How to find a therapist who understands coercive control — and not be helped with a problem you don't have

> **If you are not alone right now, this page will be in your browser history. You can read it in a private window, or clear it when you are done.**

A therapist who understands coercive control treats it as a pattern of conduct rather than a series of incidents, does not work with it as a communication problem between two people, and does not require you to have decided anything before you begin. Most therapists have never been trained in it specifically. That is a gap in the training, not a defect in them.

Therapy is licensed state by state, which means the state you are physically sitting in during a session decides who may lawfully treat you, however that session is delivered. This page sets out what specialist training in coercive control consists of, what to ask any therapist before booking, and where the limits sit. Nothing on this page is an assessment of any person or any relationship, and no page can tell you whether a particular therapist is the right one for you.

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Why haven't most therapists been trained in this?

Most therapists have not been trained in coercive control because it is not in the required curriculum. The 2024 standards of the **Council for Accreditation of Counseling and Related Educational Programs**, the accreditor most US master's counseling programs are measured against, require content on trauma, crisis and violence in general terms — standard 3.G.14 requires "procedures for assessing clients' experience of trauma," and 3.E.20 requires "crisis intervention, trauma-informed, community-based, and disaster mental health strategies." Intimate partner violence, domestic violence and coercive control are not named anywhere in the required curriculum (CACREP, 2024 Standards).

A thoughtful, well-supervised therapist can finish a good program, pass a national exam and enter practice having never been taught what a course of conduct is or how to recognize one. She will have been taught to work with what the client brings. That instinct is usually right, and it is precisely the wrong instinct here, because what you bring is a handful of small deniable items you are already embarrassed to be raising.

The clinical difference is a whole framework, not a fact. **Evan Stark**, the forensic social worker who developed the concept, argued that approaches organized around discrete assaults rather than a course of conduct "fragment and trivialize the reality of partner violence for women and children." A therapist working from the incident model will keep asking what the worst thing was. A therapist working from the course-of-conduct model will ask what your Tuesdays are like, and will not be surprised when the answer contains nothing that would sound like anything in a report.

Women who have already tried therapy usually describe the same hour. They brought three small things, the therapist responded to the third one on its own terms — communication, or stress, or his work — and they left having been helped with a problem that was not the problem. They did not go back, and most of them concluded that they had explained it badly.

What should I ask a therapist before I book?

Asking a therapist direct questions before you book is normal, and a specialist will expect it. What follows is not a test with a passing score. It is a set of questions whose answers reveal a therapist's **case conceptualization** — the working model she is using to explain what is happening — and you are listening for whether the pattern is understood, not for a particular phrase.

"What experience do you have with coercive control specifically?" You are listening for something concrete: training, a caseload, a way of describing the pattern. "I work with a lot of trauma" is a true answer to a different question. A specialist should be able to say what coercive control is in her own words without reaching for a list.

"Would you ever want to see us together?" This one matters more than any other. The answer you want is a clear no while there is fear or ongoing control, with a reason attached. An answer that treats conjoint sessions as a reasonable option to explore tells you the framework, and it is the framework that will shape every session after it.

"Do I need to have decided whether I'm leaving?" You do not. Any therapist who makes a decision a condition of treatment — in either direction — has confused her role with an advocate's, a lawyer's, or your family's. Not having decided is not a reason to wait, and staying is a legitimate place to start therapy from rather than a problem to be solved before the work can begin.

"What do you have to report, and to whom?" Ask this out loud rather than guessing, because the guess is almost always more frightening than the answer. The rules differ from state to state, they turn mostly on children rather than on you, and they are worth hearing exactly, from the person who would be doing the reporting.

"How will you contact me, and can I change that?" A therapist should be able to accommodate a reasonable request about how and where she reaches you without asking why. If appointment reminders, voicemails, statements or a shared email account are a live problem, say so at the start rather than after the first message lands.

"What would the first few months actually look like?" You are listening for sequencing — some account of what comes before what. A therapist who leads with the deep trauma work in the first month is offering you the hardest part first, and a therapist who cannot describe an order does not have one.

Why won't a specialist see you as a couple?

Couples work is contraindicated where there is coercive control because the mechanism that makes it useful is the mechanism that makes it dangerous. Couples therapy runs on mutual disclosure and shared responsibility: both people say true, unflattering things in front of each other, and both hold a piece of the problem. Where one person can make the other pay for what was said, the session becomes an inventory of admissions and the drive home becomes the consequence.

Two further things happen inside the frame itself. The first is the **identified patient** problem — a systems model looks for what each party contributes, so the partner who is dysregulated, tearful, angry or "reactive" in the room becomes the visible problem, and by month three the sessions are about her anger. The second is the **no-secrets policy** many couples therapists hold, under which information disclosed individually may be shared in the joint session. That policy is a reasonable safeguard in most couples work. Where there is fear, it removes the only place a true account could have been given.

At least one state regulator has put the same conclusion in writing. Colorado's **Domestic Violence Offender Management Board** standards provide that approved providers "shall not recommend alternative therapies such as couples counseling, anger management or stress management in lieu of domestic violence offender treatment" (DVOMB Standards, July 2025, 4.07(I)(E)). That is a rule about court-ordered offender treatment rather than about private practice, and it is not a rule about you. It is worth knowing that a state has already decided couples counseling is not a substitute for the thing it replaces.

If you have already done six months of it and came out feeling like the identified problem, there is a mechanism behind that and it is not your failure.

> **If you are in immediate danger, call 911.**
>
> **National Domestic Violence Hotline — 1-800-799-7233**, 24 hours · text **START** to **88788** · thehotline.org
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> **988 Suicide and Crisis Lifeline** — call or text **988**
>
> Deaf, DeafBlind and hard-of-hearing callers: National Deaf Domestic Violence Hotline videophone **855-812-1001**, 24 hours (a partnership between the National Domestic Violence Hotline and Abused Deaf Women's Advocacy Services).
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> Calling leaves the number in your call log and texting leaves the thread in your messages. Both can be deleted afterwards. If that is not something you can do safely, a friend's phone or a payphone is the safer route.

What is EMDR for, and what is it not for?

EMDR is a structured trauma therapy for memories that talking about has not touched — the ones that still arrive in the body as though the thing were happening now. It rests on the **adaptive information processing model**, the proposition that some disturbing experiences are stored in an unprocessed form and can be brought into ordinary memory through recall paired with bilateral stimulation (Defense Health Agency evidence brief, 2025). The 2023 VA/DoD Clinical Practice Guideline gives EMDR a "Strong For" recommendation as an initial treatment for PTSD. A Cochrane review found it more effective than waitlist or usual care while rating the quality of that evidence low, and both statements belong in the same sentence.

EMDR is not a first appointment and it is not the whole of the work. The standard protocol has eight phases, and the first two — history taking and preparation — exist to build the capacity to tolerate what the later phases do. EMDRIA's own description is that "some clients need quite a bit of time in phases 1 and 2 in order to feel ready to move on" (EMDRIA). Reprocessing a memory also presumes the event is over. Where the situation is ongoing, the work is different, and it is still work.

A credential distinction worth knowing before you book. EMDR Trained means a clinician has completed an EMDRIA-approved basic training: a minimum of 50 hours of lecture, practicum and consultation. An **EMDRIA Certified Therapist** has done that and then more — two years of post-licensure experience, at least 50 EMDR sessions with a minimum of 25 clients, and 20 hours of consultation with an EMDRIA Approved Consultant (EMDRIA, Training vs Certification). Trained and Certified are different things, and some directories blur them. You are entitled to ask any therapist which one she holds, and the answer should come back in one sentence without hedging.

What actually happens in the first session?

The first session is an assessment conversation, not a retelling. You will not be asked to give an account of the worst thing that happened, and a therapist who goes for the trauma narrative in the first hour is working in the wrong order. What she should be doing is finding out how you are functioning now — sleep, eating, drinking, work, the children, what your week is organized around — and what is currently safe to touch.

The order has a name and a reasonable evidence base behind it. **Phase-based treatment** sequences the work into stabilization first, processing second, and rebuilding a life third — a structure **Judith Herman** set out in *Trauma and Recovery* in 1992 and that the **International Society for Traumatic Stress Studies** later adopted. In its expert consensus survey for complex PTSD, 84% of 50 expert clinicians endorsed a phase-based or sequenced approach as first-line treatment (Cloitre et al., ISTSS Expert Consensus Guidelines, 2012). Expert consensus is a weaker form of evidence than a trial, and it is what exists for this population.

You can decline to answer anything. Saying "not today" to a question is information a good clinician uses rather than pushes past. **The thing women brace hardest for is the question about drinking**, and it is usually the question that produces the most relief, because whatever has been getting you through the evenings is part of the same story rather than a separate problem to be fixed first.

A therapist should ask about safety, and one who does not is doing the job badly. Safety planning itself — the sequence, the timing, the practical arrangements — belongs to trained advocates who do it free, by phone, with information no website and no first session can see. A specialist routes that to them rather than improvising it.

Does the state I live in decide who can see me?

The state you are physically located in at the time of a session decides who may lawfully treat you, and it is your location that counts rather than the therapist's. As the Counseling Compact puts it, "counselors must have a license or a privilege to practice in the state where the client is located" (Counseling Compact FAQ). That rule holds however the session is delivered — video, phone or in a room — and it is not a formality a willing therapist can waive for you.

The Counseling Compact is live in only a handful of states, and it is not something to plan around. As of this review it is operating for licensees in Arkansas, Arizona, Georgia, Indiana, Louisiana, Minnesota, Ohio, Tennessee and Wyoming. Other states are working toward it with no published date, and until a state is actually issuing and receiving privileges the compact does nothing for anyone in it (counselingcompact.gov). A therapist who tells you the compact means she can see you across a state line should be asked which state issued her privilege.

You can check any therapist's license yourself, in about two minutes, and it costs nothing. Every state licensing board publishes a public lookup — usually run by a department of health, of regulatory agencies, or of labor and licensing — and searching your state's name together with "license lookup" finds it in one step. What you are checking is that the license is current, in your state, and in the name she gave you. Verifying a stranger before you tell her anything is a reasonable thing to do, and nobody sensible will mind being asked.

What the licensure rule does not limit is what you can read. The questions in the section above work in any state, and so does everything else on this page.

What this page can tell you, and what it cannot

This page can tell you what specialist training in coercive control consists of, what to ask before you book, why conjoint work is contraindicated where there is fear, what EMDR is built for, and how state licensure decides who may treat you. This page cannot tell you what is happening in your relationship, whether any particular therapist is right for you, or what you should do. Those are questions for a person, with time, and with your actual situation in front of her. This page recommends nobody.

A next step does not have to be an appointment. It can be reading about what coercive control actually is and how to tell it from a difficult marriage, or about whether it is abuse or whether it is his condition, which is the question most women arrive with.

If you would rather talk to somebody today, the **National Domestic Violence Hotline** is **1-800-799-7233**, 24 hours, or text **START** to **88788**. For legal questions, WomensLaw.org is free and organized state by state.

You do not have to have decided anything to start asking. Not leaving. Not staying. Nothing at all.

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