Women & Therapy

Routledge
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ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wwat20

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To cite this article: Leslie Maureen Tutty (2023): "Looking Back, the Programs Kept Me Alive": Women's Impressions of Counseling for Intimate Partner Violence, Women & Therapy, DOI: 10.1080/02703149.2023.2167309

To link to this article: https://doi.org/10.1080/02703149.2023.2167309

Published online: 27 Jan 2023.

WOMEN & THERAPY
https://doi.org/10.1080/02703149.2023.2167309

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"Looking Back, the Programs Kept Me Alive": Women's Impressions of Counseling for Intimate Partner Violence

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ABSTRACT

The copious research on formal help-seeking of women abused by intimate partners, rarely narrows to counseling services. This mixed-methods secondary analysis examined 660 Canadian women and their use and impressions of counseling. The women's racial backgrounds were 50.8% Indigenous, 43.1% White, and 6.1% visible minority. Women who did not seek counseling reported less serious IPV and fewer PTSD symptoms. Most rated counseling as quite a bit/very helpful (77–87%), with the exception of marital counseling (8.3%). The women commented about IPV-specific counseling, general counseling, faith-base, addictions, couples counseling, and Indigenous traditions. Comments revealed strengths and concerns, including counselors lacking IPV knowledge and difficulties accessing resources. Implications are provided for clinicians and researchers.

KEYWORDS

Counseling; domestic abuse; help-seeking; intimate partner violence; violence against women

While concern about the serious impact of intimate partner violence is world-wide, in their individual responses to being physically, sexually, and emotionally abused by their intimate partners, many women seek assistance (Ravi et al., 2021). Nevertheless, studies often focus on what they describe as the "many" women who do not engage with formal services (Addington, 2022; Sabina & Ho, 2014; Voth Schrag et al., 2021). Meyer (2016) suggests that focusing on women who do not seek assistance essentially "blames the victims" yet again.

The question of which women are more likely to access formal services has been of considerable interest. According to one Canadian study (Ford-Gilboe et al., 2015), "Health variables (high disability chronic pain, symptoms of depression and PTSD), low income, and mothering were the most consistent predictors." (p. 419). Some suggest cultural differences, with White women more likely to seek formal assistance than those of Latina/Hispanic or African American heritage (Satyen et al., 2019). In their analysis of Canadian women, Hyman et al. (2009) concluded that racial

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minority women (not including Indigenous women) were much less likely to use social services than White women. However, "formal services" is a broad term that encompasses the criminal justice system, VAW shelters, and health and mental health services.

Accessing Counseling

Several Canadian population-based studies have examined help-seeking in women abused by intimate partners that mention counseling (Ansara & Hindin, 2010; Barrett & Pierre, 2011) with the most recent, a secondary analysis of the 2009 Canadian General Social Survey-Victimization (Barrett et al., 2020) reporting that the severity of violence, fearing for one's life and experiencing two or more violent episodes increased the probability of seeking help from a counselor or psychologist. Notably, though, this analysis included both men and women IPV victims. The authors clarified that 32% of female survivors of IPV sought help from counselors or psychologists compared to only 16% of males. However, no information about their impressions and satisfaction with the counseling was available. This is the focus of the current study, which considers counseling options in two categories: those specific to addressing intimate partner violence and those that are not, either because of a lack of education about IPV, or because the basic tenets of the approach are contrary to identifying IPV as problematic.

IPV-Specific Counseling Options for Abused Women

Those counseling women abused by intimate partners use various therapeutic approaches. Trauma-informed practice has become a strategy in offering group or individual counseling to women (Baird et al., 2021; Wilson et al., 2015). Cognitive therapy is one of the most common strategies for PTSD, with some models developed specifically for women abused by intimate partners (Arroyo et al., 2017), applied in some VAW shelters (Johnson et al., 2011).

Groups, whether support, psychoeducational, or therapeutic, can be a powerful medium for women abused by intimate partners and are, arguably, the most documented and studied interventions for women whose partners abuse them. Support groups for abused women are an integral part of many shelters and community programs (Abel, 2000). Research on women's support and therapy groups for IPV reports statistically significant pre-test/post-test improvements in areas such as self-esteem, anger levels, attitudes toward marriage and the family, and depression (Allen et al., 2021; Tutty et al., 1993, 2016).

Peer-led groups for women abused by intimate partners have been described although rarely studied (Fearday & Cape, 2004; Tutty et al.,

2017a). The major benefits are sharing stories, learning from the experiences of other women, and realizing that their circumstances are not unique. The group leaders, themselves previously abused by partners, also benefit by bearing witness to other women in similar circumstances, sharing their stories, and, thus, acknowledging their own healing (Tutty et al., 2017b).

Violence against women (VAW) shelters offer many services, including information about IPV and crisis counseling (referred to as advocacy in the US). While shelter evaluations seldom consider these separately from other important roles, such as helping women access housing, jobs, and schooling for their children (Hughes, 2020), some studies of shelter residents refer to the emotional support and crisis counseling from shelter staff as vital to assisting them (Sullivan & Virden, 2017; Tutty, 2015).

Although less commonly available, group treatment for aggressive women, which the women themselves often describe as "anger management," have been developed for women referred to treatment because of their aggressive behaviors toward partners (Buttell et al., 2012; Macy et al., 2013; Tutty et al., 2009; Walker, 2013), often in response to police laying dual charges (Fraehlich & Ursel, 2014). The controversy about these groups is that the women are often also victims of their partner's violence, so some argue that the therapeutic focus should include their own victimization (Tutty & Babins-Wagner, 2017).

Controversial or Nonspecific IPV Counseling

Several counseling approaches with women abused by intimate partners have been controversial or contraindicated because of the manner in which they conceptualize IPV, including couples counseling and faith-based counseling.

Traditional marital and family therapies have been accused of failing to address IPV (Oka & Whiting, 2011) arguing, for example, that therapist neutrality ignores the power dynamic central to IPV. Nevertheless, the fact that so many women return to abusive partners suggests that feminist-informed couple's IPV intervention for women who remain in relationships might be appropriate (Lechtenberg et al., 2015; Rowe et al., 2011), sometimes in a couple group treatment format (Johannson & Tutty, 1998; Todahl et al., 2013). In their recent review, Stith et al. (2022) concluded that cognitive behavioral couple treatment to reduce IPV is "possibly" effective.

Couples-intervention specific to IPV is sometimes offered in substance abuse treatment agencies (Klostermann et al., 2010) although, in most cases, the IPV is "situational couple violence" where the abuse is "low-level" and mutual (Johnson et al., 2014). Evaluations of programs addressing both

IPV and substance abuse generally report improvements (Murphy & Ting, 2010; Tutty & Babins-Wagner, 2017).

Mental health professionals such as psychiatrists and psychologists have been critiqued for their potentially stigmatizing responses to women seeking counseling. While women with preexisting mental health diagnoses are more vulnerable to IPV (Brownridge et al., 2022), women abused by intimate partners may develop mental health consequences in response to the abuse (White & Satyen, 2015). Nevertheless, professionals should not assume that abused women necessarily have mental health problems (Tutty et al., 2021). As mentioned, mental health symptoms are commonly better seen as the result of PTSD, and trauma-informed counseling is recommended (Baird et al., 2021; Wilson et al., 2015).

Women of various faiths often turn to their religious leaders for counsel (Sevcik et al., 2015). While clergy may cling to traditional religious values such as the "sanctity of marriage" (Dyer, 2010; Ringel & Park, 2008), others have advocated for training faith-based leaders about abuse in intimate relationships (Drumm et al., 2018; Le Roux et al., 2016).

Indigenous communities have a number of traditional healing approaches and rituals such as Healing Circles, sweat lodges, and consulting with Elders, all of which could be resources for Indigenous women seeking support to address their partner's abusive behaviors (McCormick, 2009; Olsen Harper, 2006; Puchala et al., 2010). None are specific to IPV and, as they constitute alternative healing practices, their efficacy has seldom been evaluated.

With unique access to a large study of Canadian women abused by intimate partners from three Western Canadian provinces, the goal of the current secondary data analysis was to examine the counseling experiences of 660 women in terms of their demographic locations, IPV, and mental health severity. Further, there is a paucity of studies on counseling experiences of Indigenous women. Given that over half of the women in the current study were Indigenous, we considered this an important focus.

Method

This exploratory secondary analysis used a mixed-methods approach (Long-Sutehall, 2011; Sandelowski, 2000), including both quantitative and qualitative components. The data was from the "The Healing Journey," a longitudinal, Canadian study with a convenience sample of 660 women who had experienced IPV in the three prairie provinces of Alberta, Saskatchewan, and Manitoba. The original study aimed to assess characteristics of women abused by intimate partners including mental health and general wellbeing (Tutty et al., 2021a), experiences of mothering (Nixon

et al., 2017; Ateah et al., 2019), and following them over 2.5 years (Tutty et al., 2021b). Both academics and community agency research team members designed the research, recruited participants, and interpreted the results. Data were collected in seven waves between 2005 and 2009, with one wave specific to an economic analysis (DeRiviere, 2014).

The current study used quantitative methodology, including standardized measures, to assess potential differences between women who did and did not access counseling services. Qualitatively, the women were asked whether they had ever participated in a counseling program, the type of program, and its perceived helpfulness. While the women could list up to ten programs, they had only one opportunity to comment, the focus of the current analysis. The comments were generally short, ranging from one-word to up to five sentences.

Study Participants

The research protocols were approved by the Research Ethics Boards of the six associated universities (Universities of Calgary, Manitoba, Regina, Brandon, Lethbridge, Winnipeg). Each province conducted an environmental scan of agencies (i.e., women's shelters and counseling agencies) to cover urban, rural, and northern sites from which to recruit. The criteria for inclusion were: minimum 18 years of age; the most recent incident of IPV no sooner than three months and no longer than five years prior; commitment to stay in the study for the full four years; and no debilitating mental health issues. Honoraria ($50 CAN) were given to participants at each wave.

Research Measures

Data in the original study were collected with respect to four major areas: demographic background and history of abuse, general functioning and service utilization, health, and mothering over 4 years. The surveys included standardized measures as well as open- and closed-ended questions developed specifically for the study (all administered verbally by trained research assistants). The current mixed methods secondary analysis used data from the first two waves of the Healing Journey study. The core demographics, incuding the severity of IPV of the total sample, and women's comments with respect to the counseling they received were obtained in Wave 1. Mental health measures were collected in Wave 2.

Intimate Partner Violence

The nature of the IPV was assessed by the Composite Abuse Scale (CAS) (Hegarty et al., 2005). This screening measure consists of 30 items rated for

frequency in the past 12 months on a six-point scale from never to daily, with a possible total of 150. The four subscales are: Severe Combined Abuse (8 items; range of scores 0–40; suggested cutoff of 1), Physical Abuse (7 items; range of scores 0–35; cutoff of 1), Emotional Abuse (11 items; range of scores 0–55; cutoff of 3), and Harassment (4 items; range of scores 0–20; cutoff of 2). The suggested clinical cutoff for the Total CAS score is 3 or 7 to minimize false positives. The scale has demonstrated convergent and discriminant validity (Hegarty et al., 2005). Cronbach's alpha for the CAS in the current study is .93.

Child Abuse and Disability

Child abuse history was collected via structured questions (yes/no answers): "Were you abused as a child or adolescent? (a) physical, (b) sexual, (c) emotional/psychological, (d) witnessing abuse among family members" (consistent with Elias et al., 2012). We asked the women to self-report physical and mental health conditions (whether or not diagnosed by medical personnel), and to assess disability (whether these conditions affected their employability or the kind or amount of daily activities).

Mental Health and Well-Being

The Symptom Checklist Short Form (SCL-10) (Nguyen et al., 1983) is a screening tool to assess global mental health functioning and psychological distress in the previous week. Items (e.g., "In the past week, how much were you distressed by feeling lonely?") are endorsed with a 0 to 4 Likert scale (0 = *not at all*; 4 = *extremely*). Higher scores indicate more distress. Published clinical cutoffs for the 10-item version were not found. However, since clinical cutoff scores are one standard deviation above the mean (Jacobson et al., 1986), we used Müller's data (Müller et al., 2010) reporting a mean score of 7.8 (*SD* of 6.3), resulting in a clinical cutoff score of 14.2. Cronbach's alpha in the current study is .89.

The CES-D-10 (Center for Epidemiological Studies - Depression) is a short form of the CES-D-20 (Radloff, 1977) used to document depression symptoms in the previous week (Andresen et al., 1994). Ten items (e.g., "In the past week I was bothered by things that usually don't bother me?") are rated on a 0 to 3 Likert scale, with zero as *rarely or none of the time (less than 1 day)* and three as *all of the time (5–7 days)*. Internal consistency and test-retest reliability are good (Björgvinsson et al., 2013). Cronbach's alpha in the current study is .84. Björgvinsson et al. suggest that a cutoff of 15 has the best sensitivity and specificity.

The PTSD Checklist (PCL) (Blanchard et al., 1996) is a 17-item self-report questionnaire that measures PTSD symptoms in the past month.

Items (e.g., "In the past month how much have you been bothered by repeated, disturbing memories, thoughts or images of abuse or violence?") are endorsed with a 0 to 4 Likert scale with zero meaning *not at all* and 4 meaning *extremely*. Blanchard et al. recommend a clinical cutoff of 44. The scale has good psychometric properties (Cronbach's alpha = .94; Blanchard et al., 1996). Cronbach's alpha in the current study is .92.

The original 25-item Quality of Life Questionnaire (Andrews & Withey, 1976) was shortened by Sullivan and Bybee (1999) to nine items (QoL-9) measuring satisfaction with her overall quality of life (e.g., "How do you feel about life as a whole?") and satisfaction with particular areas (e.g., "How do you feel about yourself?; your personal safety?; the amount of fun and enjoyment you have?"). Items are rated on a 7-point scale (1 = *extremely pleased*, 7 = *terrible*). Higher scale scores indicate poorer QoL. Cronbach's alpha in the current study is .84.

The women were asked to rate the helpfulness of the different types of counseling they had experienced. They rated the counseling as 1 = *Not at all helpful/a little bit helpful*; 2 = *Somewhat helpful*; and 3 = *Quite a bit/Very helpful*.

Research Procedures: Qualitative Component

We used descriptive qualitative health research to analyze the women's comments about their counseling. This method is particularly appropriate for mixed methods research (Neergaard et al., 2009) and for "assessing, developing and refining interventions with vulnerable populations" (Sullivan-Bolyai et al., 2005, p. 127). Descriptive qualitative methods use the practicality of the research question as the guiding principle, rather than epistemological confines of qualitative traditions such as grounded theory or phenomenology (Neergaard et al., 2009).

Data Analysis

The demographic characteristics of the women and their scores on the CAS are presented descriptively. Demographic characteristics of the women and the perceived helpfulness of the counseling were compared using Pearson's chi-square analysis based on whether they had sought counseling, with effect sizes calculated with Phi or Cramer's *V*. Standardized residuals were calculated to identify the category differences responsible for the statistically significant chi-square analysis (Field, 2009). Effect sizes were interpreted using Rea and Parker's (1992) suggested benchmarks of under .10 as a "negligible" association; between .10 and under .20 as a "weak"; between .20 and under .40 as a "moderate", and between .40 and under .60 as a

relatively "strong" association (p. 203). The mean scores on the standardized measure were compared with independent *t*-test based on whether or not they had sought counseling for IPV. Cohen's *d* (Cohen, 1988) is used to interpret statistically significant *t*-tests with a d between 0.2 or 0.3 be considered a "small" effect size, 0.5 represents a "medium" effect size, and 0.8 a "large" effect size.

Secondary qualitative analysis entails a re-analysis of already-available narratives. The analysis of the comments followed established qualitative content analysis processes. We identified the major themes, subthemes, and categories (Graneheim & Lundman, 2004; Neergaard et al., 2009). First-level coding entailed word-by-word scrutiny of the comments to identify prominent themes and subthemes (Braun & Clarke, 2006). Second-level coding involved looking within the themes and subthemes to identify similarities, differences, and gaps using the constant comparative method (Thorne, 2000).

Results

Demographics of the Study Participants

The 660 women respondents were an average age of 36.4 years ($SD = 10.9$), while their partner/ex-partners were an average of 38.7 years ($SD = 11.2$). The women's racial backgrounds were 50.8% Indigenous, 43.1% White, and 6.1% visible minority, while the partner/ex-partners ($N = 657$) were White (47.6%), Indigenous (44.6%), and 7.8% visible minority. The majority of the women (90.8%) had children.

The women primarily lived in large urban centers (72%) with populations of more than 100,000, with 13.9% in smaller urban centers (30,000–99,999) and 14.1% in rural centers (less than 29,000). With respect to their highest level of education, 42.5% of the women had not completed high school, 20.9% had completed high school, while 36.6% had some post-secondary education, either in technical institutes (17.3%) or universities (19.3%). Their average total income in the past year was $21,693 ($SD$ = $24,556); about half of the women's incomes fall below the poverty-line for that time in the three Canadian provinces (DeRiviere, 2014). This low yearly income is partly explained by the fact that the majority of women (61.9%) were not currently working, another 20.8% worked casually or part-time, and only 17.3% worked full-time.

With respect to a history of child maltreatment, 20.9% reported none, 24.6% reported a child abuse not including child sexual abuse, and over half (54.5%) reported having been sexually abused as children. Almost half of the women (290 of 656 or 44.2%) reported that they had at least one disability. Of these, about one-third (30.7%) had a physical disability only,

one-quarter had a mental health disability only, and 44.1% self-reported having both a physical and a mental health disability. Two thirds of the women (68%) perceived their disability as resulting from abuse (both childhood and IPV).

Average scores on the CAS subscales were well above the suggested clinical cutoff scores. None of the average scores on measures of mental health functioning was in the clinical range. Average scores on the Quality of Life Questionnaire were 31.9, $SD = 8.8$ (no clinical cutoff).

Differences Based on Any Counseling versus None

As can be seen in Table 1, as compared to women who sought counseling, those who did not were significantly younger, had partners who were significantly younger, and were significantly more likely to be Indigenous (of those who had not sought counseling, 79.1% were Indigenous). They had more partners who were Indigenous and more cohabited with their abusive partners. Furthermore, those who did not seek counseling, as compared to those who did, had significantly lower annual incomes, fewer had completed high school, and fewer were less currently working.

As is apparent in Table 2, women who did not seek counseling had lower scores on the Severe Combined Abuse and the CAS Emotional Abuse subscales, both indicating less IPV, and they reported fewer PTSD symptoms.

Counseling Programs

Simply examining the number of counseling experiences, 204 listed having accessed one counseling type or program, 135 listed two, 111 listed three, 41 listed four, 32 listed five, and 42 women listed six or more (with an upper limit of ten). This total of 1,383 programs (at a minimum) indicates an average of 2.45 programs for the 565 women who attended counseling. The programs varied by the agency source (general versus IPV-specific), with some addressing group or individual counseling programs provided by VAW shelters, some specifying couples counseling, and some accessing Indigenous traditional healing methods.

Table 3 provides an analysis of the perceived helpfulness of these approaches. Shelter individual and group counseling were seen as the most helpful (86 women or 87.6%); IPV-specific programs were next (45 women or 80.4%); then general counseling (i.e., not IPV-specific) (276 women or 78%). The small number of women who used traditional Indigenous healing practices were generally pleased (17 women or 77.3%). Notably though, couples counseling was statistically significantly less helpful to the small

Table 1. Comparison of women's demographics by sought counseling or not ($N = 660$).

Variable		Counseling ($n = 564$)	No counseling ($n = 96$)	Sign.	Effect size
Age		36.9 years ($SD = 10.9$)	33.4 years ($SD = 10.8$)	$t = 2.9$; $p = .002^{**}$	Cohen's $d = .32$
Partner age		39.2 years ($SD = 11.2$)	36 years ($SD = 11.1$)	$t = 2.6$; $p = .009^{**}$	Cohen's $d = .29$
Racial/ethnic background	White ($n = 282$)	261 (92.9%)	21 (7.4%)	$\chi^2 = 21.6$; $p < .001^{***}$	Cramer's $V = .18$
	Indigenous ($n = 334$)	263 (79.2%)	69 (20.8%)**		
	Visible Minority ($n = 40$)	34 (85%)	6 (15%)		
Partner race					
	Indigenous	232 (79.5%)	60 (20.5%)*		
	Visible Minority	44 (86.3%)	7 (13.7%)		
	White	281 (90.9%)	28 (9.1%)*	$\chi^2 = 15.9$; $p < .001^{***}$	Cramer's $V = .15$
Current partner relationship	Not together ($n = 540$)	475 (88%)	65 (12%)	$\chi^2 = 15.0$; $p = .001^{***}$	Cramer's $V = .15$
	Together ($n = 120$)	89 (74.2%)	31 (25.8%)*		
	Children?	Yes ($n = 599$)	512 (85.5%)	87 (14.5%)	$\chi^2 = 0.0$; $p = .96$ n.s.
No ($n = 61$)		52 (85.2%	9 (14.8%)		
Urban/rural Community	Small rural < 29,999 ($n = 93$)	77 (82.8%)	16 (17.2%)	$\chi^2 = 4.4$; $p = .08$ n.s.	
	Medium (30,000–99,999) ($n = 92$)	73 (79.3%)	19 (20.7%)		
	Large more than 100,000 ($n = 475$)	414 (87.2%)	61 (12.8%)		
Highest education	No complete HS ($n = 280$)	225 (80.4%)	55 (19.6%)*	$\chi^2 = 10.1$; $p = .018^{*}$	Cramer's $V = .12$
	HS or GED ($n = 138$)	123 (89.1%)	15 (10.9%)		
	Post sec-tech ($n = 114$)	102 (89.5%)	12 (10.5%)		
	Post sec-univ ($n = 127$)	113 (89%	14 (11%)		
Currently working?	No ($n = 401$)	329 (82%)	72 (18%)	$\chi^2 = 9.1$; $p = .01^{**}$	Cramer's $V = .12$
	Full-time ($n = 135$)	122 (90.4)	13 (9.6%)		
	Part-time/casual ($n = 112$)	102 (91.1%)	10 (8.9%)		
Income		$22652.70	$15761.20	$t = 3.6$; $p < .001^{***}$	Cohen's $d = .28$
VAW shelter stay?	Yes ($n = 422$)	367 (87%)	55 (13%)	$\chi^2 = 2.2$ ($p = .13$ n.s.	
	No ($n - 237$)	196 (82.7%)	41 (17%)		
Child abuse?	No ($n = 138$)	120 (87%)	18 (13%)	$\chi^2 = 0.9$; $p = .65$ n.s.	
	Any sexual abuse ($n = 359$)	308 (85.8%)	51 (14.2%)		
	No sex abuse but other abuse ($n = 162$)	135 (83.3%)	27 (16%)		
Type of disability	No disability ($n = 366$)	305 (83.3%)	61 (16.7%)	$\chi^2 = 7.3$; $p = .06$ n.s.	
	Physical ($n = 89$)	73 (82%)	16 (18%)		
	Mental health ($n = 73$)	66 (90.4%)	7 (9.6%)		
	Physical & MH ($n = 128$)	117 (91.4%)	11 (8.6%)		
Disability from abuse?	No ($n = 135$)	110 (81.5%)	25 (18.5%)*	$\chi^2 = 9.2$; $p = .002^{**}$	Cramer's $V = .15$
	Yes ($n = 287$)	263 (91.6%)	24 (8.4%)		

Table 2. Scores on standardized measures by received counseling or not.

Scale	Counseling ($n = 558$)	No counseling ($n = 96$)	*t*-Test	*Cohen's d*
CAS severe combined ($n = 629$)	7.5 ($SD = 7.1$)	5.6 ($SD = 5.2$)	3.1; $p < .001^{***}$	.28
CAS emotional abuse	28.6 ($SD = 14.1$)	24 ($SD = 13.0$)	2.9; $p < .002^{**}$	.33
CAS PHYSICAL abuse	12.6 ($SD = 8.6$)	12.6 ($SD = 7.8$)	0.5; $p = .48$ n.s.	
CAS Harassment	7.9 ($SD = 5.3$)	7.1 ($SD = 4.9$)	1.3; $p = .09$ n.s.	
CAS total score[1]	55.5 ($SD = 28.8$)	50.3 ($SD = 25.4$)	1.5; $p = .07$ n.s.	
SCL-10 total score	12.9 ($SD = 8.9$)	12.4 ($SD = 8.8$)	0.5; $p = .33$ n.s.	
CES-D-10 total score	12.2 ($SD = 6.3$)	12.4 ($SD = 8.8$)	0.77; $p = .22$ n.s.	
PTSD checklist	27.3 ($SD = 14.5$)	23.9 ($SD = 14$)	2.0; $p = .048^{*}$	.24
QoL	32 ($SD = 10.$)	31.0 ($SD = 9.3$)	0.5; $p = .3$ n.s.	

Table 3. Helpfulness of counseling type ($N = 542$).

Type of counseling	Not at all/a little bit helpful	Somewhat helpful	Quite a bit/very helpful	Total
Professional counselor	34 (9.6%)	44 (12.4%)	276 (78%)	354
Shelter counselor/group	7 (7.1%)	5 (5.1%)	86 (87.6%)	98
IPV-specific program	6 (10.7%)	5 (8.9%)	45 (80.4%)	56
Couples counseling	8 (66.7%)***	3 (25%)	1 (8.3%)**	12
Indigenous healing	0	5 (22.7%)	17 (77.3%)	22

Chi-square = 58.1; $n = p < .000^{***}$; Cramer's $V = .23$.

number that accessed systemic approaches, with eight (or 66.7%) identifying this as "not at all" or "only a little bit helpful."

Qualitative Content Analysis of Counseling Programs

IPV-Specific Counseling

Counseling in the Shelter. Almost two thirds of the women (422 of 659 or 64%) had stayed in a VAW shelter at some point. The question about counseling was not specific to VAW shelters, yet a number of the women gave examples of the counseling received from shelter staff ($N = 69$), some with respect to second-stage shelters ($N = 16$).

The most common subtheme included positive comments about the counseling experience and the counselor (44 for emergency and 10 for second-stage shelters), noting, for example, "You can say anything and they will listen. They are very caring. Very helpful to kids. You could talk for hours and they would just listen," "Helpful, a neutral person to talk to. They asked the right questions, encouraged you to do you own problem-solving. Encouraged self-esteem. She showed a lot of compassion, non-judgmental."

> [second stage housing]-Individual counselling is excellent because I'm not judged. She's so patient in allowing me to explore why I think things happened and links that help me to keep running back. Keeps me from getting discouraged.

Another subtheme was with respect to learning about IPV (16 in emergency and 4 in second-stage shelters), with comments such as, "Made me realize that there are more kinds of abuse than just physical," and "Helped me see a lot of things that I went through were serious such as being

raped. Learning about physical and emotional abuse because where I come from the behaviour (abusive) was normal. It opened my eyes to how bad it really was. Learned lots."

Some women commented on the importance of being provided resources (10 first stage shelter, one second-stage) such as, "Education on facilities. Day care. They taught me how to use public transportation. Gave me maps of the city and took me to a doctor." And, "As an immigrant woman, I find many doors closed, and they helped me open them. I had no one who can vouch for me. They will do this. They helped me get a house, food, necessities, everything I need."

In contrast, 15 women in first-stage and four in second-stage shelters raised concerns. The most common issue was a lack of accessibility to counseling and resources (six in emergency and two in second stage), including the following: "I had to ask my counsellor for resources. She never talked to me about the resources." "I felt better talking to an outsider. They listened but didn't give me practical help. They didn't follow up," and "Staff changes a problem, cancelled appointments, gaps in counselling so it affects trust (second-stage shelter)."

Four women in first stage and one in second-stage were concerned about the counselors, commenting: "Weakened me, 'you shouldn't, you're weak,'" "Counsellor just listened. That doesn't help. I was looking for answers, there were none," and, "Did not get along well with counsellors, did not have the same ideas about life. Therefore, it doesn't work well."

IPV Groups. Eighty-five women commented about IPV-specific groups they had attended. Some were offered in VAW shelters and others in the community, although we could not distinguish between these. The most commonly strength ($n = 45$) was the importance of hearing other women's stories and becoming aware that they are not alone. Comments included, "I learn about myself and my situation. Feels support and caring from other group members. Does not feel so alone. Feel like I belong and am needed," and "To be with women and listen to their stories and realize that my relationships could get worse. I was able to help them too. Give a little and take a little. Enjoyed it. Felt a sense of belonging."

Twenty-five women mentioned the importance of learning about IPV and community resources, "I learned a lot about abuse, I learned I'm not alone, not crazy. I learned that I can live an abuse-free lifestyle." "Learned what abuse was and how to cope with starting to heal. They showed me how to get lawyers, social assistance." "Program is very helpful in identifying all the effects of abuse. It is also a place where I can find further resources."

Twenty-three women highlighted what they had personally gained from the groups, including self-esteem, "Learned a lot of positive coping skills, to recognize feelings and emotions, to cope with stress."

> They were helpful, made me stronger. Made me realize that a woman shouldn't get abused. I've carried this cycle for many years. I've seen my grandmother get beat up. That's the first time I knew that's not how it was supposed to be. It was normal for me.

Three women compared group and individual counseling. Two recommended group over individual, noting, "Individual counselling was not as helpful as group. I thought individual counselling would be more helpful, but it wasn't," and, "Individual counselling was not as helpful as group counselling. In group you learn things from others and from their experiences." A third saw the benefits of both:

> Group therapy in combination with individual is great. Group allows you to hear other people's stories and you realize you're not alone. Individual therapy allows you to talk about things you might not feel comfortable talking about in public.

Thirty-one women raised concerns about the IPV groups. The most commonly mentioned ($n = 21$) were group process issues, including a need for longer groups and better group leadership, "It should have been more than once a week and should have been longer," "Lacking regular participation by other clients. Control of group could have been better (moving along women holding up the discussion)." Nine women preferred individual counseling over group, "Would have preferred they start with one on one," and, "I don't feel groups are safe. Most are exclusively psychoeducational - but I want to share feelings, experiences, and connections. Peer support would be good."

Another four women were simply unenthusiastic, "I started going to group and found it somewhat helpful. Most of the stuff in group, I already know," and "I was so wrapped up in my own problems, I couldn't give a shit about other people's problems."

Aggressive Women Groups. Ten women participated in groups that most called "anger management." Eight had positive comments about its usefulness: "They helped me manage my anger, revealed the cycle of abuse." and, "It is more a healing program for me. I got more than I expected. I was court-appointed." Two mentioned concerns including, "I cannot see any results. Frustration about finances and living arrangements overshadow any productivity. It takes way too long to get into a program," and "wished it was longer."

Generic Counseling Programming

A number of the comments (228 of 265 or 86%) were generally positive about the women's experiences in generic counseling that was not

necessarily IPV-specific. These were captured under three sub-themes: outcomes of the counseling such as improved self-esteem and a positive relationship with the counselor, learning about IPV and IPV services, and general comments about the counseling being helpful. Many women described more than one counseling experience and some comments were with respect to more than one sub-theme.

Comments with respect to positive therapy outcomes and the relationship with the counseling were documented for 158 women including: "For the first time in my life I feel able to express myself and face some demons I've let sleep for years," "She helped me see my strengths. I was suicidal when I started seeing her," and "She confirmed what I felt/thought. She saw he was controlling. She talked to his counsellor; they were both concerned for my safety."

> They always welcomed me back. I needed time to process information and to face the abuse in my relationship. They never pushed and the door was always open. I worked on self-esteem and relationship issues.

More general comments about the counseling being helpful were documented by 70 women including the following: "If it wasn't for these programs, I would have ended up dead. At the time, I expected to feel extremely better but, looking back, the programs kept me alive;" and, "Made me who I am today, extremely helpful." Another comment simply said, "Life changing – wouldn't have gotten to where I am today without it."

Fifty-two women noted the importance of learning about the dynamics of IPV, IPV resources, and that the abuse is not her fault. Examples included: "I learned safety issues and the dynamics of abuse, how to recognize the signs so I won't get caught up in it again;" "All were great. Help you be strong, help you understand that it's not your fault – the abuser has the problem," and, "Counselling helped me identify different types of abuse and the warning signs. Heal from the abuse that I've suffered."

In contrast, 48 women raised concerns about the counseling process, their counselors, and/or the focus of the counseling. In critiquing their counselor(s), 24 women described them as "Superficial," "I didn't get a welcoming feeling from the counsellor," "Not all the workers are nice, some were pretty rude." "I didn't like her method of talking to me." "Counsellor seemed distracted and didn't provide feedback." "Very young women counsellors did not have any practical experience but were dealing with my problems more bookishly," and "Talked to me about a woman's role; he was a chauvinist."

Eleven women complained about the counseling process in general, noting, for example, that, "Counselling, is only a temporary relief. Going to the different service takes me back to the incidents. Retelling is

painful," "I didn't feel any different after I was finished the one-on-one counselling. I didn't know if it was me or the program," and "They didn't do anything. It took a lot for me to walk in there and, in the end, I wasted my time."

Finally, 16 women believed that the counseling focus was not appropriate for them, making comments such as: "He doesn't focus on abuse issues. He was superficial on domestic violence," and "Individual counselling wasn't overly helpful in meeting my needs - I need legal assistance," "They simply listened but didn't give me practical help. It didn't help," and "Counselling is cold. They aren't willing to take you by the hand and lead you to things that might help. They aren't flexible. Not helpful at all."

Forty-one women commented about difficulties with the counseling process. The most common issue ($n = 20$) was counseling not being accessible (no programs; long waitlists) or, once accessed, phone calls not being returned, counselors quitting or retiring with no replacements stating, for example. "You have to be a detective to find help. You seemed to need to be in crisis before people would tell you." This was compounded in rural communities according to one woman, "In rural it's much more difficult. You can't just walk out your door and get help. Too many people know you."

Eight women were concerned about the cost of counseling, no transportation or daycare, and sessions being too short. Seven commented that the type of counseling offered was not a good fit, such as group rather than individual, or medication versus talk therapy, "helping with the mental aspect, medication. Didn't really help with the abuse." A final six women noted that they had not been ready for counseling when they received it such as the following: "I wasn't really ready for help; I went to make my family happy."

Couples Counseling. Thirty-five women discussed couples counseling ($n = 33$) or family therapy ($n = 2$). Congruent with the primarily negative rating for couples counseling in Table 3, the majority suggested significant problems. Nineteen women described major issues, commenting, for example, that, "Counsellor had no control over the session and let my husband yell at me," "What I talked about in counselling would upset him and make the situation worse," "Panicked when my husband 'lost it' in a session - he didn't know what to do. Had no life experience," and "Many don't know signs of abuse in children, symptoms and how to deal with it. No strategies," "He never admitted that he abused me. I feel extremely let down by the counsellor. She really seemed to be buying into his story/was sympathetic with him."

> The abuse escalated. The counsellor was an ass. He completely embarrassed me because there was no physical abuse and my husband laughed at me. It made it worse.

> The worst was a marriage counsellor. I felt like I was to blame for my husband's behaviour. The sessions justified his abuse and that of his family to me. I expected the counsellor to hear me and see the dilemma my marriage was in and help us work on corrections. Not send me home with a manual telling me I had low self-esteem. My husband was told to read "Men are from Mars; Women are from Venus"!!

Twelve women described ways that the couples counseling was helpful for them but not their partners, commenting, "Couples counselling helped my decision to leave him, but not in repairing relationship because it was clear he didn't want to be there," and "My ex refused to keep going so wouldn't pay and accused me of having an affair with the psychologist." Another commented, "My husband and I had marriage counselling. While I received something out of it, my husband did not. He was just there because his probation demanded it. My husband was just not interested in changing."

Three women described the couples/family intervention as useful in some ways, including, "Counselling helped by the counsellor telling my husband how stressful his behaviour was on me. In counselling I was able to vent my feelings. I can think clearer and worry less," and, "It helps me allow my kids to be kids and not listen to my problems. Healthy boundaries."

Mental Health Counseling and Addictions. Nineteen women of 32 considered that their psychiatrist/mental health counselor was helpful, noting that the medication helped ($n = 6$), that having a diagnosis was useful ($n = 5$), that they were assisted with the IPV, or a history of sexual abuse ($n = 5$), and that the counselor provided useful resources and support ($n = 5$). With respect to medication, "I needed medication the first two years of counselling because of PTSD." "Medication has helped." Regarding an appropriate diagnosis, "He understands my depression. He diagnosed the bipolar and the eating disorder started to fade." Comments regarding assistance in addressing IPV or sexual abuse included, "The counselling at the [hospital name] is good because they help me deal with my sexual abuse and the domestic violence," and, "Very, helpful. He believed me when I talked about the abuse." Another woman commented about the support and resources help, "I was insecure about how I was dealing with problems and stress. She helped me realize what I was doing was good and helped me deal better with the stress. She gave me feedback, she referred me to books, helpful."

In contrast, thirteen women commented negatively about their psychiatrist or mental health counselor, seven noting that they did not connect, "waste of time, condescending, not good experience - never talked to her," "He seems vague when I ask questions about my diagnosis." Three women

mentioned that their mental health professional seemed to know little about IPV, "No one asked me about the abuse; I didn't know what was happening was related to it." "Felt they blamed me for the abuse or that I'd made it up," and, "Saw the psychiatrist for five minutes. He referred me to a social worker who didn't know anything about abuse." Two women were prescribed unwanted medications, "My psychiatrist prescribed medication I didn't want to," and "Pushed drugs and they never helped. My depression is situational."

Sixteen women commented about their addictions counseling (including AA), with the bulk of the comments ($n = 13$) noting its usefulness. Comments included, "They helped me overcome addiction and realize I don't need to numb myself to deal with life problems," It helped me understand that I was in a codependent relationship with an addict, helped me understand addictions, and to focus on me rather than how I could change." "It helped me through listening to other people's day to day problems, dealing with alcoholism. Gave me strength to quit. It helped me leave the abusive relationship." One woman mentioned that it "helped deal with addictions at that time in my life but didn't help me see the abuse; I was in denial about the abuse." Two additional women raised concerns, one suggesting that gender-specific groups would be more effective. One suggested a longer program than two weeks, and the other that sessions should be once a week rather than twice.

Christian Counseling. Thirteen women described benefits and problems with the Christian counseling that they had received. Eight women found the counseling supportive, commenting, "Helpful for compassion, empathy and direction. A healing experience, nice to have someone to listen without judgment," and, "Minister prays with her and for her. Listens and offers understanding and support."

Five women identified limitations, including that the faith leader was too busy, "Helpful spiritually but hard to get an appointment," and "They never did counselling, just read from a book," and "The main focus was living in a biblical background – wasn't helpful." Two mentioned serious issues with not properly addressing IPV, including, "Christian counsellor told my ex that what he was doing was okay - escalated the emotional abuse" and, "The counsellor was more focused on reconciliation. My ex convinced the counselor that he has turned over a new leaf. The counselor was taken in by him."

Indigenous Healing Approaches. Nineteen Indigenous women commented about Indigenous programs or ceremonies that they had attended, with 16 describing the programs as helpful and connected them with their identity

or spiritual beliefs: "Most effective were the ones with an Aboriginal world-view and more holistic counselling (e. g., included spirituality as an important thread in the healing journey)" "I went on sweats. They showed me ways to cope, anger management;" and "Very helpful because the counselling was based more on my world-views and always included a spiritual component. Always ended in ceremony and prayers."

Three women described how Indigenous individuals helped them learn about their partner and sexual abuse: "Medicine Man provided validation that I was not the problem and that my husband needed to change. He offered support," and "Sharing Circles at the Healing Lodge are very helpful;" "Aboriginal programming was very helpful. Enabled women survivors get together and practical information to deal with flashbacks."

Discussion

The current study is unique in that it provides a broad overview of the women's perceptions of their counseling for IPV in Canada's three prairie provinces. Those who did not access counseling were younger, Indigenous, reported less annual income, had not completed high school, were not currently working, and were less likely to report a disability that they attributed to either childhood abuse or IPV. Their partners were younger, more were Indigenous, and the couple were more likely to still live together. Women who did not seek counseling had lower scores on the Severe Combined Abuse subscale, the CAS Emotional Abuse subscale, and reported fewer PTSD symptoms, all suggesting that the IPV was less serious, and they reported fewer mental health trauma-related concerns. As such, not seeking counseling makes some sense, as they may not have seen the need for it, were not aware of the serious nature of the IPV, or did not have the means to access agencies that are fee-for-service. Some results are comparable to Ford-Gilboe et al. (2015), who found that health variables such as high disability chronic pain and PTSD symptoms predicted services use (broadly defined), but not lower income (a significant variable in the current study) or higher depression (not significant). That more severe IPV was associated with seeking counseling is congruent with Barrett et al. (2020).

Contrary to the bulk of the research on abused women suggesting that many do not seek formal services (i.e., Addington, 2022; Sabina & Ho, 2014; Voth Schrag et al., 2021), most in the study connected with multiple counseling service types, 2.45 services on average. Most evaluations of counseling specific to women abused by intimate partners focus on developed programs or groups rather than day-to-day experiences in general counseling agencies or mental health or faith-based organizations. As such,

the current study adds important perspectives that have not previously been captured in the research literature. Overall, the women found most counseling helpful, although shelter counselors and IPV-specific programs received the highest satisfaction ratings (87.6% & 80.4% Quite a bit/Very helpful respectively).

Across the comments about the most often-used counseling types (shelter-counseling [$N = 85$, 88% positive], IPV groups [$N = 85$, 80% positive], and general counseling [$N = 265$, 80% positive], most referred to the women's personal improvements while connecting with the counselors and, secondly, learning about IPV and community resources. The first theme reflects core counseling values, improving individual efficacy with the support of a counselor (Rothery & Tutty, 2016). The latter theme is similar to what Ravi et al. (2021) concluded in their review of 24 studies of formal services, that "provider knowledge, support, accessibility (p. 1)" were key factors. In the current study, negatives largely concerned accessibility to counseling, not connecting with the counselors, or questions about the counselor's focus, including their lack of knowledge about IPV. Only small numbers commented about mental health/psychiatric counseling ($N = 32$, 60% positive), IPV groups for aggressive women ($N = 10$, 80% positive), Christian counseling ($N = 13$, 61% positive), and addictions counseling ($N = 16$, 81% positive). While most comments were positive, others raised concerns about the lack of connection or the counselor's lack of knowledge about IPV.

In comparison to these approaches, the dissatisfaction with couples counseling ($N = 35$, 45.7% positive) was notable. Seeking couples counseling is not atypical for women whose partners behave abusively, but it behooves therapists to assess for IPV in all couples seeking assistance (Tutty, 2022). While couples counseling that focuses explicitly on the IPV may be an option (Stith et al., 2022), the general dissatisfaction and concerns raised by the women in the current study with respect to counselors not understanding IPV or siding with the abusive men echo older critiques of systemic therapy approaches (Oka & Whiting, 2011).

Given that more than half of the women in the current study were Indigenous, that 19 accessed traditional Indigenous techniques and rituals, mostly finding them helpful (comments were 100% positive), is important. These approaches are rarely described in mainstream counseling journals. In-depth interviews with 40 Indigenous women in the original study (Ogden & Tutty, under review) also identified the utility of Indigenous healing strategies and rituals. Notably, a new approach incorporating a number of strategies such as healing circles led by Elders has been developed in British Columbia, Canada (Varcoe et al., 2017) and may prove useful across Canada and North America.

Implications for Clinicians and Researchers

This secondary analysis of a study conducted over a decade ago, nevertheless, raises questions about how well clinicians of various professional backgrounds are educated about IPV. Recent studies with respect to social work graduates (Fedina et al., 2018), nursing students (Connor et al., 2013), and mental health professionals (Nyame et al., 2013) all document the general lack of information about IPV and the importance of education in post-secondary institutions or professional training programs.

Researchers examining help-seeking among women IPV survivors should enquire more explicitly about, not only counseling, but the type of counseling and the women's views of its efficacy. Counselors come from numerous professional backgrounds such as psychology, social work, nursing, physicians, and most work in generic counseling agencies, not programs specific to IPV. The lack of information about day-to-day IPV counseling practices until the current study represents a gap in counselors' knowledge about best practices and potential pitfalls. More research that parallels and expands the clinical focus of this study is needed.

Study Strengths and Limitations

When conducting secondary analyses, one is limited by the nature of the original study, which, in this case, relied on a convenience sample of women from VAW shelters or counseling agencies. The current results are not generalizable to other women abused by intimate partners from Canada's prairie provinces, as most were engaged through IPV-specific services, which increases the likelihood that they had received counseling for IPV. The 85% of the 660 women who accessed counseling cannot be directly compared to the results of other nationally conducted studies, where only 32% percentage of women received counseling (Barrett et al., 2020). The current sample primarily reflects those who had actively sought counseling.

A strength of the current study is that the women constitute a large sample of intimate partner violence survivors from the Canadian prairies, with more than half of Indigenous background, a group whose well-being is particularly important in Canada but who may not be included in IPV research. The women's candor with respect to their opinions about the counseling that they received for the abuse from their partners adds important feedback to counseling agencies that assist women abused by intimate partners.

Conclusion

Among the many studies on formal resources for women abused by intimate partners, this research is unique in focusing on counseling. Although the comments were sometimes brief, most conveyed clear opinions about what, when, and whether their counseling experiences were helpful or not. Also unique was the finding that Indigenous women were much less likely to access any type of counseling, which suggests the need to target this group with information about the advantages of counseling for IPV. Some women's use of Indigenous healing traditions and ceremonies is also unique and an area about which more research is needed. The open-ended question about counseling allowed women to describe their experiences with generic counselors, faith-based counselors, as well as addiction and mental health treatment, in addition to the more common IPV specific programs such as counseling from shelters workers and IPV support and therapy groups.

To conclude, the women's impressions and views of the counseling that they received for the IPV from their partners offers a unique perspective of counseling and counselors in general that, we would argue, has not previously been documented. The generally positive nature of most of the comments provides important feedback to clinicians. The negative comments and suggestions merit attention and careful consideration, particularly the difficulties with couples' assessment and counseling.

Acknowledgments

The Research team (excluding the author): Dr. E. Jane Ursel and Marlene Bertrand (Manitoba Department of Family Services and Housing, MB) are the Co-Principal Investigators; Dr. Kendra L. Nixon; Dr. Christine Ateah; Dr. Janice Ristock; Dr. Lori Wilkinson; Colin Bonnycastle; Dr. Jocelyn Proulx (University of Manitoba); Dr. Johanna Leseho; Dr. Roberta Graham (Brandon University); Dr. Linda DeRiviere; Dr. Michelle Owen (University of Winnipeg); Anna Pazdzierski (Nova House, Selkirk, MB); Karen Peto (YWCA Brandon); Margaret Marin & Darlene Sutherland (Osborne House, Winnipeg); Dr. Mary Ruklos Hampton; Dr. Bonnie Jeffery; Dr. Darlene Juschka; Dr. Wendee Kubik (University of Regina); Dr. Stephanie Martin (University of Saskatchewan); Carol Soles (Prince Albert Emergency Shelter for Women); Debra George (Family Services Regina); Dr. Karen Wood (Tamara's House, Saskatoon); Maria Hendrika (Provincial Association of Transition Houses Saskatchewan); Angela Wells (Family Support Centre, Saskatchewan); Dr. H. L., Radtke; Dr. W. Thurston; Dr. Erin Gibbs Van Brunschot (University of Calgary); Dr. Caroline McDonald-Harker (University of Alberta); Dr. Ruth Grant Kalischuk (University of Lethbridge); Jan Reiner & Carolyn Goard (Alberta Council of Women's Shelters); Brenda Brochu (Peace River Regional Women's Shelter); Kristine Cassie (YWCA Lethbridge); Pat Garrett (WINGS of Providence, Edmonton).

Disclosure statement

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

Funding

This research was supported in part by grants from the Social Sciences and Humanities Research Council (SSHRC) Community University Research Alliance (CURA); Alberta Center for Child, Family, & Community Research; Alberta Heritage Fund for Medical Research; the Prairieaction Foundation; and TransCanada Pipelines.

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