likely to inquire about IPV or allow for further discussions surrounding IPV when they do not feel confident in their abilities to address IPV, thereby failing to address the needs of the client. To address this, the second recommendation is for

MHPs to attend training specific to IPV and for education programs to offer information about working with IPV survivors in mental health therapy. Formal education will allow MHPs to learn about the prevalence, warning signs, different types, and ways to respond and support survivors who disclose experiences with IPV (Alvarez et al., 2018; Sutton et al., 2021; Wilson et al., 2021). Having a strong understanding of IPV may additionally provide MHPs with the confidence to inquire about IPV experiences with survivors, demonstrating their competence to address the clients' needs (Forsdike et al., 2019; Sutton et al., 2021; Vranda et al., 2022; Wilson et al., 2021). Furthermore, learning about IPV-specific resources in the community, especially any resources that cater to specific populations such as cultural groups or LGBTQIA+ individuals, will assist MHPs with supporting IPV survivors, as it will demonstrate the MHP's knowledge and preparation for such concerns (Alston et al., 2021; Asante, 2024; Reed et al., 2024).

Stigma and bias are significant barriers to creating therapeutic alliances with IPV survivors (Maghsoudi, 2018); therefore, learning to identify and manage one's own biases as an MHP will be essential for developing such relationships. To address this, my recommendation for MHPs is to consult with supervisors or colleagues when they experience countertransference reactions to clients in session, which will help to identify and explore any biases or stigma that may be present. It is of the utmost importance for MHPs to be aware of their biases to prevent them from influencing their work with clients who are seeking support (Cardenas, 2024; Maghsoudi, 2018; Periyasamy et al., 2024; Voth Schrag et al., 2021a).

In a similar vein, self-awareness and monitoring are essential when considering burnout. MHP burnout is common when working with vulnerable populations, specifically IPV survivors, which demonstrates the importance of supports for those who work with this clientele (Yang & Hayes, 2020). The final recommendation is for employers to provide their employees with connections for mental health support, opportunities for debriefing after

difficult sessions, and to emphasize the importance of balance and self-care in the workplace (Lundy & Crawford, 2024, 2025). Furthermore, MHPS need to be aware of their mental health state, seek support from employers or colleagues, and engage in their own mental health therapy and self-care to prevent or minimize the risk of burnout (Delgadillo et al., 2018; Lundy & Crawford, 2024, 2025).

Summary of Chapter 4

In chapter 4, I reviewed the themes that emerged from the literature review in chapter 3, specifically the themes of therapist preparedness to work with IPV survivors, the role of trust, stigma, and bias in the therapeutic relationship, therapist burnout, and IPV survivor treatment engagement. The results of this study are directly applicable to MHPs who work with IPV survivors, as they demonstrate the importance of the therapeutic alliance and taking steps to develop trust with IPV survivors in mental health therapy. The recommendations based on the results of the literature review included working at the survivor's pace and taking the time to learn about their individual background, MHPs taking specific training related to IPV and working with IPV survivors, MHPs learning to identify and manage their biases concerning IPV and IPV survivors, and finally engaging in strategies to mitigate the risk of burnout. By making these changes, MHPs can reduce the challenges they notice for IPV survivors in mental health therapy, making the process less daunting and more accessible for clients. By following the recommendations to maintain self-care as MHPs, they can be better prepared to support their clients.

The following chapter will review the major findings and discuss the take home messages of this capstone. I will then outline my recommendations for future research, examining research questions that will be beneficial for future studies and potential methodologies to address the limitations of the research discussed in the literature review. Finally, I will conclude the capstone with a personal reflection on the lessons I personally

learned throughout the research process, and how I plan to apply these findings to my professional practice.

Chapter 5: Conclusions and Recommendations

This review explored the current literature on the perspectives of MHPs on the challenges they face when working with IPV survivors in mental health therapy to develop therapeutic alliances and how these challenges impact survivor participation in therapy. The purpose of this research was to identify and understand the perspectives of MHPs who work with this population and the challenges they face in building therapeutic alliances and promoting treatment engagement for this population. In addition to this objective, the study's goals were to provide insight for MHPs into the common challenges they face and how to overcome them to support their clients. This topic arose out of the need for additional research on MHP perspectives. A significant amount of research has been conducted to examine the perspectives of survivors (Barrios et al., 2021; Cardenas, 2024; Dichter et al., 2020; Sorrentino et al., 2021; st. Vil et al., 2021); however, there have been a limited number of studies investigating MHP experiences (S. Taylor et al., 2024; Wilson et al., 2021). The research question to be addressed was: *“What challenges do MHPs perceive in forming therapeutic alliances with IPV survivors, and how do these challenges impact treatment engagement?”*

This chapter will summarize the findings of the literature review, identifying the themes and discussing the important messages from this study. I will detail the take-home message, based on which I will provide recommendations for clinical practice for MHPs working with this population. Finally, I will suggest recommendations for future research directions, identifying potential research questions and methods to address the limitations of the studies discussed in the literature review.

Study Summary

IPV is a diverse phenomenon that becomes more diverse and prevalent each year, with IPV rates increasing by 13% between 2018 and 2023 (Government of Canada, 2024).

The effects of IPV not only include physical harm, but also financial, emotional, and psychological harm (Statistics Canada, 2024; World Health Organization, 2022). While many IPV survivors may not seek assistance for leaving an abusive relationship due to concerns for their well-being, the impact on their family, or the risk to their reputation, income, or livelihood, many seek support to address their mental health concerns and experiences with trauma (Anguzu et al., 2023; Lee et al., 2021). Given the rates of IPV in Canada, MHPs are likely to work with clients who have experienced IPV in their lifetime (Kahraman & Bell, 2017; Lee et al., 2021); therefore, this study explored the challenges that MHPs face when working with this population. Developing therapeutic alliances with survivors of IPV can be difficult due to their history of betrayal in relationships and the trauma of violence; however, it is essential for effective treatment (st. Vil et al., 2021). The literature review compared the current research on the perspectives of MHPs that work with IPV survivors in mental health therapy to determine the challenges they face and how these challenges influence survivor treatment engagement.

Using the thematic framework method, a total of six themes with six subthemes were found in the literature. The first five themes answered the first component of the research question, examining the challenges faced by MHPs in building therapeutic alliances with IPV survivors. These themes included Trauma- Informed Care, MHP preparedness to work with IPV survivors, building a therapeutic alliance, responsivity to specific client issues, and the impact of MHP burnout (Alston et al., 2021; Alvarez et al., 2018; Burns et al., 2022; Forsdike et al., 2019; Kennedy et al., 2024; Maghsoudi, 2018; Periyasamy et al., 2024; Reed et al., 2024; st. Vil et al., 2021; Van Deinse et al., 2019; Vranda et al., 2022; Wilson et al., 2021; Zarzycka et al., 2022a; Zarzycka et al., 2022b). Sub-themes of trust, the effects of stigma and bias on the therapeutic relationship, population considerations, and the COVID-19 pandemic also emerged (Asante, 2024; Berry et al., 2024; Delgadillo et al., 2018; Fogarty et

al., 2022; Messing et al., 2022; Mollah et al., 2018; S. Taylor et al., 2024; Voth Schrag et al., 2021a; Williams et al., 2021; Yang & Hayes, 2020). The fifth theme was client treatment engagement and outcomes, which was separated into the sub-themes of MHP perspectives and survivor perspectives (Anderson & Overby, 2020; Dichter et al., 2020; Mengo et al., 2023; Sorrentino et al., 2021). These themes were viewed from an Attachment Theory framework, which emphasizes relationships with attachment figures, and explains how trauma can influence an individual's behaviours, relationships, and perspectives (Bowlby, 1969; st. Vil et al, 2018). Based on this lens and the emerging themes, I determined that trust was one of the most essential components of a therapeutic alliance that facilitated treatment engagement from the perspectives of both MHPs and survivors; however, it was also the most challenging to establish (Dichter et al., 2020; Kennedy et al., 2024; Messing et al., 2022; Robinson et al., 2021; Voth Schrag et al., 2021a).

This is a problem that needs to be researched because it is important to ensure that steps are taken to provide the best possible care to IPV survivors in mental health therapy. It is additionally important to be aware of the barriers that MHPs face and support them in overcoming such challenges to provide the best treatment they can. By identifying the challenges and how they impact treatment engagement, patterns emerged that hinder or support the therapy process. To determine the impact on treatment engagement, it was important to consider survivor perspectives and whether their perspectives align with those of MHPs, as misaligned ideas of goals and challenges may make it difficult to find success in therapy (Mengo et al., 2023). The findings in this study showed that MHPs and survivors may have differing definitions of success; however, they appeared to agree that the main challenge to overcome was building trust (Berry et al., 2024; Kennedy et al., 2024; Mengo et al., 2023; Messing et al., 2022; S. Taylor et al., 2024). Trust is the foundation of a therapeutic alliance and is influenced by many factors, such as MHPs' abilities to support their clients,

cultural competence, and burnout (Alston et al., 2021; Anderson & Overby, 2020; Asante, 2024; Green et al., 2024; Lundy & Crawford, 2025; Mengo et al., 2023; Messing et al., 2022; Mollah et al., 2018; Sullivan, 2018; Voth Schrag et al., 2021b; Wilson et al., 2021; Yang & Hayes, 2020; Zarzycka et al., 2022b). My goal with this study was not only to identify challenges for MHPs but also to provide insight to MHPs about these common barriers in working with this population and ways to overcome them.

Take Home Message

Trust was a prominent theme throughout the research and was found to be an underlying component of the remaining themes, as the development of trust is affected by MHP preparedness, stigma, bias, and cultural considerations (Kennedy et al., 2024). Preparedness refers to the MHP's ability to assess for IPV experiences and the risk level, inquire about such experiences, and respond to IPV disclosures (Alvarez et al., 2018; Burns et al., 2022; Forsdike et al., 2019; Vranda et al., 2022; Wilson et al., 2021). When MHPs are not prepared to support clients with their needs, express judgment, or lack insight into supporting individuals from marginalized communities, clients are less likely to feel the trust that is necessary to disclose and discuss their trauma (Kennedy & Prock, 2018; Kennedy et al., 2024; Messing et al., 2022; S. Taylor et al., 2024). As such, it is of the utmost importance that MHPs have appropriate education that prepares them to work with IPV survivors (Sutton et al., 2021; Wilson et al., 2021). By offering specialized training for working with IPV survivors and additional courses on IPV, MHPs may begin to feel more comfortable asking about IPV with their clients and feel empowered to support clients with such experiences, preventing further stigmatization (Todahl et al., 2020). MHP's comfort level with discussing IPV will indicate to clients that it is safe to discuss their experiences in sessions, allowing for trust to develop (Forsdike et al., 2019; Voth Schrag et al., 2021a).

In Canada, services are available for IPV survivors, such as non-profit organizations, shelters, support groups, and supportive workers, such as social workers or MHPs; however, many of these services are designed for general populations and lack culturally specific support or emphasis on cultural sensitivity (Asante, 2024). Cultural sensitivity involves MHPs adapting to their clients' needs and accounting for differences between themselves and their clients (Mollah et al., 2018). To create a culturally welcoming environment, Mollah et al. (2018) noted that those in higher positions, such as employers or managers, must demonstrate cultural competence and foster it within their staff. The authors suggested actions like hiring diverse MHPs who speak multiple languages as steps to make services more accessible to clients. They further suggested that when management promotes diversity, acceptance, and education, MHPs are more likely to exhibit these behaviours and seek to understand their non-dominant clients better, creating relevant treatment plans. This ensures that MHPs are working in accordance with the Canadian Psychological Association (2017) Code of Ethics and prioritizing client welfare in their sessions. MHPs can also advocate for diversity initiatives within their workplaces to better serve these populations and take steps themselves to become more culturally competent and aware (Mollah et al., 2018; S. Taylor et al., 2024).

Given the lack of culturally appropriate resources that are available to IPV survivors (Asante, 2024), changes can be made on a larger scale to make these supports available to clients from non-dominant demographics. Connecting with community resources such as shelters, LGBTQIA+ support groups, or immigrant community support centres may help bridge the gap between services and connect individuals with mental health resources they did not previously have access to, while also promoting inclusive care (Loncar & Scott, 2023; Mollah et al., 2018). Advocating with local governments to create more resources that support IPV survivors, including culturally diverse populations, may be effective for

increasing awareness of the need and perhaps lead to changes in available funding. MHPs working to create awareness within the community may assist with creating significant change, while at a minimum, providing messaging to clients that there are spaces where they can seek assistance from MHPs. This may help alleviate the feelings of distrust that some individuals have with MHPs and mental health services, based on past negative experiences and trauma (Alston et al., 2021; Reed et al., 2024)

In addition to challenges finding culturally and personally relevant services that IPV survivors can trust, it is also common for IPV survivors to face financial difficulties due to changes in their relationship that lead to changes in economic status, such as becoming self-reliant financially, financial responsibility for children, experiencing housing instability, or moving into shelters (Ravi et al., 2022; Wood et al., 2023). Considering and addressing financial challenges by offering options such as low-cost counselling will support treatment engagement for IPV survivors by providing opportunities that may not have been otherwise available (Anderson & Overby, 2020). Providing these options to clients will demonstrate MHPs' awareness of the difficulties that this population faces, reduce barriers to treatment, and ultimately increase opportunities for building trust (S. Taylor et al., 2024).

Finally, supporting clients through their trauma and experiences can lead to trauma for the MHP due to the nature of the concerns their clients are dealing with (Lundy & Crawford, 2024, 2025). Consistent exposure to stories of violence and abuse, combined with feelings of responsibility for client wellbeing, can lead to mental health consequences such as burnout (Lundy & Crawford, 2025; Yang & Hayes, 2020). While MHPs may be focused on supporting IPV survivors in mental health therapy, this becomes more difficult when experiencing burnout and compassion fatigue, as these conditions affect MHPs' ability to remain present and invested in their clients (Yang & Hayes, 2020). This disengagement can significantly harm the therapeutic alliance and hinder the development of trust between the

client and their MHP (Delgadillo et al., 2018). Therefore, to prevent or manage burnout and protect the therapeutic alliance, it is recommended that MHPs prioritize their own mental well-being, engage in self-care practices, attend therapy for themselves, and find ways to disconnect from work outside of work hours (Delgadillo et al., 2018; Lundy & Crawford, 2025; Yang & Hayes, 2020). Furthermore, to reduce the risk of MHP burnout, Yang and Hayes (2020) recommended that employers and supervisors provide opportunities for support to the MHPs by allowing for debrief opportunities after difficult sessions. When workplaces encourage self-care practices and offer suggestions on ways to do so, MHPs may be more likely to follow these recommendations and be better able to support their clients.

The above-noted recommendations are based on the findings that emerged in the literature review, which were interpreted through a trauma-informed perspective. There are several barriers that MHPs face when working with IPV survivors, with one of the most prominent underlying components being trust (Berry et al., 2024; Kennedy et al., 2024; Mengo et al., 2023; Messing et al., 2022; S. Taylor et al., 2024). By making the recommended changes, MHPs can show their willingness to work with IPV survivors, meet their needs, and demonstrate the trustworthiness that is essential for IPV survivors to proceed with therapy (Kennedy et al., 2024; st. Vil et al., 2021). IPV survivors need to believe they can trust their MHP with their personal stories and are safe to disclose their trauma experiences, and when MHPs provide a space to do so, they can begin building a therapeutic alliance.

Future Research Directions

The current topic of the perspectives of MHPs working with IPV survivors is one with many areas for future exploration. As noted in previous chapters, a significant limitation in most of the studies reviewed was the small sample sizes and the lack of diverse study locations; therefore, future studies on this topic should include larger sample sizes with

diverse participants. While smaller sample sizes allow researchers to connect with participants on a deeper level, such samples prevent the researchers from generalizing the results to the broader population (Creswell & Poth, 2024). Furthermore, given that few studies have been completed in Alberta or Canada, it would be beneficial to conduct more research on this topic in Canada to gain a deeper understanding of the challenges faced by MHPs living and working here. An additional limitation was that many studies in the literature review were completed in urban settings, which provides opportunities to select more diverse samples; however, the challenges faced by MHPs in urban settings could be significantly different from those in rural settings due to access to resources and smaller populations. To address these limitations, I recommend the following for future research questions:

1. What challenges do MHPs working in rural Alberta face in working with IPV survivors in mental health therapy, and how do these challenges impact treatment engagement?
2. How do MHPs in rural and urban Alberta build trust with IPV survivors in mental health therapy?

An additional theme found in the literature review was the risk and presence of burnout. While research indicated that the experiences of burnout and compassion fatigue impact an MHP's ability to work, there was no concrete answer about how this influences treatment engagement (Yang & Hayes, 2020). As such, future research could additionally ask the following question to determine the exact effects of these experiences.

3. How does MHP burnout influence client treatment progress and treatment engagement in mental health therapy?

Finally, my study did not specifically examine different demographics of the IPV survivors that the MHPs were working with. The literature review was broad in that it

reviewed cultural considerations in general, rather than focusing on specific cultures or particular cultural beliefs for MHPs to be mindful of in therapy. Furthermore, the majority of MHPs in the included literature worked with women survivors (Dichter et al., 2020; Lundy & Crawford, 2025; Maghsoudi, 2018; Periyasamy et al., 2024; Van Deirse et al., 2019). This brings up additional potential questions that can be used to look at building therapeutic alliances with specific demographics of clients:

4. What challenges do MHPs face in building therapeutic alliances with IPV survivors from diverse cultural backgrounds?
5. What strategies do MHPs use to build therapeutic alliances with male IPV survivors in mental health therapy, and how do they address challenges?

By asking more questions about working with specific demographics, we can continue to develop a deeper understanding of the nuances involved in working with IPV survivors. This can provide new ideas for interventions in mental therapy, clarity in the resources needed to support these clients, and additional steps that MHPs can take to assist these clients based on their individual needs. Understanding the unique characteristics of clients and MHPs can create stronger connections and more successful therapeutic alliances, thereby supporting treatment engagement.

Personal Reflections

Beginning this project was an incredibly intimidating task due to the size of this capstone. The largest challenge encountered was related to the amount of literature from the perspectives of MHPs that was available, given that there was less available literature than I initially expected. Although there was a lack of literature specifically examining MHP perspectives, this reinforced the importance of the current manuscript and highlighted the need for further research on this topic in the future. This project demonstrated the nuance in working with IPV survivors and the importance of being prepared to work with individuals

who have not only experienced IPV but also the additional trauma that they may have endured. Any client who attends for mental health therapy will have their individual experiences, and MHPs need to be prepared to address their unique needs.

The reason I chose this topic is due to the amount of client attrition I had while working as an intern at an IPV shelter with survivors in mental health therapy. I wondered if there was something I was doing that was causing this issue. The biggest lesson I learned is that while clients may not continue with therapy due to problems in their lives outside of treatment, there are several things MHPs can do to build trust and create safety within the therapy environment to make it easier for them to stay. The findings of this manuscript demonstrate the importance of MHPs continuously engaging in education, training, self-reflection, and self-care to prepare for working with clients from various backgrounds.

This capstone helped me reconnect with my goal of becoming a registered psychologist, as the research emphasized the good that can be done for clients when MHPs are adequately able to support them. This motivated me to pursue all the training I can to support my clients in the future. Learning about the challenges faced by those who are already working in the field gave me insight into how to overcome them, which will assist me in preparing for my own career as an MHP.

Closing Summary

The initial purpose of this manuscript was to determine the challenges faced by MHPs in developing therapeutic alliances with IPV survivors in mental health therapy, the findings of which aligned with the initial purpose. The literature review found that therapeutic alliances are based on trust, which is built through themes of MHP preparation, population considerations, responsiveness to changing therapy landscapes, and is influenced by burnout. From a trauma-informed perspective, developing a strong therapeutic alliance based on trust was found to be essential for client treatment engagement and success, with clients being

more likely to participate in therapy when they trusted their MHP. This manuscript contributes to the existing body of research on the topic, additionally providing recommendations for MHP practice and starting points for future research. Through continuous research and following these recommendations, MHPs can continue to develop their skills for working with IPV survivors.

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Table 1**Articles Included in the Literature Review**

Article Title	Authors	Type of Article	Participants	Theme
Mental Health Therapists' Perceived Barriers to Addressing Intimate Partner Violence and Suicide.	Wilson et al. (2021)	Qualitative Study	23 MHPs	MHP preparation to work with IPV survivors, barriers faced by clients
Mental Health Care in the Context of Intimate Partner Violence: Survivor Perspectives.	Sorrentino et al. (2021)	Qualitative Study	50 IPV survivors	Survivor perspectives, including responsiveness, intersectionality, safety
Development and training of mental health professionals in providing psychological intervention and support for women survivors of intimate partner violence – A pre–post evaluation study.	Vranda et al. (2022)	Quantitative Study	30 MHPs in a mental health clinic in India	MHPs lack of preparation and education to support IPV survivors, training improves
Mental health professionals' perspectives on group intervention for women survivors of intimate partner violence: A qualitative study.	Periyasamy et al. (2024)	Qualitative Study	9 MHPs	Strategies and challenges for working with survivors, building trust
The Experiences of Licensed Clinicians Counseling Lesbian, Gay, Bisexual, and Queer Survivors of Intimate Partner Violence.	Alston et al. (2021)	Qualitative Study	10 MHPs	Mental health counselling with LGBTQIA+ IPV survivors
Provider perspectives on the provision of safe, equitable, trauma-informed care for intimate partner violence survivors during the COVID-19 pandemic: a qualitative study.	Williams et al. (2021)	Qualitative Study	18 MHPs	Concerns and adaptations made by MHPs for survivors during the COVID pandemic
Intimate Partner Violence and Women with Severe Mental Illnesses: Needs and Challenges from the Perspectives of Behavioral	Van Deirse et al. (2019)	Qualitative Study	28 MHPs	Developing trust and rapport with IPV survivors

Health and Domestic Violence Service Providers.				
“...It’s just the barriers that can be so vast and different”: Domestic violence advocates’ perceived barriers for service across survivor subpopulations.	Reed et al. (2024)	Mixed Methods Study	16 MHPs	Population considerations- Perceived barriers and considerations for LGBTQIA+ IPV survivors
Serving IPV survivors in culturally diverse communities: perspectives from current service providers.	Taylor et al. (2024)	Qualitative Study	11 MPHs	Cultural considerations for diverse IPV survivors
“We have to build trust”: Intimate partner violence risk assessment with immigrant and refugee survivors.	Messing et al. (2022)	Qualitative Study	75 MHPs	Population considerations- MHP experiences with immigrant and refugee IPV survivors