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Perception of Counselor Cultural and Intimate Partner Violence Competence: As Perceived by Latina Survivors of IPV

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Abstract

Intimate Partner Violence (IPV) formerly known as domestic violence, is a chronic public health crisis affecting millions of women. Significant research has been generated related to the prevention and treatment of IPV; however, despite these efforts, there continues to be discrepancies in screening, referrals, and treatment of IPV which are compounded for ethnic minorities. Latinos are the fasting growing minority population in the United States, yet there continues to be a lack of public awareness and research related to Latina survivors of IPV. There are currently no studies exploring the subjective experience for Latina survivors of IPV in therapy.

The objective of this study was to ascertain a culturally grounded understanding in Latina survivors of IPV perceptions of therapists' cultural and IPV competence using a qualitative methodology. For this study, 10 Latina women over the age of 18 were selected, who self-reported experiencing IPV and who had participated in therapy for their IPV experience. Participants were recruited using flyers distributed in various community agencies, domestic violence shelters, and by Snowball sampling method. Each participant was interviewed twice and using a phenomenological methodology, structural and textural descriptions were generated and clusters of themes were identified from interview transcriptions.

Findings in this study suggest that therapist characteristic's that allowed for a positive rapport was not necessarily related to their perceptions of their therapists' cultural competence or competence in providing IPV counseling. Additionally, an ethnic match alone did not seem to compensate for cultural or IPV competence as expected. Themes generated from participant interviews identify specific behaviors perceived as Accepting Behaviors and Rejecting Behaviors. These themes provide valuable information on how culturally relevant interventions can be further enriched and developed in working with Latina survivors of IPV.

In addition to themes generated from participant interviews, related to the proposed research questions, a number of contextual themes were identified. These themes provide a contextual framework for the cultural variables informing participant perceptions of therapy and the therapeutic alliance. They also provide valuable information on how cultural and socio-environmental factors deter Latina survivors of IPV from seeking treatment or disclosing IPV.

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PERCEPTION OF COUNSELOR CULTURAL AND INTIMATE PARTNER

VIOLENCE COMPETENCE:

AS PERCEIVED BY LATINA SURVIVORS OF IPV

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Dellena R. Aguilar

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Title: PERCEPTION OF COUNSELOR CULTURAL AND INTIMATE PARTNER
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This dissertation is dedicated to my cousin Roman Archuleta, an ingenious muse destined for greatness. The academic rigor and political hurdles intrinsic in a doctoral program which at times proved more demanding than I had ever imagined, would have been no match for Roman. Roman was destined to lead me through the PhD process, and he did; only it was his spirit.

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I would like to thank Dr. Maria Riva for her relentless commitment to the doctoral process and helping me navigate through it. I would also like to thank Dr. Jesse Valdez, Dr. Nick Cutforth and Dr. Anne DePrice; your wisdom and insight is greatly respected. I am profoundly indebted to Dr. Hans Foote, Dr. Joe Courtney, Dr. Carla Bradley and dear friend Gay Cotter, for believing in me and allowing me to see my true potential.

I would be remiss if I didn't acknowledge the Latinas interviewed for my study. It was an honor to learn from these remarkable women. They deserve vindication not only for the trauma experienced as a result of intimate partner violence but from systems of oppression that serve to ensure their silence. To all of these women, I am deeply grateful and humbled.

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CHAPTER I

Introduction

Intimate Partner Violence (IPV), previously known as domestic violence, is an insidious public health problem with global reach. In the Multi-Country Study on Women's health and domestic violence against women conducted by the World Health Organization (2005), it was found that violence committed by men against women was pervasive in all of the countries included in the study. According to this study, between 20% and 75% of women reported experiencing emotional abuse across all countries.

Given the high incidence of IPV, the impact of which cuts across health care, legal, and educational systems, considerable research has been conducted on IPV within various disciplines including: counseling psychology, clinical psychology, social work, nursing, medicine, law, and criminal justice (Btoush, 2009; Spencer et al., 2008; Wathen, et al., 2009). Interventions to assist survivors of IPV have been considered and implemented by law enforcement agencies, social services, courts of law, and by mental health care providers (Stover, Meadow, & Kaufman, 2009). Nonetheless, such efforts have not yielded the results needed to reduce rates of IPV, as evident by the sustained high incidence of IPV reported in the United States (U.S. Department of Justice, 2007). Current research exploring reasons for continued pervasiveness of IPV has been reviewed and will be discussed in this paper.

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This dissertation study focuses on Latina IPV survivors' experiences and perceptions of their counselor's IPV competence and cultural competence. It was expected that an ethnic match would be associated with participant's overall satisfaction with therapy. In addition, it was thought than an ethnic match might influence a positive therapeutic alliance which was expected to exceed the importance of counselor IPV competence. Current literature related to client perceptions of cultural competence in IPV counseling has been conducted with several different ethnic groups, however, focus on Latinas has been minimal. This study aims to help fill that void.

In order to highlight the pervasiveness of this issue, Chapter 1 begins with a brief overview of IPV prevalence worldwide and within the United States. It also discusses the global and national response to this public health issue, and the lack of training counselors receive regarding IPV. The second section describes research revealing the lack of counselor training in how to respond to IPV, despite the reported frequency and incidence across the nation. This is followed by a discussion of current trends in the health care system, which attempt to address IPV. The fourth section explores the incidence and prevalence of IPV among Latinas as well as barriers faced by Latinas in accessing resources and therapeutic services. Chapter 1 concludes with a discussion of how women IPV survivors view the clinical counseling experience and their perceptions of IPV treatment strategies.

Overview of the Literature

The impact of IPV and its deleterious effects on society has been widely documented within social science and psychological literature. The World Health

Organization conducted a global survey and found that 10% to 69% of women reported physical assault by an intimate partner. Physical abuse was often in conjunction with psychological abuse, and between one-third to over one-half of these cases included sexual assault (WHO, 2004). It has been established that IPV occurs for both men and women; however, women continue to report a higher incidence of abuse than men (Beeble et al., 2008). It is estimated that females experience about 1.3 million intimate partner related physical and sexual assaults while male survivors account for 835,000 intimate partner related physical assaults annually in the United States (Tjaden & Thoennes, 2000). Intimate partner violence accounts for 64% of the women who reported being raped, stalked, and physically assaulted. In comparison, 16.2% of men reported rape or being physically assaulted by an intimate partner (Tjaden & Thoennes, 2000).

Despite growing research illustrating the prevalence of IPV against men; women continue to experience IPV at a higher rate including a higher level of severity. Victims of homicides committed by an intimate partner are nearly double for women than men, one in five rapes or sexual assault incidents for women is committed by an intimate partner, and women are at higher risk of stalking than men. (U.S. Department of Justice, 2009).

IPV prevalence worldwide has initiated a call for scholarship with an objective to reduce and eliminate IPV incidence. IPV research is extensive and includes an examination of prevalence, precipitating factors contributing to IPV, and co-occurring disorders associated with IPV. Research on the development and implementation of IPV assessments, interventions, theories, IPV curricula, and an exploration of barriers

impeding IPV survivors and perpetrators from receiving available resources has also garnered much attention (WHO, 2004).

Co-occurring disorders are common issues among IPV survivors (Campbell et al., 2006; El-Bassel et al., 2000; Robertiello, 2006, Wathen et al., 2009). Women who have experienced IPV demonstrate greater psychological difficulties than non-IPV victims and report psychological symptoms such as depression, anxiety, low self-esteem and post-traumatic stress disorder (Edelson, Hokoda & Ramos-Lira, 2007; Wathen et al., 2009). Among IPV survivors, the most commonly reported psychological disorder has been post-traumatic stress disorder (PTSD) (Herman, 1997; Schnurr & Green, 2004). Long-term psychological affects include depression, hopelessness, suicidal ideation, anxiety, fatigue, insomnia, and the development of eating disorders (Dutton, 1992; Goodman et al., 1993; Herman, 1992; Walker, 1979).

Assessing for IPV risk and the occurrence of IPV has gained considerable attention (Corraneo, 2007, Kress, Protivnak, & Sadlak, 2008). Physical and psychological aggression against women has been associated with increased physician visits and higher rates of physical illnesses (Coker et al., 2002). There is an increased risk of abuse or homicide for women who try to leave the relationship (Campbell et al., 2003; Glass et al., 2004). The impact of IPV transcends various disciples and the urgency for effective interventions is evident on a systemic level.

Studies exploring factors related to perpetration of IPV have also increased in recent years. Identifiers predicting severe assault, recidivism related to assaults, and homicides have been explored in hopes of better understanding the causes of IPV

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perpetration and how to eliminate it (Corraneo, 2007). Research exploring predictors and personality profiles of perpetrators although extensive, continues to demonstrate mixed findings (Reed et al., 2008). Despite correlates linking an increase in IPV perpetration with substance abuse (Menard, Anderson, & Godboldt, 2009), lack of male role models, witnessing IPV as a child, use of pornography, exposure to violence and skewed beliefs related to IPV (Menard, Anderson, & Godboldt, 2009; Reed et al., 2008; Simmons, Lehman, & Collier-Tenison, 2008; Whitefield et al., 2003), perpetrators of IPV are represented across class, ethnicity, and education.

IPV risk as assessed by clinicians continues to be a source of great controversy and debate, as studies report the inability of clinicians to accurately assess the danger IPV poses to clients (Cattaneo, 2007). The issue of competence is compounded for counselors who work with clients from diverse ethnic backgrounds. Research suggests that current interventions fall short in effectively treating people of color, as evidenced by the disparities that exist for this community within the health care system (Abu-Ras, 2007; Adames & Campbell, 2005; Gillum, 2007; Silverman, 2002).

In an attempt to better prepare students for working with diverse populations within the mental health field, an emphasis on the development and implementation of training in culturally competent services has increased (Darcy, 2004; Helms, 2002; Kocarek et al., 2001; Ponterotto, 2002; Ponterotto & Rogers, 1997; Sodowsky et al., 1994). Multicultural awareness and competency have become integral aspects of most training programs (Abreu, Gim Chung, & Atkinson, 2008; Arredondo & Arciniega, 2008; Constantine & Sue, 2008). Clinician's ability to understand a client's cultural worldview

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is an important component of cultural competence (Constantine & Sue, 2008). Given the disproportionate numbers of ethnic minorities receiving services, competency assessments have been developed to serve as tools to ensure counselors are providing culturally appropriate and effective interventions in working with diverse populations (Pope-Davis, 1997; Sue et al., 1992; Sue & Sue, 2003).

Cultural competence has been described by Sue and Sue (2003) as the counselors' ability to have self-awareness related to their own biases. Counselors are expected to have an awareness of the values and beliefs of their clients, including an understanding the client's worldview, and to intervene in a culturally appropriate manner. Cultural competencies have been constructed to assist clinicians in gaining the necessary skills to provide more effective interventions when working with diverse clients (Sue et al., 1992).

Counselors working with ethnically diverse populations are expected to have an understanding of the socio-political conditions impacting their clients and how that plays out in therapy. When treating survivors of IPV, counselors should have an understanding of the client's perspective on IPV and the cultural norms that contribute to the formation of those beliefs. Roysircar (2008) asserted that "social privilege and multicultural competencies are inversely related" (p. 377) and therefore awareness around the social inequalities for various groups and the ubiquitous social privilege afforded clinicians is vital. Roysircar explained, "counselor trainees, because of their privilege of being well-educated, trained in potential classist theories of therapies, and associated with professional associations, may themselves adopt middle-class social status" (p.378). As

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these dynamics play out in session, social status differences between client and therapist quite possibly have impacts on therapeutic outcomes.

Minorities' experiences of oppression are often perpetuated and experienced within the counseling relationship (Hays, 2008). Social justice education within the mental health care system requires that clinicians gain an understanding of societal oppression experienced by non-dominant groups. In doing so, clinicians gain awareness of factors contributing to the under-utilization of services and increased attrition rates among these populations. Through social justice education, counselors advocate for marginalized groups to gain access to mental health services similar to their dominant counter-parts (Roysircar, 2008). Due to an increase in awareness related to the relationship between current and historical oppression of minorities, it is ethically critical that counselor educators continuously assess trainees' eagerness to serve as advocates for marginalized groups (Hays, 2008).

The disparities evident in the health care system for people of color compounded by the lack of training in IPV for clinicians, pose an additional risk for women of color seeking IPV services. Understanding cultural variables that impact Latinas' reluctance to seek help for IPV and their perception of IPV counseling, will hopefully help counselors develop interventions that fit within the cultural context of this population.

Review of the Problem

There is extensive research in IPV, however studies exploring client perceptions of counselor effectiveness, expertness, and multicultural competence is minimal and is nonexistent for Latinas in particular. Given the rapid growth of the Latina/o population

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in the United States, the inevitability of providing mental health services to Latinas/os contributes to the importance and urgency of conducting studies relating to the issue of IPV.

Becoming culturally competent requires that clinicians understand a problem through the client's worldview (D'Andrea et al., 1991; Pope-Davis & Dings, 1995). Working with Latina IPV survivors requires multifaceted approaches, the need for counselors to be knowledgeable of IPV interventions is but one aspect of effective counseling. Counselors must also have an awareness of how IPV differs for Latinas. This includes having an understanding of cultural nuances that are inherent to that group in order to determine which interventions would be most effective and culturally appropriate. The IPV literature would benefit from exploring the experiences Latina survivors of IPV have in the counseling setting. Therefore, exploring client perceptions of IPV counseling and experiences, which have contributed to their recovery from IPV, can help lay the foundation for future research on the subject.

This qualitative study assessed Latina IPV survivors' perception of their experience in receiving IPV counseling. An emphasis on counselor competence of IPV, as well as cultural competence in providing counseling to Latina IPV survivors was of particular interest. It was expected that Latina IPV survivors will report a higher level of counselor cultural competence and IPV competence for ethnically matched counselors.

Importance of Studying the Problem

Despite the nascent research in IPV and women of color, current interventions for women of color fall short of being culturally sensitive and competent. This dissertation

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will add to the existing literature in several ways. Little is known about counselor competence with women of color and more specifically Latinas (Gonzales, Hurwitza & Kraus, 2005). For the purpose of this study, competence was described to the participants as a counselor's awareness, skills, knowledge related to IPV and the Latina culture. This study explored the following key constructs during the interview and follow up questions:

1. Latina experiences in receiving IPV counseling.

2. Latina IPV victim's perceptions of counselor competence in providing IPV counseling.

3. Latina IPV victim's perceptions of their counselor's cultural competence in providing IPV counseling.

4. Finally, socio-political and environmental variables impacting people of color were analyzed, including cultural values, religion, racism, discrimination and interactions with various institutions including their community.

Until now, there have not been any studies conducted examining the influence that these factors have on Latina IPV survivors' perceptions of IPV counseling including cultural competence and IPV competence of counselors. This study hopes to contribute to the existing Latina IPV research by shedding light on the way in which Latina survivors of IPV make meaning of their IPV counseling experience as well as on what factors inform their perceptions of competent IPV counseling. Themes and constructs identified through this study may serve as a foundation for the development of future studies. Findings of this research may offer specific variables that can be further explored quantitatively.

Review of Methodology

Due to the fact that the objective of this study is to ascertain a culturally grounded understanding of Latina survivors of IPV perceptions of their counseling experience including their perceptions of counselor cultural and IPV competence, a qualitative research approach was utilized. A phenomenological approach was selected in an effort to understand how Latina survivors of IPV make meaning of their IPV counseling experience, which is consistent with Smith and Osborn's (2003) description of phenomenological inquiry. An exploratory study involving an in-depth understanding of client perceptions as disclosed by the client can lay the foundation for future studies in IPV. A qualitative approach can shed light on areas of inquiry that had not been considered prior to this study.

Research Questions

1. What factors contribute to Latina IPV survivors' assessment of counselor competence?

2. What meaning do Latina survivors of IPV make regarding their IPV counseling experience?

3. To what extent does socio-environmental, cultural, and political experiences contribute to clients' perceptions of IPV counseling?

4. What interventions contribute to client perceptions of effective and or positive IPV counseling experiences?

Definitions

Intimate Partner Violence (IPV) refers to "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that

relationship. It includes acts of physical aggression (slapping, hitting, kicking or beating), psychological abuse (intimidation, constant belittling or humiliation), forced sexual intercourse or any other controlling behaviour (isolating a person from family and friends, monitoring their movements and restricting access to information or assistance)" (World Health Organization, 2004, p. 89)

Perpetrator is "a person who inflicts the violence or abuse or causes the violence or abuse to be inflicted on the victim" (Saltzman et al., 2002, p. 22).

Intimate Partners includes current spouses (including common-law spouses), current non-marital partners, dating partners, including first date (heterosexual or same-sex), boyfriends/girlfriends (heterosexual or same-sex), former marital partners, divorced spouses, former common-law spouses, separated spouses, former non-marital partners, former dates (heterosexual or same-sex), former boyfriends/girlfriends (heterosexual or same-sex) (Saltzman et al., 2002).

Mental Health Care "includes individual or group care by a psychiatrist, psychologist, social worker, or other counselor related to the mental health of the victim. It may involve inpatient or outpatient treatment. Mental health care excludes substance abuse treatment. It also excludes pastoral counseling, unless specifically related to the mental health of the victim" (Saltzman et al., 2002, p. 22).

Physical Violence "is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping;

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punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person" (Saltzman et al., 2002, p. 22).

Violent Episode. A single act or series of acts of violence perceived to be connected to each other and that may persist over a period of minutes, hours, or days. A violent episode may involve single or multiple types of violence (e.g., physical violence, sexual violence, threat of physical or sexual violence, psychological/emotional abuse) (Saltzman et al., 2002, p. 22).

Sexual violence is divided into three categories: "1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact" (Saltzman et al., 2002, p. 22).

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources (Saltzman et al., 2002).

Stalking refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business,

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making harassing phone calls, leaving written messages or objects, or vandalizing a person's property" and is considered to be a form of IPV (Tjaden & Thoennes, 1998, p.1).

Latino— are those people who classify themselves as Mexican, Mexican American, Chicano, Puerto Rican, or Cuban, Spanish, Spanish-American, Hispanic, Hispano including those whose origins are from Spain, the Spanish-speaking countries of Central or South America, the Dominican Republic. (U.S. Census Bureau, 2000)

Culture is defined as "the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes and organizations" (APA, 2002, p. 8).

White Privilege is a term coined by Peggy McIntosh referring to "unearned skin privileges" afforded to Whites in the United States. The privileges for White Americans is often subconscious yet serve to perpetuate oppression against people of color (McIntosh, 1988).

Immigrant "is an alien admitted to the United States as a lawful permanent resident. Permanent residents are also commonly referred to as immigrants; however, the Immigration and Nationality Act (INA) defines an immigrant as any alien legally admitted for permanent residence in the United States, except for persons legally admitted under specific nonimmigrant categories (INA section 101(a)(15)". (Center for Disease Control and Prevention, 2007)

Ethnicity. In this study, ethnicity refers to the group norms and practices of one's culture of origin and the concomitant sense of belonging" (APA, 2002, p. 9).

Ethnic Minority. In this study, ethnic minority is defined as an individual who identifies as American Indian and Alaska Native, Asian, black or African American, Hispanic or Latino, and Native Hawaiian and Other Pacific Islander (Office of Management and Budget, 2000).

Multicultural Competency. In this study multicultural competence refers to the knowledge, attitudes, and skills that are necessary in the counseling profession, in providing services related to assessment, practice, training, and research (Sue, Arredondo, & McDavis, 1992).

CHAPTER II

Review of the Literature

Intimate Partner Violence (IPV) has gained international attention in response to the alarming incidence rate worldwide (World Health Organization, 2007). Given the probability of clinicians treating IPV survivors, efforts have been made to prepare clinicians to effectively assess and provide appropriate interventions. Despite these efforts, research suggests that clinicians are ill prepared to work with IPV survivors due to lack of training in IPV (Campbell et al., 2006; El-Bassel et al., 2000; Kernic et al., 2000; Robertiello, 2006). Cultural barriers pose additional challenges for clinicians providing IPV services to women from diverse ethnic backgrounds (Ammar, Orloff, Dutton, & Aguilar-Hass, Inram, 2007; Gonzales, Hurwitz, & Kraus, 2004; Kasturirangan & Williams, 2003; Murdaugh, 2004; Rios, 2003). Latina survivors of IPV are susceptible to the deficiencies of counselors who are not adequately trained in IPV and cultural sensitivity.

This chapter begins with a focus on the prevalence of IPV in the United States in order to establish the necessity for increasing IPV training in general. It also addresses the need for attention to culture specific training. This section then is followed by research focusing on concerns related to a lack of training in IPV for counselors. The next section discusses current trends in the health care system to address IPV. The section

identified as Latina defines the term Latina/o and provides current demographic information for Latinas/os living in the United States. This section will also include incidence and prevalence of IPV with Latinas both non-immigrant and immigrant. This section will also include barriers faced by Latinas in accessing IPV resources. The next section will review research related to ethnically diverse IPV clients' perceptions of IPV counselors. The purpose of this chapter is to summarize relevant research related addressing the implication of counselors' cultural competence and IPV competence in working with Latina IPV survivors.

IPV Prevalence

Intimate Partner Violence (IPV) refers to "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that relationship. It includes acts of physical aggression (slapping, hitting, kicking or beating), psychological abuse (intimidation, constant belittling, or humiliation), forced sexual intercourse or any other controlling behaviour (isolating a person from family and friends, monitoring their movements, and restricting access to information or assistance)" (World Health Organization, 2004, p. 89). Intimate partner violence (IPV) also includes dating violence among young people, same-sex couples, and women perpetrating violence against men (World Health Organization, 2004).

There is ample evidence illustrating the prevalence of IPV nationally and globally. The World Health Organization (WHO) responded by conducting an extensive study in 2005, examining the prevalence of IPV and its impact from a public health perspective. Results of the WHO survey found that 10% to 34% of women report being

physically assaulted around the world. It is estimated that the costs associated with IPV in the United States is $12.6 billion a year, England and Wales £5.7 billion a year and Canada $1.1 billion a year (World Health Organization, 2003).

It is estimated that 1.5 million women are raped or physically assaulted in the United States each year (Tjaden & Thoeness, 2000). The Bureau of Justice Statistics' National Crime Victimization Survey (NCVS) gathers information on crimes committed against individuals over the age of 12 through a nationally representative sample of U.S. households. NCVS confirmed that IPV against women is more prevalent than against men. Between 2001 and 2005 based on the annual percentage of reported IPV, 96% of females who experienced nonfatal IPV were victimized by a male and about 3% by a female. The total attempts or threats reported by women between 2001-2005 were 67.2%. Twenty-seven percent of female survivors reported that their offender threatened to kill them. Results also suggest 7.2% of female survivors reported being raped, 62.7% reported being hit, slapped or knocked down while 54.9% report being grabbed, held or tripped. Less than one-fifth of survivors who reported an injury sought treatment following the injury. Thirty percent of homicides by intimate partners were committed against women versus 5% against men (U.S. Department of Justice, 2003).

Given the overwhelming number of IPV incidence in the United States, IPV survivors are represented across all health care systems (Btoush, 2009; Hamberger, Ambuel, & Guse, 2007; Hamberger & Phelan 2004; Spencer et al., 2008; Wathen, et al., 2009). Research has shown the physical health effects of IPV on women include psychological effects. Co-occurring disorders are common issues among IPV survivors

(Campbell et al., 2006; El-Bassel et al., 2000; Robertiello, 2006). Physical and

psychological aggression against women has been associated with increased physician

visits and higher rates of physical illnesses (Coker et al., 2002). Among IPV survivors,

the most commonly reported psychological disorder has been posttraumatic stress

disorder (PTSD) (Herman 1997; Schnurr & Green, 2004). Long-term psychological

effects include depression, hopelessness, suicidal ideation, anxiety, fatigue, insomnia, and

the development of eating disorders (Dutton, 1992; Goodman et al., 1993; Herman, 1992;

Walker, 1979).

Olson et al., (1999) examined 313 female suicides in New Mexico. This study

found that nearly half of all suicides for women under 40 years of age, were due to IPV

or interpersonal conflict. This study also reported that many women seek medical

attention for abuse related injuries prior to attempting suicide. The significant correlation

between incidents of IPV and suicide for women further demonstrates the importance of

exploring effective strategies in providing therapeutic interventions when working with

survivors of IPV.

<p style="text-align:center">Social Response</p>

The United States Congress passed the Violence Against Women Act of 1994

(VAWA 1994). The Act improved prosecution of violent crimes committed towards

women. As a reaction to the increased prosecution and investigations related to

victimization of women that came about due to VAWA; the need for local services and

resources increased. VAWA was reauthorized in 2000 and again in 2005 in order to

remedy laws towards becoming more efficient in dealing with IPV. The reauthorization

in 2000 augmented the original provisions by including protection for battered immigrants, dating violence, and sexual assault survivors. In 2005, VAWA reauthorized grant programs, which established new programs that were Cultural Specific and emphasized access to services for underserved populations. VAWA 2005 enhanced programs for American Indian and Alaska native women, it developed programs assisting children and teens living with domestic violence as well as provided housing programs for women at risk of becoming homeless. VAWA 2005 also provided training for health care providers in order to improve health care systems' response to IPV (VAWA, 2005).

The response to the pervasiveness of IPV has prompted health care professionals to participate actively in the reduction and elimination of IPV. In 2007, the American Psychological Association Division 38 (Health Psychology) organized a summit to address the standards of graduate curricula and training in doctoral programs. Lists of foundational and functional core competencies were outlined. The foundational competencies were developed to be applicable to all health service providers in professional psychology (France et al., 2008).

The American Psychological Association (APA) responded to the need for IPV-related training by publishing guidelines for assessment and intervention. Such efforts include the establishment of the APA Task Force on Male Violence Against Women in 1994 and the APA Presidential Task Force on Violence and the Family in 2005. Both task forces issued a book discussing the pervasiveness and the impact that IPV has on women and families as well as information on how psychology as a field can be proactive in reducing IPV incidence and provide effective treatment to survivors (APA, 1996).

Lack of IPV Training

These effects of IPV are often manifested both physically and psychologically with co-occurring symptoms. As such, health care providers will inevitably treat clients who are affected by IPV (Campbell et al., 2006; El-Bassel et al., 2000; Kernic et al., 2000, Robertiello, 2006). Despite countless research declaring IPV as a major problem nationally, there continues to be an absence of IPV training in many institutions (Btoush & Campbell, 2009; Campbell et al., 2001; Garimella et al., 2002; Spencer et al., 2008; Wathen et al., 2009).

There have been several studies suggesting that psychologists are not adequately trained in assessing for IPV risk and are unable to confidently address IPV when survivors have disclosed their violent circumstance in session. Findings report that even when trainees have access to IPV assessments, they still do not inquire about IPV (Blau & Long, 1999; Bograd & Moderos, 1999; Wilson, 2006).

Samuelson and Campbell (2005) found that 95% of psychologists across the country agreed that it was their responsibility to provide treatment for survivors of IPV, however less than 19% stated that they actually screened for IPV. Common reasons given for why psychologists were reluctant to assess for IPV were due to perceived lack of training in IPV issues, the victim's unwillingness to disclose information, the belief that screening may be overwhelming for clients, and that they do not have sufficient time during the intake process. Despite the fact that most respondents reported having had IPV training, only 57% were able to identify domestic violence (Dersch et al., 2006).

Clinician's abilities to effectively treat women who experienced IPV are confounded by their perception of why they are battered in the first place. The concept of blame-the-victim was first described by Ryan (1971) as it related to race dynamics; this attitude was later applied by Walker (1984) to perceptions of women reporting abuse. Research findings suggest that mental health professionals at times place blame on IPV survivors with certain characteristics. One particular study compared clinicians' perceptions and empathy towards non-traditional women (e.g., career) and a traditional woman (e.g., housewife) who experienced IPV. This study found that counselors tended to empathize more with traditional women and believed that non-traditional women had more options to leave an abusive situation. They also reported feeling as though non-traditional women provoked incidents of abuse (Capezza & Arriaga, 2008).

Continuing with the view that survivors to a certain degree are accountable for the abuse experienced in their relationships, Celani (1994) stated that women who have been in more than one abusive relationship tend to be diagnosed with borderline personality disorder. "In general the diagnosis of borderline personality disorder is appropriate for most of the women who are physically abused" (Celani, 1994, p. 138). "There is little question that many, if not most, battered women unconsciously seek out batterers" (Celani, 1994, p. 139).

Although Celani goes on to explain that despite this tendency, women are "not guilty of anything or deserve the abuse they receive" (Celani, 1994, p. 139). To what extent the diagnosis is a true reflection of pathology or simply the tendency to blame the victim for their circumstances is unclear.

A study on mental health providers' ability to identify and intervene with IPV, found that 5% of respondents blamed the victim and only 12% blamed the perpetrator. The remaining respondents stated that they did not have sufficient information to make an appropriate assessment of the situation or attributed IPV on various external factors. Marriage and family therapists (MFT's) were 20% more likely to identify violence in the relationship than were psychologists (Dudley, McCloskey, & Kustron, 2008). The responses suggest a lack of awareness related to severity of the situation, an inability to understand IPV dynamics and to accurately predict lethal outcomes even when risk factors of lethality were present

Research examining factors associated with what informs a clinicians' assessment of risk is sparse (Corraneo, 2007). In a study assessing counselor and victim's perception of IPV risk, it was determined that client and counselor perceptions vastly differed. Clients' perception of severity of IPV is often determined by their reaction to the trauma experienced, perception of violence perpetrated by the abuser, level of psychological abuse, and whether they were living with their partner at the time of the IPV incident. Counselors on the other hand, based their assessments on the history reported by the client of physical and psychological abuse, whether there were children involved, and the level of the batterer's substance use (Cattaneo, 2007). This same study found that when PTSD symptoms were present, clinicians tended to focus on the survivors' mental health rather than the relationship between victim and perpetrator or the batterer's inclination to batter in the future.

In one study examining the impact of counseling IPV survivors on counselors, counselors reported feelings of inadequacy, powerlessness, stress, and anxious. They reported feeling personally responsible when the safety of their client and children were at stake. Participants also stated that they struggled with maintaining respect for their clients and their clients' choices (Iliff & Steed, 2000).

One study found that mental health clinicians questioned whether it was their responsibility to assess or address "social problems". They justified this reluctance by suggesting that their primary role was to diagnose and treat the diagnosis. They stated they were neither trained nor equipped to effectively intervene in domestic matters and these should be left to other agencies, which specialize in these cases (Gondolf, 1998).

Cultural Competencies

Given the marked increase in ethnic minorities in the United States and the myriad of psycho-social issues impacting this population, an increase in programs attempting to better prepare students for working with diverse populations within the mental health field has increased (Darcy, 2004; Helms, 2002; Kocarek et al., 2001; Ponterotto, 2002; Ponterotto & Rogers, 1997; Sodowsky et al., 1994). Training programs have aggressively included multicultural issues in most classes. Multicultural awareness and competencies have been demonstrated to be critical areas necessary for mental health providers to consider when working with diverse populations (Constatine, Ladany, Inman, & Ponterotto 1996; Ponterotto, Fuertes, & Chen, 2000; Sue et al., 1998; Sue & Sue 1999). The impact of racism, discrimination and social injustice has been well documented in multicultural counseling literature. Mental health providers are expected

to understand a client's worldview by becoming cognizant of current social problems their clients' experience (D'Andrea et al., 1991; Pope-Davis & Dings, 1995).

There have been studies illustrating the disparities for ethnic minorities within the health care system (Abu-Ras, 2007; Adames & Campbell, 2005, Gillum, 2007; Raj & Silverman, 2002). Members of racial and ethnic minority groups continue to be underrepresented in the health care system and are more likely than Whites to live in neighborhoods that lack adequate health resources (The Sullivan Commission, 2004). Women of disadvantaged communities are twice as likely to experience IPV as women of advantaged neighborhoods. More African American women report IPV as a result of living in poorer neighborhoods. When comparing IPV incidents for Whites and African American women from comparable income levels, reported IPV incidents were similar (Benson & Fox, 2004).

According to the Health Care Quality Survey conducted by the Commonwealth Fund in 2006, 28% of Latinos and 22% of African Americans report having little or no choice in where to seek care, while only 15% of Whites report this difficulty. The study also found that African Americans and Latinos are twice as likely as Whites to rely on a hospital outpatient department as their regular source of care, rather than a doctor's office, which makes continuity of care more difficult. Some reasons for disparities within the field have been attributed to cross-cultural differences and cultural barriers (Pope-Davis, 1997; Sue et al., 1992; Sue & Sue, 2003).

In order to ensure that training programs are progressive in addressing the heterogeneity of cultures in the United States, a number of competency assessments were

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developed (Pope-Davis, 1997; Sue et al., 1992, Sue & Sue, 2003). These assessments

have been critical tools in evaluating the effectiveness of programs that prepare students

as well as address the disparity that exists between the services provided to ethnic

minorities

<center>*Latina/os*</center>

The United State Census Bureau define Hispanics as individuals living in the

United States "who indicated that their origin was Mexican American, Chicano, Mexican,

Mexicano, Puerto Rican, Cuban, Central or South American, or other Hispanic" (The

United State Census Bureau, 2002). The Office of Management and Budget (OMB) must

first approve race categories for the United States Census Bureau for data collection

purposes. In 1997, OMB made revisions to the standards for the classification of federal

data on race and ethnicity. The revisions state that OMB will no longer accept the single

term "Hispanic." Instead, OMB will use both the term "Hispanic or Latino." The

reasoning for accepting Latino was due to the fact that the term Hispanic has been

"commonly used in the eastern portion of the United States, whereas Latino is commonly

used in the western portion" (The Office of Management and Budget, 1997). OMB stated

that the inclusion of Latino may contribute to improved response rates in data collection.

The term Latino will be used interchangeably with Hispanic throughout this paper in

order to maintain the terminology used in the research cited.

According to the current census data, there are approximately 44.3 million

Latina/os living in the United States (The United State Census Bureau, 2003). Latinos

compromise 14.8% of the United States population. According to a report by the National

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Latino Alliance for the Elimination of Domestic Violence (ALIANZA), it is estimated that by the year 2050 Latinas/os will account for 25% of the total U.S. population. Approximately half of all Latino/as are under the age of 26. Forty percent of all Latinas/os living in the United States are foreign born (Rios, 2003). It should be noted that these numbers might not accurately reflect the number of undocumented Latinas/os as they are not counted by the U.S. Bureau of Census.

Latinas/os continue to have the second highest rate of unemployment, occupy the lowest paying jobs and the lowest rate of home ownership (Ramirez & de la Cruz, 2003). Furthermore, only 9% of Latinos receive a four-year college degree compared to 24% of non-Hispanic (U.S. Bureau of Census, 2003). Ultimately minimal education, unemployment, or low paying jobs lead to lack of insurance, access to mental health, and medical services. The statistics for Latinas/os imply that in addition to socio-environmental factors, cultural barriers also further challenge Latinas/os.

Given the increasing number of Latinas/os in the United States, the incidence of IPV among Latina women also has been reported to be on the rise with 54.9% reporting having experienced violent victimization (Murdaugh et al., 2007). As such, the incidence of IPV among Latinas /os' is a growing concern for health care providers suggesting a need to develop culturally competent interventions to work with this population.

Latina IPV Survivors

Of the limited research that exists for Latina IPV survivors, finding are mixed when comparing IPV prevalence between Latinas and non-Latinas. Studies have provided explanations for these differences by suggesting that Latinas underutilize

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services, are reluctant to disclose IPV as well as suggest that IPV reports differ for Latina subgroups such as Mexican versus Mexican American (Edelson, Hokoda, & Ramos-Lira, 2007). Similarly, 1000 pregnant Latina women were surveyed for IPV; findings of the study suggested that Latina women reported an alarming rate of IPV during their pregnancy compared to non-Latina women. When the sample was divided into ethnic subgroups, results showed a higher rate of reported abuse among Puerto Rican women compared with Central American women (Campbell et al., 2002).

Kantor and colleagues (1994) found that being born in the United States increased the risk of wife abuse by both Puerto Rican and Mexican husbands. Puerto Rican husbands were 10 times more likely that Cuban husbands to batter their wives and twice as likely as Anglo husbands. Sorenson and Telles (1991) found that Mexican-born Mexican Americans reported a lower rate of IPV than American-born Mexican Americans and Caucasians.

Comparative research between Latina and non-Latinas has suggested significant differences. In a study looking at the impact of IPV on Latinas and non-Latinas, depressive symptoms were significantly higher for Latina versus non-Latina women. They also were shown to experience more intrusive thoughts, overall trauma related symptoms, and lower self-esteem than non-Latinas. Latina IPV survivors have overall poorer outcomes than non-Latinas (Edelson, Hokoda, & Ramos-Lira, 2007). Several studies have found that Latina women are more likely to experience violence over a longer period of time. Mexican women were also more unlikely to consider behaviors

such as slapping, shoving, pushing, grabbing, and throwing objects at them as physical abuse (Gondolf et al., 1988; Torres, 1991).

In a national sample of 2,000 Latinas, Cuevas, Sabina, and Picard (2010), explored multiple incidents of victimization and the increase in psychological distress. Results found that 40% of all women report at least one form of victimization and almost two thirds experienced multiple incidents of victimization. Psychological symptoms were shown to be significantly higher for women with multiple trauma experiences versus a single incident. This study illustrates the psychological impact of cumulative trauma among Latina survivors of trauma.

Barriers to Counseling Latina Women

Given the difficulties associated with counselors providing IPV counseling to survivors in general, it is expected that counseling IPV survivors of color would further complicate counselors' ability to effectively provide appropriate culturally sensitive services. This is especially the case if there exists a deficiency in cultural competency or awareness on the part of the mental health provider. There are countless pieces of literature documenting the disparities that exist in mental health for communities of color (Abu-Ras, 2007; Adames & Campbell, 2005; Gillum, 2007; Raj & Silverman, 2002). These disparities are the predominant issues discussed in multicultural counseling and multicultural counseling competencies.

Ursula Colon-Morales, a psychologist and battered women's advocate, discusses the barriers associated with effective treatment services for Latina IPV survivors due to a mental health training that is Eurocentric and based on ideologies of the dominant

culture. As such, cultural differences related to Latina women and IPV are often neglected or dismissed (Rios, 2003). "Latinas are separated from their beliefs, encouraged to assimilate to the new culture and, often forced to adapt and respond to their situation, according to the social expectations of a culture that is unfamiliar to them and which does not understand the interpretation the Latina client gives to the events in her life" (Rios, 2003, p.32).

Cultural values and norms also impact the Latina IPV survivors' perception of IPV and their willingness to seek help. *Familismo* refers to the concept of family and includes extended family members as well as those non-related (Hurtado, 1995; Velasquez et al., 2004). The family plays a central role in providing economic, emotional support, and is a sense of identity for Latinas/os. Latina/o families strive to maintain unity and cohesion, which ultimately contributes to their fear of bringing shame to the family (Rios, 2003). The cultural value of *familismo* can provide protection from abusers yet can also serve as a barrier in that Latina women may feel, as they are being disloyal if they attempt to leave or seek outside help. The stigma associated with divorce and remarriage also contributes to Latina women's reluctance to leave an abusive relationship (Flores-Ortiz, 1992; 2003). Similar to *familismo, personalismo* describes the focus on personal interactions with others with an emphasis on courtesy, compassion, an avoidance of conflict, and expression of negative emotions (Edwards, 2004; Hurtado, 1995). These concepts serve to discourage Latinas from disclosing IPV and seeking IPV services.

Machismo is a concept within the Mexican culture, which refers to a man's role and identity within the family. It is a standard of behavior for Mexican men and dictates

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the manner in which they interact with others. Most research related to machismo describes this concept as hypermasculine, masogonistic, and chauvinistic (Edelson, Hokoda, & Ramos-Lira, 2007). Machismo which involves dominating women whose primary responsibility is to maintain the family and rear children (Casas et al., 1994; Castillo, 1994; Mayo & Resnick, 1996), is a patriarchal value that is intrinsic in Mexican families and serves to subjugate women. Machismo has also been associated with violence and heavy drinking (Alaniz, 1996; Neff, Prihoda, & Hoppe, 1991). However attempts to provide a more positive perspective of machismo have been made in research suggesting that machismo can serve as a sense of pride displayed by a man responsible for protecting and providing for his family (Arciniega, 2008; Ramos-Lira, Koss, & Russo, 1999; Velasquez, 1998).

Marianismo is the cultural counter-part of machismo and predominantly a value held within Catholicism describing the virtues of the Virgin Mary (Miranda et al., 2003). This concept also includes the notion of self-sacrifice, enduring suffering and living up to the virtues of the Virgin Mary (Arredondo & Rivera 2002). Kasturirangan, Nutt, and Williams (2003) suggested that Marianismo describes a woman's ability to endure suffering without protest (*aguantar*) and is one of the key concepts of this value and which serves as a deterrent in Latina women seeking help for IPV. Enduring abuse and severe discontent is often a result of socio-cultural constructs, which have been internalized by Latina women and are not an uncommon phenomenon (Ramos-Lira, Koss, & Russo, 1999; Vasquez 1994).

Familismo, machismo, and marianismo are culturally sanctioned ideals and standards of behaviors ascribed to Latina/o families. These concepts and values significantly impact how IPV is perceived and how it should be treated and addressed. It should be noted that these terms may be used specifically by scholars for the purpose of translating cultural practices and may not be identifiable idioms within the communities themselves.

Aside from general counseling practices, ethnocentricism and eurocentric training has been identified as a barrier in counseling Latina women IPV survivors (Bonilla-Santiago, 1996; Flores-Ortiz, 2004; Gillum, 2008; Raj, 2002). In an interview conducted by the National Latino Alliance for the Elimination of Domestic Violence (ALIANZA), Dr. Fernando Moderos commented:

> Many of the helping systems and legal remedies offered to battered women frame the solution or the achievement of safety in terms of protecting or establishing an autonomous self; establishing safety for a woman and her children is framed in terms of separating her from the offender and from her community. Protective/ restraining orders emphasize removing the offender. Shelters offer women refuge from the offender, but separate them from their communities. This is more culturally appropriate in European American society where the ideal of individuality or the autonomous self has great resonance (ALIANZA, 2003, p. 18).

ALIANZA compiled and reviewed 215 materials from various domestic violence providers and found that some of the materials were poorly translated and had not been culturally tailored to be more applicable to Latinas/os. Latinas/os values differ from those of European Americans in that there is a stronger emphasis on kinship, interdependence, and collectivism versus independence, individualism, and personal achievement (Rios, 2003).

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IPV prevention programs with a primary focus on the individual versus the family may dissuade Latinas who are family-oriented from participating (Gonzales, Hurwitza, & Kraus, 2005).   Most commonly used interventions in the United States have been designed according to the Western values of individualist societies and are not always effective with diverse populations (Gillum, 2008). A better understanding of cultural norms for Latinas and reporting IPV is necessary in order to reduce the number of IPV incidence among this population (Flores-Ortiz, 1993; Gonzales, Hurwitza, & Kraus, 2005)

For many Latina/o families, sex, violence and gender roles are interrelated. In one particular study, both men and women condoned the use of physical force as punishment for women who were seen as sexually promiscuous (Ascencio, 1999). Therefore, it is not that uncommon for Latina women to remain in abusive relationships in order to preserve their reputation and to not be perceived as promiscuous. Women who were unfaithful or who recently engaged in a new relationship after a break up were subject to violence by their former partner (Ascencio, 1999).

Cultural scripts and social constructs that IPV is acceptable behavior ultimately become risk factors for IPV and women's willingness to seek assistance for IPV (Kantor & Jasinski, 1994; Sorenson, 1996). Some research has suggested that within the Latino IPV or exerting control over women is acceptable behavior and a cultural norm (Senturia, Sullivan, Ciske, & Shui-Thornton, 2001; Torres, 1991). The World Health Organization's World Report on Violence and Health (2003) explains that a strong predictor of low

levels of violence in a community is determined by the family and community members'
willingness to intervene in cases of IPV.

Mexican American women's perceptions of rape and sexual abuse are determined
by cultural norms, religious beliefs and gender roles for their culture. Their perceptions of
rape and sexual assault also influence their inclination to seek help or report sexual
assault (Ramos-Lira, Koss, & Russo, 1999). There have been numerous studies
suggesting that Hispanic women report less sexual assault and rape than non-Hispanic
women (Sorenson & Siegel, 1992; Tjaden & Thoennes, 1998). These findings may not be
accurate in terms of sexual abuse prevalence among Latinas but rather reflect their
perception of sexual assault by an intimate partner and their reluctance to report sexual
assault to authorities (Ramos-Lira, Koss, & Russo, 1999).

Psycho-social factors significantly contribute to Latina women willingness and
ability to seek mental health treatment. Socio-cultural attitudes that suggest IPV is
acceptable in certain situations further obscure the prevalence of IPV among Latina
women as well as their inclination to seek assistance. Developing interventions, which
recognize and integrate these values, can serve to promote trust and build a positive
rapport with clients.

Cultural barriers for Latinas include their inability to identify incidents of abuse.
This concern was explored in a study by Ahrens et al. (2010) who identified sociocultural
beliefs impacting Latinas' identification and disclosure of IPV and sexual assault. In this
qualitative study, the role culture plays in informing perceptions of violence and
disclosure were examined. Gender role ideology, traditional beliefs about marriage, lack

of community resources fear of violence, respect for authority, familism, and taboo against talking about sex were described as cultural barriers.

Ingram (2007) found a significant difference between Latinos and non-Latinos in awareness of community resources for IPV and in service professionals' inquiry in their IPV experience. The study found a significant difference between Latinos and non-Latinos in the types of services sought. Fourteen percent of non-Latinos compared to ten percent of Latinos reported seeking services from battered woman's shelters. Finally, more non-Latinos than Latinos reported having been asked if they were afraid or hurt by an intimate partner. Among Latino IPV survivors, more non-immigrants (14.7%) than immigrants (6.9%) contacted a formal service agency for services.

One study found that when compared to non-Hispanic White Americans, Latina women were less likely to use specialized services, such as services provided by social services agencies, than their non-Hispanic White counterparts. This is particularly true for immigrant Latina women (Torres, 1991). General findings have indicated that Latina women underutilize IPV services and therefore may be more reluctant than non-Hispanic White women to seek help for IPV (O'Keefe, 1994; West, Kantor, & Jasinski, 1998).

Latina survivors of IPV were found to be younger, less educated, and more impoverished than Non-Latina women. Findings also showed that Latinas who sought IPV assistance tended to be more acculturated. Low acculturation, as measured by preference for the Spanish language, was found to be the only significant cultural barrier to Latina women's willingness and ability to seek help for IPV (West et al., 1998).

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Latina Immigrants

Despite the extensive research in IPV, little is still known about IPV and immigrant Latinos (Adames & Campbell, 2005). Immigrant Latino's experience of IPV likely differs compared to others due to the various sociocultural issues they face as immigrants. A shift in gender roles and power relations that undermine traditional cultural norms as a result of the acculturation process is a common occurrence for immigrants. Furthermore the stressors related to the acculturation process can also contribute to a women's vulnerability (Abu-Ras, 2007; Adames & Campbell, 2005; Raj & Silverman, 2002).

Studies related to undocumented immigrants who experience or report IPV are scarce despite the high incidence of reported IPV for immigrants (Raj & Silverman, 2002). Immigrant women are at a greater risk of IPV due to their immigration status, isolation, economic dependence, and conflicting cultural views. Traditional Western ideologies can often conflict with the cultural norms for many women and increase their vulnerability of being abused (Raj & Silverman, 2002).

Currently, limited research provides various factors contributing to Latina women's inability to seek or receive services for IPV (Ammar, Orloff, Dutton, & Aguilar-Hass, Inram, 2007; Gonzales, Hurwitz, & Kraus, 2004; Murdaugh, 2004; Rios, 2003). Limited language, fear of deportation, financial constraints, social isolation, shame and fear of governmental agencies are but a few barriers precluding Latina women from accessing much needed resources (Bonilla & Santiago, 2002; Flores-Ortiz, 2004; Kasturirangan & Nutt Willliams, 2003; Lown & Vega, 2001; Perilla, 1998; Raj, 2002).

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Studies have also suggested the impact migration has on Latina women, particularly those who are economically forced to work outside the home resulting in an imbalance in gender roles (Rodriguez et al., 2001). Parilla (1994) found that women who financially contributed to the family tended to experience more abuse. This phenomenon was attributed to the imbalance in traditional gender roles and the propensity for men to exert control physically in order to maintain gender role hierarchy.

Many non-documented immigrant Latinas do not qualify for government assistance which then limits their ability to establish child care, medical insurance, and transportation, forcing them to financially remain dependant on their abusers (Flores-Ortiz, 2004). This is especially true of Latina immigrants who have limited or no family in the United States. In a study of 280 immigrant Latinas, findings reported that 49% indicated a lifetime prevalence of domestic violence. For Latina immigrants who reported being currently married or having been married previously, the physical and sexual abuse rate increased to 59.5% (Hass et al., 2005).

Murdaugh et al. (2005) conducted a survey of 309 mostly immigrant Latina women assessing IPV and barriers to receiving treatment. Approximately 70% of women reported experiencing victimization by violent acts within the past 12 months and 43% reported physical violence several times during the last year. Seventy-seven percent of the women reported being seen at a hospital or emergency department for injuries sustained by their partner. Seventy-four percent of these women stated they had not told the provider how they had been injured. The primary reason for not disclosing IPV was attributed to feeling ashamed or embarrassed (59%), an inability to speak English (41%),

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or feared of retaliation by their partner if they discovered that IPV had been disclosed (40%). One third of Latina women stated that the issue was a personal matter, feared their children would be removed from the home, and stated that they were unaware that their health care provider could assist them.

Non-English speaking Latina women may feel reluctant to call an agency for help. Latina women who identify English as their second language may not be able to effectively articulate the intensity of emotions and nature of the relationship when discussing IPV (Leong et al., 1995; Wilson 1997). A study conducted by ALIANZA (2003) found that 25% of participating agencies had no bilingual/bicultural staff. ALIANZA also conducted focus groups with 75 Latina IPV survivors in 9 different cities across the United States and developed a list of barriers experienced in seeking or receiving treatment. The study reported a lack of information related to legal rights, options and resources provided to Latinas. Immigrant Latinas reported feeling fearful that they would be denied their citizenship or deported if they reported IPV to police. This fear was underscored by an underlying fear of police in the United States due to past negative experiences. Women participants also disclosed frustration and negative experiences in receiving treatment in various battered women's shelters such as long delays, shortage of shelter beds, lack of bilingual staff/ interpreters, geographic inaccessibility and difficulties with transportation.

Traditional attitudes for Latino men related to being the primary providers in the home, a shift in gender roles due to acculturation may possibly impact their sense of manhood (Adames & Campbell, 2005). Current interventions promoting assertiveness

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and independence could be more harmful to immigrant Latinas as they challenge the cultural norms inherent for this group (Adames & Campbell, 2005). In one study, women attributed the conflict in the relationship to their partners' machismo and need for control. The pressure of gender roles in relation to the expectation that women should be subservient to their men was also listed as a source of conflict in their relationships. All the women stated that they were not in a good relationship. One participant stated "until now, I have not met anyone who has a good relationship" (Adames & Campbell, 2005, p. 1351) The study also found that immigrant Latina, readily identified verbal and physical aggression as abusive but not emotional and sexual aggression (Adames & Campbell, 2005).

Immigrant concept and perception around sexual assault and rape have been demonstrated to be different for many immigrant women versus American women (Abu-Ras, 2007; Flores-Ortiz, 2000; Raj 2007; Ramos-Lira et al., 1999). In a study, which explored factors that inform Mexican women's conceptualization of rape and sexual assault, it was found that gender roles, religion, level of acculturation, values, norms, and victim blaming attitudes were all factors that influenced their perception of sexual victimization (Ramos-Lira et al., 1999). This study also suggests that immigrant Latinas may not see sexual assault as abuse when it occurs in the context of an intimate relationship.

Linguistic barriers, fear of deportation, financial constraints, social isolation, shame, and fear of governmental agencies are but a few barriers precluding Latina women from accessing much needed resources (Flores-Ortiz, 2004; Kasturirangan &

Nutt Willliams, 2003; Raj, 2002; Bonilla Santiago, 2002; Lown & Vega, 2001; Perilla, 1998). Effective interventions for Latina Immigrant IPV survivors are necessary and should include an understanding of language barriers, acculturation, biculturism, accessibility to resources, gender roles, and documentation status (Adames & Campbell, 2005).

Client Perception of IPV Counseling

Given the lack of research in Latina IPV survivors' perspective of IPV counseling, comparable literature using women of other ethnic groups was examined. In a qualitative study conducted by Gillum (2009), African American women who received IPV counseling were questioned about their experience in receiving services from "mainstream agencies" compared to a cultural specific service agency. The author found that although most African American women felt welcomed and comfortable in mainstream agencies, in general they preferred services from a culturally specific agency. A culturally specific agency embodies the cultural values of the target group and its cultural awareness is reflected in the resources available, staff employed and décor of the agency. Representative staff was also one of the factors necessary in establishing a culturally specific agency (Gillum, 2009).

Qualitative research exploring perception of IPV counseling with battered Arab immigrants has highlighted the need for culturally competent services when working with diverse populations. Findings reveal the tendency for Immigrant Arab IPV women to seek assistance from family (68%) and legal services (52%) versus mental health (20%). Explanations for the lack of services sought by immigrant Arabs include, lack of health

care insurance, poverty, language barriers, lack of culturally relevant information, and lack of Arab staff. This study mentions various barriers experienced in receiving culturally appropriate counseling as they relate to cultural norms for Arabs, sex-role expectations, perceptions of wife-beating, values related to shame and honor (Abu-Raas, 2002).

Despite the number of studies and literature available related to IPV, there continues to be a gap in the literature as it related to the experience of IPV within ethnic minority communities (Abu-Ras, 2007; Adames & Campbell, 2005; Gillum, 2007; Raj & Silverman, 2002; Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). Cultural and linguistically appropriate interventions are critical in order to effectively meet the needs of a growing diverse population in the United States (Hokada et al., 2006).

Summary

This chapter reviewed literature on IPV and Latina women. Included in this chapter were statistics related to IPV prevalence nationally and for Latina women specifically. Research on barriers to counseling IPV survivors was reviewed. Common behaviors and interactions that are experienced in counseling IPV survivors were discussed. This chapter also explored cultural concepts and values prevalent in Latina/o families and how these values can often serve as barriers for Latina women to seek counseling. This chapter concludes with the studies related to women of colors' perception of counselors providing IPV counseling.

The research illustrates the absence of literature related to IPV and Latina women but more specifically the intersection between cultural and IPV competence as perceived

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by Latina IPV survivors. Research that addresses IPV for Latinas is particularly
important in that Latina women are a population have been reported to experience a high
incidence of IPV yet are underutilizing mental health services. The need for further
research for Latinas affected by IPV is imperative to address the disparities that currently
exist for this community. The next chapter will outline the exploratory study conducted to
ascertain from Latina IPV survivors, their experience in receiving IPV counseling and to
identify factors contribute to Latina IPV survivors' perception of counselor IPV and
cultural competency.

CHAPTER III

Methods

This chapter describes the methodology that was used in this study of Intimate Partner Violence (IPV). This chapter begins with a rationale for selecting a qualitative research methodology, discussion of the design and the phenomenon to be explored. This is followed by a description of the participants, measures, and procedure which were utilized in this study. This chapter concludes with a discussion of the data collection procedures and the methods used to verify the data.

The purpose of this study was to explore the experience Latina survivors of IPV have in IPV counseling sessions, with particular interest in counselor competence in IPV as well as counselor cultural competence as perceived by the participants. There is no existing research exploring Latina IPV survivors' perceptions of their counselors' competence in providing IPV counseling. Most studies related to IPV counseling experiences have been quantitative and have been conducted with non-Latina groups. While quantitative research does provide valuable empirical data, it fails to capture the lived experience of the participants as well as identify the underlying meanings of the experience. As such, a qualitative research approach was selected for this study in order to explore underlying factors contributing to the perceptions of Latina survivors of IPV concerning their counselors and their counseling experience.

Rationale for the Selection of Qualitative Methodology

Given the lack of culturally sensitive and challenging linguistic issues inherent in current assessment measures for Latina clients, a qualitative methodology was selected for this study. A qualitative approach allows for in-depth analysis of the participant's experience that likely will not be acquired through quantitative methodological studies alone. Furthermore, qualitative studies allow for a greater understanding of how one's perceptions are constructed rather than attempting to explain the causes of these perceptions. Obtaining participant perceptions first hand allows for a richer description of their experience that can be lost in quantitative research.

Creswell (1998) outlined the rationale for selecting a qualitative research methodology by explaining that qualitative research is selected when the topic requires further exploration and variables are not easily identified. A qualitative study offers an in depth view of the topic, calling for the researcher to share participant stories from the participant's perspective rather than to assume the role of expert. Qualitative methods allow for an interaction to take place between researchers and participants, thus creating openness and dialogue that is often not possible when conducting quantitative research (Storey, 2007). This approach is especially appropriate for Latina IPV survivors who may have had negative counseling experiences for IPV, or who mistrust others in authoritative positions and might not participate in research without a more personal connection with the researcher. Given the researcher's shared culture and familiarity with the norms and values of Latinas, the possibility of creating a space that is safe and understanding allows

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for the participant to be more forthcoming in her responses than would be afforded in a quantitative study.

This qualitative study integrated inquiry methods within phenomenology research. A phenomenological approach is aligned with the general objective of this particular study as it seeks to understand the meaning Latina survivors of IPV make regarding their IPV counseling experience. This methodology is also consistent with the goals of cross-cultural research in attempting to obtain in-depth accurate understanding of a particular culture (Liamputtong, 2008). The objective, to explore how Latina survivors of IPV form meaning from their IPV counseling experience, their perceptions and interpretations of that experience, legitimizes the use of a phenomenological methodology (Smith & Osborn, 2003). The objective of phenomenological research is to understand the situations experienced and lived through by individuals. Phenomenology "describes the meaning of the lived experience for several individuals about a concept or phenomenon" (Creswell, 1998, p. 51) by exploring how a particular phenomenon is experienced, within the context which it took place, by an individual (Gorgi & Giorgi, 2003). The meaning associated with the lived experiences from a psychological perspective can be extremely revealing (Giorgi & Giorgi, 2003).

As discussed by Smith and Eatough (2003), an interpretive phenomenological analysis is most appropriate when the goal of the research is to explore how individuals perceive a particular situation and how they make sense of their personal and social world. The two-stage interpretation process is also referred to as double hermeneutic (Smith & Osborn, 2003) and involves participants attempting to make sense of their

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experience and the researcher's attempt to make sense of the participant's interpretation. The term phenomenology as used by Husserl, refers to the fact that this method of study "only uses the data available to consciousness" (Mousktakas, 1994, p.45).

Guidelines for conducting phenomenological research studies are flexible in that there is not a single approach to data analysis, sample size, or interpretation (Smith & Eatough, 2003; Smith & Osborn, 2003; Storey, 2007). Sample sizes for phenomenological studies tend to be small with an average range of five to six participants (Smith & Osborn, 2003). A smaller sample size allows for more in-depth analysis of participant responses. Phenomenological approach methodologies suggest that the number of participants for a study should only be determined following significant "deliberation and critical reflection considering the research problem, the life-world position of the participants, the quality of the data, and the value of emergent findings with regards to research goals are required in a continuing assessment of adequacy" (Wertz, 2005, p. 171).

Conducting research in a naturalistic setting familiar to the client is consistent with the principles of phenomenological inquiry. Therefore, face-to-face interviews were conducted in participant homes, or locations of their choosing. Upon completion of the data analysis, findings were shared with each participant in order to ensure that these interpretations accurately reflect participant intentions. Semi-structured interviews were conducted allowing this researcher to follow up on important issues disclosed in the interview in real time. Interview questions included key constructs related to the IPV

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counseling experience, counselor IPV competence, and counselor cultural competence. Questions were modified according to participant response.

The *Lifeworld* is a concept in phenomenology that refers to the process in which the researcher explores meanings of the participants' experiences. "Lifeworld" illustrates the notion that when a phenomenon is explored, it is done so through real life examples and within the context of the experience. Rather than isolating variables, qualitative descriptions of lived experiences are provided by individual study participants (Giorgi, 2006). This concept also accounts for the naturalistic settings in which participants are interviewed, and the manner in which they are interviewed (i.e., open-ended questions); an approach similar to how individuals interact in the "lifeworld". As Giorgi (2006) contends, "the more psychologically sensitive the topic of the research is, and the more difficult it is for that participant to talk about, the more important the relationship between the participant and the interviewer becomes" (p. 76).

Identifying the Phenomenon

The initial preparatory step when conducting a phenomenological study is to "arrive at a topic and question that have both social meaning and personal significance" (Moustakas, 1994, p. 104). As such, my interest in this study was one of personal experience, having received IPV counseling and being negatively impressed with the cultural sensitivity and IPV counselor competence. My experience in receiving IPV counseling was the impetus for this inquiry. This study attempts to reveal and understand to what extent counselors are trained to provide IPV counseling, and furthermore, how they account for cultural differences with their patients. As I began discussing this issue

with other women, similar stories emerged with a reoccurring theme centering around cultural insensitivity and a lack of knowledge related to IPV and the intrinsic dynamics of abusive relationships.

Reflecting on my own experiences working as a therapist at a battered women's shelter in the years prior to receiving IPV counseling myself, I contemplated the attrition of Latina women seeking IPV resources, including counseling, and wondered about their experiences in receiving IPV counseling at the shelter. I considered my own knowledge, skill level, and attitude regarding IPV as a therapist providing counseling to women at that time, and became painfully aware of my own lack of IPV training. I had learned about Pence and Paymar's (1993) Duluth Model and the Power and Control Wheel which simply describes the types of abuse against women. This information, although helpful, did little to inform me on how to assess for IPV and about the interpersonal dynamics common in abusive relationships.

My experience in receiving IPV counseling left me discouraged as I found my therapist to be inept at providing IPV counseling and culturally insensitive. My therapist at the time was male who purported specializing in couple and family therapy for the previous twenty years. During the initial meeting, the apathy of the counselor was noticeable as evidenced by his lack of eye contact and personal engagement in session. Even after disclosing that I was currently in an abusive relationship in the presence of my abusive partner, he minimized my assertion and questioned my actions suggesting that I had encouraged the abuse. The therapist did not assess for risk or my safety nor did he explore my use of the word "abusive" in order to gauge severity of the abuse. Leaving the

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session, I wondered how many women experienced similar reactions and if any had been further victimized by their perpetrator for discussing abuse in counseling. I also wondered if my negative experience was in part due to the fact that the counselor was male, my partner was White, or that the counselor was White.

Given my own experience of being in an abusive relationship, I was afforded particular insight as to why women stay in abusive relationships and the challenges many women face in leaving the relationship. I was forced to reassess my role as a therapist working with survivors of abuse and the type of interventions utilized in working with this particular population. I felt obligated to learn more about IPV and in doing so I became interested in exploring the perceptions women of IPV reported regarding their counseling experience. Unfortunately, there is a gap in the literature related to survivors' perceptions of IPV counseling and it is non-existent for Latina IPV survivors. As a Chicana, this realization inspired me to explore this issue further through research. My experience as a therapist working with survivors of IPV and as a victim of IPV offers me particular insight into the possible experiences Latina women may have in receiving IPV counseling. It is this insight that has allowed me to develop a trusting relationship with the participants in order to obtain a detailed description of their perceptions and experience in receiving counseling for IPV.

The interest in exploring women's account of their experience and to obtain in-depth understanding of their lived experience was the bases for selecting phenomenology as the methodology. This need for establishing a personal connection with the topic is supported by Moustakas (1998) who stated that when discussing the role of the

researcher "the researcher's excitement and curiosity inspires the research. Personal history brings the core of the problem into focus" (p.104).

The term intersubjectivity is a fundamental concept of phenomenology that describes the process of the researcher relating to participants' experience based on the memories of their own similar experience. Giorgi (2006) discusses how the researcher can achieve intersubjectivity by having an understanding of the "cultural, historical, social context in which the participant is embedded both in regards to the interview as well as the data analyses" (p.77). She also states that the researcher should have "some experience of his or her own" that's similar to the participants in order to relate to their experience (p.77).

Participants

The ethnic identity and IPV victimization of the 10 women were based on self-reports. Self-identified Latinas included: Two Hispanic, four Chicana, one Indigenous–Chicana, one Biracial (Hispanic and Canadian) and two Latina. Nine women reported that they had participated in therapy in the past but are no longer receiving mental health services. One participant was currently participating in therapy. All participants were either bilingual or fluent in English.

Women under the age of 18 years were not included in the study. The age range of participants was 22-62 years of age. Women who reported current IPV were excluded in order to maintain the safety of the participant and this researcher. Finally, women who reported a history of suicidal attempts were excluded to avoid the possibility of depression or post-traumatic stress disorder symptoms that might be retriggered as a

result of the interviews. Participants who did not qualify for the study due to

psychological concerns were redirected to their counselor, agency, and a list of IPV

referrals were provided to them.

It is important to note that during the interviews two participants disclosed a prior

suicide attempt. One participant disclosed a suicide attempt when she was a teenager and

had received therapy following the attempt. This participant expressed an interest in

participating in the study despite this incident. She assured me that if she experienced

distress due to the topics discussed she would voluntarily stop the interview. The second

participant reported a suicide attempt during the interview but did not disclose when this

incident had occurred. As described in the procedure section, participants were allowed to

speak without interruption and therefore she was not questioned about this specific

incident. At the end of the interview, the participant was asked whether this incident

impacted her ability to participate in the interview. This participant was currently in

therapy and stated that she would process her reaction if necessary in therapy if she felt

triggered by the discussion. She reassured me that she felt comfortable to proceed with

the second interview. The change in selection criteria was discussed and approved by

IRB.

Measures

Demographic Questionnaire. This measure was developed for the purpose of this

study. The Questionnaire includes demographic variables relevant to the study (Appendix

A). The survey includes 9 questions with information on the following: age, gender,

race, ethnicity, language fluency, ethnic identify, education, employment status, and if

their IPV experience is current or prior to counseling. This questionnaire was used to screen participants for study eligibility.

The Semi-Structured Interview. The interview consisted of questions related to Latina survivors' perceptions of their IPV counseling experience. Questions were then developed or modified continuously depending on the issues disclosed during the interview. These questions served to clarify and explore participants' personal experiences with IPV counseling. Although key constructs were used to guide the interview and the questions asked, the participants served as the expert and were allowed to share their story as they deemed appropriate. Questions were developed with the objective of encouraging the participants to discuss their experience with minimal prompting from the researcher (Smith & Osborn, 2003). An informal rapport was established prior to beginning of the interview. Cultural differences as they relate to colloquial terminology and education were considered when asking questions throughout the interview, therefore the semi-structured interview questions provided in Appendix B served as a general guideline but questions asked were not verbatim.

In order to ensure that questions were not leading and are consistent with the philosophy of phenomenological analysis, consultation with the dissertation advisor and colleagues was sought prior to finalizing the interview questions. This strategy ensured that the questions remain general enough to allow for in-depth discussion and so that the questions were not based on the researcher's assumptions and personal biases.

Although Creswell (2007) recommends several interviews for each participant in a phenomenological study, this study utilized two interviews for each participant in an

effort to minimize the emotional distress for participants. The decision to conduct only one additional interview was made after it became clear that all participants felt compelled to discuss their IPV experience during the initial interview, which was often severe and emotionally charged. Therefore, conducting two interviews was an ethical decision in helping respect the women's right to privacy and mental wellbeing.

Procedures

   Recruitment and Sample. Three different recruitment methods were utilized for participant selection. The first method consisted of contacting local mental health centers and domestic violence shelters for participant referrals. Permission was sought from these centers to recruit participants who are IPV survivors and who had participated in therapy as a result of their IPV experience. Information related to the purpose of this study was discussed with each site, which included either the director or senior staff members. Members for each site were given information about the study including the consent form and contact information for this researcher. Counselors were asked to identify clients that were appropriate for this study and provide those individuals with information regarding the study. The consent form included this researchers' contact information, therefore interested participants were able to contact this researcher directly in order to further discuss the study. Interestingly, none of the participants recruited for this study were identified by mental health centers, directors or senior staff. The second method was through the use of flyers. Flyers describing the study were distributed to several counseling sites and businesses in Denver. Interested participants were asked to call the phone number provided in the flyer in order to screen to ensure that women were at least

18 years old, were not currently in an IPV relationship and were fluent in English. One participant was selected through this method. The final recruitment approach was through the use of snowball sampling which Noy (2008) described as the process in which the researcher "accesses informants through contact information that is provided by other informants" (p.4). Nine of the ten participants were recruited through this method.

Two participants contacted this researcher via private message on Facebook, four by e-mail and four via phone. Interview locations were determined by the participant: 5 were held at the participant's home, 2 at a local coffee shop, 2 at their place of employment and 1 over the phone. Due to the nature of the topic being studied, considerations were made to ensure researcher and participant safety. Interviews were audio recorded for later transcriptions. All interviews and transcriptions were conducted by this researcher.

At the time of the initial meeting, participants were read a description of the study and informed that the focus of the study is about their experience receiving IPV counseling and not their IPV experience. Participants were asked to complete the demographic questionnaire during the initial meeting. Participants were assured confidentiality and that their participation was voluntary. Latina IPV survivors were informed that this study is independent of their counseling program; therefore their refusal to participate in the study would not affect their ability to receive services at the agency.

Participants who qualified for the study and were willing to participate were asked to sign a written consent form. Participants were informed that the study is a three-part

study and that they would be interviewed twice, the first interview would consist of general questions related to their IPV counseling experience, and the second interview would expand on themes revealed during the initial interview. All participants were later contacted via e-mail and were asked to review transcriptions of their interviews in order to authenticate the findings including their section of the dissertation write up. Participants were given the opportunity to validate and offer feedback on the transcriptions and interpretations made by the researcher. One participant asked for clarification regarding her section and changes were made to reflect her intended response. Five participants agreed with the accuracy of the transcriptions and write up and four did not respond.

The interviews were approximately an hour long. The interview protocol began by discussing the purpose of the study. Efforts to build a positive rapport were made by the researcher by becoming more familiar with the participant. Once it was determined that a comfortable rapport had been established, the interview began by asking the participant to "Please describe your experience in receiving IPV counseling". Subsequent questions varied as they were dependent on the responses of each individual participant. At the time of the interview, participants who discussed their IPV experience were not interrupted unless it was deemed that their IPV experience was distracting from the focus of the study. All participants were able and willing to continue with the interview despite their emotional reactions. Three participants became tearful during the interview in reaction to the information discussed. In an effort to reduce anxiety or emotional distress, interviews were momentarily paused so that participants can take deep breathes and

regain composure. Participants were reassured and reminded that they were under no obligation to continue with the interview if they felt it was too emotionally distressing. IPV referrals were provided to these participants and all participants regardless of their reaction to the interview were encouraged to continue therapy.

At the completion of each interview, a date and time was scheduled for the next interview. The second interview consisted of questions related to responses given in the initial interview and the participant was asked to elaborate on various themes that were identified during the initial interview. Similar to the first interview, the participant was given the opportunity to discuss and elaborate on the questions without interruption by the researcher in order to allow the phenomenon to emerge naturally.

Two research assistants were selected to assist with authentication of data. A request for research assistants interested in participating in the data analysis of this study was sent out including this researchers' contact information using the Psychology department list serve at the University of Colorado at Boulder. The two research assistants selected for transcript authentication were in the process of completing an internship at the Psychological Health and Psychiatry department at the University of Colorado at Boulder. Both students graduated from the University of Denver; one post-doctoral male student in clinical psychology and one post-masters male student in social work. They were asked to review transcriptions and the textural descriptions. Identifying information of participants was de-identified in order to ensure participant confidentiality. Research assistants were asked to provide feedback as to whether they

agree with the textural descriptions of the transcriptions. The textural descriptions were

discussed collaboratively with research assistants and a consensus was made.

Data Analysis

All interviews were transcribed by this researcher and analyzed using several

principles of phenomenology. All transcribed interviews were reviewed and coded based

on prominent themes identified for each participant including themes shared by more

than one participant. The process of taking an objective approach in identifying and

coding themes is consistent with phenomenological reduction.

Phenomenological reduction refers to the process in which the objects of the

experience are reduced to the phenomenon or the essence presented (Giorgi, 2009;

Moustakas, 1994). In other words, the information is obtained from the participant

without judging whether in fact the experience occurred. The first step of

phenomenological reduction is by the researcher attempting to gain epoche (Giorgi,

2006). The *epoche* refers to the suspension of judgment or presuppositions by the

researcher. This idea is also referred to as "bracketing" (Creswell, 1998, p. 52). The

researcher is asked to restrain herself from having any agenda and allows the participant

to discuss what she chooses to, thus permitting themes to emerge on their own. Epoche

requires that the interviewer allow participants to express themselves freely and requires

that the researcher not impose her own values on the participant (Giorgi, 2006). As such,

each response given by the participant was given the same value referred to by

Moustakas (1994) as horizonalization. Horizonalization occurs when the "condition of

the phenomenon" is ascribed a "distinctive characteristics" by linking them to specific

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statements. (p. 97) this means that each statement related to the phenomenon will be described using specific characteristics which will later be organized in clusters. Horizonalization was achieved by reviewing all transcriptions and selecting statements that contained vivid descriptions of their experience both emotional and physical. These statements were identified as prominent invariant qualities or dynamics and contain descriptions that allow for a better understanding of the participant's experience. The next step in phenomenological reduction is transforming the horizons into "clusters of meanings expressed in psychological and phenomenological concepts" (Creswell, 1998, p. 55).

Imaginative Variation

The next step in phenomenological reduction is imaginative variation which describes the process used to develop multiple descriptions of the data obtained or imagining several possibilities of meanings associated with the particular phenomenon (Giorgi, 2006). Moustakas (1994) postulates that "the aim is to arrive at a structural description of an experience, the underlying, and precipitating factors that account for what is being experienced" (p. 98). This process requires that the phenomenon be described from various perspectives. Imaginative variation "enables the researcher to derive structural themes from the textural descriptions that have been obtained through phenomenological reduction" (Moustakas, 1994, p. 99)

The final step in phenomenological data analysis is synthesizing meanings into a "unified statement of the essences of the experience of the phenomenon as a whole" (Moustaks, 1994, p. 100). Synthesis of meaning is achieved by grouping or combining

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structural and textural descriptions with similar themes. The underlying meaning or essence is extracted from descriptions.

Imaginative variation was achieved by imagining different meanings and possible perspectives of the statements identified through horizonalization; identifying the context in which these statements were made. The textural meanings assigned to these statements were used to develop themes. Once themes were identified, all transcriptions were reviewed and coded in order to determine occurrence for each theme for each participant.

Textural descriptions were developed by integrating the invariant qualities and cluster of themes which include verbatim examples from the transcriptions. Textural descriptions were later used in developing structural descriptions "the themes and qualities that account for *how* feelings and thought" relate to the phenomenon (Moustakas, 1994, p.135).

Quality and Trustworthiness

Validity and reliability of research as applied in quantitative research differs vastly for qualitative and has been one of the central criticisms of qualitative research (Smith, 2003). Qualitative research does not aim to generalize to the population as a whole but rather to draw detailed data in order to better understand and gain insight into a particular issue (Creswell, 2007). An effective method of validating data as suggested by Moustakas (1994) is to request each participant to review the transcripts and ask that corrections be made.

Authentication is defined as the process in which the participants' account is represented accurately in the results obtained (Gillum, 2008). Validation was achieved

after transcriptions and interpretations were reviewed by participants requesting them make corrections if necessary so that the interpretations accurately reflect their responses. Participant feedback was considered when finalizing the findings and discussion chapters. Transcriptions and descriptions of the structures were given to two research assistants to review in order to ensure reliability.

Summary

A qualitative study using a phenomenological methodology was selected for this study in order to explore the phenomenon or essence of the experience Latina survivors have in receiving counseling for IPV. The rationale for selecting a qualitative methodology and phenomenology was discussed. Methods of conducting the research, selection of participants, and procedure were included in this chapter. Data were obtained using the demographic questionnaire and semi-structured interviews. Data analysis included obtaining epoche, horizonalization, developing clusters, creating textural and structural descriptions. The finals step in data analysis was achieved by synthesizing the textural and structural descriptions to create the essence of the phenomenon. This chapter is concluded with a discussion of quality and trustworthiness of the study.

CHAPTER IV

Results

The essence of the phenomenon related to cultural and IPV competence of

clinicians was the purpose of this study. This chapter is divided into four sections. The

first section provides descriptions of *epoche* which describes how personal assumptions

and opinions were bracketed from data analysis. The second section provides

demographic information and descriptions of the interview for each participant. The third

section outlines the findings of the study in the form of textural and structural

descriptions of participants perceptions related to their clinicians' IPV and cultural

competence. The fourth section provides a synthesis of the structural and textural

descriptions in order to present a comprehensive understanding of the participants

experience in therapy and their perceptions of their therapists' IPV and Cultural

competencies. The final section provides a description of common themes including

contextual themes that emerged from the interviews. The contextual themes are not

specific to participant perceptions of clinician IPV and cultural competence, yet are

significant in understanding the cultural variables that influence participants' perceptions

regarding their therapists as well as their motivation to participate in therapy.

Textural descriptions refer to *what* the phenomenon is and include participants'

thoughts and feelings related to the experience "Qualities are recognized and described;

every perception is granted equal value, non-repetitive constituents of the experience are linked thematically, and a full description is derived" (Moustakas 1994, p 96). . The participants' structural descriptions offer "vivid accounts of the underlying dynamics of the experience" (Moustakas 1994, p 135). In this section the qualities and feelings associated with how the experience of cultural and IPV competence were experienced by the participant is described.

The analysis of participant interviews yielded vital and descriptive data related to the participants' experience in session with their therapists. Cultural influences informing their perception of competence are provided and discussed. Aside from obtaining specific examples of effective interventions in working with IPV survivors, themes across participants accentuated the complexities Latina IPV survivors face prior to seeking therapy.

Epoche

The first step in "Phenomenological Reduction" according to (Moustakes, 1994) is for the researcher to attempt to gain epoche, which refers to the suspension of judgment and assumptions in order to allow participants to express themselves freely. As an "Insider Researcher" and one who shares many of the experiences participants disclosed, this task was more challenging than what was anticipated. My training as a licensed therapist, made it particularly difficult to restrain the urge to project my opinions about the cultural competence and IPV knowledge of their therapists based on their descriptions of their therapists. Many of the participants disclosed limited exposure to therapy;

therefore at times, they perceived their therapist as competent despite the numerous discriminatory and insensitive comments made in session.

In an effort to bracket my personal feelings and presumptions, notes were made after each interview, describing my experience, assumptions and reaction to each interview and participant. Suspending judgment was particularly important as I began synthesizing the data in order to ensure that I was accurately capturing the participants' experience and not interjecting my own thoughts and ideas. Conscious efforts were made in conceptualizing participants' experience without imposing my own assumptions and perspective.

Consultation from a licensed psychologist was sought regarding my experience and reaction to the stories disclosed during the interviews. This psychologist served as my clinical supervisor during internship. Supervision and consultation was not only helpful in encouraging self-reflection but also in processing the shocking and often emotionally overwhelming details disclosed in the interviews. Participant identifying information was never disclosed during supervision in order to maintain participant confidentiality. Most discussions in supervision focused on issues of my countertransference and my impulse to want to disclose concerns regarding the participants' therapists' competency in providing therapy.

Description of the Participants

The tremendous effort involved in obtaining participants for this study was unanticipated. Some women who responded to the participant search who disclosed experiencing IPV but never sought therapy were unable to participate in this study

because they did not meet criteria. One respondent was in a same sex relationship and was unwilling to be audio-taped. Another woman responded seeking monetary compensation for her participation in the study because she and her husband were struggling financially. This respondent was referred to her county's mental health services. A total of ten Latina survivors of IPV participated in this study. Below is a table summarizing the demographics of the participants. The names of all participants were changed in order to protect their privacy, they were given pseudonyms listed in alphabetical order which correlate to the order in which they were interviewed.

Table 1
Participant Demographics

Name	Age	Education	Ethnicity
Ana	52	PhD	Indigenous Chicana
Beatrice	26	In college	Chicana
Carla	46	13 +	Latina
Delores	62	MSW	Chicana
Elena	47	GED	Chicana
Felicia	22	1st semester	Latina
Gloria	44	BA & BSN	Hispanic
Helen	26	In college	Biracial (Mexican and Canadian)
Indra	31	H.S.	Latina
Josephina	46	In college	Hispanic

A broad spectrum in responses was given by participants in regards to their motivation to participate in therapy, number of visits and the type of counseling received

was discussed by participants. Despite the range of responses, themes regarding cultural beliefs, therapists' accepting and rejecting behaviors in session and emotions experienced prior to therapy emerged as a shared experience between participants. The participants' experience and perceptions presented in this chapter are provided using verbatim examples to accurately reflect the interaction and experience from the participants' point of view. These responses include environmental factors, emotional experience and specific interventions used in therapy using textural and structural descriptions. The demographic information was obtained from the Demographic Questionnaire and the interviews. For some participants, details regarding their occupation or community involvement were either intentionally omitted or described obscurely to protect their privacy.

Ana

Ana was my first interview and referred to me by a local indigenous therapist/ professor. I initially met Ana at a Temazcalli (an indigenous sweat lodge ceremony). Ana's contact information was given to me and an e-mail. I sent her an e-mail asking if I could consult with her regarding a cultural diversity project I was involved in. During the initial meeting, I mentioned this research study and requested potential referrals for participants; she unexpectedly admitted a history of IPV and volunteered to participate. We met at her home in downtown Denver. Her home was decorated with indigenous art and smelled of pinto beans boiling on the stove. She was immediately welcoming and offered me something to drink and eat. She sat across from me at her breakfast bar covered by a colorful serape (blanket). Colorful tiles peaked out from under the blanket

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where the counter met the stove. I explained the purpose of the study and asked her to sign the demographic questionnaire and the consent form. She stated that she was happy to share her story to help other women and was eager to begin. I turned the tape recorder on and began asking questions. Ana was enthusiastic and candid about her experience in therapy. Given that her experience was positive, she had much to say about the impact her therapist had on her ability to overcome the history of abuse endured. Ana was much more forthcoming in the second interview in that she offered descriptive details about her childhood and early exposure to violence.

Ana is a 52 year old self-identified Indigenous-Chicana with a PhD. She describes herself as a feminist actively involved in social justice issues facing the Chicano community. Ana was referred to her therapist by a close friend who had also experienced IPV and was familiar with the therapist's area of expertise. Ana had been out of the relationship for several years and discussed the motivation to seek therapy. She discussed gaining awareness of negative behavioral patterns in her relationships after leaving her abusive partner. Ana's therapist processed the trauma disclosed using various interventions such as collage, drawing, photography, and journaling.

> I hit a gold mine with this woman... I didn't like the idea of drawing at the beginning. I was like why draw, I don't know how to draw, I don't want to do this because I don't know how and she says … well it's okay, she says you want to color and I says no, I don't want to draw, I don't want to color. She said, whatever comes to mind, she said you know, whatever.

> So I met this woman – Chicana (therapist) and at first she wanted to meet with me twice a week and I told her she would kill me emotionally, but I met with her once a week for a year.

Ana described her emotions associated with therapy both prior and after. She initially described a reluctance to be open. She also discussed the cultural and personal stigma related to participating in therapy.

> It's for people that are psychotic, like it's not really something you do just because, you know, you might be feeling a little depressed or you might need somebody to talk to. It's still something that's thought of as for people who are crazy.

Despite Ana's reluctance to disclose personal information in therapy, she had a preconceived impression of her therapist's credibility because of the strong recommendation from her peer. Ana had researched her therapist's credentials and knew she was from a city known for its high concentration of Hispanic residents. Familiarity with this community offered more than just affirmation about the therapist's cultural awareness but also her therapists' awareness of oppression experienced by marginalized groups.

> She was a little thing, a Chicana, she was from East LA, and when I knew she was from East LA I thought (laughing) home girl, she's not going to fuck around, she's going to make me work.

> You could tell she was Chicana as soon as you walked into the room.

Ana acknowledged the positive impact her therapist had on her and her personal development throughout the interview. Ana felt that her therapist was emotionally invested in her and genuinely wanted her to overcome the residual effects of the trauma she experienced beginning in childhood.

> She cared for me; she was going to make sure that I was going to be okay….she listened, really listened not just as a therapist but as a human being. And the thing is, what I liked about her is that she never cried with me cause her crying with me would have been like, oh man……come on…Come on I need you to be the anchor, she never did, but I could tell just by the look in her eyes, that she

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had been there, you know what I mean? She had been to all those places that I had been taking about.

This sense of relating to Ana's story was especially powerful for Ana in that she was assured she did not have to justify her behavior or decisions as a result of her traumatic experiences; her therapist understood these dynamics first hand. Similarly, her therapist understood the cultural, environmental and socio-political issues Latino's endure which was essential for Ana. Ana's social activism and awareness of critical race issues informed her perception of her therapists' cultural competence. Ana was asked whether she would work with Caucasian therapists:

> Their white privilege I think many times, it hinders them from understanding you know, critical race and racism in society.
>
> White therapists, it's that they have to really understand how White privilege operates in this society and unfortunately it operates you know at the deepest levels of all humanity and the way we communicate……I wouldn't go to another White woman because you know, that's where for me, it seems to be the root where real differences begin to emerge, it's the whole notion of White privilege, privilege and power and it has to be negotiated, it has to be interrogated and it has to be engaged - critically engaged.
>
> I think it is possible, it takes a lot of work, you know. It's work that a lot of people haven't engaged in. I think it takes really being in the community you know, not having an office in Cherry Creek and expect somebody from my background to go over somebody who's in the community and knows the community and I think that they can. They have to feel, the spirit of those people and they can't do it, self- removed. You know, that probably goes for anyone but in general, you know if you grow up in a Chicano or Latino culture

Ana remarked that Caucasian therapists can be effective in working with diverse populations but they must immerse themselves in the community for a particular ethnic group in order to fully appreciate the cultural nuances and linguistic differences.

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Beatrice

Beatrice was my second interview and took place in her home. Beatrice is a single mother working full-time while attending college. We sat on the couch adjacent to each other. We began the interview to the tick tick sound of the baby swing rocking in the background as her 4 month old child lay sleeping. After reading and signing both consent and demographic questionnaire, Beatrice stated she was ready. Soon after beginning the interview it was apparent that she was somewhat anxious or guarded as evident by the brief responses given.

Beatrice is 26 years old who explained that her mother is Hispanic and her father White, although she identifies ethnically as Chicana. Beatrice completed a year of college before pursuing a nursing degree. Beatrice was referred to me by a mutual friend who is a therapist. Beatrice contacted me expressing an interest in participating in the study. A description of the study was discussed over the phone and her level of reservation was assessed given that we had a shared friend. Beatrice was reassured that all information would be kept confidential and that her willingness to participate in the study would not be disclosed. Beatrice denied any concerns and was eager to participate in this study. The first question asked was "could you tell me first what made you decide to go to counseling"? Beatrice whispered if it was okay to say that she was court-ordered, to which I replied, "it's okay to be completely honest". Beatrice had a negative experience in therapy and was forthright about her emotional reaction in session.

> I felt mostly like she was trying to acknowledge what I had done, and what part I had played. To accept responsibility for that but we didn't really go into why it happened or what lead me to that point or anything like that.

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Beatrice commented on the lack of empathy she experienced in session with her therapist. She reports feeling judged, criticized and blamed for being in an abusive relationship and for the behavior that ultimately led her to be court ordered for domestic violence counseling. This interaction and experience led Beatrice to feel as though her therapist was not competent in providing IPV counseling. She stated she was aware of her responsibility in how she responded to the abuse but felt that a thorough assessment of the situation was not done in order to accurately conceptualize the situation and the relationship. The fact that she was required to participate in domestic violence treatment, despite the abuse she had endured by her partner, was infuriating. Beatrice acknowledged the possibility that the circumstances that ultimately led to her experience in therapy may have negatively impacted her perception of her therapists' IPV and cultural competence.

Beatrice was a Chicano Studies major prior to choosing to pursue a nursing degree. Similar to Ana, her understanding of oppression and the importance culture plays in identity development, allowed her to have a more accurate gauge for what constitutes cultural competence.

> [Researcher] – Was she culturally competent?
> [Participant] – Oh no. No (laughs)
> [Researcher] – Why do you feel that?
> [Participant] – Um, cuz that was never brought up. Cuz a lot of the girls in the group sessions were minorities….. That was never addressed like you know, what did you grow up like, where do you come from or let's talk about family relationships or how that may influence your decisions at all.

Beatrice was adamant that an ethnic match is not necessary for a positive therapeutic interaction. She explained that her exposure to "good" therapists of all ethnic backgrounds has allowed her to embrace the potential for positive therapeutic outcomes

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despite therapists' ethnicity. However, awareness of cultural nuances that influence behavior and perception were qualities she believed to be necessary when working with other ethnic groups.

> I think it's important to acknowledge cultural differences. I think it's very important because what you're exposed to and the differences between cultures they can be vast, they can be diversified but they can also be very exacting. It's important to acknowledge that, because it might not be exactly like me

Beatrice had not been to therapy prior or after, therefore her personal experience in therapy was limited. Given her career choice and her current employment, she has developed relationships with numerous therapists who have provides counsel and advice as needed.

Carla

Carla was my third interview and she obtained my contact information from a flyer posted at a community center for women. Carla initially emailed me asking for information regarding the study. Although we exchanged phone numbers, she only communicated via e-mail. She asked to meet at a Denver based community center for Latinas. We met in one of the group rooms where events are typically held. The art and décor reflected the population it served. Immediately entering the center there is a tlalmanalli (altar) displaying candles, and other personal and spiritual objects. We sat facing each other on a couch. The spaciousness of the room made it somewhat awkward but Carla reassured me that she was comfortable.

Carla is 46 years old, self-identified Chicana who stated she has over 13 years academic training. She currently leads therapy groups for Latina women and has been

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doing so for several years. Carla was the only participant who had worked with a

therapist specializing in "energy work". She stated that she had experienced an increase

in irritability and discovered that she was struggling to manage her anger years after the

IPV relationship. Her desire to provide a healthy environment for her children was the

impetus to seeking therapy.

Carla found her therapist when she was looking to rent a room and came across a

therapist advertising a room for rent. Soon after meeting this woman, the therapist

commented to Carla "you're not in your heart". The honesty of this comment stunned

Carla which motivated her to ask the woman if she would be willing to provide

individual therapy to her. Carla's experience with her therapist was profound in her

ability to overcome many of the emotional burdens she assumed. However, Carla

believes that her therapist was a "vessel" and that the work "just happened", alluding to a

spiritual process that occurred rather than adhering to a treatment plan for Carla. Carla

made it a point to mention her aversion to "talk therapy" and believes that many people

do not benefit from traditional talk therapy.

> What I was looking for, was somebody who was understanding, nonjudgmental,
> not asking a lot of questions. I didn't want a psychologist… I'm such a private
> person that I don't want people to know what I've been through. I was always the
> person that held the cross and kept it to myself no matter how heavy it was. I
> didn't want people to know about it, embarrassment. I mean, the way we were
> brought up, you never talk about your problems.

During the second interview, Carla was much more guarded about her experience

and spoke in the third person when answering questions. She answered questions by

discussing other survivors of IPV and their experience rather than disclosing her own

perceptions or feelings. This reluctance and demeanor may either reflect her discomfort

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in disclosing personal information or possibly an indication that a rapport had not been effectively established prior to the initial interview.

Carla disclosed the cultural values and experiences that had shaped her identity during the initial interview. She stated she had actively participated in the "Movement" referring to the civil rights movement in Colorado. Despite her personal knowledge and beliefs about oppressed groups, she was open to participating in therapy with a non-Latina therapist. However, in describing her therapist, it became apparent that the therapist's exposure to "Hispanics" provided credibility to the therapist's abilities to appreciate Carla's world view.

> She lived in a very small town that was 90% Hispanic and she was like the only huerita (laughs). She was from a small town so she understood a lot of things about culture and stuff.

Therapists' patience and practice of allowing clients to gradually process their IPV experience in their own time, is a common quality shared by most participants to developing trust and rapport. This attribute was particularly important for Carla, because of her averseness to expressing vulnerability with others.

> You'd walk in there and she was a bundle of love. You would feel the intensity of the compassion, concern and sometimes like I said, she wouldn't push you to talk. Sometimes I just needed to lie down on the table and just have somebody touch me, just do the energy work. And as she would do that energy work, you could just feel that love and I would just bawl, cuz of that release, I just needed that release and at that time….touch is so important for any abused person because they're so used to being hit that when you have somebody touch you with love and compassion it's just you know, you just let it all out.

Carla disclosed that she was especially impressed with the fact that the therapist was willing to challenge her beliefs despite eliciting a negative reaction from Carla. The

experience of being challenged in this way was uncommon for Carla but necessary. Carla

was able to connect with her therapist immediately because her therapist challenged her

beliefs, specifically about her culture and her defenses, which allowed Carla to feel as

though her therapist was able to fully recognize who she was and what she was

experiencing.

> She was always like; you're so much in your head. You're a phony, she would
> call me a phony….I wasn't in my heart…I wanted to fight her so that's oh that's
> how I met her…I wasn't in my heart and I needed to get into my heart if I wanted
> to get into this work and that triggered me and when she said that I knew that she
> knew. She saw straight through me, because that was the only person that ever
> saw straight through me and I was like oh, this girl can help me. So that's how we
> met, by her insulting me and it was good.

> Similar to all the other participants, Carla expressed the importance in therapists'

gaining skills and knowledge in cultural differences and the impact on identity

development. Interestingly, she did not feel that she would have been able to benefit from

a Latina therapist more than she had with her therapist. The fact that her therapist offered

a different cultural perspective was found to be effective in challenging strongly held

beliefs.

> Because she wasn't a person of color, she was able to challenge me, not challenge
> me but challenge my beliefs and maybe not challenge me but made me think
> about it and maybe see it from a different light.

Delores

Delores had been referred to me by a psychologist in Denver who had been

contacted to discuss this study and to request referrals for participants. Delores contacted

me via e-mail disclosing that she was an IPV survivor and had received therapy years

ago. Information about the study, exclusionary criteria and my phone number were e-

mailed to Delores. Delores requested to meet at her home in Denver. Her home smelled of candles and instrumental music played in the background. She immediately offered me coffee, tea or Chai, which I obliged. After we spent approximately 15 minutes of getting to know each other, she began disclosing the impact her IPV relationship had and continues to have on her life.

The lingering impact of her IPV relationship was unavoidable during the interview. She disclosed that she was currently unemployed due to physical disability. She revealed her ex-husband broke her back during the last incident of violence which was approximately 12 years ago. Delores continues to experience chronic back pain and was forced to receive monthly injections to manage the pain. Unfortunately, due to her insurance limitations, she is no longer able to receive this procedure.

She talked from the kitchen while making us tea. At one point I reminded her that interview had to be audio-recorded so that she wouldn't have to repeat the information. She served us tea, sat down and continued the discussion she began in the kitchen while signing the consent and demographic questionnaire.

Delores is 62 years old who identifies as Chicana with her MSW and has led group therapy for women infected with HIV. Her home had various indigenous art but the primary art displayed were pictures of her children and grandchildren who she discussed with great reverence. Delores stated that she had seen two other therapists prior to the one described in this study. The first therapist was a Caucasian female and after four sessions she discontinued therapy due to lack of rapport. She was referred to a Caucasian male psychiatrist who recommended medication, which she found to be

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offensive. Finally after pleading with her insurance representative to find a therapist of

color, she was referred to a Latino she found to be extremely supportive. Though,

initially reluctant to see a male therapist, she agreed.

> After him and I started talking…because he asked me, how do you feel about me
> being a man? I said, I know I might not like it but you know I'll be open to it.…
> So yeah, because he asked me what I think, just asking that one question on his
> behalf was more meaningful and gave me a lot more trust in that.

Delores's therapist was able to establish a rapport because he disclosed his

awareness of gender roles prevalent in Latino families. He was able to validate her

experience and challenge the cultural norms she had internalized. His familiarity with

IPV dynamics and generational transmission of dysfunctional patterns within many

Latino families served as credibility and allowed Delores to be open to ideas or

interventions proposed in session.

> He was very helpful, it was quite a difference and it didn't matter if he was a male
> or a female, but that he had an understanding about what I was going through,
> feeling, and he let me.

Delores stated that she would not have chosen a male therapist if given the option,

but was glad for the opportunity to work with this therapist. She stated she experienced a

cognitive dissonance regarding traditional gender roles of Latinos through her work with

him. She commented that she would not have been able conceptualize Latino men as

supportive and empathic without the guidance of her therapist. Not only did he condemn

violence in relationships, he expressed empathy and validation, which she had never

experienced by anyone, including members of her family.

> It showed me that even though he was a male and I already had that perceived
> idea that they had privilege that he went and made it very clear that, I'm going to
> listen to what you have to say whether I am a man or whoever. I'm here to listen

to you. It's your story, you tell me how I can be helpful to you and even though he was a man, it was almost as if he told me don't be scared (she sobbed) and I wasn't and I could have been, I know I could have been….he would let me cry. You know, whatever I needed to do and he was okay with it.

Delores was asked if she could provide specific examples of interventions or behaviors that influenced her perception of the competence for the first two therapists. As Delores described her experience and the interaction with these clinicians, it became apparent that their lack of cultural competence and lack of awareness regarding IPV relationships were the reasons a positive rapport was not established.

It was very hard for me to identify with her because, first of all she was….I don't think she understood the complexity of my cultural background….

She didn't do a very good job of doing an assessment that really tried to understand where I was coming from.

I did see a psychiatrist too and he was Caucasian and he was just as horrible because I immediately felt…I don't know if you understand this but when people are racist or have their own biases sometimes it's their attitude, their presentation, it's the way that they talk to you, I knew immediately that it was there and so I shut down with him.

Not acknowledging the fact that I have my own skills and my own experiences my own information and she could help dispel them if they were distorted but she never ever gave me that collaboration.

In this interview Delores spent significant time discussing in detail the experiences she had as a child and in her family. She disclosed that she had witnessed the devastating effects of violence by her father towards her mother. She also discussed other forms of abuse as a child and was given explicit messages of maintaining family matters confidential. The importance of mentioning these details is to illustrate the difficulty Delores had in simply identifying the relationship as abusive. Going to therapy

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not only challenged cultural norms for Delores but also illuminated the pervasiveness of abuse in her family.

Delores' interview was heart wrenching given the severity of abuse both she and her mother endured. Delores was given referrals to other therapists at the end of our interview when she indicated an interest in continuing therapy. Her insurance only covers six sessions and could no longer afford individual therapy.

Elena

Elena's name and contact number were given to me by a Delores who had discussed the study with Elena. Elena was contacted via phone and a date and time were scheduled for the initial interview. The interview took place at Elena's home in Denver. Her home was minimally decorated but comfortable and inviting. Soon after I arrived, her boyfriend went to the bedroom in order to provide privacy to both Elena and myself. Elena signed the consent and demographic questionnaire.

Elena is 47 years old and has her GED. Elena had contracted HIV from her abusive ex-husband and was referred to group therapy for women living with HIV. She stated that the group leaders were African American and Caucasian (separate groups). She had a negative experience with both these group leaders explaining it was due to lack of cultural sensitivity for the Hispanic women in group. She disclosed that one of the group leaders introduced herself as Doctor which immediately set a hierarchy for the group. Elena had a strong reaction to the experience of a power differential between therapist and clients. Elena had seen two therapists; the initial therapist was Caucasian and did not have a positive experience with citing that it felt too formal. When Elena was

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asked about the formality of the interaction with her first therapist, she discussed the awkwardness of shaking her therapist's hand. She explained that as a Chicana, hugs are a common form of expression in both affection and greeting while hand shaking, was usually associated with a business interaction. She stated that she would have preferred the therapist to not extend her hand at all. Elena's second therapist was Latina and described as a blessing. She saw this therapist for approximately three years.

Elena was candid about her reluctance to participate in therapy. She discussed the stigma associated with therapy and in particular the condemnation of therapy in her family. The term "mental" is a colloquial term among Chicanos that refers to someone who is crazy. She discussed the reaction she had when she was referred to a mental health therapist.

> It was really weird because they kept saying that it was a mental health therapist that was going to talk to me about my mental health and I kept thinking I'm not crazy, I'm not crazy, I don't need to see anybody, I'm not mental.

> You're already being told that you're a crazy bitch, you're stupid and this and this you know what I mean. By their partner or who ever being abusive to them and now I'm supposed to go to someplace where they're really going to say I'm mental. Now I'm gonna be a piece of paper in a file saying that I'm mental.

Elena described herself as a private person who has learned to keep personal matters to herself including from her family. The primary quality which allowed Elena to build trust and allow for vulnerability in session, was that Elena was encouraged to disclose emotionally charged issues at her own pace. Elena commented that her therapist allowed her to speak and engage in ways that were authentic for Elena. This experience

was a theme described by all participants who had a positive experience with their therapist.

> She was like a cousin. She didn't jump in right away and start asking me well does he hit you, you know. She was like tell me about your childhood, tell me about how you grew up and you know the more that I was able to talk about who I was the more I started to see that I was living in that. For me it was really empowering that she gave me the opportunity to live, I mean to visualize how I was living.

The experience of seeing her therapist as a friend and not a doctor was another attribute that was common for four of the participants. Elena described her therapist as having an emotional investment in her progress. This collaborative and personal interaction allowed Elena to understand her self-worth. Several of the participants, including Elena, discussed feeling dismissed and judged by other therapists. This behavior was described as the therapist acting as though she was "better than" the client. Elena described how this hierarchy perpetuates the abusive relationship she had been in. The central behaviors that expressed hierarchy were therapists' formality, note-taking and the disregard in a rapport prior to delving into personal issues.

> She wasn't overpowering you know like sometimes you go to the doctor.

> She didn't introduce herself as Dr. so and so, she was like my name is Michelle and you know, let me tell you a little bit about who I am and where I'm from you know. She talked about her grandma and remedies so I had that connection like she is like me but she has a little bit more education and understanding

> She wasn't like a counselor you know, when I talk to somebody I go ah you know Michelle and they go, oh your friend and I'm like no she's not my friend, we're not friends she's my counselor and they go well, you talk about her like she's your friend

> When I talked to her and I'd start to cry, I would look for the tissue and she said what are you looking for and I said well aren't you gonna give me Kleenex and

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she's like why? Do you need it? And I'm like I need to cry and she said well then cry. And I'd come out of there 50 lbs. lighter

Non-traditional therapeutic interventions were described as powerful methods of healing by four of the participants. The participants who opposed medications, found these interventions appealing. For Latinos many of these alternative interventions are familiar and consistent with their traditions. Elena stated she was introduced to "teas" and "oils" by her therapist as a means of managing symptoms of anxiety and depression.

Elena described the environmental factors that contributed to her feeling welcomed and comfortable. Staff and décor that reflected her culture and heritage were described as elements that allowed Elena to know that she was among people who could relate to her, at least culturally.

> [Participant] - The people were like Hi how are you? And they were like very welcoming. It was like a very welcoming place so as soon you walked in the door you felt like…
> [Researcher] – Welcomed
> [Participant] – Welcomed and there was cultural stuff on the walls and maybe that's why I felt so comfortable
> [Researcher] – Do you remember what was on the walls?
> [Participant] – They had some pictures like uh you know like uh, my mom used to have, like a shadow box with little knick knacks and stuff like that. They had like a picture like a cultural picture, like a picture that looked like a Latina. And in her office it was like very uh I could smell the, she would burn Sage and incense and stuff like that and so that was very soothing to me. I felt like this is where I was supposed to be

Elena's relationship with her therapist was life changing. She discussed the value in a therapist's willingness to self-disclose their experience of IPV to relate to the client. Elena remarked that anyone could be effective in providing therapy with Latina survivors of IPV but understanding the values related to family, secrecy and prevalence of physical

abuse within communities of color were necessary skills for a therapist prior to working with this population.

Felicia

Felicia contacted me via e-mail after her professor sent an e-mail to her students regarding this study, which included my contact information. Felicia e-mailed me and disclosed that she had been in an abusive relationship for 6 years beginning in high school and had participated in therapy a year after ending the relationship. She requested more information about the study including the exclusionary criteria. We e-mailed each other for several weeks in an attempt to set an interview date. Several options were given to Felicia in terms of locations to meet. She chose to meet at a coffee shop downtown Denver. She was asked whether she preferred to sit outside given the noise level and lack of privacy. Felicia expressed her comfort in remaining inside. I had already been waiting when she arrived. She approached me with coffee in hand asking if I was Dellena. Felicia seemed energetic and excited to share her story. She was asked once again if she felt comfortable talking in close proximity of others, to which she replied yes.

Felicia is 22 years old and in her first semester of college. She denied a history of psychotherapy and stated her only experience was with one therapist. Felicia stated she had observed patterns of behaviors attributed to her IPV relationship which were impacting her current relationship. These patterns were the motivation that Felicia to seek help. When she finally made the decision to participate in therapy, she specifically searched IPV counseling centers on the internet. She chose a battered women's shelter that offered individual therapy on a sliding scale. Her therapist was a Caucasian intern

who she saw once a week for 4 months. Despite the several examples Felicia provided

regarding the lack of cultural and IPV competence of her therapist, she describes the

overall experience of therapy as positive.

> A lot of the times she would go and ask, like one of the licensed counselors
> outside that was there for advice. Like she would say, excuse me while I step
> outside real fast and then come back in um, so that was kind of awkward but (she
> laughs). So that's kind of the part I knew, that she was very limited in her
> experience and that she was new to the whole thing.

> I think in the beginning she really helped me understand those feelings and really
> validate why I did the things that I did.

Given that Felicia's experience in therapy was limited she was unable to provide

specific examples illustrating effective interventions utilized in therapy. However, she

was able to provide qualities and attributes of therapists that she would seek out in the

future. Felicia stated she would prefer a therapist who is Latina and who could

understand the experience of being in an IPV relationship. Felicia commented that she

would appreciate therapists' self-disclosure regarding their IPV experience in that it

would help establish trust.

> Like I always think, to me like, Hispanic culture, there's so much about their
> family and their so much about their pride, and the hard work and dedication, it's
> like, you know, I just felt. I don't know I guess if someone can understand the
> same thing they can help me understand…because they come from the same kind
> of background that I came from.

Felicia had been hospitalized as a result of the abuse she experienced by her ex-

partner. She was one of two participants who had not been exposed to violence within her

family. Felicia stated if the hospitalization had not occurred, her family would have never

known about the abuse. A report was filed against her partner by the police after the

police were notified by the admitting hospital. Felicia was notified that a report had been

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made, although she does not recall receiving any counseling referrals or the protocol in resolving the assault charge in court. Not until a little over a year later did she begin looking into resources herself.

Gloria

Gloria volunteered to participate in the study after hearing a conversation between myself and another clinician. Gloria works at the site where I was describing my study in in an effort to recruit participants through referrals. Gloria stated that her IPV relationship and counseling experience was many years ago but was willing to offer what she remembered. We met privately down the hall in an office to schedule a date and time for the interview. About a week later we met in a small office at this facility to conduct the interview. Gloria was pleasant and engaging but also appeared anxious about the interview.

Gloria is 44 years old. She obtained her nursing degree and has worked in several psychiatric and medical facilities. Gloria stated she had seen many different therapists throughout the years and the therapist that she saw specifically for her IPV relationship was through a health center. She stated her ex-partner was an IV heroin user and therefore she went to this health center in order to be tested for STD's. She stated she had met with one of the counselor's and during the intake, had disclosed her IPV relationship. After describing the abuse she had endured, the intake counselor offered to provide individual therapy. Gloria stated her therapist was a Caucasian male and although he wasn't culturally competent and minimally competent in providing IPV counseling, she found him to be helpful.

I don't think he really understood my culture very well but I think he tried the best that he could. I think that he saw after a while that it had a component, a definite component and he tried to understand it as best he could do.

Well I, I was very angry because he challenged me on a lot of my beliefs… and I swore every time that I wasn't going to go see him again.

I think I needed to be challenged.

I felt he was very empathetic, which was one reason I kept going back.

Gloria could not identify any specific interventions that were particularly effective but articulated the feelings she experienced in being validated and supported. Despite the lack of cultural and IPV competence demonstrated by the therapist in session, Gloria was able to connect with him because she perceived him as invested in helping her process her IPV experience in order to resolve issues related to this experience. She perceived her therapist as caring and felt cared for by him.

He was very caring and he did tell me things like I know this is hard for you and I know that I challenge you but I feel like you're worth it he gave me a sense of worth, that he thought there was something in me that I could be developed, that I could be happy. So he kind of tapped into my goal and it really gave me a sense of you know, I don't know, it really touched me.

Gloria identifies as Hispanic but during the interview commented that she does not fit the typical stereotype of a Latina because her parents were educated and because she is light-skinned.

Because I am very light skinned and everything, I don't have an accent or anything, I felt kind of alienated from my culture number one, because they were always like, you're so white, you could pass.

I think an ethnic match would certainly help because even though I wasn't really that ethnic, you know I still came from that background, my parents came from that background and I think it would have been a lot more helpful

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I came from that background and the women's views about how things are. So I think it would have been helpful if somebody had been understanding of that you know.

In spite of her description of her father as a "Macho Mexicano" and her early exposure to violence, Gloria's ability to "pass" defined her ethnic identity and negated all other cultural factors that are associated with Latino culture. Gloria's internal struggle with her self-identity impacts her willingness to seek mental health therapy from a Latina therapist even though that is her preference.

But I wonder how it would have been if I had had a person of color or something maybe I stayed away from it because I thought, I felt alienated and I felt like I wouldn't be understood.

At the end of the interview, when asked about her overall experience, Gloria experienced therapy as helpful particularly during that time in her life. She commented that she might have been able to get more out of therapy, if she were more honest with her therapist. She was asked about her reluctance to be open in therapy, which she responded by saying, she still held the belief that she "deserved" the abuse and feared judgment by her therapist.

Helen

Helen was referred by a colleague who posted a search for participants over Facebook. Helen responded to the post via internal message to my colleague and was given my contact information. Helen responded via internal message on my Facebook. We exchanged phone numbers and e-mails with a plan to schedule an interview as soon as possible. Helen is originally from Denver but is now living in Kentucky. She expressed an interest in participating but was unsure when she would return home to visit

family. After several weeks we decided to do a phone interview. Helen expressed a comfort in discussing her counseling experience via a phone interview. We decided to proceed with the interview, aware, that if the phone interview impacted Helen's responses, this interview may be omitted and a face-to-face interview would be scheduled. After deciding on a date and time, Helen was contacted and the interview was conducted over speaker phone. The consent form and demographic questionnaire had been emailed to her a week prior to the interview, which she signed, scanned and e-mailed back. The interview lasted approximately 45 minutes.

Helen is 26 years old and currently enrolled in college. She was court ordered to group therapy after having been charged with a DUI. During her intake she met with the group leader and disclosed a past IPV relationship. The group leader offered to provide individual therapy in addition to group therapy as a result of the IPV disclosure. Helen's therapist was a Caucasian female who although may not have been trained specifically in IPV, was perceived to be competent in providing IPV therapy after she self-disclosed a personal history of IPV. Depending on Helen's emotional state, she saw her therapist up to three times a week for seven months. The combination of shared IPV experience and Helen's level of motivation were the reasons Helen believed her therapist offered to provide individual therapy to her.

> I was completely comfortable with that because I also knew that she wasn't telling me she had experienced it and she wasn't still messed up about it. She experienced it and so there was hope to recover and have normal relationships again.
>
> She really just let me go at my own pace. She didn't push me, she had to identify. I mean, besides saying that she identified with me, she also knew how hard it is to

get through everything and not have someone picking at you and pushing you in trying to make you disclose everything. She let me do it on my own time.

Helen's interview although unorthodox in the approach, provided constructive feedback regarding the utility of alternative therapeutic interventions with survivors of IPV. The interventions described by Helen typically are considered to be violations of therapeutic boundaries and professionalism in the counseling field as it is considered to be a dual-relationship. However it was these interventions that allowed Helen to establish a trusting relationship to process trauma.

> she knew that I hated sitting in an office and doing therapy so she would let me come to her apartment to do sessions and like hang out with her cats and she really, she tried to make me as comfortable as possible and feel as safe as possible because I, I just had so many people in my personal space and who abused my personal space that she knew that I really needed an area that I knew that no one was going to hurt me

Alternative interventions such as those discussed particularly those considered deviations or violations in the therapist-client relationship were surprising yet thought provoking. The following statements are not considered to be standard care of practice in providing therapy to clients yet it is difficult to argue the impact of these behaviors and interactions on Helen's treatment outcome.

> I was in a store shopping with my mom and she saw me there and when I went to actually try on clothes she came back there and she like hugged me and told me how much she missed me and she was like crying because she got to see me. She was absolutely wonderful.

> Every once in a while she would text me and say hey I'm thinking about you, are you doing okay?

> I never felt like we were crossing the line and we are going to be friends or anything after, like she was still a very, a very big boundary there, where it wasn't anything that was inappropriate, as far as a relationship between the therapist and a patient.

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Helen was also impressed by her therapists' use of non-traditional healing practices. She described her as "worldly" and "respectful of other cultures". She described meditating at the beginning of every session. Helen reported a tendency to disassociate when emotionally overwhelmed and these interventions helped ground her. The use of touch was perceived as emotive and as effective in creating safety.

> When I would meditate and stuff she would put her foot on top of my foot just so that I would be okay with somebody touching me, like I knew they weren't going to hurt me.

Helen admitted the first time she experienced her therapist's foot on hers that she was startled and perceived the approach as violation of physical boundaries. After reassurance from her therapist that she was safe, she began to anticipate this practice and experienced touch as comforting. She described experiencing 1-2 hour sessions with her therapist's hand on hers or foot on top of hers. She began to look forward to this interaction and eventually internalized how her IPV experience influenced her perception of physical touch.

Helen had seen two therapists prior to this one. She worked with one female Caucasian and one male Caucasian. She reported a negative experience with both. In an effort to understand behaviors that lend to a negative experience, she was asked to describe the feelings she experienced when working with her previous therapists.

> I just felt like I was an appointment to them. We had a time limit and when that was done, it didn't really matter where I was emotionally….I didn't really feel like a person and I think that from having to give so many police reports and things of that nature, I just really wanted to feel like a person again.

The experience of feeling like a "statistic" and just another client is a negative experience reported by other participants. Helen describes the rigidity of therapists or the policies clinicians must abide by as the sign that they did not see her as a person. She was asked to give an example of an interaction informing her perceptions of therapists' lack of interest.

> Well the one guy that I went to, like he sat across the desk he sat me down in a chair, and he was just like ferociously writing after I would answer anything and it wasn't like he was really even listening to me or trying to help me.

Helen also commented that she felt judged by the Caucasian female and that she intuitively knew this therapist had never experienced IPV and could not understand Helen's experience. She disclosed that this therapist alluded to the possibility that her parents played a role in the type of relationships she was drawn to. Helen was not only offended by this assumption but felt the therapist was exposing issues she was not ready to explore. It is possible this approach may have been effective had a rapport been established with Helen.

Indra

Similar to Helen, Indra was referred to me by colleagues via Facebook. Indra responded to the request for participants and sent an internal message through Facebook. Indra provided a phone number to call and was contacted the same day. The purpose of the study was discussed as well as the protocol of the study. We scheduled a date and time for the initial interview. Indra stated that she would prefer meeting in a public place. We met at a coffee shop near her residence. Indra and I exchanged texts the day of the interview, confirming the time and place. When I arrived at the coffee shop, Indra was

already seated in the corner in a leather chair. There were a few tables with patrons in close proximity which compromised Indra's privacy. This observation was discussed with Indra and a recommendation was made to sit outside. Indra politely declined and reassured me that she felt comfortable in that particular location.

Indra is a 31 year old mother of two. She is a high school graduate and is the only participant I interviewed who was currently in treatment for IPV. Indra left her abusive boyfriend after she suspected him of abusing her children. She disclosed that she left a tape recorder under the bed in her children's room on a day that her ex-partner looked after the children. She listened to the tape the following day, and heard her boyfriend physically abusing both children (4 years old and 4 month old sons). She contacted the police and a restraining order was placed against her boyfriend. Indra was referred to her therapist through her insurance provider. She was initially referred to a male therapist but did not feel comfortable talking to a man about issues related to men. Indra describes a positive relationship with her current therapist and feels therapy has had a significant impact on her life. Therapists' flexibility around time and communication were essential traits of therapy.

> She's very comfortable for me to talk to, she's very compassionate, she doesn't make me feel like she's just doing her job, she makes me feel like she's genuinely trying to help me and sometimes I go over my time limit and she's like don't worry, keep going, we'll keep going. I just have like a real nice bond with her, I get excited to see her, I look forward to my next appointments with her.

> It's things that she says to me, she not only tries to get into depth with the abuse, she also tries to understand my life, what I do for my living, she likes to ask how are your kids doing, she mentions them by name said to me that makes me feel like she just really genuinely cares.

She makes me feel like she pays attention to the little things that maybe I don't pay attention to or maybe my boyfriend doesn't pay attention to and it's like, it just makes you feel good that someone notices something little that you never would have noticed and no one would have ever mentioned to you for the whole day. So she just takes that little bit of extra time to always give me a compliment, it was nice.

Having a personable approach with clients allowed Indra to know she was valued. This approach and interaction was described by several participants as the primary quality of therapy that was effective; more so than cultural and IPV competence. Indra stated her therapist is a Caucasian female and was unsure if she was competent in providing IPV counseling. She did not perceive her therapist as culturally competent yet found this to be a strength in their relationship.

She tries to understand. She'll tell me explain it, explain it to me more so I can understand where you're coming from. The more I explain it to her the more I feel like she's exploring a new thing also with me being Hispanic so in a way it's nice because I feel like not only she teaches me something, I'm teaching her something new that she just wasn't open to or familiar with.

That's why I think I feel I get so much more out of my sessions with her because I feel like I'm teaching her something as well as she's teaching me something

Indra believes that an ethnic match is not necessary in order to provide effective therapy. Nonetheless, she did say that if she had an option, she would have preferred a Latina therapist. However, there are no therapists of color at her site. Indra was adamant she would not be open to working with a male therapist because of her history of trauma she experienced by men.

There are no Hispanic counselors there, they're all Caucasian and all the men are Caucasian. It would probably be more comfortable for me; I just think Hispanic women are raised to see life differently

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Josephina

Josephina was referred by Indra who is Indra's maternal aunt. Indra had shared her participation in the study with Josephina and asked her if she would participate. Indra called me and stated her aunt expressed an interest in participating in the study. Indra provided Josephina's contact information and I contacted her immediately. Josephina was very playful and informal over the phone. When asked where she would like to meet, she teasingly stated that she preferred meeting at her house because she was "too lazy". We scheduled a date and time for the interview. I met Josephina at her home in Denver. She offered me something to drink soon after walking into her home. We sat adjacent from each other on her couch. She asked for a copy of the consent form so she could look it over again later. She signed the demographic questionnaire and the consent form.

Josephina is 46 years old and a mother of three. She stated she was in a physically violent relationship for 13 years and sought therapy after her husband became aggressive with her in front of their children. Josephina had tolerated the abuse for 13 years because it was done only when the children were in bed. Josephina called the police who placed a restraining order against her husband. This incident was the last time she had any interaction with her husband. The police referred her to a Denver based organization dedicated to prevention and education around of domestic violence. Josephina saw her therapist only four times for individual therapy although she participated in family therapy for a short time. Despite the limited number of sessions in individual therapy, Josephina stated that therapy empowered her to change the trajectory of her life.

I remember her face being real serious, like you know, you shouldn't have been through that. I can see the emotions on her face but I don't think she ever teared up. She was real sympathetic.

She helped me really understand that you know, don't be shameful, it happens, you're not the first woman it happens to, it is something that happens and they gradually brainwashes you to think that it's your fault.

Josephina was unable to articulate whether her therapist was culturally competent or competent in providing IPV. Her therapist described common beliefs shared by survivors of IPV and prepared her by discussing common symptoms experienced by survivors of trauma.

She did help me and empower myself by letting me know that you know, it's okay for you to talk about it, you're going to be fearful, you might cry, you might get scared when you come back, you might have nightmares but you're going to be okay

Similar to other participants' experience in session as being just another victim or statistic, Josephina discussed her fears about how she would be perceived by her therapist. Josephina commented on how the therapist was able to convey a genuine interest in her.

She was a real attentive listener, she didn't interrupt me, she made sure she heard me completely and sometimes repeated what I said back. And then you know, she may be feel validated, she made me feel like she was listening and that I wasn't just another case.

Despite the fact that Josephina had only been to therapy for a limited time, the lasting impact on her self-esteem was profound to witness. She was able to internalize the messages of empowerment received in therapy and has found ways to create change through community involvement.

I now realize I don't care how heavy I am, I am beautiful, I am strong, I'm the best person you'll ever meet, I have a warm heart, I'm gorgeous.

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You are in control of your happiness, nobody can take your happiness away from you and if you let them it's because you're letting them do that. So I will never let anybody take it from me again.

Josephina is biracial but identifies as Hispanic. She stated that her mother is Mexican and her father Spanish and German. She describes herself as light-skinned and disclosed comments made by her family about being White. Unlike most of the participants, she had not been exposed to violence early in her life. She credits her church and her parent's involvement in church for the cohesion of her family.

Table 2 provides therapist demographics and participant perception of therapist competence in providing general therapy, providing IPV counseling, and cultural competence. Four participants stated that they were unsure of either their therapists' cultural competence or IPV counseling competence and therefore were labeled as Unknown. This table provides a clear illustration of the variations between participant perceptions of therapists' cultural or IPV competence and overall counseling experience. Possible explanations for these discrepancies are provided in Chapter 5.

Table 2
Therapist Characteristics

Name	Therapists' ethnicity	Gender	IPV competent	Culturally competent	Overall experience
Ana	Chicana	Female	Yes	Yes	Pos
Beatrice	Caucasian	Female	No	No	Neg
Carla	Asian	Female	Unknown	Yes	Pos
Delores	Latino	Male	Yes	Yes	Pos
Elena	Latina	Female	Yes	Yes	Pos
Felicia	Caucasian	Female	No	No	Pos
Gloria	Caucasian	Male	Yes	No	Pos
Helen	Caucasian	Female	Yes	Unknown	Pos
Indra	Caucasian	Female	Unknown	No	Pos
Josephina	Latina	Female	Yes	Unknown	Pos

Research Questions Answered

1. What factors contribute to Latina IPV survivors' assessment of counselor competence?

The primary themes for counselor competence identified by participants were: Counseling, IPV and Cultural competencies. Descriptions given by participants regarding their perceptions were used to identify attributes and behaviors of the therapist- client interaction demonstrating competencies in these three categories. Participants described an overall positive experience in therapy with clinician's that expressed unconditional positive regard for participants which allowed them to establish a positive rapport in session "she said thank you, for giving me the opportunity to work with you, it has been

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an honor. And I said wow, she made me cry". Credibility and ethnic match were also

identified as characteristics influencing participant positive perception of therapy and

their therapist "She was doing therapy with every Chicana in that town".

Participants perceived their therapist as IPV competent when they were sensitive

to the trauma associated with these relationships and allowed participants to go at their

pace when disclosing IPV relationship/s. Cultural Competence was perceived by

participants when clinicians expressed an interest in participant's cultural background and

the influences which shaped their development. It's important to note that participant

overall satisfaction with therapy was not associated with therapist competence in

providing IPV counseling or cultural competence. Given that all participants disclosed

their inability to disclose IPV to friends and family, it is possible that simply having a

person to confide in about their experience was perceived as beneficial and empowering

which exceeded the importance of therapists' IPV and cultural competence. Therefore,

therapist characteristics that allowed for a positive rapport was not necessarily related to

their perceptions of their therapists' cultural competence or competence in providing IPV

counseling. Additionally an ethic match alone did not seem to compensate for cultural or

IPV competence as expected. Therapists' who expressed an interest in understanding

participants' culture was perceived as a positive experience "he tried very hard to

understand my culture". One participant described her therapists' lack of cultural

competence as a positive interaction.

> She'll tell me explain it, explain it to me more so I can understand where you're
> coming from. The more I explain it to her the more I feel like she's exploring a
> new thing also with me being Hispanic so in a way it's nice because I feel like not

only she teaches me something, I'm teaching her something new that she just wasn't open to are familiar with.

2. What meaning do Latina survivors of IPV make regarding their IPV counseling experience?

All but one participant had a good experience with their therapists. Their IPV counseling experience was described by several participants as a "blessing". They were adamant that they would have continued to engage in abusive relationships if not for the transformation they experienced in therapy. One participant stated that therapy "saved" her life. Participants motivated to seek therapy in order to offer a better life for their children, reported that the entire family significantly benefited from their participation in therapy. Gaining the knowledge and skills to break dysfunctional patterns was seen as the primary objective in participating in therapy.

3. To what extent do socio-environmental, cultural and political experiences contribute to clients' perceptions of IPV counseling?

A shared experience and belief of all participants, was that socio-environmental, cultural and political experiences had a profound impact on how they perceived therapy and their therapists' competence level. Detailed explanations of these variables and their influence on participant's perceptions are provided in the Contextual Themes section of this chapter.

4. What interventions contribute to client perceptions of effective and or positive IPV counseling experiences?

The feeling of being "cared for" was more important than therapists' cultural competence or IPV competence. Three participants stated that they did not perceive their

therapist as culturally competent yet reported an overall positive experience. One participant did not experience her therapist as IPV competent yet reported a positive counseling experience. All participants disclosed that the therapeutic relationship was important in session the therapeutic relationship had a greater impact on their ability to process their IPV experience than specific interventions. Specific interventions and client-therapist interactions are outlined in the Accepting Behaviors section of this chapter.

Themes Across Participants

Themes that emerged from participant interviews regarding their experience with their therapist were divided in two broad categories: Accepting behaviors and Rejecting behaviors. Accepting behaviors were related to participant's experience with the specific therapist discussed in this study while rejecting behaviors included interactions and behaviors experienced by participants with previous therapists. Themes were identified for each of these categories by reviewing and coding transcriptions including the process of imaginative variation. The themes include environmental factors, specific therapeutic interventions and qualities or characteristics of the therapist. These themes are presented in Table 3.

Transcriptions were reviewed and coded to determine frequency of occurrence for each participant. Categories used to identify frequency of occurrence of themes were labeled using the procedures recommended by Hill et al. (2005). This approach applies the term "general" to include all or all but one of the participants, "typical" referring to

more than half which would include 6-8 cases and themes that applied to 2-5 participants

were referred to as "variant". The frequency of occurrence for each theme is presented in

Table 3.

Themes

Accepting Behaviors	Ana	Beatrice	Carla	Delores	Elena	Felicia	Gloria	Helen	Indra	Josephina
Being Present	X		X	X	X	X	X	X	X	X
Interest in their lives	X		X	X	X	X	X	X	X	X
Challenged beliefs	X		X	X	X		X	X	X	X
Validated	X		X	X	X	X	X	X	X	X
Met the client where she was	X		X	X	X	X	X	X	X	X
Referred alternative interventions	X		X		X			X	X	X
Provided alternative interventions	X		X					X		X
Non-traditional boundaries			X		X			X	X	
Touch			X		X			X		
Flexibility with time	X				X			X	X	
Called or texted					X			X	X	
Credibility	X		X	X	X			X	X	X
Allowed for pt to go at their pace	X		X	X	X	X	X	X	X	X
Therapist was like a friend			X		X					
Environmental factors	X		X	X	X			X		
Client was open/ready	X		X	X	X	X	X	X	X	X
Understood cultural nuances	X			X	X					X
Therapist Self-disclosed			X		X			X	X	
Sliding scale or free					X	X	X	X		X
Agency only had Caucasian therapists		X		X		X	X	X	X	
Rejecting Behaviors										
Did not ask about culture or values		X		X	X	X	X	X	X	
Did not validate		X		X	X		X	X	X	
Blamed/ criticized		X		X	X		X	X		
Abusive relationship patterns		X					X	X	X	
Couldn't relate		X		X	X	X	X	X	X	
No empathy		X		X	X		X	X		
Lectured participant		X		X	X			X		
Thought they were better than me					X			X		
Recommended meds				X	X		X			
Took Notes					X			X		
Felt like a statistic		X			X			X		

Table 4
Themes

Domains and Category	N	Frequency
Accepting Behaviors		
Being Present	9	General
Interest in their lives	9	General
Challenged beliefs	8	Typical
Validated	9	General
Met the client where she was	9	General
Referred alternative interventions	6	Typical
Provided alternative interventions	4	Variant
Non-traditional boundaries	4	Variant
Touch	3	Variant
Flexibility with time	4	Variant
Called or texted	3	Variant
Credibility	7	Typical
Allowed for pt to go at their pace	9	General
Therapist was like a friend	2	Variant
Environmental factors	5	Variant
Client was open/ready	9	General
Understood cultural nuances	4	Variant
Self-disclosed	4	Variant
Sliding scale or free	4	Variant
Therapist of color not available	5	Variant
Rejecting Behaviors		
Lack of Inquiry	6	Typical
Did not validate	7	Typical
Blamed/ criticized	6	Variant
Abusive Relationship Patterns	5	Variant
Couldn't relate	4	Typical
No empathy	7	Variant
Lectured participant	5	Variant
Thought they were better than me	4	Variant
Recommended meds	2	Variant
Took Notes	2	Variant
Felt like a statistic	3	Variant

Accepting Behaviors

The nine participants who reported a positive experience with their therapist, felt as though their therapist was genuinely invested in their happiness and well-being. The essence described was the feeling of being "cared for". As they began to describe the qualities and behaviors that informed their perception of feeling cared for; the following seven themes were identified as effective qualities and behaviors: a) Being present, b) interest in their lives, c) challenged beliefs, d) validated, e) met the client where she was, f) offered or provided alternative interventions in healing, and g) non-traditional boundaries

Being Present

The therapist's conveyance of being present in session was described by participants as "truly listening". These therapists did not take notes while the client spoke but were engaged in the dialogue. They repeated back what they heard and explained how they understand what was being told. They had read the client's file ahead of time and had a basic understanding of what they were coming to therapy for. For two of the therapists who were perceived as not culturally competent, they had expressed a strong desire to understand the client's worldview and the variables that influence their perceptions which was appreciated by the participants.

Interest in Their Lives

Participants shared that they felt at ease soon after the therapist made an attempt to get to know who they were. Rather than immediately asking questions specific to the abuse, they spent time becoming acquainted with the participant. Sessions later, they remembered information about clients' families, children, jobs and things that are

important to them. The therapist did a thorough assessment in order to understand the clients' childhood and their relationships with their family. They were able to get a sense of the dynamics that perpetuated violence in the participant's family and the internal and familial challenges she faced prior to participating in therapy.

> It makes me feel like it's not so textbook. Like I just don't go in there and tell her what I'm feeling for that few weeks or what happened since our last session. I'm just excited to see her, she makes me feel like she cares, she's concerned.

Challenged Beliefs

Challenging the participant's beliefs was a positive experience for several participants but for participants who had not established a rapport, this therapist behavior negatively impacted the relationship "I just needed to be challenged, and just needed to see a different point of view". Those who reported that they were greatly impacted by being challenged were those who were the most resistant to therapy and described themselves as experiencing chronic and intense anger. These women had learned to use their anger as a means of self-preservation; therefore when their therapist exposed their defenses; they felt as if they were finally seen. They felt as though the therapist recognized that their anger masked the pain they suppressed. For these participants, anger was used to cope with internalized oppression, awareness of negative patterns of behavior, shame and guilt for remaining in the relationship as well as an awareness of racial disparities.

Validation

This was perhaps the most empowering behavior a therapist was able to provide to the client. Validation, particularly for abused women, is a behavior that is not only

foreign interpersonally but institutionally. The experience of being dismissed or excluded was one that was a social construct that played out in all areas of their lives. The process of being validated for their experience, their emotions and their behaviors allowed clients to renounce the guilt and responsibility they had assumed for their experiences. They were empowered by gaining awareness that they were not alone and that their experience of oppression was not their burden.

Met the Client Where She Was

Meeting clients where they were in their process was a profound experience for participants. This was illustrated by the therapists patience in allowing clients to disclose information at their pace. They did not push their own agenda on clients and did not assume that clients were ready to process the trauma immediately. They also did not assume that the client was ready to leave the relationship.

Participants discussed the fact that they would cry in session without being asked to talk at all. Some discussed the fact that it took them several months before they were able to talk about the abuse and for many of them, it took this long to simply identify and verbalize the emotions they had experienced.

> The first thing I would do is throw myself on the couch because it was so comfortable in her environment and I would just cry. Cry the full hour, just cry and cry and cry and she understood why and I thought what is wrong with me.

Referred or Provided Alternative Interventions

Many participants discussed their aversion to medications; therefore alternative interventions of healing offered a less stigmatizing approach in managing their symptoms. For many women, alternative interventions of healing are congruent with their own cultural beliefs and traditions "she would burn Sage and incense and stuff like that

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and so that was very soothing to me. I felt like this is where I was supposed to be". The use of teas, oils, sage and meditation are methods of healing which have been used for generations among indigenous populations. The use of these traditions is often visible among marginalized groups given the lack of resources due to language, location and socio-economic status. Alternative interventions allowed participants to perceive their symptoms as circumstantial and not pathological.

Non-traditional Boundaries

Professional boundaries between therapists and clients are a standard code of conduct that is expected of all clinicians. Violations of these boundaries potentially jeopardize a clinician's licensure to provide therapy. Due to fear of potential litigation and the restrictions imposed by managed care, the opportunity for therapists' flexibility in the way in which sessions are conducted are rare. Rigid adherence to boundaries in session reportedly negatively impacted the therapeutic alliance for Latina survivors of IPV.

All the women who reported therapists' flexibility in terms of boundaries as effective also stated that they were clear that the relationship was still professional. The flexibility discussed by participants were around touch, interacting outside office hours and the office, communication via text and e-mail, and the use of self-disclosure by the therapist in session. Other non-traditional boundaries included going over the time limit, calling clients at work and therapists expression of empathy by become tearful in session with their clients. It was the therapists who had experienced IPV first hand, who expressed a genuine concern for participants by being flexible in how sessions were conducted and in how they communicated with participants.

Contextual Themes

In the process of coding interviews, a number of themes emerged which provided a context for factors influencing participant perceptions of therapy, their therapist, identifying their relationship as abusive and, their reluctance to disclose their IPV experience. Included in these Contextual themes were references to cultural identity and their perceptions of themselves in relationship to the majority culture. The occurrence of these themes was difficult to ignore in that they provide a vivid description regarding variables that influence motivation in disclosing personal information. These themes were included in this study in order to provide a context for participant perceptions. They also provide guidance for practitioners and in training clinicians to work with this particular population. Contextual themes are organized and presented in Table 5 and frequency in occurrence for each theme is presented in Table 6.

Table 5
Contextual Themes

	Ana	Beatrice	Carla	Delores	Elena	Felicia	Gloria	Helen	Indra	Josephina
Early exposure to violence	X	X	X	X	X		X		X	
Poly-victimization	X	X		X	X		X		X	
History of abuse	X			X					X	
Abuse was normal	X	X	X	X	X		X		X	
Taught to maintain the silence	X	X	X	X	X		X	X	X	
Commented on racism	X	X	X	X	X	X	X	X	X	
Suicidal ideation	X	X		X	X		X	X	X	
Substance abuse	X	X	X	X	X			X		
Emotions maintained silence	X	X	X	X	X	X	X	X	X	X
Blamed themselves	X	X	X	X	X	X	X	X	X	X
Anger	X	X	X	X	X	X	X	X	X	X
Fear	X	X	X	X	X	X	X	X	X	X
Feared judgment	X	X	X	X	X	X	X	X	X	X
Shame	X	X	X	X	X	X	X	X	X	X
Depression	X	X	X	X	X	X	X	X	X	X
Police involvement		X		X	X	X		X	X	X
Rejected by systems meant to help	X	X		X	X			X		
Hospital				X		X				
Church	X			X			X			X
Police	X	X		X	X			X		
Cultural Identity	X	X	X	X	X	X	X		X	X
Focus on the family	X	X	X	X	X				X	X
Ethnic match is not necessary	X	X	X	X	X	X	X	X	X	X
Preferred Latina therapist	X	X		X	X	X	X		X	
Commented on their light skin			X				X	X		X
Kids served as motivation			X	X	X				X	X
Maintained IPV from family	X	X	X	X	X	X	X	X	X	X
Initially resistant to therapy	X	X	X	X	X		X	X	X	X
Homicidal Ideation	X	X	X	X						X

Table 6

Contextual Themes

Domains and Category	N	Frequency
Early exposure to violence	7	Typical
Polyvictimization	6	Typical
History of abuse	3	Variant
Abuse was normal	7	Typical
Taught to maintain silence	8	Typical
Commented on racism	9	General
Suicidal ideation	7	Typical
Substance abuse	6	Typical
Emotions maintained silence	10	General
Blamed themselves	10	General
Anger	10	General
Fear	10	General
Feared judgment	10	General
Shame	10	General
Depression	10	General
Police involvement	7	Typical
Rejected by systems meant to help	5	Variant
Hospital	2	Variant
Church	4	Variant
Police	4	Typical
Cultural identity	9	General
Focus on the family	7	Typical
Ethnic match is not necessary	10	General
Preferred a Latina therapist	7	Typical
Commented on their light skin	4	Variant
Kids served as motivation	5	Variant
Maintained IPV from family	10	General
Initially resistant to therapy	9	General
Homicidal Ideation	5	Variant

Poly-victimization

Most of the participants disclosed a significant history of abuse; sexual, physical and emotional not only by intimate partners but members of their family. Some of the women discussed that the abuse they endured began in childhood and continued through adulthood. These woman could not identify anyone who protected them from abuse much less validated their experience. Other forms of abuse were described as racism and discrimination. Racism as either experienced or awareness was a common theme discussed in relationship to poly-victimization. This theme is further discussed under the Rejection of Various Systems subheading.

Given that questions related to history of abuse were not a component of this research, details or the nature of the abuse were not explored. Therefore, the occurrence for this theme may not actually reflect the experience of poly-victimization or frequency of abuse for each participant since only those who disclosed abuse were included in Table 6.

Abuse Was Normal

The experience or expectation of abuse in relationships for all except two participants was seen as a cultural norm. Many participants described a notion that violence is normal. Their early exposure to violence and emotional abuse informed their perception of what constitutes a relationship. One woman discussed substance abuse and violence as a common occurrence in her family. She stated "in my head that was part of who I was, that it was part of my life". Violence as a cultural norm was a shared sentiment among participants. Many participants described their fathers as controlling

and abusive. They also shared the belief that the need to control women is typically an inherent quality among Latino men. "Hispanic men in my opinion, they are very controlling". One participant's therapist asked why she continued to choose men that were abusive. She discussed her attempt in educating her therapist about Latino men by stating: "In a way, it's attractive to me, the controlling and stuff like that but to her (the therapist) it seems very unhealthy".

Participants discussed horrific accounts of family members who had also experienced IPV and had not sought help because they believed this to be typical in relationships. Some of the participants were unable to seek help from family members or friends because they too were experiencing abuse or had experienced abuse much more severe than theirs "Everyone else was going through it. All my friends were going through it all their parents; we had the same old fuckin dads". Another participant stated "I lived through it, all my sisters lived through it, you know, my mom did, so it was around us all the time". The pervasiveness of violence within their culture often made it difficult to identify the relationship as abusive. Five of the ten participants discussed protecting their siblings from either witnessing their father's abuse their mother or from abusing their siblings. One participant stated "I used to tell them, stay here and don't leave! You know, I would give them food and blankets you know, while my dad was ripping into my mom".

Taught to Maintain Silence

This particular theme was identified by all participants as a reason for concealing the abuse they experienced. Emphasis on the family was described as an attempt to

protect the family honor or reputation. It is important to differentiate between familial expectations in protecting the family and the participants concern in burdening the family by disclosing the abuse. Familial expectations to maintain family secrets were often related to fear of exposing family dysfunction to others, including members within the immediate family. The value of familia was described by one participant: "There's negative aspects to this whole idea of familia". Numerous examples were provided in the interviews related to fear of judgment and criticism from family members and community members. Participants disclosed receiving explicit messages from family members; often their mothers, to conceal the abuse.

> In my head I thought first you don't tell anyone your business and second you live with it, this is, in so many words when I got with my partner my mom told me, well you're gonna have a baby from him so now that's your life, you're gonna have to deal with whatever, you know, that's the life you chose so now you have to deal with whatever comes along with it, so in my head that was her telling me, this is what you have to do.

Participants discussed witnessing family members exposed or ridiculed by other family members and friends for deviating from the cultural norm. The impact of (chisme) gossip among family members was often ostracizing towards the individual and often brought shame to the family. The negative behavior of one individual typically reflected poorly on the parents and the way in which they raised their child. For a community that is marginalized, the exclusion from potential social networks was seen as horrendous. One participant stated: "I don't remember my mother ever using religion because she was excommunicated for getting divorced". This was particularly devastating for families who have strong connections with systems of authority such as community members and church.

I'm coming from this, as someone who looks at Catholicism as a colonial tool, you know patriarchal towards women… My mother used religion to justify her situation and you know, my mom has such a terrible life, she wanted things just to be good.

Protecting the family name and honor is a common value among Latinos; this core belief was common throughout many of the interviews. Participants disclosed the reticence in disclosing IPV was either to protect the family cohesion, even if it were only esthetically or a fear of burdening their family who were typically fraught with their own stressors. One participant described listening to the horrifying violence perpetrated on her mother by her father which left her mother physically disfigured. When asked whether her mother sought help after this incident, she replied: "she didn't go to the hospital. She didn't do anything. So she held on to it all these years, she still is". Two participants disclosed their shame in disclosing IPV to their family because they "weren't raised that way" referring to the fact that they had not been exposed to violence.

Emotions Maintained Silence

Participants disclosed the impact their emotions had on their willingness and ability to disclose IPV. All participants disclosed a broad range of emotions all of which are consistent with a diagnosis of Posttraumatic Stress Disorder as outlined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, p.469). Although a range of emotions were disclosed by participants, they all described the following emotions as pervasive and profound: blamed themselves, anger, fear, feared judgment, shame, and depression. Fear and fear of judgment were categorized separately because fear was associated with fearing for their safety or their life versus fear of how

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they would be perceived by others if IPV was disclosed. Many women described specific

incidents in which their partner threatened to kill them.

> I never really talked to anybody or I never really I was so afraid and so ashamed and so scared because he had threatened that if I ever left him, he did physically threaten me and my son and he said he would kill us. He scared me; he did pull a gun on me before. He held a gun to my head and then he held it to his head um he did do it to my son when my son was 9 months old he stuck a screwdriver to my neck and told me he'd kill me and then kill my son so I lived in fear for a long time and because of that I never asked questions when he didn't come home or he was gone, or what he was doing or because if I did I got hit.

> It wasn't that we were told not to talk about the abuse that we saw and what he had put my mom through but it was more I think a fear that he made us feel. He never told us, don't you tell anybody about this, it was just pure fear of I think we just knew that if we ever said anything to anybody and he found out that we were going to get it.

The theme Homicidal Ideation includes any comments made by participant

related to harming any perpetrator who had abused them or homicidal threats directed

towards the participant by their intimate partner. All ideations related to harming their

perpetrators were described as past ideations and no longer relevant to their situation.

This theme was included in order to demonstrate the pervasiveness of anger among

participants related to their IPV experience.

Resistant to Therapy was associated with the reluctance to re-experience the

trauma or emotions related to their IPV experience. The fear of becoming overwhelmed

with emotions was often described as the primary reason participants appreciated the

therapist honoring the pace at which the participant was able to process the trauma in

session.

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Cultural Identity

All participants made a distinction between their beliefs and that of their therapist's by articulating a significant difference between their cultural identity and that of the majority culture. They all commented on environmental, psychosocial and inter-personal factors that contributed to either their IPV or their reluctance to seek therapy. The influence of these variables is evident throughout the interviews and offer a first-hand perspective on some of the barriers and challenges both clinicians and clients face in building a rapport in therapy.

Many of the participants described gender roles within Latino families by describing women as subservient to their husbands. For many of the women they did not have role models who were exceptions to this ideology. The participants' description of Latino men as "machismo", "controlling" and "abusive" were disclosed with a conviction that suggested that these are culturally excepted qualities for Latinos. Although many of the women stated that they no longer adhere to these beliefs, these are still commonly held attitudes in their family and culture as a whole.

> I think more about cultural identity meaning my identity my political identity is really a reflection of my experiences which involve my culture, which is a way of living, particular values around family… so I wanted somebody that was going to be able to understand and embrace that in a critical way.

Rejection by Various Systems

Participants discussed their experience in seeking help from various organizations only to be rejected or re-victimized. Many participants discussed their experience of racism as a reason for not wanting to disclose information to Caucasian therapists. All participants described experiencing intense anger, shame and guilt associated with

disclosing their IPV relationship in session. Participants, who disclosed a negative

experience with a therapist, attributed their perception to the therapists' lack of

understanding related to their culture or feeling judged. The following examples are

related to participant perceptions of therapists who lack cultural competence:

> The thing about White therapists is that they have to really understand how White privilege operates in this society and unfortunately it operates you know at the deepest levels of all humanity and the way we communicate. It's not that it can't be done, it can, but it takes a lot of work I mean they have to relinquish a lot of power and privilege which in essence is who they are as people. So they have to go through their own transformations

> It felt like she thought she was better than me….they would look at my paperwork and be like oh, she's a victim and I really just felt like a statistic. I didn't really feel like a person anymore.

> They don't understand racial privilege or you know just by some of the comments they make you can tell that they don't really understand.

> The inability to seek refuge from violence was not only due to the rejection within

their family but also the exploitation by institutions that were meant to help such as

church and police. Participants who were court ordered to counseling had been arrested

for retaliating against their perpetrator; even after they disclosed the abuse they were

enduring in the relationship. The women who participated in mandated group therapy

stated that the majority of the women were women of color. The mistrust in police was

described by a participant: "we never went to cops, they were never helpful". One

participant described that despite her involvement in church, she was still not accepted.

When asked if she felt there was redemption through religion, she responded: "I have

been abused quite a bit, so religion, I always felt that God just forsaken me". The

dismissal and rejection from various institutions reinforced the ideology of maintaining silence related to IPV and other concerns.

One participant discussed the experience of "political torture" when she was detained at an airport in the United States. She described the various forms of abuse she experienced at the hands of male and female police officers. Details related to this experience are not included in order to protect the participant's anonymity. For many communities of color, the police do not offer the same support and protection often afforded the dominant culture.

Summary

The purpose of this study was to obtain the essence of the phenomenon related to cultural and IPV competence of clinicians. This chapter provided descriptions of how *epoche* was achieved. Descriptions of each participant were provided including textural and structural descriptions specific to their perceptions and experience with their therapist. A composite of the structural and textural descriptions integrating individual textural descriptions was developed and described in this chapter. This chapter is concluded by providing contextual themes unrelated to therapists' cultural and IPV competence. These themes shed light on the cultural complexities contributing to participants' willingness to participate in therapy and the assumptions Latina survivors of IPV may have of their therapist prior to initiating therapy.

Chapter V

Discussion

This research is a qualitative study of ten Latina IPV survivors who received

counseling for IPV. The purpose of the study was to obtain the participants' perceptions

of their counselors IPV competence and their cultural competence. The women in this

study provided rich descriptions of their experiences in the sessions with their therapist

and were able to describe qualities which contribute to IPV competence as well as

cultural competence. In addition to participant perceptions of therapist competencies,

participants were able to provide their perceptions of interventions that were effective and

not effective for them in their IPV therapy. There were several themes that were

highlighted by all or many of the participants.

General and Typical Themes

With regard to General Themes endorsed by all participants, one of the most

important finding of this study was that participants felt that therapy was most effective

when the therapist expressed a genuine interest in them. This is consistent with research

suggesting self-disclosure for patients is based on mutual respect and the belief that their

provider cares for them. This is particularly true for ethnic minorities (Beach et al., 2005;

Julliard et al., 2008). The women in this study provided many examples of their therapist

demonstrating interest in them by being present, validating them, allowing them to set the

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pace in therapy, and remembering pertinent information and personal details about them.

Although these are standard counseling skills, developing a trusting relationship may be

even more important for IPV survivors in that a corrective experience of trust and dignity

can be established in therapy with their therapist. The implications for these findings

relate to both training and practice.

Another General Theme found in this study was therapist behaviors that

demonstrated being present or fully engaged in the conversation. For the women, this

engagement was related to their overall satisfaction in therapy. Basic communication

skills including attentive listening are fundamental competences necessary for clinicians

who provide therapy. Regardless of one's theoretical orientation, most therapeutic

interventions require that the therapist actively listens to the client without making

premature assumption or suggestions. Although every client deserves this basic courtesy,

survivors of IPV may be particularly sensitive to nonverbal communication and have an

increased awareness of the therapists' lack of interest or behaviors that suggest that the

therapist is rushed or does not have enough time for them (Rodriguez et al., 2001). It is

standard practice s to expect that therapists are present in the sessions, ask clients for

clarification, and summarize what was said. Participants in this study who perceived their

therapist to genuinely "caring" for them attributed this to the therapists' ability to remain

present in session and actively listen to them. For the women who reported an overall

positive experience in therapy, the experience of feeling "cared for" by the therapist was

seen as more important than whether they perceived the therapist to be competence in

IPV or competent in understanding their culture. Conversely, negative perceptions of

therapist interactions were attributed to the women feeling they were not listened to which was demonstrated by behaviors such as the therapist interrupting, making assumptions, and giving advice. The theme of Therapist Being Present in Session underscores the vital nature of effective communication for therapists working with IPV survivors.

An essential component in establishing trust with the therapist was whether the women saw their therapist as credible. Therapist Credibility was a General theme given by all participants in this study and was described as therapists' knowledge of the Latino community, knowledge of oppression, and therapists' own personal experience with IPV. Other examples that led women to see their therapist as credible were the therapists' utilization of self-disclosure in session, areas of interest such as IPV and trauma provided in their curriculum vita, the fact that they were Latina, and recommendations by friends who had their own firsthand experience in therapy with that particular therapist. The importance of being seen as credible highlights the necessity for the inclusion of IPV and cultural competencies in clinical training programs.

Research results are mixed as to whether an ethnic match between the therapist and client is a predictor of treatment outcomes (Maramba, & Nagayama Hall, 2002). All of the women in this study stated that they did not believe an ethnic match was necessary in providing effective therapy, yet all participants except one, stated that if they had a choice, they would prefer to work with a Latina therapist. The primary reason for preferring a Latina therapist would be their familiarity with the cultural nuances for Latinos and their perceived credibility. This assertion was also shared by participants

who perceived themselves as not being "ethnic" enough due to their light skin. According to this study, an ethnic match is not necessary; nonetheless it may help Latinas feel more connected to the therapist more quickly.

A Typical Theme discussed by six participants was that the therapist Recommended Alternative Interventions and a Variant Themes reported by five participants was the Provided Alternative Interventions. Research demonstrating the effectiveness of alternative, holistic, and integrative approaches with IPV survivors provides quantitative and qualitative support for these methods (Allen & Wozniak, 2011). Traditional models of therapy may not be suitable for clients of diverse ethnic backgrounds as they may be counterintuitive to their cultural beliefs and traditions. Interestingly, many of the alternative interventions discussed by participants such as meditation, oils, sage, and energy work are rooted in indigenous practices and are utilized across various ethnic communities (Wintrob, 2009). The utilization or recommendation of alternative healing approaches in session may provide a more culturally responsive intervention that is congruent with the clients' cultural beliefs. If therapists are committed to cultural inclusivity, becoming familiar with integrative and alternative healing interventions would be beneficial.

Therapists' Lack of Inquiry about culture or interests was a Typical Theme endorsed by seven women that contributed to the negative perceptions of their interpersonal relationship with their therapists. This finding is consistent with research demonstrating IPV survivors' reticence in IPV disclosure with therapists who fail to inquire about clients' abuse (Rodriguez et al., 2001). Conducting a risk assessment is

standard protocol across all health agencies, yet there continues to be evidence suggesting that clinicians tend to fall short in accurately assessing for IPV (Cattaneo., 2007). To address this issue, the language and terms used in conducting IPV evaluations should be assessed to reflect clients' understanding and knowledge of IPV. For example, screening tools often incorporate terms that are unfamiliar to patients, particularly those from diverse ethnic backgrounds. Therefore, describing various forms of abuse constituting IPV should be provided to clients in an effort to accurately assess for IPV and to raise awareness. Studies report that Latina women are unlikely to consider behavior such as slapping, pushing, shoving and throwing objects as abusive (Gondolf et al., 1988; Torres, 1991). Also, clinicians' attentiveness to risk factors and characteristics associated with IPV can inform clinicians of the presence of IPV in spite of client lack of endorsement. The challenge for clinicians is that there continues to be a debate about behaviors that constitute abuse (Nicolaidis & Paranjape, 2009).

Contextual Themes

The interviews provided details of themes that were not part of the original questions posed in the study. They are discussed her because of their importance and relevance to the practice and training of IPV counseling. For example, one contextual theme that was endorsed by all women was the experience of emotional distress which was described as severe and constant. Based on participants' descriptions and perceptions of their IPV experience, it is irrefutable that trauma and IPV are interrelated. Given that IPV and trauma are interrelated, therapeutic interventions and techniques in the treatment of trauma should be fundamental components in IPV training. For example, training

should emphasize the corollaries between trauma and IPV as it provides a context for the underlying emotional burden that survivors of IPV assume. While most IPV training focuses on the cycle of violence and the forms of violence, responsiveness to trauma specific to IPV is essential.

The prevalence of Poly-victimization and Early Exposure to Violence were also Typical Themes disclosed by participants. Seven participants disclosed early exposure to violence in their interviews and six women had experienced multiple incidents of abuse throughout their lifetime. The increased emotional and psychological distress for survivors of IPV who have experienced additional adverse trauma is significantly higher than for those survivors of IPV who do not experience earlier trauma (Graham-Bermann, Sularz, & Howell, 2011). These participants disclosed the pervasiveness of IPV within their family and community, which in turn influenced their perceptions and understanding of IPV. Similarly, another Typical Theme disclosed by seven participants was Abuse Was Normal. The perception of abuse as "normal" contributes to IPV survivors' inability to identify incidents of abuse. These findings are consistent with research illustrating the cultural barriers for Latinas in identifying incidents of abuse (Ahrens et al., 2010). Gaining awareness of the incidence of violence for marginalized communities provides a framework for understanding the barriers and challenges IPV survivors encounter in identifying abuse and their willingness to seek treatment.

Another Typical Theme disclosed by seven participants was Suicide Ideation. Although this theme is consistent with existing IPV research (Olsen et al., 1999), the pervasiveness of suicidal ideation was not hypothesized for this limited sample size. As

such, it is crucial that clinicians gain awareness of the increased risk of suicide for IPV

survivors and acquire the knowledge and skills necessary to conduct thorough diagnostic

assessments of psychological symptoms associated with higher suicide risk.

IPV Competence

Although it was hypothesized that the majority of the participants would perceive

their therapist as lacking in IPV competence, given current research illustrating the

prevalence of clinicians' inability to identify IPV, this perception was not endorsed by the

women in this study. It is possible that many participants may not have been aware of the

conceptual definition of IPV which may explain the frequency in which participants

perceived their therapist as IPV competent. Despite participants' perceptions of therapist

IPV competence, they were able to identify behaviors that led to negative perceptions of

their therapists.

While cultural variables contribute to clients' ability in identifying incidents of

IPV, a consistent definition of IPV among health professionals is essential. The most

basic yet essential training protocol for IPV competencies is clinicians' ability to

accurately identify IPV that is occurring currently and in the clients past. A challenge

clinician's face in screening and assessing IPV is related to the subjective definitions of

IPV. The lack of awareness of the changes in terminology in response to sociocultural

trends over time hinders the possibility of a consensus in a consistent definition for IPV

(Nicolaidis & Paranjape, 2009). To help resolve this issue, trainings in IPV should begin

with an introduction on the multiple forms of abuse embedded in IPV definitions in an

effort to fully understand all aspects inherent in the term IPV. Such attentiveness to IPV

distinctions will allow for a more accurate assessment of IPV despite clients lack of endorsement. Also, familiarity with state reporting mandates and legal definitions related to IPV is critical.

An interesting finding related to emotional distress, was that all participants reported the following Themes: Anger, Fear, Fear of Judgement, Shame, Depression, Blamed Themselves and Emotions Maintained Silence as a result of IPV. Furthermore, a Typical Theme reported by six participants was Substance Abuse. The devastation embedded in acts of violence has a culminating affect that exceeds beyond the individual but also impacts those around them. Co-morbid disorders such as depression, anxiety, PTSD and substance abuse are common for survivors of IPV (Campbell et al., 2006; El-Bassel et al., 2000; Robertiello, 2006). Six of the participants reported that they initially went to therapy in order to obtain assistance in managing their depression, anger and, in one case, substance abuse which led to their disclosure of IPV. Certainly addressing these symptoms alone can help reduce client distress; however, as reported by many of the participants, the increased risk of multiple victimizations is a shared reality for survivors of IPV that contribute to their distress (Graham-Bermann, Sularz, & Howell, 2011). Therefore, addressing the underlying issues related to client symptoms can help reduce the reoccurrence of an IPV relationship.

Agencies and programs specializing in IPV treatment and prevention should provide specialized training in IPV for all staff and clinicians providing services to IPV survivors. IPV agencies which offer such training opportunities to clinical students should be cognizant in selecting trainees that are clinically appropriate for their site. The

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experience discussed by one participant who sought therapy at an IPV specific agency of her therapist leaving mid-session in order to seek supervision, highlights the importance of training staff and trainees in IPV interventions and is consistent with studies reporting an absence of IPV training in most institutions (Btoush & Campbell, 2009; Campbell et al., 2001; Garimella et al., 2002; Spencer et al., 2008; Wathen et al., 2009).

Interestingly, a Variant Theme endorsed by four participants worth noting, is Abusive Relationship Patterns. Participants discussed their emotional reaction to their therapists' proclivity to point out the frequency in selecting partners that were abusive. While all but three participants reported that this tendency was counterproductive, all four participants found this approach emotionally distressing. These women perceived their therapist as blaming them for their IPV experience, which again is consistent with one study that reported that clinicians felt that marginalized women provoked incidents of abuse (Capezza & Arriaga, 2008). In order to accurately address IPV, a multifaceted approach is necessary, requiring clinicians to be familiar with current theoretical research in IPV including evidence-based treatments. Similarly, another Variant Theme disclosed by three participants was Felt Like a Statistic. When therapists interjected their own beliefs and values in session, or when the participants felt that the therapist was just there for a "paycheck", they saw these as markers indicating therapist bias or lack of respect. Clinicians' reluctance in respecting decisions made by IPV survivors is consistent with existing research (Iliff & Steed, 2000). It is understandable that clinicians at times will question the choices and behaviors of clients but it is vital that objectivity is maintained

with clients. These two themes underscore the importance of specialized training in IPV in an effort to reduce the risk of "victim-blaming".

Cultural Competence

Discussions of cultural differences between Latinas and the majority culture including the prevalence of racism were consistent for all interviews. The General Themes reported by nine participants were Commented on Racism and Cultural Identity. The discussions of racism were either related to their own experience of racism or their parents' disclosure of racist incidents they had endured. All participants discussed the importance of clinicians gaining awareness in the cultural nuances for Latinos since familiarity with these variables can be used to develop and implement culturally inclusive as well as relevant services. An understanding of critical race issues and oppression were discussed by participants as essential in becoming culturally competent. The objective in gaining familiarity with the socio-political and socio-environmental issues impacting ethnic minorities assumedly will provide an internalized appreciation for the multifaceted factors influencing client perceptions.

Understanding cultural variables for Latinas has important implications in the conceptualization of clients' presenting concerns (Ahrens et al., 2010). Cultural norms and beliefs were discussed by all participants as factors influencing their perceptions of therapy and willingness to participate in therapy. Clinician's awareness of cultural differences and willingness to explore those differences were significant influences in establishing a therapeutic alliance.

Future Research

The purpose of this study was to explore the experience Latina survivors of IPV have in IPV counseling sessions with their therapist. This study was particularly interested in participants' perceptions of counselor competence in providing IPV counseling including their cultural competence. This research sets the foundation for quantitative studies related to client perception of therapists' competencies in IPV and culture.

The Contextual Themes identified in this study generated valuable information regarding factors contributing to IPV survivor's reluctance in participating in therapy. An in-depth exploration of the impact of various institutions' condemnation or support correlated with participant's willingness to participate in therapy such as police, hospitals and churches as described by participants in this study would be beneficial in demonstrating the influence of environmental factors for Latina IPV survivors' willingness to seek treatment.

Additional research is necessary to understand the contextual factors that influence survivors of IPV to seek treatment. The participants in this study explained their motivation to disclose the violence and abuse they endured as well as the potential risks in exposing their experiences. By exploring how Latinas assess personal and familial risks in defying cultural and social expectations to maintain silence, can provide valuable information regarding individual and cultural motivational factors in seeking

treatment. Future research that explores the consequences for IPV disclosure or participation in therapy will also be beneficial.

Also, comparison studies in perceptions of cultural and IPV competence between therapists and clients may shed light on factors contributing to mental health discrepancies associated with ethnic minorities. Studies exploring clinicians' assumptions of Latina IPV survivors can potentially offer data related to perceptual discrepancies and possible erroneous assumptions made about Latina survivors of IPV.

Many of the participants discussed their preference for a therapist who self-disclosed their own IPV experience as a way to assist them in working through own IPV experience. Comparison studies between clinicians with and without personal IPV experience and how this relates to a positive therapeutic alliance and therapeutic outcomes are other areas for future research. Studies that look at the effectiveness of specific interventions will help to guide best practices with IPV clients.

Limitations of the study

As is the case with any study, there are several limitations to consider when reporting results. While valuable information and detailed descriptions of participants' experiences were obtained in this study, the following categories were identified as limitations.

Generalizabilty

Given the small sample size of Latina participants, these findings do not generalize to all Latina survivors of IPV. In addition, the term Latina encompasses a broad range of individuals from various regions which may also impact generalizability across ethnic subgroups of Latino descent. While participants selected for this study comprised a wide range of demographics such as age, education, history of abuse and assumed socioeconomic status, the sample size limits the amount of conclusions that can be drawn from this study.

Several of the contextual themes were obtained from participants unprompted disclosures during the interview. Because inquiries related to these themes were not anticipated, they were not included in the semi-structured questionnaire and therefore were not a standard feature of the interviews. Given the sensitive nature of the information disclosed and the potential for emotional distress for participants, inquiries exploring several of the contextual themes mentioned in prior interviews were not explored further in subsequent interviews. Therefore, there may be themes that are applicable to more participants than those identified in this study.

Subjectivity

Despite efforts to control researcher bias in the process of obtaining epoche, it is possible that information provided by the participants may have been inadvertently misinterpreted. The challenges in obtaining epoche is explored and discussed by Moustakas (1994). Suspending all judgments and beliefs that may interfere with

perceiving information as unique and distinct requires tremendous self-discipline. It is

unclear to what extent my experiences, knowledge, and assumptions influenced the

findings reported in this study. The two research assistants used in this study to

authenticate the transcriptions were Caucasian males and therefore they may have

assumed that my familiarity with the culture was sufficient in interpreting the

transcriptions, thus inhibiting them from making corrections. It is possible that the gender

differences between research assistants and participants may have influenced their ability

to accurately authenticate transcriptions. Perhaps other researchers or research assistants

would have interpreted these results differently.

Sampling Method

Another limitation of this study was the sampling method utilized. A snowball

method was used due to the difficulty experienced in recruiting participants through

mental health outpatient agencies and domestic violence shelters. Snowball sampling

refers to obtaining participants through contact information that is provided by other

individuals (Noy, 2008). Although snowball method is a methodology commonly used in

participant recruitment, a disadvantage of this methodology is the inability to obtain a

random sample. The sampling method used for this study may have resulted in excluding

women or disproportionately including some women.

Despite efforts in recruiting participants from various mental health agencies, not

one agency provided a referral to this study and further research is necessary in

understanding the reticence in participant referrals. Perhaps the nature of a qualitative

study versus a quantitative study increases the potential for emotional distress among IPV survivors. It is also possible that the specific criteria for participants related to ethnicity and language fluency served to limit referrals.

Personal Reflection

This study was inspired by my personal conceptualization of cultural competencies which I began to contemplate early in my academic career as I gained clinical experience in working with IPV survivors and my own IPV experience. My awareness of the complex issues relating to diversity in counseling, coupled with my familiarity with Latina/o culture, compelled me to ensure that professionally incongruent and insensitive policies are addressed and changed.

During the course of my employment and academic experience, I began questioning the manner in which clinicians and counseling students were trained in multiculturalism. I had encountered a wide array of discrepancies in the information about diverse populations presented in multicultural discourse and viewed these courses as offensive and to be relying on over generalized stereotypes of a given ethnic group; negating the heterogeneity among and within ethnic groups. Furthermore, the notion that clinicians can be culturally competent by accepting their unearned privilege, making a conscious effort to relinquish that privilege, seemed irrational. I felt this idea offered an idealistic "feel-good" approach to working with marginalized communities in an effort to distract from the harsh realities of oppression in the United States, while also negating corollaries between pathology and socio-political factors.

Based on my own negative experience in IPV counseling, coupled with the lack of training I had received in IPV, I assumed that most clinical programs and counseling agencies neglected specialized training in IPV. I imagined that the inadequate training in both IPV and multiculturalism would be reflected in the interviews conducted for this study.

Interestingly, as a result of the women's interviews in this study, I have come to realize that, while specialized training in IPV and cultural diversity is certainly important, the therapeutic alliance had a greater influence on overall positive perceptions of the therapist, counseling satisfaction for clients, and participant comfort in disclosing IPV in session. In fact, projecting a sense of investment and positive regard for the client is sufficient in developing a positive rapport. Moreover, by simply inquiring about client's cultural values and beliefs was adequate in demonstrating therapists' cultural sensitivity as well as their inclusivity.

This isn't to say that therapists' cultural competencies play a less significant role in establishing a therapeutic alliance but based on the women's interviews, all women are cognizant that in the United States, there continues to be racial factions that impact the manner in which minorities perceive the majority culture, and vice versa. This is an awareness that resonates with my experiences both academically and professionally. For me, this meant relentlessly assessing people's perceptions of me and questioning the extent to which I could possibly assimilate to a culture which felt vastly different than my own. The first time I was introduced to the works of W.E.B Dubois (1995), I took particular fascination in his description of "double consciousness" which he described as

"the sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in an amused contempt and pity" (p.44).

I can't say that the experience of "double-consciousness" applies to the women I interviewed, but I can only assume the therapists' both explicit and implicit interactions which expressed a genuine concern and investment in the women, allowed for clients' reprieve from the constant appraisal of one's self or wondering whether they are perceived as inferior. The therapists' knowledge and compassion for the overwhelming emotional toll felt by the clients due to internalized oppression, I presume plays a prominent role in the clients' ability to develop trust with therapists; which may also explain why all ten women were initially resistant to therapy.

The impetus to obtain a PhD was to develop a multicultural curriculum that more accurately reflects the cultural nuances and experiences of the populations within that discourse. I've come to realize that issues of racism and discrimination are a systemic issue which requires those in positions of power, particularly health providers, to gain awareness and more importantly, compassion for how oppression impacts marginalized communities. Such realizations may influence how therapists interpret clients' psychological and interpersonal presentation. It is this compassion that can convey respect despite cultural differences.

As I began this study I expected that my identification as a Chicana would assure a better degree of influence in my accessibility of participants and that I would be positively accepted by the community and participants vital to this study. Certainly, both

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my familiarity with the culture as a Chicana and my experience of IPV would provide a certain leverage necessary to recruit participants and establish a rapport for an uncensored discussion of IPV counseling experiences; however, both these factors were insufficient in accomplishing these goals.

In terms of cultural connectedness, I assumed that my social activism, familiarity with the culture, and personal connections within the community would afford me an insider perspective but again I was shocked when I encountered difficulties recruiting participants for this study. I was also astonished by the reluctance of various Latino based agencies and domestic violence shelters to provide referrals, including friends in the health care industry. I was never denied directly access to participant referrals but rather I felt as though I was constantly chasing referrals. I was unclear whether the challenges I faced were attempts to protect Latina survivors of IPV from exploitation and emotional distress, or whether I was seen as an outside researcher.

The possibility of perceptual differences in my role as a researcher became more apparent during the interviews with several women. I became cognizant of participants' use of formal language, apologizing for using colloquial terms or curse words, and their reticence in disclosing certain information. I became aware that despite my "Just–one–of–the-girls" mentality, I was a researcher gathering personal information in order to meet the requirements for a PhD. There was an inherent hierarchy, or at the very least a difference in roles established prior to initiating the interview that I had little control over.

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Additionally, I quickly realized that the definition of IPV was culturally subjective. I had not experienced IPV in any manner that remotely resembled what I had heard in the course of these interviews. I had not experienced the gut wrenching childhoods described and I found myself humbled by the resilience demonstrated in their stories. I often fought back tears during interviews as I heard women's accounts of IPV and the destruction generated as a result of violence, and on one occasion unable to contain my emotional reaction, I sobbed with a participant. I have heard countless stories of tragedy and loss in my counseling experience, but I was unprepared for the stories I heard during the course of this study. I respectfully accepted the fact that I am privileged and that I *am* an outside researcher.

This study has inspired me to continue exploring effective and ethically considerate interventions in working with survivors of IPV. I have also begun to reassess the way in which I conceptualize multicultural discourse and will continue to negotiate the manner in which this information is disseminated in training counseling students; with a particular interest in identifying salient factors that demonstrate inclusivity that will allow for a respectful therapeutic alliance

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APPENDIX A

Demographic Questionnaire

Age: _____

Education: _____

Employed: Yes ☐   No ☐

Relationship Status: Married: ☐   Single ☐   Divorce ☐   Separated ☐

Widowed: ☐   Dating: ☐   Committed Relationship ☐

Ethnicity: Chicana   ☐   Other: _____

Latina   ☐

Mexican   ☐

Hispanic   ☐

Bi-racial   ☐

Language Fluency	None	Moderate	Fluent
English	☐	☐	☐
Spanish	☐	☐	☐

Physical domestic violence is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person. Domestic violence also includes emotional, psychological abuse, stalking and sexual assault.

Are you currently in an abusive/domestic violent relationship? Yes ☐   No ☐

Do you need referrals for domestic violence?   Yes ☐   No ☐

Do you have a history of suicidal attempts? Yes ☐   No ☐

Appendix B

Interview Questionnaire

Thank you for participating in this important study. This interview should last approximately one hour. If at any point, you feel uncomfortable or would like to stop please let me know and we will discontinue the interview. Do you have any questions for me before we start? If not, I will now begin the interview.

1. Would you tell me more about your experience in session with your counselor?

2. What were some thoughts you had related to your counselors ability to identify with what was being discussed in session? With you as a Latina?

3. What were the emotions you experienced as you described your IPV experience? As you listened to feedback/ advice given by the counselor?

4. What was your experience in feeling validated by your counselor as you discussed IPV?

5. What were or would be effective strategies in ensuring that you were understood by your counselor?

6. Describe interventions or strategies that negatively impacted the session

7. How do you feel your culture influences the way you perceived the

8. competence level of your counselor? Their cultural sensitivity?

9. What environmental factors if any influence the way you perceived the competence level of your counselor? Their cultural sensitivity?

10. Describe your overall impression of your IPV counseling experience.

11. Do you have anything else you would like to add or clarify before we end this interview?

Appendix C

Participant Consent Form

Perception of counselor cultural and intimate partner violence competence: As perceived by Latina survivors of intimate partner violence

You are invited to participate in a study that will explore counseling experiences for Latina victims of intimate partner violence (IPV), formerly known as domestic violence. My name is Dellena Aguilar, a doctoral student in the Counseling Psychology program at the University of Denver and the primary investigator for this study. This research study is being done to complete my dissertation under the direction of Maria Riva Ph.D., Counseling Psychology Program, University of Denver, 303-871-2484, mriva@du.edu.).

This is a three-part study; the initial meeting requires participants to complete a demographic questionnaire. Part one of the study will involve participation in a face-to-face interview. Interviews will take approximately one hour to two hours to conduct. The second part of the study will involve a second interview asking participants to elaborate on responses given in the first interview. The final part of the study will ask participants to review the transcriptions of the interviews and to offer their feedback regarding the data obtained. Information gathered from t/he questionnaires and interviews will be used to improve current interventions in working with IPV victims and more specifically with Latina IPV victims.

Participation in this project is strictly voluntary. The risks associated with this project are minimal. If, however, you experience discomfort you may discontinue the interview at any time. All information obtained from this study will be used for research. Information gathered such as questionnaire information and phone interviews will be confidential identifiable information will not be disclosed. Your responses will be identified by code number only and will be kept separate from information that could identify you. This is done to protect the confidentiality of your responses. Only the researcher will have access to your individual data and any reports generated as a result of this study will use non-identifying information. However, should any information contained in this study be the subject of a court order or lawful subpoena, the University of Denver might not be able to avoid compliance with the order or subpoena. Although no questions in this interview address it, we are required by law to tell you that if information is revealed concerning suicide, homicide, or child abuse and neglect, it is required by law that this be reported to the proper authorities.

If you have any concerns or complaints about how you were treated during the interview, please contact Susan Sadler, Chair, Institutional Review Board for the Protection of Human Subjects, at 303-871-3454, or Sylk Sotto-Santiago, Office of Research and Sponsored Programs at 303-871-4052 or write to either at the University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121.

Your signature however, does not bind you to this study if you change your mind. If you have any questions related to this study you con contact Dellena Aguilar at 720-320-6936, dellena_a@yahoo.com or Maria Riva at 303-871-2484, mriva@du.edu.

I have read and understood the above description of the study. Information and technical language related to this study have been explained to me to my satisfaction. I understand that I am able to withdraw from this study at any time without penalty or negative consequences. I have received a copy of this consent form.

_____   _____
Signature of participant   Date

___ I agree to participate in the phone interview

___ I do not agree to participate in the phone interview

___ I agree to be audio-recorded

___ I do not agree to be audio-recorded

___ Do to safety concerns, I do not want to be contacted via phone. Please use the information provided below to contact me for the interview: (e-mail, phone number of friends/ family, counselor, case manager and etc.)

Appendix D

IRB Letter of Approval

7/23/10

Dear Participant,

My name is Dellena Aguilar and I am a doctoral student in the Counseling Psychology program at the University of Denver. I am conducting a research study to complete my dissertation under the direction of Maria Riva Ph.D., Counseling Psychology Program, University of Denver, 303-871-2484, mriva@du.edu.

I am interested in exploring counseling experiences for Latina victims of intimate partner violence (IPV), formerly known as domestic violence. We plan to explore Latina clients' perspective of their counselor's cultural competency and expertise in providing IPV counseling. We are hopeful that the information gathered from this study will help determine more effective strategies and intervention in providing IPV counseling to Latina IPV clients. Exploring client perspective off their counseling experience will hopefully raise awareness to current barriers in IPV counseling.

Research in IPV is extensive, however little information exists related to counseling women of ethnically diverse backgrounds for IPV. There is even less information regarding counseling Latina IPV victims. The information obtained in this study will hopefully contribute to the current literature in IPV counseling as well as offer concrete examples of ways IPV counseling can be further enriched and developed in working with communities of color.

If you're interested in participating in the study, or know of someone who may be interested, I can be reached by e-mail dellena_a@yahoo.com or by phone, 720-320-6936. Your participation and support of this study is greatly appreciated.

Thank you,

Dellena Aguilar
PhD candidate
University of Denver