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Walden University

College of Social and Behavioral Sciences

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Barbara Bryant

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Walden University
2018

Abstract

Therapists' Experiences of Domestic Violence Among African American Lesbians

by

Barbara Bryant

MA, University of Michigan, 1981

BA, Western Michigan University, 1975

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

February 2018

Abstract

Historically, African American lesbians (AALs) experiencing intimate partner violence (IPV) have received little or no support from therapists due to stigmas concerning the same-sex relationships of AALs in particular, who have been racially marginalized. The purpose of this study was to explore the experiences, attitudes, and perceptions of therapists who provide counseling for AALs who have experienced IPV. The findings of this study may help to better understand the challenges, perceptions, and attitudes of therapists regarding their experiences in working with AALs in domestic violent relationships because existing research was limited on mental health therapists' perceptions of working with AALs who are experiencing IPV in their relationships. Attribution theory provided a framework through which to explore and describe this topic. A phenomenological research design was used to explore the perceptions and lived experiences of 10 mental health professionals who have worked with AALs in IPV relationships. Data collection, using semistructured continued until data saturation was attained. Moustakas' phenomenological steps for data analysis were used to identify 4 themes in the data: challenges, IPV, resources available, and outcomes. Understanding the attitudes and experiences of therapists working with AALs in abusive relationships may result in positive social change through increasing knowledge of the issues involved. This may result in improved counseling and other services to AALs.

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Dedication

This study is dedicated to my parents, Rev. John and Constance Stringfield. Their pervasive words convinced me to undertake this journey. Though they both have gone on, my dream has become a reality.

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This dissertation would not be possible without the help of my committee, Dr. Jane Lyons, my chair; and Dr. Robin Friedman and my URR Dr. Milanesi. Each committee member provided me with extensive personal and professional guidance.

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Chapter 1: Introduction to the Study

Introduction

African American lesbians (AALs) have found it challenging to find professional therapists who are knowledgeable about gay and lesbian concerns (Hill, Woodson, Ferguson, & Parks, 2012). Researchers have consistently reported that most therapists are unprepared or underprepared to work effectively with AALs on issues specifically related to intimate partner violence (IPV; Ard & Makadon, 2011; Rutherford, McIntyre, Daley, & Ross, 2012). Hill et al. (2012) reported that AALs did not seek help because of their fears that their situation would not be taken seriously by the mental health and legal services. The researchers found that AALs thought that these systems perceived them as "deviant, hypersexual, innately aggressive, and therefore at fault for their own problems" (p. 409). Options for IPV services are limited for AALs due to the overlapping realities of racism, sexism, and heterosexism (Hill et al., 2012).

In this study, I used a qualitative research design to explore the experiences, attitudes, and perceptions of licensed mental health therapists who have worked with AALs who are involved in IPV relationships. Experiences of mental health therapists who provided services to AALs are underrepresented in the literature. Competent mental health support services may not be available to AALs (Hill et al., 2012).

Research regarding therapists' capacity to counsel same-sex partners who are domestic violence victims is essential to improving patient outcomes (Hancock, McAuliffe & Levingston, 2014; McGeorge & Carlson, 2011; Oswald, Fonseca, & Hardesty, 2010). Hill et al. (2012) asserted that AALs may encounter more barriers to

receiving therapy than Caucasian lesbians because of discriminatory treatment by the law and court systems; the absence of culturally-competent resources within the community; and isolation in society as well as in neighboring ethnic, sexual, or gender minority communities. To work more effectively with lesbian clients, providers should be open to understanding differences through self-exploration and education (Mitchell, 2009; Oswald et al., 2010; Rutherford et al., 2012). AALs are part of the larger category of lesbian, gay, bisexual, queer, and transgender (LGBQT). Since many researchers have focused on the larger category, I will use both terms when discussing literature in Chapters 1 and 2 of this study.

The results of this study may help increase awareness of therapists' personal biases and how these biases are shaped by their experiences working with AALs. A need exists among therapists to be aware of gender stereotypes (Freeman, Rule, Adams, & Ambady, 2010). Increased understanding of the reported experiences of therapists who work with AALs in IPV relationships can improve services for these clients. Social change can result from reinforcing awareness that mental health therapists must be competent to treat victims of IPV between AALs.

In this chapter, I will present the background and research problem of the study and a brief overview of how the study was conducted to address the gap and answer the research questions. The theoretical framework describing attribution theory will also be described. as well as definitions of terms, assumptions of the study, delimitations, and limitations. This chapter will also include the significance of the study and the anticipated social changes to society resulting from the study. A summary will complete the chapter.

Background

In the last 15 years, the literature base for couple and family therapy (CFT) has expanded (Constantine, Juby, & Liang, 2001; Erskine, 2002; Hardy & Lazloffy, 1998; Laird, 2000; McGoldrick, 1998; Pewewardy, 2004). This growth of research has provided evidence that professionals in the CFT field have a growing commitment to explore topics related to gender, race, and sexual orientation. Research often integrates topics concerning gender and race into studies on the cultural influences of sexism and racism; however, little research has been published in the CFT field that is associated with the larger cultural influence of heterosexism.

According to Hardesty (2011), some mental health therapists may be uncomfortable treating lesbian clients or lack the necessary training for working with these individuals. As a result, lesbian clients may not receive appropriate interventions. Historically the lack of support of AALs from therapists may have been the result of stigmas concerning same-sex relationships and maltreatment to AALs who have been racially marginalized (Hardesty, 2011; Rounds, McGrath, & Walsh, 2013).

Many AALs are unwilling to disclose their sexual identity (Durso & Meyers, 2013). Practicing nondisclosure of sexual identity may provide security for many clients who have experienced IPV to avoid concerns regarding potential mistreatment. Many members of the lesbian population who are from ethnic minorities have used nondisclosure of identity as a protective mechanism when seeking help from mental health professionals (Durso & Meyers, 2013). Oswald et al. (2010) studied the perception of lesbians who had been abused and their counseling experiences. They found that

therapists tended to minimize or neglected to recognize the abuse. The therapists in their study suggested couple therapy rather than separating the partners and enhancing safety as a priority for all those involved (Oswald et al., 2010). They found therapy with same-sex couples to be generally ineffective because participants reported the abusers were manipulative and intimidating during sessions. Also, therapists regarded them as heterosexual couples rather than same-sex and did not focus on the severity of the abuse (Oswald et al., 2010)

Basow and Thompson (2012) developed a vignette study to examine the effects of service providers' perception of a client's sexual orientation on their willingness to accept an LGBQT individual as a client. Basow and Thompson concluded that therapists had trouble deciding the victim in same-sex scenarios but less difficulty with heterosexual cases. Therapists tended to consider that lesbians were involved in mutually abusive situations rather than viewing one partner as the victim and the other partner as the perpetrator (Basow & Thompson, 2012).

Therapists are not always willing to have lesbians as clients, make recommendations for services, or refer them to shelters (Whitmen & Bidell, 2014). Basow and Thompson (2012), in surveying mental health therapists, found that 9.7% reported they did not discriminate against lesbians who were in abusive relationships in providing services. However, some therapists also reported they needed more evidence that abuse took place in the lesbian relationship than in a heterosexual relationship (Basow & Thompson, 2012). Therapists' decisions to treat a woman who was a victim of IPV was based on evidence that physical or nonphysical abuse was occurring and not the

sexual preference of the woman seeking treatment (Basow & Thompson, 2012). The lack of understanding and differences in service were listed as barriers to lesbians in acquiring adequate services from providers; therefore, being viewed as a nonvictim may result in not being accepted as a client (Basow & Thompson, 2012).

Alhusen, Lucea, and Glass (2010) conducted a mixed-methods study to examine risk and protective factors for IPV in lesbian relationships. The qualitative element of their study included the use of focus groups and face-to-face interviews using participants in the parent study. The topics of these qualitative elements were specific to perceptions of abused partners and their experiences with support systems, including domestic violence shelters as well as criminal justice and health care services. Alhusen et al. reported that research has not increased recognition of same-sex IPV and that most treatment and IPV prevention have been focused on heterosexual abuse. Healthcare workers assumed lesbian clients were heterosexual and continued to treat them as such (Alhusen et al., 2010). Many sexual minority women felt disrespected and discriminated against when seeking services (Alhusen et al., 2010). As a result, many survivors failed to form trusting relationships with therapists that prohibited them from receiving appropriate treatment or resources (Alhusen et al., 2010). Furthermore, being in abusive relationships that were compounded by therapists' attitudes concerning their sexual identity and not always being understanding and supportive, lesbians did not feel comfortable speaking about their IPV in a same-sex relationship (Alhusen et al., 2010).

Research is limited on the attitudes of therapists on the treatment of lesbians in IPV relationships. Banks and Fedewa (2012) conducted a literature review to study

domestic violence among the LGBQT community as well as therapists' use of specific procedures when working with these individuals. Banks and Fedewa concluded that therapists' treatment of same-sex partners generally differed from that of heterosexual partners. Therapists need to become more aware of these differences and work to reduce negative attitudes toward same-sex partners (Banks & Fedewa, 2012).

Brown and Groscup (2009) used a quantitative research design and found substantial biases among crisis center staff members when working with cases of gay and lesbian domestic violence partners. Crisis staff members (*N* = 120) were asked to read a vignette on a domestic violent dispute and respond to a questionnaire to measure their perceptions of the incident and parties involved (Brown & Groscup, 2009). The sex of the victims was manipulated in the study, with all other aspects of the vignette held constant. Brown and Groscup found that the study participants were apathetic and less serious regarding the instances of abuse among same-sex cases than heterosexual relationships. In heterosexual IPV, participants indicated they were more confident in treatment decisions and more apt to make recommendations to their clients (Brown & Groscup, 2009).

Lesbians, regardless of ethnic or racial backgrounds, who decide to press charges for the abuse often received unequal support from mental health professionals. Understanding the AAL experience in IPV is important. Mental health professionals are not as knowledgeable regarding the needs of AALs affected by IPV and are not able to provide adequate support and care (Eaton, 2008). Additionally, AALs have experienced community services that cater mostly to heterosexual women in IPV situations (Eaton,

2008). While research on IPV among AALs is limited, in the information that exists, researchers have hypothesized that IPV typically occurs because of unequal status in the relationship (Eaton, 2008). Therefore, AALs have found seeking help from mental health professionals to be compounded by social barriers (Eaton, 2008). Some of the social barriers include homophobia, sexism, and misperceptions that IPV is less of a threat when two women are involved (Eaton, 2008). These social barriers can prohibit women who lack power in the relationship from seeking help (Eaton, 2008). According to researchers (i.e., Robinson, 2010; Szymanski & Gupta, 2009), AALs have experienced minority status in two ways: one in being African American and the other being identified as a sexual minority. Historically, AALs were underrepresented and lacked support from both White and Black communities in getting the necessary mental help needed to combat multiple minority challenges (Szymanski & Gupta, 2009).

Hill et al. (2012) asserted that limited research had been published that explored therapists' perceptions of risk factors concerning AALs in IPV situations. This gap in the literature continues to exist regarding mental health therapists' experiences providing treatment for AALs involved IPV. The present study was needed to help educate law enforcement and social service professionals as well as dispel myths associated with this population (see Hill et al., 2012). For example, the myth that all African American women are aggressive and are less affected by violent experiences is not true (Hill et al., 2012). The knowledge obtained from this study could be used by clinicians and researchers to develop therapeutic intervention strategies that could assist AALs in healing and empowering AALs in IPV relationships.

The experiences of mental health therapists who have provided services to AALs continue to be underrepresented in the literature. Despite the number of AALs who may experience IPV being similar to their Caucasian counterparts, research concerning the availability of mental health therapists who have experience in treating AALs in IPV relationships is lacking (Dibble, Ellison, & Crawford, 2012). According to Hancock et al. (2014), competencies needed by mental health therapists to work with sexual minority IPV victims include (a) attitudes and behaviors of the therapists, (b) influences of the multicultural counseling model, (c) graduate level training, and (d) professional associations. Further research is needed to establish specific factors that are important to enhance the competencies of mental health therapists for working with sexual minority victims of IPV and provide best practices for this sensitive population (Hancock et al., 2014). Improving access to the services of competent mental health professionals is needed to help AALs who are in IPV relationships.

Problem Statement

Research on diversity in CFT has grown since the late 1990s (Constantine et al., 2001; Erskine, 2002; Hardy & Lazloffy, 1998; Laird, 2000; McGoldrick, 1998; Pewewardy, 2004). Based on the findings of these studies, interest in exploring issues related to gender, race, and sexual orientation is increasing. Typically, researchers have focused on issues related to gender and ethnicity to the overarching constructs of sexism and racism. However, the influence of heterosexism in CFT has not been explored.

Limited data may exist due to the small population and their unwillingness to discuss their experiences when working with AALs or other gay and lesbian partners

(Simpson & Helfrich, 2014). According to Brown and Groscup (2009) and Hill et al. (2012), additional research is needed with mental health therapists regarding treatment of AALs who have been exposed to IPV. They concluded that more culturally competent mental health therapists are needed to provide interventions for AALs who may be affected by IPV. Hill et al. (2012) found that AALs encounter more barriers in attaining resources.

Historically, AALs experiencing IPV have received little or no support from therapists due to stigmas concerning same-sex relationships and maltreatment to AALs in particular, who have been racially marginalized (Hardesty, 2011; Rounds et al., 2013). When judgments about clients' behaviors are based on the therapist's internal attributions, increased emphasis may be placed on the client (Murray & Thomson, 2009). Research that examined the lived experiences of therapists who provided treatment to AALs in intimate violent relationships is limited (Hill et al., 2012; Robinson, 2010). According to Hancock et al. (2014), understanding factors that contribute to the experiences and attitudes of mental health therapists when working with sexual minority IPV victims, specifically AALs is important.

Literature is lacking that explores the experiences, attitudes, and perceptions of therapists who provide counseling for AALs who have experienced IPV. To address this gap in the literature, I conducted this study to provide the necessary additional research needed to understand therapists' lived counseling experience when working with AALs in IPV relationships. Understanding the therapists' lived experiences may provide

valuable insight for professional development programs to produce strategies and cultural understanding that therapists can use to provide appropriate treatment.

Purpose of the Study

I used phenomenological research to understand the lived experiences of therapists working with AALs involved in IPV. According to Simpson and Helfrich (2014), therapists are often reluctant to discuss their experiences with working with gay and lesbian clients, specifically AALs in IPV relationships. The purpose of this study was to explore the experiences, attitudes, and perceptions of therapists who provide counseling for AALs who have experienced IPV.

Research Questions

The two main questions that guided this study were:

RQ1: How do therapists describe their lived experiences of providing counseling treatment for AALs who experience IPV?

RQ2: What are therapists' attitudes and perceptions regarding working with AAL victims of IPV?

Conceptual Framework

Norcross (2010) defined a therapeutic relationship as the working alliance between the therapist and the client, including the feelings and attitudes the therapist and client have for each other. When a person begins therapy, the relationship that is formed between the therapist and the client is important to the treatment and therapeutic outcomes of the client (Kelley, 2015). Developing trust within the therapist/client relationship early in the therapy is important for positive outcomes (Kelly, 2015). Many

theories have been developed to explain the dichotomy of client and therapist relationships.

The conceptual framework that I used to guide this study was attribution theory (AT), developed by Weiner in 1974 (Lewis, 2009). Mental health therapists base their decisions and actions on the way they perceive the world, their professional preparation and training, the lack of training for working specifically with LGBQTs and AALs, as well as through their stereotypical perceptions of AALs (Lewis, 2009; McGeorge et al., 2015). Cognitive attributions about sexual orientation can affect how a client is perceived by the therapist and how the therapist understands and ascribes meaning to a gay client's presenting problems (Reyna, Wetherell, Yantis, & Brand, 2014). AT can provide a framework for understanding how possible attribution bias can influence therapists and affect their ability to treat AALs.

I used AT to assess the ways that therapists explain the manner in which they provide treatment for their clients. The interview responses of the therapist participants provided the contextual lens through which their experiences were integrated with AT. Attribution bias occurs when therapists make casual judgments based on insufficient information about an individual's behavior (Lewis, 2009). Individuals base their decisions and actions on the way they perceive the world through their stereotypes and cognitive attributions (Lawvner, 2012). Therapists' cognitive attributions about sexual orientation influence how the therapist perceives AAL clients and how the therapist understands and ascribes meaning to their issues (Reyna et al., 2014). AT has been used

in previous studies to explain the therapist's perceptions and treatment recommendations for clients (Murray & Thompson, 2009).

Understanding therapists' perceptions and cognitive attributions regarding their clients' behaviors can be helpful in developing best practice strategies and solutions for assisting AALs in IPV relationships. Murray and Thomson (2009) viewed the concept of AT as therapists' perceptions of an individual's behavior despite any changing conditions. The relevant practices of AT assisted in gaining a deeper understanding of the preconceived attitudes that exist among therapists in dealing with the gay and lesbian problems (Murray & Thomson, 2009). Williams, Greenleaf, and Duys (2013) found that researchers have shown that attribution has an influence on the selection of counseling strategies and client outcomes. I will present a detailed discussion of AT in Chapter 2.

Nature of the Study

For this study, I applied a phenomenological design to explore the perceptions and counseling experiences of licensed mental health therapists who worked with AALs involved in relationships involving interpersonal violence. Phenomenology is a method used to explore the lived experiences of a small number of participants who experienced the same phenomenon (Merriam, 2009; Moustakas, 1994). I used a purposive sampling method to recruit licensed mental health therapists who had at least 1 year of practice and had experienced working with AALs in domestic violence relationships. Purposive sampling was used to assure that participants in a sample met the inclusion criteria and had unique perspectives on the topic being studied (see Robinson, 2014). Ten mental health therapists were recruited for the study. These therapists included licensed

psychologists, counselors, and social workers who were members of the Association of Black Psychologists, a national organization. Potential participants were recruited from the local chapter. Gender was not a factor in selecting the participants for the study. The therapists were asked to participate in face-to-face, semistructured interviews. Before conducting the interviews, I asked the therapists to read and sign the informed consent form and then complete a short demographic survey (see Appendix A). The interviews were expected to take approximately 60 minutes.

The interviews were audiotaped and transcribed by a transcriptionist. The transcriptionist signed a confidentiality agreement prior to transcribing the interviews (see Appendix B). All identifying information was eliminated from the audiotapes before being sent to the transcriptionist. I read the transcripts while listening to the taped interviews to assure accuracy. I then e-mailed a summary of the findings to participants to review and return with any comments.

I analyzed the data using methods suggested by Moustakas (1994) to examine the data by grouping, reducing, clustering, creating themes, and developing a description of the meanings and essences of the experiences of the therapists regarding their work with AALs. From the themes that emerged from interviews, the phenomenon of therapists' experience in working with AALs in IPV relationships were described (see Moustakas, 1994). As a final step in the data analysis, I used member checking where participants verified key findings from their interviews.

Definitions

In this section, definitions of the key terms used in this study are defined. The context of the definitions may be specific to this study. Some of the terms were used interchangeably throughout this study (i.e., domestic violence and IPV and lesbians and same-sex).

African American Lesbian (AAL): Women of African descent, born in the United States, and identified as a female who are attracted to other female-identified persons, emotionally, romantically, and sexually (Green & Peterson, 2004)

Attribution bias: A cognitive bias that refers to the methodical errors made when people evaluate or try to find explanations for their own and others' behaviors (Perry, Stupnisky, Hall, Chipperfield, & Weiner, 2010).)

Attribution theory (AT): This theory explains the way a person understands their life and draws conclusions of others based on what information that is known to them (McLeod, 2010).

Domestic violence: A pattern of abusive behavior (physical, emotional, social, or financial) that one partner may use to seek control of another partner (Rathus, 2013).

Intimate partner violence (IPV): The use of intimidation by one partner over another partner to maintain power and control. The abusive acts may include, but are not limited to, verbal, sexual, financial, and physical forms of abuse (Duke & Davidson, 2009).

Lesbian, gay, bisexual, queer, and transgender (LGBQT): This term is used to designate the population whose sexual identity is different from those who identify as

being heterosexual. Heterosexuals are people attracted to the opposite sex. LGBQT people come from all walks of life and include all races, ethnic groups, socioeconomic statuses, and all parts of the world (Center for Disease Control and Prevention, 2014).

Licensed therapist: A person who has the necessary education, skills, techniques, and strategies and has met regulatory requirements in the form of a state licensing examination to provide a patient intervention to minimize or change behavior (Carbajosa, Boira, & Tomás-Aragonés, 2013). For the purpose of this study, licensed therapists will include psychologists, counselors, and social workers.

Sexual identity: The act of a person identifying him or herself physically as male, female, neither, in-between, or beyond (Green & Peterson, 2004).

Sexual orientation: A term that is used when an individual is physically and/or emotionally attracted to the same and/or opposite gender. For example, gay, lesbian, bisexual, and straight are all examples of sexual orientations (Zea & Nakamura, 2014).

Therapeutic relationship: The working alliance between the therapist and the client, including the feelings and attitudes the therapist and client have for each other (Norcross, 2010).

Assumptions of the Study

My goal with this study was to understand the experiences of mental health therapists who worked with AALs who had been involved in abusive relationships. I identified two assumptions for this study. The first assumption was that participants would be willing to share experiences associated with working with AALs. When using a phenomenological research design, the second assumption was that all participants have

shared common experiences with the focus of the study. Based on this assumption, it is necessary that all included participants would be willing to discuss their experiences with AALs who have lived through IPV episodes without violating ethical considerations regarding confidentiality.

Delimitations and Scope of the Study

The scope of this study included 10 licensed mental health therapists who had at least 1 year of experience and worked with AALs in IPV relationships. The mental health therapists who agreed to participate were licensed in a large state in the Midwest. According to Guest, Bunce, and Johnson (2006), data saturation generally occurred after analyzing 10 interviews. The focus of the study was on the experiences and attitudes of mental health therapists regarding providing therapy to AALs who were in IPV relationships. Therapists who had not treated these specific individuals were not included in the study. Increased understanding of reported experiences of therapists who work with AALs in IPV relationships could improve services for a fragile population that may need help.

When qualitative research findings can be used with other populations or settings, transferability could occur (Houghton, Casey, Shaw, & Murphy, 2013). According to Cope (2014), transferability occurs if the purpose of the qualitative study is to allow generalizations about the phenomenon being studied. However, Lincoln and Guba (1985) asserted that transferability was the responsibility of the user of the research and not the original research.

Two theories, social ecology theory and social constructivism theories were considered for this study, but I found that they did not fit the goal of the study, which was to examine the experiences and attitudes of mental health therapists regarding working with AALs who were in IPV relationships. The first theory, social ecology theory, was conceptualized as the study of communities using an interdisciplinary approach ((Hawley & Williford, 2015). These approaches integrated psychology, culture, and institutional contexts related to the human-environment relationships (Hawley & Williford). This theory was intended to study interactions across different forms of activity (Hawley & Williford). However, this theory did not fit because the focus of the study was not on the interaction between mental health therapists and AALs in IPV relationships, instead it was on an examination of the experiences and attitudes of the therapists in providing therapy to AALs in IPV relationships.

I also considered social constructivism theory for this study. Social constructivism theory had been associated with Vygotsky's and Bruner's developmental theories as well as the social cognitive theory developed by Bandura (Kim, 2016). Social constructivism theory was based on understanding the culture and context of society and constructing knowledge based on this understanding (CITE). According to Kim (2016), three assumptions underlie social constructivism: reality, knowledge, and learning. This theory could have been used to examine how a therapist could develop knowledge based on the interactions with AALs who are in IPVs. However, the purpose of this study was not to study the interactions between the therapists and their AAL clients but to explore the experiences and attitudes of the therapists. One of the goals of the study was to use these

experiences to make suggestions regarding future training of mental health therapists to work with clients from sensitive populations.

Limitations

One limitation of this study was the use of a volunteer sample. While the inclusion criteria included mental health professionals who had worked with at least one AAL in an abusive relationship, some therapists who had experienced this phenomenon might not want to discuss their experiences and were not included in the study. Another limitation of the study was the use of self-reported subjective data that could not be verified. According to Yu (2016), self-reported data could be inaccurate due to flaws in memory caused by transience, absent-mindedness, blocking, misattribution, suggestibility, bias, and persistence. Yu suggested that self-reported data could be a limitation in most qualitative studies. While I assumed that the participants would discuss their experiences with AALs in IPV situations honestly, some therapists may have excluded important details of their experiences because of confidentiality issues.

To control for issues of investigator bias, I examined my personal prejudices, perspectives, and beliefs. *Epoche* is a Greek word that means to look at an experience or situation without judgment and necessitates the researcher to look at experiences of the participants without preconceived ideas (Moustakas, 1994). The use of the ordinary way to view an experience needs to be ignored. Instead, Moustakas (1994) suggested that in the epoche phase of deriving knowledge from the interviews, the investigator needs to abstain from making judgments and avoid common ways of perceiving the comments from the participants.

Significance of the Study

The results of this study have the potential to lead to a better understanding of the experiences and perceptions of mental health therapists who have worked with AALs in IPV relationships. Mental health therapists who were more aware of their feelings and perceptions regarding AALs who experience IPV in their relationships might become more aware of attribution bias and be more able to recognize any limitations they might have in providing interventions to this group. Once personal belief systems and biases are understood, therapists can begin to provide effective interventions for a vulnerable population or if necessary, refer the client to another therapist.

Mental health therapists who have worked with AAL clients could provide insight into the challenges involving working with these individuals. Based on the outcomes of this study, professional development programs could be developed for mental health therapists who could provide appropriate therapeutic interventions and facilitate better quality outcomes with AAL clients. Colleges and universities with psychology programs could use the outcomes to develop coursework to prepare potential mental health therapists to work with this underserved population. The goal of college coursework and professional development programs is to provide effective therapy for all people, including AALs in abusive intimate relationships. The use of relevant research might improve the work of mental health therapists who treat AALs in abusive relationships.

Social Change

Domestic violence is widespread in AAL couples, yet little research exists pertaining to the effectiveness of support and resources for the AAL population (Banks &

Fedewa, 2012). Understanding challenges of working with this particular population from the therapists' perspectives was important to improve, support, and help develop effective strategies for working with AALs in abusive relationships. Results of this study could provide information on how therapists' experiences, perceptions, and attitudes influence their work with AALs in domestic violent relationships. To work more effectively with AAL clients, providers should be open to understanding differences through self-exploration and education (Mitchell, 2009; Oswald et al., 2010; Rutherford, 2012). The results of this study also might help therapists better understand the instances of IPV in AAL communities.

The findings of this study might also provide an impetus for the development of scholarly courses on AAL lifestyles in psychology programs in colleges and universities. These courses could focus on providing factual information about AALs experiencing IPV in their relationships, eliminating the stigma associated with alternative lifestyles, and helping individuals who are in abusive relationships. This type of course could help to prepare students to work with AALs effectively.

Summary

Research is needed to understand the experiences of licensed mental health therapists who work with AALs who are in abusive relationships to understand how their experiences influence the way they provide treatment. Understanding the experiences of licensed mental health therapists who provided therapy to AALs in IPV relationships is essential to help eliminate myths and stereotypes associated with this group. Too many therapists lack the necessary skills and intervention strategies to treat IPV among AALs

adequately (Hill et al., 2012). Because of this reality, investigating the lived experiences of therapists who treat AALs in IPV is important.

Understanding personal attributions and biases of licensed mental health therapists associated with treating AALs in IPV is important for providing appropriate therapy to this vulnerable group. For this reason, I used AT in this study to address possible barriers that therapists may have in treating clients of the same sex in domestic violent situations. AT explains how therapists interpret their clients' behavior (Lewis, 2009). I used a phenomenological design to capture the lived experiences of therapists who provide treatment for AALs in IPV. Ten licensed mental health professionals who had experience working with African American clients in abusive relationships were recruited as participants in the study. The importance of this study lies in the results helping mental health professionals explore their possible biases or limitations that could limit their ability to provide adequate resources for AAL clients. The findings of this study could help therapists become aware of their attribution biases and improve client outcomes.

In Chapter 2, I will present a concise review of literature relevant to the licensed mental health therapists' experiences associated with providing therapy to AAL clients who are in IPV relationships. I will explain my literature search as well as key search terms used. I will also discuss the use of AT as the conceptual framework for the study.

Chapter 2: Literature Review

Introduction

The purpose of this study was to explore the experiences, attitudes, and perceptions of therapists who provided counseling for AALs who have experienced IPV. The idea of same-sex domestic violence (SSDV) has received little recognition by society (Banks & Fedewa, 2012). As a result, shelters, group support, and/or treatment programs generally are not available for the gay population (Ahmed & Jindasurat, 2014). Banks and Fedewa (2012) suggested that domestic violence among same-sex partners is a growing issue in the United States and the prevalence of domestic violence among AALs partners may be higher than heterosexual couples.

My comprehensive review of the literature produced little research on mental health professionals' experiences when working with AALs. Much of the research has focused on LGBQT individuals, a population that includes AALs, seeking treatment for mental health concerns. In this chapter, I will present a review of literature on the history of how therapists have treated LGBQT clients and research on perceptions of therapists concerning domestic violence among lesbians. Where available, research focusing specifically on therapists providing counseling for AALs will be discussed. However, most of the literature on IPV amongst same-sex partners does not delineate AALs from the larger LGBQT community. I will also review AT as the theoretical basis for this study.

Literature Search Strategy

Accessing the Literature

I used multiple databases to access the research literature needed to complete the literature review . Walden University's library provided access to the databases used for this study. The databases, included Academic Search Complete/Primer, CINAHL, Proquest, Psybooks, ScoIndex, PsyArticles, PsyCritique, Jestor, Medline, and Sage full text. A variety of Internet search engines, such as Google Scholar and Google search engines, were also used for this literature review.

Key Search Terms

Some of the key words I used in the literature search included: therapist; mental health professional; African American (AA); lesbian; attribution theory; abuse; attitude; experiences; perception; relationships; competency; same-sex; domestic violence; intimate partner violence; interpersonal violence; intimate partner abuse; treatment; proficiency; homophobia; sexual minorities; lesbian, gay, bisexual, queer, transgender (LGBQT); underrepresented; intervention; strategies; discrimination; training; working alliance; bias; stereotype; counseling; phenomenological; clients; and *ability*. These terms were used singly and in combination to obtain research relevant to the topic. The majority of the searches involved refereed journal articles, with some dissertations and Internet reports on the topic also included.

Conceptual Framework

Many theories have been developed to explain the dichotomy of client and therapist relationships. Lewis (2009) asserted that research on AT has influenced the

work of many qualitative studies, with some research linking attribution theory to African Americans. Heider (1958) is considered the originator of AT, and the theory was based on two concepts:

1. When people explain the behavior of others, they look for enduring internal attributions, such as personality traits. For example, people attribute the behavior of a person to their naivety, reliability, or jealousy.
2. When people try to explain their own behavior, they tend to make external attributions, such as situational or environment.

Kelley (1967) offered a definition of AT using a logical model that could be used to assess if a particular action could be attributed to an internal characteristic of an individual or the environment (external). According to Brickman et al. (1982), AT is defined as conclusions that counselors develop on the cause of and solution to situations reported by clients. McLeod (2010) suggested that AT is concerned with how and why ordinary people explain events as they do. AT is used when people attempt to provide a cause regarding why people do what they do, and one or more causes may be attributed to a particular behavior (CITE).

In 1974, Weiner further refined AT (Lewis, 2009). Weiner (2010) asserted three principles that were important to understanding AT:

1. Attribution is a three-stage process: (a) behavior is observed, (b) behavior is determined to be deliberate, and (c) behavior is attributed to internal or external causes.

2. Achievement can be attributed to (a) effort, (b) ability, (c) level of task difficulty, or (d) luck.
3. Causal dimensions of behavior are (a) locus of control, (b) stability, and (c) controllability.

A person can make two types of attributions: (a) an internal attribution, where the inference is that a person is behaving in a certain way because of something about the person, such as attitude, character, or personality; and (b) an external attribution, where the inference is that people are behaving in certain ways because of something about the situation in which they find themselves (Brickman et al., 1982; Malle, 2011; Weiner, 2010). Weiner (2010) asserted that ability and effort are internal attributions, and level of task difficulty or luck is an external attribution. Internal attributions are considered controllable and external attributions are beyond the control of the individual (Weiner, 2010).

Therapists working with clients bring their educational background and prior experiences to therapy sessions, which can shape their ability to help a variety of clients. The effort they expend when providing help to solve a client's concerns is a measure of the therapist's internal attributions (Brickman et al., 1982; Malle, 2011; Weiner, 2010). An example of external and internal attributions related to the treatment of the therapist is the termination of a client (Murdock & Edwards, 2011). A therapist might consider his or her treatment of the client ineffective if the therapeutic relationship was not good. This judgment would be considered an internal attribution. However, if the client prematurely terminated therapy because of changes in insurance or relocation, the attribution would

be considered external. In this circumstance, the therapist would not have feelings of personal failure or the inability to provide effective treatment (Murdock & Edwards, 2011).

When therapists use internal attributions to make judgments about a client's behavior, the client is considered in control or responsible for the situation (Murray & Thompson, 2009). However, if the therapist ascribes a situation as external, an environmental circumstance is considered to be controlling the event. Factors for internal or external causes must be identified by the therapist to manage the therapeutic relationship. Blame type emotions from the therapist toward the client may affect judgments made about the client's behavior. Therapists who make premature internal or external attributions regarding a client's situation could lead to serious mistreatment for the client (Murray & Thompson, 2009).

Therapists base their decisions and actions on the way they perceive the world and through stereotypes developed in their practices, and AT addresses the way in which therapists explain the behavior of their clients. According to Heider (1958), an individual's perceptions of another person or situation are derived from dispositional characteristics (e.g., stable factors, such as gender or race that are internal to the person). The person's behavior often is assessed from character traits that are considered consistent, even if the person is exhibiting inconsistencies (Ross, 1977). Ross (1977) asserted that dispositional characteristics may be overvalued and situational explanations for actions have been identified as fundamental attribution error.

Cognitive attributions about sexual orientation can influence how a client is perceived by the therapist and how the therapist understands and ascribes meaning to problems presented by a gay client (Reyna et al., 2014). The benefit of using AT is that therapists can become more aware of attribute bias that could affect their ability to treat AALs. Without a personal awareness of bias, therapists could damage the therapeutic relationship. A better understanding of the theory allows for an increase in healthier psychological and emotional outcomes (Kelley, 2015; Robinson, 2010). Therapists perceive the world through their stereotypes and cognitive attributions (Lawvner, 2012), and AT has been used to explain therapists' perceptions and treatment recommendations for clients.

Attribution Theory (AT) and the Therapeutic Relationship

Lewis (2009) argued that therapists are likely to experience some kind of emotional response toward their clients, but understanding these responses is important in the determining treatment outcomes. In 1910, Freud first mentioned this feeling toward the patient and warned that therapists' best interest should be focused on the client and to treat him/her in a kindly manner to maintain the relationship (Lewis, 2009). When the information concerning the client is only partially present, biased conclusions may be drawn regarding causes for the event (Lewis, 2009). Attributions can determine reactions, with the therapist reacting with distorted countertransference responses (Lewis, 2009).

In working with LGBQT clients, therapists must become familiar with the unique stressors that are associated with LGBQT individuals who are underrepresented in society, literature, and research. Therapists who have demonstrated homophobic beliefs

could place additional burdens on the client (Pachankis & Goldfried, 2013). Many therapists are not prepared to handle issues concerning the gay community, specifically AALs (Pachankis & Goldfried, 2013).

Attribution Bias

Attribution bias occurs when a person interprets events of a person's behavior based on how they are affected by the interpretation and assumptions, not on facts (Lewis, 2009). In the therapeutic environment, attribution bias occurs when therapists make casual judgments based on insufficient information about a client's behavior (Lewis, 2009). Brooks and Clarke (2011) concluded that therapists should have an open and honest relationship with their clients to avoid AT bias. Also, therapists should foster respect and care, be empathetic, and understand and show sensitive feelings for their clients as individuals (Brookes & Clarke, 2011). The therapist's focus should be on the situation and problem of the client and not on the client as the therapist sees him/her (Brookes & Clarke, 2011). Therapists who demonstrate AT bias because of their faith in doing things in a particular way may resist making changes in their practice (Brooks & Clarke, 2011).

I used AT as the framework for this study because attributions have been shown to influence therapists' interactions with clients. Attributions that counselors make concerning solutions to help their clients can have a direct effect on client outcomes (Williams et al., 2013). Counselors who have had more experience and/or training are less likely to perceive a client negatively and are more apt to be multiculturally sensitive with less AT bias (Williams et al., 2013). Additionally, counselors who are more

confident tend to be flexible in using therapeutic strategies and exhibiting communication and empathy (Williams et al., 2013).

Therapeutic History of Intimate Partner Violence with AALs

Most lesbians fail to seek help with domestic abuse due to concerns regarding homophobia and sexism along with racism and other societal prejudices (St. Pierre & Senn, 2010). Treatment of lesbians' IPV by therapists and other health professionals has been a challenge. Mental health risks faced by this population are complex because the multitude of oppressions including social stigmas, isolation, and traumatization (Robinson, 2010).

Most AALs have been treated with greater discrimination and less respect and courtesy by mental health therapists (Hill et al., 2012). Hill et al. (2012) suggested these discriminatory actions might have resulted in poorer mental health for this population. Studies conducted among AALs who had experienced consistent discrimination found that this population tended to exhibit psychological distress, especially depression and anxiety (Hill et al., 2012). AALs who have experienced attributions associated with racial discrimination are more likely to have lower self-esteem and social identity along with greater minority stress (Hill et al., 2012; Robinson, 2010; Szymanski & Gupa, 2009).

Racial discrimination attribution adds to the burden of poorer mental and physical health among AALs. Devaluing a minority group also can contribute to serious psychological distress (Chae, Lincoln, & Jackson, 2011). Serious psychological distress is affiliated with poorer mental and physical health among AALs, who have a double minority status and may experience greater possibilities of poor mental health (Chae et

al., 2011). Therefore, therapists need to understand that attribute bias may exist in their therapeutic process (Chae et al., 2011).

Researchers reported that AALs might not have access to sources of mental health care, although 28% have been in domestic violence situations with another woman (Dibble et al., 2012; Mays, Yancey, Cochran, Weber, & Fielding, 2002). A crisis center may be one of the first places a victim of domestic violence contacts. Staff members must exhibit nonjudgmental behaviors to assist victims of abuse and failure to do so can have serious consequences (Brown & Grosup, 2009). Crisis centers and staff play active roles in the prevention of further acts of domestic violence. Crisis center staff assists victims of IPV from further harm in their relationships, and addressing any bias is vital in situations that may elevate cases of violence in same-sex situations. However, domestic violence among same sex partners often is perceived differently than IPV among opposite sex partners. Any biases need to be addressed in cases of same-sex domestic violence (Brown *&* Groscup, 2009).

Gay and lesbian domestic violent relationships often are perceived as less serious than heterosexual abuse cases (Basow & Thompson, 2012). The National Coalition of Anti-Violence Programs (2015) reported in the LGBQT community domestic violence occurs typically at the same rate as heterosexual relationships (approximately 43 to 49%). St. Pierre and Senn (2010) also determined that domestic violence among same-sex partners have some of the same characteristics that are seen in opposite sex relationships. For example, same-sex partners use physical violence, stalking, and even fatal injuries to control or harm their partners (Blosnich, & Bossarte, 2009). Lesbians reported more

verbal threats, lower self-esteem, and property damage than opposite sex partners (Bimbi & Palmadessa, 2007).

Basow and Thompson (2012) found those mental health professionals' responses to scenarios of domestic violence with lesbians felt less accepting of lesbians as clients than heterosexual women. Basow and Thompson also noted that mental health professionals felt they needed stronger evidence to conclude lesbians were actual victims of the abuse than is needed for heterosexual women. Because of this bias, lesbian victims might receive different treatment, as they are less likely to be perceived as believable victims. A consequence of bias toward lesbian domestic violence victims is that an individual's experience in an abuse situation is minimized, which can be a potential barrier for people who are lesbian and victims of IPV.

In exploring mental health professionals' attitudes regarding same sex domestic violence relationships, Banks and Fedewa (2012) reviewed a study by Poorman, Seelau, and Seelau (2003) that examined perceptions of SSDV among 171 university students. Based on responses from the scenarios given to the participants, the study outcomes were that same-sex violence was perceived as less serious than heterosexual domestic violence (Banks & Fedewa, 2012). Wise and Bowman (1997) evaluated responses of 78 master and doctoral counseling candidates who read scenarios of same sex domestic violent victims. Treatment for heterosexual couples was different than those recommended for same sex partners (Banks & Fedewa, 2012). Heterosexual couples' situations were regarded as more serious than lesbians, because women were not considered as dangerous as men (Banks & Fedewa, 2012).

To determine if ATB affected attributions of the therapists when working with domestic violence victims, Brown and Groscup (2009) used a sample of 120 crisis center staff members who were given a vignette and asked to complete a questionnaire involving both heterosexual and same-sex domestic violence situations. The staff members considered same-sex relationships less serious than those of heterosexual couples (Brown & Groscup, 2009). The results indicated that participants believed that same-sex partners were not at risk for physical or fatal harm in the vignette. Their findings also revealed that the mental health providers had negative attitudes toward members of the LGBQT population, which had a potential influence when rendering services (Brown & Grosup, 2009).

Mental Health Professionals Who Work with the Lesbian Population

The extent of successful treatment that lesbians receive from therapists is contingent upon target training and professional development. Strategies for appropriate health services and training may change the perception of treatment for individuals who do not conform to the mainstream of society (Simpson & Helfrich, 2014). Research that exists concerning the competency of therapists in same-sex domestic violence has been almost entirely quantitative (Murray & Mobley, 2009; Stuart et al., 2008). Limited research has been produced that focuses on successful treatment of lesbians in abusive relationships (Hancock et al., 2014). Rutherford et al. (2012) explained that even if a provider is a lesbian, she might lack the experience or knowledge to treat the other sexual minorities. Additional training should be ongoing for lesbian identified providers.

Clinical issues to consider when working with AAL clients is not to assume the client is heterosexual. If the mental health professional becomes aware of the sexuality of the client, she/he needs to treat the client's problem and not the sexual identity. AAL clients generally are skeptical of mental health professionals' competence in treating their issues and expect that mental health professionals to gain proficiency handling them (Pachankis & Golfried, 2013).

Guidelines have been developed for conducting psychotherapy with LGBQT clients by the American Psychological Association (APA; 2002, 2012), but there seems to be no explicit training for mental health professionals to integrate these guidelines into their practices. Pachankis and Golfried (2013) noted that mental health professionals have a habit of misunderstanding sexual minorities. To reduce these misinterpretations, mental health professionals need to familiarize themselves with recent research that makes recommendations regarding their work with LGBQT clients (Pachankis & Golfried, 2013). Most graduate programs in psychology and social work base their curricula on a heterocentric society (Pachankis & Golfried, 2013).

The issues of LGBQT clients can be unique to mental health professionals and incorporating and understanding these issues can reduce the influence of society's homophobia on this community. Understanding LGBQT issues also can increase mental health professionals' comprehension of human behavior. Mental health professionals who work with ethnic or racial LGBQT clients need to be aware of the possibility of the increased risks of discrimination associated with their sexual identity. The discrimination

may not only be with the dominant culture, but within their own ethnic group as well (Pachankis & Golfried, 2013).

Graham, Carney, and Kluck (2012) suggested that most training reflects programs use a general educational approach that integrate LGBQT contents, but do not offer specific courses related to LGB issues. Cultural competency awareness in educational programs for mental health professionals is significantly limited. This lack of training may be the reason why so many post-training practitioners find themselves inadequately prepared to meet the needs of LGBQT clients (Graham et al., 2012).

Singh and Shelton (2011) developed a 10-year review that examined counseling among LGBQT using four counseling psychology journals. Singh and Shelton did not provide specific information regarding therapists providing counseling to AALs. According to Singh and Shelton, LGBQT individuals seek help from mental health professionals from two to four times that of heterosexual individuals resulting in a need for these professionals to develop a structured empathetic knowledge of LGBQT issues. Singh and Shelton asserted that without a structured methodology, research on issues concerning LGBQT population might continue to be either ignored or misunderstood. The discrimination and prejudice that continues in the practice of counseling and psychology could send erroneous messages to the LGBQT community indicating they are not as worthy of study as heterosexual clients.

Historically, mental health professionals have continued to neglect issues related to LBGQTs, as well as support society's negative perceptions of homosexuality and positive support for heterosexism. Because of these views, Singh and Shelton (2011)

argued that most mental health professionals might have reservations when working with LBGQT issues. The discrimination against LGBQT results from the American Psychiatric Association pathologizing same sex behavior and gender variance as mental health disorders (Singh & Shelton, 2011). Equally important is the concern that counselors and psychologists may lack training to provide adequate services to LGBQT clients. A concentrated effort by the American Counseling Association (ACA), American Psychological Association (APA), and the Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) has attempted to rectify deficits in training for treating the LGBQT population, but research continues to be deficient on regards to the LGBQT issues (Singh & Shelton, 2011).

Graham et al. (2012) conveyed that as the number of diverse families continues to increase, so does the use of mental health services. An increasing number of gay and lesbian individuals have turned to therapy because of the tensions and dilemmas, such as anxiety, depression, and substance abuse that occur in these family structures. Most mental health therapists (86%) indicated they had worked with at least one LGB client in their practices, with 56% reporting they were aware that an LGB client had been seen in the last week (Graham et al., 2012). Despite treating LGB clients in their practices, mental health professionals typically feel under-prepared to provide proper care for their increasingly diverse client base. Mental health therapists have voiced concerns regarding their professional ability to meet the needs of the LGB community adequately. Additionally, few research journals focusing on gay or lesbian sexuality are available. Mental health professionals have an obligation to become aware of diverse cultural and

sexual minorities, as well as their own beliefs and biases as it relates to these components. Self-awareness of the gay and lesbian clients is important to the therapeutic environment (Graham et al., 2012).

The curriculum of most mental health programs includes a course in diversity, although in many instances this course is an elective and not required for their programs (Green, Callands, Radcliffe, Luebbe, & Klonoff, 2009). The coursework on diversity focused generally on gender, ethnicity, race, and culture, virtually ignoring sexual orientation, religion, language, and physical disabilities. APA (2002) defined diversity as "dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions" (pp. 9-10). Green et al. (2009) found that students in mental health professions were satisfied with their training related to race/ethnicity, but were generally dissatisfied with preparation to work with other diverse members of society. The students rated the need to address all types of diversity in their professional preparation as very important.

Graham et al. (2012) studied the effects of different types of training for preparing mental health professionals to work with LGBs. Beyond classroom instruction, they looked at the value of workshops, training sessions, and attendance at conferences related to LGB clients. They found that workshops and training sessions were more useful for increasing the competency of mental health professionals. However, conference attendance was not as effective. Participating in a workshop or training session provides more depth in the presentations than what is available at a conference session.

Many LBGTQ clients do not seek health care due to concerns about discrimination and problems associated with communicating with the healthcare provider (Rounds et al., 2013). Because lesbians and gay individuals avoid seeing their healthcare providers, they are at greater risk for developing health-related problems. Members of the LGBTQ community are more likely to express concern about the attitudes their healthcare providers have about homosexuality and gender variance. They are more satisfied with the quality of their care when they feel they can trust their providers who are licensed to treat and prevent illness. They feel they can safely disclose their concerns about their sexuality with them (Rounds et al., 2013).

When seeking out mental health services, gay and lesbian clients do not often receive the services they need and may end therapy prematurely (Kelley, 2015). In many cases, stopping therapy may have been due to the client's perceptions that the therapist lacked knowledge concerning issues pertaining to sexual minorities. Clients who perceived that their therapist used exemplary practices in their practices were more likely to continue therapy (Kelley, 2015). Clients from LGBQT minorities found that therapist characteristics of trust, respect, caring, and confidentiality were positive, while therapists who exhibited negative characteristics, such as being disrespectful, disengaged, and uncaring had difficulty in developing strong relationships with clients from sexual minorities (Kelley, 2015). In developing positive client/therapist relationships, therapists were more likely to display sensitivity and empathy with LGBQT clients. Due to the amount of stress and anxiety attached to sexual minorities, and especially one of color, therapists must develop trusting relationships with clients. Trusting relationships should

be established for sexual minorities' clients of color, especially those involved in abusive relationships (Kelley, 2015).

Lyons (2010) discussed the difference in satisfaction with psychotherapy between LGBQT clients who self-identified as people of color and their Caucasian LGBQT counterparts. Lyons attributed LGBQT client dissatisfaction with psychotherapy to their perceptions that the therapists lack of competence that might be demonstrated through erroneous assumptions about LGBQT clients. Epstein and Hundert's (2002) definition of competence focused on the need to maintain competence in their practice. Their definition of competence is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p. 227).

The APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) indicated that three elements comprise multicultural competence: knowledge, skills, and awareness. Knowledge is therapists' understanding of the cultural backgrounds of their clients, developmental models, and prior experiences with discrimination. Skills are the interventions that are sensitive to the culture of the client. The therapists' ability to consider their personal prejudices, assumptions, and concerns is considered awareness. Many psychologists reported having no formal training that was focused on working with these clients, while those who had proper training showed more confidence. Rutter, Estrada, Ferguson, and Diggs (2008) conducted an experimental study that compared didactic and experiential training for counseling students working with LGBQT clients. When the treatment and control groups were compared, statistically

significant differences were found for knowledge and skills, but not awareness. In a comparison of the pre-and posttest outcomes, statistically significant gains were found for the skills component, but not for knowledge or awareness.

Research on Mental Health Professionals' Treatment of IPV among Lesbians

Members of the LGBQT populations who have experienced interpersonal violence (IPV) have been neglected by mental health professionals (Ard et al., 2011). While this study did not focus on AALs, they were included in the larger designation of LGBQT. Despite the prevalence of IPV among the LGBQT, heterosexual women are the primary targets for IPV screening (Ard et al., 2011). LGBQT clients have found their services options are limited when experiencing IPV. Shelters for LGBQT victims range from nonexistent to rare in many parts of the country (Ard et al., 2011). Despite the fact that attitudes concerning LGBQT issues are beginning to shift, the majority of IPV programs remain focused on heterosexuals' experiences associated with IPV. AALs are not treated as a separate group, but are included in the larger LGBQT population. LGBQT victims of IPV found mental health professionals often lack cultural competency and moral support (Ard et al., 2011). In many cases, the lack of therapist competence has led the victim to return to the abusive situation, only to be retraumatized (Ard et al., 2011). Some of the barriers that LGBQT clients who are seeking help encounter include, but are not limited to lack of family support, homophobia, stereotypes, and employment discrimination. The lack of appropriate training among mental health professionals has had a negative effect on LGBQT individuals in regard to seeking services. LGBQT victims of IPV may feel revictimized in other ways when they are discriminated against

by mental health providers due to the myths regarding the gay community (Duke & Davidson, 2009). As many mental health therapists do not view IPV in same-sex relationships as sexual assaults, their inaccuracies have contributed to the dearth of services and the lack of help needed to support the LGBQT survivors of abuse (Duke & Davidson, 2009).

Mental health professionals' attitudes regarding LGBQT IPV have been the disbelief that battering exist between same-sex partners, but rather that the offense is mutual battering (McClennen, 2005). McClennen did not discuss AALs specifically as they are included as part of the LGBQT population. Being rebuffed by service providers and the perceived lack of helpfulness has resulted in some victims remaining silent about their abuse. A plethora of information and proper training is needed about the abuse for mental health professionals to be willing to access interventions for LGBQT victims who are seeking help.

Research on Intimate Partner Violence

IPV has been a health issue in the United States for millions of people each year (Breiding et al., 2014). IPV has been harmful to people and is a burden to public health due to the extent of long-term health issues connected with the abuse. Some of the health issues include a number of physical injuries, poor mental health, and even death. The report by the National Intimate Partner and Sexual Violence Survey (NIPSVS, 2011) examined the overall prevalence of IPV victimization. Burge et al. (2013) reported that 4.1 billion dollars in medical costs yearly are due to injuries related to IPV. IPV was ranked the 12th in the nation in 2010 of lives lost.

The data found in the NIPSVS (2011) could be used by researchers, policy makers, and advocates to describe the need for health services and form efforts to prevent IPV (Breiding et al., 2014). Although, some progress has been made in an effort to decrease the incidence of abusive situations among partners, results of this survey indicated that a substantial number of adults and young people continue to experience IPV (Breiding et al., 2014). Therefore, careful surveillance of IPV and associated health issues need to continue to assess the effectiveness preventive methods. Nationwide the National Coalition of Anti-Violence Programs (NCAVP, 2015) reveals an increase of domestic violence of 14.0% in the LGBQT communities of color. LGBQT of color experienced two times more physical violence than those in the White middle-class LGBTQ community (NCAVP, 2015). Finally, LGBQT of color who are under 30 years of age reported experiencing physical abuse four times that of middle class white LGBTQ individuals (NCAVP, 2015).

Cases of IPV among AAL are underreported due to the amount of oppression these individuals have to endure (Robinson, 2010). Some of these factors include anxiety, depression, and substance abuse. These factors have been said to contribute to high risks of IPV among AALs. African American lesbians are less likely to report IPV in their relationships because social and legal restrictions do not to leave a safe haven for reporting the abuse (Robinson, 2010; Hill et al, 2012).

Research on Primary Risk and Protective Factors for Interpersonal Violence

Primary risk factors that have influenced the existence of IPV often consists of patterns of control that can lead to violence (Buzawa & Buzawa, 2013). Some of the

behavioral characteristics may include being intimidated, isolated, emotionally abused, Primary risk factors related to IPV among sexual minorities include: low self-esteem, racism, lack of power in the relationship, substance abuse, isolation, attachment anxiety, socioeconomic status, risky sexual behavior, control over sexual and social life and being younger in age than the other partner (Andrask, Valentine, & Pantalone, 2013; Barrett & St. Pierre, 2011; Edwards & Sylaska, 2014). This marginalized group is more susceptible to mental stressors that may lead to suicide and interpersonal violence (Moe, Finnerty, Sparkman, & Yates, 2015).

The family structure that may include lower income families who are facing economic crisis also can contribute to IPV. One of these economic crises could be the result of unemployment, low-income, or being financially disadvantaged. These economically stressful conditions can place a strain on intimate relationships (Renzetti, 2009).

Another factor that may contribute to IPV is substance abuse that subsequently results in impaired judgment and reduces a person’s ability to interpret social cues adequately, leading to a decrease of inhibitions to violence. Over time, substance abuse can lead to aggression (Buzawa & Buzawa, 2013). Other risk factors that have been associated with IPV are being abused as a child or witnessing a parent being abused (Buzawa & Buzawa, 2013).

Protective factors for LGBQT in IPV relationships reduce barriers for help-seeking victims. According to Edwards and Sylaska (2014), providers need to be educated to respond to LGBQT in IPV relationships who are seeking help. The therapists

need to use language that does not address IPV as just a heterosexual issue (Edwards & Sylaska, 2014). The acceptance and recognition of diversity among people has increased in today's society, with safer access to competent, qualified mental health professionals becoming an important factor in the lives of gay people (Moe et al., 2015). Furthermore, mental health professionals are ethically bound to expand their competencies in working with LGBQT clients (Edwards & Sylaska, 2014).

A protective factor for IPV is primary care screenings by physicians. These screenings were supported by the Violence against Women Act of 1994 (Ross, Walther, & Epstein, 2004). Another protective factor is the development of an IPV risk-screening questionnaire by Ross et al. (1997). Social support is a viable protective factor for those individuals who have experienced IPV (Canady & Babcock, 2009). Individuals who provide social support to victims of IPV include family members, friends, and medical health professionals. Having social support helps victims maintain their mental health, increase self-esteem, and become educated about IPV. In addition, social support can assist victims to acquire positive coping strategies (Canady & Babcock, 2009). Protective factors for LGBQT in IPV relationships can reduce barriers, allowing victims to receive the help they need.

Historical Background of AAL Integration into the Gay Liberation Movement

The historical significance of challenges AALs faced in their integration of the Gay Liberation movement needs to be explained to provide information about the disparities of resources available to lesbian survivors of IPV. African Americans lesbians are marginalized, and the extent of discrimination is not limited to employment

(Mechanic & Pole, 2013; Sanford, 2014). Most AALs born before the 1970s referred to themselves as gay (Moore, 2011). However, during the 1960s and 1970s, the Gay Liberation movement took place. AALs did not take an active part in this movement due to different paths than their Caucasian counter parts (Moore, 2011). For example, Caucasian lesbians who were attending college became aware of the Gay Liberation movement through college classes and consciousness-raising meetings during the 1960s and 1970s. In contrast, AALs learned about the movement through social organizations and events in other environments (Moore, 2011).

AALs interests lay in racial concerns. They did not want to be identified as a lesbian, because that could have deteriorated their already limited social place in the African American community (Moore, 2011). Most AALs social worlds were comprised of private house parties and other private gatherings in their neighborhoods. The Gay Right Movement of the1960s and 1970s shaped their environment into helping them explain their identity to the world (Moore, 2006). They were able to form cohorts and organize themselves as social groups, especially for those AALs who would come after them.

The Caucasian lesbian movement did not serve in the best interest of AALs who were more interested in police brutality and job equality. Being identified as stud, butch, or bull dagger was an identifiable label that was not accepted in the AAL community, nor was being labeled queer or funny (Moore, 2006). These homophobic attitudes could be detrimental to their relationships in the African American social and religious community (Moore, 2006). Being African American already was a portrayal to their present world of

being inferior and ostracized, along with a fear of not doing anything to call attention to them. Writings, conferences, and presentations describe their struggle and give them a scholarly voice that was once historically excluded (Wilson & Johnson, 2011).

Historically, research that has reported on the experiences of African American LGBQTs' feelings and attitudes related to being both a sexual and racial minority is limited. Although Caucasian lesbians may have multiple stereotypes that could impede their ability to live without discrimination in a society that is comprised of heterosexual ideology, AALs have been exposed to more barriers than Caucasian lesbians (Szymanski & Gupta, 2009). AALs face discrimination associated with being African American in a racist culture and being homosexual in a heterosexual society (Szymanski & Gupta, 2009). LGBQT women of color are exposed to a double jeopardy of excess stress related to racism and homophobia (Szymanski & Gupta, 2009).

Research on African American Lesbians and Intimate Partner Violence

Due to barriers including racism and homophobia (Szymanski & Gupta, 2009), AALs are in greater danger of becoming victims of domestic violence, therefore, demanding more attention from mental health professionals (Simpson & Helrich, 2014). AALs face domestic violence situations without the help of resources or protection, such as shelter and transitional services that are available to heterosexual victims of IPV (Simpson & Helrich, 2014). Because domestic violence is considered to be a heterosexual issue, and the myth that men are perpetrators and women are victims continues, same-sex domestic violence remains underreported (Banks & Fedewa, 2012). Greene (2004) noted that the mental health treatment of AALs who are IPVs often is viewed as inappropriate.

The current mainstream methods of therapy have been insensitive to the needs of this diverse group of people. AALs were given labels or misdiagnosed and blamed for their misery (Green, 2004). Theories and practices regarding African American sexual minorities have been slow to change (Green, 2004).

A paucity of data exists concerning IPV among AALs. Hill et al. (2012) reported that there has been little research conducted on AALs in IPV. Additionally, AALs in IPV are considered a high-risk population that has been under-researched and underserved (Hill et al., 2012).

Statistics on the prevalence of abuse among lesbians has been reported by the National Violence against Women (NVAWS). The survey findings showed that IPA among all lesbians is 13 to 75% for physical violence, and that approximately 11% goes unreported. According to Hill et al. (2012), 25 to 40% of AALs may experience some form of IPV, the higher percentage more likely if nonphysical forms of aggression (verbal abuse, intimidation, and coercion) are included. Specific information on AALs is not available from NVAWS, in seeking professional help, (Balsam, 2001; Bowleg, 2008; Miller & Astra Parker 2009; Purdie-Vaughns & Eibach, 2008; Tigert 2001). When seeking help, AAL victims are seen the cause of the problem rather than people who are in need of assistance. AALs have been viewed as innately aggressive, deviant, hypermasculine, and less affected by abusive experiences (Hill et al., 2012). The gay population is small, with AALs a small subset of the gay population. Trying to seek help for IPV can be a fearful experience that may involve being isolated from an already small group of AALs (Robinson, 2010).

Research concerning the phenomenon of IPV among same sex partners is relatively recent. Most research focuses on the perceptions of the victim or incidences of IPV involving Caucasian partners. Specific information concerning the attitudes of the helping profession for the AALs involved in IPV is uncommon (Hill et al., 2012). Most individuals in LGBQT communities neglect to get help with abuse due to homophobia, sexism and with AALs racism, among other society's prejudices (Peterman & Dixon, 2003).

Robinson (2010) conducted a study to raise awareness of challenges faced by many adolescents and young adults who were seeking psychosocial, emotional, and sociocultural services at a community center in the Detroit area. Black lesbians discussed their concerns regarding needed to work within several identities at the same time and their lack of access to adequate resources and appropriate role models. Mental health therapists can learn about the life styles of Black lesbians and make adaptations to their practice to provide culturally competent interventions. Robinson (2002) provided recommendations tailored specifically for therapists' counseling practices of AALs, including the use of specific intervention techniques to address homophobia and recognize same-sex battering.

Simpson and Helfrich (2014) conducted personal interviews with AALs to obtain information on challenges that exist among the AAL population. The purpose of the study was to describe barriers to acquiring service among a marginalized group of women of color. Intimate partner violence affected many women, but the findings of this research suggested that it might not affect all women equally. The findings from the

interviews were to help mental health providers adjust their practices for working with AALs. Ethnic and racial minority members continue to have negative experiences with the institutions run by the dominant culture that are influenced by their views of how to distribute services for IPV clients (Simpson & Helfrich, 2014). Another concern raised in this study was that African American lesbians of color were fearful of the responses of the criminal justice service that has reacted abusively toward same-sex victims of IPV. However, the study found the most pervasive obstacle that AALs found in finding solutions to their problems and their safety of IPV abuse was homophobia (Simpson & Helfrich, 2014). Simpson and Helfrich (2014) made recommendations for more research that examined the experiences of lesbians who were women of color and in IPV relationships. Findings from research continue to stress the need for service providers to understand diversity among the cultures and gay community.

Presently, the use of a survey questionnaire has been effective in detecting the presence of abuse. Bradford (2010) suggested that the two instruments that are used most often are the Intimate Justice Scale (Jory, 2004), and the Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). If the survey results detect violence present in a relationship, a treatment plan can be devised to ensure the best outcomes. Safety is the first consideration of the plan for the client (Bradford, 2010).

Summary

Minimal research has been published that addresses mental health professionals' competency in providing therapeutic services for AALs in IPV situations. Because of this gap in the literature, this study was needed to provide an understanding of the

experiences of mental health professionals when working with AALs in IPV relationships. Most research on IPV has been conducted using the larger LGBQT population and has not distinguished separate groups within this population. Among the LGBQT population, people of color have experienced severe forms of IPV (NCAVP, 2015). IPV among the LGBQT population generally, and AALs specifically, has been regarded as less serious by mental health professionals (Bascow & Thompson, 2012). Mental health professionals' responses to LGBQT individuals as clients have not been as welcoming as heterosexual clients (Bascow & Thompson, 2012). The lack of concern for LGBQT IPV issues in general and especially for AALs in abusive relationships has created potential barriers for this population to seek and receive help. Research concerning same-sex abusive situations has been mostly quantitative (Murray & Mobley, 2009).

AT was used as the theoretical model to provide insight on how mental health professionals assign meaning to the problems presented to them by gay clients (Lewis, 2009). The benefit in using AT was to make mental health professionals aware of any biases that would affect treatment to LGBQT clients in general and to AALs specifically. Training for most mental health professionals focuses primarily on gender, with curriculum on diversity incorporating a small segment on LGBQT issues (Graham et al., 2012). Formal training needs to be develop or required for working with LGBQT clients and especially those of color is limited.

AALs have encountered negative experiences with healthcare professionals when seeking help for their issues with IPV (Simpson & Helfrich, 2014). As a result, many IPV

situations go unreported and mental health professionals have been insensitive to the needs of this population (Green, 2004). Due to this lack of sensitivity, AALs may have greater difficulty in receiving appropriate treatment. Therapists' perceived challenges of working with AAL victims of domestic violence or IPV has not been the subject of research. Additional research is needed to explore how therapists describe their lived experiences of providing counseling treatment for AALs who experience domestic violence.

The therapeutic history of AALs in IPV reveals several concerns why these individuals fail to seek help for domestic abuse. Some of these fears included sexism, homophobia, and racism (St. Pierre & Senn, 2010). Other mental health issues consist of traumatization, stigmas, and isolation (Robinson, 2010). As for AALs, many of these individuals have encountered multiple acts of discrimination. Many of these acts may have resulted in mental health issues, such as lower self-esteem, anxiety, depression, and social identity. AALs have a double minority status that therapists need to consider in providing treatment for this group of clients (Chae et al., 2011).

Although crisis centers may be the first option for most abused victims to find refuge, some staff members have been known to treat gay and lesbian victims of abuse with less urgency than heterosexual situations (Brown & Grosup, 2009). Minimizing this act of violence has become a potential barrier for gay and lesbian individuals and has resulted in a risk of greater physical or fatal harm (Brown & Grosup, 2009). In view of this observation crisis center, staff may need to be concerned about any biases when rendering service to AAL victims of abuse.

Mental health professionals have had limited training to prepare them to provide therapeutic treatment for AAL clients in abusive situations (Graham et al., 2012; Hancock et al., 2014). Most college curriculums focus on heterocentric society and use a general education approach to LGBQT concerns (Graham et al, 2012). APA has guidelines in place for mental health professionals on conducting therapy for LGBQT clients, but has not provided instructions on how to incorporate these guidelines into their practices (APA, 2012). Due to this lack of training and incorporation of guidelines, mental heal professionals continue to neglect issues related to LGBQT individuals (Singh & Shelton, 2011). Sexual minorities of color do not trust mental health professionals when reporting their abusive relationships (Kelley, 2015). Due to these barriers, a need exists to work beyond the classroom participating in workshops, conferences and training sessions for mental health professionals to serve those clients in the gay and lesbian communities adequately (Graham et al., 2012).

Although attitudes in this country have started to shift in a positive way to recognize the issues of the LGBQT community, not enough has been done to eliminate the limited options of services for IPV (Ard et al., 2011). IPV has been a national concern in the United States for millions of diverse people. Many lives have been lost, and billions of dollars have been spent in medical costs (Burge et al., 2013). Enough data have been recovered about IPV among the LGBQT and those of color to encourage researchers, policy makers, and advocates to develop efforts for prevention (Breiding et al., 2014).

This study addressed a gap in the literature regarding the challenges that mental health professionals experience while working with AALs in IPV relationships. Much of the research on IPV has been conducted on therapists work with people in heterosexual relationships, with little or no research presented on the therapists' working with LGBQT couples. In Chapter 3, details regarding the methodology are described that were used to select the sample, as well as collect and analyze the data needed to address the research questions posed for the study.

Chapter 3: Methodology

Introduction

The purpose of this study was to explore the experiences, attitudes, and perceptions of therapists who provide counseling for AALs who have experienced IPV. In Chapter 3, I will describe the methods that were used to collect and analyze the data needed to address the research questions developed for this study. The topics that are included in this discussion are the research design and rationale, research tradition, role of the researcher, participant selection, data collection, data analysis, trustworthiness, and ethical considerations.

Research Design and Rationale

I used a phenomenological research design composed of face-to-face interviews with licensed mental health therapists in this study. The data resulting from the interviews were used to address the two research questions that guided this research:

RQ1: How do therapists describe their lived experiences of providing counseling treatment for AALs who experience IPV?

RQ 2: What are therapists' attitudes and perceptions regarding working with AAL victims of IPV?

Research Tradition

In this study, I used a phenomenological research design. My focus was to explore the lived experiences of mental health therapists who had worked with AALs involved in IPV in their relationships. This type of research design is appropriate when participants who are included in the study have experienced the same phenomenon

(Merriam, 2009). According to Moustakas (1994), phenomenological research is used with participants who are asked to describe their experiences with the phenomenon under study. The participants' descriptions should be comprehensive and provide a basis for analyzing the data to reflect the heart of the individual and combined experiences of the mental health therapists in treating AALs who have been in IPV relationships (Moustakas, 1994).

Phenomenological research is used when the researcher assumes the participants have experienced shared encounters in their practice (Merriam, 2009). Merriam (2009) explained that the experiences of participants regarding the phenomenon of interest are grouped, condensed, and compared to determine commonalities and differences among the participants. Phenomenological researchers are then expected to describe the underlying structure of the phenomenon and put aside their beliefs or biases regarding the experience to eliminate personal interferences that could affect the study (Merriam, 2009).

Rationale

I considered other types of qualitative research designs when deciding which tradition to use for this study. Five different types of qualitative research designs (i.e., narrative research, phenomenology, grounded theory, ethnography, and case study) identified by Merriam (2009) were reviewed as possibilities for use. Traditions that I considered, but chose not to use, were narrative, grounded theory, ethnography, and case study.

Narrative research is used to study the life of an individual through stories of their personal experiences (Merriam, 2009). Narrative research involves people telling their stories, with a beginning, middle, and end, as well as how they understand the world around them, and the key to successfully conducting narrative research is to use data in the form of stories (CITE). This type of research is also referred to as autobiographical, life history, oral history, and biography (Merriam, 1994). Narrative research studies are stories about how we communicate with each other (Merriam, 1994). I did not select this research design because participants in narrative studies are not required to have experienced the same type of phenomenon.

Grounded theory is used to establish a theory based on data collected from the field (Merriam, 2009). A study using grounded theory usually addresses questions about something that has changed over time (Merriam, 2009). Grounded theory involves using multiple stages of data collection and comparisons and differences of that data (Creswell, 2012). In this research study, I was not attempting to establish a theory regarding therapists' attitudes toward treating AALs in IPV relationships, so grounded theory was not an appropriate research design.

Ethnographic research describes a problem in terms of a group that shares a common culture, and the focus is on human society and culture (Creswell, 2012). Researchers who engage in a study that involves ethnography must spend time with the individuals being studied (Creswell). A study of the culture requires researchers to have firsthand involvement with activities that take place in the culture, perform intense work, and conduct data collection over a lengthy time period (Creswell). Ethnography is written

as a description, with researchers describing the culture and depicting their understanding of the phenomenon (Creswell). While all participants in this study were therapists, the results of the study were not intended to represent the culture of the group so ethnography was not a suitable design.

Case studies are a research design that are used to study a problem, program, event, situation, activity, or process in depth (Creswell, 2012). A case study can be used to provide a description of single or multiple cases. In most case studies, data are triangulated through interviews and additional data, such as artifacts, to support the information provided by the participants (Creswell, 2012). The purpose of this study was to understand the lived experiences of the participants, which is not a primary focus of a case study.

A phenomenological research design is used to provide a description of the lived experiences of a group of people who have shared a common phenomenon, using data from semistructured, in-depth interviews (Moustakas, 1994). In this study, the phenomenon being studied was the lived experience of therapists who have treated AAL clients who have experienced IPV in a same-sex relationship. With this research design, data from personal interviews for a small group of participants who have experienced the same phenomenon can be analyzed to determine similarities and differences within the group (Moustakas, 1994).

Two forms of phenomenological research can be used: hermeneutical (van Manen as cited in Moustakas, 1994) or empirical, transcendental phenomenology (Moustakas, 1994). Hermeneutical phenomenological research is concerned with learning about the

lived experience (phenomenology) and interpretation of the data collected from the participants (van Manen as cited in Moustakas, 1994). In contrast, empirical, transcendental phenomenology examines participants' experiences of a shared phenomenon (e.g., providing mental health services to AALs in interpersonal abusive relationships) with a focus on interpreting the experiences (Moustakas, 1994). For this study, I used an empirical, transcendental phenomenological research design.

According to Moustakas (1994), there are methods and procedures for an organized and systematic study in phenomenological research. These methods and procedures include:

1. Discovering a topic and question rooted in autobiographical meanings and values as well as involving social meanings and significance;
2. Conducting a comprehensive review of the professional and research literature;
3. Constructing a set of criteria to locate appropriate coresearchers [participants];
4. Providing coresearchers [participants] with instructions on the nature and purpose of the investigation and developing an agreement that includes obtaining informed consent, insuring confidentiality, and delineating the responsibilities of the primary researcher and research participants, consistent with the ethical principles of research;
5. Developing a set of questions or topics to guide the interview processes;

6. Conducting and recording a lengthy person-to-person interview that focuses on a bracketed topic and question. A follow-up interview may also be needed; and
7. Organizing and analyzing the data to facilitate development of individual textural and structural descriptions, a composite textural description, a composite structural description, and a synthesis of textural and structural meanings and essences. (pp. 103–104)

Role of the Researcher

Prior to starting the interviews, I took the time to examine my experiences with the phenomenon as a means of becoming aware of my personal prejudices, perspectives, and beliefs. *Epoche* is a Greek word that means to look at an experience or situation without judgment (Moustakas, 1994). The use of the ordinary way to view the experience needs to be ignored. Instead, epoche necessitates the researcher to look at the experiences of the participants without preconceived ideas (Moustakas, 1994). Moustakas suggested that in the epoche phase of deriving knowledge from the interviews, there is a need to refrain from making judgments and to avoid common ways of perceiving the comments from the participants.

While I have never worked with AALs in IPV relationships, I have become aware of many prejudices and biases that affected the way that these individuals are treated in therapy. I am an African American female who has worked for 37 years in the field of counseling. In conducting interviews with adults in various situations, I have enhanced my listening skills and ability to be open about understanding the context of the situation

being discussed. My clients included individuals who were involved in domestic violence, child neglect, and drug and alcohol addiction. As a counselor, I have had opportunities to understand the influence of therapist perceptions and biases on treatment outcomes. During this study, I maintained a journal in which I wrote down my biases to remind myself continuously that I must look at the interviews with participants as new and not judge or use preconceived ideas when reviewing them.

A researcher presents him or herself to participants as authentic and transparent (Mitchell, 2011). In doing so, participants were given the permission to discuss issues that may be unspeakable or taboo. A researcher should gently probe questions in a way that could promote empowerment (Mitchell). Additionally, the researcher should avoid manipulation of participants and respect the participants' right to be open (Mitchell, 2011).

Throughout this research, I bracketed any bias and personal feelings that could influence what I might hear from the participants. Bracketing is a way by which the researcher identifies and his or her own perspectives of the research (Fischer, 2009). According to Chan, Fung, and Chien (2013), bracketing is a difficult process that requires the researcher to put aside his/her beliefs and understandings of the phenomenon begin studied. Chan et al. suggested four strategies that could be used by the researcher to bracket his/her feelings on the topic: mentally assessing the researcher's personality, identifying areas of personal and potential bias, keeping a reflexive diary to maintain control of biases and preconceptions, and allowing the participants to answer openly. Using a notebook for field notes, I wrote my feelings and biases and referred to them

often when conducting the interviews and analyzing the data. Maintaining an awareness of any personal biases helped me read and analyze the interviews without prejudice. I also used reflexivity, which is an honest examination of my values and interests that may impede upon the research (see Fischer, 2009). A reflexive journal was used to write down thoughts, feelings, and perceptions. I also refrained from doing any harm or causing distress to those who volunteered to participate in the study. I provided sufficient time for the mental health professional participants to answer each interview question as they revealed their experiences and challenges when working with AAL clients who were involved in abusive relationships.

Participant Selection

The participants for this study were male and female mental health therapists licensed in a large midwestern state. These professionals were psychologists, counselors, or social workers. The inclusion criteria were that the mental health therapists had worked in their respective fields for a minimum of 1 year and had worked with AALs who experienced IPV in their relationships. Some participants were recruited from the local chapter of Association of Black Psychologists (ABPSI), a national organization of African American psychologists, social workers, and counselors.

The sample included 10 mental health professionals who I invited to participate in face-to-face, semistructured interviews. I asked the president of ABPSI to place the flyer for the study in their newsletter (see Appendix C). Membership in the ABPSI includes psychologists, social workers, and counselors. Data saturation was reached with the 10 participants and no additional interviews were needed. Data saturation, as described by

Samure and Givens (2008), is the time in data collection when no new or relevant information is obtained from an additional participant.

A purposive sampling plan was used to recruit participants who met the criteria for inclusion in the study. Purposive sampling, also called judgment, selective or subjective sampling, is a sampling method that was used to assure that participants met the inclusion criteria (Merriam, 2009). According to Robinson (2014), purposive sampling was used when recruiting participants who had the necessary expertise to address the phenomenon being studied. In this type of nonprobability sampling, the researcher depended on his or her expertise to invite mental health professionals who met the criteria for the study to participate in the study. This type of sampling strategy is used when conducting qualitative studies, especially phenomenological research (Merriam, 2009). Purposive sampling requires the researcher to have sufficient knowledge of the phenomenon being studied to invite the appropriate individuals to participate (Robinson, 2014). The advantages of using a purposive sample are that appropriate candidates are recruited for the sample. Purposive sampling may be the sole method necessary to obtain therapists who meet the criteria for the study (Merriam, 2009). If additional participants were needed, snowball sampling procedures were used to recruit additional participants. The individuals who agreed to participate were asked to refer other mental health professionals to participate in the study (Vogt & Johnson, 2011).

Data Collection

After receiving approval from the Institutional Review Board (IRB) at Walden University to conduct the study, I contacted the ABPSI to ask that a flyer to introduce the

study (Appendix C) be included in their newsletter and on their websites. The flyer included a short description of the study and my contact information for interested licensed mental health professionals who worked or had worked with AALs in IPV relationships.

When a mental health therapist contacted me expressing interest in participating in the study, I explained the purpose of study and if he or she agreed to participate in the study, I went through the demographic questions (Appendix A) to make sure that the therapist met the criteria for a participant and obtain basic background information. Then I explained the consent process and either emailed or sent the consent form to the participant by United States Postal Service (USPS). After determining that the participant was interested in participating, I made an interview appointment at a mutually agreeable time and place, such as his or her office or a private meeting room in a public library. The locations assured privacy and confidentially for the participants. All interviews were in person to encourage an open dialogue about therapists' experiences when treating AALs who had been in abusive relationships. The participants were assured that all information obtained would be confidential.

Prior to beginning the interview, the participant was given two copies of the informed consent form). I reviewed the informed consent form and ask the participant to sign the form. The informed consent form I used included the purpose of the study, provided procedures for conducting the interviews, obtained permission to audio-record the interview, assured confidentiality of all responses, and indicated that participation was voluntary. The participant was given a copy for his or her records and I retained the

signed copy. I audio-recorded the interview, as well as took notes on the responses. Each interview lasted approximately 60 minutes, with time allowed for the participant to add any additional comments related to the study, but not included on the interview questions. After completing the interview, I thanked the participant for taking the time to participate.

Semistructured interview questions (See Appendix D) were used to collect data regarding the lived experiences of licensed psychologists in their work with AALs who had been in abusive relationships. While all participants were asked the core questions, additional probes were used to elicit more in-depth information or to clarify any ambiguous responses. Semistructured interviews were used to be flexible and allow me to follow the direction of the conversation in capturing their unique experiences, while obtaining similar information from each therapist. Through this dialog, I was able to obtain in-depth information that provided rich documentation on the topic. Interviewing becomes necessary when behaviors cannot be observed, and past events cannot be replicated.

Data Analysis

A separate audiotape was used for each participant. At the end of the interview, I gave the audiotape to a trained transcriptionist to be transcribed. No identifying information was provided with the tapes. They were labeled as Participant1, Participant 2, and so on. The transcriptionist was asked to sign a confidentiality form (Appendix B). The transcriptions were stored on a password-protected USB drive. When the transcribed

interview was returned, I compared the transcription with the audiotape and added details from my field notes to provide clarity.

Moustakas (1994) recommended analyzing the interview data by reading and rereading the interview transcripts to develop themes and patterns in the data. His steps include:

1. Listing and preliminary grouping.

   List every expression relevant to the experience (Horizonalization).

2. Reduction and elimination to determine the invariant constituents.

   Test each expression for two requirements:

   a. Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?

   b. Is it possible to abstract and label it? If so, it is a horizon of the experience. Expressions not meeting the above requirements are eliminated. Overlapping, repetitive, and vague expressions are also eliminated or presented in more exact descriptive terms. The horizons that remain are the invariant constituents of the experience.

3. Clustering and thematizing the invariant constituents;

   Cluster the invariant constituents of the experience that are related into a thematic label. The clustered and labeled constituents are the core themes of the experience.

4. Final identification of the invariant constituents and themes by application: Validation

   Check the invariant constituents and their accompanying theme against a complete record of the research participants. (1) Are they expressed explicitly in the complete transcription? (2) Are they compatible if not explicitly expressed? (3) If they are not explicit or compatible, they are not relevant to the coresearcher's experience and should be deleted.

5. Using the relevant, validated invariant constituents and themes, construct for each co-researcher [participant] an individual textural description of the experience. Include verbatim examples from the transcribed interview.

6. Construct for each co-researcher [participant] an individual structural description of the experience based on the individual textural description and imaginative variation.

7. Construct for each research participant a textural-structural description of the meanings and essences of the experience, incorporating the invariant constituents and themes.

   From the individual textural-structural descriptions, develop a composite description of the meanings and essences of the experience, representing the group as a whole. (pp. 120-121)

The results were checked for discrepant cases. According to Creswell (2014), including discrepant or nonconforming cases is important to provide information that

might contrast other views of the phenomenon. By presenting all points of view, the findings become more realistic and as a result, more valid (Creswell, 2014). Member checking was used after writing the initial draft of the findings. Member checking is used to determine if the researcher's descriptive results are comparable to their experiences with the phenomenon (Creswell, 2014). I sent a summary of each participant's findings to them either by email or regular mail. The participants were asked to review the findings to verify their accuracy and provide any additional comments.

Trustworthiness

The trustworthiness of qualitative research has been related to reliability and validity in quantitative research. According to Guba and Lincoln (1981), four criteria typically were used to provide assurances of the trustworthiness in qualitative research:

1. Credibility (in preference to internal validity),
2. Transferability (in preference to external validity/generalizability),
3. Dependability (in preference to reliability), and
4. Confirmability (in preference to objectivity). (p. 64)

Merriam (2009) stated that the trustworthiness of qualitative research resides in the reader who decides what parts are applicable to his or her context. According to Lincoln and Guba (1985), the goal of trustworthiness in a phenomenological study is to provide support that the study results are relevant. To address the rigor required for this qualitative study, specific guidelines were used to confirm the trustworthiness of the qualitative research process.

Credibility

Guba and Lincoln (1992) asserted that credibility is important in verifying trustworthiness. According to Merriam (2009), credibility is defined as the extent to which the findings of the study reflect reality. Credibility is the idea of being consistent and providing evidence that the study has been done (Merriam, 2009). Credibility for this study was established by providing participant member checks, assuring that my interpretations were reflective of the interviewees' meanings, and providing rich descriptions of the participants' *experiences* with the phenomenon (Creswell. 2009). As part of meeting the criteria for credibility, I maintained field notes and made entries on a regular basis that provided confirmation about my decisions and the reason for making them. I l used a reflective journal to document my thoughts throughout the research process.

Transferability

According to Merriam (2009), transferability is the extent to which the findings of the present study are applicable to other settings or contexts. Transferability is a form of external validity that has been a source of disagreement among phenomenological researchers (Beck, 1994). Transferability is often referenced as generalizability, but the very nature of phenomenological research does not lend itself to generalizability beyond the participants being studied (Waters, 2015). Waters (2015) stated that the goal of phenomenological research was to provide an in-depth description of the lived experiences of a select group of people. The themes that emerged from the data analysis could be expanded and related to similar experiences that participants discussed or

described. Therefore, data and theme analysis in phenomenological research is subjective, so generalizability of the findings is limited. Transferability of the findings is usually left up to the reader and not the researcher (Merriam, 2009). Merriam (2009) also indicated that the researcher could not know to which contexts the reader might want to apply the findings.

Dependability

Dependability is defined as the stability of the research process in being able to do what was planned and conducted. Polit and Beck (2016) suggested that the dependability indicates that the findings are a representation of the participants' lived experiences with the phenomenon being studied and did not reflect the researchers' biases or viewpoints. An audit trail was used to establish dependability. This type of audit details the chronology of research activities and processes that are used in collecting and analyzing the data.

Confirmability

Confirmability is equivalent to the validity in a quantitative study. According to Lincoln and Guba (1985), confirmability is established by how the person reading the report interprets the study findings and not the researcher's predispositions, interests, or concerns. The researcher should be objective, minimize bias, and be objective to the greatest extent possible. The findings should reflect the situation being researched, with the beliefs, theories, and biases of the researcher minimized. Bracketing is important in separating the researcher's biases from the study results (Merriam, 2009; Morrow, 2005). Reflexivity is used by phenomenological researchers to explain and describe their biases,

dispositions, and assumptions regarding the research (Merriam, 2009). Using a reflexive journal allows the researcher to write down his/her thoughts and maintain a nonbiased perspective when conducting the interviews (Watt, 2007).

I developed a research protocol (Appendix E) for assuring consistency across the interviews. The use of an informed consent form also was included in the research protocol. The informed consent form assured participants that the researcher was following university guidelines for conducting ethical research. The informed consent form indicated that the interview was held at the participants' convenience and at a time agreeable for both the interviewer and participant. The informed consent form also informed the participants that the interviews were to be audio-recorded.

I maintained a research journal throughout the study, making notes during the interviews that reflected facial expressions of participants, comments that provided important information about participants, and other data that were related to the study outcomes. I used this journal prior to the interviews to keep track of interview times and places

Ethical Considerations

Prior to beginning the study, I obtained approval from the Walden University IRB (IRB; Approval Number 04-24-17-0170883). I asked the ABPSI to place the flyer on their website to avoid any concerns about coercion in recruiting participants for the study. I used no influence to pressure participants into making a decision to participate in this study. I used the preinterview process to allow participants to decide if they wanted to participate in the study. The consent form clearly stated the participants had the right to

refuse to answer any question with which they felt uncomfortable. They could withdraw from the study at any time and ask for any information given in an interview to be destroyed. None of the participants withdrew from the study, either during of following the interviews. All information provided by the participant was kept confidential. All data collected was presented in aggregate, with no individual identifiable in the final dissertation. Any data obtained would not be provided to any outside source. The study did not use language that may seem biased against any person (Creswell, 2007).

To ensure that all participants were treated ethically in this research, I protected their identities by using pseudonyms for interview transcriptions and in writing the results section. I was the only person who had access to the transcripts of the interviews. The participants were made aware of the purpose of the study and understood that the transcripts of their interviews would be available to my dissertation committee and the research department at Walden University. The data will be stored securely in a locked file cabinet located in my home for a minimum of 5-years. At the end of the 5-years, paper copies of the interview transcripts will be shredded, and data stored on a USB drive will be deleted from the drive using a shredder program.

Summary

The present study used a phenomenological design that was appropriate to explore the experiences of mental health therapists who had worked with AALs in IPV relationships. Ten participants was asked to participate in the study using a purposeful sample selection process. The participants for the study included male and female mental health therapists licensed in a large midwestern state. These professionals were

psychologists, counselors, or social workers who were licensed in their fields. The inclusion criteria were that the mental health therapists must be licensed in their particular profession, had worked in their respective fields for a minimum of one year, and had worked with AALs who experienced IPV in their relationships. Data collection consisted of semistructured face-to-face interviews. Data analysis was accomplished using Moustakas' (1994) process for analyzing phenomenological data. An explanation of trustworthiness was given for this qualitative research to ensure credibility and dependability of the study. Ethical procedures were carefully considered to ensure and protect the confidentiality of the participants. The results of the data analysis are presented in Chapter 4.

Chapter 4: Results

Introduction

I conducted this study with a diverse group of therapist participants. These participants were provided with an avenue to express their experiences and challenges of working with AALs in abusive relationships that have been underrepresented and underserved. The purpose of this study was to explore the experiences, attitudes, and perceptions of therapists who provided counseling for AALs who had experienced IPV. This study was guided by two research questions:

RQ1. How do therapists describe their lived experiences of providing counseling treatment for AALs who had experienced IPV?

RQ2. What are therapists' attitudes and perceptions regarding working with AAL victims of IPV?

Chapter 4 will begin with an overview of the setting, demographics, data collection procedures, data analysis, evidence of trustworthiness, and a presentation of the results. Following that, I will summarize my interpretation of the themes that emerged from the analysis of the interviews with support from the participants' reflections of their experiences of the AAL clients that were involved in IPV relationships.

Setting

The participants for this study were therapists who were recruited from the local chapter of the ABPSI. I conducted the interviews in either the participants' offices or in a private room in a library. During the interviews, no interruptions or influences hindered the responses from the participants.

Demographics of the Therapists

I used a phenomenological design to explore the lived experiences of mental health professionals who had worked with AAL individuals in abusive relationships. All participants met the following criteria: (a) licensed in their field, (b) had worked in their respective fields for at least 1 year, (c), and had worked with at least one AAL who experienced IPV in her relationship. To protect the identity of the participants, each one was assigned a code number, which I will use throughout Chapters 4 and 5. Table 1 presents the demographic data of the participants.

Table 1

*Demographic Characteristics of the Sampl*e

Participant	Age	Gender	Ethnicity	Profession
1	55	Male	African American	Social worker/ counselor
2	75	Female	African American	Psychologist
3	37	Female	African American	Social worker
4	56	Female	African American	Psychologist
5	49	Male	Caucasian	Counselor
6	58	Female	Caucasian	Psychologist
7	53	Female	African American	Psychologist
8	51	Female	African American	Counselor
9	62	Male	African American	Counselor
10	65	Female	Caucasian	Social worker

The 10 participants included five African American women, two African American men, one Caucasian man, and two Caucasian women. Three participants freely expressed their identities as lesbian. Five participants were at the doctoral level as

therapists, with the remaining five at the master's level. Three therapists indicated their professions as social workers, four were psychologists, three were counselors, and all were licensed in their respective fields. One of the social workers also indicated that he was a counselor. The years of experience the therapists had in their respective fields ranged from 6 to 30 years. The participants indicated they had lesbian clients, with the percentages of gay and lesbian clients who had sought services ranging from 1% to 80%.

Data Collection

After receiving approval from the IRB at Walden University to conduct the study, I contacted the local chapter of the ABPSI to place a flyer in their newsletter and on their website to introduce the study (see Appendix C). The flyer included a short description of the study and my contact information for interested licensed mental health professionals who worked or had worked with AALs in IPV relationships.

The mental health therapists e-mailed me regarding their interest in participating in the study. I called them back to further discuss the study, including a discussion of the purpose and their involvement. If the therapist agreed to be interviewed, I obtained demographic information from them using the survey (see Appendix A) to determine that they met the inclusion criteria for the study. I sent a copy of the consent form to the therapist by mail through the USPS. The therapist was asked to review the consent form and call me if they had any questions regarding the consent process.

Potential participants who were interested in participating and met the inclusion criteria were asked to indicate a date and time that they would be available to participate in the semistructured interview. The participant was able to select the location (e.g., their

office or a private room in a public library) where the interview would be conducted. The choice of locations provided assurances that participation would be private and confidential. All interviews were face-to-face to provide an environment for an open dialogue to discuss the participants' experiences in providing therapy to AALs who were in abusive relationships. I assured the participants that all information obtained in the interviews would be kept confidential and that no individual would be identifiable in the final report.

Before beginning an interview, I gave the participant two copies of the informed consent form. The participants were encouraged to ask questions regarding their participation in the study. The participants were asked to sign one copy of the informed consent form and retain the second copy for their records. The interviews were audio-recorded with the consent of the participant. In addition, I took notes on each interview, recording body language, facial expressions, and any specific information that was relevant to the interview. The interviews lasted an average of 60 minutes, including time for the participants to make additional comments related to their work with AALs in abusive relationships. At the end of each interview, I thanked the subject for participating in the study.

The interviews consisted of semistructured questions (see Appendix D) that I asked to obtain information regarding the lived experiences of licensed psychologists who were working AALs in abusive relationships. All therapists were asked the same core questions during the interviews. In addition to the core questions, I asked probing

questions to obtain additional information and clarify any ambiguous responses. Through the interview process, I was able to collect rich, in-depth information on the topic.

Data Analysis

I used a separate audiotape for each interview and upon completion, had a trained transcriptionist transcribe the tapes. Prior to analyzing the data, I sent the transcripts to the participants for member checking. The participants were asked to respond in 5 working days if they wanted any changes or additions made to the transcripts. Two therapists responded indicating that the transcripts were correct, while the remaining eight therapists did not respond, indicating they were giving tacit approval to the transcripts.

The data were transcribed and then arranged by interview question. I considered each statement to determine its relevance to the lived experiences of the therapists in working with AALs who were in abusive relationships. The statements were tested to determine if it included a part of the experience that was necessary and sufficient for understanding it. In addition, the statement had to be labeled and abstracted for its relevance. Statements not meeting these requirements were eliminated as the requirement for horizonalization was not met. I then clustered the statements into groups and themes started to emerge. These initial themes became the core themes for the study. I examined the groups and themes to determine if they were compatible among the responses from all of the participants. The themes were examined for each participant and then combined to determine the lived experiences of the participants that were common to all. The outliers were also considered as they represented a different view of the situation that could be

important in understanding how therapists perceived working with AALs who were living in abusive relationships.

Findings

I developed two research questions to guide this study. Six interview questions addressed the first research question: How do therapists describe their lived experiences providing counseling for AALs who experience IPV? I will begin this section by first presenting a summary of the major responses for the first six interview questions.

The first interview question was: What has been your experience working with AALs who have experienced IPV in a relationship? Responses to this question varied across the 10 participants. The terms that were found included codependence among partners, learning experience, more verbal abuse than physical abuse, most are self-referrals, and previous work with domestic violence.

The second interview question of About how many clients do you have or had in the past year have had experience with this problem? What percentage is this of your client case load? garnered responses that ranged from 3 to 20, with percentages varying from 1% to 50%. Again, there was variation in the type of responses where some participants gave numbers and some gave percentages, making summarizing the responses more difficult. Some of the participants reported in the past and some reflected current caseloads which also made summarizing difficult.

The responses to the third interview question of What training do you have in working with domestic violence issues? were more cohesive. The responses included training, substance abuse, mental health, domestic violence, graduate level coursework on

domestic violence, workshops, to no specific training, to on-the-job experience, in-services online, personal research via the Internet, and training from battered women's organizations. The respondents had not completed any education or training program that was focused specifically on AALs.

When asked the fourth interview question, How have you learned about the issues of AALs in abusive relationships? the responses became somewhat more focused. The participants reported they had learned about issues of AALs through personal experiences. Some of these experiences occurred by talking to friends, reading research, on-the-job training, through the clients themselves, involvement in the gay and lesbian community, attending workshops, and working with abusive shelters.

The fifth interview question of What specific training do you have relative to IPV in lesbian relationships? was similar to the third research question, except it was specific to lesbian relationships. The responses from the participants reflected little to no specific training on lesbians but instead generalized training for domestic violence and personal research using the Internet. Most of the training, if any, seemed to be informal or on-the-job training for working with lesbian clients.

Responses to the sixth interview question of How adequate has this information been to assist you in your work with this group? What other resources or information would you find useful? elicited varied comments. Their responses were more aligned with the second part of the question as they had little or no training for working with AALs in abusive relationships. Their responses indicated that attending codependence groups, talking to lesbian friends, focusing on domestic violence in general, attending

conferences and seminars, getting information from their supervisors, and talking to their clients were the resources they had turned to.

A second set of nine interview questions were asked to obtain information from the therapists to address the second research question, What are therapists' attitudes and perceptions regarding working with AAL victims of intimate partner violence? The majority of responses to the nine interview questions are presented.

The first interview question was, When you first meet with a new client seeking counseling for domestic violence, how do you know if they are in a heterosexual or lesbian relationship? At what point does this information surface: at intake; first visit; or sometime later? The participants generally indicated that the information regarding the type of relationship generally occurs at intake, first visit, or they disclosed the type of relationship in conversation.

The responses to the second interview question, What problems or challenges have you experienced in working with AALs in intimate partner violence? This interview question elicited a variety of responses. For example, potential for harm; making sure biases are in check; being open to listening to their concerns; providing correct labeling for their issues; working with the younger population; determining the root cause of the issues, and lack of resources.

The third interview question, Do you feel there is any difference in the issues that lesbians experience with intimate partner violence compared to African American women in general? produced a lot of discussion from the participants. Their responses included being a society issue; issue is minimized because it is not understood; Black women

reported more physical assault; lesbians reported verbal abuse; to no difference; violence was violence; income disparity; heightened level of shame; lack of resources for lesbians when compared to heterosexual women, and a lack of community support.

The responses to the fourth interview question, Based on your experience, what is the most serious concern or issue facing a woman in a domestic violence situation? indicated a consensus among the participants. According to the therapists, the most serious concern or issue was safety. In addition, the participants discussed concerns about being killed; embarrassment; legal ramifications, and making it in the world without her partner.

The fifth interview question, What is the most serious concern or issue for AALs in a situation of IPV? was similar to the fourth interview question. The participants' responses were the same as for the fourth question. However, they added that self-hatred; lack of support from family or friends, and lack of resources were also serious concerns for AALs in IPV.

The sixth interview question, What community resources do you recommend for African American women in general experiencing domestic violence? yielded a variety of responses. The participants indicated anger management; domestic violence; family planning; emergency protocols; housing; care for kids; legal support; community organizations; lack of resources; shelter programs and on-line services.

Similar to the sixth interview question, the seventh interview question, What community resources do you recommend for AALs experiencing violence in their relationships? elicited responses that echoed the previous question. The responses

indicated shelters; support groups; nothing specific to sexuality; churches in the area and shelters such as Affirmations or the Ruth Ellis Center.

The eighth interview question, What services or resources are available specifically for lesbians in this community? produced responses that were indicative of little or no available resources for lesbians. They commented that few resources were available, but they knew of none. They thought campuses for students would have safe places or shelters. Programs in the tricounty area were more women-centered; support groups, and Affirmations and Ruth Ellis Center.

The responses to the ninth interview question, What other perceptions do you have about working with this population? were interesting. The therapists indicated that the lesbian population was growing faster than gay males; potential for violence is increasing; lesbian relationships tend to be ignored or minimized; more training is needed; educating the general public; more resources are needed; lesbians are becoming angrier; burden to prove something; need as many resources as the heterosexual population, and there are a lot of unmet needs among this group.

After reading and rereading the interview transcripts, themes began to emerge. These themes were grouped by research question. These themes are presented in Table 2.

Table 2

Themes

Research Question	Themes
1. How do therapists describe their lived experiences of providing counseling treatment for AALs who experience intimate partner violence?	a) Training b) Personal associations
2. What are therapists' attitudes and perceptions regarding working with AAL victims of intimate partner violence?	a) Challenges b) Intimate partner violence c) Resources available d) Outcomes

Evidence of Trustworthiness

Credibility is defined as the extent to which the findings of the study reflect reality (Merriam, 2009). Credibility for this study was established by providing assurance that my interpretations reflected the interviewees' descriptions and lived experience of the phenomenon (Creswell, 2014). I maintained field notes and used a reflective journal to document my thoughts as part of the criteria for credibility. Waters (2015) regarded transferability as an in-depth description of the lived experience of a select group. I addressed transferability by using participants who were social workers, counselors, and psychologist who had various levels of expertise in their field. Using this process allowed me to provide an in-depth description of the themes that had emerged from the data.

Dependability is defined as the stability of the research process in doing what was planned and conducted. Polit and Beck (2016) suggested that dependability indicated that the findings were a representation of the participants' lived experiences with the phenomenon being studied and did not reflect the researchers' biases or viewpoints. An

audit trail that detailed the chronology of research activities and processes that were used in collecting and analyzing the data that were used to establish dependability.

To establish dependability in the present study, I used an audit trail, taking steps to describe my research. The steps included:

1. I used a flier that was posted on the ABPSI website that summarized my study.
2. I contacted the mental health professionals who indicated they were interested in participating in the study.
3. I emailed the consent form to potential participants.
4. I made an appointment with each participant to interview them at either their office, or a room in the library.
5. I conducted the interview in person to encourage an open conversation about their lived experiences with working with AAL clients in abusive relationships.
6. After the interview, I asked participants about other possible mental health professionals who might be interested in participating in the study.
7. After the interviews were transcribed, each participant was emailed their transcription to make adjustments or any added comments.

According to Lincoln and Guba (1985), conformability is established by how the person reading the report interprets the study findings and not the researcher's predispositions, interests, or concerns. Conformability was addressed in the present study by asking each participant in the study the same questions in the same order. Each

participant was emailed their transcription for review. I bracketed my personal feelings and biases to minimize any reactions to the responses that could have influenced the participant's answers to the interview questions.

Results

Research question 1, How do therapists describe their lived experiences of providing counseling treatment for AALs who experience intimate partner violence. Two themes, training and personal associations, emerged from the thematic analysis of the interview responses for the first six questions asked to all participants. Each of these themes is discussed in detail, with specific comments from the participants.

Theme 1: *Training.* When asked about training for working with AALs who experience IPV, the participants indicated that they had had some training for working with domestic violence, but generally no specific training for working with AALs in abusive relationships. Five had completed doctoral degrees and five had obtained master's degrees. All were licensed in their fields, which included social workers, counselors, and psychologists. One therapist reported completing a class in his/her master's degree on domestic violence and substance abuse. Participant 2 indicated:

> I am trained in both substance abuse and mental health, so in that component it would fall under anger management . . . I've been trained in domestic violence, parental relationships, adult relationships, HIV and AIDS, so I am aware with dealing with alternative lifestyle and those types of situations.

Participant 6 indicated that "I didn't take any specific classes or any specific training in that." Participant 7 commented that "mostly its on-the-job experience, the

clients suffer from the same type of depression and anxiety as others and sometimes post-traumatic stress disorder (PTSD), and his/her training in those applies to the population." Participant 4 shared that "presentations were made on domestic violence during my doctoral program and have been in the field for 29 years." Participant 9 stated:

> My academic training from Wayne State prepared me to work with all populations. You know, as an adjunct to that, I attend as many workshops as I possibly can, not just on lesbian domestic violence, but on domestic violence in general. I do my own research, you know, via the internet, but particularly I read medical and psychological journals.

When asked about training for IPV in lesbian relationships, none of the participants had specific training on the topic. Four participants indicated they had read books and journal articles, while two reported they had worked in shelters like Affirmations and Ruth Ellis Centers. Participant 3 commented on specific training that was relative to IPV in lesbian relationships:

> None in particular. Other than the atypical PTSD, or traumatization, or domestic violence. I have not done any particular research particularly to the lesbian population regarding domestic violence because the symptomatology seems to be somewhat similar.

Participant 6 commented about training, saying:

> I've read some books. I've read some articles, and I've subscribed to different journals over the years. I again haven't had any real formal training about

> domestic violence at all. I haven't had any formal training about working with gays and lesbians. I've, again, had to be self-taught.

According to Participant 7, "I've not taken any coursework or anything like that, just the normal training that we get, like disaster recovery for first responder type training and it's broad, it's not specific to lesbian or gay."

The therapists did not appear to have formal training outside of their graduate programs for domestic violence in general or domestic violence for AALs. However, most did not think they needed to have specific training in these areas. Most of the therapists felt that they should be able apply what training they had to their work with lesbians in abusive relationships.

Theme 2: *Personal associations.* During the interviews, the participants discussed how they had become aware of AALs in abusive relationships. Their responses indicated that their awareness had come through a variety of avenues, with the most common answer through personal experiences. Participant 2 commented:

> I talked to some of my friends who are lesbians – and asked them questions . . .. I asked them about the life of what it was like to be a lesbian and to be in a partnership and how the social factors that became involved in it. One of the things that really help me was to understand that it is not uncommon for domestic violence to happen in those relationships.

According to Participant 4:

> On-the-job training. Through my exposure with clients who disclosed this area of difficulty during my working with them. Additionally, I would go to trainings and

> workshops on this and other areas to help hone my skills in working effectively with this segment of the population that I serve.

Participant 5 indicated that he/she learned about AALs in abusive relationships from the clients themselves. Participant 7 shared:

> I have a lot of personal experience because my sister is lesbian, now married, and has had a history of volatile relationships for maybe the last 25 years, so I understand that world. . . . Then with treating them, I can show empathy and no judgment, because I've actually been a bystander and seen it happen.

Research Question 2: What are therapists' attitudes and perceptions regarding working with AAL victims of IPV? To answer Research Question 2, four themes emerged from the interviews. These themes were challenges, IPV, resources available, and outcomes. The therapists' comments in regard to these themes were varied, depending on their personal and professional experiences with AALs.

Theme 3: *Challenges.* The participants responded to challenges and problems they encountered while working with AAL clients in abusive situations. While they had all experienced challenges, their comments supported that they viewed these challenges differently. Some challenges were associated with culture. For example, Participant 6 observed that: "I am not familiar enough with the Black culture, and the cultural differences. Sometimes I feel I may not have the same sensitivities, or I may not respond the same way that would be helpful." Participant 3 noted, "I try to make sure of my own biases are in check. I am careful to hear their conversation and put them at ease."

Participant 5 remarked, “that the challenges were no different than that of heterosexual, polyamorous or bisexual, but African Americans come with a lot less family support.”

Other challenges were associated with general concerns about the health and welfare of the client. For example, Participant 1 commented, “I have to know if they are in any potential harm or danger.” Participant 2 indicated, “sometimes they realize I am not a lesbian. I tell them I am an ally and I have family that are gay and lesbians.” Participant 7 stated “the challenge is that there seems to always be some kind of substance abuse involved with the partner and the violence comes out when they are under the influence.” Participant 8 mentioned that “there are financial stressors [of the client] that I have to deal with and a great amount of dysfunctional backgrounds.” According to Participant 9, “when I finally uncover the some of the causes and the domestic violence, they’ll terminate counseling.” Participant 10 reported, “the greatest challenge is lack of resources to help my clients.” Some of the challenges were cultural differences, others were general concerns about abusive relationships.

Theme 4: *Intimate partner violence.* As all participants had worked with AAL clients who were in abusive relationships, concerns about the amount of IPV was pervasive throughout the interviews. The participant provided responses regarding the issue of IPV from many different perspectives. Most of the comments from the participants were concerned with the safety of the client. Client safety was the primary concern of Participants 1, 2, 3, 4,6, and 10. Their responses that pertained to client safety included: concerned they will be killed; situation could be life threatening; having a safe space; emotional violence; sexual violence; verbal abuse; mental abuse and financial

abuse. Participant 5 indicated, “the client was concerned about being ostracized, ashamed, embarrassed and lacked support from family and friends.” Participant 7 reported, “the client found that there would be the most serious legal ramifications.” Participant 8 commented, “she [the client] may feel that she can’t make it out in the world and she goes back [to the relationship].” Participant 9 was concerned that “when you [the therapist] uncover the root of the violence, they [the client] start backing away from counseling.” Participant 10 warranted “there seems to be a tremendous fear of judgment, internalized homophobia, and on top of that, shame.”

Theme 6: *Resources.* Throughout the interviews, most participants voiced concern regarding limited resources that are available for AALs in abusive relationships. Participant 1 comments about available resources were “I haven’t seen any… for domestic violence, maybe family planning.” Participant 2 reported that “shelters like Haven and there are places for African Americans, or lesbians, but not African Americans lesbians.” Participant 3 reported, “maybe support groups, help lines, and emergency protocols. There is none that stand out.” Participant 4 mentioned, “I am thinking about Affirmations and the Ruth Ellis center.” Both of these centers were mentioned by a number of participants. Participant 5 commented that “there are standard domestic violence organizations that treat everybody the same …. they don’t specialize in lesbian or gay communities.” Participant 6 remarked that, “there are some LGBQT churches and I network with some other therapists. I don’t have a lot else other than that.” Participant 7 noted, “I don’t have any resources or support groups that would be specific to that population.” Participant 8 concluded, “there is nothing specific to her sexuality,

you know she would go to a shelter like everybody else." Participant 9 explained, "it's becoming more and more apparent that we [AALs] need just as much resources as the heterosexual population. As counselors, we should establish ourselves as that resource, rather than search for the resources." Participant 10 suggested, "the college campuses have much more accessibility."

Theme 7: *Outcomes*. Comments about the perceptions of outcomes when working with this population were varied by the participants. Outcomes were in reference to whether they were successful in helping their clients meet their goals; did the client return to the abusive relationship, or did the client leave therapy prior to attaining their goals. Participant 1 indicated that "it [AALs in abusive relationships] was growing faster than the gay males and the potential for violence was increasing." Participant 2 concluded that "just as mental illness is one of those things we tend to ignore in our community, lesbian relationships are also something that we tend to ignore. Participant 3 projected, "more training definitely … more openness can help us." Participant 4 responded, "I think the more we normalize it and get the word out that it's ok to talk about it, the stigma around it will subside." According to Participant 5, "I think you are going to see more of the African American community that are going to reach out and seek resources and seek help." Participant 8 commented that "we are experts at what we do, so I say, we're moving toward the future on openness and it's going to get better. It takes more of us to be dedicated. We can get there." Participant 9 indicated that "when I finally uncover the causes of domestic violence, they'll terminate counseling." Participant 10 "there are a lot

of unmet needs and we have access to more information than we ever had in our life…. and yet, you know there are still very limited resources."

Summary

The interviews conducted with mental health therapists working in a large midwestern state were conducted either in their offices or in private rooms in public libraries. The participants were psychologists, counselors, and/or social workers who were licensed by the State. Of the 10 therapists who participated in the study, seven were female and three were male. They ranged in age from 37 to 75 years. Seven participants were African American and three were Caucasian. Three participants freely disclosed that they were lesbians. The years of experience in their respective fields ranged from 6 to 30 years. All participants had AALs as clients.

After reading and rereading the interviews several times and coding them to determine similarities and differences, six themes emerged. Two themes: training and personal associations, answered the research question, How do therapists describe their lived experiences of providing counseling treatment for AALs who experience intimate partner violence? Four themes: challenges, intimate partner violence, resources available, and outcomes, emerged from the interviews to address the second research question, What are therapists' attitudes and perceptions regarding working with AAL victims of intimate partner violence? Chapter 5 presents a discussion of these themes along with the literature that pertains to them. Implications for practice and social change also was presented. The chapter ends with recommendations for further research on this topic.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

I used a phenomenological research design to understand the lived experiences of therapists working with AALs involved in IPV. According to Simpson and Helfrich (2014), therapists are often reluctant to discuss their experiences working with gays and lesbians, specifically AALs in IPV relationships. The purpose of this study was to explore the experiences, attitudes, and perceptions of therapists who provide counseling for AALs who have experienced IPV.

There were 10 mental health therapists who met the inclusion criteria to participate in semistructured, face-to-face interviews for this study. The participants had a minimum of 1 year of experience working with at least one AAL involved in an abusive relationship. My rationale for choosing this topic was to address the gap in the literature (see Hill et al., 2012; Robinson, 2010) regarding the experiences, attitudes, and perceptions of therapists who counseled AALs in abusive relationships.

In this study, I used an interview protocol with 15 open-ended questions to collect data from the participants. The interviews were audio-recorded using a digital recorder. A certified transcriptionist transcribed the resulting data. Using Moustakas' (1994) data analysis techniques as a guide, I analyzed the interview transcripts. My analysis of the participants' responses to the 15 interview questions produced six themes: (a) training, (b) personal association, (c) challenges, (d) IPV, (e) resources available, and (f) outcomes. I used these six themes to address the two research questions.

I used AT, developed by Weiner in 1974 (see Lewis, 2009), in this study to examine the experiences of mental health therapists who provided treatment for their clients. Therapists can have biases that affect their relationships with their clients (Freeman et al., 2010).. By being aware of these biases, therapists can provide interventions for their clients that can promote better outcomes (Freeman et al.).

The participants discussed their lack of training on providing therapy for AALs in abusive relationships either in their graduate programs or professional development. The training of the mental health professionals on this topic ranged from some training to no specific training at all. For example, therapists who had some training for working with AALs reported they had attended workshops, conducted online research, and had participated in training in similar or related fields of domestic violence. The participants indicated they had gained experience with AALs by personal association. Some participants' personal associations stemmed from training received on the job, having friends and family members who were lesbians, and by not being judgmental and showing empathy.

Participants reported challenges in providing therapy to AALs included lack of family support, few available resources, potential harm of the client, returning to the abuser, and dropping out of counseling. Many participants expressed their feelings regarding the outcomes of working with this population. Most therapists agreed that more training, specifically on this population, was needed and additional resources should be accessible. As the needs of this population continues to be ignored and the number of

AALs in IPV continues to increase, additional training should be available as more clients are reaching out for help.

Interpretation of the Findings

My findings in this study were in accordance with the identification of themes from interviews with the participants. A total of six themes, two associated with research question 1 and four with research question two, emerged from the semistructured interviews. The themes are discussed in relationship to conceptual framework and the review of literature.

Findings Related to the Conceptual Framework

I used AT in this study to examine the therapists' perceptions and treatment recommendations for their clients. According to AT, people try to understand their life and make predictions of their life based on information they have (McLeod, 2010). The participants expressed their attributions about working with AALs in IPV as complex, with different dynamics, and trying to be as open as possible. The participants discussed the importance of avoiding their biases by making sure they listened as their clients described their experiences, showing genuine empathy, and putting their clients at ease and not letting them become defensive. One participant was able to minimize her biases by letting her clients know she was an ally of the LGBQT community. Two participants who were African American females had lesbians in their family and were familiar with IPV issues.

Participants brought their educational background and prior experiences to their work with AALs. These experiences varied and consisted of being a medical specialist in

the National Guard, attendance at workshops, and searching the Internet for research on AALs and IPV. Another participant who worked in a domestic violence shelter felt that training was needed to work effectively with AALs in IPV. The tendencies to attribute qualities or characteristics were based on the participants' experiences. The participants used these experiences to explain the needs of their clients. Researchers of AT have suggested that mental health professionals' therapeutic recommendations had a direct effect on client outcomes (Williams et al., 2013). The participants recommended that AALs in IPV could benefit from being in groups that focused on domestic violence. They also indicated that talking to other colleagues about their experiences could help expand their treatment protocols. One participant had a supervisor who was a lesbian and worked with the LGBQT population, specifically with Affirmations and Ruth Ellis, centers for LGBQT population that had support groups comprised of gay people.

Comparison of Data to Literature Review

Theme 1: Training. I asked the participants about the extent of training they had to work with AALs in abusive relationships. All participants confirmed they could have benefited from more specific training with this vulnerable group. Simpson and Helfrich (2014) found that the extent of successful treatment was based on appropriate training of the therapist. Rutherford et al. (2012) confirmed additional training should be on-going for providers working with lesbians. Although guidelines are available for psychotherapy with LGBQT clients, no specific training was offered in regard to AALs in IPV (APA, 2002, 2012). As confirmed by Graham et al. (2012), most programs offer a general approach to LGBQT, but no specific training. Additionally, Singh and Shelton (2011)

echoed the assertion that no specific training or information concerning counseling of AALs was available. While my findings in this study indicated that most mental health professionals felt underprepared to provide proper care for the increase in diverse clientele, Graham et al. (2012) confirmed that workshops and training sessions were useful for increasing the proficiency of therapists in treating the LGBQT population. The participants indicated they would have benefitted from focused training on working with AALs in abusive relationships.

Theme 2: Personal association. Most participants became aware of their clients' abusive relationships indirectly, through conversations that occurred during sessions or from off-handed remarks. Occasionally, a client would be open about the abusive relationship during the intake phase of treatment. According to Heider (1958), therapists based their client decisions and treatment on how they viewed the world. Lewis (2009) suggested that most therapists were more than likely to express emotional responses toward their clients. Also, in working with their clients, the participants were more inclined to become familiar with stresses associated with being gay and underrepresented in society, literature, and research. Additionally, trusting relationships should be established for any sexual minority and especially those of color in abusive relationships (Kelley, 2015).

Theme 3: Challenges. Although a variety of challenges were discussed by the participants, many were related to the literature. The challenges of providing treatment to AALs in abusive relationships included decreasing biases when treating AALs in abusive relationships, making sure the client was safe from harm, and helping clients obtain

needed resources. The participants acknowledged that their clients were experiencing stress from multiple oppressions, including social stigmas, isolation, and traumatization (see Robinson, 2010). A challenge for the participants was the limited resources available that focused on lesbians in abusive relationships for successful treatment (see Hancock et al., 2014). Even if the mental health therapist is a lesbian, she may lack the knowledge that comes with treating a same-sex client in an abusive relationship (Rutherford et al., 2012). Other challenges include AALs who seek therapy, lack family or other outside support, and encounter homophobia from others (Duke & Davidson, 2009). Another challenge is working with clients who are substance abusers and have impaired judgments, which can lead to the probability that IPV will occur. More factors include clients who have problems with the criminal justice system, dysfunctional families, financial dilemmas, or problems with safety (Simpson & Helfrich, 2014).

Theme 4: Intimate partner violence. Most participants were concerned with the safety of their clients and the stigma associated with being a lesbian in an abusive relationship. The literature on IPV has substantiated the negative effect of IPV, especially among lesbians. One of the primary risk factors that contribute to IPV were patterns of control (Buzawa & Buzawa, 2013). Some characteristics associated with control include intimidation, emotional abuse, isolation, low self-esteem, racism, and attachment anxiety (Andrask et al., 2013; Barrett & St. Pierre, 2011; Edwards & Sylaska, 2014). The LGBQT population is small and AALs are a small segment of that community and when seeking help for IPV, the fear of additional isolation may occur (Robinson, 2010). The client might lack confidence in the therapist and may choose to return to the abusive

situation only to be retraumatized (Ard et al., 2011). Although some progress has been made to decrease IPV in the gay community, domestic violence is higher among LGBQT communities of color than their Caucasian counterparts (NCAVP, 2015). Finally, policy makers need to make greater effort to prevent IPV among AALs (Breiding et al., 2014).

Theme 5: Resources. Resources for AALs in IPV are limited, especially in terms of training for therapists to work with AALs in abusive relationships and the resources for providing safe housing for AALs in abusive relationships, including support groups and help lines. Previous literature has validated these findings (Graham et al., 2012). Cultural awareness and educational programs to increase awareness of AALs in IPV for mental health professionals are limited and need to be expanded because research is deficient regarding LGBQT issues (Singh & Shelton, 2011). Therapists have voiced concerns regarding their ability to meet the needs of the increasing gay community clientele, especially those AALs in IPV (Graham et al., 2012). Also, AALs face continuous exposure to domestic violence situations because of the lack of available shelters, protection, or transitional services available to them unlike heterosexual victims (Simpson & Helfrich, 2014). Theories and practices regarding African American sexual minorities have been slow to change (Green, 2004). A paucity of data exists concerning IPV among AALs. Hill et al. (2012) reported that limited research has been conducted on AALs in IPV. Additionally, AALs in IPV are considered a high-risk population that has been underresearched and underserved (Hill et al., 2012).

Theme 6: Outcomes. Outcomes, as described by the participants, included success in helping their clients meet their goals, clients returning to the abusive

relationship, or a client leaving therapy prior to attaining their goals. The perceptions of working with AALs in IPV varied in the literature as well as in participant responses. Graham et al. (2012) reported that as the number of families with diverse lifestyles continues to increase, the use of mental health services also increases. A growing number of gay and lesbian individuals have turned to therapy because of the tensions and dilemmas, such as anxiety, depression, and substance abuse that occur in these family structures (Graham et al. (2012). While the mental health therapist participants in this study indicated they had worked with at least one LGBQT client, they also asserted that education on providing therapy for families with diverse lifestyles was lacking in most professional programs for psychologists, counselors, and social workers (see Green et al., 2009). Mental health professionals are ethically bound to improve their competencies in working with LGBQT clients (Edwards & Sylaska, 2014). Protective factors for LGBQT in IPV relationships can reduce barriers, allowing victims to receive the help they need.

Social support is a viable protective factor for those individuals who have experienced IPV (Canady & Babcock, 2009). Individuals who provide social support to victims of IPV include family members, friends, religious affiliations, and health professionals. Having social support helps victims maintain their mental health, increase self-esteem, and become aware of IPV Canady & Babcock, 2009). In addition, social support can assist victims in acquiring positive coping strategies (Canady & Babcock,).

Limitations of the Study

The study had three main limitations. One limitation was that the study only used a small sample of participants which may not have been a representative sample of

mental health therapists in the Midwest. The inclusion criteria included mental health therapists who had worked with at least one AAL in an abusive relationship. Some participants were willing to discuss their experiences in great length, while other were not as forthcoming about their work with this vulnerable group.

Another limitation was the use of self-reported subjective data that could not be verified. According to Yu (2016), self-report may be inaccurate due to flaws in memory caused by transience, absent-mindedness, blocking, misattribution, suggestibility, bias, and persistence. The data obtained for the study was solely based on my interviews and observations. While an assumption of the study was that the participants would discuss their experiences with AALs in IPV situations honestly, some participants may have excluded important details of their experiences because of confidentiality issues.

To control for issues of investigator bias, I examined my personal prejudices, perspectives, and beliefs. *Epoche* is a Greek word that means to look at an experience or situation without judgment and necessitates the researcher to look at the experiences of the participants without preconceived ideas (Moustakas, 1994). The use of the ordinary way to view the experience needs to be ignored. Instead, Moustakas suggested that in the epoche phase of deriving knowledge from the interviews, the investigator needs to abstain from making judgments and avoid common ways of perceiving the comments from the participants.

Recommendations

According to the literature and the participants in this study, more training is needed for mental health professionals who work with AALs in abusive relationships.

The lack of training is limited in the area of cultural competency for many mental health professionals and this may be why practitioners find themselves unprepared to meet the needs of LGBQT clients, and specifically AALs in abusive relationships (Graham et al., 2012). Additional research is needed to explain and understand the lived experiences of therapists working with AALs involved in IPV. Without a structured methodology in the research on the issues concerning the LGBQT population, this situation could continue to go ignored or misunderstood (Singh & Shelton, 2011). Additionally, courses and workshops need to be developed that specifically focuses on the AALs in abusive relationships which seem to be increasing according to the data from participants in this study and the literature. Most graduate programs base their curriculum in the fields of social work and psychology when it pertains to heterocentric issues (Pachankis & Golfried, 2013) of the AAL community.

Implications for Positive Social Change

Implications for social change have emerged from the findings of this study. Domestic violence is widespread in AAL couples, yet little research exists pertaining to the effectiveness of support and resources for the AAL population (Banks & Fedewa, 2012). Understanding challenges of working with this particular population from the therapists' perspectives is important to improve, support, and help develop effective strategies for working with AALs in abusive relationships. Results of this study may help in the understanding of how therapists' experiences, perceptions, and attitudes influence their work with AALs in domestic violence relationships. To work more effectively with AAL clients, providers should be open to understanding differences through self-

exploration and education (Mitchell, 2009; Oswald et al., 2010; Rutherford, 2012). The results of this study could help therapists better understand the prevalence of IPV in AAL communities. The findings of this study could provide an impetus to develop scholarly courses on AAL lifestyles in psychology and social work programs in colleges and universities. Courses need to focus on providing factual information about AALs experiencing IPV in their relationships; eliminating the stigma associated with alternative lifestyles and presenting ways to help individuals who are in abusive relationships. These types of courses could help to prepare students and mental health professionals to work with AALs effectively.

Conclusion

Mental health therapists need to recognize the challenges associated with providing help for AALs in IPVs. This population has had difficulty in finding mental health professionals who are knowledgeable about gay and lesbian concerns (Hill, Woodson, Ferguson, & Parks, 2012). AALs in abusive relationships have been underserved and underrepresented by the mental health profession in general. Additionally, professionals working with this vulnerable group need to recognize that there are a limited number of competent mental health support services that are available for AALs in abusive relationships (Hill et al., 2012).

In this phenomenological study, data were collected from 10 participants, five with masters, and five at the doctoral level. The data collected was important in describing the lived experiences, attitudes, and perceptions of mental health professionals while working with AALs in abusive relationships. Most indicated that they had no

specific experiences when working with this clientele and were not formally trained to work with AALs in IPV. Some pointed out that their training had been on the job, at workshops, or application of training in other related fields.

Although, the therapists had encountered a number of challenges among participants working with this population, the primary challenge was the lack of resources. Other concerns centered on what the client was going through, such as financial stressors; client safety, and how the client may or may not be viewed if they were not a lesbian. The results of this study could help future students and mental health professions to better understand the issues concerning AALs in abusive relationships.

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Appendix A: Demographic Survey

Hello my name is Barbara Bryant. I am from Walden University. I am working on a research project about your experiences working with African American lesbians in intimate violent relationships. I am going to ask some questions that will take about 15 minutes to complete.

1. How old are you? __________ years

2. What is your gender? □ Male □ Female

3. What is your ethnicity? ____________________

4. What is your highest level of education?
   - □ Bachelor's degree
   - □ Master's degree
   - □ Doctorate
   - □ Other ____________

5. What is your profession?
   - □ Psychologist
   - □ Counselor
   - □ Social Worker

6. Are you currently licensed to practice in Michigan? □ Yes □ No

7. Have you ever had gay or lesbian clients in your practice? □ Yes □ No

8. What percent of your gay or lesbian clients are African American? ___%.

9. How many of your African American gay/lesbian clients are seeking services related to being involved in an abusive relationship? ________

Appendix B: Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

Name of Signer: Shawna Gobel

During the course of my activity in collecting data for this research: Shawna Gobel I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:** 05/01/16

Appendix C: Recruitment Flyer

DO YOU THINK YOU MIGHT BE INTERESTED IN PARTICIPANTING IN A RESEARCH STUDY ON YOUR EXPERIENCES IN PROVIDING SERVICES FOR AFRICAN AMERICAN LESBIANS IN INTIMATE PARTNER VIOLENT RELATIONSHIPS?

Barbara Bryant

Doctoral student at Walden University

Is looking for Mental Health Professionals who have had at least one year of experience working with African American lesbians who have been in intimate partner violent relationships. Interested therapists will participate in a 60 minute semi-structured interview in which they would answer questions about their experiences in providing counseling for these women.

For more information please call:

Barbara Bryant

or send an email to

Appendix D: Interview Questions

Research Question		Interview Questions
RQ1:	How do therapists describe their lived experiences providing counseling for AALs who experience intimate partner violence?	1. What has been your experience working with African American lesbians who have experienced IPV in a relationship? 2. About how many clients do you have or had in the past year presenting with this problem? What percentage is this of your client case load? 3. What training do you have in working with domestic violence issues? 4. How have you learned about the issues of African American lesbians in abusive relationships? 5. What specific training do you have relative to intimate partner violence in lesbian relationships? 6. How adequate has this information been to assist you in your work with this group? What other resources or information would you find useful?
RQ2:	What are therapists' attitudes and perceptions regarding working with AAL victims of intimate partner violence?	1. When you first meet with a new client seeking counseling for domestic violence how do you know if they are in a heterosexual or lesbian relationship? At what point does this information surface: at intake; first visit; or sometime later? 2. What problems or challenges have you experienced in working with AALs in intimate partner violence? 3. Do you feel there is any difference in the issues that lesbians experience with intimate partner violence compared to African American women in general? 4. Based on your experience, what is the most serious concern or issue facing a woman in a domestic violence situation? 5. What is the most serious concern or issue for African American lesbians in a situation of intimate partner violence? 6. What community resources do you recommend for African American women in general experiencing domestic violence? 7. What community resources do you recommend for African American lesbians experiencing violence in their relationships? 8. What services or resources are available specifically for lesbians in this community? 9. What other perceptions do you have about working with this population?

Appendix E: Research Protocol

The purpose of this study is to explore the experience, attitudes, and perceptions of therapists who provide counseling for African American lesbians who have experienced intimate partner violence. First, I will seek approval from IRB at Walden to conduct my study. Following approval, I will contact the Association of Black Psychologists, a local chapter of the Association of Black Psychologists, a national organization, to have a flier put on their listserv to introduce and explain the purpose of the study. Mental health professionals licensed in the state of Michigan who have had experience with working with this clientele will be asked to participate in the study. The potential participants will be asked to contact me by email to determine their eligibility to participate in the study. I will telephone prospective participants to screen each to ensure they meet the criteria for inclusion in the study.

After determining eligibility, an appointment will be made to meet at a mutually agreeable time and place for the interview. Possible places include the participant's office or a private study room in a public library.

A phenomenological research design will be used with this study. I will use a reflexive journal to write down thoughts, feelings, and other perceptions before, during, or after the interview. Before the interview begins, a consent form will be reviewed and all questions will be answered, the participant will be asked to sign two copies of the consent form. They will give one copy to the researcher and retain the second copy for their records. During the semi-structured interviews, I will be flexible and sensitive in my questioning to allow participants to answer questions openly to obtain an in depth source

of information. I also will be as objective a possible during the interviews. While all participants will be asked the same set of questions, they will be encouraged to provide any additional comments and clarification that can result in in-depth information on the topic. The interviews are expected to last approximately 60 minutes. All interviews will be audio recorded with field notes taken for each session. A separate audio tape will be used for each person.

At the end of the interview, I will ask participants if they have any additional information. I will give no incentives, but thank the participants for their time. Any identifying information will be removed before giving the tapes to a professional transcriptionist. The transcribed interviews will be stored on a password-protected USB drive. I will review the transcripts with the audio-recordings and make any corrections to the transcript. The data will be analyzed using Moustakas' (1994) phenomenological steps for data analysis.

The identity of the participants will be protected by using pseudonyms in the final report. The data will be stored in a locked file cabinet for five years in my home, after that time the data will be destroyed by deleting and shredding information.