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Sharon E. Harp
An Exploratory Study of
Mental Health Providers'
Awareness of Internalized
Oppressions of Women Who
Experience Same-Sex
Intimate Partner Violence

ABSTRACT

This exploratory study's purpose was to examine mental health providers' awareness of the intersecting and compounding internalized oppressions (racism, sexism and homophobia) of women who experience same-sex intimate partner violence. The research attempted to address the question: Are mental health providers aware of the internalized oppressions among women who are in same-sex relationships in which intimate partner violence occurs?

A qualitative study was conducted using a semi-structured, self-designed interview guide with open-ended questions. The sample included a total of twelve mental health providers recruited using a non-probability, convenience method.

The findings indicate all twelve participants were aware of internalized oppressions experienced by their clients. In addition, eight participants believed these oppressions intersected. Ten participants perceived a relationship between internalized oppressions and the violence. Additional research is necessary to further understand the relationship between these variables and enhance clinical intervention.

AN EXPLORATORY STUDY OF MENTAL HEALTH PROVIDERS' AWARENESS
OF INTERNALIZED OPPRESSIONS OF WOMEN WHO EXPERIENCE SAME-SEX
INTIMATE PARTNER VIOLENCE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2008

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CHAPTER I

INTRODUCTION

The purpose of this study is to examine mental health providers' awareness of the internalization of multiple oppressions such as racism, sexism and homophobia and the impact of these internalized oppressions on women's same-sex relationships in the form of intimate partner violence (IPV). The foundational question for this research is "Are mental health providers aware of internalized racism, sexism and homophobia in relationships that involve same-sex intimate partner violence (SSIPV)?" While there have been studies on the prevalence of SSIPV, as well as investigations on oppression experienced by women in same-sex relationships, there are few studies that investigate the relationship between the two (Balsam, 2001, 2005). Given the paucity of empirical literature on the intersection of these multiple oppressions in relation to SSIPV and effective interventions, this research begins by asking the question to providers who provide direct service to women in these relationships. Prior research indicates that mental health providers' treatment of women in relationships involving SSIPV can often present barriers related to actual or perceived experiences of racism, sexism and homophobia or heteronormative framing of the situation (Kanuha, 1990; Ristock, 2001; Simpson & Helfrich, 2005; Turell, 1999). It is hoped that interviewing clinicians about their experiences will provide insight into views and interventions as well as their understanding and response to the barriers faced by women in violent same-sex relationships.

In reviewing the relevant literature, numerous gaps exist. The most noticeable is the lack of attention even within SSIPV literature to the topic of internalized oppression. If internalized oppression is discussed, it is most often focused solely on internalized homophobia and rarely includes internalized racism and internalized sexism much less the intersection of all of these oppressions. A contributing factor to this exclusion of a thorough discussion of internalized racism and sexism seems to be a problem with recruitment of participants, sampling sizes and methods. Another disparity in most studies of SSIPV seems to be the inconsistency of the definition of intimate partner violence as well as the types of violence measured. Lastly, the literature often focuses on women's experience of the violence and/or the multiple oppressions rather than mental health providers' attentiveness and interventions used in their work with these clients.

Recruitment Issues: Who Are We Talking About?

Even in these few empirical papers, the impact of internalized racism is generally neglected due to recruiting methods and/or the focus of the prior research. Most of the studies have relied on convenience sampling often recruiting participants from LGBTQ businesses and organizations that are located in White neighborhoods, frequented predominantly by White patrons and publicly identify as LGBTQ. In such studies, internalized homophobia remains the focus of study and analysis. Furthermore, the scarcity of participants who are women of color underlines problems in recruitment and self-selection for studies on internalized racism and its relationship to internalized homophobia in SSIPV.

While this research has been informative to identifying phenomena of internalized homophobia in SSIPV, data relevant to the study of internalized racism is limited in

generalizability. An objective of this research is to give voice to the experiences of all women in same-sex relationships that experience IPV, but also to acknowledge there is not one monolithic group of women who are involved inSSIPV. The experiences are unique for each woman and cannot be generalized. As part of this exploration, the study will consider internalized racism, internalized sexism and internalized homophobia in same-sex relationships that involve IPV.

Definition Issues: What Are We Talking About?

The Centers for Disease Control uses the term “intimate partner violence” (IPV) instead of domestic violence because the former can be distinguished from violence against children and older adults and it is also inclusive of all intimate relationships despite marital status and/or gender (Centers for Disease Control and Prevention, 2007; McClennan, 2005). In reviewing the literature, however, there is only one definition of women andSSIPV offered (Potoczniak, Mourot, Crosbie-Burnett, & Potoczniak, 2003). Hart (1986) describes lesbian battering as “a pattern of violent and coercive behaviors whereby a lesbian seeks to control the thoughts, beliefs or conduct of her intimate partner or to punish the intimate for resisting the perpetrator’s control” (Hart, 1986, p. 178). In most studies onSSIPV, researchers use the terms abuse, violence, battering and assault interchangeably as well as heterosexual models of IPV, which further confuses the issue as well as the data. Although Hart definedSSIPV, researchers focusing on same-sex relationships continue to utilize terms such as battering, abuse, and domestic violence without providing a definition of these terms. Further, researchers note that IPV terminology such as “pushing, hitting and slapping” and severity of the violence is often defined by the researcher and not considered in the woman’s sociocultural context. In

one study, African American women interviewees did not always perceive physical attacks to be as violent, but all believed acts of racism were violent (Sokoloff & Dupont, 2005).

Additionally, researchers also need to clearly define specific behaviors in terms of applicability to a particular category of SSIPV such as physical, psychological, sexual, economic, etc. (Baum & Moore, 2003; L. K. Burke & Follingstad, 1999). The lack of a consistent, uniform definition of SSIPV, as well as questionable sampling methods and underreporting, leads to disparities between data collected regarding prevalence rates and types of SSIPV experienced (Potoczniak, Mourof, Crosbie-Burnett, & Potoczniak, 2003). Despite these incongruities, researchers agree the incidence of SSIPV is equal to or greater than that experienced by heterosexuals, at a rate of approximately 25% to 35% (Baum & Moore, 2003; Greenwood et al., 2002; Heintz & Melendez, 2006; McClennan, 2005; Tjaden & Thoennes, 2000b) with a range of 36% to 68% of women experiencing SSIPV (T. W. Burke, Jordan, & Owen, 2002; National Coalition of Anti-Violence Programs, 2003; Waldner-Haugrud, Vaden, & Magruder, 1997). Notably absent from these prevalence rates are statistics concerning the number of women of color who experience SSIPV. Similar to the incidence of heterosexual IPV, SSIPV occurs in same-sex relationships and does not discriminate based on race, ethnicity, religion, education, profession, age or socioeconomic status (Walker, 1994). However, the risk of IPV or SSIPV cannot be generalized in that research indicates that low-income African American women are its most common and severely injured victims. Although there is a popular myth or stereotype that a woman who is more masculine must be the perpetrator and the woman who is more feminine must be the victim, SSIPV can be perpetrated or

received by either partner. (Jablow, 2000; Renzetti, 1997b; Ristock, 2003; Speziale & Ring, 2006; C. M. West, 2002).

Language Issues:SSIPV is not IPV

Despite the discrepancies, this research is not about prevalence rates. It is not disputed that SSIPV exists at a disturbing and often ignored or overlooked rate. Even though there are a number of ways in which SSIPV differs from heterosexual IPV, perhaps the key difference between the two is that the former always occurs in the context of homophobia (Balsam, 2001; Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006; Helfrich & Simpson, 2006). As Pharr (1986) describes:

There is an important difference between the battered lesbian and the battered non-lesbian: the battered non-lesbian experiences violence within the context of a misogynist world; the lesbian experiences violence within the context of a world that is not only woman-hating, but is also homophobic (Pharr, 1986, p. 204).

Homophobia was originally defined by Weinberg (1972) as an intense, irrational fear, hatred and intolerance of homosexuality (Balsam, 2001; Syzmanski & Chung, 2001; Weinberg, 1972). Tatum (2000) defined racism as systemic oppression based on racial diversity that includes “cultural messages and institutional policies and practices as well as the beliefs and practices of individuals” (Tatum, 2000, p. 80). Mirroring Tatum’s definition of racism, oppression of gender diversity could be substituted for racial diversity. For women experiencing SSIPV, the negative stereotypes, beliefs and attitudes of homosexuality, race and gender are often internalized. The experience and internalization of these oppressions can often lead to feelings of guilt, shame, fear, self-hatred and physical and psychological stress which in turn can lead to social isolation and possibly intimate partner violence (Balsam, 2001, 2005; Clark, Anderson, Clark, &

Williams, 1999; Helfrich & Simpson, 2006; Krieger, Rowley, Herman, Avery, & Phillips, 1993; Landrine, Klonoff, Gibbs, Manning, & Lund, 1995; Shorter-Gooden, 2004; Syzmanski & Chung, 2001; Syzmanski, Chung, & Balsam, 2001; Tull et al., 1999). Women who perpetrate the violence will also isolate their partners from established social support networks as a means of further control and emotional abuse (McLaughlin & Rozee, 2001). Partners will often utilize their partner's fear of potential retribution for being "out" combined with this social isolation to manipulate her into maintaining silence about any emotional, physical and psychological violence (Balsam, 2005; Cano & Vivian, 2001, 2003; Helfrich & Simpson, 2006; McLaughlin & Rozee, 2001).

The Importance of the Current Study

While an objective of this study is to fill the void of research on women's SSIPV and multiple oppressions, the primary aim is to provide clinical social workers and other service providers with information to develop culturally-competent interventions for women in same-sex relationships who experience SSIPV. As of 2006, there were less than 30 agencies in the U.S. that provided services to victims of SSIPV. Five of these agencies are located in California. Thus, SSIPV survivors often turn to mainstream domestic violence shelters and services. Of the approximately 1,500 shelters in the U.S., none reserve services to women who identify as LGBTQ (Helfrich & Simpson, 2006). Clearly, the assessment, service availability, and sensitivity to SSIPV need to be enhanced. If workers possess an increased awareness of the contribution of internalized racism, sexism and homophobia, it may allow for a more thorough assessment of women who experience SSIPV. If workers are more aware of the dynamics involved in SSIPV, it will be more likely that these women will receive adequate services that address their

individual experience. Workers may also become attuned to the ways in which their agency mirrors the racism, sexism or homophobia present in the larger society that maintains the cycle of SSIPV for these women. In keeping with the mission of the social work profession as stated in the preface of the NASW Code of Ethics, the hope is that the research will “enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (National Association of Social Workers, 1999).

As part of this study’s aim to offer useful information to providers with regards to current knowledge and effective interventions in addressing internalized oppressions within SSIPV, it seems a good place to start would be with the mental health providers who are on the front lines. Given the focus on mental health providers, a qualitative, flexible, semi-structured exploratory interview guide was used to allow themes to emerge concerning perceptions of internalized oppressions and interventions in working with clients. A total of 12 mental health providers (psychologists, social workers and IPV workers) from various parts of the U.S. participated. The interview questions solicited their thoughts and reactions to internalized oppression within their clients as well as the relationship to SSIPV. The following chapters establish the background and details of this study. Chapter II, the Literature Review, provides the background of internalized racism, sexism and homophobia, IPV and women in same-sex relationships. Chapter III, Methodology, details the procedure and methods used to conduct the study. Chapter IV, Findings, reveals the results of the data collected. Lastly, Chapter V, Discussion,

analyzes the data collected and considers the relationship to past literature on the topic as well as the contribution to current and future policy, research and clinical practice.

CHAPTER II

LITERATURE REVIEW

Intimate Partner Violence – Background

Before turning to the complex relationship between multiple internalized oppressions and SSIPV, it is helpful to review background information about IPV and SSIPV to build a foundation. The Centers for Disease Control (CDC) defines IPV as “abuse that occurs between two people in a close relationship” that includes current and former spouses, cohabitating same- and opposite-sex partners as well as dating partners (Centers for Disease Control and Prevention, 2007; Tjaden & Thoennes, 2000b).

Although IPV includes single incidents, it most frequently involves a pattern or cycle of coercive behavior such as physical, sexual and emotional abuse as well as threats of these types of abuse (Tjaden & Thoennes, 1998). Despite the increasing amount of research, public awareness and advocacy, IPV remains a significant health and criminal justice problem in the U.S. From 1995-1996, the National Institute of Justice (NIJ) and the Centers for Disease Control (CDC) conducted the National Violence Against Women Survey. The findings revealed that women experience a greater number of IPV incidents than men with approximately 4.8 million physical assaults and rapes annually and a lifetime prevalence rate of 22% (Centers for Disease Control and Prevention, 2007; Tjaden & Thoennes, 2000a). Intimate partners are responsible for 64% of all rapes, physical assaults and stalking reported by women (Tjaden & Thoennes, 2000b). This statistic is startlingly tragic in that a woman is more likely to be raped, stalked and

assaulted by someone she presumably knows and trusts. African American women experience a far greater incidence of IPV compared to women of other races. An African American woman has a 35% greater chance of being involved in IPV than a White woman, and 2.5 times greater than women of other races (Arnette, Mascaro, Santana, Davis, & Kaslow, 2007; Rennison & Planty, 2003; Rennison & Welchans, 2000). Between 1993 and 1999, 10.7 (per 1000 persons) African American women compared to 7.8 European American women reported IPV (Rennison & Planty, 2003) and as many as one out of three African American women (Hampton & Gullotta, 2006; Tjaden & Thoennes, 2000b; C. M. West, 2004) and 23% of African American couples report IPV (Caetano, Schafer, & Cunradi, 2001). While some studies indicate African American women are more likely than Caucasian women or women of other races/ethnicities to be represented in these statistics, other studies indicate there is not an association between race/ethnicity (Thompson et al., 2006), especially when the variable of socioeconomic status has been removed (C. West, 2005). Some literature presents these statistics in a way that seems to connect or blame the victim's or perpetrator's race on the occurrence of IPV, but statistics point to socioeconomic status as an indicator rather than race. African American women are more likely to be in relationships that involve IPV due to factors such as their socioeconomic status and the racial inequalities they face rather than because African Americans are more violent.

Even though the numbers are shocking, they cannot adequately convey the physical, emotional/psychological and economic toll. Physically, women who experience IPV sustain minor injuries such as cuts, scratches and bruises and more severe, chronic injuries such as internal bleeding, head trauma, gastrointestinal and gynecological

problems, including sexually transmitted diseases. Psychologically, women often suffer from posttraumatic stress disorder, sleep and appetite dysregulation, anxiety, feelings of helplessness and hopelessness, cognitive distortions, low self-esteem, depression, somatization, suicidal ideation and attempts (D. Campbell, 1999; D. W. Campbell, Sharps, Gary, Campbell, & Lopez, 2002; J. C. Campbell, 2002; Centers for Disease Control and Prevention, 2007; Coker et al., 2002; Gerlock, 1999; Holmes & Resnick, 1998; Jones, Hughes, & Unterstaller, 2001; Kaslow et al., 2000; Kaslow et al., 1998; Krishnan & Hilbert, 2001).

Although the physical injuries alone are staggering, they contribute to and their inadequate treatment is exacerbated by the economic hardship of women who endure them. While socioeconomic status does not predict IPV, research indicates that women who are African American, young, poor who have children under age 12 and live in urban areas are most likely to experience IPV (Rennison & Welchans, 2000; Robinson & Chandek, 2000a, 2000b). Women who experience IPV are more likely to suffer work-related disability than women who do not (Coker, Smith, Bethea, King, & McKeown, 2000). IPV not only detrimentally impacts individuals, but the societal cost of IPV was estimated to be \$5.8 billion in 1995 and, updated to 2003 dollars, the figure would be \$8.3 billion which includes medical and mental health costs as well as lost work productivity (Centers for Disease Control and Prevention, 2007; Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004). Of this figure, medical care comprises 45% while mental health accounts for 25%. The remaining 30% is equally divided between loss of time in productive activities and murder by an intimate partner (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004).

Given the frequency of IPV and the numbers of women impacted, physically, psychologically and economically, clinical interventions are needed to decrease the economic and societal price of this public health epidemic. However, the statistics do not end with the numbers presented above, many women are not even counted in these figures because they either do not report the violence or they are involved in SSIPV which is often not legitimized in these statistics or the literature related to IPV.

Same-Sex Intimate Partner Violence – Background

Prior to the 1980's, research on SSIPV was virtually nonexistent. Although many founders of the battered women's movement were lesbians, these women, along with heterosexual women, chose to focus their efforts only on intimate partner violence in heterosexual relationships. Historically, the battered women's movement limited the definition of IPV to include only heterosexual relationships and attributed the issue to male gender roles and socialization in a culture that endorses violence against women. In a sense, this denial of SSIPV compounded the secrecy and isolation of women in same-sex relationships. Women who endured SSIPV could not relate to the depiction of IPV provided by the battered women's movement. It led to an increased feeling of shame about their relationships and helplessness in these situations.

Acknowledging SSIPV challenged entrenched cultural views that women cannot be violent and threatened the feminist construct that IPV is rooted in a patriarchal power imbalance involving men and women (Miller, Greene, Causby, White, & Lockhart, 2001; Ristock, 2003). Lesbian feminists also sought to protect the image of their relationships as ideal, nurturing, and loving (McLaughlin & Rozee, 2001). Women did not want to endorse the idea that women could be violent with one another. If people believed they

could be physically threatening, then the feminist theory that IPV evolved from heterosexual gender roles would be decentralized. In addition, the LGBTQ community suppressed discussion of the issue to protect their communities from further homophobia and perpetuation of the myth that LGBTQ people are pathological and deviant (L. K. Burke & Follingstad, 1999). If people thought same-sex relationships were dangerous, there would be further reason to exclude LGBTQ members from society.

Beginning in the early 1980's, SSIPV has been frequently studied as a way to obtain funding for social service agencies, ratify the issue in the public sector and secure data to allow for a greater understanding of the prevalence and types of violence within the LGBTQ communities (Ristock, 2003). Although the literature has increased over the last twenty years, there is still a paucity of research on SSIPV and the majority of the literature focuses on lesbians rather than gay men and transgendered people, and on Caucasians rather than men and women of color. Possibly, feminists who spearheaded the research on interpersonal violence excluded males because they are more concerned with the issue as it relates to women. Furthermore, a focus on male victims of IPV would be another concession that women could be violent and thus that IPV was not just related to a power differential between genders. Since IPV has been known as an act that is promulgated by a man against a woman, it is difficult to believe that a man could be the victim of violence whether perpetrated by a man or a woman. In instances of SSIPV, most people choose to believe that men are of similar size and could fight back so the issue is minimized for men. For people of color, the sampling methods and sizes are inadequate and cannot be generalized. Further, in some studies, there is simply a lack of attention to inclusion of people of color.

Although it has been well established that SSIPV exists, the prevalence rates remain disputed. Researchers argue that prevalence rates cannot be accurately determined or compared to heterosexual IPV because most studies rely on small, nonrandom samples of women who self-report. In addition, similar to heterosexual IPV, the association between IPV and race/ethnicity cannot be determined based on the predominantly Caucasian samples. The studies also do not use a consistent definition or means of measuring the violence in same-sex relationships (Girshick, 2002; Ristock, 2003; Speziale & Ring, 2006). However, in one study examining the psychological distress of African American lesbians and heterosexual women unrelated to intimate partner violence, the rates of physical and verbal abuse reported were comparable (Hughes, Matthews, Razzano, & Aranda, 2003). Despite such discrepancies in the overall data, findings indicate that between 41% and 68% of lesbians experience SSIPV (T. W. Burke, Jordan, & Owen, 2002; Helfrich & Simpson, 2006; National Coalition of Anti-Violence Programs, 2002; Simpson & Helfrich, 2005) with 25-50% of women's same-sex relationships involving SSIPV (McClennan, Summers, & Daley, 2002). Even though the statistics vary widely depending on the study, the sample, etc., it seems that at least half of all women in same-sex relationships experience SSIPV.

Historically, the incidence and prevalence of SSIPV has not only had to contend with the feminists committed to the battling heterosexual IPV, but also a host of myths of SSIPV that serve as barriers to women in these relationships. It is possible these myths preclude the victim's identification of the violence and stifle attempts at help seeking. Clinicians need to identify and challenge their belief in these myths to provide culturally sensitive services to these women and to empower women.

Myths and Types ofSSIPV – Similarities and Differences from Heterosexual IPV

In addition to similar prevalence rates, the literature also reveals that the types of violence and the power and control dynamics experienced by same-sex partners resemble IPV in heterosexual relationships. SSIPV can be physical, emotional, psychological, sexual and economic and often results from power and control of one partner over another. The violence often intensifies over a period of time and the injuries become more severe. In a pioneering study by Renzetti (1992) and a later follow-up regarding SSIPV among 100 women, Ristock indicated power imbalance as the pre-eminent variable predicting incidence and severity of SSIPV followed closely by dependency, jealousy, substance abuse, intergenerational transmission of violence, internalized homophobia and personality disorders (Renzetti, 1992, 1997a). Among these variables, internalized homophobia stands out as a distinguishing characteristic of SSIPV. It predicts the occurrence and intensity of SSIPV, yet few studies measure or even discuss internalized homophobia. Renzetti's groundbreaking study addressed its importance and a handful of others follow her in highlighting the association between internalized homophobia and SSIPV.

During the development and validation of the Lesbian Partner Abuse Scale, McClennan (2002) added the variables of social and communication skills, fake illnesses and status differentials to Renzetti's previously discovered variables (McClennan, Summers, & Daley, 2002). As many as 90% of women have reported some form of psychological or verbal abuse occurring in a same-sex relationship while 7% to 48% and 7% to 55% have experienced physical and sexual violence, respectively (Balsam, 2001; L. K. Burke & Follingstad, 1999; C. M. West, 2002). While power and control generally

rests with the male in heterosexual IPV, the power and control inSSIPV is typically more fluid (Ristock, 2003). Though, some same-sex relationships are either stereotyped into heterosexual gender roles or, perhaps as part of the internalized homophobia, women in these relationships try to model them. In biracial relationships, the non-White partner may traditionally have less power by virtue of her lack of societal privilege and a lower position in the hierarchy of oppression. Thus, for women of color in biracial relationships, they may be more likely to be abused by their White partner given their lack of social and relational power. Again, the internalized homophobia compounds these racial inequalities. As with heterosexual IPV, SSIPV remains underreported due to the victim's fear of retaliation from the perpetrator.

Unlike their heterosexual counterparts, women in same-sex relationships contend with additional components of homophobia, the myth of mutual battering and gender role stereotyping (Helfrich & Simpson, 2006; McClennan, 2005; Simpson & Helfrich, 2005; C. M. West, 2002). SSIPV is difficult enough to identify and admit to oneself and others without these variables, but the additive of homophobia becomes an overwhelming barrier for these women in terms of seeking and receiving help from mental health providers and intimate partner violence agencies. Women are not likely to seek help and, if they do, often hide their involvement in a same-sex relationship. In contrast to male batterers, females often control and manipulate using the victim's fear the relationship or their sexual identity will be exposed and they will lose their already limited family and social support and/or employment. Behaviorally, after perpetrating the violence, women often threaten to "out" their partners to friends, family or employers to prevent them from seeking help or telling others. Moreover, perpetrators often augment the victim's

internalized homophobia and/or racism by convincing her that service providers will not believe the victim if she chooses to report; essentially saying that she ‘deserved’ it or normalizing the violence in the context of the relationship (Balsam, 2001; Kanuha, 1990). If a woman believes something is wrong with her for being in a same-sex relationship, then her partner can easily heighten this feeling by telling her that she is sick, bad, or dirty and the violence is justified. If the victim chooses to report, she may also be at risk for further traumatization by homophobic service providers (Kuehnle & Sullivan, 2003; Tully, 2001). Service providers may minimize the violence by using terms like “mutual violence” or “cat fight” and not provide services or equal services to the women. As part of the service provider’s funding or belief system, they may also refuse services or proselytize and condemn same-sex relationships with hopes the women will denounce their same-sex attractions. If allowed into shelters, other residents may also taunt the woman with homophobic name-calling or even inflict physical abuse. Victims also fear retribution from members of the LGBTQ community or loss of mutual friends if they report (Kuehnle & Sullivan, 2003; Peterman & Dixon, 2003). Although the LGBTQ community is beginning to recognize and provide SSIPV services, there is still a lack of funding and a hesitancy to confirm the existence of the violence to prohibit portraying same-sex relationships as even more aberrant and dangerous. Perpetrators often restrict the victim’s contact with friends, family and employment as part of their exercise of control and to prevent others from discovering the violence. All of these factors result in dependency of the victim on the perpetrator, which increases the victim’s sense of isolation (Peterman & Dixon, 2003). Women will be less likely to report the violence or to put themselves in situations where others might notice physical scarring or bruising or

they may sustain emotional injuries from friends, family and homophobic service providers who reject them.

Further, women in same-sex relationships are impacted by the myth thatSSIPV is mutual battering though research discredits this myth (Helfrich & Simpson, 2006; McClennan, 2005; Poorman, 2001; Simpson & Helfrich, 2005; C. M. West, 2002). As noted above,SSIPV involves a power differential regardless of gender. In a recent study of 347 marriage and family therapists' responses to IPV scenarios, both partners in the same-sex scenarios were implicated as victim and perpetrator (Blasko, Winek, & Bieschke, 2007). For clinicians,SSIPV presents a challenge in terms of accurately screening, assessing and providing the appropriate treatment to the batterer and the victim. In some agencies and shelters, mental health providers and workers may not correctly establish the perpetrator's role due to assumptions of mutual battering or the lack of appropriate screening forms and knowledgeable staff to complete the assessments. Training and assessment ofSSIPV can be time-consuming and involve additional resources for agencies and mental health providers. The shelter will then provide services to the perpetrator and deny services to the victim. A mutual battering myth or assumption also prevents the perpetrator from the need to accept responsibility and can often assign blame and confuse the woman who is the real victim, especially if she does fight back to protect herself. Perceived mutual responsibility does not seamlessly map onto a heterosexual model of IPV. Dynamics in a same-sex relationship threaten conventional understanding crafted on the heterosexual model. For example, as with heterosexual IPV,SSIPV involves a perpetrator and a victim. Since both partners are of the same gender and often described as equally matched in size and strength and often

one partner may fight back as a result, the victim is often mistaken to be the perpetrator or the violence is perceived to be mutual. These acts of self-defense are often confused with intentional, voluntary provocations of physical violence. The victim who fights back in self-defense may also believe she is the perpetrator and/or she may not realize that SSIPV is not mutual battering. Further, the victim generally believes she is responsible, minimizes her injuries and maintains a caring stance towards her partner while holding guilt and shame about her participation. In contrast, the perpetrator rarely accepts full responsibility, continuously shifts blame to the victim and infrequently seeks services (Giorgio, 2002; Pitt & Dolan-Soto, 2001; Renzetti, 1992; Tully, 2001; C. M. West, 2002). Since mainstream society follows the heterosexual model of IPV, it is difficult to distinguish the victim and perpetrator since they share the same gender. The perpetrator is often assumed to resemble heterosexual male batterers though data indicates there is not a similarity (Robson, 1997). In fact, victims of SSIPV are challenged to name the violence because the literature focuses on heterosexual IPV. Women in same-sex relationships cannot identify with the heterosexual model and pronouns and thus cannot translate their experience of SSIPV (Giorgio, 2002). This model contributes to gender role stereotyping by service providers with the partner ascribed as more “masculine” often accused of perpetrating the crime and the more “feminine” assigned the role of victim (Giorgio, 2002; C. M. West, 2002). Again, it may seem simpler and easier to distribute responsibility and provide services based on gender roles and/or the heteronormative framework of SSIPV. However, this false assumption leads to further emotional and physical distress on the part of the victim. As mentioned, in many relationships in which there is one African American partner, she is not only

oppressed by the relational power differential, but also suffers injustice by the racial stereotyping and unfair assignment of the perpetrator's role.

Internalized Oppressions – Racism, Sexism and Homophobia

In research reporting rates of IPV among African American women, presumably heterosexual, African American women are the victims of over half of the violent deaths and IPV-related homicide is reported to be the primary cause of death among African American women, ages 15-34 (Hampton, Oliver, & Magarian, 2003). Further, IPV in African American communities typically assumes more violent forms compared to Caucasian communities (Hampton & Gelles, 1994; Hampton, Oliver, & Magarian, 2003; Kessler, Molnar, Feurer, & Appelbaum, 2001; Tjaden & Thoennes, 2000b). Although the prevalence, types of abuse and dynamics of heterosexual IPV and SSIPV have been researched, the literature lacks a meaningful discourse of SSIPV among African American women despite the fact that IPV is more likely to occur among poor African American women (Sokoloff & Dupont, 2005). Due to the inherent racism within the feminist community prior to the 1980s when the issue of IPV was first exposed, women of color in heterosexual violent relationships were excluded from these discussions (Kanuha, 1990; Lorde, 1983). Kanuha (1990) also points out that communities of color often equate lesbianism and feminism with Whiteness (Kanuha, 1990). For this reason, African American women may avoid identifying as lesbian and may often use terms such as women loving women. These women may be reluctant to access services, especially when advertised in predominantly White, lesbian newspapers or areas. An association with feminism is attributed to the sexism within communities of color. However, some women of color may resist joining feminist causes to prevent identification with a group

of people that are ostracized by Whites to decrease further racial oppression. For people of color, homophobia and sexism manifest in the fear of annihilation of the culture and the threat that women of color will be able to live independently. Thus, African American women experiencing SSIPV often do not have anywhere to turn. These women are often displaced within their African American communities as well as the larger society and unsupported by the White LGBTQ community (Kanuha, 1990).

As a result of the institutional, cultural and interpersonal experiences of racism, discrimination or harassment, African American women may adopt negative stereotyped images of African Americans at the same time as they battle against IPV. Internalized racism “refers to the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves” (Williams & Williams-Morris, 2000, p. 255). The psychological consequences of internalized racism include shame, decreased self-esteem, paranoia, interpersonal insensitivity, hostility and depression (Speight, 2007; Thomas, Witherspoon, & Speight, 2004). The shame of internalized racism compounds the shame of reporting a violent same-sex relationship and victims may also hide their sexual identity and relationships from the African American community (Mays, Cochran, & Rhue, 1993). Thus, the fear of being “outed” and ousted from their community as well as the shame of being in a violent relationship that challenges this community’s beliefs, serves as another barrier in terms of accessing services. African American woman may also endorse the stereotype of the “strong black woman” and believe that they need to suffer through the abuse without seeking support or counsel from others because to do so would be an admission of weakness (Neal-Barnett & Crowther, 2000; Thomas, Speight, & Witherspoon, 2004). The failure to report may

also be a fear of confirming the negative stereotype that African Americans are more violent, IPV is somehow associated with race or ethnicity, and the internalized racism of the African American woman that tells her she deserves the abuse (Donnelly, Cook, van Ausdale, & Foley, 2005; Sokoloff & Dupont, 2005).

Another hypothesis is that African American women do not seek help because they do not trust service providers, especially White service providers, and/or their functioning within the relationship is adaptive. Reporting the SSIPV, similar to reporting problems related to anxiety, would allow for the possibility of experiencing a range of emotions that would thwart their daily functioning and the shield donned by these women to endure racial oppression (Neal-Barnett & Crowther, 2000). As a result, the failure to report for African American women is often pejoratively stereotyped as resilience or lack of need for services rather than based on their fears of race betrayal or increased victimization, especially since most IPV services are located in White areas, operated by predominantly White staff members and advertised to White lesbians (Donnelly, Cook, van Ausdale, & Foley, 2005). Further, the research delineating types of abuse again lacks an exploration of the issue of White privilege and power being used to control and dominate the woman of color in biracial relationships. Yet, women of color have reported being verbally, emotionally and physically abused by their White partner who will hurl racial slurs at them, reenact master-slave roles, threaten to “out” their partner and extinguish their cultural ties or fight about the color of their skin based on White standards of beauty (Kanuha, 1990; Mays, Cochran, & Rhue, 1993). Despite this relational oppression, women of color in biracial relationships are often designated as the perpetrator because race is associated with masculinity and lower in the cultural hierarchy

(Giorgio, 2002). As Kanuha (1990) notes, same-sex women of color in violent relationships face a “triple jeopardy” of racism, heterosexism, and homophobia (Kanuha, 1990; Poorman, 2001).

Additionally, women of color are not immune to racism even within the LGBTQ community. This colorblindness may contribute to this community’s unification around the primary oppression of homophobia and minimization of the “triple jeopardy” experienced by women of color (Kanuha, 1990; Mays, Cochran, & Rhue, 1993).

African American women may also minimize their participation in SSIPV to avoid further pathologizing the African American community and oppression by the dominant culture (Kanuha, 1990; Sokoloff & Dupont, 2005). In addition, underreporting and fears of exposure for same-sex women of color may be exacerbated by the fact that they face the possibility of losing cultural barriers against racism that exists in the LGBTQ community and in the larger society (Greene, 1997; Kanuha, 1990; Mays, Cochran, & Rhue, 1993; Sokoloff & Dupont, 2005).

Although prevalence of SSIPV is beginning to be established, the research to date is lacking with regard to the definition, prevalence and impact on women of color. It is hoped that this study will provide mental health providers’ and IPV workers’ thoughts on the relationship between the “triple jeopardy” and multiple internalized oppressions of racism, sexism and homophobia and SSIPV.

Internalized Sexism

Recent research indicates that women experience lifetime and current sexist events ranging from workplace harassment, objectification in media, verbal assault and discrimination to more brutal forms of rape, physical assault and IPV that lead to an increase in physical and psychological distress (Fischer & Holz, 2007; Klonoff, Landrine, & Campbell, 2000; Landrine, Klonoff, Gibbs, Manning, & Lund, 1995; Moradi & Subich, 2002, 2003, 2004; Swim, Hyers, & Ferguson, 2001). For African American women, sexism occurs in the requirement to work outside the home and in atypical gender role professions since the time of slavery. In addition, the unattainable measure of feminine physical beauty is based on a White female (Greene, 2000). Although some of these studies included small samples of African American women, studies specific to African American women also point to an association between sexist events and psychological and physical distress (Landrine, Klonoff, Gibbs, Manning, & Lund, 1995; Moradi & Subich, 2003). In one of these studies, sexism played a particular role in variance of psychological distress when controlling for racist events or the intersection of racist and sexist events (Moradi & Subich, 2003). The psychological and physical symptoms of distress include premenstrual difficulties, interpersonal sensitivity, depression, anxiety, obsessive-compulsive traits, somatic concerns and disordered eating (Fischer et al., 2000; Landrine, Klonoff, Gibbs, Manning, & Lund, 1995; Moradi, Dirks, & Matteson, 2005). In a two-week diary study of undergraduate men and women, women reported a greater number of sexist events at a rate of two incidents per week. These events were associated with an increase in anger, anxiety, depression and a decrease in self-esteem (Swim, Hyers, & Ferguson, 2001).

Internalized sexism results when women relate to the negative stereotypes of their gender, individually or collectively, deny or ignore cultural, individual or institutional experiences of sexist events or generally believe that men are dominant to women and women should hold traditional gender roles. Similar to the exposure to sexist events, internalized sexism results in psychological distress such as low self-esteem, disordered eating, anxiety and depression (Fischer & Holz, 2007; Moradi & Subich, 2002; Snyder & Hasbrouck, 1996). In one of the studies examining recent and lifetime sexist events and feminist identity development, internalized sexism and recent sexist events were the only variables that accounted for a unique variance in psychological distress (Moradi & Subich, 2002; Szymanski, 2005b). Mental health providers need to pay special attention to the language women use in talking about their relationships and their feelings about their role in the relationship as well as society. It will be important to also observe and consider the somatization of these feelings.

As with the literature on IPV, these studies do not indicate the sexual identity of the women involved or explore the relationship or association between sexual identity and internalized sexism or psychological distress. In the only study of internalized sexism in lesbians, the results indicated that internalized sexism is not associated with psychological distress (Szymanski, 2005b). Again, this study relied on a small, convenience sample of predominantly Caucasian women. Although the research has not identified internalized sexism as a link to psychological distress orSSIPV in lesbians, the sexist socialization of women often encourages women to consider others' needs ahead of their own which produces intense, dyadic relationships between women contributing to relational isolation. If one partner threatens to disturb the homeostasis of this dyad by

pursuing individuation, this could prompt feelings of abandonment and result in the use of violence by the other partner (McClennan, Summers, & Daley, 2002). For women who are involved in SSIPV, the power and control and resulting physical, emotional and psychological violence creates and can grow out of the isolation. Women may also deny the violence based on the internalized sexism that women are not strong enough to hurt one another (McLaughlin & Rozee, 2001).

Some women may also have internalized the popular belief that when SSIPV occurs it is also not as severe as heterosexual IPV (Poorman, Seelau, & Seelau, 2003). Internalized sexism or the stereotype that relationships between women are always nurturing may prompt some women to resist identification and reporting of the violence. If women in same-sex relationships pattern their relationship after traditional heterosexual gender roles, there may also be some acceptance of the power differential or the abusive behavior. The internalized sexism also feeds into already low self-esteem in that women may also feel they deserve the violence because they are women and somehow less than their partner. Even though internalized sexism may coincide with internalized homophobia and internalized racism, and women may not recognize the experiences of sexist events and internalized sexism, mental health providers need to be attuned to the psychological and physical symptomology in assessments to begin to provide a corrective, empowering experience for these women.

Internalized Homophobia

Originally, Dr. George Weinberg (1972) defined homophobia as “the dread of being in close quarters with homosexuals – and in the case of homosexuals themselves, self-loathing” (Weinberg, 1972). Meyer and Dean (1998) define internalized homophobia as “the gay person’s direction on negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts with poor self-regard” (Meyer & Dean, 1998). Internalized homophobia is not only the adoption of social attitudes, but also cultural, religious and familial attitudes and assumptions about same-sex relationships and non-heterosexual people (Sophie, 1987; Szymanski, 2005a). Shidlo (1994) writes about the salience of internalized homophobia because all gay men and lesbians are exposed to it at some point in the process of their identity development as a result of their participation in the greater homophobic society (Shidlo, 1994). The concept of internalized homophobia though psychologically and developmentally damaging to a multitude of women has been scarcely researched (Davies, Hickson, Weatherburn, & Hunt, 1993; Wagner, Brondolo, & Rabkin, 1996; Williamson, 2000). In most studies, the research combines gay men and lesbians and the focus on lesbians as a separate group is rare (McGregor et al., 2001).

In some sense, there is a message in this lack of research that women may experience internalized homophobia in a different way. For a woman who does not identify as heterosexual, internalized homophobia turned inward not only becomes self-loathing and anger but leads to intense shame, isolation, perception of lack of social support and psychological distress (McGregor et al., 2001; Tigert, 2001). As Plummer (1994) notes the stigma “leads the experience to become an extremely negative one;

shame and secrecy, silence and self-awareness” (Plummer, 1994). Researchers posit that internalized homophobia and shame contribute to the perpetration of or victimization by a same-sex partner (Renzetti, 1998; Tigert, 2001) and can lead to a number of physical and psychological sequelae including depression, anxiety, somatic complaints, and low self-esteem, self-harm, lower levels of social support or satisfaction with social support and poor relationship quality (Bennett & O'Connor, 2002; Meyer, 2003; Meyer & Dean, 1998; Syzmanski, Chung, & Balsam, 2001; Syzmanski, 2005a, 2005b; Williamson, 2000). Many of these symptoms are similar or the same as the symptoms indicated for internalized sexism. We are also reminded of the co-occurrence of isolation as a symptom and risk factor of the violence.

Given we live in a society founded on the values and beliefs that a dominant breadwinning male paired with a female heads traditional families, it is difficult to acknowledge thatSSIPV exists when the relationships themselves are virtually invisible. Renzetti (1998) theorized that internalized homophobia contributes to perpetration of violence against members of one’s own group (Renzetti, 1998). As is the case with the experience of internalized sexism, women in same-sex relationships are often silenced by the dominant heterosexist society and rely on their partners for the sole source of emotional, economic and cultural support. The fear of harassment or discrimination as well as her internalized homophobia impedes a non-heterosexual woman’s self-disclosure which exacerbates internalized homophobia, thwarts positive identity development and leads to psychosocial distress (Herek, Cogan, Gillis, & Glunt, 1997; McGregor et al., 2001; Mohr & Fassinger, 2000; Radonsky & Borders, 1995; Sophie, 1987; Syzmanski & Chung, 2001). Further, when IPV occurs, a woman is not likely to seek help due to the

shame surrounding her own internalized homophobia as well as her shame and assignation that she has been violent with or violated by another woman (Tigert, 2001). Women who experience SSIPV not only have the shame of disclosing their relationship, but also the violence they experience in the relationship that can be multiply stigmatizing.

Even though the LGBTQ community also internalizes societal homophobia by minimizing the prevalence and existence of SSIPV to avoid further marginalization (McLaughlin & Rozee, 2001), most women involved in SSIPV cannot name the violence due heterosexist framing of IPV. They are not able to apply the model of heterosexual IPV to their situations (McLaughlin & Rozee, 2001). The IPV media and advertisements do not feature pictures of relationships or people that resemble them. It is vital that mental health providers help women name their experiences in a way that validates them and their same-sex relationships, but also be aware of the resistance to do so.

Further, internalized homophobia may also contribute to SSIPV in that women are often projecting their self-loathing onto their partner until they perceive SSIPV as an attack on the self. Same-sex partners may view their extant oppression as a loss of control over friends, family, jobs, housing, etc. If they choose not to disclose their sexual orientation, women in same-sex relationships also relinquish control to the larger society in that they are always vigilant in self-monitoring their activities, statements and behavior (Miller, Greene, Causby, White, & Lockhart, 2001). SSIPV becomes a means to remedy their own feelings of powerlessness and lack of control (Tigert, 2001). A woman may also use her partner's internalized homophobia and the threat of being "outed" to prevent her from reporting the violence (Helfrich & Simpson, 2006; McClennan, Summers, & Daley, 2002; Simpson & Helfrich, 2005). Finally, women who are victimized by same-

sex partners may believe their sexual identity contributed to the abuse or the violence is somehow justified because they do not identify as heterosexual (Balsam, 2005; Girshick, 2002).

Intersection ofSSIPV and Internalized Racism, Sexism and Homophobia

Until this point, internalized sexism, internalized racism and internalized homophobia present as individual variables that impact women who experience SSIPV. However, these variables often intersect and it can be difficult to discern the individual internalizations of oppressions. Some literature argues that women in same-sex relationships experience a greater level of violence and “minority stress” due to hate crimes, their marginalization as oppressed members of society and internalization of these multiple oppressions (Balsam, 2001; Bernhard, 2000). These minority stressors are then added to the usual stresses of daily life such as financial, occupational and interpersonal issues which can increase the occurrence and severity of SSIPV (Balsam, 2005). Indeed, it can be argued that women of color experience SSIPV as a result of minority stress as it relates to the multiple oppressions of internalized and external racism, sexism and homophobia. Unlike their White counterparts, women of color cannot choose to segregate themselves based on gender or sexual identity because they need communal support to fight against racism (Kanuha, 1990). Thus, for women of color in same-sex relationships, the oppression is not based solely on homophobia, but the intersection of racism, sexism and homophobia. If this is the case, it seems the levels of minority stress for same-sex women of color would be even greater than for their White counterparts.

Similar to internalized homophobia, the internalization of these multiple oppressions may affect the occurrence and intensity of the violence and decrease reporting of SSIPV among African American women. For African American women, multiple internalized oppressions increase the likelihood of remaining in the abusive relationships as well as the underreporting of the violence. As Greene (2000) explains, African American families may be able to aid their daughters in negotiating and buffering the experience of racism and sexism, but ill-equipped, and possibly extremely homophobic, to do the same for sexual identity (Greene, 2000). Added to the homophobia, internalized racism prompts African Americans to perceive acceptance or condoning of any sexual orientation other than heterosexuality as a threat to their chances for assimilation into the dominant White culture (Greene, 2000). When sexist or racist stereotypes are internalized, women in violent relationships feel they deserve the abusive treatment they receive (Greene, 2000). It may be that these women will not report the violence or, when they present for service, they may express some of the psychological symptoms of the violence such as depression, low self-esteem, etc. Mental health providers need to be able to assess and listen for the description of the relational dynamics of violence.

Moreover, in one study examining the concurrent effects of racism and sexism on African American women, the researcher found that racism and sexism inimitably impacted psychological distress, but when examining separately only sexism contributed to psychological distress (Moradi & Subich, 2003). Indeed, similar to Moradi's (2003) and Bowleg's point, it may be difficult to separate the internalization of racism and sexism (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Moradi & Subich, 2003;

Thomas, Speight, & Witherspoon, 2004). Rather, like the original experience of the discriminatory event, whether sexist, racist, or homophobic, the particular internalization or the impact of the internalization may also be challenging to discern. As a result, African American women struggle to develop their multiple identities, gender, sexual and racial, concurrently rather than individually (Thomas, Speight, & Witherspoon, 2004). For some African American women, racial identity may be established prior to gender or sexual identity and for others it may be difficult to separate the multiple self-concepts (Thomas, Speight, & Witherspoon, 2004).

However, as mentioned above, and even in studies on women who experience SSIPV that discuss “minority stress,” the demographics for African American women in same-sex relationships are nonexistent since this population has been excluded from the literature or does not identify with the definitions of SSIPV. The demographics of women included in the SSIPV literature are remarkably similar in that they are White, age 30-40, and well educated. Further, most studies recruited participants from presumably lesbian bars, social events, businesses, publications and organizations which fails to account for the fact that many women of color may not identify as lesbian or bisexual for fear of loss of cultural supports. Thus, the prevalence rates and demographics do not adequately represent the magnitude of this social problem for women of color.

In the only study located that examines the intersection of internalized heterosexism or homophobia and internalized sexism in lesbians, research indicated internalized homophobia contributed to psychological distress, but internalized sexism did not contribute to psychological distress (Szymanski, 2005b). As with all literature examining multiple internalized oppressions, it is questionable as to whether women can

sort whether the discrimination is based on gender, sexual or racial identity and whether these concepts can be individually measured.

Mental Health Providers' Awareness of Internalized Oppressions and SSIPV

Often, mental health providers may not be educated to the specific needs and assessments for women in violent same-sex relationships and may be inclined to follow a heterosexual model of IPV to the detriment of same-sex victims/survivors/perpetrators (Helfrich & Simpson, 2006). In fact, there are few agencies or providers that designate services for SSIPV (Helfrich & Simpson, 2006). Some providers harbor their own prejudices, racist, sexist or homophobic, or heterosexist assumptions and myths of SSIPV that further silence women in violent same-sex relationships and minimize or deny the existence of SSIPV (Giorgio, 2002; McLaughlin & Rozee, 2001; Poorman, 2001; Renzetti, 1992; Tully, 2001). Although there are individual issues that contribute to service barriers for same-sex women, one study revealed that most mental health providers were interested and willing to provide SSIPV services, but they were often limited by the heterosexist policies of the agencies as well as the lack of resources and knowledge (Helfrich & Simpson, 2006; Simpson & Helfrich, 2005). Research indicates mental health providers are also more likely to suggest couples counseling to women in same-sex relationships, but would not recommend couples counseling in heterosexual relationships since it endangers the victim/survivor (Poorman, 2001; Renzetti, 1992; Wise & Bowman, 1997). Providers may also attend to a single part of the woman's identity rather than the intersection of race, gender and sexual identity or perceive IPV as a colorblind issue and fail to provide culturally appropriate services (Donnelly, Cook, van Ausdale, & Foley, 2005). Since the predominant heterosexual gender marker does not

exist to identify the perpetrator, the provider can often confuse the victim and perpetrator placing the victim at further risk (Giorgio, 2002). Women in same-sex violent relationships are often forced to turn to friends or remain with their partner due to the perceived or experienced lack of helpfulness of mental health providers (Giorgio, 2002; Helfrich & Simpson, 2006; McClennan, 2005).

Given the intersection of the multiple internalized oppressions, it is crucial for mental health providers to be mindful of the individual's self-concept rather than address only one part of her identity (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Thomas, Speight, & Witherspoon, 2004). It is also important to recognize that homophobia does not impinge upon all women in the same way, but this is especially true for African American women since they are subjected to the added oppression of racism (Kanuha, 1990; Poorman, 2001). Mental health providers need to assess the woman's internalized oppressions by exploring her beliefs and the influence of the negative stereotypes on her thoughts and behavior. In addition, mental health providers could gently challenge these stereotypes and begin to establish a positive expression of identity. If the provider offers positive social support, the effects of the internalized oppressions may be minimized (Szymanski, Chung, & Balsam, 2001).

Likewise, Szymanski (2005) offers that feminist mental health providers may provide a healing approach to internalized heterosexism or homophobia in understanding the multiple internalized oppressions, sociocultural context and the impact on psychosocial functioning (Szymanski, 2005a). These mental health providers often minimize the power differential between the provider and the woman seeking treatment

to empower the client rather than reinforce the feeling of marginalization (Szymanski, 2005a).

Mental health providers need to advocate for culturally-competent services that are at least commensurate with services offered to heterosexual IPV survivors in addition to holding an awareness of the impact of the multiple oppressions (Donnelly, Cook, van Ausdale, & Foley, 2005; Kanuha, 1990). Often, women in relationships with SSIPV are reluctant to approach mental health providers because they perceive counseling as a White, middle class service with little understanding of their cultural or identity needs (Ristock, 2002). For instance, some women, particularly African American women, may be reluctant to disclose their sexual identity or may not identify as lesbian. They may also be concerned for their confidentiality and anonymity (Ristock, 2002). It is important for mental health providers to allow for the possibility that the partner may not be opposite gender, use neutral language and inform the woman that her sexual identity or relationship will remain confidential.

Additionally, providers need to play a role in educating themselves and other providers as well as their clients as to multiple internalized oppressions and SSIPV. Turrell (1999) perceives counseling for SSIPV as problematic in that it frames the issue as individual, intrapsychic rather than one rooted in systemic and institutional oppression. These internalizations arise from the larger oppressive societal structures. Thus, mental health providers need to educate the LGBTQ community about SSIPV as a public rather than private concern to mobilize for expanded services and community support (Turrell, 1999). This education translates into society and the LGBTQ community accepting a

greater responsibility for addressing the violence rather than increasing the feeling of blame and shame in the individuals who experience it.

Another suggestion for mental health providers is that they use assessment materials specific to SSIPV (McClelland, 2005). Since victims/survivors are often isolated from social support networks, mental health providers need to reconnect their clients and familiarize themselves with social services that will not be revictimizing (McLaughlin & Rozee, 2001). Finally, providers need to demonstrate their openness through outreach efforts and welcome all women in same-sex relationships to provide a safe, trusting environment to allow the disclosures to unfold.

Given the paucity of research on the topic of multiple internalized oppressions among women in same-sex relationships in which IPV is present, this study explores the awareness and interventions of mental health providers working with this underserved, vulnerable population. While literature exists regarding the internalized homophobia and sexism of these women, few studies include an examination of the multiple oppressions given the predominantly White, middle class samples. It is hoped that this study will narrow the existing gap in the research to provide greater understanding and possibly enhance social and clinical services and interventions for these women.

The following chapter, Methodology, provides the study purpose, design, and sampling procedures to provide a connection between the research question and the previous discussion.

CHAPTER III

METHODOLOGY

The purpose of the study is to explore the ways in which the internalization of multiple oppressions (racism, sexism and homophobia) affects the experience of intimate partner violence for women in same-sex relationships. Given the issues with recruiting a representative sample of a sensitive, vulnerable, marginalized population, the target population for this study was comprised of mental health providers (psychologists, social workers and intimate partner violence workers) across the United States who provides psychotherapy, advocacy and support to women who have perpetrated or been victimized/survived SSIPV. The research question driving this study concerns mental health providers' consciousness of the multiple internalized oppressions of women involved in SSIPV. The following chapter provides a detailed description of study design, recruitment methods, data collection and analysis.

Research Design

For the purpose of this research, a flexible qualitative method was utilized. An English-language interview guide that contained semi-structured, open-ended interview questions was created for use in the study. A flexible method allowed for the incorporation of emergent concepts during the course of the data collection process. The interviews were recorded using digital and/or audiotape to gather the narrative descriptions of the experiences of women in relationships involving SSIPV as seen through the lens of the mental health providers. The open-ended format also allowed the providers to elaborate on their own thoughts, feelings and interventions in their work with their clients.

For purposes of this study, SSIPV was defined as “a pattern of violent and coercive behaviors whereby a lesbian seeks to control the thoughts, beliefs or conduct of her intimate partner or to punish the intimate for resisting the perpetrator’s control” (Hart, 1986). Internalized racism, sexism and homophobia were defined as the negative beliefs, thoughts and stereotypes based on one’s race, sexual orientation or gender. As part of the criteria used for participation in the study, mental health provider was defined as a psychologist, social worker or intimate partner violence worker who provides direct clinical service or support. Clinical service and support can be in the form of inpatient or outpatient individual or group psychotherapy or intimate partner violence services (shelter, advocacy, support groups, intervention groups) that include women in same-sex relationships.

Sample

The sample for this study included a total of twelve mental health providers who were recruited using non-probability, convenience sampling method. The recruitment criteria and information about the research was distributed using a snowball sampling technique for feasibility and accessibility. An email was distributed to professional colleagues across the United States, several organization email listservs and the Smith School for Social Work listserv.

The specific inclusion criteria required that participants identify as a mental health provider, e.g. psychologist, social worker or intimate partner violence worker who provides direct clinical service in the form of inpatient or outpatient individual or group psychotherapy or intimate partner violence services (shelter, advocacy, support groups, intervention groups) that include women in same-sex relationships. Participants were

required to be 18 years of age or older and of any racial/ethnic background, socioeconomic status, sexual orientation and gender identity. In addition, participants needed to possess sufficient English language skills to understand and respond to the interview in English and commit to a 45-minute interview process to participate. Lastly, participants needed to agree to sign an informed consent to be included in the research.

As part of the snowball sampling method, a recruitment email describing the research and interview process as well as the inclusion criteria was initially sent to the researcher's professional network and distributed to the organizational listservs of the Association of Counseling Center Training Agencies (ACCTA), a national organization, the Georgia Society of Clinical Social Workers (GSCSW) and current students of the Smith School for Social Work. The recruitment email was also distributed to two organizations that provide clinical intervention and support groups related to SSIPV, the Nia Project and the Atlanta Lesbian Health Initiative, in efforts to provide a more diverse sample. The Nia Project is located in a large, urban university-affiliated public hospital and provides IPV services to low-income African American women. The Atlanta Lesbian Health Initiative is a non-profit organization that provides a variety of services to women including Georgia's only court-mandated SSIPV program. As part of the email, recipients were asked to forward the email to other professional colleagues. Responses were screened to ensure participants met the requisite inclusion criteria.

Data Collection

In order to protect the rights and privacy of participants, the researcher complied with federal guidelines as well as the NASW Code of Ethics in conducting research with human subjects. Before recruiting participants and collecting data, the researcher

obtained approval from the Smith School for Social Work Human Subjects Review Board (see Appendix A). Following receipt of this approval, the researcher distributed the recruitment email (see Appendix B) with a description of the purpose of the research as well as the criteria for participation and details regarding the interview procedures. When the potential participants contacted the researcher, two copies of the informed consent form were mailed to them (see Appendix C). The informed consent form explained the nature of participation, the minimal risks and benefits involved as well as information regarding confidentiality. If the participant agreed with the informed consent form and met criteria for the study, they were asked to sign and return one copy using the enclosed self-addressed stamped envelope. The participant was instructed to maintain one copy of the informed consent form for their records. When the researcher received the signed informed consent forms, they were coded and stored in a locked cabinet separate from other data to protect the participants' privacy. The informed consent forms will be maintained for three years, as federal regulations require. After the consent form was received, the researcher contacted the participant by phone or email to schedule the interview via telephone or in-person at their office, agency that they are affiliated with, or any other place mutually agreed upon. All telephone recordings were conducted in a private location to protect the participant's confidentiality and enhance recording quality. Prior to the interview, the researcher indicated the nature of the interview in that it included questions related to demographics (e.g. gender, race, age, sexual orientation, degree, work setting), training, education and work experience with SSIPV and the participant's experiences and interventions in working with these women. Participants were given the opportunity to ask questions about the research methods, confidentiality

or publication of the data. They were also reminded that they would not be compensated for participation and could choose not to answer questions and withdraw their participation until March 1, 2008. Participants were read an introduction to the study that included the purpose and the definitions of SSIPV, internalized racism, internalized sexism and internalized homophobia. The researcher then asked open-ended questions following the Interview Guide (see Appendix D) to allow for the participant's narrative response including feelings, thoughts and experiences. During the interview, the researcher took brief notes regarding any change in participant's tone, facial expression or body language (if face-to-face) in response to the questions and/or noted follow-up questions. The flexible nature of the research provided an opportunity for follow-up questions, clarification and incorporation of these follow-up questions in remaining interviews. The individual interviews lasted 45 to 60 minutes and were recorded using two methods, digital voice recorder and an audio tape recorder for backup purposes. The audiotapes and researcher's notes were marked with the participant's code rather than an identifying name to protect the participant's privacy. After the interview, the digital recording was uploaded to a password-protected computer and the researcher transcribed the recorded interviews. Any writings or publications on this topic will be presented in the aggregate. Quotes used for illustrative purposes will not contain identifying information. At the conclusion of the study, the digital recordings will be transferred to a disk and stored along with the tapes, notes and transcriptions under lock and key for three years as required by Federal regulations. After the three years, all data (tapes, notes, informed consent forms and transcriptions) will be destroyed.

The following steps were taken to institute reliability and validity throughout the study. First, the interview guide was pilot tested with a non-participant clinician who met criteria for feedback as to the content and structure of the Interview Guide, clarification of questions and the length of the interview. Second, the researcher maintained a log during the interview process to record the researcher's own thoughts and reflections as a way of monitoring and restricting the influence of research bias. Review and discussion of the log material with the research advisor also provided a safeguard against introduction of bias to enhance reliability and validity.

Data Analysis

Demographic data was analyzed manually and data from the open-ended questions was transcribed, coded and analyzed for content and theme. After the transcription of the data, the transcripts were reviewed to become familiar with the data. While rereading the transcripts, emerging themes were highlighted and coded. In addition, the information from the researcher's log was incorporated. This method allowed for a continuous comparison of similarities and differences and predominant themes throughout the data collection and analysis process. The coded phrases were entered into an Excel spreadsheet by question across participants using the participant's assigned codes to allow for visual representation and ease of sorting. The researcher then reread and analyzed these phrases to identify recurring or disparate themes and patterns. Results of the data analysis are presented in the Findings chapter.

CHAPTER IV

FINDINGS

This chapter reveals the findings of the open-ended, semi-structured interviews with 12 mental health providers and intimate partner violence workers who offer psychotherapy, support and advocacy to women who have perpetrated or been the victim of SSIPV. The purpose of this study is to explore the question: “Are mental health providers aware of internalized racism, sexism and homophobia in relationships that involve same-sex intimate partner violence (SSIPV)?” If mental health providers endorsed awareness, the open-ended interview guide posed questions to elicit whether or not these providers noted any association between the internalized oppressions and the SSIPV. Initially, demographic questions were asked to gather information as to the mental health providers’ age, gender, geographic location, racial identity, sexual identity, training, experience and numbers of clients who experienced SSIPV. The providers were then asked a few demographic questions about their clients’ age, racial identity, sexual identity and socioeconomic status. Following these demographic questions, questions were asked concerning whether or not they believed these clients experienced internalized oppressions. The structure of the questions allowed for responses concerning providers’ examples, thoughts and reactions to their clients’ internalized oppression. The next portion of the interview related to the providers’ awareness of their own gender identity, sexual orientation and racial identity as they provided services to their clients. A final portion of the interview focused on mental health providers’ interventions, conversations and knowledge of the literature related to SSIPV and internalized

oppressions. In closing, providers shared their thoughts on how or whether they would do the work differently.

Data collected from these interviews will be provided in the following sequence: (1) mental health providers' and clients' demographics, (2) thoughts and reactions related to internalized oppressions of women who experience SSIPV, (3) interventions, conversations and knowledge of the literature, and (4) the ways in which the work would look differently in hindsight.

Mental Health Providers' Demographics

As previously noted, the study included a total of 12 participants, eleven females and one male. Participants ranged in age from 26 to 52 with two participants in their 20s, six participants in their 30s, three participants in their 40s and one participant in their 50s. Nine participants considered themselves Caucasian/White; one person claimed a multiracial identity; one person identified as Korean American and one person as African American. Six participants were heterosexual/straight. Four participants identified as lesbian. There were two participants who identified as bisexual and gay, respectively. The majority of these participants (n=9) were working in the southeast, predominantly in the metropolitan area of Atlanta, Georgia. Two participants worked in settings in Massachusetts and one participant worked in a suburb of Chicago, Illinois. The work settings varied with four participants in community mental health or agencies, three participants in university counseling centers, two participants in private practice, one participant in a large, urban county hospital in clinical research related to IPV, one participant in clinical research related to SSIPV and private practice and one participant in an LGBTQ agency. All of the participants held advanced degrees ranging from

PhD/PsyD and/or PhD in process (n=4), M.A., M.S.W. or M.S.W. in process (n=8).

Years of experience ranged from one to twenty with an average of 7.75. Experience in SSIPV ranged from six months to twenty years with the average of 6.5 years.

Client Demographics

Participants noted they have worked with between one and two hundred clients who have experienced SSIPV. However, most of the participants (n=8) worked with fifteen or fewer clients. Clients ranged in age from 19 to 65, with most in their 20s to 40s. Five participants indicated the majority of their clients were African American and two of these participants worked solely with African American women. Four participants worked with clients who were predominantly Caucasian/White. Two of these participants worked with seemingly equal numbers of African American or Biracial and Caucasian/White clients. One participant noted that her client was Filipino.

Socioeconomic status for clients ranged from poverty to upper class with the majority in lower class to lower middle class. Participants offered their own categories for socioeconomic status without definitions or salary ranges so these categories may be subjective. In addition, the interview did not solicit whether clients identified a particular race or ethnicity when they sought services or whether the providers also subjectively assigned these categories. Similar to racial identity, participants were asked their clients' sexual orientation. Nine participants reported the majority of their clients identified as lesbian followed by bisexual. Two participants stated that their clients did not identify with a specific sexual orientation and one participant's clients were queer. Participants were not asked to provide the length of their clients' relationships that involved SSIPV or the number of relationships in which they experienced SSIPV.

Awareness of Internalized Oppressions

In this section, data are presented concerning participants' awareness of their clients' internalized oppressions of homophobia, racism and sexism. Participants' thoughts and reactions as well as relevant examples of these internalized oppressions will be included. Further, this section will also detail participants' awareness of their own race, gender and sexual orientation in working with their clients.

Initially, participants were questioned as to whether their clients in relationships involving SSIPV seemed to experience internalized oppressions. If they witnessed internalized oppressions, they were asked to provide examples. Two follow-up questions were then asked related to their thoughts of these internalized oppressions and whether they noticed any relationship or association between the SSIPV.

In their response to the first question, all of the participants believed their clients were experiencing internalized oppressions. Eight of these participants conceptualized these internalized oppressions as intersecting with one another in a way that at times was difficult to discern or discuss each internalized oppression independent from another. As one participant noted, "it's hard for me to answer because it feels it's just so much a part of all of us on some level...I feel like it's sorta a fabric." In addition to the three internalized oppressions provided, three participants stressed that they also noticed internalized classism impacted their clients' thoughts and behavior. One participant summed it up by saying that "several people I worked with were from lower SES backgrounds and because of that there was a lot of shame...about having come from a family history where there was not only the whole issue of being economically underprivileged..." Two participants indicated mental illness stigma compounded

internalized oppressions for their clients. Attending to the individual internalized oppressions, when possible, one participant reported that the intersection was primarily between internalized racism and homophobia while two participants believed the internalized oppressions for their clients were homophobia and sexism and one thought there was more of an intersection of racism and sexism. In contrast, one Caucasian participant who identified as lesbian and worked predominantly with African American women indicated an absence of internalized racism and homophobia in her response:

Younger women in the African American community that I worked with and younger White women...there wasn't so much of that...it was sort of like...I'm not gonna bear that shame...and in fact I don't even know what you're talking about...they were pretty spunky kids and...you know racial identity was a powerful force in their lives, but it wasn't like there was internalized racism that I could see.

Turning to the relationship between internalized oppressions and SSIPV, ten participants believed an association exists whether internalized oppression contributes to the violence or the violence exacerbates internalized oppression. Of these participants, six acknowledged internalized oppressions increased their clients' vulnerability to SSIPV. As one participant stated, "I think what was starkly different for me in working with these women versus with women that are straight...it was like quadruple the level of vulnerability." Another participant likewise opined:

Intimate partner violence happens in every one of those groups and you know also in any combination of those groups whether it's a combination of gender and sexual identity or it's a combination of race and gender or age. I mean we know that any cross-section can make people more vulnerable to begin in an abusive relationship...anytime you start to pair them up or even have more than two it just increases that individual's vulnerability to being in a potentially...being in an abusive relationship.

Two participants indicated the internalized oppressions interacted with SSIPV in that women were unable to leave the relationship as a result. As one participant shared:

These internalized oppressions that were keeping her from being able to leave and so when she would be in a pretty good place, respecting herself as a woman and respecting her sexuality that was when she could talk pretty clearly about making a plan to leave...and then she would trip on these internalized oppressions and fall back down into you know but I'm sick and I don't deserve better treatment so it was really that was I felt like the sort of working edge of our relationship was her internalized oppression.

The second participant agreed that "identifying as queer, being a woman and being Asian American, I think all of those things can certainly have interacted of course along with any sort of mental health issue she was having...I think all of those interacted to keep her where she was." This latter participant stressed that she believes the internalized oppressions impacted the violence, but she did not have data to prove her theories.

Two participants commented that the violence or cycle of violence intensified as a result of the internalized oppressions. One participant summed it up as follows:

I really believe it does...I think it intensifies the abuse because I think there's...from what...I can only go by what my clients say and they talk about how...it's been a theme throughout the relationship that it's just not acceptable and think that because the abusers have never come to terms with that...it seems it's all part of what takes place...one of my clients was hospitalized three or four times...and I mean some horrific injuries and it seemed like as unfortunately as the abuse goes it usually intensifies.

The second participant reported that "those feelings that are all about hating yourself and who you are...when a person is dealing with that, then sure...there's going to be more attempts to vent that negative feeling...and absolutely that a lot of the violence that we see comes from the feelings."

While some could articulate a relationship between internalized oppressions and SSIPV, two participants could not state with certainty the relationship between the two variables though they admitted that an association was certainly possible or contributes to additional stressors for these women. One of these participants noted that the clients “all probably experience internalized oppression, but I couldn’t say for sure if that was due to the intimate partner violence they were experiencing with a same sex partner or if it was that plus the poverty plus...a lot of other things.” After being asked whether she noticed a relationship between these internalized oppressions and SSIPV, the second participant stated, “well, yeah, maybe just in terms of the stress that these women are under...and the work environments...and how oppressive they are both as a woman and as a lesbian and often as a person of color...yeah, sure.”

Finally, as part of their awareness of internalized oppression, providers were asked about the interplay between their own racial, gender and sexual identities and their clients’ identities. Of the six participants who claimed a heterosexual identity, four participants acknowledged their difference in sexual orientation and realized the difference when working with these clients, but did not indicate or recognize the impact of their heterosexual privilege on the work with their clients. In fact for one participant, she reported that she used her heterosexual relationship “as a barometer of what a relationship...should look like...what behaviors are appropriate.” Looking back on her work with her clients, she also admitted that her reactions to various situations with these clients “I could not have articulated it then, but that was my privilege that it was shocking to me that that would happen.”

For one of the participants who recognized the impact of this difference on the relationship with her clients, she stated:

Absolutely. I think definitely...so much of my training was around privilege and being someone who is of a racial/ethnic minority background, part of what was always very salient to me was my lack of privilege as a result of that, but what became very salient to me in working with these different women was the privilege that I had by virtue of the fact that I'm heterosexual... I think that when people talk about white guilt, I definitely felt some hetero guilt.

The second participant conceded the difference in sexual orientation

definitely had to be worked through where you were able to come to a place where you could say we don't share those things but we share gender...but you've worked with people who have had experiences to help you try to understand what they're going through, but I think it definitely had to be worked through.

In considering the seven participants' consciousness of their racial difference in working with these clients, three participants did not discuss or identify their racial difference in working with these clients. Four participants mentioned their racial difference and the influence on the relationships with clients. As one participant mentioned,

I really started working on my own racism because the way they talked about sexism...I thought I can finally have...OH...like I could make more of a connection around race...not that I could understand what a black person was going through, but somehow that like light bulbs really went on early for me about my own racism...now I could never have owned that I have racism because as a White person...like I'm not racist [laughs] so I think personally hearing these stories...I have done a lot of personal work.

Another participant stated that the racial difference contributed to her own cognizance and thoughts of "as a White lesbian...how is my life different than as a Black lesbian."

For two of the participants who identified as Korean American and Multiracial, they indicated that their racial identity allowed them to establish earlier relationships with their

clients and they could also identify with their clients. One of these participants noted that she could

definitely relate a lot...when you're a woman of color in particular life's not easy...and so when that sometimes when that came up for my clients that really resonated with me...so I felt a huge understanding of that and I think the way it came out in my clinical work was absolutely a protectiveness around that kind of understanding.

Another participant felt that "when you're looked at as being African American or being tied to that culture...rapport tends to be established a little faster."

In terms of the gender difference between client and provider, the one male identified participant recalled he usually speaks to "clients at intake about...the client/therapist intersections. I definitely think about the intersection of race, class and sexual orientation and gender presentation and religion when working with my clients...I try to keep an awareness because I do think it's important." Thus, this participant maintained awareness of the gender, racial and many other differences in his work with these clients.

Examples of Internalized Oppressions

In reviewing examples participants provided of the internalized oppressions, four themes emerged: (1) discussions of each specific internalized oppression; (2) emotional/psychological or behavioral sequelae; (3) the influence on reporting the violence; and (4) minimizing the violence or resistance to change or leave the relationship.

When possible to separate the individual oppressions of racism, sexism and homophobia, participants provided examples of their clients' experience of each to solidify their awareness of these internalized oppressions. Beginning with internalized

racism, six participants offered examples of their clients' experiences of internalized racism. However, three participants, one identified as Multiracial and the other two as Caucasian/White, reported that they did not witness any signs of internalized racism and could not provide examples though one of these participants believed the client might have been dealing with internalized racism. As one participant described, an "African descendent" client felt:

There was very much the sense of like this is our plight...like people won't help...people in places of power aren't going to help black people...I do think there was this sense of...because her partner was White...I do think there was a sense of kinda this is the way things go...buying into that I'm Black, she's White, I'm kinda like married up...and so it was kinda a privilege that she could be with someone that was White because she was Black and then at the same time a lot of anger because she very much held the belief that even if she tried to get help that people wouldn't believe her because when it came down to it she was like I'm Black, she's White.

Notably, another participant stood out from the rest in her conviction that internalized racism was the principal internalized oppression and referred to her clients' use of the

N word when they were talking about themselves or other Black people. There were a few that would quickly make a comment like...oh, you know oh they not gonna listen to us or they won't help us...you know...we just some poor Black people. They really would voice as if like their belief that they didn't have any power or wouldn't be heard or wouldn't be taken serious.

A third participant indicated that "one of the tactics that was used by the abusers sometimes it was also the racism...this sorta constant putting down and sometimes it would be because of their color...so things that were already there for them were reinforced."

When possible, four participants spoke specifically about internalized sexism and the ways in which they heard evidence of this internalized oppression in their clients. As one participant noted, "women who grew up in traditional homes where there was abuse

existing in the family of origin so their belief was that this is the kind of thing that women endure.” For another participant, she had a difficult time sorting the internalized sexism from homophobia, but indicated her client

didn't think very highly of herself as a woman...like she didn't feel like she deserved to feel empowered or she felt sort of very subservient in her relationship...it's like she was with a woman, but she also believed that a woman's role in a relationship is to attend to the other person's needs and ignore her own needs.

Although it was not identified as internalized sexism, one participant's clients disparaged women who were more feminine as “bitch” or “whore.” Similarly, another participant's client felt “where I sit in the world...the men are in power...where I sit in the world where I'm only a woman.” As with internalized racism, the clients' experience of gender reflects a sense of women's plight in the world or something to be endured and not believed.

Finally, seven participants discussed clients' internalized homophobia similar to the above examples of internalized racism and sexism. However, unlike the examples for the latter two internalizations, participants readily and more frequently provided examples of internalized homophobia. One participant mentioned she did not witness her clients' thoughts, feelings or behaviors concerning their internalized homophobia. For one participant, her clients spoke about their fears around disclosing their identity because it was not “appropriate to be a lesbian” and “being a lesbian in the world is hard.” Another participant's client was “struggling to stand strong in her lesbian identity and having the extra barrier of justifying or explaining that her relationship was valid and loving and qualified for...social services were more than she wanted to deal with.” A third participant's client opposed returning to her parents' house because

she didn't want them to think that it was because it was like a lesbian relationship that the violence happened...and she didn't want them to have any evidence that her being a lesbian was gonna be like a bad thing...[she] was really like afraid of giving anybody else any proof for homophobia being correct then at the same time she hated herself for being gay and was really ashamed of being gay.

The ways in which clients' identified their sexual orientation or relationships manifested degrees of internalized homophobia. Some clients "didn't identify themselves as lesbian because they felt that a lesbian is just a horrific label about themselves" and participants "didn't hear the L word floating around the black community." Two participants held groups advertised for "women partnering with women" to encourage women who did not choose to label themselves as lesbian to attend. Contrasting to these views, clients who sought services from LGBTQ service providers or agencies seemed more confident in their lesbian identity and were more trusting of the providers. In summary, women questioned if they "were in a different situation...a different color...a different race...a different gender or orientation...would my beating up on my partner have caused such a stir."

As illustrations of these internalized oppressions and/or a combination of the internalized oppressions andSSIPV, participants noted their clients endorsed a series of emotional or psychological responses including shame, low self-esteem, anger, hopelessness, depression and suicidal ideation. Six participants either felt or heard their clients indicate they deserved the violence as part of their multiple identities. One participant commented that her client "didn't feel she deserved something better...because I'm a woman or I identify as homosexual I am somehow less than." Similarly, another participant related that her client stated, "of course my girlfriend treats me this way because I'm so sick I deserve it...I deserve to put up with this kind of

treatment.” An equal number of participants mentioned their clients felt shame about their identities and/or the abuse. There was shame in “living a lifestyle sorta outside what was expected” and a need to “navigate their own feelings of shame” while they deal with the “shame of being in a domestic violence situation...especially with the politics of the LGBTQ community trying to...gain respect...they don’t want to take away from the movement or expose that that community has negative behaviors.” Four participants also reported that their clients evidenced low self-esteem associated with these internalized oppressions. The clients had “extraordinarily low self-esteem and for different reasons depending on the woman” which “sometimes that translated into that more passive behaviors...sometimes that translated into that more selfless...sometimes it translated into general compliancy.” One participant summarized it by saying that “their self-esteem is so shattered...it’s a process to kind of help them to kind of build them themselves up and come to a place where they don’t feel like they need to take it anymore.”

Although less frequent than feelings of shame, low self-esteem and deserving the abusive treatment, participants spoke about clients’ feelings of anger, hopelessness, depression and suicidality. One participant observed that some of her clients were “angry...they wouldn’t classify it was because they were depressed. They would say it was because they were angry...some of them had attempted suicide and I don’t think some of them would have identified their suicide attempt with depression.” Another participant’s clients felt “hopeless about the future,” “isolated and identifying less with their family and friends,” “desperate,” “out of control,” “rageful...feeling retaliatory sometimes...um and hopeless.” Whether identified as the internalized oppressions alone or in conjunction

with the violence, these women experienced a number of difficult feelings, reactions and behaviors.

Participants seemed to attribute the internalized oppressions combined with the resulting feelings and behaviors as an impact on their clients' help seeking or reporting the violence. Clients expressed fear of seeking help or reporting the violence which participants connected to internalized homophobia and internalized racism. Three participants recognized the impact of the disclosure in reporting and named this process as a "double coming out." As one participant reflected:

What made it difficult in these relationships was not only that maybe they were dealing with sexual violence...but the homophobia or the piece that they were partnering with a woman also became that could be used against them...so kinda a double coming out that can happen.

Another participant thought her client "was fearful about how I might view the fact that she was being hurt by another female and in addition to that how I might look at her relationship...so I think...those fears...were tied to...the feeling of internal oppression." One participant also associated underreporting as a "major" sign of internalized oppression, specifically internalized homophobia, which derives from "messages in the media that domestic violence is a heterosexual phenomenon...same-sex relationships are mutual battering...and negative experiences of...dealing with police as lesbian not trusting the systems that are supposed to protect." Further, there is a "wish to not air the dirty laundry" of the "marginalized community."

Additionally, participants noted unique barriers to seeking help or reporting violence for their African American clients. As stated in earlier quotes, African American women did not believe they would be heard or responded to if they reported,

based solely on their race. Clients made comments that “they not gonna listen to us or they won’t help us” and “people in power aren’t going to help black people.” One participant shared “they really would voice as if like their belief that they didn’t have any power or wouldn’t be heard or wouldn’t be taken seriously.” It seems internalized racism exacerbated internalized homophobia for these women along with their previous experiences with institutions that did not provide adequate services. One participant observed that “there are views...that African Americans are more violent...so how does that play out in people’s coming out or seeking services is one of the ways internalized racism affects” clients. Perhaps it may be attributed to the fact that:

LGBT communities there is a lot of internalized racism and there’s a lot of racism within the community that keeps LGBT people from ever feeling a part of that community...I use the term cultural outlaws...they’re not really fully accepted in the LGBT community...and they’re not particularly considered to be in the African American community...because they are LGBT...and I think that identity struggle and amount of racism within the LGBT community...and the amount of homophobia within a lot of marginalized racial communities has a lot of bearing on the way that somebody moves through the world.

Finally, a common theme emerged in that clients would minimize the violence thereby failing to report and remaining in the violent relationships as a result. Two participants believed their clients were not able to frame the violence in a same-sex context and would adopt heteronormative ideas of relationships as well as internalizing homophobic myths thatSSIPV is mutual. These participants shared that “a couple of them conceptualized this was that it was a fight as if there was an equal power dynamic when there wasn’t.” Another participant indicated her client “didn’t think what was going on...was as toxic as what had been happening in her relationships with men...her perceptions of it were different of it than perhaps if it had been perpetrated by a man.”

Strikingly, one of the participants who identified as heterosexual claimed her own bias towardsSSIPV and had to continuously “check” herself from thoughts of “how do you let another woman beat on you.” This participant’s awareness of her bias may have been a parallel process she shared with her clients. Another way in which clients minimized the violence and perhaps another sign of internalized sexism and/or homophobia was in their expectation that women were not violent or same-sex relationships are safe. Two participants spoke of these assumptions for their clients. After another woman sexually assaulted one client, the fact that another woman perpetrated it

was not really anywhere in her paradigm...like being a lesbian is sort of safe...particularly women who have partnered with men...it’s this double betrayal that’s happening...not only is violence happening...and violence is violence...it’s traumatizing, but there is this piece that your head has to wrap around that this happened by a woman so there’s this betrayal again.

As with the above participant, this participant identified her own parallel process with the clients in examining her own assumptions that women and lesbians are safer. The second participant also admitted her acceptance that

the first thing that came to mind was within heterosexual relationships...I had not thought about it given as much time...that it was happening in same-sex relationships, especially among women...women are the nurturers and to think that we’re capable of this...was something I had to grapple with in the beginning.

In addition to her clients’ difficulty understanding or making sense ofSSIPV, the participant reported her clients minimized the violence as women of color because these women felt their “target” status was the reason for the abuse and their “fragile sense of themselves” made it easier for the perpetrator to manipulate their internalized racism or homophobia. Lastly, one participant stated that her client felt she had to remain in the relationship to “protect the good name of lesbians.” As noted earlier, there was a sense of

remaining in the relationship to prevent further demonizing of an already marginalized community.

Interventions

When asked about the interventions providers used when working with internalized oppressions andSSIPV, six participants felt validation, normalizing and support was helpful to their clients. An equal number of participants believed group therapy was effective in facilitating the validation, normalizing and support. As one participant stated, group therapy allowed her client to connect with other women in a similar situation, which may have been even more powerful than individual therapy in terms of decreasing the feeling of isolation and normalizing the experience. Further, this participant referred her client to a predominantly heterosexual IPV group so she could gain a new experience that the violence was not just happening because she was a lesbian. Four participants believed that it was important to provide a nonjudgmental safe space for these women to feel comfortable sharing their stories and expressing their resulting thoughts, feelings and emotions, especially given these clients rarely feel safe in their world. Five participants provided psychoeducation or education. It seemed a common theme of the psychoeducation concerned the cycle of violence or violence in general, communication and conflict resolution skills and feminist and/or same-sex literature. One participant reported that he often uses the LGBTQ power and control wheel in psychoeducation with his clients. This wheel allows clients to identify the type of violence experienced whether psychological/emotional, physical, sexual, etc. within the context of a same-sex relationship. Two participants shared feminist/same-sex related literature andSSIPV literature with their clients in an attempt to alter their internalized

oppression and gain an understanding that they are not alone in their experience. For three of the participants, they believed their clients benefited from their modeling and empowerment, especially in terms of what behavior was appropriate in a relationship regardless of whether the relationship was same-sex and to provide another alternative to remaining in the violence. Two participants thought they offered unconditional positive regard for their clients, which aided in establishing an environment of safety and trust. Another intervention used by two participants who worked with perpetrators was to ask the women to become accountable for their violent behavior and treatment of their partners. Surprisingly, only one participant discussed the intervention of connecting clients to resources, especially those in the LGBTQ community.

In the process of the interventions, six participants did not have specific conversations or could not recall specific conversations related to the clients' internalized oppression. However, four participants talked to their clients about internalized oppressions and used the clients' language to facilitate understanding and awareness while maintaining connection. The remaining two providers discussed internalized oppressions with clients and named them as such in the process.

As part of the interview, participants were asked whether they were familiar with literature related toSSIPV, internalized oppressions or both and if they used the literature in their work with their clients. Six participants were aware of the literature related to both topics and used it in their work while three participants were not aware of the literature and, as a result, did not use it to inform the interventions. Of the remaining three participants, two participants were aware of the internalized oppression literature,

but did not believe they used it in their work. One participant was aware of heterosexual IPV literature only and used this knowledge in her interventions.

Looking Back: What Providers Would Do Differently

When asked how their work would look differently if they could do it again with their current knowledge, only one provider stated that the work would not be different. The remaining participants' responses varied with two common themes: (1) increased learning specific toSSIPV, and (2) initiate conversations about internalizations and the impact on the relationship. The first participant indicated she would have asked questions similar to those she asked her heterosexual clients in long-term relationships, particularly those involving the client's family support and the financial connection to the perpetrator. This participant also felt she would have performed more psychoeducation related to the cycle of violence, particularly the emotional violence. The second participant would have addressed the conflict in the group between the need to support the client and the group's urging this client to leave the relationship. She also would have discussed the impact of the client's internalized oppressions on her decision to remain in the relationship.

As with this participant, the third participant echoed the sense of wanting a long-term therapeutic relationship in which to facilitate active discussions of internalized racism and sexism. Similar to the participant two, the fourth participant shared that she wishes she established more safety to build the relationship with the client instead of imposing her urgency that the client leave the relationship. She also thought she would be more aware of her privilege and gentler in her conceptualizations with these clients. The fifth participant thought she would invite a provider who is experienced inSSIPV to

co-facilitate the group and familiarize herself with SSIPV literature. As with participant four, participant six would be more mindful of her reactions, particularly to perpetrators, and enhance safety for the victim. She also stressed the need to continue her own learning process. Participant seven noted that her training related to SSIPV could have been improved. She believed she would increase her sensitivity to her clients' needs. Participant eight felt she needed more support, particularly peer support, in her work with her clients. While participant nine admitted the work would not look much different, she also thought she would raise the issue of internalized oppressions earlier to build the relational bridge. If participant ten could change her early experiences, she would work in a shelter that was more accepting and welcoming of difference. Finally, participant twelve would have recommended group therapy for her clients.

CHAPTER V

DISCUSSION

This research aimed to explore internalized oppression among women who have experienced SSIPV to answer the research question: “Are mental health providers aware of internalized racism, sexism and homophobia in relationships that involve SSIPV?” The findings point to a general awareness among mental health providers of internalized oppression. Providers also recognized an association between internalized oppression and SSIPV. In most cases, providers were not able to separate the individual internalized oppressions (racism, sexism and homophobia) and struggled to find language to discuss their clients’ experience of these oppressions. Themes emerged in the findings in that most providers pointed to the psychological/emotional sequelae, underreporting and remaining in the violence as well as minimizing the violence as a result of the internalized oppressions.

In this chapter, the findings will be reviewed in connection with the literature and a discussion of the strengths, limitations, clinical implications and future research will ensue.

Connection Between Study Findings and the Literature

Overall, the study findings refute the literature indicating that mental health providers are not aware of multiple internalized oppression and/or SSIPV. The mental health providers were not only able to acknowledge their cognizance of internalized oppressions, but were also able to enumerate ways in which they relate to SSIPV. As

mentioned in the literature, providers often struggled to find the language to discuss the topic and/or conceptualize the relationship between the two variables. It was as if providers were in a parallel process with their clients at times in that they felt challenged by all of the oppressive factors, external and internal, that exacerbated the abuse and reporting of the abuse. Further, the interview process allowed them the opportunity to be able to name these internalized oppressions and SSIPV. Similar to Balsam's (2005) literature on minority stressors, providers noted the multitude of daily stressors that create an additive effect to increase vulnerability to the violence. Several providers referred to these stressors and even included an additional potential internalized oppression of classism and a few felt mental illness (or the stigma) contributed. However, as reflected in the literature (Giorgio, 2002; McLaughlin & Rozee, 2001; Poorman, 2001; Renzetti, 1992; Tully, 2001), providers were not exempt from their own racism, sexism and homophobia. In fact, a few providers admitted their own adoption of beliefs that same-sex relationships cannot be violent and minimized the violence as a result and others failed to acknowledge the internalized racism or their own racial and heterosexual privilege.

In consideration of the literature related to the themes that emerged in the findings, providers noted clients' experience of psychological and emotional sequelae such as shame, low self-esteem, hostility, depression, self-harm and isolation as a result of internalized racism, sexism or homophobia. Several previous researchers noted these symptoms related to internalized sexism, homophobia and sexism (Bennett & O'Connor, 2002; Fischer & Holz, 2007; Meyer, 2003; Moradi & Subich, 2002; Snyder & Hasbrouck, 1996; Speight, 2007; Swim, Hyers, & Ferguson, 2001; Syzmanski, Chung, &

Balsam, 2001; Szymanski, 2005a, 2005b; Thomas, Speight, & Witherspoon, 2004; Williamson, 2000).

Turning to the individual internalized oppression of internalized racism, six of the nine participants who worked with African American clients were aware of internalized racism. As prior research shows, participants generally spent more time and could more easily cite examples of internalized homophobia than internalized racism (Kanuha, 1990; Mays, Cochran, & Rhue, 1993). However, a few providers expressed the “triple jeopardy” (Kanuha, 1990; Poorman, 2001) for African American women in abusive same-sex relationships. Further, as Kanuha (1990) indicated, one provider even referred to these women as “cultural outcasts” in that they often feel displaced by the African American community, society and the LGBTQ community. These findings agree with Kanuha’s (1990) writings that African American women resist identification as lesbians to prevent further chances of rejection from these communities. Although some participants pointed to internalized racism in their clients, they often struggled to speak in detail or provide examples of internalized racism.

As with the literature, providers rarely mentioned internalized sexism and seemed unaware of ways in which this presented apart from the other internalized oppressions. The findings on internalized sexism were congruous with the brief mention in the literature in that women often consider others’ needs ahead of their own and follow heterosexual patterns of relationship with the more masculine partner holding the power (McClennan, Summers, & Daley, 2002).

The primary internalized oppression referenced by providers was internalized homophobia. Providers were aware of clients’ mirroring the most common findings of

prior studies that women are not violent or the violence is mutual (Helfrich & Simpson, 2006; McClennan, 2005; McLaughlin & Rozee, 2001; Simpson & Helfrich, 2005; C. M. West, 2002). In addition, another common theme for providers was that their clients seemed challenged to name the violence in the context of same-sex relationships given that IPV media is often heterosexual.

Providers were not only aware of the internalized oppressions, but were also aware of their contribution to theSSIPV in that their clients often minimized, remained in or failed to report the violence. These findings parallel the literature that internalized oppressions contribute to perhaps the most prevalent feeling that the women deserve the abuse as a result of their race, gender or sexual orientation (Balsam, 2005; Donnelly, Cook, van Ausdale, & Foley, 2005; Girshick, 2002; Greene, 2000; Kanuha, 1990; Sokoloff & Dupont, 2005) and often avoid seeking help for fear of disclosing the relationship as well as theSSIPV (Tigert, 2001).

Contrary to prior research, the majority of participants attended to the multiple identities of their clients and did not perceive IPV as colorblind (Donnelly, Cook, van Ausdale, & Foley, 2005). However, while participants were aware of their heterosexual privilege, none mentioned their racial privilege in relation to their clients. Further, at least three participants failed to recognize or denied their clients' internalized racism. Curiously, one of these participants also identified as Multiracial and seemed guarded during the interview. Although one participant used the stereotypical argument that IPV happens to women of any race, sexual orientation, etc., she did not minimize the multiple identities and even highlighted the "double whammy" and multiple "burdens" by women with more than one identity.

Similar to literature on SSIPV and internalized oppressions, participants provided positive support as well as listened and used their clients' language with regard to their self-concept which may have minimized the clients' experience of internalized oppression (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Syzmanski, Chung, & Balsam, 2001). Additionally, several participants referenced their attempts to empower clients and most were aware of their clients' larger sociocultural contexts. Similar to recommendations in earlier writings, only one participant utilized assessment materials specific to SSIPV and one participant shared her attempt to connect her client to resources that would not retraumatize her (McClelland, 2005; McLaughlin & Rozee, 2001). It seems these areas need more attention and improvement in working with clients who experience SSIPV. Further, as the research indicates, society needs to be educated that SSIPV is a public rather than private concern (Turell, 1999). While a few participants emphasized their attempts to educate their clients as to the sociocultural construct of SSIPV, none mentioned their involvement in SSIPV outreach or advocacy.

Strengths

The primary strength of this study is that it used qualitative methods to explore providers' awareness of internalized oppressions. Although the data could have been collected through quantitative methods, an exploratory, qualitative method provided space for the richness of the voices of the participants and, through them perhaps, their clients' voices. A flexible interview format also allowed for the development and more fulsome responses to an intricate topic.

Another strength of the study is that there was diversity in terms of the participants' age, gender, sexual orientation, race, training and years of experience.

These participants also worked with clients who varied in terms of their age, socioeconomic status and racial identity.

Lastly, reliability and validity measures were followed throughout the study. Prior to participant interviews, a pilot interview was conducted with a non-participant, experienced mental health provider who met study criteria. This pilot provider's interview and subsequent feedback resulted in improvements to the interview guide to enhance organization, lucidity and relevance. During the interview process, participants also provided feedback to the interview to aid with necessary revisions to augment data collection. An interview log was also maintained to reflect the interviewer's thoughts, reactions and observations as a way to reduce bias. The research advisor also reviewed the data during the coding process to validate the interviewer's thematic findings and conceptualization.

Limitations

The major limitation of this study is the data collection methods used to secure a sample of participants. A non-probability, convenience sample of twelve participants was collected using a snowball technique in consideration of time, financial and feasibility constraints. The researcher distributed the recruitment email to a professional network and various organizational listservs. In addition, participants suggested other potential participants during the interview process. Although the above bias reduction measures were established, there was a chance that this recruitment method introduced bias into the study. Further, the study's sample was more limited than expected and, as a result of the diminutive size, the findings are not generalizable beyond the current study.

Even though the sample's diversity is a strength, it is also a weakness in terms of the variability of the participants' experience. While providers with little experience in the field added useful data and themes to the topic, they also acknowledged that they felt hampered by their fundamental lack of experience with the clients and were challenged at times to respond in a way they felt adequately represented their work. It was too difficult to make comparisons or relate the thematic findings to the literature for a small, extremely diverse group of participants.

Finally, another potential weakness connected to the lack of experience is the brief contact with the clients for many of the providers. Several participants felt they would have been able to have conversations related to the internalized oppressions if they spent more time with the clients, but given the agency restrictions, the nature of the crisis intervention or other client-related reasons, it was not possible. Participants also mentioned during the interview that they felt they were having a parallel process with their clients in that they had not fully conceptualized the association between internalized oppression and SSIPV until the interview. A few were even stunned by their inability to articulate their thoughts and/or felt overwhelmed in the process. Thus, it may have been useful to have more than one interview to allow the participants to process the material and share additional thoughts. While it may not have been a weakness, this researcher's racial identity, gender or sexual orientation may also have impinged upon the data collection and contributed to the sense of guardedness on behalf of two participants.

Implications for Social Work

It is hoped that this study will contribute to the growing, but limited literature on internalized oppression and SSIPV. Mental health providers need to consider more

thorough initial assessment tailored to unique psychological, sexual, financial and physical issues of power and abuse in same-sex relationships to accurately determine whether the client is a perpetrator or a victim to provide culturally competent, effective services. Given the findings of this study, providers will need to be conscious of their own privilege based on race, sexual orientation and gender and the impact and intersection of their multiple identities with the identities of their clients. A few participants noted their mindfulness of their multiple identities as well as a close examination of their own power and control dynamics in relationships improved their empathy and effectiveness in their work. Further, this understanding will need to be paired with the providers' interventions aimed to establish and maintain a therapeutic alliance which may be challenging considering the clients' lack of safety, trust and the significant degree of shame these clients' hold in being in a violent same-sex relationship. Providers will need to establish an open, safe environment and provide psychoeducation, empowerment, validation and language for their clients to understand their internalized oppressions in the context of the violence. It may be necessary for the providers to consider the timing of discussions in terms of the relationship with their clients as well as the needs of the individual. As occurred during the interview process with participants, this study's focus will enable providers to alter their initial conceptualizations in working with their clients to allow for an expanded consideration of the client's sociocultural context and the intricacy of the intersection of multiple internalized oppressions in the midst of the violence. Similar to the experience of their clients, it will be important for providers to seek support, self-care and peer supervision or consultation to prevent a sense of isolation and reduce any vicarious psychological symptoms and burnout that

may contribute to terminating their work with these clients. Lastly, this research also indicates the need for advocacy and community education concerning SSIPV and the damaging effects of racism, sexism and homophobia.

Future Research

In the future, an empirical study could be conducted with a larger sample of clinicians to further investigate effectiveness of assessments and interventions. It would also be a contribution to current literature to conduct a qualitative and possibly quantitative study of a large sample of women who have experienced SSIPV to assess their understanding and awareness of internalized oppressions. The former would provide an opportunity to hear the voices of the individuals as they experience the violence and internalize the daily multitude of societal oppressions so providers could be better informed and utilize this information to improve the cultural competence of their services.

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Appendix A

Human Subjects Review Board Approval Letter

January 8, 2008

Dear Sharon,

Your revised materials have been reviewed. You have done a thorough job of revision and all is now in order. We are therefore now glad to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your interesting project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Stefanie Speanburg, Research Advisor

Appendix B

Recruitment Materials

Friends and colleagues,

This email has been sent to ask you to participate in research related to my thesis as a part of my Master's in Social Work at Smith School for Social Work. Please read the following and contact me at this email address or at the phone number listed below if you are interested in participating.

What is the purpose of the research?

This research will examine mental health providers' awareness of internalized oppressions (racism, sexism and homophobia) experienced by women in same-sex relationships where intimate partner violence is involved.

Who can participate?

All mental health providers (psychologists, social workers or intimate partner violence workers) who provide direct clinical service or support. This can be in the form of inpatient or outpatient individual or group psychotherapy or intimate partner violence services (shelter, advocacy, support groups, intervention groups) that include women in same-sex relationships.

What does participation involve?

Participation will involve a confidential interview lasting approximately 45 minutes and will be scheduled to occur via telephone or at your office, agency that you are affiliated with, or any other place mutually agreed upon. Participants will need to be able to understand and respond to the open-ended interview questions in English. Confidentiality is assured and participants have the right to withdraw at any time prior to March 1, 2008.

Please forward this email to any friends or colleagues who may be interested in participating. Thank you for your time, and assistance!

Sharon E. Harp
MSW Candidate 2008
Smith School for Social Work

Appendix C

Informed Consent Form

Dear Research Participant:

My name is Sharon Harp and I am a graduate student at Smith College School for Social Work. I am conducting a research study on mental health providers' (psychologists, social workers and intimate partner violence workers) awareness of internalized oppressions experienced by women in same-sex relationships where intimate partner violence is involved. The data from this study will be used in my Master's thesis and for future presentation or publication.

Nature of Participation:

You are being asked to be a participant in this study because you have provided direct clinical service or support in the form of inpatient or outpatient individual or group psychotherapy or intimate partner violence services (shelter, advocacy, support groups, intervention groups) that include women in same-sex relationships. You must be able to understand and respond to the open-ended interview questions in English. The in-person or telephone interview will last approximately 45 minutes. The interview will be digitally recorded or audio taped and transcribed. The interview will contain demographic questions such as your gender, race, age, sexual orientation, degree and work setting as well as questions regarding your experience of treating women in same-sex intimate partner violent relationships, whether a correlation between internalized oppressions and intimate partner violence has been observed, and your experiences in this field.

Risks:

There may be minimal risk or discomfort associated with participation in this study. Participation may cause difficult or distressing thoughts and feelings as you reflect upon your work with women who experience same-sex intimate partner violence.

Benefits:

Participating in this study may help you reflect on this issue as well as your work with women who have experienced same-sex intimate partner violence and perhaps provide new meaning, as well as provide invaluable awareness and further the discussion on same-sex intimate partner violence. You will not be financially compensated for your participation in this study.

Confidentiality:

Confidentiality, but not anonymity, will be maintained throughout this study. Your name will not appear on any notes or recordings, but rather codes will be assigned to your information. After participant identities are removed, my thesis advisor and I will review and analyze this data together. Any writings or publications on this topic will be

presented in the aggregate. All notes, transcriptions, audio or digital recordings will be maintained on a password-protected computer or in a locked cabinet. Signed consent forms will be securely maintained in a locked cabinet separate from the recordings and notes or transcriptions. Any person working with the data or assisting with transcription will be required to sign a confidentiality agreement. Any quotes that will be used for illustrative purposes will not contain any identifying information. The information gathered (audio tapes, transcriptions, notes, and signed informed consent forms) will be locked for a period of three years or maintained on a password-protected computer, as required by Federal guidelines. After that three-year period, all data will be destroyed by deleting or shredding. If the data is kept beyond the three-year period, it will be maintained in a securely locked cabinet until no longer needed, at which time the data will be physically destroyed by deleting from computers or shredding.

Your participation in this study is voluntary. You may withdraw from the study, or choose not to answer certain questions, without penalty, nor will information regarding your participation be disclosed. You may withdraw until March 1, 2008. Please contact me at the number or email below if you choose to withdraw from the study, or if you have any questions regarding this process. For any further questions or concerns, you may also contact Smith School for Social Work's Chair of the Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

(Participant Signature) _____ (Date) _____ (Researcher Signature) _____ (Date)

Please keep a copy of this form for your records.

Thank you for your participation in this study.

Contact information:
Sharon Harp

Appendix D

Interview Guide

Introduction

This study is focused on exploring mental health providers' (psychologists, social workers and intimate partner violence workers) awareness of internalized oppression (racism, sexism and homophobia) experienced by women in same-sex relationships that involve intimate partner violence. Before beginning the interview, I will review definitions of internalized racism, sexism and homophobia as well as intimate partner violence that will be used for the purpose of this study.

This study uses the definition of *same-sex intimate partner violence*, offered by Hart (1986): "a pattern of violent and coercive behaviors whereby a lesbian seeks to control the thoughts, beliefs or conduct of her intimate partner or to punish the intimate for resisting the perpetrator's control." (Hart, B. (1986). *Lesbian battering: An examination*. In K. Lobel (Ed.), *Naming the violence: Speaking out about lesbian battering* (pp. 173-189). Seattle: Seal Press).

Internalized racism shall be defined as a person's adoption of negative beliefs, thoughts or stereotypes based on their own race.

Internalized sexism shall be defined as a person's adoption of negative beliefs, thoughts or stereotypes based on their own gender.

Internalized homophobia shall be defined as a person's adoption of negative beliefs, thoughts or stereotypes based of their own sexual orientation.

Demographic Information of Therapist

- Age:
- Gender:
- Ethnicity/Race:
- Sexual Orientation:
- Geographic location:
- Work Setting:
- Degree or Education Level:
- Years experience:
- Years experience in intimate partner violence? Same-sex intimate partner violence?
- Approximate number of women clients in same-sex intimate partner violent relationships?
- Where did you receive training?

Demographic Information of Therapist's Clientele

- Client age range:
- Is there a predominant ethnicity/race? Socioeconomic status?
- Is there a predominant sexual identity/orientation claimed (e.g. queer, gay, lesbian, women-loving-women, butch, femme, stud, etc.)?

Experience with Clients

- Have you worked with women in same-sex relationships involving intimate partner violence who seem to experience internalized oppressions? If so, can you give examples?
- What are your thoughts on the experience of all three oppressions for these women?
- How do you experience the intersection of race, gender and sexual orientation when working with these clients? What feelings come up for you?
- What is your reaction to a client's internalized oppression as it relates to same-sex intimate partner violence? How do clients' internalized oppressions affect you?

Intervention

- What interventions, if any, do you believe have been effective in addressing a client's internalized oppressions?
- Do you have conversations with clients about their internalized oppressions? Can you give an example?
- Are you familiar with the literature related to same-sex intimate partner violence and/or internalized oppressions or both? Do you use the literature in your work with these clients?

Closing

- How did your work with these women affect you?
- If you were to do the work differently, knowing what you know now, how would you do it differently?

Thank you for your time and assistance. If you decide to withdraw your participation in this research, you can contact me at _____ or by email at _____. The deadline to withdraw participation is March 1, 2008.