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The Lived Experiences of Counselors Who Work With Female Intimate Partner Violence Victims

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Abstract

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by

Lekesha L. Thomas-Davis

MEd, Delta State University, 2006

BS, Drake University, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Intimate partner violence (IPV) is a global health concern that affects victims, families, and the communities. Master's level counselors, who work in mental health settings, are in key positions to provide identification and intervention services to female victims of IPV with mental health issues. This study explored the lived experiences of master's level counselors who worked with female victims of IPV to gather a deeper meaning into the values, attitudes, and beliefs that master's level counselors hold in working with female victims of IPV. This study was conducted as a hermeneutic phenomenological study through a feminist poststructuralist lens to guide the research. The 5 participants in the study obtained a master's degree from a CACREP accredited counseling program and have worked with female victims of IPV. Semistructured interview questions were used to collect the data. The data were analyzed using first and second cycle coding. NVivo 12 software was used to organize the data. Key findings indicated that participants valued their work with victims of IPV but believed that there were not enough resources available to properly assist clients. Participants also acknowledged that they did not receive training in their master's programs to equip them to successfully work with victims of IPV. The results of this research study may inform counselor education programs by increasing awareness of needed improvements in training and education of master's level counselors may improve overall treatment provided to this population. Improved treatment may decrease the number of health concerns, in turn decreasing the number of emergency room visits and improving the overall family dynamic.

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Dedication

This dissertation is dedicated to all my family. My children Johnny and Laila, once you came into my life I was forever changed for the better. You both inspire me to never quit. To my Mom, Louise Savoy, when I could not find a way, you made a way. Without you I would have never made it this far. To Lisa, Sara, Becky, and Gwen who encouraged me and cheered for me and most importantly prayed for me throughout this entire process, I share this milestone with you all.

To my grandmother Lucy, who has inspired me since childhood. You did not know it, but I have gone through this world trying to emulate your strength and courage. I hope that I have made you proud to call me granddaughter.

To my grandfather, H.T. Thomas, who raised his children and grandchildren to value education and hard work. I know that you are looking down on me and smiling. Your legacy will live on through your children, grandchildren, great-grandchildren and all those to come.

Finally, to all the counselors, who give tirelessly to help those in need: you make a difference in this world. Continue to fight for those with no voice. If you never hear the words, thank you…THANK YOU!

Acknowledgments

This has been a journey that has taken me through highs and lows. I never believed myself to be a quitter until I began the dissertation process. Through the insecurities and uncertainty, I prevailed. This has been a journey of self-discovery: a journey that I may not have completed had it not been for the support and encouragement of my dissertation committee.

First, I would like to acknowledge my chair, Dr. Corinne Bridges. I appreciate your dedication, encouragement, and firmness when needed. There were moments that I was on the verge of quitting and you would always pop up and offer me the nudge to keep going. Thank you for agreeing to be my chair. I could not imagine going through this process with anyone else. Dr. Jenkins, my committee member, thank you for you continued support and encouragement. Whenever I needed assistance or had questions, you were there. I would also like to give a huge thank you to my URR member, Dr. Katarzyna Peoples, for guiding me throughout this process. You all made this possible.

I would like to give a special acknowledgement to Dr. Donna Sheperis. When I decided to pursue my PhD, I reached out to Dr. Sheperis and inquired about Walden University. It was her guidance that led me to choose this university and I am so thankful I did. All the professors, throughout this journey, have been amazing supports who have collectively contributed to this moment. I am forever grateful.

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Chapter 1: Introduction to the Study

Introduction

An issue that may benefit from advocacy, leadership, and social change is domestic violence, more recently known as intimate partner violence (IPV). My focus in this study is on the treatment services provided by master's level counselors to female victims of IPV. The ingrained societal view, which men have the right to control their spouses, has perpetuated the acceptance of violence within the home and led to the growth of IPV over the years (Cho, 2012).

IPV is a leading cause of death among children, adolescents, and young adults in the United States (Sumner et al., 2015). This issue has been a growing concern since the women's civil rights movement of the 1970s, which catapulted the issue into the forefront of the media (Williams, 2012). IPV affects victims both physically and psychologically, affects children and families, and can create financial hardships on communities (Cerulli, Talbot, Tang, & Chaudron, 2011; Levendosky, Bogat, & Martinez-Torteya, 2013).

Dersch, Harris, and Rappleyea (2006) noted that approximately 65% of victims of IPV, who initiated mental health treatment, did not return for follow up treatment. Ambuel et al. (2013) shared that early identification and intervention may lead to a reduction in health concerns and death of females who experience IPV. In this study I will provide a means of understanding the beliefs, values, and attitudes of master's level counselors who work with victims of IPV and to enhance treatment provided in mental health settings and decrease the rate of physical and mental health issues for victims and families. The implications for positive social change could have a considerable influence

on counselor education and best practices. I will address the background, problem statement, purpose of the study, research question, nature of the study, assumptions, limitations, and delimitations in Chapter 1.

Background

I conducted a thorough review of the literature by searching full-text articles in PsychINFO and SocINDEX in the Walden University library. In addition, I used the multidisciplinary database, Academic Search Complete to search ERIC and PsycARTICLES databases in the Walden University library. I included peer-reviewed publications in the literature review. I used the following terms to conduct the searches: *domestic violence*, *intimate partner violence*, *mental health*, *counseling*, *counselors*, *counselor education*, *violence*, *feminist theory*, *competence*, *training*, *bias*, *trauma-informed care*, *trauma-focused treatment*, and *marital/intimate partner sexual abuse*, as well as alternate forms of these words. The selected articles are relevant to the identification and treatment of IPV within inpatient as well as outpatient health facilities. Some of the articles also highlighted whether professional staff was able to successfully identify and aid individuals who have experienced IPV:

1. Hanson et al., (1991) conducted a germinal study with 362 marriage and family therapists to determine whether clinicians were able to identify and respond to overt descriptions of family violence. Although the study is more than 15 years old, it is one of few studies that specifically address whether clinicians were able to both identify and respond to family violence. Participants were provided with two vignettes that described extreme incidents of relationship violence (Hanson et

al., 1991). Forty percent of the participants did not identify or address overt descriptions of IPV (Hanson et al., 1991). Fifty-five percent of the participants stated they would not intervene by providing interventions to the family members experiencing violence (Hanson et al., 1991). The study highlighted the lack of identification and intervention strategies employed by clinicians who work with families (Hanson et al.,1991).

2. Spangaro, Zwi, Poulos, and Man (2010) conducted a cross-sectional study to understand how women used screening programs to disclose abuse and access needed services. Spangaro et al. (2010) conducted the study in 10 Australian health care settings with two samples of women from March 2007 and July 2008. The two samples consisted of 122 individuals who reported abuse and 241 who did not report abuse (Spangaro et al., 2010). Twenty-three percent of women who revealed abuse did so for the first time during the screening (Spangaro et al., 2010). Of the participants who initially screened negative for abuse, fourteen percent actually experienced abuse but chose not to disclose that information during the screening (Spangaro et al., 2010). The researchers highlighted the benefit of routine inquiry about abuse. Spangaro et al. (2010) examined disclosure of abuse from the perspectives of the abuse victims, which provided useful insight into factors that contribute to a woman's decision to report abuse.
3. Spangaro, Zwi, and Poulos (2011) conducted a qualitative study with 20 women who had provided positive responses, six months earlier, to IPV screening questions. Ten women shared that they only disclosed abuse after considering

themselves to be safe; six disclosed abuse when directly asked (Spangaro et al., 2011). Seeing the counselor as trustworthy contributed to abuse disclosure. Six women reported that safety from their abuser contributed to disclosure (Spangaro et al., 2011). Safety from shame and safety from institutional control also emerged as reasons women disclosed abuse (Spangaro et al., 2011). The researchers offered insight into what prompted abuse victims to disclose abuse in clinical settings (Spangaro et al., 2011). Trustworthiness, being directly asked, and fear of institutional control is particularly relevant to my research as those factors relate directly to clinicians (Spangaro et al., 2011).

4. Svavarsdottir (2010) conducted a descriptive cross-sectional design study on 101 women seeking medical care from an emergency department (ED) and 107 pregnant women seeking prenatal care from a high-risk prenatal care clinic (HRPCC) in 2006 over a seven-month period. Women who participated in face to face interviews disclosed physical abuse more often (Svavarsdottir, 2010). However, women who sought services in the emergency department disclosed emotional and sexual abuse more often when completing the self-reporting assessment (Svavarsdottir, 2010). Fifty-one women seeking services at the ED reported physical abuse, while 42 at the HRPCC reported physical abuse (Svavarsdottir, 2010). The result of the researcher's study contradicts previous studies, as the results did not determine which method of assessment was more effective in revealing abuse (Svavarsdottir, 2010). The researcher noted that the development of a trusting relationship could have contributed to the results

differing from previous research on similar topics (Svavarsdottir, 2010). The research study lends itself well in determining whether the type of facility contributes to a willingness to disclose abuse.

5. Williston and Lafreniere (2013) conducted an interpretive phenomenological analysis to evaluate semi-structured interviews with nine healthcare professionals: the researchers interviewed six family medical practitioners and three nurse practitioners in this study. The researchers wanted to explore how health care professionals asked patients about abuse and how they handled disclosure of abuse (Williston & Lafreniere, 2013). An overarching theme shared by the majority of the participants was that they believed they were overstepping their clinical boundaries by asking about abuse (Williston & Lafreniere, 2013). Another theme the researchers identified was the notion that abuse was not curable and therefore practitioners struggled with how they could create solutions to reports of abuse (Williston & Lafreniere, 2013). The researchers posed the question of whether health professionals believe it is their responsibility to inquire about personal issues such as abuse (Williston & Lafreniere, 2013).
6. Colarossi, Breibart, and Betancourt (2010) conducted a study at three family planning clinics in New York of 64 healthcare staff. The researchers conducted a mixed method study: having participants complete a survey about attitudes and barriers to IPV screening (Colarossi et al., 2010). The researchers performed a chi-square analysis to identify any differences in licensed and unlicensed professional's duties and responses (Colarossi et al., 2010). Unlicensed staff noted

the importance of screening but did not believe it should take precedence over family planning (Colarossi et al., 2010). Licensed professionals displayed a more positive attitude about identifying and responding to IPV (Colarossi et al., 2010). The researchers indicated that possibly licensure and increased experience contributed to the identification of IPV (Colarossi et al., 2010).

7. Rhodes, Kothari, Dichter, Cerulli, Wiley, and Marcus (2011) conducted a retrospective longitudinal cohort study that linked police, prosecutor, and medical records to examine emergency department identification and response to abuse from 1999-2002. Victims of IPV generated 3426 police incidents in the course of four years (Rhodes et al., 2011). The majority of emergency department visits occurred for medical complaints after a documented incident of IPV: Seventy-two percent of the women who presented for medical complaints after an IPV incident were not identified as victims of abuse by healthcare professionals (Rhodes et al., 2011). The majority of victims of IPV were unlikely to have the abuse identified or receive any interventions for IPV (Rhodes et al., 2011). The study was significant in highlighting the lack of identification of IPV.
8. Hamberger, Guse, and Griffin (2010) investigated whether prompting healthcare professionals, on healthcare records, to inquire about IPV would increase physician's inquiry into IPV during healthcare screenings. The researchers noted that before the prompt only two percent of female patient's records documented IPV during screenings (Hamberger et al., 2010). After implementing the prompts, ninety-two percent of women received documented IPV screenings (Hamberger et

al., 2010). After removing prompts, documented screenings of IPV decreased to thirty-two percent (Hamberger et al., 2010). The researchers suggested that providing prompts in client's records increased screening for IPV (Hamberger et al., 2010). Without inquiry by health professionals, the identification of IPV diminishes (Hamberger et al., 2010).

The literature review highlighted the value in identifying and providing treatment for victims of IPV. There is significant literature showing the effects of IPV on victims, families, and communities. However, there is a gap in the literature regarding the values, beliefs, and attitudes of master's level counselors, and how those views impact treatment and best practices provided to individuals and families affected by IPV.

Problem Statement

According to Karakurt, Dial, Korkow, Mansfied, and Banford (2013), approximately one in four women will experience IPV victimization in her lifetime. IPV can co-occur with substance abuse and mental health issues, such as depression and post-traumatic stress disorder (Karakurt et al., 2013). Between the years 2003 and 2012, relationship violence accounted for more than 21% of all violent crimes: females (76%) experienced more relationship violence victimization than males (24%; Bureau of Justice, 2012).

In a foundational study, Hanson et al., (1991) assessed whether therapists were able to identify and subsequently respond to violence experienced by clients. The researchers found that less than half of the clinicians in the study were able to recognize abuse in the vignettes provided to the participants (Hanson et al., 1991). Dudley,

McCloskey, and Kustron (2008) replicated the study by Hanson et al. (1991). Dudley et al., (2008) hoped to see improvement in therapists' ability to identify and successfully intervene in treating victims of IPV. The replicated research consisted of 111 licensed psychologists, clinical social workers, and marriage and family therapists. Only about 13% of the participants in the replicated study failed to identify any conflict in the vignettes provided. Overall approximately 78% of the respondents identified violence as a form of relationship conflict, which was a significant improvement from the previous study (Dudley et al., 2008). The studies by Hanson et al. (1991) and Dudley et al. (2008) highlighted whether clinicians were able to identify IPV. My proposed research will delve beyond whether mental health counselors can identify violence and explore the meaning that counselors place on their work with female victims of IPV. Emergent themes could illuminate the significance placed on those experiences with victims of IPV and impact identification and treatment modalities.

Although there is significant documentation on the effect of IPV on victims, families, and communities, many counselors do not engage in formal assessments for IPV with clients (Daire et al., 2014). Despite studies that highlighted the need for effective treatment for IPV victims and families (Ambuel et al., 2013; Cronholm et al., 2011; Stride, Geffner, & Lincoln, 2008), minimal treatment protocols exist for victims (Ambuel et al., 2013; Black et al., 2011). Counselor's beliefs, attitudes, and values towards this population may affect treatment provided to female victims of IPV. A possible cause, of minimal treatment protocols for victims of IPV, could be a lack of understanding of the experiences and perceptions held by counselors tasked with working with victims of IPV.

A phenomenological study that explores the lived experiences of master's level counselors who work with female victims of IPV may reveal education, training, knowledge, or bias that affect how efficiently counselors identify and counsel this population. Understanding the perceptions of counselors tasked with working with female victims of IPV may inform counselor education and training programs and improve services rendered to female victims of IPV.

Purpose

Although the awareness of IPV has increased through the years (Tower, 2006), I continued to witness more instances of IPV in my community and on the news. After viewing and reading about recurring incidents of interpersonal violence within my neighborhood, I was driven to further research on IPV. I found significant research on the effects of IPV (Ambuel et al., 2013; Cronholm et al., 2011; Stride et al., 2008); however, I found a gap in the literature surrounding clinicians who provided treatment and intervention to victims of IPV. I wanted to learn whether clinicians felt equipped to work with victims of IPV or whether some biases and attitudes influenced their work with victims of IPV. The purpose of this hermeneutic phenomenological qualitative research study was to gather a deeper understanding of the lived experiences of master's level counselors who work with female victims of IPV, to explore and understand whether those experiences affect counselors who treat mental illness associated with IPV.

Research Question

Main Question

What are the lived experiences of mental health counselors who provide treatment to individuals struggling with mental health disorders associated with IPV?

Framework

Martin Heidegger was a seminal thinker in the development of hermeneutic phenomenology (Dowling & Cooney, 2012). Heidegger was a student of Husserl who sought to expound upon describing other's experiences (McConnell, Chapman, & Francis, 2009). Heidegger wanted to understand the deeper hidden meaning behind experiences (McConnell et al., 2009).

Gadamer, who was a student of Heidegger, was a decisive figure in the development of Hermeneutics in the 20th century (Malpas, 2016). A central idea in hermeneutic phenomenology is the concept of the hermeneutic circle. A primary tenant of the hermeneutic circle is to understand the interdependence of the whole and parts of a structure (Malpas, 2016). If we are to understand anything we must find ourselves already in the world along with that which is to be understood (Malpas, 2016). Hermeneutic phenomenologists are concerned with the understanding of text and uncovering hidden meaning within text (Cohen, 2001). I used hermeneutic phenomenology as the theoretical framework by which I conducted this study.

Feminist theory comes from a sociological perspective in which violence is viewed as a result of social structure as opposed to the pathology of individuals (Lawson, 2012). Feminist theorists purport that IPV occurs because of the social inequalities that

exist between men and women (Lawson, 2012). Within the feminist perspective abuse is a way for men to express and maintain dominance over women (Lawson, 2012). Society viewed violence against the wife separately than violence against children or others within the household and therefore should not be seen through the same theoretical lens as family violence (Lawson, 2012). Kurz (1989) acknowledged feminist activists as contributing to the increased awareness of violence towards women in the 1970s. Feminist theorists do not deny that women may engage in violence against men; however, these theorists believe that men are far more likely to engage in violence towards women: noting that women may engage in violence towards males as a form of self-defense more often than initiating violence towards men (DeKeseredy & Dragiewicz, 2007).

I combined hermeneutic phenomenology and feminist poststructuralist theory to frame my research study. The feminist poststructuralist theory provides a method of analyzing the interactions between men and women as fluid as opposed to linear (Gavey, 1989). Feminist poststructuralist theory shifts focus on who has power, to how power is used (Healy, 2005). The theory lends itself well to the understanding of gender disparities prevalent in the decision-making practices of healthcare professionals (Arslanian-Engoren, 2002). I will use feminist poststructuralist theory as a lens to analyze data and inform interview questions. Semistructured interview questions will be used to elicit a deeper understanding of whether societal norms and gender bias contribute to the meaning mental health counselors place on treatment services provided to victims of IPV.

Fricker (2007) introduced the idea of hermeneutical injustice and noted that inequalities occur because of individuals in positions of power, neglecting or avoiding meaningful interpretations of the social experiences of marginalized groups. Through hermeneutic phenomenology, combined with a feminist poststructuralist theory lens, master's level counselors in mental health settings may be neglecting or misinterpreting the experiences of victims of IPV based on their values, beliefs, and attitudes toward this marginalized group. This notion poses a fundamental question: Are individuals in power aware of their marginalization of non-dominant groups (Mason, 2011)?

I will use feminist theory to gather a more in-depth understanding and uncover whether this inequality is prevalent when providing mental health services to female victims of IPV. The overarching goal of this study is to improve the quality of services provided to female victims' of IPV. Feminist theory strives to close the gap between services provided to women (Lawson, 2012). Learning about therapist's perceptions towards women experiencing interpersonal violence may improve services rendered to this population.

Nature of the Study

Qualitative

The nature of the study was a qualitative hermeneutic phenomenological study. Hermeneutic phenomenology is a form of inquiry researchers' use when exploring the lived experiences of human beings (Laverty, 2003). This approach begins with the recognition that human behaviors and experiences always have a deeper meaning (Guignon, 2012). The purpose of hermeneutic research is to shed light on aspects of

human experiences that may be taken for granted or appear trivial on a day-to-day basis, thus creating meaning and understanding of lived experiences (Wilson & Hutchinson, 1991). I focused on understanding the meaning mental health counselors place on their work with victims of IPV.

I used purposive and snowball sampling and recruited five to ten mental health counselors in counties in Mississippi for participation. I chose the four counties due to the proximity to me. I used a semistructured interview to ask open-ended questions to illicit more in-depth information about the lived experiences of these counselors.

I allotted one 90-minute interview with each participant. I traveled to one mental health center and conducted interviews at that location. I requested permission to recruit participants from the clinical director via email.

Definitions

The following definitions are presented to provide context and clarification in understanding IPV:

Attitudes: The way we think and feel about self, other persons, ideas or things (Miles, Huberman, & Saldana, 2014).

Beliefs: Part of a system that includes values and attitudes, personal knowledge, opinions, prejudices, experiences, morals and other perceptions in the social world (Miles et al., 2014).

Intimate partner violence: Physical, psychological, and/or sexual aggression displayed towards a romantic partner (Nathanson, Shorey, Tirone, & Rhatigan, 2012).

Master's level counselor: Professional who received a master's degree from a CACREP accredited counselor education program.

Values: The importance we attribute to ourselves, another person, thing, or idea (Miles et al., 2014).

Assumptions

Assumptions are circumstances that are out of the researcher's control; however, if those assumptions disappear the researcher would not be able to conduct the research study (Simon, 2011). I assumed that the master's level counselors in the selected counties have worked with female victims of IPV. If any of the counselors have worked with only perpetrators of IPV or other groups impacted by IPV, I will not have the appropriate data to conduct my study. Based on statistical data showing that 76% of females are victims of IPV (Bureau of Justice, 2012) I presumed that master's level counselors have worked with someone within this population at one point in time. In addition, I assumed that clinicians possessed attitudes, beliefs, and values, which affected therapeutic interactions in some way.

Scope and Delimitations

Delimitations to a study are circumstances that define boundaries of research and limit the scope of the study (Simon, 2011). While limitations may be out of the researcher's control, delimitations are within the power of the researcher (Simon, 2011). A delimitation of my study was the choice to focus on female victims of IPV rather than other groups who experience IPV. Participation in the study was delimitated to only master's level counselors who had previously or currently worked with female victims of

IPV. Due to time and resource constraints, the research was centralized to four counties in rural Mississippi.

Limitations

Limitations are possible weaknesses in a study that are out of the researcher's control (Simon, 2011). One limitation of the research was the limited diversity amongst the participants within the geographical location. I researched counties primarily comprised of female master's level counselors. There were not any males available to participate in the research study. In addition, overall there were more African American master's level counselors in the locale than other racial groups. The study was limited to master's level counselors in four specific counties and therefore may not be generalized to other master's level professionals who work as mental health therapists or individuals who live outside of these locations.

Significance

IPV is a crisis that affects not only victims but also families (Cronholm, Fogarty, Ambuel, & Harrison, 2011). Due to the prevalence and complexity of IPV, researchers, scholars, and practitioners need a deeper understanding of mental health counselors' lived experiences, when working with victims of IPV, and how those experiences contribute to their effectiveness in working with female victims of IPV. Despite prevalence rates and agreement that IPV is an important social issue with significant effects on physical and mental health (Ghandour, Campbell, & Lloyd, 2015), screening for IPV when working with individuals or couples on relational issues is generally conducted ineffectively (O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011).

The results of this research study will inform counselor education programs by increasing counselors' and educator's understanding and awareness of their beliefs, values, and attitudes that may hinder effective treatment for victims of IPV. Improvements in training and education of master's level counselors may improve overall treatment provided to this population (Ghandour et al., 2015). Improved treatment may decrease the number of health concerns, in turn reducing the number of emergency room visits and improving the overall family dynamic (Brown, Weitzen, & Lapane, 2013).

Implications for Positive Social Change

IPV is under-detected in mental health settings, with only approximately 10% to 30% of violence either asked about or disclosed in mental health settings (Howard, Trevillion, & Agnew-Davies, 2010). Lack of assessments for IPV may lead to a higher risk of danger for female victims of violence (Tower, 2006). Research indicates that IPV affects entire communities beyond victims and families (Robinson & Spilsurbry, 2008). However, according to Tower (2006), early identification and intervention may lead to a reduction in health concerns and death of females who experience IPV. Therefore, understanding the meaning mental health counselors place on their work with victims of IPV may help strengthen services provided to this population. Hence, the implications for positive social change could have a profound impact on counselor education and best practices.

Summary

In Chapter 1, I highlighted the impact IPV has on female victims, families, and communities. Women have silently experienced violence within their interpersonal relationships for many years until the women's movement shed light on this growing concern (Tower, 2006). Master's level counselors in mental health settings are responsible for identifying and providing treatment to victims of IPV. Gaining a greater understanding of the attitudes, values, and beliefs held by this group may lead to improved treatment outcomes and decrease the burden on families and communities. In Chapter 2 I reviewed the significant literature and included a more detailed description of the feminist poststructural theoretical framework. In Chapter 3 I will follow with a description of the study design; participants, procedures, assessments to be used and how any information gathered will be assessed.

Chapter 2: Literature Review

Introduction

Although significant documentation exists on the effect of IPV on victims, families, and communities, many counselors do not engage in formal assessments for IPV with clients (Daire et al., 2014). Despite studies that have highlighted the need for effective treatment for IPV victims and families (Ambuel et al., 2013; Cronholm et al., 2011; Stride et al., 2008), there remains a lack of appropriate treatment for victims (Ambuel et al., 2013; Black et al., 2011). Counselor's beliefs, attitudes, and values towards this population may influence treatment provided to female victims of IPV. A possible cause of this problem could be a lack of understanding how the experiences and perceptions held by counselors tasked with working with victims of IPV impede the facilitation of treatment. A phenomenological study that explores the lived experiences of master's level counselors who work with female victims of IPV may reveal hidden themes and views that impact how effectively counselors identify and counsel this population. The purpose of this hermeneutic phenomenological qualitative research study is to gather a deeper understanding of the lived experiences of master's level counselors who work with female victims of IPV, to learn how those experiences influence a counselor's ability to identify and treat IPV.

I provided a thorough literature review in this chapter which highlights the significance of my proposed study. I included, in this chapter, the literature search strategies I employed while conducting my literature review. Next, I summarized the feminist poststructuralist theory, which provided the lens through which I conducted my

research. I reviewed literature related to my proposed study that highlighted the effect of IPV, mental health consequences of IPV for female victims and families, and mental health services available and necessary to treat victims of IPV and their families.

Literature Search Strategy

I presented a review of research strategies to aid in identifying articles for future reference. I conducted a thorough examination of the literature by searching full-text articles in PsychINFO and SocINDEX in the Walden University library. In addition, I used the multidisciplinary database, Academic Search Complete, to search ERIC and PsycARTICLES databases in the Walden University library. I also used the Google search engine to search for scholarly articles related to the research topic, design, and data analysis. The literature review included peer-reviewed publications. Terms that I used to conduct my searches included *domestic violence*, *intimate partner violence*, *mental health*, *counseling*, *counselors*, *counselor education*, *violence*, *feminist theory*, *poststructuralist theory*, *competence*, *training, bias*, *trauma-informed care*, *trauma-focused treatment*, and *marital/intimate partner sexual abuse*, as well as alternate forms of these words.

I focused on articles that addressed the influence of IPV on victims, families, and communities in the literature review. In addition, I sought articles that addressed the need for interventions needed to treat victims of IPV. I searched for articles that discussed any bias and attitudes held by counselors who work with victims of IPV. I conducted a literature review that centered on feminist poststructuralist theory and the interrelatedness between that theoretical foundation and hermeneutic phenomenology. I was unable to

find significant ongoing research addressing feminist poststructuralism as well as current studies that specifically addressed the attitudes, beliefs, and values of clinicians and how those views impacted the rendering of services to victims of IPV. I included earlier studies to highlight previous research and the need for current research on this topic.

Theoretical Foundation

Phenomenologists believe that human behavior is determined by one's experience rather than external objective reality (Cohen, Mannion, & Morrison, 2007). This method of qualitative research gathers meaning through the analysis of spoken or written language (Kyale & Brinkmann, 2008). Hermeneutics is a form of phenomenology developed by Martin Heidegger (Smith, Flowers, & Larkin, 2009). Hermeneutics is an observer's interpretation of language or text (Smith et al., 2009). Heidegger believed that a researcher was unable to separate, detach, or bracket, themselves from the essence of a phenomenon (Smith et al., 2009). Interpretation of the meaning individuals place on an event is at the core of Heidegger's work (Smith et al., 2009). Gadamer was an influential hermeneutic philosopher (Regan, 2012). Gadamer suggested understanding was interpretation and vice versa (Gadamer, 2004). Gadamer identified the language as the medium for knowledge and a means of sharing the complexities of human experience (Gadamer 2004). The hermeneutic circle is a major component of hermeneutics (Regan, 2012). An important focus of the hermeneutic circle is to understand the interdependence of the whole and parts of a structure (Malpas, 2016). Researchers look at the text and stories told by participants and interpret the text: breaking the whole into parts or codes

and themes (Langdridge, 2007). Laverty (2003) noted that data is interpreted by reading, reflection, and interpretation.

Feminist poststructuralist theorists examine power relationships, how meaning is constructed, and the influence of language on the decision-making (Arslanian-Engoren, 2002). Poststructuralists see meaning as open to interpretation rather than fixed (Sands & Nuccio, 1992). French feminists such as Kristeva, Cixous, and Irigaray as well as the works of Foucault, Derrida, and Barthes have influenced poststructuralism (Gavey, 1989). Weedon (1987) noted feminist poststructuralists use social processes, institutions, and language as a means of understanding power within relationships as well as learn methods to change the power differentials prevalent in society. Feminist poststructuralists examine how women are affected by society as well as the role of power and knowledge in shaping how women view society and how society can be changed (Saulnier, 1996). Feminist poststructuralist theorists explore how dialogue and systems of power work to suppress individuals as well as how power can be transformed through critique and reflection (Wendt, 2008). Through a poststructuralist lens, there's an acknowledgment of diversity in the experiences and the meanings of IPV without ignoring power relationships between men and women within violent relationships (Wendt, 2008).

Wendt (2008) conducted a study aimed at understanding the culture in rural communities and how culture affects women's experiences and men's perpetration of IPV. The researcher conducted semistructured face-to-face interviews with 21 women who had experienced IPV and 12 human services workers (Wendt, 2008). Participants shared that Christianity influenced their views on IPV (Wendt, 2008). The church had a

dominant position in the community, religious beliefs shaped the decision women made regarding their relationship, and there was a concern as to how the church responded to IPV in the community (Wendt, 2008).

Men, who abused their partners, were not challenged in the community by the church, which allowed abuse to continue (Wendt, 2008). Women struggled to uphold their Christian values with their desire to leave abusive relationships (Wendt, 2008). Men often used religion to justify abuse and guilt women into staying in abusive relationships (Wendt, 2008). Through the feminist poststructuralist lens, dialogue about femininity and masculinity are not fixed and therefore can be challenged and changed (Wendt, 2008). As a result, both men and women can change as they recognize the societal limitations of sex roles and confront issues of power and control within interpersonal relationships (Wendt & Cheers, 2004).

Both feminist poststructuralist theorists and hermeneutic phenomenologists stress the meaning of experience and the influence of language interpreting meaning (Arslanian-Engoren, 2002; Smith et al., 2009). A feminist poststructuralist theoretical lens supports the notion that lived experiences should be viewed from the perspective of those who have the understanding because individuals constructed meaning through social interaction (Wendt, 2008). This theoretical lens also recognizes the power relationships between men and women that perpetuate power differentials (Dominelli, 2002). In my study, I explored the values, beliefs, and attitudes of master's level counselors who work with female victims of IPV. I explored how those perceptions affect the rendering of services to female victims of IPV.

Review of Literature

Mental health counseling professionals are responsible for providing effective interventions to victims of IPV (Feder, Wathen, & MacMillan, 2013). IPV has a far-reaching influence on families, and appropriate interventions are vital in reducing the negative effects of IPV on families and communities. The following literature review highlights the control of IPV as well as the importance of appropriate treatment for victims of IPV.

The Effects of IPV

IPV is a global concern with rates ranging from 10% to 75% depending on the country (Feder et al., 2013). IPV is the leading cause of death among adults, teens, and children (Sumner et al., 2015). Children experiencing abuse have a 78% increased rate of contracting a sexually transmitted infection, 54% increased the chance of developing a depressive disorder, and a 32% increased chance of being obese (Sumner et al., 2015). Twelve million women and men reported experiencing some form of violence from an intimate partner; however, only approximately 480,000 injuries are reported to police annually (Sumner et al., 2015). Of those reported, only about 150,000 of those reported injuries received medical treatment (Sumner et al., 2015).

IPV costs have exceeded more than 8.3 billion dollars which included 6.2 billion dollars for physical assault, 460 million dollars for rape, 461 million dollars for stalking, and 1.2 billion in the cost of the loss of life (Centers for Disease Control and Prevention, 2003). Although there is significant research highlighting the detrimental impact of IPV on families and communities, only 2% of the national budget is spent on funding public

health and IPV constitutes a small portion of the overall public health funding (Keller & Honea, 2016). The increased cost of health care for victims of IPV remains prevalent for as long as 15 years after the termination of the abuse (Rivara et al., 2007).

Female victims of IPV may display difficulty completing activities of daily living which may result in job loss and loss of support networks (Lilly, Valdez, & Graham-Bermann, 2011). Victims of severe forms of IPV lose approximately 8 million days of paid work per year (Centers for Disease Control and Prevention, 2003). This total is equivalent to the loss of 32, 000 full-time jobs per year (Centers for Disease Control and Prevention, 2003).

Children, exposed to violence, either as victims or witnesses, have a higher likelihood of exposure to violence or are at an increased risk of perpetrating violence as adolescents and adults (Millett, Kohl, Jonson-Reid, Drake, & Petra, 2013). Children may be victimized by IPV in two ways, as the recipient of physical and emotional violence and by witnessing the abuse of a parent (Izaguirre & Calvete, 2015). Younger children who saw and experienced IPV may experience sleep disturbances, including bedwetting, nightmares, and difficulty falling asleep as well as somatization issues (Stanley, Miller, & Richardson, 2012). In addition, children exposed to IPV are at an increased risk of experiencing depression, defiant behaviors, a decrease in school performance, and developmental delays (Kearny, 2010; Rivara et al., 2007).

Izaguirre and Calvete (2015) conducted a study to assess the effect of IPV on children, from the perspective of the children's mothers. The participants consisted of 30 women recruited from six different agencies that assisted victims of IPV in Bilbao and

San Sebastian Spain (Izaguirre & Calvete, 2015). The researchers conducted semistructured interviews for this qualitative research study (Izaguirre & Calvete, 2015). Five themes emerged: direct victimization of children, child witnesses of violence, children's reactions, consequences for children, and strategies for protecting children during and after violent incidents (Izaguirre & Calvete, 2015). Twenty-two mothers shared that their children suffered from direct psychological abuse, three of those mothers reported that their children experienced physical violence (Izaguirre & Calvete, 2015). Ninety-seven percent of the women shared that their children witnessed IPV indirectly (Izaguirre & Calvete, 2015). Three mothers stated that their child hid in rooms when the abuse occurred (Izaguirre & Calvete, 2015). Eleven mothers reported that their children attempted to interrupt the abusive episode (Izaguirre & Calvete, 2015). Four of the 11 women stated that their children tried to communicate with the father (Izaguirre & Calvete, 2015). Four participants indicated that their children would watch the incident, while other children cried or screamed (Izaguirre & Calvete, 2015). Gathering an understanding of women's views of their children's IPV experiences provides master's level counselors a better opportunity to understand the impact of IPV on family systems (Izaguirre & Calvete, 2015).

Mental Health Consequences

IPV has been shown to have a negative influence on the mental health status and substance use patterns of victims (Matheson, Daoud, Hamilton-Wright, Borenstein, Pedersen, & O'Campo, 2015). Women who experience IPV are at increased risk of developing mental health issues such as depression, anxiety disorders, and posttraumatic

stress disorder (PTSD) (Beck et al., 2014). Mental health conditions may increase the likelihood for women to remain with abusers which increases the risk of continued abuse (Minh et al., 2013).

According to Svavarsdottir, Orlygsdottir, and Gudmundsdottir (2014), interpersonal trauma has a stronger link to PTSD than other forms of trauma. PTSD is associated with depression, suicide, diabetes, obesity, as well as an increased likelihood of victims experiencing recurring abuse (Svavarsdottir et al., 2014). Symptoms of PTSD include continued re-experiencing of a traumatic event, numbing and avoidance of situations associated with the traumatic experience, and increased arousal both psychologically and emotionally (American Psychiatric Association, 2013).

Simmons et al. (2017) conducted a study to explore whether or not helping professionals who assist victims of IPV should also screen for mental health issues. Surveys were given to 325 professionals who primarily supported victims of IPV (Simmons et al., 2017). Snowball sampling and invitations were used to recruit participants for the sample (Simmons et al., 2017). Participant ages ranged from 24 to 72, most possessed bachelor's degrees or higher (n=168), and participants averaged 12.24 years experience working with victims of IPV (Simmons et al., 2017).

There were four possible multiple-choice responses to the question of whether helping professionals should screen IPV victims for mental health issues: 67 answered yes, 94 responded maybe, it depends, 20 answered no, absolutely not, and six answered I have no opinion (Simmons et al., 2017). Thirty-seven respondents stated a need for training to address client needs (Simmons et al., 2017). Fifty participants shared a

concern of pathologizing IPV victims with mental health labels (Simmons et al., 2017). Seventeen participants noted that trauma symptoms are common amongst IPV victims and feared misdiagnosing victims (Simmons et al., 2017). Twenty-five participants stated the benefits of screening but stated that due to the limited time they had to work with victims of IPV, they might not have enough time to assist victims with mental health concerns (Simmons et al., 2017). Forty-nine respondents noted the benefits of screening for mental health issues which included enhancing services and the need for interventions to help victims improve (Simmons et al., 2017). Nine participants noted that screening for mental health issues would be helpful to make appropriate referrals to outside agencies (Simmons et al., 2017). Seventeen participants believed it necessary to refer clients to outside agencies for mental health testing and assessments (Simmons et al., 2017). Thirteen participants shared barriers to screening for mental health concerns, which included limited funds and limited agency resources (Simmons et al., 2017). Three respondents noted that, while screening would be helpful, there are more important issues to focus on which included safety, financial assistance, and housing (Simmons et al., 2017).

An overwhelming number of participants shared various concerns regarding screening victims of IPV for mental health issues, including fear of misdiagnosing, inadequate training, reduced resources, and more pressing issues that need addressing (Simmons et al., 2017). Professionals who provide services to victims of IPV often focus on addressing the immediate physical need rather than holistically assisting victims with

both physical and emotional needs (Simmons et al., 2017). This study highlights a need for improved training in counselor education programs.

Nathanson et al. (2012) conducted a study with female victims of IPV, who did not reside in a shelter community, to examine the pervasiveness of mental disorders within the sample. One hundred and one women initially participated in the study (Nathanson et al., 2012). The average age of the participants was 32.85 with 61.4% identifying as Caucasian and 31.7% identifying as African American (Nathanson et al., 2012). The study focused on the Caucasian and African American participants in the study (n = 94) (Nathanson et al., 2012).

The results indicated that 57.4% of the overall sample met criteria for PTSD and 56.4% of the sample met the criteria for depression (Nathanson et al., 2012). Participants reported alcohol dependence at a rate of 18.1% while alcohol abuse was reported at a rate of 3.2% (Nathanson et al., 2012). Participants reported substance dependence at a rate of 6.4% while 6.4% reported substance abuse (Nathanson et al., 2012). Forty-five percent of the participants displayed a co-morbidity of depression and PTSD while 12.7% of the sample reported both depression and substance dependence, followed by 11.7% reporting alcohol dependence and PTSD co-morbidly (Nathanson et al., 2012). There were no differences amongst ethnic groups in the frequency of violence; however, Caucasian women presented with a higher rate of PTSD than African American participants (Nathanson et al., 2012). No significant differences were noted amongst both ethnicities with depression, alcohol abuse, alcohol dependence, substance abuse, and substance dependence (Nathanson et al., 2012).

There are implications in this study for mental health counselors who work with victims of IPV in a community setting. The inconsistencies among victims who received treatment could be due to feelings of hopelessness evident in those experiencing depression or the significant rate of avoidance in individuals with PTSD (Brush, 2000). In addition, women who are victims of IPV who suffer from depression, PTSD, and alcohol/substance abuse and dependence may see little hope to leave abusive relationships successfully, particularly if their resources are limited (Raghavan, Swan, Snow, & Mazure, 2005).

Mental Health Interventions and Services

While the health-related consequences for women who experience IPV have been well documented, and victims often seek medical treatment (Cronholm et al., 2011), detection and treatment for IPV and mental health concerns that arise as a result of abuse, remains limited (Simmons, Whalley, & Beck, 2014). Programs designed to help victims of IPV often focus on more pressing issues such as housing or safety concerns and often neglect mental health screenings for IPV victims (Simmons et al., 2014). Many professionals in the allied health fields, including social workers, psychologists, and counselors, are tasked with assisting victims of IPV. However, they are not trained to assess, identify, and treat mental health-related concerns (Simmons et al., 2014). Mental health professionals are in positions to aid victims and families who experience violence, yet these professionals have difficulty addressing issues of IPV (Simmons et al., 2014).

According to Seelau and Seelau (2005) the sex of the victim and perpetrator of abuse, as well as the sexual orientation of the couple, affects the criminal justice's

response to IPV. Police are less likely to arrest perpetrators of IPV if the perpetrator is not male and the victim is not female, which may be due to societal stereotypes that men cannot be victims and women cannot be abusers (Seelau & Seelau, 2005). These sex-role stereotypes, regarding IPV, are not just held by those in law enforcement, those in the medical and mental health fields may carry these same biases as well (Seelau & Seelau, 2005).

An older, yet significant study conducted by Tilden et al. (1994) explored whether factors such as training and gender impacted clinician's management and assessment of abuse victims. The researchers mailed 2100 questionnaires, 1521 were completed and used in the study (Tilden et al., 1994). Psychologists, social workers, dental hygienists, dentists, nurses, and physicians were included in the research study (Tilden et al., 1994). Of the groups, 40% reported receiving education on spousal abuse, 27% received education on elder abuse, 64% reported receiving education on child abuse, and 33% received no education on any of the types of abuse listed (Tilden et al., 1994). The results of the study indicated that suspecting abuse was directly linked to educational training (Tilden et al., 1994). Approximately 20% of those with education in abuse, commonly suspected physical and sexual abuse while only roughly seven percent of those with no educational background suspected abuse (Tilden et al., 1994). A significant number of professions in the study did not view themselves as accountable for intervening, and those who did intervene did not report abuse to the proper authorities (Tilden et al., 1994). These findings indicated a need for improved educational curriculum on interpersonal violence (Tilden et al., 1994).

Crnkovic, Del Campo, and Steiner (2000) conducted a study that compared the responses of mental health professionals to the reactions of female victims of interpersonal violence to gauge how accurately these professionals perceive family violence. Mental health professionals were asked to complete the Family Environment Scale with responses they believed female victims of IPV would provide (Crnkovi et al., 2000). The study consisted of 300 mental health professionals: 100 Licensed Marriage and Family Therapists (LMFTs), 100 Licensed Master of Social Work (LMSWs), and 100 Licensed Professional Clinical Counselors (LPCCs) (Crnkovic et al., 2000).

The mental health professionals believed that the female victims of violence experienced less safety in expressing their needs, feelings, and opinions and a lesser sense of bonding than the women, who were victims, actually believed (Crnkovic et al., 2000). In addition, the mental health professionals thought the women felt a lessened interest in cultural and recreational activities, a minimized sense of assertiveness in the home, and a lessened concept of a higher power that guide behaviors which contrasted with the views of the women who experienced violence in the study (Crnkovic et al., 2000). The professionals and women who suffered abuse reported similar responses regarding the amount of power a single family member possesses, the level of aggressiveness in the home, the competitiveness of achievements within the home, and the rigidity of roles within the home (Crnkovic et al., 2000). The researchers suggested that clinicians tend to view females, who experience abuse, as helpless victims (Crnkovic et al., 2000).

Cater (2014) conducted a qualitative study that interviewed children between ages of eight and fifteen who witnessed IPV. The participants were interviewed to gauge how children perceived the interventions, based on the Staircase model, employed during counseling (Cater, 2014). The model consisted of three primary steps: establishing rapport and contact with the child, recreating the violent incident, and teaching the child proper reactions to trauma and crisis events (Arnell & Ekbom, 2000). Thirty-six children received the intervention the year this data was collected, of those 36, 29 participants completed the interview (Cater, 2014). The researchers indicated that if children did not have the opportunity to participate in making decisions regarding essential occurrences in their lives, the children might feel disregarded (Cater, 2014). These feelings could lead the child to not take advantage of interventions provided to help cope with IPV (Cater, 2014). The researchers shared implications for clinicians who provided therapy for children affected by IPV (Cater, 2014). Allowing children to feel empowered in the treatment they received may improve the outcome and success rate of treatment provided to children who have witnessed or experienced IPV in the home (Cater, 2014).

Summary and Conclusion

In conclusion, I found limited current research on the values, attitudes, and beliefs of master's level counselors and how those views influence the meaning counselors place on treatment provided to female victims of IPV. Master's level mental health counselors must remain aware of various symptoms and presentations of victims of IPV to offer interventions to this group. IPV training has been linked to increased comfort levels among professionals when they intervene with victims of IPV (Phillips, 2011). I further

addressed questions generated by germinal research conducted by, Hanson et al. (1991), which examined whether clinicians were able to identify and appropriately respond to family violence. This current study delved deeper into the meaning master's level counselors place on their work with female victims of IPV.

Numerous research studies were conducted, highlighting the impact of IPV on victims, families, and communities (Cerulli et al., 2011; Levendosky et al., 2013). There have been studies conducted that gauge whether clinicians were able to identify and subsequently respond to IPV (Hanson et al., 1991; Dersch et al., 2006; Dudley et al., 2008). I found limited current research that explores the meaning that master's level counselors impart on their work with female victims of IPV. I have seen no studies that explore how the values, attitudes, and beliefs counselor's have, impact their work with female victims of IPV impacts best practices and services rendered to this population.

A phenomenological qualitative study explores the meanings individuals place on a phenomenon (Christensen, Johnson, & Turner, 2010). I chose to conduct a phenomenological qualitative study because this study lends itself well to my research question (Christensen et al., 2010). The next chapter highlights the research design and rationale, methodology, recruitment and participation procedures, as well as any issues of trustworthiness.

Chapter 3: Research Method

Introduction

Master's level counselors are responsible for identifying, intervening, and assisting victims and families who are affected by IPV (Bogat, Garcia, & Levendosky, 2013). Victims and their families are affected physically and mentally, which can have longstanding consequences (Reynolds & Shepherd, 2011). Although significant information exists on the effects of IPV, I discovered limited information about the attitudes, beliefs, and values held by professionals who work with this population. To narrow this gap, I conducted a hermeneutic phenomenological qualitative research study to gather a deeper understanding of the lived experiences of master's level counselors who work with female victims of IPV, which can inform counselor education programs and training for master's level counselors.

In Chapters 1 and 2, I highlighted the influence of IPV on families and communities as well as the need for proper identification and treatment interventions for victims of IPV. In this chapter, I will highlight the research design and rationale, role of the researcher, methodology which includes participant selection, instrumentation, procedures for recruitment and data collection, and data analysis, issues of trustworthiness, ethical processes, and summary that will be used to increase understanding of the experiences of master's level counselors who work with female victims of IPV.

Research Design and Rational

I explored the research question within a phenomenological research tradition. The objective of a phenomenological study is to elucidate the essence and meaning of a group of people or individual about a specific phenomenon (Christensen et al., 2010). Researchers who engage in phenomenology believe that how individuals construct and perceive experiences are grounded in a specific perspective within time and space (Simon, 2011). Generally, phenomenological research begins with a phenomenon rather than a particular theory (Simon, 2011). Heidegger was a seminal thinker in the development of hermeneutic phenomenology (Dowling & Cooney, 2012). Heidegger was a student of Husserl (McConnell et al., 2009). Heidegger sought to understand the in-depth meaning behind experiences (McConnell et al., 2009).

Hermeneutics is an observer's interpretation of language or text (Smith et al., 2009). Heidegger believed that a researcher was unable to separate, detach, or bracket, themselves from the essence of a phenomenon (Smith et al., 2009). Heidegger extended the meaning of Hermeneutics from interpretation of the text to the explanation of all forms of human understanding (Smith et al., 2009). Both feminist poststructuralist theorists and hermeneutic phenomenologists highlight the meaning of experience and the impact of language on interpreting meaning (Arslanian-Engoren, 2002; Smith et al., 2009).

Gadamer studied Heidegger's work as was an influential figure in the development of 20th-century hermeneutics. The hermeneutic circle is an essential aspect of hermeneutics (Sad, 2002). To understand the entirety of something, one must

understand the individual components; likewise, to understand the individuality of something, one must understand its entirety (Malpas, 2016). I used Hermeneutic phenomenology as the theoretical framework by which I conducted this study. This approach urges researchers to reflect on what the entire text is saying and breaking that text into smaller fields (Sharkey, 2001). The researcher is encouraged to become lost deep within the text, flowing between parts of the text and the entirety of the text (Sharkey 2001).

Hermeneutic phenomenology is a form of inquiry researchers' use when exploring the lived experiences of human beings (Laverty, 2003). This approach begins with the recognition that human behaviors and experiences always have a deeper meaning (Guignon, 2012). The purpose of hermeneutic research is to shed light on aspects of human experiences taken for granted or that appear trivial on a day to day basis: thus, creating meaning an understanding of lived experiences (Wilson & Hutchinson, 1991).

I explored the research question: What are the lived experiences of mental health counselors who provide treatment of mental health disorders associated with IPV? There are beliefs, values, and attitudes held by individuals that affect how people interact with one another (Miles et al., 2014). I chose feminist poststructuralist theoretical lens because it provides insight into how power influences gender disparities prevalent in the decision-making practices of health care professionals (Arslanian-Engoren, 2002). The meaning master's level counselor's place on their work with female victims of IPV is the core of my research design.

Role of the Researcher

My role consisted of several moving parts. The researcher is enmeshed in all aspects of the research from conception to interviews, transcription, and analysis of data, as well as verifying and reporting themes (Sanjar et al., 2014). According to Denzin and Lincoln (2003), the researcher serves as an instrument in the data collection process. As an active instrument in the research study, I described any assumptions or biases I possessed as well as any experiences that qualified me to conduct the research study (Greenback, 2003).

Positionality

I am an African American female who has worked with victims of IPV for approximately 17 years. In addition, I have supervised master's level mental health clinicians, who work with female victims of IPV, for the past 6 years. My experiences working directly with IPV victims and supervising clinicians who work with this population has afforded me the opportunity to better understand the important role of master's level counselors who work with victims of IPV. My varying experiences, working with both victims and professional counselors has increased my awareness of the reported experiences of both groups.

My experience of working in-depth with female victims of IPV, from a counselor's perspective, enables me to better understand how master's level counselors engage in treatment with IPV victims. I conducted a phenomenological study based on Heidegger's views on phenomenology. Heidegger rejected the notion of bracketing and believed that a researcher was incapable of separating description from their own

interpretation (McConnell-Henry, Chapman, & Francis, 2009). Individuals are not detached from experiences but understand experiences based on their perspectives (McConnell-Henry et al., 2009). My experience as a counselor who has worked with victims of IPV will provide a better understanding of the data that I analyzed. I maintained a reflexive journal to reduce the potential for bias within my research study.

Research Methodology

Qualitative research can be difficult to measure but offers valuable perspectives that cannot be achieved through quantitative methods (Sayre, 2001). A foundational study by Hanson et al. (1991) and two replicated studies by Dersch et al. (2006) and Dudley et al., (2008) explored whether clinicians were able to successfully identify and treat victims of IPV. I purposefully selected master's level counselors who have worked with female victims of IPV. Sampling from this population allows for specific experiences of the attitudes, beliefs, and values held by master's level counselors who work with female victims of IPV. Participants were selected from four counties in rural areas in Mississippi.

Study Participants

I contacted the clinical director of my specified recruitment site to ask permission to conduct face to face semistructured interviews with master's level counselors who (a) have received a master's degree from a CACREP accredited counseling program, and (b) are currently working with female victims of IPV in an individual or group setting, or (c) have previously worked with female victims of IPV beyond an intake assessment, or (d) have engaged in crisis work with a female victim of IPV. I provided the Clinical Director

with a recruitment email to forward to potential participants. After I received approval from the Executive Director of the recruitment site, I asked each participant to take part in one 90-minute individual interview. No incentive was provided to recruit participants.

Sampling Procedures

Samples used in qualitative research tend to be much smaller than quantitative sample sizes (Mason, 2010). One occurrence of a data set may be sufficient because qualitative research is concerned with eliciting meaning rather than generalizing (Mason, 2010). The participants consisted of at least five but no more than ten master's level counselors. I used purposive sampling and snowball sampling to identify participants who are currently or have worked directly with victims of IPV. Purposive sampling occurs when participants are intentionally chosen based on qualities that they have (Etikan, Musa, & Alkassim, 2015). Purposive sampling is often used in qualitative research to select participants who have insight into a phenomenon (Etikan et al., 2015).

Snowball sampling occurs when a researcher identifies possible participants by contacting individuals due to information provided by a third party (Noy, 2008). Those participants then provide a list of other potential participants and the sampling process continues through this method (Noy, 2008). I choose master's level counselors who have worked with female victims of IPV, based on their knowledge and experience. Participants consisted of females who have worked with female victims of IPV during their time as a master's level counselor in a mental health or private practice setting.

I recruited participants by contacting the Clinical Director of a local mental health center via email asking permission to conduct my research at recruitment locations

(Appendix A). I focused on potential participants in four counties within the recruitment region. The clinical director forwarded an email to the clinicians in each county to identify whether they possessed a master's degree in counseling from a CACREP accredited program, have worked with female victims of IPV, and whether they were interested in participation in the study (Appendix B).

I explained informed consent to each participant at the beginning of each interview, answered any questions about informed consent, and emailed an informed consent document for each participant to sign (Appendix C). I scheduled one 90-minute interview with participants from the four counties in the recruitment region. I developed the interview protocol to administer to the participants (Appendix D). Participants were debriefed after the interview session to ensure no harm or ethical issues arose. If individuals required follow up care to process issues that surfaced, from the interview, referrals were made for treatment (Orb, Eisenhower, & Wynaden, 2000). I referred participants to the Mississippi State Board for Licensed Professional Counselors for a list of licensed clinicians in the area if needed.

Saturation occurs when the collection of data no longer sheds light on the research topic (Mason, 2010). There are several factors that influences sample size; however, saturation is a primary principle used during data collection (Mason, 2010). More focused and direct studies may achieve saturation quicker than a larger study that explores a general concept (Mason, 2010). I attained saturation within the number of proposed participants. Saturation may occur with as few as one participant, depending on the nature of the study (Mason, 2010)

Procedures for Recruitment, Participation, and Data Collection

I used the following procedures to recruit participants, collect and code data, and authenticate data. I chose four mental health facilities as research sites based on proximity to me. I solicited the clinical director via email (Appendix A) to assist in identifying clinicians for my study who (a) possessed a master's degree in counseling form a CACREP accredited counseling program, and (b) currently work with female victims of IPV individually or in a group setting, or (c) have worked with female victims of IPV individually or in a group setting beyond an intake assessment, or (d) who have provided crisis services to female victims of IPV.

I asked the clinical director to send a recruitment email (Appendix B) to each potential participant, outlining the nature of the study. Potential participants responded to me via email. At that time, I scheduled a date and time for the interview. I discussed informed consent with each participant (Appendix C). I allotted time to conduct one 90-minute interview with participants from the four counties in the recruitment region. I conducted the interviews in a private locked office to protect and maintain anonymity. I audio recorded each interview (Appendix D). I transcribed the audio footage verbatim and identified emerging themes from transcripts.

Data Analysis Plan

I used a separate audio recording for each participant. I labeled each audio recording as Participant 1, Participant 2, and so on. I transcribed and organized the data. I took the following steps to analyze the data:

1. Read the entire transcripts.

2. Inserted the transcripts into NVivo 12 software.
3. Identified and summarized themes.
4. Interpreted findings.
5. Triangulated data.
6. Summarized and concluded.

Illustrated Steps

First, I read the entire transcript for each participant and compared the transcript to the audio recordings. I recorded each set of data in its entirety using NVivo 12 software. I used first cycle coding and second cycle coding to analyze the data (Miles et al., 2014). I assigned codes to sets of data to identify reoccurring patterns (Miles et al., 2014). Values coding reflects the beliefs, values, and attitudes participants place on certain phenomenon (Miles et al., 2014). Beliefs include experiences, prejudices, and opinions placed on the social world, values include the importance that is placed on ideas, things, people, and one's self, and attitudes are the ways people think feel and act towards self, others, and ideas (Miles et al., 2014).

After completing first cycle coding, I explored pattern coding and reduced initial codes to smaller themes (Miles et al., 2014). I explored coding groups to gather a deeper meaning within the text data. I explored all data retrieved from the master's level counselors to identify themes relating to values, beliefs, and attitudes of master's level counselors who work with female victims of IPV. I cross checked my data by re-reading transcripts and keeping a reflexive journal. Lastly, I summarized the data and findings.

Issues of Trustworthiness

Qualitative research is iterative, meaning researchers flow between research designs and implementation to ensure continuity among research questions, literature reviews, data collection and analysis (Morse et al., 2002). Assessing the quality of qualitative research is typically less straightforward than assessing quantitative research (Mason, 2012). Rigor encompasses the thoroughness, accuracy, and trustworthiness in qualitative research (Le Roux, 2015). Mason (2012) noted that trustworthiness is achieved when data gathering, and analysis are honest, careful, thorough, and accurate. There are various aspects to ensuring trustworthiness in qualitative research. Reflexivity is a continuous evaluation of self during the research process (Shaw, 2010). Reflexivity is vital in engaging in the double hermeneutic (Rodham, Fox, & Doran, 2015). Instead of setting aside the researcher's assumptions, as done in bracketing, the researcher monitors self and how the impact of bias, experiences and beliefs impact research (Rodham et al., 2015). The goal of reflexivity is to improve the credibility and accuracy of research (Berger, 2015). The researcher should engage in continuous self-reflection on how his or her experiences and biases influence various stages of the research process (Dowling, 2006; Koch & Harrington, 1998). Researchers should remain aware of external and internal responses while maintaining an awareness of the researcher's relationship to the research topic (Dowling, 2006). The use of a journal is one tool that can help researchers maintain reflexivity and increase the credibility of a research study (Wall, Glenn, Mitchinson, & Poole, 2004).

In seminal work conducted by Guba (1981), he developed a model to ensure trustworthiness within qualitative research. Guba (1981) proposed four ideals to ensure trustworthiness: truth value, applicability, consistency, and neutrality. More recently, Le Roux (2015) proposed five criteria to evaluate qualitative research which included subjectivity, self-reflexivity, resonance, credibility, and contribution (Le Roux, 2015). Subjectivity occurs when the research is aware of the description which represents the research (Le Roux, 2015). Self reflexivity involves the researcher's awareness of his/her role in the context of the research study (Le Roux, 2015). Resonance occurs when the audience can connect with the information presented in the research study (Le Roux, 2015). Credibility takes place when research is trustworthy, credible, and honest (Le Roux, 2015). Contribution occurs when research makes a positive impact on social change (Le Roux, 2015).

I ensured my research question aligned with my research design. Next, I confirmed that the participants being sampled possessed knowledge of the research topic. Appropriate data collection and participation were achieved by saturation. Saturation involves interviewing participants until themes and ideas are replicated (Mason, 2010). I kept a reflective journal throughout my research study to decrease any potential bias and ensure reflexivity.

Ethical Procedures

Qualitative researchers experience issues such as privacy, honesty, and ensuring data are not misrepresented (Sanjari et al., 2014). Some important ethical concerns that should be considered while carrying out qualitative research are: Anonymity,

confidentiality and informed consent (Sanjari et al., 2014). Ethical procedures for this study will include gaining access to participants, recruitment, data collection and protections, and data storage protocols. I addressed each ethical concern in this section.

Accessing Participants. I completed Walden University's Institutional Review Board (IRB) application prior to collecting data for my study. I submitted a letter of cooperation (Appendix A) to the clinical director of the recruitment site and obtained approval to recruit for this study. I completed informed consent and confidentiality agreements (Appendix C) with each participant in this study.

Recruitment. I recruited master's level counselors who have graduated from a CACREP accredited master's program. Participants currently worked with female victims of IPV or have worked with victims of IPV individually, in a group setting, or through crisis work. Participants were asked to voluntarily participate in this study. There was no coercion or incentives offered to participate in the study. I addressed early withdrawal and refusal to participant in the consent form (Appendix C). There was no adverse response or punishment within the participant's place of employment for early withdrawal or refusal to participate in this study. Although there was no known harm to participants in the study, if participants experienced distress or harm associated with this research study, a referral for services was made.

Data Collection and Protections. Each participant was notified, via informed consent, of the purpose of the study. I informed participants that participation in the study was completely voluntary. There were no negative repercussions for early withdrawal or refusal to participate in the study. The collected data was kept confidential and will not be

accessed by anyone outside of the research committee without specific approval by the Walden University IRB.

I provided pseudonyms to each individual, to secure the privacy of the research participant. I removed any participant and client identifying information from the research study. Individuals who participated in the study may reveal information about specific clients they are or have worked with.

Data Storage Protocols. I will keep all audio recordings and transcripts in a locked safe in my office on a password protected computer. The only individual who will have access to these files will be the researcher and those appointed to assist in transcribing and coding the data. All electronic documents are secured in a password protected laptop that is locked in my office. I will destroy the raw data from the study five years after the publication date of the dissertation.

Summary

I outlined, in Chapter 3, the research design and rationale for performing this study as well as my role as the researcher within the study. In addition, I have included the research methodology which includes the choice of participants in the study, sampling procedures, measures and recruitment procedures, participation, data collection, and analysis. Issues of trustworthiness were also addressed in this chapter which included ethical procedures for conducting the study. I included the data analysis and interpretation in Chapter 4. In Chapter 5 I will include the conclusion of the research study.

Chapter 4: Results

Introduction

My purpose in this hermeneutic phenomenological qualitative research study was to gather a deeper understanding of the lived experiences of master's level counselors who work with female victims of IPV. I did so, to learn how those experiences affected the counselor's ability to identify and treat IPV. In Chapter 4, I summarize the research questions, data collection methods, findings of the study, the demographics of participants, as well as themes that emerged during data analysis. The research question for this study was: What are the lived experiences of mental health counselors who provide treatment of mental health disorders associated with IPV? I discuss themes, in detail, for each interview question.

Setting

I conducted interviews in person and in private office spaces and conference rooms at a mental health facility in Mississippi. All participants have worked with or currently worked with female victims of IPV. I collected data via semistructured, in-depth interviews.

I was responsible for all data collection. I allotted 90 minutes for each participant; however, most interviews took 30 to 40 minutes per participant. The participants moved through each interview question fluidly and answered follow up questions more quickly than anticipated, which is why the interviews were conducted in a shorter time than allotted. I collected data over a 5-week period. I did not provide incentives for participation in the study.

Demographics

I required participants to meet criteria to participate in this study which included (a) possess a master's degree in counseling form a CACREP accredited counseling program, and (b) currently work with female victims of IPV individually or in a group setting, or (c) have worked with female victims of IPV individually or in a group setting beyond an intake assessment, or (d) who have provided crisis services to female victims of IPV. I excluded potential participants who did not meet the criteria. I labeled participants as Participant 1, 2, 3, 4, and 5 to conceal their identity.

Data Collection

I obtained Walden IRB approval prior to collecting data (number 11-30-17-0303943). I emailed the Clinical Director of the recruitment site to solicit participation in this study. The Clinical Director forwarded the participant email to master's level counselors currently working at the recruitment site. Eight participants signed consent forms. I conducted six interviews. The first interview did not record due to an audio malfunction; however, saturation was reached at five interviews.

I collected data over the course of five weeks. I recorded the data using a digital audio recording device and laptop. Following each interview, I engaged in reflexive journaling. I debriefed the participants for any discomfort and need for follow up referrals. I did not conduct any follow up interviews because participants thoroughly answered all interview questions with no need for follow up clarification.

I began data collection and conducted interviews. I used semistructured open-ended questions to elucidate in-depth insight into the experiences of the participants.

After I recorded each interview, I transcribed the data recordings and I stored all interviews in a Microsoft Word document. I encountered one difficulty during the data collection process: the audio recording of the first interview was inaudible. However, I completed five additional interviews. To rectify the audio issue, I replaced the recording device with an internal recording device on a laptop. I recorded the additional five interviews and stored them on a separate hard drive and placed them in a locked storage cabinet. I will save the data for the required time of 5 years.

Data Analysis

To properly code qualitative research, raw data must first be processed, followed by first cycle coding, which compartmentalizes data into chunks, followed by second cycle coding which explores patterns and themes within the data (Miles et al., 2014). The first stage of data analysis involved reviewing and rereading each participant transcript. I reviewed all five transcripts together, and then reviewed each transcript individually. I highlighted phrases and segments and noted emergent themes. I explored the meaning of phrases and segments of the detailed and descriptive text. I repeated this process for all five transcripts.

The second stage of data analysis involved highlighting emerging themes as I read and reread the descriptive data. I reduced the text to themes that defined the phenomenon of the experiences of master's level counselors who work with victims of IPV. I combined the emergent themes from each transcript and highlighted the overall meaning and significance of the themes. I reviewed the entire transcript to ensure that the themes were in alignment with participant responses.

I designated which themes developed from a specific participant, by labeling participants one through five. I identified five themes. I collaborated with my dissertation chair to highlight emergent themes that reflected the purpose of the study and related to the research question.

I conducted semistructured interview questions that explored the lived experiences of master's level counselors who provided mental health treatment to female victims of IPV. I analyzed each transcript and developed five themes: insufficient education and training, views on IPV, emotional responses, presenting vs. actual concerns, and needed improvements. I used NVivo 12 software to organize my data. Through the feminist poststructuralist lens, I was able to explore participant's responses about regarding inequities in services and trainings available to assist victims of IPV.

Evidence of Trustworthiness

Credibility

Trustworthiness is accomplished when data gathering, and analysis are careful, thorough, and accurate (Mason, 2012). One method used to establish trustworthiness in qualitative research is credibility (Le Roux, 2015). As stated in Chapter 3, credibility is established when research is trustworthy, credible, and honest (Le Roux, 2015). I employed the following procedures to increase the probability that the research was trustworthy: triangulation, and semistructured interviews. Triangulation is the process of collecting data through various approaches to increase the validity or credibility of a study (Mason, 2012). Triangulation may be established through various approaches including methods, investigators, theories, and interviews (Mason, 2012). I established

triangulation by interviewing various participants, which permitted me to compare various participant responses to the same research questions. I also asked a set of semistructured interview questions to each participant and participants could expound on information. I gained a broader amount of information by using these interview questions so that I could address the same concepts with each participant (Le Roux, 2015). To maintain credibility, I did not include the first interview that did not record. In addition, I established triangulation by engaging in reflexive journaling after each interview, audio recording each interview, and using NVivo 12 to aid in organization and formation of thematic clusters.

Transferability

In qualitative research, transferability refers to the ability to apply the research findings to individuals in other settings (Anney, 2014). Researchers provide detailed descriptions of the participants, site, and data collection procedures to allow other researchers to assess whether generalizing the results is warranted (Anney, 2014). To aid with this process, I have provided a detailed description of the study and findings that can apply to future research studies. However, transferability may be limited due to sample size and location of the study.

Dependability

Dependability is established by displaying consistency in the research findings (Mason, 2012). Dependability is determined by detailing an audit trail that describes the exact methods used to collect, analyze, and interpret data (Anney, 2014). The audit trail allows another researcher to reproduce the study (Anney, 2014). I used an audit trail to

establish dependability in this study. The steps taken in my audit trail included sending a flyer to the director of a local mental health center to distribute to master's level counselors, contacting master's level counselors who responded to the email and indicated an interest in participating in the study, emailing consent forms to participants, scheduling appointments at a mental health center office, conducting interviews in person to encourage dialog about their lived experiences working with female victims of IPV, transcribing data and keeping information in a secure location.

Confirmability

Confirmability establishes that findings originate from the data, not the researcher's personal opinions and views (Anney, 2014). Confirmability may be achieved through triangulation, an audit trail, and reflexive journal (Anney, 2014). I established confirmability by conducting audits of the data results and interpretations. The audit trail consisted of a reflexive journal. My reflexive journal included documentation of what occurred throughout the research study, personal thoughts, as well as my perceptions of the research topic to interpret and appropriately plan data collection (Anney, 2014).

Results

Five overall themes emerged from the study results: (a) insufficient education and training, (b) views on IPV, (c) emotional responses, (d) presenting vs. actual concerns and (e) needed improvements. These themes explored the educational, professional, and personal experiences of each participant. I have summarized each theme along with participant responses.

Theme 1

My research explored the lived experiences of clinicians who provided mental health treatment to victims of IPV. Educational programs train future clinicians to diagnosis and treat mental illness; however, do these educational programs sufficiently train counseling professionals to treat the complexities that arise when the mental illness is a result of IPV? Overall, master's level counselors did not feel they had received sufficient educational course-work to work with victims of IPV. For example, P-2 stated, "No, not specific training, a generalized training that was in something else." According to P-5, "No, uh, they did not have specific course work. In order to be certified as a domestic violence facilitator I had to work under somebody who was already a domestic violence facilitator." P-4 stated, "I've had to get that on my own. There's been no training specifically to deal with that issue." P-3 stated, "I haven't received…training throughout my semesters. I have not had any formal training." I specifically asked P-3 if her employer provided specific training to work with this population and the responses was "No." (P-3). P-1 shared, "I took a trauma course in my master's program that generally discussed different types of trauma, but no specific courses to work with victims of IPV."

Master's level counselors sought training, outside of the educational course-work, to work with victims of IPV. This trend shows that the counselors had individually identified the need for specialized training. For example, "I had training outside of my job. I had to sit in 40 hours of direct group observation in order to get my hours as a domestic violence facilitator." (P-5). "Yes, I did do some outside workshops with

marriage and family therapy that focused on domestic violence." (P-2). The participants acknowledged insufficient educational training in their master's program. All participants admitted that they received specialized training, post-master's, to work with victims of IPV.

Insufficient education and training was a theme that emerged from the data. There was agreement among all participants that they did not receive appropriate educational training to work with victims of IPV. Although the participants believed they were trained sufficiently to be counselors, they lacked the educational training to specifically assist victims of IPV once they graduated from their CACREP program. Four of five participants sought additional training and workshops to better understand and work with this population. Prior to receiving additional training, some participants shared how their beliefs about IPV affected their views of victims of IPV, until additional training increased their understanding of this population.

Theme 2

The participant's views on IPV ranged from their beliefs on the perpetuation of violence, to reflections of their own experiences and how those experiences have shaped their work with victims of IPV. Two participants shared personal experiences with IPV and how those experiences have shaped their current views on IPV. P-5 shared some of her personal experiences in her relationships:

> Before I started working in this field, I never would have thought that I personally was an abuser. And I realized, after I started working in this field, I saw some of the same tendencies that abusers have. I was emotionally abusive to my husband

> and I really didn't even realize that the emotional abuse was the same tactics that men use to control women, I found myself using some of those things. I wasn't really around couples in healthy relationships, so I didn't have knowledge of what a healthy relationship was. It really affected my relationship. But after I started going to trainings and I actually started facilitating classes and learning more about what abuse is. I realized that I needed to make some changes immediately. I'm a very strong personality and he's more of a passive kind of personality type and so um his perception of my tone and my body language and all that was very aggressive in nature . . . . My perception now about intimate partner violence is definitely, it happens more often than people think. And it's happening in just regular couple relationships and people are just totally unaware, and I think it's probably one of the biggest causes for divorce . . . it's not just physical, a lot of times I used to think that it was just when people physically attacked somebody. But I'm just learning, oh my God, that it's more emotional abuse and verbal abuse.

P-5 further expounded on her childhood experiences and the emotional impact it had on her views of IPV:

> This is a specialized field. Not everyone can work with victims of domestic violence. You have to do your own training before you're able to work with this population. Make sure the bias and the beliefs you have about victims . . . you have to work through a lot of your own personal issues. My mom was involved in a domestic violence relationship. At the time back then it didn't have a name this

> was just something that you know . . . . We came home saw blood; you know on the floor and all over the walls, you know all that. And I never really dealt with that. You know I felt that was normal. So, as I start working in this field I realize that, my mom was in a domestic violence relationship. What affected me is that I became this guarded person; I became a very controlling person in a way that I was going to control my destiny. No one was going to ever make me feel vulnerable. But I did it in such a way where it pushed people away from me . . . . the type of person I am and the experience I experienced I was like oh my God I'm never gonna stay in a relationship like that. Because a lot of times people say . . . . And even after I had the training and education and all that, I still ask myself why does she stay? So, it's taking time for me to understand and I understand it more.

P-1 also shared how past personal experiences shaped her current work with victims of IPV:

> I was in an abusive relationship. I don't talk about it much, but it really had an impact on me. After what I went through it makes me want to help other women that much more. When I have a client, who is an abusive relationship I think I work that much harder to try to help her because I am a woman and I know what she's going through.

P-2 shared her initial struggles about not understanding why women stayed in abusive relationships:

> Obviously, I don't think it's a good thing. I think personally, one of the hardest things I have to work with is that a lot of the time. It took a long time for me to wrap my mind around how you can get hit on a repeated basis and not wanting to leave. I kinda had to really go through the whole cycle of abuse and really understand because to me, I couldn't connect. I couldn't understand. Once somebody hits me I'm pretty much done, but I also didn't realize, after taking some trainings I realized there's a serious personal connection with that person. It's not that the abuse happens all the time but when it does happen it seems like a short period of time compared to all of the other things that they are losing. Whether it's financial, whether it's family, whether it's security . . . and how important those things really are.

P-3 shared her views on IPV and how those views have changed:

> Well I can honestly say right now I would say my views have changed from my younger days until now. And I say that because when I was younger I always thought that men should never put their hands on a female while in a relationship or period. However, I find now that women are becoming more violent towards men. So, my views are more so, don't put your hands on anyone if you don't want them to put their hands on you. . . . I believe it is higher amongst men abusing women, um, I do feel that most men can be more aggressive. However I feel that women are using more tools nowadays such as knives or things that can really physically hurt the man versus just using their hands now.

P-4 also shared experiences based on her personal views and experiences of family and friends:

> I feel like regardless of the situation nothing should ever lead to violence nobody should put their hands on the other person I don't care how angry they get I feel like each person should respect one another, have boundaries and if you feel like you're getting to the point where you feel angry or wanna hit somebody you should probably just leave or isolate yourself from the situation.

When asked if her personal views have changed or stayed the same over the years:

> I feel they stayed about the same . . . . So now working more with people who have dealt with this, now you can understand the hurt. I didn't grow up experiencing anything like this so knowing about it from maybe watching television watching movies and things like that and then hearing from classmates or friends or family that dealt with it, you know you kinda learn but actually hearing it from somebody first hand and them wanting you to help them with the situation, you learn a lot more.

Views on IPV was a theme that emerged from the data. All the participants were shaped by their experiences. Whether views on IPV were shaped by past personal trauma, experiences of loved ones, or just personal views of IPV in general, the participants experienced emotional responses that shaped their work with victims of IPV.

Theme 3

Clinicians are at increased risk of experiencing vicarious trauma, compassion fatigue, and burnout when hearing recurring stories of abuse and trauma (Way et al.,

2004). Coupled with the fact that counselors are trained to express empathy (Teding van Berhout & Malouff, 2015), it is no surprise counselors may experience a range of emotions when working with victims of IPV. The participants in the current study expressed emotional responses that ranged from uncertainty, to frustration, to depression. P-2 shared how her emotional reactions have changed over time:

> I think in the beginning I was probably a little too attached and I would become very empathetic and wanting to help out or I'll watch the kids while you go do this. If they were really doing what they said or not, I don't know. Talking, you know working and volunteering to do other stuff outside of the counseling part and things like that. Now I'm a little bit more, salty, I guess. I realize that if I invest too much. . .I still invest, and I want people to reach their full potential, but I also have to realize that I shouldn't be doing more work than they are. If I'm calling all the places and making the appointments and I'm doing all this, I'm not a counselor anymore, I'm their social worker and then their secretary and that's really not going to help them because they have to learn to do this without me.

P-2 further shared her thoughts on whether the emotional shift has come from experience in the field or burnout:

> Actually, I think it's about 50/50 I think there's a certain amount of burnout for anyone who works with victims in any kind of trauma state. Sometimes their problems because something you can kind of turn on and off. Early on I couldn't do that. I can do that better now. I remember having a mentor and she would be always asking questions and she would be like right, right, right, right and it used

> to feel very insincere to me. She was getting all the information and hearing everything they said. It's just she had done it so often and for so long that she had a set answer. And I wonder sometimes if I come off like that, do I come off as a set answer rather than sincere and really trying to hear, so.

P-3 initially focused on her passion for working with this population:

> Well I am extremely passionate about what I do. I'm passionate about the job and I'm passionate about my clients. I have a strong connection with them. Some of my clients I see weekly. I see them more than I see my own family and it's as if I'm looking at them like they are family and I wouldn't want my family to be in this situation. I see they have so much potential to be better and do better. So, I try to work with her, not just her but all my clients. Sometimes it's emotional because I can be very passionate about certain situations and certain things so.

When I asked the P-3 to go deeper in sharing emotions she experienced when working with the population her body language displayed some hesitation, "I do try to empathize with them. Showing emotions in front of them or getting angry at them or irritable with them, in my mind I may feel this way but I would never express or show that to them or display that in front of them." (P-3). I then asked her to share some of the emotions that she may not display in front of clients. "Yeah, I think that can be pretty natural, yeah. . .what's stopping her from getting this divorce and then I realized she has yet to let go. So, then I try to work on her letting go of the pain." (P-5). The participant continued to share experiences but not emotions and I reflected the emotion of frustration. "Exactly, Exactly. Yes, yes. Yes." (P-3).

P-4 shared hurt feelings about her perceived limited abilities to help victims of IPV:

> I feel, you know empathy for them. But you kinda feel hurt too because you have to sit here and listen to it but there's only so much you can do about it. And you know, you wanna reach out and remove them from this environment and try to show them that it's gonna be better but deep down inside you know, you try to do the right thing, but you're thinking, what else can I do. You're hurting with them.

P-5 expressed her emotional responses when unable to give a client the help she needed:

> It made me feel helpless I was depressed. I felt helpless I felt like I failed her. I felt like this is all a joke, they talk about all these resources and her she is calling for help and couldn't get help. I didn't know who to call and I didn't have any money. And it made me want to learn what I can do more to be in a better position to help these victims when they do call. I want to raise money, so I am in the process of starting my own 501c3. At first I didn't want to do that but as these women and people are calling and I see the need it's like I gotta get grant money or something as a way to help them and so it kinda motivated me so that when the next person calls I'll be in a better position to do something and I won't have to depend on anyone else besides myself so that's how it affected me. . . . That's because I remember how I felt. . . . And seeing what women in general have to deal with in society, and the silence.

P-1 shared her emotional reactions to working with victims of IPV:

> I hate to see what the women are going through. And it's like I can't stop until I get them the help they need. I'm so passionate about this work and sometimes it keeps me up at night. I know what it feels like to go through this and I want to help in any way I can.

I stated that it sounded like she was sometimes re-triggered when she worked with victims of IPV and the participant agreed to a certain extent. "Yeah in a way. It just makes me want to fight that much harder to get them the help they need." (P-1).

Emotional response was a theme that emerged from the data. The participant's emotional responses were shaped by their attitudes, beliefs, and values. These views developed based on their personal experiences and were further shaped by continued training outside of educational course work. I further explored whether these views affected rapport building when victims of IPV presented for mental health treatment.

Theme 4

About half of female victims of IPV display symptoms of depression (Ouellet-Morin et al., 2015). Although victims of IPV may also have dual mental health concerns, it is difficult to gather a full understanding of presenting problems when victims do not disclose their IPV experiences (Dersch et al., 2006). P-3 stated "depression" as the most common reason women presented for treatment. P-1 shared that women initially presented for treatment for depression. "The most common reason women seek treatment at my agency is depression." She further shared her experience with victims of IPV. "They typically aren't comfortable saying they are in an abusive relationship at first.

Yeah, they suffer from depression but a lot of the times it is because of the abuse. But after they get more comfortable they do eventually open up about the abuse." (P-1).

P-2 also acknowledged that women originally presented with another initial concern. "They'll say depression or wanting to figure things out, personal reasons." P-2 shared that even though depression may not be the primary reason for coming, women are seeking help with IPV because of their children. "Many times, it has gotten to a point where they are fearing for their children, not necessarily for themselves." (P-2).

P-4 also shared her views on why women seek treatment, "Is probably depressed mood." She expounds on whether women are comfortable opening up about IPV:

> I think it depends on if the person wants to seek help. I have some that come in and they will just tell their whole life story and everything that's bothering them, and I have some you kinda have to press to open them up. So, it's like 50/50. When it's more of a warm environment they are more likely to open up because the other ones they may have a fear, or they may feel like they won't be understood, or they have nobody to listen to them.

P-5 shared experiences with victims who presented with uncertainty:

> They usually come because they are just not sure if they are actually in an abusive relationship. So, they usually come and say I just wanted a bit more information about what domestic violence is and to learn about what are the signs and symptoms of a person who's involved in domestic violence relationships. Or sometimes they just kinda wanna know, from the batterer's standpoint, what are some of the acts of abuse just, so they can have a better idea if the person they are

> involved with is an abuse. . . . At times it's a lot of denial. You know they come for a couple of months but then they stop coming. And since they're not ready to deal with that and talk about domestic violence. They know, at the time that they aren't in a position to leave the relationship. I think they start contemplating leaving the situation, but they aren't ready.

Presenting versus actual concerns was a theme that emerged from the data. Most victims initially presented with mental health concerns because they were not comfortable sharing their experiences with IPV. However, most eventually shared insight about IPV after rapport building. In addition to rapport building, the participants shared views on other needed improvements to assist victims of IPV.

Theme 5

In rural communities it is more difficult to locate necessary community resources for victims of IPV (Edwards, 2015). The clients in the current study expressed a passion and desire to help victims of IPV, many verbalized concerns with the number of available community resources. Participants also shared views on needed educational improvements to better equip further counselors who may work with this population. P-5 expressed her views on needed improvements:

> I just feel like that it's a whole specialized field just like substance abuse, I mean they can incorporate some basic information but until you actually experience it by working in the field doing it hands on…we need some more hands on, I think they have it in some programs where interns come through and work with

> batterers and victims…that's about all I think that really needs to be done, because you would have to add more hours to the program if they added that.

P-5 further expressed her views, "I'm still learning in this field. . . . More training on healthy relationships versus unhealthy relationships, more training on the difference between domestic violence and anger. Just basic social skills kinda curriculum. Yes, prevention programs, being more proactive . . . about relationships in general."

P-4 expressed concerns about the availability of resources for victims of IPV:

> I don't feel like there are enough services available. I don't think there are enough resources in this particular area. I feel like more funding should be provided to help people. You know not just for a couple of nights and them not knowing where they're gonna go after there, you know. Maybe resources can help them get set up with everything they need so they can go on and hopefully live a better life a more safe life. I feel like maybe we could possibly offer more classes and possibly more groups where people can participate in and maybe do more to educate ourselves on the resources, even if it's not in our area, maybe the outside area and neighboring states maybe connect with so they'll be our go to if we have somebody that wants to leave and get out we'll already have something put in place to help that person immediately.

P-3 shared her views on training at her agency and educational improvements:

> I know a couple months or years ago they had someone who worked with victims of domestic violence; however, it's not something that's mandatory here. We don't have to have that in order to have this position. I do feel like though that that

is something that we should have. That along with other things and training should be implemented and a part of the position. I think that educational wise we tend to stick or be stuck on a certain topic. We talk and are more educated on molestation and rape than we are intimate partner violence and I feel as though the educational system can do more to. I actually think they should bring it out in the high schools because it starts pretty young.

P-2 shared her views on accessibility to IPV services in community mental health center:

I think that a woman, who shows up to just a general mental health program or something like that, may find it harder to get connected to the right places. Even in my practice I may deal with a parent who has had some issues, you tend to give them some phone numbers and tell them to call these resources but there are issues around city or county, if you have this education but not that education. If you're going to go to the shelter then you have to not have contact with family, you don't tell anyone you're going. You just not show up. For instance, you take kids out of school and if you're running and you take kids out of school and don't tell the school where you are going then it becomes a truancy thing. You're creating all these walls that you have to break down later on and I don't think there's anything in place to make that transition easier.

P-2 further shared views on treating victims of IPV in mental health settings:

I definitely think that those who work with adults need to be, and even with children in the sense that a lot of times we have parents coming in with a bunch of different issues and we haven't said how we will sit down and address this when

> it comes up because it affects the children as well. Even when case management and things like that we could be sending community support workers and people like that into situations that they don't know anything about it. And then you have this upset parent and upset partner with the kid in the middle and then you don't know, do you leave, call DFS, what do you do. So, I think definitely some training to address it if it becomes an issue.

P-2 also discussed whether educational programs should provide training to help work with this population:

> I definitely think it's needed, I also realize that there are so many specializations, it may be something that is offered but I don't know if it would work to make it something that is mandatory, because there are some people who just don't have the patience for that particular group. For example, I'm not good with working with people in corrections, that's not my cup of tea but somebody else that may be where they wanna go and if they are offered a course where they can learn about that, I think that would be great: where I would want to deal more with adolescents, children, and maybe family violence, and family therapy so being able to offer that. I don't think a lot of programs do that right now.

P-1 discussed current resources at her agency:

> We don't have any resources to work with victims of abuse. We do not have groups, or someone specifically trained to work with victims of abuse. But I think we should have someone training at the agency who specifically works with victims when they come into the center.

P-1 also shared insights into educational training. “Well there are alcohol and drug certifications and trainings. I think there should be specialized programs in school that students can take if they want to specifically work with this population.” (P-1).

Needed improvement was a theme that emerged from the data. Even though participants believe they were passionate and possessed a desire to helpful victims of IPV, they acknowledged limited needed resources in their communities to assist this population. Overall the participants expressed a need for improved resources and training, both educationally and within their organizations.

Summary

I discussed the research questions, the outcome of the study, and themes that emerged from the participant responses in Chapter 4. I used NVivo 12 to code the interview data and develop themes. I generated themes, from the interviews, which highlighted the perceptions and experiences of each participant. Theme 1: Insufficient Education and Training; Theme 2: Views on IPV; Theme 3: Emotional Responses; Theme 4: Presenting vs. Actual Concerns; Theme 5: Needed Improvements. In Chapter 5 I will display the study findings and results as it relates to the literature. In Chapter 5, I will conclude with the social change implications, recommendations, and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

IPV damages victims, families, and the social and economic framework of society (O'Doherty et al., 2015). IPV is one of the leading causes of death among children and young adults in the United States (Sumner et al., 2015). IPV has been present for many years; however, this issue has moved into the mainstream consciousness over the past 30 years or more (Williams, 2012). IPV negatively affects family and community systems (Cerulli et al., 2011; Levendosky et al., 2013). The purpose of this hermeneutic phenomenological qualitative research study was to gather a deeper understanding of the lived experiences of master's level counselors who worked with female victims of IPV, to learn how those experiences influenced a counselor's ability to identify and treat IPV.

Understanding the perceptions of clinicians; who provide direct treatment to victims of IPV, is an important step in improving interventions provided to victims of IPV. I used five semistructured in-depth interviews of master's level counselors who worked with victims of IPV. Five main themes emerged which included (a) insufficient training and education, (b) views of IPV, (c) emotional responses, (d) presenting vs actual concerns, and (e) needed improvements.

I include in Chapter 5 a discussion of the findings of this study. I begin with an interpretation of the findings, followed by limitations, recommendations, and implications. I conclude this chapter by highlighting a summary of the research study.

Interpretation of Findings

The participants shared insight into their experiences working directly with female victims of IPV, as well as their experiences working with other counselors in a mental health setting. Five themes emerged from the data: (a) insufficient education and training, (b) views on IPV, (c) emotional responses, (d) presenting versus actual concerns and (e) needed improvements. I summarized the themes below.

Theme 1

Insufficient training and education was a theme that emerged from the data. All participants stated they had not received any educational training to work with victims of IPV in their educational curriculum. The participants shared they received training, to work with this group, on their own or through on the job training. Several of the participants believed that more specialized training was necessary for clinicians to have the skills to properly work with this population.

An older, yet significant study conducted by Tilden et al. (1994) explored whether factors such as training and gender impacted clinician's management and assessment of abuse victims. A total of 1,521 professionals participated in the study (Tilden et al., 1994). About 67% of the participants received education on abuse (including elder and spousal abuse). More than half of the participants received education on child abuse while about 33% reported no education on abuse (Tilden et al., 1994). The results indicated that suspecting abuse was directly linked to educational training (Tilden et al., 1994). Participants in the current study acknowledged limited knowledge of IPV, and a

lack of understanding why women stayed in abusive relationships, prior to receiving additional training (P-2 & P-5).

Simmons et al. (2017) explored whether helping professionals, who aided victims of IPV, should also screen for mental health issues. Participants verbalized hesitation when screening for IPV (Simmons et al., 2017). The study by Simmons et al. (2017) highlighted a need for improved training in counselor education programs to improve clinician's comfort level when screening for IPV. This study correlates with the finding of my study. All participants in the current study expressed a desire for improved training for counselors who work with victims of IPV; to better equip professionals to work with this population (P-1, P-2, P-3, P-4 & P-5).

Colarossi et al. (2010) conducted a study at family planning clinics in New York with healthcare staff. Participants completed a survey about attitudes and barriers to IPV screening (Colarossi et al., 2010). Participants who did not have a licensed acknowledged the importance of screening for IPV but did not believe it should take priority over family planning (Colarossi et al., 2010). Licensed professionals verbalized a pro-assessment attitude about identifying and responding to IPV (Colarossi et al., 2010). The researchers indicated licensure and increased experience contributed to identification of IPV (Colarossi et al., 2010). Some participants, in the current study, identified that increased training and experience contributed to an improved ability to work with victims of IPV (P1, P2 & P5), which aligns with the previous research.

Theme 2

The participants expressed their attitudes, values, and beliefs towards their work with victims of IPV. P-1 and P-5 were shaped by personal experiences. P-1 was a victim of IPV and P-5's mother was killed in an IPV relationship and the participant became a perpetrator of abuse in adulthood.

Training, postmasters, positively influenced the perceptions of P-2 and P-5. Both participants wondered why women stayed in relationships; however, acknowledged that training decreased those perceptions. Counselors are trained to increase their understanding of bias; however, many counselors enter the field with strong bias that effects their interactions with clients (Notestine et al., 2017).

P-3 and P-4 believed that abuse was wrong, no matter the sex of the perpetrators and victims. Initially, P-3 viewed IPV as men abusing women, but over time she has come to realize that women also perpetrate violence against men. Although there is an increased awareness of the existence of IPV, there remains a societal view that men have the right to control their spouses (Hays et al., 2007).

Theme 3

Participants shared a range of emotions when they discussed working with victims of IPV. These emotions ranged from feelings of frustration, depression, to passion. One P-5 expressed feelings of depression and hopelessness when she was unable to help a victim of IPV. P-3 shared frustration with the inconsistent progress her client was making. All participants shared a desire and passion for working with and helping victims of IPV. Previous studies have examined whether clinicians were able to identify

and treat IPV (Dersch et al., 2006; Hanson et al., 1992); however, I have not found a study that explored the emotional reactions counselors displayed when working with female victims of IPV.

However, Hanson et al. (1991) conducted a germinal study to determine whether clinicians were able to identify and respond to explicit descriptions of family violence. The study is over fifteen years old but is one of few studies that specifically address whether clinicians can both identify and respond to family violence. Participants were given two scenarios that described incidents of relationship violence (Hanson et al., 1991). Forty percent of the participants did not identify IPV (Hanson et al., 1991). More than 50% of the participants stated they would not intervene by providing interventions to the family members experiencing violence (Hanson et al., 1991). Although the study by Hanson et al (1991) highlighted concerns with clinician's abilities to identify and treat IPV, the study did not explore the emotional responses the clinicians may have experienced. I found a gap in the literature on research exploring the emotional responses of clinicians when working with female victims of IPV.

Theme 4

According to Beck et al. (2014), women who experience IPV are at an increased risk of developing mental health issues which includes posttraumatic stress disorder (PTSD) and depression. My current study findings align with the findings by Beck et al. (2014). Four of the five participants identified depression as a mental health concern that victims of IPV disclosed when they initiated mental health services. Nathanson et al. (2012) conducted a study with female victims of IPV, who were not residing in a shelter.

The main participants in the study were Caucasian and African American women (Nathanson et al., 2012). Over half of the participants met the criteria for PTSD and over half of the sample met criteria for depression (Nathanson et al., 2012). Four participants of the five participants, in the current study, stated that clients presented for treatment for depression. Mental health conditions may increase the likelihood for women to remain with abusers, which increases the risk for continued abuse (Minh et al., 2013). Mental health issues are a significant concern for victims of IPV, yet professionals often focus on the physical need instead of holistically assisting victims with both physical and emotional needs (Simmons et al., 2017).

The previous studies highlighted that victims of IPV often possess mental health issues. These studies align with my current study. Clinicians will benefit from understanding mental health issues and how they align with IPV to improve services to this population.

Theme 5

All participants agreed that improvements were needed to successfully assist victims of IPV. However, the participants shared different views regarding the improvements that were needed. Several participants stated that educational programs should offer a specialized elective that students can take that would directly educate counselors on how to work with victims of IPV (P-1, P-2, & P-5). One participant shared that IPV was such a specialized field that it would not be beneficial to incorporate an IPV course into the general counseling curriculum but instead have electives that students could choose to take (P-5). Two participants expressed a need for a specified individual,

in a mental health setting, who was primarily responsible for aiding victims of IPV (P-3 & P-4). This individual would receive specialized training prior to working with this population.

Feder et al. (2013) noted mental health counseling professionals as those who are responsible for providing effective interventions to victims of IPV. The participant responses in my study suggested improvement in training and education for professionals who work with victims of IPV. Their views were in alignment with the study conducted by Simmons et al. (2017): Where participants voiced concerns when screening victims of IPV, which included poor training, and poor resources.

The current study aligns with previous studies that assessed the need for improvement in training. Counselors may feel for comfortable working with this population if they have needed resources to work with this group. In addition, improvement in resources may better equip staff to work with this population.

Theoretical Implications

Phenomenology details the participant's experiences of a phenomenon rather than the perception of the researcher (Eddles-Hirsch, 2015). Hermeneutics is the interpretation of language or text (Smith et al., 2009). Hermeneutic phenomenology focuses on the interpretation and meaning of an experience (Eddles-Hirsch, 2015). At the core of Heidegger's work is the interpretation of the meaning individuals place on an experience (Smith et al., 2009). Both feminist poststructuralist theorists and hermeneutic phenomenologists emphasize the meaning individuals place on their experiences and how that meaning is interpreted (Arslanian-Engoren, 2002; Smith et al., 2009).

Martin Heidegger believed understanding to be the basic function of human existence (Laverty, 2003). Gadamer was a student of Heidegger, and a decisive figure in the development of hermeneutics in the 20th century (Regan, 2012). A central idea in hermeneutic phenomenology is the concept of the hermeneutic circle (Regan, 2012). The main tenet of the hermeneutic circle is to understand the interdependence of the whole and parts of a structure (Malpas, 2016).

I used hermeneutic phenomenology as the theoretical framework to conduct this study. Hermeneutics is the philosophy and theory of interpreting and understanding text (Regan, 2012). A main tenet in hermeneutics is the notion of Dasein or presence (Heidegger, 2003). Dasein does not control the construction of meaning or initiate understanding, nor does it regulate meaning (Hermeneutics, 2003). Being in a meaningful and already interpreted world makes reflective and prereflective understanding possible in research (Heidegger, 2003).

I maintained a reflex journal to preserve the authenticity of the research findings. I read and reread the transcripts to ensure that my presence did not affect the outcome of the study. The research findings were distinctly different from my experiences with clinicians who have worked with victims of IPV. I did not attempt to control the meaning the counselor's placed on their experiences, nor did I attempt to alter the meaning of their experiences. I reflected on the participant's experiences and extracted meaning from the text.

Both researchers and participants must allow their understanding to be explored by one another to increase awareness of assumptions (Regan, 2012). P-5 reported finding

herself in a situation where she attempted to aid a female victim of IPV but was unable to find resources. She exhausted outlets but was still unable to bring about necessary change to help her client. This difficulty caused the clinician to feel a sense of hopelessness and depression. P-2 shared her experiences working at an IPV shelter. She had no control over the women who were admitted into the shelter but recalled a woman who presented with three children. She recalls coming to work a few days later and learning that the lady had left the shelter with her children. The participant voiced uncertainty whether the individual returned to her abusive partner. Participants initially reported feelings of frustration and sadness when being in the world with victims of IPV. Over time, the participants began to accept that there was only so much they were able to do with the limited resources in their communities.

Gadamer noted that engaging authentically with text required an awareness of the inter-subjective nature of understanding (Regan, 2012). This understanding enhanced thoughtful engagement with the text (Regan, 2012). The researcher's knowledge and understanding of fore-sight (bias) and authenticity are vital to interpreting written word (Regan, 2012).

I have worked with victims of IPV, and supervised clinicians who work with victims of IPV, for more than a decade. My experiences have been with clinicians who displayed explicit bias towards victims of IPV. These individuals would make references to not understanding why women stayed in abusive relationships. In addition, my experience has been with clinicians who had no desire to work with or aid victims of IPV. However, all five participants expressed a passion and desire to help victims of

IPV, which contrasted with my preconceived knowledge regarding master's level counselors' perceptions of their work with victims of IPV.

Several participants shared preconceived knowledge and views about victims of IPV. P-2 and P-5 both shared a lack of understanding why women remained in abusive relationships. P-2 and P-5 shared a shift in their understanding of victims of IPV after receiving additional training and working with victims of IPV. P-3 shared experiences and views that men were the main perpetrators of abuse. The participant shared that over time, through experience and training; she learned that women were also perpetrators of abuse. All five participants acknowledged a shift in their preconceived knowledge of victims of IPV after working in-depth with this population and obtaining more training.

Interpretation is cyclical, moving from the entire transcript to individual text, which is known as the hermeneutic circle (Regan, 2012). As I read and reread all transcripts and reflected on each individual participant transcript, I gathered a deeper understanding of the value participants placed on their work with female victims of IPV. Each theme was developed from looking at all transcripts, reviewing individual responses, and flowing between the entire transcript and individual responses. As I reviewed and rereviewed responses, I gathered a deeper understanding of the desire and passion clinicians felt for victims of IPV. My understanding shifted as data revealed that counselors wanted to see improvement in services rendered to this population.

Participants shared an overall shift and growth in their understanding of victims of IPV. External trainings and extensive work with victims of IPV contributed to a revised understanding of the experiences of victims of IPV. Some participants acknowledged that

their experiences working with victims of IPV broadened their understanding of this population and increased their desire and ability to assist this population.

I used a feminist poststructuralist lens to guide data analysis. This theory highlights the interplay of power within relationships (Wendt, 2008). When the participants shared stories of victims, all shared stories of women who were abused by their husbands. P-5 expressed feelings of helplessness due to helping a client whose husband had significant power within the community. Everywhere she sought resources there were roadblocks because the husband's influence affected access to those resources. P-3 shared a story of a client who was affected by her husband's actions years after they separated. The client continued to compare her current relationships with her estranged husband, which impeded her ability to maintain a healthy relationship.

All participants in this study shared stories of powerlessness, when discussing their client's circumstances. The victims left their homes, families, and support networks to get away from their abusers. P-2, P-3, and P-5 all shared uncertainty in their ability to truly help the victims they had worked with. Feminist poststructuralist theory focuses on how power is used to marginalize women (Healy, 2005). Due to the power differentials, expressed by the participants in this study, victims of IPV were forced to leave their homes and start over with limited resources. Counselors in the study verbalized attempts to assist victims of IPV but reported feelings of helplessness when unable to locate needed resources and aid this marginalized group.

Limitations of the Study

One limitation to this study was the restricted ability to generalize the results of the study. I used purposive sampling to specifically seek master's level counselors who had worked with female victims of IPV. Purposive sampling occurs when participants are deliberately chosen based on specific qualities (Etikan, Musa, & Alkassim, 2015). Purposive sampling is used in qualitative research to select individuals who possess a thorough knowledge of a phenomenon (Etikan et al., 2015). I conducted the study in a rural area in Mississippi. Due to the sampling strategies, location, and sample size I may not be able to generalize the results of this study to other geographical locations or other master's level counselors who may or may not have worked with victims of IPV.

Although I understand the concerns of generalizing this hermeneutic phenomenological study, the main goal of the study was to gather a deeper understanding of the experiences of master's level counselors who work with victims of IPV in a mental health setting. This study provided a unique perspective of the experiences of counselors, in a rural setting, who provided mental health services to victims of IPV. In addition, all participants were African American women. As a result, it may not be possible to expand this research to male master's level counselors, or counselors of a different race or ethnicity.

Snowball sampling is another possible limitation of this study. Snowball sampling occurs when potential participants are contacted via a third party for recruitment in the study (Noy, 2008). The Clinical Director of a specific region of the recruitment site was responsible for disseminating flyers to current mental health staff. As a result, there may

have been staff that met qualifications, but were left out of the potential participant pool. They may not have received the flyer, or they may not have checked their email in a timely manner. However, I specified, in this study, that I would interview five to ten participants and I was able to meet the specified goal.

Recommendations

The findings of this study indicated recommendations for further research. Future researchers may repeat this study in an urban area to explore the experiences of counselors who may have different experiences due to geographical location, race, ethnicity, and access to resources. In addition, researchers who replicate this study may want to expand the participant pool to include male participants to gauge how counselor's experiences may vary based on gender. Also, future researchers may want to explore counselor's experiences with IPV in same sex relationship couples and learn whether counselor's experiences differ depending on the sexuality of the couples with whom they work. This study focused on the perceptions of counselors who work with female victims of IPV, future researchers may want to explore the experiences of victims of IPV who received community mental health services.

The second recommendation is for counseling education programs to reevaluate the training provided to master's level counselors. Counselor education programs may consider including specialized IPV training courses, in the curriculum, as an elective for individuals who may want to work with victims of IPV. This option will allow future counselors the opportunity to obtain specific educational training to work with this population after graduation.

The third recommendation is for community mental health centers to evaluate the training provided to clinicians who work with victims of IPV in a community mental health setting. In addition, community mental health centers may invest in training a staff person to become the specialist who works with victims of IPV. This change may provide improved access to treatment for victims of IPV.

Implications for Social Change

IPV is under reported in mental health settings (Howard et al., 2010). The effects of IPV span beyond victims to include family and community members (Robinson & Spilsurbry, 2008). One important social change implication resulting from this study was the contribution of knowledge to help improve training of master's level counselors in community mental health centers who work with victims of IPV. Improvement in training will have a ripple effect, positively impacting victims of IPV, families, and the community. Improved training improves overall health and functioning of victims and families (Brown et al., 2013).

This qualitative study provided an initial step in understanding the views and experiences of individuals who provided treatment and interventions to victims of IPV. Understanding these experiences provided insight into the educational and training needs of master's level counselors who work with victims of IPV. Also, participants highlighted ways to improve services to victims of IPV: provide specialized electives, in counselor education programs, specifically geared towards working with victims of IPV and provide specialized training to a community mental health clinician to work specifically with victims of IPV.

Conclusion

I conducted this study to identify master's level counselor's perceptions of their work with victims of IPV, and how those perceptions impacted services rendered to victims of IPV. Results indicated that master's level counselors possessed a desire and passion for helping victims of IPV but felt there was a lack of educational training to properly assist this population. Also, results indicated that victims of IPV often presented with mental health issues, such as depression, when seeking assistance. These findings confirm literature that states that victims of IPV often have mental health issues such as depression (Beck et al., 2014; Matheson et al., 2015; Sumner et al., 2015). Although there was disagreement amongst participants as to whether IPV has improved or worsened, all participants agreed that there is a need for an improvement in services and access to services for victims of IPV.

The findings of this study may be used to improve access to services for female victims of IPV, particularly in a rural setting. The social change implications of this research study have the potential to affect counseling educational programs and the courses that are offered to master's level counseling students who work with victims of IPV. This change may improve access to services and decrease the negative impact to families and communities.

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Appendix A: Recruitment Letter

JULY 31, 2017

[redacted] – Executive Director
[redacted] – Mental Health Coordinator
[redacted]

Dear Mrs. [redacted],

My name is Lekesha Thomas-Davis and I am a doctoral candidate at Walden University. I am conducting dissertation research on the perceptions of master's level counselors who work with female victims of intimate partner violence (IPV). There are a significant number of studies that address the impact of intimate partner violence on victims, families, and communities, as well as the mental health consequences for victims and families. However, there is limited research, within the past five years, on the attitudes, beliefs, and values of clinicians and how those perceptions impact services rendered to victims of IPV. This research will provide insight into the experiences of master's level counselors who work with female victims of IPV which may inform counselor educators and training provided to these professionals.

Your assistance in conducting this much needed research is important. If willing, I need you to identify master's level counselors who work within your agency. Once identified, I would like to meet with them to discuss the nature of this study. The participants of this study need to hold a master's degree in counseling and have, in the past, or currently work with female victims of IPV. The participants are free to choose whether or not to participate and can discontinue participation at any time. Information provided by the participants will be kept strictly confidential.

I would welcome a telephone call from you to discuss any questions you may have concerning this study and your role in identifying research participants. I can be reached at (662) 822-2059 or emailed at lekesha.thomas-davis@waldenu.edu.

Sincerely,

Lekesha Thomas-Davis, PhD
Doctoral Candidate
Walden University

Appendix B: Letter to Participant

Date
Name of Participant
Address

Dear Participant:

My name is Lekesha Thomas-Davis and I am a graduate student at Walden University. I am studying Counselor Education and Supervision with an emphasis on Trauma and Crisis. I am sending this letter to explain why I would like you to participate in my research study on the perceptions of master's level counselors who work with female victims of intimate partner violence (IPV). There are a significant number of studies that highlight the impact of IPV on victims, families, and communities. However, there are few studies within the last five years that explores the attitudes, values, and beliefs of mental health professionals who work with victims of IPV. This research study will provide insights into improvements needed in educational programs and training to help clinicians successfully work with this population.

I realize that your time is important to you and I appreciate your consideration in participating in this study. In order to gather an in depth understanding of your experience working with female victims of IPV, we need to meet on one occasion for approximately ninety minutes. This meeting can be held at a location of your choosing and will not require you to do anything you don't feel comfortable doing. This meeting is designed to get to know you and learn about your experiences working with female victims of IPV. Your answers will be audio recorded with your permission, and they will be kept strictly confidential.

Please contact me at your earliest convenience to schedule a date and time that we can meet. My telephone number is (662) 822-2059. You can also email me at lekesha.thomas-davis@waldenu.edu. I look forward to hearing from you. I thank you for your time and hope that you will participate in this study.

Lekesha Thomas-Davis, PhD
Doctoral Candidate
Walden University

Appendix C: Informed Consent

Lived Experiences of Counselors Who Work with Female Intimate Partner Violence Victims

I would like to invite you to participate in a research study examining the lived experiences of master's level counselors who work with female victims of intimate partner violence, which will add to the knowledge related to counselor education programs and training to mater's level counselors. My name is Lekesha Thomas-Davis and the data collected in this interview will help fulfill the requirements for a PhD in Counselor Education and Supervision at Walden University. I am under the supervision of my dissertation committee chair, Dr. Corinne Bridges.

Participation Requirements of You: To be interviewed for one ninety-minute session about your experiences working with female victims of intimate partner violence. There is no planned use of deception involved in this study.

Your Privacy: Your participation in this study and your responses will be kept confidential. Any reference to you will be by pseudonym, including any direct quotes from your responses. This document and any notes or recordings that might personally identify you as a participant in this study will be kept in a locked place that only the researcher will have access to. Only the researcher and the research supervisor might know who has participated in this study. Five years after the completion of this research study all personally identifying information will be destroyed.

Risks to you: There are five acknowledged risks generally associated with participation in research studies such as this one: Physical, psychological, social, economic, and legal. The researcher foresees minimal risk for those who choose to participate in this study. There are no foreseen physical risks associated with this study; other risks might include the following: You might experience anxiety, discomfort, or negative emotions as a result of responding to the questions asked of them in this research study. If you experience a negative reaction, you may choose to skip the question, to withdraw from the study, or you may contact my dissertation chair or the Walden University Institutional Review Board, especially if your discomfort continues after the study. See the contact information on the page below. You might experience social, economic, or legal implications if you share your responses or your participation in this study with others. If you choose to participate in this study, you are encouraged to keep your participation in this study and your responses confidential. The researcher will maintain your confidentiality throughout the study, and will destroy the records of your participation five years after the study is complete.

Benefits to You: There are no foreseen direct benefits to you regarding participation in this study beyond the general knowledge that you are assisting in furthering the knowledge related to this research topic, and assisting the researcher in completing the

PhD degree requirements. There is no compensation associated with participation in this study.

This document acknowledges you understand your rights as a participant in this study, which the researcher has explained to you prior to signing this document. I acknowledge that the researcher has explained my rights, the requirements of this study, and the potential risks involved in participating in this study. I understand there is no compensation for, or direct benefit of participating in this study. By signing below and providing my contact information I am indicating that I consent to participate in this study, that I am at least 18 years of age, and I am eligible to participate in this study. You may withdraw from this study at any time by notifying me by email. If you have any concerns regarding your participation in this research study you may contact my faculty advisor, Dr. Corinne Bridges, or the Walden University IRB committee. You may ask for a copy of this document for your own records.

Signed Name: _____ Date: _____
Printed Name: _____
Phone Number, Email Address, or Postal Address: _____
_____

Thank you for your participation,
Lekesha Thomas-Davis PhD in Counselor Education and Supervision Walden University
Email Address: lekesha.thomas-davis@waldenu.edu
Dr. Corinne Bridges Dissertation Chair Walden University
Email Address: corinne.bridges@waldenu.edu
Walden University Institutional Review Board (IRB)
Email Address: research@waldenu.edu

The Walden University Institutional Review Board (IRB) oversees the ethical practice of research involving human participants conducted by students of Walden University.

Appendix D: Interview Protocol

Interview Protocol

Date:_____

Location:_____

Name of
Interviewer:_____

Name of
Interviewee:_____

Interview Number: One

1. Please describe the educational and professional training you have received that specifically relates to work with victims of intimate partner violence?

2. What are the most frequent reasons women give for coming into the office?

3. Can you describe your personal views of intimate partner violence? Professional views?

4. Can you describe your most memorable experience with a female client who was a victim of intimate partner violence? How did the experience originate, what you did, and what the client did?

5. Can you describe your emotional reactions when working with victims of intimate partner violence?

6. Share your beliefs on whether IPV has changed over the years? Gotten better? Worse? Stayed the same?

7. What changes in behavior, attitudes, and policies of the personnel in which you work would better facilitate your work with victims of intimate partner violence.