2023

Physical intimate partner violence of African American women: promising practices and pitfalls in treatment

Melissa Erinn Duncan

Pepperdine University

Graduate School of Education and Psychology

PHYSICAL INTIMATE PARTNER VIOLENCE OF AFRICAN AMERICAN WOMEN: PROMISING PRACTICES AND PITFALLS IN TREATMENT

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Melissa Erinn Duncan

August, 2023

Thema Bryant-Davis, Ph.D.- Dissertation Chairperson

This clinical dissertation, written by

Melissa Erinn Duncan

under the guidance of Faculty Committee and to be approved by its members, has been submitted and hopes to be accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Thema Bryant-Davis, Ph.D., Chairperson

Carrie Castañeda-Sound, Ph.D.

Shavonne Moore-Lobban, Ph.D., ABPP

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DEDICATION

I would like to dedicate my dissertation to my grandmother Mary Louise. Your intelligence, beauty, love, humor and your “always kept it real” attitude is supremely missed. Not a day goes by that I do not think about you. I love you so much.

ACKNOWLEDGMENTS

To my family, thank you for the lifetime of unconditional love and support you've given me. Your support and empathy throughout my doctoral studies were unmatched. Thank you for pushing me when I needed it the most and keeping me motivated whenever I felt stuck or wanted to give up.

To Dr. Thema, your mentorship and support have impacted me immensely. Thank you for believing in me when I doubted myself. Your guidance and encouragement have pushed me to become a stronger clinician and researcher.

I would also like to thank my committee members, Dr. Carrie Castañeda-Sound, and Dr. Shavonne Moore-Lobban, for their encouragement, knowledge, and support. Their thoughtful feedback assisted me in every aspect of the development of my dissertation. My sincerest gratitude for the knowledgeable and culturally-sensitive work my committee members dedicated to this project.

To Dr. Gregory Canillas, thank you always for your support, mentorship, your faith in me and for constantly pushing me out of my comfort zone throughout the years. Thank you for the wealth of opportunities you have allowed me to participate in. Words cannot express how much you mean to me, both professionally and personally.

To my friend and would be Dr. Natalie Sisneros by the time this is published, thank you so much for being incredibly supportive of my doctoral journey since day one. I do not know how I could have gotten through this program without you.

VITA

EDUCATION

Pepperdine University *September 2017 – (Anticipated Graduation) August 2023*
Psy.D. Program in Clinical Psychology (APA Accredited Program)
Dissertation Title: "Physical Intimate Partner Violence of African American Women; Promising Practices and Pitfalls in Treatment"
Dissertation Chair: Thema Bryant-Davis, Ph.D.
Dissertation Committee Members: Carrie Castañeda-Sound, Ph.D. and Shavonne Moore, Ph.D., ABPP

Pepperdine University *September 2014 – December 2016*
Master of Arts in Clinical Psychology: Marriage and Family Therapy

University of California, Riverside *September 2007- June 2012*
Bachelor of Arts in Psychology
Bachelor of Arts in Media & Cultural Studies

CLINICAL EXPERIENCE

Posttraumatic Stress Disorder Postdoctoral Fellow, VA Boston Healthcare System
Boston, MA *Anticipated Start August 2023 - Anticipated Completion August 2024*
PTSD Clinical Team (PCT) Rotation
Supervisor: Scott Litwack, Ph.D.

- Will provide evidence-based treatment for male-identified veterans with posttraumatic stress disorder (PTSD), trauma-related issues as well as comorbid diagnoses including substance use disorders, depression and others
- Will facilitate trauma-based groups which provide psychoeducational skills focused on reducing the symptoms of PTSD including: re-experiencing, avoidance, hypervigilance, and negative thoughts and feelings
- Will administer comprehensive assessment reports to establish possible PTSD diagnosis, deepen understanding of clinical presentation and needs, formulate case conceptualization and devise treatment plan
- Will provide individual supervision to a pre-doctoral intern

Women's Trauma Recovery Team (WTRT) Rotation
Supervisor: Eve Davison, Ph.D.

- Will provide gender-specific and culturally-sensitive individual weekly psychotherapy using evidence-based trauma treatment for female-identified veterans
- Will receive training as a member of the department-wide comprehensive Dialectical Behavior Therapy program
- Will collaborate with the Women's Mental Health interdisciplinary team for clinical consultation.
- Will conduct diagnostic assessments, engage in collaborative treatment planning, and write evaluation reports

Clinical Psychology Pre-Doctoral Intern, Louis Stokes Cleveland VA Medical Center
Cleveland, OH *August 2022 - Present*
PTSD Clinical Team Rotation (August 2022 - December 2022)
Supervisor: Sara Kern, Ph.D.

- Participated as a member of multidisciplinary treatment team for veterans with posttraumatic stress disorder (PTSD), trauma-related disorders, and persisting co-morbid diagnoses including substance use disorders (SUD), major depressive disorder (MDD), traumatic brain injury (TBI)
- Engaged in Cognitive Processing Therapy (CPT) for PTSD with individual veterans diagnosed with PTSD and other trauma related disorders following a range of traumatic experiences (e.g., combat, interpersonal trauma, childhood trauma)
- Co-facilitated therapy groups including psychoeducational/supportive therapy group for veterans in the mass delivery Intensive Treatment Program for PTSD as well as a skills-based Intensive Outpatient (IOP) group for women who have experienced military sexual trauma (MST) and/or Intimate Partner Violence (IPV)
- Conducted diagnostic assessments using the Clinician Administered PTSD Scale for DSM-5 (CAPS-5), engaged in collaborative treatment planning, and write evaluation reports

Cognitive Processing Therapy Enrichment (October 2022 – Anticipated Completion August 2023)
Supervisor: Kerry Renner, Ph.D.

- Attended 3-day VA CPT training from October 31st to November 2nd
- Have one day per week dedicated to seeing a caseload of 2-4 CPT therapy cases
- Will attend weekly CPT consultation meetings for the remainder of the training year

Homeless & Mental Health Residential Rehabilitation Treatment Center Rotation
(December 2022 - April 2023)
Supervisor: Kerry Renner, Ph.D.

- Provided psychological services to veterans who are homeless, resided at the domiciliary, and presented with a wide range of mental health diagnoses and psychosocial concerns
- Engaged in Skills Training in Affective and Interpersonal Regulation (STAIR) with individual veteran diagnosed with PTSD and other comorbid disorders
- Co-facilitated psychotherapy groups including Anger Management and CBT for SMI for veterans dealing with a variety of mental health concerns (e.g., anger, SMI, trauma-related disorders and substance use)
- Administered psychological assessment measures (i.e., PAI, SCID-5, BAI, BDI-II, BASIS-24, RBANS and PCL-5) and wrote comprehensive assessment reports to provide diagnostic clarification and inform future treatment

Addictions - Women's Treatment Program Rotation (April 2023 - Anticipated Completion August 2023)
Supervisor: Megan Hoag, Psy.D.

- Will participate as a member of an interdisciplinary team providing treatment to women veterans who are recovering from a wide range of substance use disorders (i.e., stimulant use disorder, opiate use disorder, alcohol use disorder, cannabis use disorder, and tobacco use disorder)
- Will conduct psychosocial assessments, individual evidence-based therapies (e.g., CBT for SUD, Motivational Interviewing), and group psychotherapy with veterans engaged in the women's treatment program, both outpatient and residentially
- Will develop individualized treatment plans based on veterans' needs, substance use history, and psychosocial challenges to aid the recovery process

Psychological Assistant, Lion Recovery and Eagle Recovery
Van Nuys, CA *December 2021 - July 2022*
Supervisor: Bruce Rush, Psy.D.

- Facilitated brief individual, family and group therapy with clients diagnosed with chronic mental health conditions and severe substance use disorders at a detox/residential treatment setting
- Administered, scored, and interpreted integrative personality and psychodiagnostic assessments to clarify diagnostic criteria (i.e., MMPI-2, TSI-2, BDI-II, BAI), inform treatment, and determine client's strengths and weaknesses
- Consulted with medical doctors, psychologists and addiction counselors to collaborate on treatment goals
- Assisted with discharge planning from detoxification/residential to intensive outpatient treatment
- Formulate progress notes and treatment plans to meet agency standards

Clinical Psychology Doctoral Practicum Trainee, Pepperdine University's West Los Angeles Clinic
West Los Angeles, CA *June 2018 - July 2022*
Supervisor: Bruce Rush, Psy.D.

- Facilitated long-term psychotherapy utilizing EBP skills (e.g., CBT, DBT, Psychodynamic) with adult clients from the greater West Los Angeles area at a university-based community clinic setting presenting with a variety of mental health conditions (common presenting issues include mood disorders, anxiety disorders, histories of trauma and relational issues)
- Conducted diagnostic intake evaluations and intake reports to assess client needs and determine goals for treatment.
- Routinely administered, scored and interpreted self-reported assessments of depression, suicidality, and client experiences of the therapeutic alliance to monitor ongoing symptomatology, client experiences in therapy, and aid in client treatment planning (e.g, PHQ-9, and Working Alliance Inventory)

Clinical Psychology Doctoral Practicum Trainee, Loma Linda VA Medical Center
Loma Linda, CA *September 2020 - August 2021*
Substance Treatment and Recovery Program (STAR) Rotation (September 2020 - February 2021)
Supervisor: Edward Singer, Ph.D.

- Participated as member of multidisciplinary treatment team in the intensive outpatient STAR Program for veterans with substance use disorders and severe persisting co-morbid mental disorders, including court-mandated patients
- Facilitated assessment and evaluation group to assess veterans' readiness for treatment utilizing motivational interviewing (MI) and psychoeducation from Dialectical Behavior Therapy (DBT)
- Co-facilitated psychotherapy groups including skills-based groups utilizing material from Cognitive Behavioral Therapy (CBT) for depression and anxiety, Relapse Prevention, and Seeking Safety, spirituality group, inpatient process group, intake group, process-oriented groups across phases of treatment, and codependency and family therapy groups for significant others of veterans participating in the program

Health Psychology Rotation (February 2021 - August 2021)
Supervisor: Nancy Farrell, Psy.D.

- Participated as a member of the multidisciplinary treatment team for the Health Psychology rotation for veterans with chronic health conditions (e.g., diabetes, chronic pain, and obesity)
- Facilitated psychotherapy groups including a tobacco cessation group, weight and stress management class, and diabetes empowerment group
- Conducted Cognitive Behavioral Therapy for Insomnia (CBT-I) and administered insomnia-based assessments (e.g, Dysfunctional Beliefs and Attitudes about Sleep Scale, Epworth Sleepiness Scale and Insomnia Severity Index) with individual veterans presenting with insomnia and related sleep concerns

Assessment Clerk, Bethel Community Mental Health Center
South Los Angeles, CA *January 2020 - January 2021*
Supervisor: Bruce Rush, Psy.D.

- Administered, scored, and interpreted psychodiagnostic, personality and neuropsychological assessments (e.g., WNV, MACI, PAI-Adolescent, WRAT-4, Conners, CARS 2, Roberts-2) for children and adults in a community mental health setting
- Integrated assessment results to formulate DSM-5 diagnostic impressions, composed psychodiagnostic assessment reports, providing treatment plans and recommendations in the feedback section

Clinical Psychology Doctoral Practicum Trainee, Gateways Hospital
Los Angeles, CA *August 2019 - March 2020*
Supervisor: Lilia Sheynman, Ph.D.

- Provided individual and group psychotherapy to adults who are ready for discharge from Institutions for Mental Disease (IMD), Acute Psychiatric Inpatient Units, Jail, State Hospitals, or Crisis Residential Facilities, who are in need of a safe place to live
- Engaged in intensive case management services including the assessment of needs, intake, coordination with conservator/legal services, development of treatment plans, and discharge planning
- Completed documentation of services through the use of electronic health record systems and compliant with Los Angeles County-Department of Mental Health (LAC-DMH) standards.
- Administered, scored, and interpreted integrative personality and cognitive assessments (e.g., MoCA, BDI -2, BAI, MMPI-2, TSI-2, WAIS-4) to clarify diagnostic criteria, address cognitive concerns, inform treatment, and determine client strengths and weaknesses to ease transition out of the program

Clinical Psychology Doctoral Practicum Trainee, Ventura Youth Correctional Facility
Camarillo, CA *August 2018 - August 2019*
Supervisor: James Morrison, Ph.D.

- Provided brief and long-term individual and group therapy to incarcerated adolescents and young adults with presenting concerns including substance abuse, trauma, gang-related involvement at the prison's "high-core" units
- Routinely administered, scored and interpreted various cognitive and personality assessments (e.g., Aggression Questionnaire, Bender Gestalt-2, Beery VMI, M-FAST, Jesness Inventory-Revised, PAI, RBANS, WAIS IV, WRAT-4, PSQ)
- Conducted evidence-based therapy, such as CBT and DBT to assigned clients
- Performed rehabilitation services to facilitate reentry into society and reduce recidivism
- Collaborated with multidisciplinary team of professionals, including psychologists, social workers, psychiatrists, and correctional officers

Clinical Psychology Doctoral Practicum Trainee, Wiseburn School District
Hawthorne, CA *September 2017 - June 2018*
Supervisor: Keegan Tangeman, Psy.D.

- Provided long-term individual therapy to adolescents with emotional, behavioral, and mental health concerns in a school setting
- Performed intakes, assessments, and evaluations to assess client needs and determine goals for treatment
- Established relationships with parents, teachers, and other school administrators in order to better develop an individualized treatment plans for clients

Marriage and Family Therapist Associate, Bel Air Valley Detox
Encino, CA *July 2017 - April 2018*
Supervisor: Carlee Shalchian, LMFT

- Provided brief individual and group therapy to adults who have acute mental diagnoses and severe substance abuse at a detox/residential setting
- Performed intakes and evaluations to assess client needs and determine goals for treatment
- Conducted case management services to monitor and follow up with client progress in treatment program
- Formulated treatment plans and progress notes to meet agency standards

Marriage and Family Therapist Trainee/Associate, Exodus Recovery Inc.
South Los Angeles, CA *January 2016 - May 2017*
Supervisor: Richard Davis, LMFT

- Provided weekly long-term individual and group therapy to adults dealing with substance abuse, trauma, severe mental illness, homelessness and other chronic mental health issues
- Developed written treatment plans to address client's needs
- De-escalated crisis and provided conflict resolution
- Assisted with improving client's social competencies, personal and emotional adjustment, and independent living skills in a community mental health (Full-Service Partnership and Wellness Center) setting
- Completed Department of Mental Health (DMH) paperwork in a timely manner

Behavior Instructor, California Psychcare
Los Angeles County, CA & Riverside/San Bernardino County, CA *August 2012 - August 2017*
Supervisor: Marina Simonyan, M.A., BCBA

- Provided Applied Behavioral Analysis (ABA) Therapy and therapeutic support for children diagnosed with autism and other social, behavioral and mental health issues
- Conducted one-on-one client care leading to many successful graduation from treatment, client stability and overall better well-being
- Collected and calculated data by graphing to evaluate clients' progress
- Effectively established relationships and worked with families and clients of different cultural and socioeconomic backgrounds

CLINICAL TRAININGS

Cognitive Processing Therapy for PTSD, Louis Stokes Cleveland VA Medical Center
Cleveland, OH *October 2022*

Biofeedback Didactic Series, Loma Linda VA Medical Center
Loma Linda, CA *February 2021 - August 2021*

Cognitive Behavioral Therapy - Insomnia (CBT-I), Loma Linda VA Medical Center
Loma Linda, CA *March 2021*

Integrating Culture into Mental Health Services for LatinX/ Hispanic Clients and Their Families, Loma Linda VA Medical Center
Loma Linda, CA *December 2020*

When Black Cracks: Black Mental Wellness In Crazy Times, Los Angeles County Department of Mental Health (LAC-DMH)
Los Angeles, CA *December 2020*

Cognitive Processing Therapy (CPT), Loma Linda VA Medical Center
Loma Linda, CA *September 2020*

Dialectical Behavior Therapy (DBT) For Justice Involved Consumers, Los Angeles County Department of Mental Health (LAC-DMH)
Los Angeles, CA *March 2020*

Urban Fellowship Program (Culture and Diversity Training), Pepperdine University
Los Angeles, CA *September 2018 - August 2019*

Cognitive Behavioral Therapy (CBT) for Substance Abuse, Ventura Youth Correctional Facility
Camarillo, CA *August 2018*

RESEARCH EXPERIENCE

Dissertation Student, Culture and Trauma Research Lab
Pepperdine University, Los Angeles, CA *September 2017 - Present*
Dissertation Title: "Physical Intimate Partner Violence Of African American Women; Promising Practices and Pitfalls in Treatment"
Dissertation Chair: Thema Bryant-Davis, Ph.D.
Dissertation Committee Members: Carrie Castañeda-Sound, Ph.D. and Shavonne Moore, Ph.D., ABPP

- Conduct a phenomenological qualitative study on the treatment experiences of African American women who are survivors of intimate partner violence

Research Assistant, Diversity Research Lab
Pepperdine University, Los Angeles, CA *August 2015 - Present*
Principal Investigator: Gregory Canillas, Ph.D.

- Conduct internet and library-based research on topics such as foster care, trauma, substance abuse and anxiety disorders amongst various cultural groups
- Provide assistance to the principal investigator for the preparation of project-related reports and presentations

Research Assistant, Anxiety Disorder Research Lab
University of California, Los Angeles (UCLA), Los Angeles, CA *August 2015 - June 2016*
Principal Investigators: Michelle Craske, Ph.D. and Michael Treanor, Ph.D.

- Provided research assistance for study that investigated ways to enhance trauma/anxiety disorder treatment
- Conducted study using lab equipment that measured skin conductance, heart rate and gave participants muscle stimulations
- Upheld safety protocols for the well-being of the participant and the experiment
- Extracted psycho physiological measures into a meaningful numerical format

Research Assistant, Social Psychology Research Lab
University of California, Riverside (UCR), Riverside, CA *September 2010 - December 2010*
Principal Investigator: Carolyn Murray, Ph.D.

- Provided research assistance that examined classroom self-handicapping behaviors as they pertained to race, socio-economic background, and other cultural variables
- Verified accuracy and validity of data entered in databases, correcting any errors

INVITED PRESENTATIONS

Canillas, G., Calhoon, H., Dickinson, K., **Duncan, M.** & Smith, E. (2020). *Family of Origin: Risk and Protective Factors in Romantic Relationships.* Workshop presented at the annual Summit on Community Resilience, Intervention, Prevention and Training, Los Angeles, CA (Virtual).

Canillas, G., **Duncan, M.**, Crisp, C. & Behar, M. (2018). *The Invisible Survivor: African American Men & the #MeToo Movement.* Workshop presented at the annual Summit on Community Resilience, Intervention, Prevention and Training, Los Angeles, CA.

PROFESSIONAL PRESENTATIONS

Canillas,G., **Duncan, M.,** Smith, E., & Calhoon, H. (2022, February). *Radical LGBTQ+ Affirmative Practice: The 2021 Guidelines for Psychological Practice with Sexual Minority Persons*. Workshop presented at the annual meeting of the Winter Roundtable, Columbia University, New York, New York.

Canillas, G., **Duncan, M.** (2019, July). *Exploring the Role of Religion in Therapy with Same Sex Attracted Men.* Poster session presented at the annual Association of Black Psychologists Conference, Orlando, FL

Canillas, G., **Duncan, M.** & Villamil, A. (2019, July). *Agents of Change: The Use of Service Learning Projects in the Training of Psychology Graduate Students.* Panel session presented at the annual meeting of the Summit on Community Resilience, Intervention, Prevention & Training (SCRIPT), Los Angeles, CA

Canillas, G., **Duncan, M.**, Silva, C.S., & Crisp, C. (2019, February). *Examining the DL Phenomenon: African American Men & Sexuality*. Workshop presented at the annual 2019 Winter Roundtable at Columbia University, New York City, NY

Canillas, G., Crisp, C., **Duncan, M.**, Irvin, T., & Howard, A. (2019, January). *Dating in the Digital Age: Treatment with African American Clients.* Poster presented at the annual Hawaii International Conference on the Arts and Humanities, Honolulu, HI

Duncan, M. & Bryant-Davis, T. (2018, November). *Using Womanist Psychology with African American Women Survivors of Intimate Partner Violence.* Workshop presented at the annual National Conference on African/Black Psychology, Tallahassee, FL

Duncan, M., Hooks, S., Saavedra, A., Choi, L. & Bryant-Davis, T. (2018). *Keep the Faith: How Religion Is Used As a Coping Mechanism for African American Women Survivors of Partner Abuse.* Poster session presented at the annual International Summit on Violence, Abuse & Trauma, San Diego, CA

Hooks, S., Saavedra, A., Choi, L. **Duncan, M.** & Bryant-Davis, T. (2018). *Impact of Racism and Race Related Trauma.* Poster session presented at the annual International Summit on Violence, Abuse & Trauma, San Diego, CA

Choi, L., **Duncan, M.**, Hooks, S., Saavedra, A. & Bryant-Davis, T. (2018). *Counseling Considerations: Asian Immigrant Families and Intergenerational Family Conflict.* Poster session presented at the annual International Summit on Violence, Abuse & Trauma, San Diego, CA

Saavedra, A., Choi, L., **Duncan, M.**, Hooks, S. & Bryant-Davis, T. (2018). *Counseling Considerations: Immigration Related and Trauma Among Undocumented Latina/o Families.* Poster session presented at the annual International Summit on Violence, Abuse & Trauma, San Diego, CA

Canillas, G., **Duncan, M.** & Crisp, C. (2018). *Dating in the Digital Age: Treatment Issues with Clients.* Workshop presented at the annual Pepperdine University Graduate School of Education and Psychology Symposium, Malibu, CA

Duncan, M. & Bryant-Davis, T. (2018). *An Examination of Intimate Partner Violence Experiences of African American Women.* Poster session presented at the annual Pepperdine University Graduate School of Education and Psychology Symposium, Malibu, CA

Duncan, M. & Crisp, C., & Canillas, G. (2018). *Aging Out: Treating Grief and Loss with Emancipating Youth.* Poster session presented at the annual Herschel Swinger Memorial Partnership Conference, Los Angeles, CA

Canillas, G. & **Duncan, M.** (2018). *Black Men & Invisibility Syndrome: Treatment Issues.* Poster session presented at the 50th annual Association of Black Psychologists Conference, Oakland, CA

Canillas G., **Duncan, M.**, Silva, C.S., & Behar, M. (2018). *The Impact of Historical Trauma in Treating African American Clients.* Poster session presented at the annual meeting of the Society for Cross Cultural Research, Las Vegas, NV

Canillas, G., Crisp, C., & **Duncan, M.** (2018). *Sex, Love & Marriage: Treatment Issues with LGBT Clients.* Poster session presented at the annual meeting of the Society for Cross Cultural Research, Las Vegas, NV

Duncan, M. & Canillas, G. (2018). *The Impact of Cultural Beliefs and Stereotypes on Black Women's Mental Health.* Poster session presented at the annual meeting of the Society for Cross Cultural Research, Las Vegas, NV

Duncan, M. & Canillas, G. (2017). *Effective Treatment Strategies to Address Mental Health Disparities and Racial Discrimination with African American Men.* Poster session presented at the annual meeting of the Society for Cross Cultural Research, New Orleans, LA

Canillas, G & **Duncan, M.** (2016). *Attachment & Family of Origin: Strategies for Caring for Youth.* Workshop presented at the annual meeting of the National Foster Parent Association, Las Vegas, NV

Duncan, M. & Canillas, G. (2016). *Substance Abuse as a Coping Mechanism for Female Survivors of Intimate Partner Abuse.* Poster session presented at the annual meeting of the International Summit on Violence, Abuse & Trauma, San Diego, CA

INVITED COURSE LECTURES AND GUEST SPEAKING

Guest Lecturer, "Clinical Practicum" Clinical Psychology Master's Level Course
Pepperdine University, Los Angeles, CA *May 2022*

Guest Speaker, "Mental Health Systems, Practice and Advocacy" Clinical Psychology Master's Level Course
Pepperdine University, Los Angeles, CA *October 2018; January 2019; May 2019; February 2020; May 2020; October 2021; February 2022; May 2022*

Guest Lecturer, "Clinical Assessment I" Clinical Psychology Master's Level Course
National University, Los Angeles, CA *January 2019*

Guest Lecturer, "Counseling Paradigms II" Clinical Psychology Master's Level Course
National University, Los Angeles, CA *July 2018*

Guest Speaker, "Preparation for Practicum" Clinical Psychology Master's Level Course
Pepperdine University, Los Angeles, CA *February 2018*

Guest Speaker, "Pepperdine University's Psychology Information Session"
Pepperdine University, Los Angeles, CA *January 2018*

TEACHING EXPERIENCE

Teaching Assistant, Master's Level Clinical Practicum Course
Pepperdine University, Los Angeles, CA *September 2015 - April 2017; September 2020 - Present*

- Provide professor with teaching assistance on curriculum that covered topics such as treatment planning, diagnosing clients and general issues in practicum
- Assist professor with organization of course and course material
- Inform students of the procedures for completing and submitting class work

Teaching Assistant, Master's Level Mental Health Systems, Practice and Advocacy Course
Pepperdine University, Los Angeles, CA *September 2015 - April 2017; September 2020 - Present*

- Provide assistance in gathering research to update course content on issues regarding community involvement, engaging consumers on mental health services, and client advocacy
- Assist professor with developing teaching materials, such as syllabi, visual aids, answer keys, and supplementary notes
- Grade exams and term papers turned in by Master's-level graduate students

Teaching Assistant, Master's Level Course, Trauma In Diverse Populations
Pepperdine University, Los Angeles, CA *June 2022 - August 2022*

- Provided the professor with teaching assistance for course on trauma psychology, which included lecture topics on multicultural competence, trauma risk reduction, and trauma intervention
- Graded term papers turned in by Master's level graduate students
- Informed students of the procedures for completing and submitting class work

OTHER PROFESSIONAL EXPERIENCE

Graduate Assistant to the Senior Assistant of the Associate Dean of Psychology
Pepperdine University, Los Angeles, CA *September 2015 - December 2016*

- Provided administrative support to the university's Senior Assistant to the Associate Dean
- Aided the Associate Dean of Psychology on various projects
- Assisted the university's faculty with preparation of course materials
- Managed university's extensive psychological assessment database by accurately inputting data

Graduate Assistant to the Psy.D. Clinical Training & Continuing Education Administrator
Pepperdine University, Los Angeles, CA *September 2014 - September 2015*

- Provided administrative support for the clinical training director and the Psy.D. professional development department
- Organized and maintained confidentiality of Psy.D. student's clinical training files
- Led university's staff for marketing and set-up of Continuing Education Workshops on campus

Administrative Assistant, All of God's Children Group Home
Moreno Valley, CA *June 2012 - August 2012*

- Assisted with providing resources and learning programs to children and adolescents dealing with trauma and various behavioral and emotional disturbances in the child welfare system
- Monitored, evaluated, and recorded client's progress with respect to their treatment goals in a group home setting

COMMUNITY OUTREACH/PROGRAM DEVELOPMENT EXPERIENCE

The Multicultural and Diversity Committee (MDC) of the VA Psychology Training Council (VAPTC)
National VA Healthcare System *November 2022 - Present*

- Assist with the development of resources to address issues of diversity in clinical training and supervision across national levels within the VA healthcare system

American Psychological Association Joint Task Force Assistant
Los Angeles, CA *February 2019 - February 2022*

- Selected by American Psychological Association's (APA) Joint Task Force member, Dr. Gregory Canillas to assist with the revisions of the professional practice guidelines for working with Lesbian, Gay, Bisexual clients

Program Evaluator, Stigma Arts
Pepperdine University, Los Angeles, CA *July 2019*
Principal Investigator: Miguel Gallardo, Ph.D.

- Collected data through interviews, surveys, and other methods for a program evaluating the stigma of mental health services with communities of color

"Healing from Racial Trauma," Exodus Recovery Inc
South Los Angeles, CA *December 2018*

- Facilitated a workshop to provide education and serve as a resource for people of color to share their experiences about racial trauma

Intern for the African American Health Institute of San Bernardino County
San Bernardino, CA *March 2010 - May 2010*

- Created a marketing plan to engage the public in the company's message of mental health disparities of various cultural groups in California
- Conducted research on the mental health inequalities of various cultural groups in California
- Designed company posters, brochures, website graphics and website designs to promote company's mental health project

PROFESSIONAL LEADERSHIP EXPERIENCE

Scholarship and Essay Reviewer, Give A Gift Scholarship Program
Pepperdine University, Los Angeles, CA *December 2018*

Lecture Table Host Volunteer, Margaret J. Weber Distinguished Lecture Series with Dr. Cornel West
Pepperdine University, Los Angeles, CA *February 2017*

President, Africana Students of Psychology and Education
Pepperdine University, Los Angeles, CA *August 2015 - December 2016*

Planning Committee, Southern California Association of Black Psychologists' (ABPsi) Annual Graduate Student Reception
Los Angeles, CA *November 2015*

ACADEMIC HONORS AND AWARDS

Pepperdine University's Graduate School of Education and Psychology Urban Fellowship Grant
September 2018 - August 2019

Pepperdine University's Graduate School of Education and Psychology Travel Award
July 2018; April 2019

Psi Chi: International Honor Society in Psychology
2015 - Present

Pepperdine University's Graduate School of Education and Psychology Colleague's Grant
2014 - Present

PROFESSIONAL AFFILIATIONS

American Psychological Association *2018 - Present*
- Division 35, Section 1: Psychology of Black Women
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ABSTRACT

Intimate partner violence is a serious health concern among African American women. It is estimated about 41% of African American women experience physical violence from an intimate partner. A number of risk factors, as well as cultural and contextual dynamics (e.g., gendered racism, low socioeconomic status, cultural norms, exposure to family violence, as well as cultural mistrust of the healthcare and legal systems), are associated with the high prevalence rate of African American women experiencing physical abuse. Due to the unique challenges that African American women survivors of partner violence often experience, there is a gap in the current literature on the best mental health practices for working with this population. This study aims to learn more about African American women survivors and their experience in therapy and the general approaches used in psychology they found helpful or not while in treatment. The present study interviewed six Black women with histories of partner abuse and utilized a phenomenological qualitative study to understand the treatment experience of the survivors.

Chapter I: Introduction

Intimate partner violence is defined as any physical, emotional, psychological, or sexual abuse; or psychological coercion or degradation that occurs between domestic or intimate partners (Walton-Moss et al., 2005). The perpetrator wanting dominance and power over the victim is also critical in explaining IPV. Current evidence suggests that the rates of intimate partner violence within both heterosexual and same-sex relationships are relatively high, with as many as one in seven American couples having at least one episode of interpersonal violence within a year (Al'Uqdah et al., 2016; Walton-Moss et al., 2005).

It has been estimated that African American women experience disproportionate physical intimate partner violence compared to White, Latinx, and Asian ethnic groups (Bent-Goodley, 2004; Lacy et al., 2015; Rennison & Welchans, 2000). Although American Indian women have a higher rate of physical intimate partner violence victimization at 45% (Breiding et al., 2014), according to the 2010 Center for Disease and Control and Prevention, African American women were physically assaulted by intimate partners at a rate of 41%, compared to White, Latinx, and Asian cultures (Breiding et al., 2014). The National Family Victim Survey also found that married Black American women were two times more likely than married White women to experience severe partner abuse (Benson et al., 2004). African American women who are victims of intimate partner violence are also more likely to be killed during an act of partner violence (Al'Uqdah et al., 2016; Bent-Goodley, 2004).

Furthermore, according to the U.S. Department of Justice (USDOJ, 2000) National Violence Against Women Survey (NVAWS) results reflected a low prevalence of IPV among women in same-sex relationships (11.4%); however, other studies have suggested that IPV rates may be higher. Of those women who experience IPV within the lesbian community, studies

suggest physical victimization ranges from 13% to 75% (Balsam, 2001; Liesring et al., 2003; Lockhart et al., 1994; McLaughlin & Rozee, 2001; D. H. Miller et al., 2001; Stevens et al., 2010) and up to 90% when verbal abuse is included (Balsam 2003; Lockhart et al., 1994). Researchers also acknowledge that the 11.4% prevalence rate of IPV within the lesbian community may result from underreporting since lesbians are more likely to report victimization by men than women (McLaughlin & Rozee, 2001). Stevens et al. (2010) quoted the NVAWS results but stated that the percentage of lesbians who have reported being in at least one abusive same-sex relationship likely ranges from 30% to 40% (Hill et al., 2012). Given the wide range of prevalence findings, it is clear that more research is needed among African American lesbians and the lesbian population in general.

Across all racial groups in the United States, there are higher incidents of reported intimate partner violence among younger couples. In particular, American women between 18 and 24 years old experienced the highest per capita rates of intimate partner violence 19.6 per 1,000 (Rennison & Welchans, 2000). It was also found that nearly one-half (47.5%) of women who experienced some form of partner abuse (rape, physical violence, stalking) were first victimized between 18 and 24 years of age (Black et al., 2011). This pattern was also found among African Americans, where severe male-to-female partner violence rates were more than three times greater for African American couples under 30 than those older 40 (Lacey et al., 2015).

In sum, intimate partner violence is a serious national health concern, given the high prevalence of intimate partner violence among African American women. Structural, cultural-community, and situational contexts, and the intersection of gendered violence and institutional racism, make African American women more prone to this cycle of violence.

Chapter II: Literature Review

Black feminist Kimberlé Crenshaw, who coined the term "intersectionality," conceptualizes Black women's experience as "double jeopardy," defined as having membership in a marginalized racial and gender group. Crenshaw further considers the dual oppressed positions of Black women who must choose which battle they wish to fight, being Black or being a woman (Anyikwa, 2015). These identities are even more critical in working with Black women who have experienced abuse by a Black man. For some African American women, the experiences of being both a woman and an African American cannot be easily separated (Anyikwa, 2015). African American women may experience racial discrimination similar to African American men and sexism similar to White women; however, African American women experience a unique form of discrimination (i.e., gendered racism) that combines the two marginalized identities: African American and woman (Thomas et al., 2008).

Historically, African American women have been the victims of abuse perpetrated by African American and White men, with few to no repercussions. When the victim is a racial minority (i.e., a Black woman), people may be more likely to believe that the victim is responsible for her assault compared to when the victim is a White woman (Long et al., 2007). Additionally, African American women are often stereotyped as Mammy figures and emasculating (Thomas et al., 2008). The Mammy figure is often depicted as the matriarch but is also aggressive, unfeminine, and emasculating towards African American men. The Mammy figure perpetuates the trope that African American women's sole purpose in life is to serve and nurture others. African American women are also stereotyped as hypersexual or the "Jezebel" (Gillum, 2002). This archetype was created during slavery when enslaved African women were subjected to sexual abuse by White enslavers. The Jezebel was depicted as a woman governed by

her libido and the antithesis of the "ideal" mid-19th-century White Victorian lady (Gillum, 2002).

Endorsement of these stereotypes may perpetuate partner abuse against African American women. Men, who believe they are being emasculated or see women as sexually promiscuous, may act violently to control the woman (Gillum, 2002). The perception that the women are behaving in this manner may make men feel they are justified in responding violently. It may also engender victim blaming that these women are responsible for the abuse acted upon them (Gillum, 2002).

Risk Factors

The risk factors that increase the likelihood of intimate partner violence within the African American community include concentrated poverty; high levels of unemployment; previous history of childhood trauma; social stigma; emotional investment; economic dependence; sexist or misogynistic cultural attitudes (as exemplified in mass media; Powell, 2008), and substance use or abuse history by the abusive partner (Al'Uqdah et al., 2016; Powell, 2008; Williams et al., 2008).

African American women comprise about 15% of the United States homeless population. African American women in socioeconomically disadvantaged communities are also more at risk of experiencing additional traumatic events that negatively impact psychological well-being and coping mechanisms (Long & Ullman, 2013). Residents in impoverished neighborhoods are more likely to experience higher rates of IPV. African American women who live in impoverished areas are also at high risk for male-to-female partner violence compared to women who do not reside in poor areas (Cunradi et al., 1999). Joblessness and poor education that results from impoverished communities likely increase the propensity of males to act violently (Waltermaurer

et al., 2006). Historical and contemporary racial inequality have stripped African American men of their economic resources and power, which results in them directing their rage against women. Disenfranchised men of color often exert their masculinity by physically and sexually abusing their intimate partners (Roschelle, 2017).

Experiencing intimate partner violence could also be a gateway to homelessness. As such, it is more common for the victim to seek alternative housing accommodations than the perpetrator. As a result, many women separating from an abusive partner enters a state of homelessness by trading in their homes for temporary housing with family, friends, or a crisis shelter (Meyer, 2015).

Furthermore, there is also a correlation between experiencing child abuse and the likelihood of being in an abusive relationship. A study by Bender et al. (2003) found a strong link between a woman's child maltreatment history and her intimate adult relationships. It was found that significant forms of childhood abuse (specifically childhood physical and sexual abuse) made the woman more likely to be at risk of intimate partner violence in her adulthood. It could be hypothesized that a woman has "normalized" abusive behaviors throughout her childhood experience and therefore is more likely to tolerate these behaviors in her adult relationships (Bender et al., 2003).

Research has found that African American women survivors also may remain in abusive relationships due to social stigmas such as fear of being without companionship or a father or father figure (if there are children involved) and thus being labeled as "another single Black mother." These fears are perpetuated by Black women's marginalization within U.S. society, which, in turn, motivates African American women to stay in abusive relationships (Potter, 2006).

Intimate partner violence can also have financial implications for the survivor. Finances are often one of the factors of the survivor deciding to stay in the relationship. Situational factors associated with evaluating the costs and benefits of a violent relationship influence the final decision to leave or stay in the relationship. The investment theory model predicts that greater levels of investment and satisfaction paired with fewer economic alternatives (such as marriage, limited education, and low personal income) correlate with a more significant commitment to the relationship. Individuals with time, money, marriage, or emotional attachment investments would be more reluctant to leave violent relationships than women without these investments (Truman-Schram et al., 2000). Additionally, low potential for obtaining a job, loss of social support network, and a number of dependent children to support may represent large costs associated with leaving the relationship (Gordon et al., 2004); thus, indicating that having limited resources for economic independence is an objective risk factor associated with a greater likelihood of returning to an abusive relationship (Jacobson & Gottman, 1998).

Regarding the mass media, Littlefield (2008) argues that print, television, and movie media serve to promote negative stereotypes of African Americans, as many images and portrayals of African Americans are derogatory. These racially derogatory scripts promote a view of African American women as hyper-sexual and dehumanized (Richardson, 2007). These messages not only have the ability to be internalized by African American girls and women but additionally can be unconsciously adopted by African American men and persons of all races that are potentially in positions to help African American women, such as police officers, jurors, and judges (Bryant-Davis, 2005).

Hip-hop music and other mainstream media outlets transmit powerful social messages regarding African American women, how they should be treated, and how masculinity should be

construed (Taft et al., 2009). Sexual relationships are portrayed as a means of securing financial security and material possessions, and to be in a relationship is to dominate or be dominated (Bell & Mattis, 2000; Taft et al., 2009). To those individuals who subscribe to these relational beliefs, violence becomes an acceptable means of being dominant in relationships, particularly with women (Bell & Mattis, 2000). While some have argued that the social impact of misogynistic forms of rap music has been overstated and that these forms of expression are simply meant to entertain (Kelley, 1997), research evidence suggests that exposure to such messages does increase some individuals' acceptance of violence, particularly violence against women (Johnson et al., 1995).

For example, Ward et al. (2005) found that adolescents exposed to music videos laden with gender stereotypes expressed more traditional views about gender and sexual relationships than those who had viewed less stereotypical content. IPV and more general forms of violence are complex, and any model which ascribes a primary role to rap music is limited and incomplete. However, some have convincingly argued that those men (and women) who do not have corrective models of masculinity may be particularly at risk of developing such distorted views, which may, in turn, exert a negative impact on relationships with women in general, and which may encourage IPV (Bell & Mattis, 2000; Taft et al., 2009).

Another risk factor for intimate partner violence is the substance use history of the abusive partner. Although the use of substances does not cause partner violence, there is an association between the occurrence of partner violence and substance use--- especially alcohol use on the part of the perpetrator (Cunradi et al., 1999). In the 1999 study by Cunradi et al., 52 male-perpetrated partner abuse case studies were reviewed. It was found that male alcohol use correlates in seven of the nine studies that evaluated male drinking and the occurrence of partner

violence. In another study conducted by the National Alcohol Survey, partner violence within Black couples, perpetrated by the man or woman, was more likely to occur if either partner had consumed large quantities of alcohol or had an alcohol problem (Cunradi et al., 1999).

These risk factors are linked to a greater likelihood of perpetration of IPV but are not necessarily a direct cause of IPV. For African American women survivors being at risk of IPV can include a combination of individual, relational, community, and societal factors. Understanding such factors can help identify various opportunities for prevention and intervention.

Cultural Barriers to Intervention and Prevention

African American women experience unique cultural factors that can hinder intervention and prevention of intimate partner violence victimization. There are also unique cultural barriers for African American women in same-sex relationships.

One cultural barrier to intervention and prevention is identified in the cultural betrayal trauma theory. In the cultural betrayal trauma theory, societal trauma (e.g., discrimination) creates the context for interpersonal trauma within minority groups to be uniquely harmful (Gómez, 2015). Cultural betrayal trauma theory is interpersonal trauma—physical, sexual, or psychological abuse—where the victim and perpetrator share at least one minority identity. Cultural betrayal is "the violation of intracultural trust in the form of trauma, abuse, violation, or other harmful interactions perpetrated by presumed in-group members of... minorities" (Gómez, 2015, p. 41). Within-group traumas in minority populations are cultural betrayal traumas due to the violation of intracultural trust.

Intracultural trust is central to understanding cultural betrayal. Intracultural trust is defined as connection, attachment, dependency, love, loyalty, and responsibility (Gómez, 2015)

to other minorities and the minority group as a whole. Found across various contexts (Cabral & Smith, 2011; Goode-Cross & Grim, 2016), intracultural trust is engendered by the need for psychological protection from societal trauma, including racial trauma, perpetrated by individuals, institutions, systems, and policies of the dominant culture. As such, Black women survivors of IPV must confront the racial ideology that tends to accuse Black women of betraying their race in those instances when they opt to report their victimization to the police or other formal public authority (Asbury, 1987; Few, 2000). Crenshaw (2000) described this oppressive racial loyalty as an ingrained feature of the racialized social reality of African American women. Thus, for the Black woman who lives with abuse, the possibility of being subjected to social stigma for betraying the race are salient considerations as she contemplates how to manage to cope with her abuse (Asbury, 1987; Few, 2000; Hampton et al., 2003)

Furthermore, intracultural pressure is a transformation of intracultural trust that occurs to protect the minority group at large to the detriment of the well-being of individual minority members. Perceived responsibility to protect Black men (Bell & Mattis, 2000) can contribute to Black women and girls' reluctance to disclose intraracial trauma (Neville & Pugh, 1997; Tillman et al., 2010; Ullman & Filipas, 2001; Washington, 2001). For example, as indicated by Gomez, 2015, "The same loyalty to innocent Black men who are abused by discriminatory police and judicial systems can also transfer to rapists: Black women are charged with protecting their attackers at the expense of themselves" (p. 43). In this way, coercion for secrecy by either the perpetrator(s) or the non-offending members of the minority group dictate that the needs of the entire minority group trump the needs of one in-group member (the victim). Intracultural pressure can manifest in various ways, including covert or overt demands for silence, suggesting

the trauma may affect the reputation of the entire minority group, and punishing individuals who disclose cultural betrayal trauma (Gómez, 2015).

Another example of intracultural pressure is shown in African American women's unwillingness to potentially incriminate an African American male or further perpetuate existing negative stereotypes about African American men (Hampton et al., 2003). A cultural factor that inhibits African American women's desire to disclose their abuse is their awareness of the systemic oppression of African American men, such as lynching, imprisonment, unemployment, and the sexual politics of sexual violence. As such, many African American women empathize with the systemic issues African American men experience, which has made African American women tolerant, and more forgiving of words and actions perpetuated by African American men that are used to hurt them (Jordan, 2016).

African American women may also experience their forms of racism from interacting with the police and others in the criminal justice system. This issue can influence their motivation to disclose abuse (Waltermaurer et al., 2006). Intimate partner violence are often cases where the offender goes without conviction. A hurdle survivors often experience is the stigma attached to the survivor disclosing their abuse in a legal proceeding. Of the victims who do choose to discuss their assault, only 5% of those cases are resolved by convicting the offender and imposition of a prison sentence. Moreso, the legal process can invalidate and humiliate the survivor (Herman, 2005).

For Black women with triple minority status, such as lesbian Black women, face challenges that pose barriers to intervention and prevention of IPV. Black lesbian IPV survivors who are also 'closeted' may face threats of being 'outed' by their partner. Closeted African American lesbian IPV survivors, who are likely already experiencing oppression based on

racialized sexism, may be even more deeply threatened by the possibility of being "outed" (Robinson, 2002). This threat is magnified, not only because of the numerous and intersecting adversities that the sudden exposure of her triple-minority status will produce within mainstream society but also because of the unique brand of heterosexism she may encounter within the African American community or the family of origin, which may be highly religious and less accepting of sexual minorities (Harris, 2009; S. J. Miller & Astra Parker, 2009). African American lesbians may also fear being ostracized within the African American lesbian community (Chavis & Hill, 2009), as the gay community, in general, is already a small one, the lesbian community is even smaller, and the African American lesbian community is even smaller (Robinson, 2002).

An African American IPV survivor lesbian who chooses to leave her partner may experience a much greater sense of fear and isolation than her heterosexual counterparts for the following reasons: in a small lesbian community, she is more likely to encounter her ex-partner at social functions, which could result in further emotional or even physical assaults; because she may be estranged from her family of origin (as a result of their heterocentric views), her only "family" may consist of friends within the lesbian community (thus, separating from her partner may result in alienation from her friends, who may be her only source of support); having internalized mainstream society's view of IPV as involving male-to-female violence, she may have trouble conceptualizing her situation as IPV; because of the lack of community resources for lesbians who are survivors of abuse, she may not feel that she has anywhere safe to turn; and she may be afraid of bringing shame and condemnation on the LGB community by speaking out against IPV to outsiders (Chavis & Hill, 2009; McLaughlin & Rozee, 2001). For these reasons, African American lesbians with minimal social support may suffer extreme levels of distress

when considering the ramifications of seeking help or leaving an abusive relationship (Hill et al., 2012).

Furthermore, there are considerable barriers for African American women survivors when accessing or considering disclosing their partner abuse to mental health care services that stem from cultural and contextual factors, such as cultural beliefs and behaviors, racism, and discrimination affecting both heterosexual and lesbian African American women. As such, mental health professionals must consider these barriers when working with African American women.

Effects of Intimate Partner Violence

Partner abuse has potential physical, financial, and psychological consequences. Black women from abusive relationships may experience psychological distress that manifests as headaches (Hampton & Gelles, 1994) or hypertension (Lawson et al., 1999). Women in physically abusive relationships experience ailments such as broken bones, chronic disorders, diseases, and gynecological problems (Dillon et al., 2013; Ellsberg et al., 2008). Also, the combination of victimization and mental health problems increases the probability that African American women will experience physical and sexual health problems. For instance, physically and sexually abused Black women, particularly if they have had multiple victimizations, reported higher rates of unintended pregnancies and abortions (Wyatt et al., 1995), reproductive health problems, such as decreased sexual desire, painful intercourse, genital irritation, repeated vaginal infections and difficulties conceiving (Campbell & Soeken, 1999; C. M. West et al., 2000).

Intimate partner abuse can also have significant economic effects on the survivor. The impact of abuse on a woman's employment is evident in her job performance and attendance. These factors can have long-term consequences on how long a woman can maintain employment

(Brush, 2000; Swanberg & Logan, 2005; Wettersten et al., 2004). It was found in several studies that women who are having difficulty concentrating due to the physical and emotional abuse they are being subjected to have left them exhausted and unable to focus on their job (Wettersten et al., 2004).

The consequences of intimate partner violence also include adverse mental health effects, such as higher levels of posttraumatic stress disorder, lower levels of self-esteem, depression and higher levels of anxiety (Afifi et al., 2008; Ellsberg et al., 2008; Sabri et al., 2013; Straus et al., 2009; Vil et al., 2016). Research findings suggest that intimate partner violence is more prevalent and severe among low-income African American women (Rennison & Welchans, 2000; Williams et al., 2008). African American women may experience trauma-like symptoms differently than other cultural groups (Lilly & Graham-Bermann, 2009).

African American women are often obligated to endure life stressors without falling apart or breaking down (e.g., emotional inhibition) in order for African American women to maintain their strength. Research suggests that the "Strong Black Woman" schema was created during slavery as a survival response to an existence rife with violence, exploitation, and oppression (Beauboeuf-Lafontant, 2007). It has been passed intergenerationally through the socialization of Black girls. During slavery, internalizing these traits was likely necessary for personal, familial, and community survival. Today, Black women no longer have to contend with institutionalized chattel slavery, but they do have to contend with significant intersectional stressors such as racialized sexism and gendered racism (Watson & Hunter, 2016). Thus, African American women survivors who endorse the "Strong Black Women" schema may feel they have to handle the assault on their own (Peterson et al., 2002).

Unhealthy Coping Strategies

To cope with the distress of experiencing intimate partner violence, survivors often engage in unhealthy coping to alleviate suffering. There are several unhealthy strategies that are utilized among African American women survivors of intimate partner violence, including cultural beliefs (i.e., the "Strong Black Woman" schema) and substance use and abuse.

"The Strong Black Woman" archetype is a set of cognitive and behavioral expectations for African American women, such as standing up for oneself, exhibiting self-reliance, and caring for others (Watson & Hunter, 2016). African American women have described the need to "show strength" as a catalyst for increasing goal-focused behavior, independence and enhancing their moral character (Beauboeuf-Lafontant, 2007). As such, the "Strong Black Woman" stereotype can serve as a protective factor against trauma-related distress due to promoting empowerment and resilience amongst African American women (Gibbs & Fuery, 1994; Wright et al., 2010). However, the "Strong Black Woman" can also be a maladaptive coping strategy. Black women who have been socialized to be strong may minimize the distress from their abuse (Thomas et al., 2008).

African American women high in SBW endorsement reported more emotional avoidance or suppression, engaged in binge eating, and experienced disproportionate rates of cardiovascular disease (Wang & Beydoun, 2007). Qualitative research found that Black women who are more accepting of the SBW ideal are at a greater risk for depression. A study by L. M. West et al. (2016) further examined the relationship between SBW and mental health; they showed that SBW endorsement moderates the relationship between stress and depressive symptoms, such that at moderate and high levels of SBW endorsement, the link between stress and depression was stronger (Watson & Hunter, 2016).

To manage the psychological distress from abuse, substance use is a common coping strategy among survivors (Sullivan et al., 2018). African American survivors of intimate partner violence reported rates of use and abuse of substances usually lower in cost and dependence, such as alcohol, marijuana, and crack cocaine (Curtis-Boles & Jenkins-Monroe, 2000; Davis et al., 1997; Marcenko et al., 2000). According to a study done by Sullivan et al. (2018), of the survivors who used substances as a coping strategy, 61.7% were more likely to use alcohol, followed by 53.3% reporting marijuana use, 14% reported cocaine use, 7.5% said opioid use, 3.7% reported hallucinogen use, 2.8% said sedative-hypnotic-tranquilizer use and .9% reported amphetamine use. Of those sampled, 42.1% met the criteria for a drug or alcohol use disorder: 28% and 18.7% met the criteria for a drug or alcohol use disorder, respectively. Few women, 4.7%, met the criteria for concurrent drug and alcohol use disorders (Sullivan et al., 2018). A history of repeated intimate partner violence victimization increases the likelihood of substance use (Huang & Gunn, 2001).

Healthy Coping Strategies

Mental health professionals have historically neglected social support and spirituality as culturally relevant factors in clients' ability to cope with psychosocial problems. Cultural relevance refers to identifying and representing cultural values, beliefs, customs, and strengths within specific domains (i.e., work, school, relationships, and therapy) for an individual, group, or community (Santiago-Rivera, 1995). Social support and spirituality are posited to be relevant coping resources in African American culture (Billingsley, 1994; Lum, 2004; Thomas, 2001). They have been found to be the preferred ways to deal with adversity in the African American community (Boyd-Franklin, 1991; Mattis, 2000; R. J. Taylor et al., 1996; Thomas, 2001) compared to formal services.

In a qualitative study, Short (2000) used focus groups to examine partner abuse among heterosexual African American and White women recently in intimate relationships. A prominent racial difference in the sample was the inclination of African American women survivors to identify social support networks (family and friends) and spirituality (religion and prayer) as sources of help and support.

Social support is an effective treatment strategy for African American women because victims of abuse who have a strong support network are likely to feel empowered and have been cited to experience less depression and enhanced self-esteem. Research has also shown that when abuse survivors seek social support, they are better positioned to increase their safety and not become seriously affected by IPV-related stressors (Mitchell et al., 2006).

Social support also improves the coping capacity of women survivors of partner abuse (Barnett et al., 1996; Tan et al., 1995; Thompson et al., 2000). It can make a difference in the likelihood of sustaining mental health and remaining abuse-free (Nurius et al., 1992; Tan et al., 1995; Thompson et al., 2000).

Spirituality refers to the perception of and interaction with the transcendent and a sense of inner strength in daily life (Underwood & Teresi, 2002). Spirituality differs from religiosity as a broader, more universal construct focusing on internalizing core values (Mattis, 2002) and an experiential sense of meaning and purpose. It is a positive factor, particularly in the lives of trauma survivors of various types (Fallot, 1997; J. E. Kennedy et al., 1998; Reinert & Bloomingdale, 1999).

Religiosity, in contrast, is a commonly studied construct that usually refers to an institutional affiliation guided by a shared system of beliefs, rituals, and behaviors (Zinnbauer et al., 1997). However, religiosity in the lives of partner abuse survivors can also be problematic if

it perpetuates abusive relationships. For instance, forgiveness or the propensity to restore relationships are religious tenets that may also be construed as encouraging efforts to forget about the abuse in the hope that it will improve (Richie, 1996). Such religious beliefs could harm women survivors' physical safety and mental health.

Incorporating spirituality and religiosity into treatment has been shown to be beneficial to Black women in coping with IPV-related symptoms (El-Khoury et al., 2004). African American women exposed to IPV are more likely to engage in spiritually-based coping strategies (e.g., prayer) than seek mental health counseling (El-Khoury et al., 2004). Also, for African American women, religious involvement is associated with increased social support, a protective factor (Gillum et al., 2006).

There is evidence that for African American women survivors of abuse, spiritual engagement, and support are critical to healing and recovery in the aftermath of IPV. As such, efforts of religious and spiritual counselors can encourage these women to engage actively in their religious and spiritual communities, which can serve as a support system for at-risk African American survivors of trauma (Al'Uqdah et al., 2016; Fischer et al., 2015). Religion and spirituality can also assist these women with constructing meaning in times of adversity (Fischer et al., 2015).

Treatment Strategies

In working with survivors of intimate partner violence, common treatment strategies include the transtheoretical stages of change model, constructing a safety plan, trauma-specific therapies, mindfulness-based interventions, motivational interviewing, as well as therapies that integrate a culturally-sensitive framework such as restorative justice approaches, narrative therapy, feminist-standpoint theory, and womanist theory.

The transtheoretical stages of change model involve six stages: pre-contemplation, contemplation, preparation, action, maintenance, and termination. In the pre-contemplation stage, the survivor demonstrates poor insight into their relationship. In the contemplation stage, the women are not ready to commit to action and may have safety concerns when attempting to escape. Next, in the preparation stage, women intend to take action in the immediate future. The maintenance stage is understood as the women working to prevent the abuse from reoccurring. Lastly, in the termination stage, the women are confident enough to leave their abusive environment. This model helps treat survivors of intimate partner violence regardless of ethnicity. The transtheoretical stages of change model have also been beneficial in understanding various behaviors that occur in partner violence (Taha et al., 2015). The transtheoretical model can help clinicians understand how to support a woman's positive movement through the stages. The model can also promote discussion on what factors may inhibit change or areas of strength for change (Reisenhofer & Taft, 2013).

Constructing a safety plan with the survivor is also a frequently mentioned intervention. This intervention aims to identify how the survivor can respond in the event of further acts of partner violence (e.g., calling a family member or the police or going to a women's shelter; Taha et al., 2015).

Mental health symptoms can develop due to abuse, such as PTSD and depression. Trauma-specific services are beneficial when working with survivors of abuse. There is also strong support for cognitive behavioral therapy (CBT) in producing reductions in PTSD and depression symptoms among survivors of interpersonal trauma (Iverson et al., 2011). There is support for cognitive processing therapy (CPT). CPT is a form of CBT shown to significantly decrease PTSD and depressive symptoms (Iverson et al., 2011). Other treatments that have been

shown to be effective include trauma-focused cognitive behavior therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR). Additionally, there are also specific behavioral models for survivors of abuse, that include Risking Connection (Saakvitne et al., 2000), the trauma recovery and empowerment model (Fallot & Harris, 2002), and Seeking Safety (Iverson et al., 2011; Najavits, 2002). Seeking Safety can also effectively treat survivors with substance use comorbidity (Najavits, 2002).

Mindfulness-based interventions have been found to be effective for African American women's IPV-related symptoms (Dutton et al., 2013). Mindfulness assists individuals with focusing on their experiences in the present moment to shift their attention from dwelling on the past or future. In mindfulness-based interventions, survivors are also taught to let mental experiences, including negative, intrusive, or positive, pass and resist holding on to them (Dutton et al., 2013).

Furthermore, motivational interviewing is another effective treatment strategy for African American women. Motivational interviewing presents an example of an evidence-based intervention that can be culturally tailored, as motivational interviewing regards individuals as experts in their own lives and capable of making decisions for themselves. The client-centered nature of motivational interviewing allows practitioners to meet survivors where they are in their process of change (Hohman, 2012).

Rasmussen et al. (2008) conducted a pilot study of 20 women receiving services in a women's shelter. Ten women received services from shelter staff trained in motivational interviewing, and ten women received regular treatment services (without motivational interviewing) from shelter staff. Findings suggest that women who received motivational interviewing-enhanced services were significantly more ready to change a behavior than those

who received regular treatment services. Motivational interviewing was also found to assist with decreasing depressive symptoms of African American women survivors of intimate partner violence (Wahab et al., 2014).

For African American women who have children, it is suggested to incorporate parenting support and techniques into treatment to prevent maladjustments and deficits with their children (Hughes & Huth-Bocks, 2007; Owen et al., 2009; Wilson et al., 2014). Parental intimate partner violence heightens a child's risk for adjustment problems such as aggression, anxiety, depression, and social withdrawal. Moreover, the longer the length of the parental IPV, the more likely the child's adjustment problems will be severe (Jouriles et al., 2018).

The restorative justice approach is a culturally-sensitive treatment that can assist with decreasing forms of African Americans' mistrust of the criminal justice system (Al'Uqdah et al., 2016; Hampton et al., 2008). Within the restorative justice approach, intimate partner violence is not considered a legal violation against the offender but a problem affecting the survivor, the abuser, and the community at large (Al'Uqdah et al., 2016; Hampton et al., 2008). Intimate partner violence is viewed as a problem that can only be solved by addressing all individuals involved. This approach suggests that rather than handing over all decisions to law officials, the concerns of the victim, offender, and the community are brought together to determine the appropriate actions toward the intimate partner abuse, and then the victim is allowed to pursue legal options if it is what they desire (Al'Uqdah et al., 2016; Hampton et al., 2008). These treatment strategies may be attractive because they discourage legal involvement within an intimate relationship and can be helpful to African Americans who may be wary of the criminal justice system. In addition, the goal of restorative approaches for the abuser is to help him accept

responsibility for his abuse and, in turn, help him become a more responsive member of society and stop his use of violence (Hampton et al., 2008; Sherman, 2000).

Other culturally-sensitive approaches are intimate abuse circles. Intimate abuse circles (IAC) incorporate many restorative justice principles, which involve the survivor, offender, and members of the community in an attempt to address the underlying causes of intimate partner abuse, create effective solutions, and reduce future acts of violence (Hampton et al., 2008). Intimate abuse circles are beneficial for couples who desire to remain together and improve their relationship. Separate circles are held for the victim and her abuser before they join a shared circle in order to ensure the victim's comfort and safety. Discussions are facilitated by professionally trained domestic violence experts who guarantee that all parties are allowed a voice while ensuring that problematic dynamics associated with violence do not get reproduced in the circle (Grauwiler & Mills, 2004). The process encourages empowerment by allowing both parties to own their concerns and take a dynamic posture toward healing from the violence (Al'Uqdah et al., 2016). IACs are viewed as a culturally sensitive alternative to the criminal justice system and have been found to be especially helpful to immigrant, minority, and religious families in which it is likely that the family will remain together and will desire the support of the community (Griffing et al., 2002; Hampton et al., 2008).

Narrative therapy is also an effective form of treatment for African American women. Narrative therapy allows individuals to re-author their life stories and challenge cultural constructions (Bohrman et al., 2017). Brosi and Rolling (2010) found that narrative therapy was helpful for women in violent relationships to make the conceptual transition from victim to survivor (Bohrman et al., 2017).

Feminist standpoint theory is also an effective treatment strategy for African American women survivors of partner violence. Feminist standpoint theory privileges the voice of women with a particular experience, such as being involved in a violent relationship. Specifically, this framework allows for the exploration of women's views of their interpersonal relationships in the context of particular historical and social settings, such as the current political climate, the community context, and how certain groups experience privileged identities. Feminist standpoint theory highlights the intersectionality of women's identities. It emphasizes mental health professionals' awareness that African American women who are in abusive relationships may also be experiencing economic inequality, in addition to racism and sexism (Bohrman et al., 2017).

Lastly, another culturally-sensitive treatment for African American women is womanist therapy. Womanism is not just a subset of feminism but has roots in African psychology. Womanist therapy is strength-based and does not pathologize the marginalized identities of Black women but sees these identities as a positive. The goals of womanist therapy are for Black women to revise dominant White feminist psychological theories of identity development and understand that Black women's negative self-images are due to centuries of historical, contemporary, and internalized oppression (Sanchez-Hucles, 2016).

Womanist theory suggests that Black women who have internalized negative gendered and racialized ideals of their identity in order to move towards a healthy identity of themselves, Black women must remove themselves externally and from societally based definitions of womanhood to internal definitions, which includes defining their values and beliefs (Sanchez-Hucles, 2016). From a womanist perspective, clinicians would investigate how oppressive

forces, along with cultural and historical factors, influence the lived experience of intimate partner violence among African American women (J. Y. Taylor, 2005).

Clinicians must also be mindful of the effects of the abuse and the cultural aspects that can influence treatment. African American women are less likely to seek mental health services than their White counterparts (Weist et al., 2014). When working with African American clients, clinicians must also be aware of their prejudices about African Americans. African American clinicians may perpetuate internalized racist thoughts, and White clinicians may harbor unconscious racism. African American clinicians may harbor distrust, anger, and disappointment toward other African Americans (Al'Uqdah et al., 2016). Additionally, White clinicians may suffer from unconscious racist beliefs and hold African American clients to White cultural norms, morals, and ideals. Clinicians overall who harbor racist attitudes may devalue people of color, blame them for their problems, and treat them harshly (Al'Uqdah et al., 2016).

In working with African American women survivors, selecting a treatment approach encompassing this population's cultural and contextual factors is essential. As noted, there are many effective treatment approaches that address the symptoms experienced by survivors of partner violence and diversity-related issues of African American women survivors.

Chapter III: Methodology

Participants

The participants of this study were six eligible volunteers. The criteria for inclusion in this study included participants who self-identified as a woman and were 18 years old or older (except for Alabama and Nebraska where the participant had to be 19 years old or older and Mississippi, the participant had to be 21 years old or older). The participants also had a previous history of intimate partner violence victimization and were of Black and/or African American descent. The nature of the partner violence had to include physical abuse, but other forms of partner abuse (e.g., sexual, emotional, and financial) were co-occurring.

The study was limited to participants who were no longer in an abusive relationship and did not fear future abuse. The study recruited participants who discussed their partner violence with their therapist at the time. It was acceptable for the participant to be currently in treatment, but it was to address an issue outside the partner abuse. Participants had to have at least four therapy sessions with a mental health professional. Therapy sessions included services from a psychologist, clinical social worker, or a marriage and family therapist associate, intern, trainee, or licensed. One session was defined as face-to-face or telehealth contact with a mental health professional for at least 45 minutes (an intake evaluation completed by a mental health professional listed above was also considered as a session).

Participants were encouraged to answer all of the questions asked in the study. However, if questions 3, 5, 6, 7, 8, 9, 10, 11, 12, 15, and 16 on the interview questionnaire were left blank or were incomplete, this eliminated the participants' opportunity to participate in the study. It was important that these questions were answered appropriately as they would provide information on the treatment protocol and its effectiveness-- which was essential information for the study's research.

Procedure

The study recruited participants within the community and social media with a large Black consumer base and that promoted Black mental wellness. The study utilized a multi-staged process.

In the first stage, the principal investigator emailed permission (see APPENDIX A) to clinic directors, owners of business, etc. to post flyers at hair salons, barbershops, community clinics and churches with a large Black consumer base at the principal investigator's current residence of northeast Ohio. In the second recruitment phase, the principal investigator posted flyers at hair salons, barbershops, community clinics and churches with a large Black consumer base within Southern California.

The third recruitment stage utilized social media. For posts on social media, the principal investigator instructed the owners that were asked to post the flyers (see APPENDIX B) to their social media accounts, to restrict their comments and utilize the option where posts were automatically deleted in 24 hours. The contact information of the principal investigator was displayed on the flyer for interested participants to reach out for questions or concerns. However, since the sample size of six participants was not gathered during the third recruitment stage, the principal investigator implemented another stage in recruitment. The owners of the social media accounts were instructed to post the flyers on their timeline for two weeks, then delete the flyers from their timeline. Comments on these posts were restricted, and if interested participants had any questions or concerns, the flyer displayed the contact information of the principal investigator to reach.

Individuals were identified for recruitment after expressing interest via email, and if individuals believed they met the qualifications of the study identified on the flyer (see

APPENDIX B). Once the email was received from prospective participants a screening questionnaire was administered digitally to determine if the participant met the inclusion criteria. If the participant met the screening criteria, the informed consent was administered digitally to the participant.

The consent form discussed the participant's rights in the study. The consent form also noted that participants could choose not to answer any questions they did not feel comfortable disclosing or could decide to end the interview if they did not wish to continue. Additionally, the form stated that the interviewer could use their clinical judgment to stop the interview if the interviewer perceived that the participant was too distressed to participate.

Once participants read and signed the informed consent, and returned it to the researcher, the researcher set up an appointment for a one-time interview consisting of completing a demographic questionnaire, a survey questionnaire, and an interview questionnaire. The principal investigator's dissertation chair was informed of all interviews conducted and was also available to be reached by phone in case a crisis intervention or mandated reporting needed to be implemented. The study also obtained all participants' phone numbers, current locations, and emergency contacts prior to the start of the interview for participants who may be at risk of harming themselves or others (see APPENDIX C). Also, the nearest hospital and police department of the participant was looked up before the start of the interview.

All data retrieved from prospective and selected participants was stored on a password protected laptop. The audio-recordings, transcribed interviews, and subsequent data was also de-identified and identifiable only by numeric code for confidentiality purposes. Audio-recordings were transcribed and then the audio-recordings were deleted immediately after the interview. The transcribed interviews were also de-identified immediately after the interview and then

stored on the secure laptop. The interviews were also conducted on a secure video conferencing platform.

Furthermore, individuals were informed of the $25 gift card compensation on the flyers for the study. Those who met the screening criteria for the study, completed the informed consent and participated in the interview to the best of their ability received $25 gift cards as incentives for their participation.

Data Analysis Plan

The study used a qualitative research design and a phenomenological approach. A phenomenological approach involved a detailed examination of the participants' world. It attempted to explore the individual's experience. It was also concerned with an individual's perception or account of an object or event, as opposed to producing an objective statement from the participant. The phenomenological approach included gathering information and perceptions through inductive, qualitative methods such as interviews and discussions and then representing it from the research participant's perspective (Lester, 1999).

One of the benefits of phenomenological research was that it was able to provide a detailed understanding of a phenomenon (Lester, 1999). Although there were also limitations to using a phenomenological approach. Due to this approach's in-depth and detailed nature, it was common for the researcher to develop biases during the interview process with the participant. As such, the researcher's biases can influence the interpretation of the data.

Given the close relationship between the researcher and the research topic, potential biases may both precede and develop during the process of qualitative research. The researcher identifies as an African American woman with a history of experiencing gendered racism in professional and personal spaces including microaggressions, as well as interpersonal gender-

based violence. Although the researcher's own life experiences with this phenomenon may not be considered as extreme as some of the women in this study, it was important for the researcher to be mindful of relating to the stories shared by the Black women in this study; feelings and biases may transpire subconsciously.

To account for possible biases, the study used bracketing. Bracketing is a phenomenological aspiration defined as putting aside preconceptions, expectations, or culturally determined interpretations to encounter the 'essence' of a phenomenon (Ladkin, 2005). One method of bracketing that was utilized included writing memos throughout data collection and analysis as a means of examining and reflecting upon the researcher's engagement with the data (Cutcliffe, 2003). Memos took the form of theoretical notes which analyzed the cognitive process of conducting research and observational comments that allowed the researcher to explore feelings about the research endeavor (Tufford & Newman, 2010). For example, the researcher attended to her own 'in the moment' bodily reactions or noted thoughts she might otherwise judge to counter potential biases and assumptions (Ladkin, 2005). These steps were necessary for the researcher to maintain an attitude of phenomenological scientific reduction. The intentionality to remain objective helped the researcher maintain a psychological attitude toward the data and safeguard her sensitivity towards the phenomenon being studied.

Rationale for Determining Themes

Thematic analysis is a method of analyzing qualitative data. It is applied to texts, such as interviews or transcripts. In thematic analysis, the researcher closely examines the data to identify common topics, ideas, and patterns of meaning that come up repeatedly, usually held by the majority of the sample (Harding, 2016). However, given that this study sampled an underserved population, it was important for the researcher to highlight the different experiences

of the survivors; thus, there were themes created in the results section that were identified by a minority of the participants.

Chapter IV: Results

This section will describe the six participants whose interviews were included in the study. To establish inclusion criteria, all participants answered questions in a screening questionnaire before participating in the interview. Additionally, the demographic surveys obtained from each participant and the information gathered within the interview will be used to describe each participant in the study. All participants were over 18 years of age, identified as either a Black or African American woman, endorsed a history of physical intimate partner violence and engagement in therapy services.

Participant 1

The first participant in this study is a 26-year-old married self-identified Afro-Latina. She further described herself as cisgender, as well as pansexual, and denied any participation in a religious, spiritual, or faith background. She reported some college education. The participant expressed she is not currently employed, and her last position was as a restaurant hostess. She stated she has a combined annual income with her spouse of $60,001 to $80,000.

She stated she was in one physically and emotionally abusive relationship for three years. The participant indicated the nature of the abuse included slapping, punching, pushing and being called disparaging names frequently by her partner. She described her partner as an African American cisgender heterosexual male and was 27-30 at the time of the relationship. She reported that she was not in an abusive relationship when she sought therapy.

The participant expressed that her therapist was a White woman in her 30s. She also noted that she was unsure of the theoretical orientation utilized during the course of treatment, but expressed mindfulness was incorporated in her sessions.

Participant 2

The second participant in this study is a 28-year-old single self-identified African American woman. She further described herself as cisgender, as well as heterosexual. She reported that she identifies with the Catholic religion and has a Bachelor's Degree. The participant stated she is currently employed as an "educator." She stated her annual income is less than $40,000.

She stated she was in one physically and emotionally abusive relationship for three months. The participant indicated the nature of the abuse included slapping, stalking and being called disparaging names frequently by her partner. She described her partner as an African American cisgender heterosexual male and was 26 at the time of the relationship. She reported that she was in this abusive relationship when she sought therapy, and during her course of treatment, she eventually left the relationship.

The participant expressed that her therapist was a White woman in her 30s. She also noted that she was unsure of the theoretical orientation utilized in therapy, but expressed she was able to gain insight of similar relationship patterns in her sessions that she was not aware of.

Participant 3

The third participant in this study is a 30-year-old divorced self-identified African American woman. She further described herself as cisgender and heterosexual and denied any participation in a religious, spiritual, or faith background. She reported some college education. The participant stated she is currently employed as a "sales manager." She expressed her annual income is less than $40,000.

She stated she was in one physically and emotionally abusive relationship for three years. The participant indicated the nature of the abuse included slapping, pushing, hair-pulling,

punching and being called disparaging names frequently by her partner. She described her partner as an African American cisgender heterosexual male and was 29-32 at the time of the relationship. She reported that she was in this abusive relationship when she sought therapy, and during her course of treatment, she eventually left the relationship.

The participant described her therapist as an African American woman in her mid-30s. She also noted that she was unsure of the theoretical orientation utilized in therapy, but stated mindfulness was incorporated in her sessions.

Participant 4

The fourth participant in this study is a 27-year-old divorced self-identified Jamaican-American woman. She further described herself as cisgender and heterosexual. She reported she identifies with the Christian religion and expressed she has a Bachelor's Degree. The participant stated she is currently employed as a "case manager." She stated her annual income is between $40,001 to $60,000.

She stated she was in one physically, financially and emotionally abusive relationship for three years. The participant indicated the nature of the abuse included slapping, stalking, pushing, choking, destroying property (i.e., breaking the front door), making threats about wanting to harm or kill her, and being called disparaging names frequently by her partner. Participant 4 stated her abusive partner at the time also physically abused her when she was pregnant and stole about $1,500 from her. She described her partner as a Jamaican American cisgender heterosexual male and was 33-36 at the time of the relationship. She reported that she was in this abusive relationship when she sought therapy and did not leave the relationship during her course of treatment. The participant stated she eventually left the relationship a few months after treatment.

The participant described her therapist as a Nigerian woman in her 40s. She also noted that she was unsure of the theoretical orientation utilized in therapy; however, stated her childhood was discussed and was assigned homework throughout her course in treatment.

Participant 5

The fifth participant in this study is a 33-year-old single self-identified African American woman. She further described herself as cisgender and heterosexual. She reported she identifies with the Christian religion and expressed she has some college education. The participant stated she is currently employed as a "Corporate Employee Developer." She stated her annual income is greater than $100,000.

She stated she was sexually abused by an intimate partner when she was in her 20s. She indicated she was in this relationship for two months. She also reported she was in one physically and emotionally abusive relationship for two years. The participant indicated the nature of the abuse included slapping, pushing, punching, choking and being called disparaging names frequently by her partner. She described her partner as an African American cisgender heterosexual male and was 45-47 at the time of the relationship. She reported that she was in an abusive relationship when she sought therapy and left the relationship during her course of treatment.

The participant described her therapist as an African American woman in her 40s. She also noted that she was unsure of the theoretical orientation utilized in therapy; however, reported she was assigned homework, was asked to discuss her childhood and gained insight of similar patterns in her relationships.

Participant 6

The sixth participant in this study is a 30-year-old single self-identified Afro-Latina woman. She further described herself as cisgender and heterosexual. She reported she identifies with the Catholic religion and expressed she has a Graduate Degree. The participant stated she is currently a "graduate student." She stated her annual income is less than $40,000.

She stated she was in one physically and emotionally abusive relationship for three years. The participant indicated the nature of the abuse included slapping, punching and being called disparaging names frequently by her partner. She described her partner as an African American cisgender heterosexual male and was 32-34 at the time of the relationship. She reported that she was in an abusive relationship when she sought therapy and did not leave the relationship during her course of treatment.

The participant stated she eventually left the relationship a few months after treatment. The participant described her therapist as an African American woman in her 50s. She also noted that she was unsure of the theoretical orientation utilized in therapy but was assigned homework weekly.

Interview Themes

This study aimed to analyze the therapy experiences of Black or African American women survivors of intimate partner violence to inform clinicians of potential therapeutic pitfalls and promising practices. A semi-structured interview was utilized with categories including their experiences of intimate partner violence as Black women and their therapeutic experiences. Throughout the interviews, several themes emerged within each category.

Lack of Community or Family Support

Lack of community and familial support was a noted theme for many of the participants in this study. Three of the participants (Participants 1, 2 and 5) spoke about feeling unsupported by their families and community in favor of protecting their abusers who were Black men. Participant 1 noted, "growing up surrounded by single mothers, and still being told any man was better than no man." Participant 1 further described some challenges she experienced about leaving her abusive relationship because her family did not support her decision. "There was relief about leaving but frustrating because I had family who did not agree with my decision." Participant 2 also shared her experience about a lack of support from the community and expressed,

> [The Black] community coddles the abuser. I just see it all the time in the news whenever there is a domestic violence situation between two Black celebrities, the community always defends the man and blames the woman. Just knowing how the community usually reacts to this issue made me initially wary about seeking help, because I did not think my story would be taken seriously.

Additionally, Participant 5 reported similar sentiments as Participant 2 about not feeling supported by her community. She expressed,

> Black women have historically not been given [community] support to help us navigate our traumas. I feel like our traumas are downplayed in the community. I was hesitant to reach out because I did not think I was deserving of getting help and just had to deal with it.

Fear or Distrust of Law Enforcement/Health Care Providers

Four of the six participants (Participants 1, 2, 4 and 5) interviewed discussed feeling fearful about allowing law enforcement or a medical provider to intervene in their relationship. Participant 4 stated she initially did not feel comfortable letting the police know about her abuse because she thought the police intervening would make the situation worse. Instead, Participant 4 opted to discuss the abuse with her partner's mother initially, "I called his mom in fear that calling the police could be fatal"; however, Participant 4 shared once she notified the police, they did not do anything to help her, "I disclosed to the police in the major city I relocated to, and they dismissed the violent messages and excessive calls." Participant 4 shared also about not disclosing her abuse with her healthcare provider,

> I didn't notify my PCP or even my OBGYN when I was pregnant in fear that they would call CPS, which could result in me losing my job. In hindsight, I should have told my OBGYN to protect my health as a vulnerable Black woman.

Participant 1 also reported choosing not to disclose her partner's abuse with her healthcare provider and law enforcement, "Doctors don't take me seriously, and police are worse." Participant 2 also expressed she did not share her partner abuse with law enforcement or a medical professional, "I didn't discuss my abuse with [the police or doctors]. People are judgmental and can victim-blame." Participant 5 reported her decision to not share her abuse with law enforcement or to a health care provider was due to fear that her partner might retaliate, “I chose not to disclose to family members, police or physicians; for fear my partner may find out and hurt me.”

Strong Black Woman

The "Strong Black Woman" schema was also a recurring theme among participants. In the interview, many participants (i.e., Participants 1, 4 and 6) discussed how they did not feel comfortable expressing their emotions as there was a need to be emotionally resilient in the context of their identity as Black women. Participant 4 stated,

> I feel [Black women] are most disrespected. I have dated only Jamaican men and I find we are viewed as goddesses in the beginning and then Black women are perceived as slaves or "mothers" who should work hard, look good, and not complain. I've never felt respected in my entire life.

Participant 1 shared that she too also felt she had to demonstrate emotional strength to cope with her partner abuse, "After being told I was overcompensating emotionally by trying to convince myself I was fine. Accepting the fact that sometimes I'm not took the pressure off me. I let myself be upset for the first time." Participant 6 also shared similar sentiments about demonstrating emotional resilience,

> After leaving my abusive relationship, there were times I wanted to breakdown and cry, but I just felt I just needed to be strong and act like everything was okay. Therapy really helped me be comfortable with expressing my feelings and learning that not being okay all the time is not a sign of weakness or failure.

Strong Black Woman: Prior Emotional Abuse

Participant 4 further discussed early socialization of the Strong Black Woman stereotype as she experienced verbal abuse within her family.

> I perceived verbal abuse as normal because my family talks rough. I thought I could manage in my relationships because it was normal and "whatever." Though I held my

> own, I didn't realize that the verbal abuse would turn physical despite my counselor warning me that I was in a dangerous situation.

Motherhood and Marriage as a Factor of Staying

Two participants (Participants 3 and 4) also discussed how being married and being a mother was a factor in them considering staying in these relationships. Participant 4 disclosed during the interview,

> In the beginning I wanted to work out my marriage because I found out I was pregnant. After the marriage counseling fell through, I wanted to work on myself so I could have the courage to leave the relationship completely. I didn't fully leave the relationship until the physical abuse began at 38 weeks pregnant and I filed for divorce the day after my baby was born.

Participant 3 also shared similar sentiments about wanting to stay in her relationship due to marriage,

> It went on for three years, and to be honest, I didn't want [my marriage] to end, we were together for such a long time, but he kept beating me and being violent to me, and it was just too much for me, and I ended up in the hospital, and then I was completely separated from him.

Restraining Order

Two of the women (Participants 2 and 4) spoke about how getting a restraining order was how their abusive relationships ended. Participant 2 expressed, "I was in the relationship for 3 months, it ended with me getting a restraining order on him. He was stalking me and my family and it was getting dangerous." Participant 4 also discussed how she was granted a restraining order to end the abusive relationship,

> I left that city and went home to my mom. Two weeks later he came to the hospital throwing a tantrum. I kicked him out the room and filed for divorce. Since then, he made fatal threats. He went to court saying he intended to warn me that he could take my baby. A restraining order was granted [to] me.

Spiritual and Religious Coping

Two of the six participants (Participants 5 and 6) interviewed discussed how they used their religious or spiritual background as a way to cope with their partner violence. Participant 5 stated, "I went to therapy, but I also prayed every day for God to help me find the strength to leave my abusive ex." Participant 6 also identified prayer as well as attending church as a way to cope outside of attending therapy,

> I used prayer a lot, but I also tried to attend church. I tried to go to church as much as I could, but when the abuse was really bad, I felt really embarrassed to be out in public especially when I had visible bruising. So, when I did not feel comfortable going to church, I made sure to pray.

Social Support

Two of the participants (Participants 3 and 5) noted how having a support system encouraged them to reach out for mental health services. Participant 3 shared "I told my friends and family about being in an abusive relationship, and with their support, they encouraged me to go to therapy." Participant 5 reported, "I made a decision to share my abusive relationship with one very close friend… My close friend was helpful and encouraged me to seek therapy."

Self-Care

Some of the methods the participants (i.e., Participants 1, 3 and 5) identified that were helpful in their coping included self-care. Participant 3 discussed how music as well as other forms of coping was an effective tool in dealing with her distress,

> My therapist told me that listening to music or playing music is a good way to relieve stress. I was able to distract my attention, reduce muscle tension and reduce stress hormones. I would turn up the volume, immerse myself in the music. My therapist suggested other things I could do if I didn't feel like playing music. I would do other hobbies like gardening, sewing, sketching, anything that requires me to focus on something a little more pleasant rather than thinking about my ex.

Participant 1 described using exercise as a way she preferred to cope outside of therapy, "I did a lot of weightlifting when I was in the process of getting out of my abusive relationship. It helped me release a lot of tension. Participant 4 described her self-care as

> I took a lot of alone time. It was helpful to me, because I was able to get to know myself and process things. What was also helpful to me was playing with and enjoying my active 1 year old.

Participant 5 also noted that self-care was suggested by her therapist, "My therapist recommended that I do something each day that I find relaxes & calms me. Such as a brisk walk, deep breathing, reading, listening to music."

Therapy Experience

During the clinical interview, the participants identified some of the symptoms they were experiencing prior to seeking help. They also described the overall result of their therapy experience on the outlook to recovery.

Distress

Four of the participants (Participants 1, 3, 4 and 5) identified both mental health and somatic symptoms they experienced due to their abusive relationships. Participant 1 reported mental health symptoms she experienced from her abusive relationship, “I was suffering from insomnia and noticed I was agitated easily.” Participant 3 reported experiencing severe anxiety and fear. Participant 3 stated, “I was constantly anxious, I was afraid he would come home from work and continue to abuse me and beat me.” Participant 3 also identified somatic symptoms she experienced "[I had an] obvious fever, headache, stress and nausea." Participant 4 noted experiencing mental health symptoms such as fear and anxiety. Participant 4 stated, “I was scared and anxious post-divorce due to the constant threats that he was going to hurt me.” Additionally, Participant 4 identified experiencing somatic symptoms as a result of her partner abuse, "I ended up with high blood pressure by the last DV incident but have since gotten back to my normal readings 13 months postpartum." Participant 5 described her symptoms as the following,

> I was constantly depressed & anxious. I was unable to sleep or perform some of my work-related responsibilities due to my level of stress. I was also getting a lot of migraines that were making it hard for me to sleep.

Hopes

Five participants (Participants 1, 3, 4, 5 and 6) shared their outlook on healing after completing their therapy sessions. Participant 1 stated, "Well it's been a while since I’ve been in therapy, and I've been in a healthy relationship since so I'm feeling good." Participant 3 also expressed feeling hopeful about her recovery, "I have expectations for the future life, looking

forward to a better future". Participant 4 shared similar positive sentiments about her mental health post-therapy,

> I feel I can recover and hope that I heal from my childhood trauma, so the cycle doesn't continue with verbal and physical abuse in my relationships. I know why I'm falling into the trap, but I look forward to learning how to avoid it all together due to my amazing therapist.

Participant 5 indicated after attending therapy sessions she is positive about her future relationships,

> I feel great about my recovery. I feel empowered & able to recognize when a relationship is not a situation that I am obligated to remain in out of fear. I am looking forward to experiencing a respectful & loving relationship moving forward.

Lastly, Participant 6 shared her hopes about the future after engaging in therapy services, “I am hopeful that I will not be in an abusive relationship due to learning about my personal strengths and gaining self-confidence. I learned that I am deserving of a happy and healthy relationship.”

Promising Practices

Several coping skills and strategies were shared by the participants that they believed were helpful in their recovery during their time in treatment. The therapeutic strategies that were identified included active listening, validation, the cultural identity of the therapist, specific therapy interventions and self-care.

Active Listening

Participant 2 discussed how feeling heard was essential in her treatment. "When I was in therapy, I think what helped a lot is to know that I had a kind and encouraging ear." Participant 2 stated she needed a safe space to further explore and discuss her feelings,

> I was just trying to process [the abuse]. I was freshly in shock at how deranged the abusive ex had become in just a few short months and I'm glad I had someone there I was able to talk to in my therapy sessions.

Validation

Two of the participants (Participants 1 and 4) spoke about how important it was to feel validated during therapy to heal. Participant 1 emphasized how affirming her emotional experience was helpful to her recovery, "I learned in therapy that I'm allowed to be upset about things I can't change, and, in many ways, I was set up for failure. I do not have to blame myself for everything." Participant 4 also agreed how feeling validated in therapy was helpful to her, "Having unbiased support to know I wasn't wrong and I'm not being dramatic. I constantly seek reassurance, but I don't need to seek it from outsiders because I can trust myself."

Therapist's Culture and Gender Identity

Five of the six participants (Participants 2, 3, 4, 5 and 6) discussed the racial or gender identity of their therapist as a factor in them feeling understood and fostering safety in their therapy sessions. Participant 4 who had a therapist who was a Black woman stated,

> "She understood my cultural background and how I perceived communication and family dynamics in my home. It was helpful because I felt she understood what I was describing in my household without judgment. I previously had a White male therapist who expressed the same fears about my ex prior to leaving him but I felt he didn't understand the family dynamics."

Participant 2 whose therapist was a White woman expressed, "Her gender made me feel safe." Participant 3 who had an African American woman as a therapist stated, "First of all, we are both women and from the same cultural background. She was very sympathetic to my suffering and

always treated me patiently when giving me psychological treatment." Participant 5, whose therapist was an African American woman, shared about how her therapist's cultural background affected her experiences in therapy, "I thought having a therapist with the same background as me was helpful. I believe my therapist was better able to advise me & help me navigate my issues as an African American woman." Participant 6 also discussed the ways her therapist's cultural identity impacted her therapy experience,

> I thought it was helpful to work with a therapist who was the same race as me because I did not have to explain cultural norms more than I would with someone who does not come from the same cultural background. I felt seen and heard and I felt like I also did not have to code switch. She knew what I meant, and I did not have to explain any further.

Therapeutic Interventions: Psychoeducation

Two of the six participants (Participants 1 and 2) discussed how being educated and given information about their symptoms was helpful in their treatment. Participant 2 stated, "therapy helped me understand why I was feeling anxious. Participant 1 stated learning that experiencing mental health affects all cultures was helpful to her, "I learned in therapy that depression and anxiety affect people of all races. I never was taught about mental health growing up or how it affected Black people."

Therapeutic Interventions: Boundaries

Two participants (Participants 1 and 4) reported the topic of setting boundaries in their relationships was discussed during their therapy sessions. Participant 1 stated, "Throughout my sessions with my therapist I felt that she was supportive. She was really good at helping me set boundaries and cutting contact with family who were triggering me." Participant 4 expressed

how learning how to set boundaries impacted her mental health and overall wellness, "When I ultimately left my ex, my therapist continued to encourage me to set boundaries, protect my child, and build my confidence so I don't continue to fall back into that abusive relationship."

Therapeutic Interventions: Mindfulness

Mindfulness was a common intervention brought up among Participants 1 and 3, that was incorporated into their therapy sessions. Participant 3 described how she was taught mindfulness skills by her therapist and included these skills in her day-to-day regimen,

> My therapist would say during mindfulness, focus your attention and calm the rambling thoughts that may be flooding your brain and causing stress. I learned mindfulness infuses a sense of calm, tranquility and balance, which was beneficial for my emotional well-being as well as overall well-being. I also used guided meditation, image-guided therapy, visualization, and other forms of meditation. I tried to use mindfulness anytime, anywhere, whether I was out walking, riding the bus to work, or waiting in the office. I also tried to use deep breathing anywhere."

Participant 1 also described utilizing mindfulness practices she had learned in therapy, "I started using mindfulness. It was a tool my therapist told me about. I used mindfulness by sitting outside more often in silence."

Pitfalls

Although all of the participants reported an overall positive experience in therapy, there are several things the participants identified in the interviews that they felt would have improved their course of treatment.

Culturally-Sensitive Care

During the interview, Participant 1 shared that her cultural background was not discussed in her therapy sessions. Participant 1 also expressed her therapist did not share a similar racial background.

> There wasn't much discourse [about my culture] on her end. She briefly discussed her experience working with women of color and that was it. Because of that I felt a little uncomfortable bringing up cultural issues because I did not think she would understand.

Advocacy/Proper Referrals

Participant 1 described a lack of advocacy during her treatment with her mental health provider. Participant 1 noted she sought treatment at an outpatient community mental health center and reported, "I wish my therapist monitored my prescriptions. The clinic would forget to refill every time and I had to go through withdrawal more than once which led me to quit [my prescriptions]."

Lack of Collaborative-Care

Two of the six participants (Participants 3 and 4) shared that they did not feel that some of their symptoms were fully addressed in their therapy sessions. Participant 3 expressed, "I still was experiencing a lot of sleep issues because I was under a lot of stress. I wish my therapist gave me some ways to help me with my sleep." Participant 4 also stated she would have wanted to learn more coping skills in her sessions, "I wanted my therapist to give me more tools to use [in session] because I felt she allowed me to just vent a lot."

Chapter V: Discussion

This qualitative, phenomenological study aimed to understand more about Black women survivors of partner violence, their experience in therapy, and the general approaches used in psychology they found helpful or not while in treatment. As illustrated by the results of the present study, there are unique challenges that Black women survivors often experience, including, but not limited to, gendered racism, cultural norms, as well as cultural mistrust of the healthcare and legal systems. The study also revealed some of the preferred approaches in therapy for this population and potential treatment setbacks that may interfere with overall mental wellness. The chapter will provide interpretations of the results, implications, and limitations of the study's findings. Recommendations for future research were made on how clinicians or future researchers can improve treatment with this population.

Interpretation of Themes

Lack of Cultural or Family Support

Black women who experience IPV must also confront societal, cultural, and familial cues that silence them from speaking up about their experiences of violence (Potter, 2006; Stockman et al., 2014). Three of the six participants identified experiencing a lack of family and community support when seeking help from their abusive partners.

Black women are often socially perceived as betraying their partner and the entire Black community when they violate their socially prescribed role of protecting their partner from the police rather than secretly suffering from victimization (Bent-Goodley, 2013; Nash, 2005). As such, Participant 2 shared about her lack of support from the community during her interview, "[The Black] community coddles the abuser…. Just knowing how the community usually reacts to this issue made me initially wary about seeking help because I did not think my story would

be taken seriously." Participant 5 also discussed similar sentiments about a lack of support for Black women who are trauma survivors, "Black women have historically not been given [community] support to help us navigate our traumas. I feel like our traumas are downplayed in the community."

In Gomez's (2019) theory on cultural betrayal trauma, she proposed that some minorities develop trust and dependence on others in their minority to protect against discrimination or societal trauma. This often pressures Black women survivors of intimate partner abuse to protect their perpetrator and community by keeping silent and sacrificing their security.

Fear or Distrust of Law Enforcement/Health Care Providers

Four participants discussed fear or distrust of law enforcement and the healthcare system. Historically, many Black women perceive the criminal justice system as a racist institution based on the disproportionate numbers of Black males involved in the legal system. To protect themselves and their partners from further discrimination (Nash, 2005), they may be ambivalent about seeking support from social service providers (Ullman & Lorenz, 2020) and the criminal justice system (Goodmark, 2008). As a result, they may be unwilling to increase that number and/or fear negative reactions, including escalation of the abuse and/or hostility or ostracization from their communities (Hampton et al., 2008). Many participants described an overall fear that involving law enforcement would worsen matters. Participant 5 reported she did not report her abuse for fear her "partner may find out and hurt [her]." As such, Simmons (2020) noted that Black women who disclose to law enforcement face additional violence from their partners.

Furthermore, the responsiveness to Black women's needs in law enforcement may also contribute to the general distrust of the legal system. A study found that police officers were less likely to make arrests with Black women survivors compared to more likely with non-Black

women survivors (Hampton et al., 2008). Consistent with the literature, Participant 4 shared that her calls to the police regarding her partner abuse were initially dismissed. A lack of responsiveness by law enforcement to Black women may also be attributed to stereotypes about Black women. The stereotypes such as the "Strong Black Woman" or the "Angry Black Woman" influences law enforcement's perception of Black women, thus seeing them as mutually combative, incapable of being merely a victim, and therefore, unbelievable (Simmons, 2020).

The participants also shared a general distrust of sharing their partner abuse with the healthcare system. Black people's views of the healthcare system are generally informed by the history of racism and racist practices within the medical field (Nicolaidis et al., 2010).

Institutionalized racism in the medical field has been well-documented regarding medical research and the quality of medical care. A notable example of institutionalized racism by medical professionals was the experimental research examining the outcome of untreated syphilis in Black men that took place over a 40-year period in Tuskegee, Alabama (Nicolaidis et al., 2010). For Black women specifically, an example of medical racism can be traced to 1845-1849. Physician J. Marion Sims performed surgical procedures on unconsenting and unwilling enslaved African women. He also failed to use anesthesia while operating, as the idea was that enslaved African women could not feel any pain (Wall, 2006). These are some examples that contribute to the long-standing distrust of medical providers by black people. For example, Participant 1 reported that her decision not to share her partner abuse with her physician was because she did not believe her doctors would take her seriously.

Strong Black Woman

The cultural gender norm of the Strong Black Woman is a stereotypical archetype often endorsed by Black women that can cause positive and negative consequences (Beauboeuf-

Lafontant, 2007). The Strong Black Woman stereotype can be traced back to slavery. The Strong Black Woman stereotype was a survival mechanism utilized by enslaved Black women to deal with the recurring heinous violence, abuse, and exploitation during chattel slavery. The Strong Black Woman continues as a survival mechanism for Black women to cope with the intersectional oppression Black women face in today's society (Watson & Hunter, 2016). These characteristics can become a suit of armor to protect Black women from the dangerous world that assaults them daily. However, this internalization to be self-reliant and suppress any outward emotional distress among Black women can also be used to normalize and justify IPV (Gillum, 2002). Three of the six participants appeared to endorse the Strong Black Women archetype and how it was used to cope with and, at times, normalize their partner abuse.

Participants 1 and 6 identified endorsements of the SBW stereotype. Participants 1 and 6 reported experiencing an invincible attitude toward their abuse and also attempted to present themselves as capable of enduring such abuse. In the article by Jones et al., 2021, it is suggested Black women who strongly endorse the SBW schema, it is important for clinicians to consider interventions that help Black women redefine the schema in an adaptive way (e.g., equating strength to emotional vulnerability; Jones & Pritchett-Johnson, 2018). Additionally, it is helpful for clinicians to support Black women clients by expanding their repertoire of coping skills, thereby helping them reduce their reliance on disengagement. Lastly, it is also essential for clinicians to help Black women clients understand how oppressive societal forces, like racism and sexism, engender the SBW schema in the first place (Greene, 1997; Jones et al., 2021). In therapy frameworks such as Womanist or African-centered therapy, clinicians consider the oppressive forces, as well as, cultural and historical factors, that influence the experience of

intimate partner violence among African American women (Grills & Rowe, 1998; J. Y. Taylor, 2005)

Strong Black Woman: Prior Emotional Abuse

Participant 4 discussed early socialization of the SBW stereotype. She indicated that growing up, she endured verbal abuse within her family. This later would set the foundation for what she would tolerate in her romantic relationships as an adult. "I perceived verbal abuse as normal because my family talks rough. I thought I could manage in my relationships because it was normal and 'whatever.'" In the study by Woods-Giscombe (2010), her findings showed that several Black women in her sample who endorsed the SBW stereotype had prior histories of emotional, physical, and sexual abuse, as well as histories of being 'let down' by their families. Furthermore, the study by Bender et al. (2003) found a strong correlation between child maltreatment and the likelihood of experiencing abusive adult intimate relationships.

Motherhood and Marriage as a Factor of Staying

Two of the six participants noted motherhood and marriage as factors considered to stay in their abusive relationships. Although women of different cultural backgrounds may adopt what is known as a "caretaker identity" (e.g., they may be likely to rescue their partner and may be likely to feel responsible for maintaining their relationship), Black women's caretaker identity is often shifted beyond the interpersonal level to the community at large (Few & Rosen, 2005). As such, there is pressure to make their relationships with Black men work to counter negative public views of Black relationships or to protect their partners from being victims of institutional racism (Few & Rosen, 2005; Gómez, 2015). Furthermore, the social stigma of being "a single Black mother" (if children are involved) may also influence Black women's decision to stay in an abusive relationship (Potter, 2006). Participant 4 noted during her interview that she wanted to

stay and work on her relationship with her partner when she found out she was pregnant. Additionally, the investment theory posits that survivors with time, money, marriage, or emotional attachment investments would be more reluctant to leave violent relationships than women without these investments (Truman-Schram et al., 2000). As such, Participant 3 described having difficulty considering leaving her relationship due to factors such as time and marriage with her partner.

Restraining Order

Restraining orders are a common route for those who are experiencing intimate partner violence (Diviney et al., 2009). A restraining order not only separates the survivor from the offender but also involves measures to decrease further risks to the survivors. Restraining orders allow judges to order offenders to restrict their movement and behaviors in ways that may include limiting their physical proximity to the petitioner; removal of firearms; specifying access to their children; and instructing the offenders not to harass, stalk, physically assault, or threaten the petitioner (Zeoli et al., 2019). Many women who apply for restraining orders with histories of partner abuse specifically mention the use of firearms in the violence (Zeoli et al., 2019). This is important to note, as Black women who are experiencing partner abuse are often more likely to be killed, usually due to firearms (Al'Uqdah et al., 2016; Bent-Goodley, 2004). Two of the six participants reported obtaining a restraining order from their abusers, especially as the abuse became severe. Research suggests that restraining orders effectively reduce domestic violence recurrence (Logan et al., 2008; McFarlane et al., 2004).

Spiritual and Religious Coping

Historically, spirituality and religion have been critical components of African American culture (B. R. Kennedy, 2013). Spirituality and religion help many Black people draw strength to

overcome various forms of adversity (Ennis et al., 2004). Two of the six participants described utilizing spiritual or religious coping to overcome their abusive relationships. Participants 5 and 6 described using their spirituality as a source of strength. As such, spirituality is often used as empowerment for comfort and relief, and coping for Black women (B. R. Kennedy, 2013). Black women survivors of intimate partner violence with religious involvement reported high levels of social support (B. R. Kennedy, 2013; Watlington & Murphy, 2006). Participant 6 also identified attending church as a coping mechanism she utilized as she was experiencing partner abuse. Consistent with the literature, the article by B. R. Kennedy & Rhodes (2019) suggests church attendance is correlated with reduced levels of intimate partner violence.

Studies have shown that Black women who reported higher levels of religious activity had lower rates of violent victimization by their intimate partners (El-Khoury et al., 2004). However, in this sample, only two participants identified religion and spirituality as a coping mechanism for their partner violence. Thus, this sample's lack of spiritual and religious coping may serve as a potential loss in the recovery process from partner violence.

Social Support

Social support was a theme discussed among two of the six participants. Not only did the participants identify disclosing their partner abuse to their support system, but they indicated their support system played a profound role in the participants' decision to seek mental health treatment. Studies have found that social support is a critical aspect in reducing women's risk for victimization, and conversely, poor social support is related to increased risk (Rose & Campbell, 2000). Social support networks may help to facilitate survivors' efforts to seek help and also may ultimately end their abusive relationships (Liang et al., 2005).

Although research indicates that Black women are more likely to disclose their partner abuse to their informal supports (Billingsley, 1994; Lum, 2004; Thomas, 2001), only a minority of the study's sample reported discussing their partner abuse with their support systems. Factors influencing Black women's decision to not disclose their abuse can include fear of negative social reactions and burdening others (Ullman et al., 2020). Perhaps these factors contributed to the lack of utilization of social support from the participants in this study.

Self-Care

Four participants described self-care as a coping mechanism utilized in response to their partner abuse. Research has found that when Black women experience high stress but have low resilience, they report poor self-report wellness. However, studies on Black women's self-care practices show that self-care has the potential to mediate stress levels and self-reported wellness (Adkins-Jackson et al., 2019). Self-care can take many expressions. As such, many participants identified various forms of self-care, including music, gardening, reading, and yoga. Research also suggests that self-care may be essential in discussing with Black women, as Black women often feel compelled to prioritize the needs of others over themselves (Adkins-Jackson et al., 2019).

Interpretation of Therapy Experience

Distress

Black women survivors of intimate partner violence frequently experience psychological distress such as depression, anxiety, stress, and somatic complaints (C. M. West, 2004). The participants in the study described experiencing mental health and somatic symptoms due to their abusive relationships. A mental health symptom that Participant 5 noted was depression. Depression is a common mental health problem in survivors of partner abuse (Huang & Gunn,

2001; Rickert et al., 2000). Additionally, Black women with a long history of abuse are more prone to depression than their White counterparts (B. R. Kennedy & Jenkins, 2018; C. M. West, 2004). Furthermore, symptoms of PTSD can also include irritability, anxiety, and insomnia (J. E. Kennedy, 2007). As such, Participants 1, 3, 4, and 5 identified experiencing sleep disturbances, anxiety, and agitation.

The article by Lara-Cinisomo et al. (2020) also showed that Black women are more likely to report somatic symptoms compared to White women. The participants in the study reported a wide range of somatic complaints due to their abusive relationships. For example, Participant 4 expressed in her interview, "I ended up with high blood pressure by the last DV incident."

Despite experiencing distress, Black women are less likely to seek care due to concerns regarding stigma (Alvidrez et al., 2008; Jones et al., 2023). Additionally, there is mental health treatment disparity for affordable and accessible care, as well as a lack of culturally-sensitive mental health providers that deter Black women's use of mental health treatment (Hall & Sandberg, 2012; Nelson et al., 2016).

Hopes

Five of the six participants described their hopes for healing after their therapy sessions. Ending an abusive relationship and recovering from it can take years. However, some data suggest that recovery can occur shortly after ending an abusive relationship (Evans, 2007). Women can provide different rationales for ending violent relationships, including changes in belief systems about violence in relationships and fear for the physical safety of themselves and their children (Patton, 2003). As such, Participants 4 and 5 identified changes in their perspective related to their views about relationships as a result of therapy. For example, Participant 4

described, "I feel I can recover and hope that I heal from my childhood trauma, so the cycle doesn't continue with verbal and physical abuse in my relationships."

In the Black community, the instillation of 'hope' has always been essential among many Black people. Endorsement of hope has been associated with reducing mental health symptoms among Black people. A study found that African Americans who believed that they had the ability to achieve their goals reported lower levels of anxiety and depressive symptoms and higher levels of vitality and life satisfaction. Additionally, African Americans reported higher anticipated life satisfaction than Whites, Asians, and Hispanics (Chang et al., 2018). As such, Participants 3 and 6 identified improvements in their self-confidence and their hopes to engage in healthier relationships in the future.

Interpretation of Promising Practices

Active Listening

Participant 2 discussed how being listened to in therapy was essential for her to move toward healing. During the interview, she indicated, "When I was in therapy, I think what helped a lot is to know that I had a kind and encouraging ear." Consistent with the literature, it is important to treat survivors with understanding and compassion when working with IPV survivors. Often survivors are used to being dehumanized, belittled, and demeaned in their relationships by their abusers, making it critical that service providers offer the human touch (Kulkarni et al., 2012). Additionally, Black women survivors have to contend with abuse and belittlement not only at interpersonal level and also at the societal level due to racism and sexism (Rice et al., 2021). When working with Black women survivors, active listening can help therapists avoid making assumptions, thus developing approaches and interventions that best meet the needs and expectations of this cultural group (Kulkarni et al., 2012).

Validation

Two of the six participants discussed how feeling validated was particularly helpful in their therapy sessions. Participant 1 noted, "I learned in therapy that I'm allowed to be upset about things I can't change." Participant 2 also shared, "Having unbiased support to know I wasn't wrong and I'm not being dramatic." Black women's experiences of oppression are often invalidated, silenced or dismissed. For example, the "angry black woman" labeling includes historical and racist underpinnings and continues to silence and undermine the realistic experience of Black women (Kent, 2021). Research indicates that a lack of validation of the intersectional experience of being both Black and female can lead many Black women into therapy with low self-worth (Elliot et al., 2018; Mose & Gillum, 2016). Therapists who validate the unique needs and the reality of Black women's struggles can strengthen the therapeutic working alliance (Elliot et al., 2018; Mose & Gillum, 2016). Validation also disrupts the dehumanizing messaging from the offender and the oppressive systems they may have encountered (Mercer et al., 2011).

Therapist's Culture and Gender Identity

Five of the six participants highlighted their therapist's ethnic identity and gender as a component that played an essential role in creating an overall positive experience in their therapy sessions. Research suggests that client-therapist ethnic matching may increase rapport, reduce attrition, and improve treatment outcomes (e.g., reduced symptoms of anxiety/depression; Jones et al., 2018). Additionally, Black clients reported a more favorable view of their therapist when their therapist shared their ethnic background (Jones et al., 2018). Participant 6 indicated the benefit of herself and her therapist sharing similar cultural backgrounds was that she did not have to "code switch." Code-switching is an impression management strategy where Black people

adjust their presentation to receive desirable outcomes (e.g., negate negative stereotypes) by mirroring the norms, behaviors, and attributes of the dominant group (i.e., White people) in specific contexts (McCluney et al., 2021).

Samples et al. (2014) found that Black women who were interviewed by a Black provider, as opposed to a White provider, reported higher levels of daily stressors and were more likely to disclose experiences of intimate partner violence. These findings suggest that for some Black clients, ethnic matching may lead to a discussion of more vulnerable content they might not otherwise share with a therapist from a different ethnic background. This may be in part due to the shared history of discrimination, marginalization, cultural mistrust, and stereotype threat among Black people (Abdou & Fingerhut, 2014; Whaley, 2001). Concerning gender matching between therapist and client, the study conducted by Bhati (2014), suggested that women clients matched with women therapists reported a strong therapeutic alliance.

Therapeutic Interventions: Psychoeducation

Two of the six participants identified that providing psychoeducation about their symptoms was beneficial in their treatment. Historically, the Black community has a stigma surrounding mental health. According to several studies, psychoeducation can help reduce mental health stigma and promote therapy engagement among Black clients (Alvidrez et al., 2008; Jones et al., 2023). The study conducted by Alvidrez et al. (2008) concluded that Black people who perceived themselves to require treatment had more significant mental health stigma reduction if they received psychoeducation. Moreover, a study conducted by Ghafoori et al. (2016) found that from a single psychoeducation session, Black people with trauma histories reported psychoeducation to be helpful and increased their therapy utilization**.** Psychoeducation is also a staple intervention in cognitive-behavioral therapies such as cognitive processing

therapy, Seeking Safety, and mindfulness-based CBT, which have proven effective for Black trauma survivors (Iverson et al., 2011).

Therapeutic Interventions: Boundaries

Two of the six participants identified setting boundaries as a therapeutic intervention discussed in their therapy sessions. Setting boundaries and risk management strategies to prevent and minimize further abuse prove essential skills in negotiating ongoing contact with men who continue to threaten, dominate, and control (Tubbs, 2010). Many women who are survivors of abusive relationships may develop boundary problems due to early and/or ongoing maladaptive interpersonal relationships (Hill et al., 2012). Participant 1 described how in therapy, she learned to set boundaries with her abusive partner and family members. For example, Participant 1 stated, "Throughout my sessions with my therapist I felt that she was supportive. She was really good at helping me set boundaries and cutting contact with family who were triggering me." Participant 4 also noted setting boundaries was critical in preventing her from falling back into unhealthy, abusive relationships.

One aspect of Black racial identity is collectivism, which has been defined as an individual's concern with the advancement of the group to which they belong (Akbar, 1991; Allen & Bagozzi, 2001; Nobles, 1991). Furthermore, collectivism is characterized as an individual's sense of connection to and responsibility for members of their group (D. M. Taylor & Moghaddam, 1994; Triandis et al., 1988). Clinicians must consider how collectivist ideals and values may affect boundary-setting among black women. Due to collectivist culture, setting boundaries may pose a challenge to Black women, and Black women may experience feelings such as guilt and stress, as well as feel selfish for putting their needs above others (Carson, 2009).

Therapeutic Interventions: Mindfulness

Two of the six participants identified mindfulness strategies incorporated into their course of treatment. Research has shown mindfulness-based interventions as an effective treatment strategy for ameliorating frequent PTSD comorbidities such as depression, anxiety, and substance abuse (Hayes & Feldman, 2004; Ramel et al., 2004; Toneatto & Nguyen, 2007). Furthermore, mindfulness does not require a mental health professional or a mental health treatment setting for effective delivery; therefore, has the benefits of potentially reducing the stigma surrounding its use (Dutton et al., 2013). The study by Dutton et al., (2013) found that from their sample of predominantly low-socioeconomic status, Black women with histories of IPV and PTSD felt that the mindfulness practices promoted healing from their trauma and reduced their everyday stress.

Interpretation of Pitfalls

Culturally-Sensitive Care

Multicultural competence continues to be an essential component of working with culturally diverse groups. Cultural humility is one distinct approach extending from cultural competence, which centers the therapist's and client's lived interpersonal experiences (Walton et al., 2023). Cultural humility is a lifelong process of self-reflection and self-critique whereby the therapist not only learns about another's culture but starts with an examination of their own beliefs and cultural identity (Hook et al., 2013). Sue and Sue (2016) noted that cultural humility and openness to diversity are important components of working effectively with culturally diverse clients. In addition, cultural humility supports a therapeutic environment of respect, equality, and "diminished superiority" over the client.

Exercising respect and displaying a humble attitude toward people of a different culture helps strengthen the working alliance between the therapist and client and supports the therapist's understanding of the client's unique dimensions of the collaborative relationship (Sue & Sue, 2016). Therapists' perspectives can be skewed by their limited understanding of intragroup diversity within racial groups (Sacks, 2018). Cultural humility creates a space for therapists to continuously reflect on and challenge their personal biases through their relationship with clients and to work more effectively cross-culturally (Hook et al., 2013).

Participant 1 expressed that her cultural background was not brought up in her therapy sessions. Participant 1 noted, "There wasn't much discourse [about my culture] on her end. Because of that I felt a little uncomfortable bringing up cultural issues because I did not think she would understand." Research indicates that cultural norms and barriers often influence Black women's decisions to remain in an abusive relationship rather than seek support services (Gumani & Mudhovozi, 2013). Thus, in working with Black women survivors, culture is important to consider in IPV intervention (Anyikwa, 2015). As such, multiple marginalized groups often accrue a higher burden of disadvantage due to living at the intersection of multiple oppressed identities (Rice et al., 2021).

Advocacy/Proper Referrals

It is common for providers who work with intimate partner violence survivors to work with a multidisciplinary team of clinicians; thus, it is important for the team to assess needs, identify resources, and develop protocols for providing services. While the mental health provider's focus may be on diagnosis and treatment, an optimal response to domestic violence necessitates that clinical interventions become part of a coordinated team response, referring the client to the proper resources or a professional with expertise in a particular area (Warshaw,

2017). For example, Participant 1 described a lack of collaboration between her medical and mental health provider, leading to barriers to her psychiatric medication for treatment.

Lack of Collaborative-Care

Research indicates that many Black clients prefer an egalitarian approach to therapy. This indicates that the therapist works collaboratively with the client to develop goals and treatment strategies that are mutually agreeable (Sue & Sue, 2016). Additionally, African-centered, Multicultural, Feminist, and Womanist therapies often emphasize a collaborative therapeutic relationship between the therapist and the client (Asnaani & Hofmann, 2012; Grills & Rowe, 1998). Two of the six participants shared that they did not feel their issues and symptoms were fully addressed during treatment. Participant 3 expressed that she was still experiencing sleep disturbances, and Participant 4 stated that she would have wanted more coping skills in her sessions.

Limitations and Contributions

The present study included limitations and contributions to understanding Black women survivors of partner violence. The sample of participants represented various ethnic backgrounds, faith denominations, sexual orientations, education and income levels, and marital statuses amongst Black women. Although the sample was diverse in many ways, there were several notable similarities that proved to be limitations to the study. For example, all participants selected for this study were in their 30s or younger; although this is consistent with the data about intimate partner violence occurring more frequently amongst younger populations (Rennison & Welchans, 2000), this limits the ability to capture the therapy experiences of Black women survivors in older generations. Additionally, all participants in the sample were in relationships with cisgender heterosexual Black men; this also limits the ability to capture the

relationship experience of Black women in relationships with other cultural groups, gender identities, and sexual orientations.

The contribution of the study is to gain a better understanding of the therapy approach for Black women and to know what treatment protocols work best with this population. There is considerable research on Black women survivors of intimate partner violence; however, there is a gap in the literature on the therapy process of Black women survivors who decide to seek treatment. Black women are disproportionately victims of intimate partner violence and also seek mental health services at a lower frequency than their White counterparts (Bent-Goodley, 2004; Lacy et al., 2015). The phenomenological approach of the study centered the experiences of Black women survivors and their encounters with mental health treatment. The findings from this study could help clinicians develop an increased awareness of the challenges and strengths of treatment when working with Black women with histories of intimate partner violence.

Areas of Future Research

Although there is a gap in the literature on African American women's therapy experience who are survivors of intimate partner violence, there is also a considerable gap in the literature on Black women of different ethnic backgrounds who are survivors of intimate partner violence and their experiences with therapy. The study sample included two Black women who identified as Afro-Latinas and a Black woman who identified as Jamaican American. Future research could continue to explore cultural beliefs and attitudes and their effect on the experience of IPV of Black women of different ethnicities.

Future research should also explore different legal options that can be used to protect Black survivors that may be more culturally sensitive and/or trauma-informed. Despite the reluctance of Black people to engage in the legal system (Hampton et al., 2008), two of the six

participants noted utilizing restraining orders to protect themselves from their abusive partners. Research should continue to explore if restraining or protective orders are preferred options for Black women survivors.

In addition, future research should also examine mindfulness as an intervention for Black women survivors of intimate partner violence. Participants 1 and 3 identified mindfulness as an intervention utilized in their therapy sessions. There are currently resources available for culturally-informed mindfulness, such as Soulfulness by Dr. Shelly Harrell and the Liberate phone app. However, further research is needed to evaluate the effectiveness of culturally-based mindfulness on African American trauma survivors.

Lastly, future research should continue to evaluate the effectiveness of the various treatment approaches of traditional and culturally-based interventions with African American women survivors of intimate partner violence. Further qualitative studies are also needed on African American partner violence offenders and therapists who work with African American partner violence survivors.

Implications and Conclusions

There are several clinical implications derived from the results of this study. This study is meant to be utilized by service providers, which may include but are not limited to therapists, IPV counselors, and healthcare providers. However, it can also be used by laypeople to understand the relationship between culture and Black women survivors of IPV as well as educate laypeople of Black women's socio-cultural needs that are often undermined and dismissed. Being informed of this information may add to the services that should be provided to this population.

Black women live within a specific cultural context that encompasses specific cultural beliefs and values shaped by their families and communities, shaping their IPV experiences. Black women often face numerous barriers when reporting their partner abuse (e.g., internalized cultural stereotypes, mental health stigma, histories of racism from law enforcement and healthcare providers, and fears of community shame and ostracization).

Service providers must consider all the unique challenges that Black women face to work with this population properly. As such, service providers and all those who treat IPV survivors should be instructed on how to effectively work with Black women survivors while considering the significant role that stigma plays in the disclosure and treatment process. Additionally, service providers should try to build a connection with outreach services in the Black communities that are frequented by Black women, such as the Black church, hair salons, community support groups, and social media support groups. Interventions in the community, such as outreach programs, would likely work to reduce the stigma of mental health services as well as assist with creating meaningful discussions about Black women's experiences of intimate partner violence. Service providers should also educate themselves on Black women's culture, allowing them to exhibit more sensitivity towards diversity and consider how diversity factors impact Black women's experience of IPV.

Furthermore, the results from this study can assist service providers with other mechanisms of healing often missed during psychological and healthcare treatment, as well as offer service providers insight into practices that may negatively impact the treatment and wellness of Black women survivors. As shown in Table 1, are key recommendations that the investigator hopes can continue to be referred to when working with this population.

Table 1

Key Recommendations

Key Recommendations
• Clinicians who treat Black women clients should educate themselves on the cultural dynamics, norms, issues, and values of Black women and how this impacts Black women's experiences of IPV
• Clinicians who work with Black women clients should be aware of how both stigma and gendered racism create challenges for how Black women navigate health care and legal systems
• Clinicians should consider integrating culturally-based practices into treatment, such as spiritual and religious coping, especially if the client identifies having a strong religious or spiritual background
• Clinicians should assist Black women IPV survivors in developing skills in creating or maintaining their healthy support systems
• Clinicians should provide Black women IPV clients with multiple legal options if their client chooses to engage in the legal system
• Clinicians should make sure to implement therapeutic interventions such as active listening and validation into practice when working with Black women clients
• Clinicians should also make sure they are providing psychoeducation to Black women clients on the therapy process and their symptoms, especially if their client is new to mental health treatment
• Clinicians should also understand the importance of ethnic and/or gender-matching between clinicians and clients and the positive impact it has on rapport building, reduction in attrition rates, and the overall treatment outcome when working with Black women clients
• Clinicians should discuss the importance of implementing boundaries for Black women IPV survivors but also be mindful of how collectivist cultural ideals and values may pose a challenge for Black women to set and follow through with boundaries
• Clinicians should attempt to integrate mindfulness or mindfulness-based practices into treatment when working with Black women IPV survivors
• Clinicians should be aware of the importance of advocacy (e.g., connection and collaboration with other health care providers) during the course of the treatment with Black women IPV survivors

Key Recommendations
• Clinicians should make sure to establish a collaborative approach for treatment when working with Black women IPV survivors
• Clinicians should develop outreach programs that addresses mental health stigma and intimate partner violence affecting Black women within Black spaces frequented by Black women

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APPENDIX A

Recruitment Email

From: Melissa Duncan
To:
Date:
Subject: Assistance requested in study about therapy experience of African American women survivors of intimate partner violence

Dear [to whom this may concern],

My name is Melissa Duncan, and I am a doctoral student under the supervision of Dr. Thema Bryant-Davis in the Graduate School of Education and Psychology at Pepperdine University. I am conducting a research study on the therapy experiences of African American women who are survivors of intimate partner violence, and I need your help! I am seeking volunteer study participants to interview.

The participation in the study will be audio recorded and is anticipated to take no more than 1.5-2 hours. Strict confidentiality procedures will be in place. Participation in this study is voluntary, and the identity as a participant will be protected before, during, and after the time that study data is collected. The data will be stored on a password protected computer. The audio-recordings, transcribed interviews, and subsequent data will be de-identified immediately after the interview takes place and identifiable only by numeric code for confidentiality purposes.

I would like to request your permission to recruit participants for this study from your facility. Attached is the flyer (8.5” x 11”) that we are using for recruitment, which provides potential participants information about the study and my contact information. If you are willing, please contact me via email at your earliest convenience. I look forward to hearing from you.

Thank you for your time,

Melissa Duncan, M.A.
Pepperdine University
Graduate School of Education and Psychology
Doctoral Student

APPENDIX B

Recruitment Flyer

Seeking African American women survivors with a previous history of intimate partner violence and who have been in therapy to participate in an interview to research partner violence of African American women

The study will be conducted by doctoral student, Melissa Duncan, M.A., and supervised by Dr. Thema Bryant-Davis of the Graduate School of Education and Psychology of Pepperdine University

The study includes a gift card compensation of $25 for a 1.5-hour – 2-hour confidential interview

To see if you qualify, please contact:

Principal Investigator	or	Dissertation Chair
Melissa Duncan, M.A.		Thema Bryant-Davis, Ph.D.

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APPENDIX C

Emergency Contact Information

Participant Information

Instructions: Please provide a response for each of the following:

1. Name

_____

2. Phone Number

_____

3. Current Location

_____

4. Emergency Contact Name

_____

5. Emergency Contact Phone Number

_____

APPENDIX D

Screening Questions

Screening Questions

1. What is your racial/ethnic background?

2. Are you 18 years of age or older? If you are from Alabama or Nebraska, are you 19 years old or older? If you are from Mississippi, are you 21 years old or older?

3. What is your gender?

4. Have you been in a romantic relationship before that involved partner abuse? What was the nature of the abuse (e.g., physical, sexual, financial and/or emotional abuse).

5. Have you attended individual therapy sessions before? If so, how many? Approximately how long was each therapy session?

6. What were the credentials or professional background of your individual therapist (e.g, marriage and family therapist, social worker, psychologist)? Were they licensed, trainee, or associate status? If you are unsure of license status, you may respond "not sure" to this part of the question.

7. Was your intimate partner violence relationship discussed in your individual therapy sessions?

8. Are you currently seeing the therapist where you discussed your partner abuse?

9. Are you currently in an abusive relationship? If not, do you fear you may experience potential abuse from a partner?

APPENDIX E

Demographic Questionnaire

Demographics Questionnaire

Instructions: Please provide a response for each of the following questions:

1. What is your age? _____

2. What is your gender?
○Cisgender Woman ○Transgender Woman ○Other _____

3. What is your marital status?
○Single ○Married ○Separated ○Divorced ○Widowed

4. What is your annual income (or combined annual income if you have a spouse)?
○Less than $40,000 $40,001○ to $60,000 $60,001○ to $80,000
$80,001○ to $90,000 $90,001○ to $100,000 ○Greater than $100,000

5. What is your racial/ethnic background?
○African American/Black ○Asian/Pacific Islander ○Caucasian ○Latino
○Other: _____

6. With which sexual orientation do you identify?
○Heterosexual ○Lesbian ○Bisexual ○Pansexual ○Asexual
Other: _____

7. With what denomination or faith tradition do you most closely identify?
_____

8. Are you currently employed?
○No ○Yes
If so, what is your most recent job title? If not, when was your last job, and what was your most recent job title?
_____

9. What is your highest level of education obtained?
○Less than High-School ○High-School/GED ○Some College
○Associate's Degree ○Bachelor's Degree ○Master's/Doctoral Degree

APPENDIX F

Survey Questionnaire and Interview Questionnaire

Survey Questions

1. At the time that you sought therapy, were you in an abusive relationship?

2. Did you remain in this relationship during the course of therapy or did you leave this relationship?

3. How many physically abusive relationships have you been in?

4. How many emotionally abusive relationships have you been in?

5. How many sexually abusive relationships have you been in?

Interview Questions

1. How do you feel about your identity as a Black or African American?

2. Are there any ways you feel that your African American identity or culture shaped your experience or influenced your experience with intimate partner violence or the process of getting help with intimate partner violence?

3. Can you describe the demographics of your therapist (e.g., approximate age, gender, ethnicity, etc.).

4. Can you describe the demographics of your intimate partner (e.g., approximate age, gender, ethnicity, sexual orientation, etc.).

5. In what ways, if any, was your therapist's age, gender, race helpful? In what ways, if any, was it harmful or challenging?

6. How did you feel about discussing intimate partner abuse with your therapist? How did your therapist react? In what ways was their reaction helpful or hurtful to you?

7. What were your thoughts about staying or leaving your relationship at the time you started therapy? How did your therapist communicate their support or lack of support for your choice? If you felt they were not supportive how did this affect your relationship with them?

8. What was the nature of the abuse? Was it physical, sexual, emotional, etc.? If you were in multiple abusive relationships, please describe the nature of each abusive relationship.

9. How long did these abusive relationships last? How did these relationships end?

10. How did your distress show up as a result of being in an abusive relationship? For example, were you depressed, irritable, or anxious? What changes did you notice with your IPV related symptoms over the course of therapy? What happened for the symptoms to change?

11. What suggestions or recommendations did the therapist make? What skills did you work on in therapy to heal from your past abusive relationships? What skills did you work on in therapy to help you in relationships going forward?

12. Please describe the treatment used over the course of therapy. For example, do you remember being assigned homework? Were you asked to discuss your childhood? Were expressive arts used?

13. Can you describe the other ways you have coped besides therapy?

14. Please share with me the decisions you made about disclosing your intimate partner violence experiences to other people than your therapist. Tell me about your decisions to share or not share with friends, family, primary care physicians, police officers or the crisis line. In what way was that helpful or not helpful?

15. Was there anything in therapy you wished your therapist had done that they did not do? Was there anything in therapy that you found helpful? If so, what was it?

16. About how long were you in therapy? How are you feeling about your recovery or your hopes for the future?

APPENDIX G

Informed Consent

Informed Consent Form

PEPPERDINE UNIVERSITY

Graduate School of Education and Psychology

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

You are invited to participate in a research study conducted by Melissa Duncan, M.A., doctoral candidate, and Dr. Thema Bryant-Davis, Ph.D., professor of psychology at Pepperdine University, because you are an African American woman survivor of partner violence and have had at least four therapy sessions with a mental health professional. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for your records.

PURPOSE OF THE STUDY

The purpose of this study is to learn more about African American women survivors of intimate partner violence and their experience in therapy. We hope to use what we learn from the study to better understand African American women survivors' experience of therapy, and find out what general practices used in psychology they found useful, or not useful while in treatment. This study also hopes to contribute to the greater understanding of African American survivors of intimate partner violence.

STUDY PROCEDURES

If you agree to be in this study, I will conduct an interview with you. The interview will include questions about your relationship, the nature of the abuse, your intimate partner violence-related symptoms, your experience with the treatment used in session. The interview will take up to one and a half to two hours to complete. With your permission, I would also like to digitally record the interview.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study include the possibility of experiencing greater than minimal psychological discomfort due to the interview containing questions about your trauma history. If you happen to experience discomfort during the interview process, please tell the researcher. You are also allowed to take a break or discontinue your participation at any time. The researcher is also clinically trained to provide relaxation and grounding exercises to reduce discomfort and distress. The researcher will also use their clinical judgment to determine if the interview should be discontinued.

The study will also obtain your phone number, current locations, and emergency contacts prior to the start of the interview in case you may be at risk of harming yourself or others. Also, the nearest hospital and police department of the participant will be looked up before the start of the interview. This information will be immediately destroyed after the interview if there is no crisis. If a crisis intervention must be implemented, the researcher will contact the appropriate sources, but then your phone number, current location and emergency contact will be destroyed once proper crisis sources have been reached. You will also be provided with a list of referrals and

resources for support, helplines, and local mental health services if deemed necessary. The interviewer will also abide by mandated reporting laws which may also pose a potential legal risk for participating in the study. Further information regarding these reporting laws are also discussed below under "Confidentiality."

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, intimate partner violence is a national health concern that affects African American women at disproportionate rates and we hope to learn more about survivors and their therapy experience.

PAYMENT/COMPENSATION FOR PARTICIPATION

For participation in this study, there will be compensation in the form of a $25 gift-card, should you choose to participate, complete this informed consent and the interview to the best of your ability.

CONFIDENTIALITY

I will keep your records for this study anonymous as far as permitted by law. However, if I am required to do so by law, I may be required to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me that you are a danger to yourself, danger to others, tell me about child abuse, dependent adult abuse and/or elder abuse. Pepperdine University's Human Subjects Protection Program (HSPP) may also access the data collected, but will not be able to listen to your recorded voice or see your identifiable information. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research participants. The data will be stored on a password protected computer. All data collected will be de-identified, including information you share about others (e.g, partners, past therapists and place of treatment) and identified by a code for confidentiality purposes.

The audio-recordings, transcribed interviews, photographs of your art mediums, and subsequent data will also be de-identified and identifiable only by numeric code. Audio-recordings will be transcribed and then the audio-recordings will be deleted immediately after the interview. The transcribed interview will also be de-identified immediately after the interview and then stored on a secure laptop. This data will also only be accessible by the researcher. Your information obtained prior to the interview (i.e., your phone number, current location and emergency contact) will be destroyed immediately after the interview if there is no crisis. If a crisis intervention must be implemented, the researcher will contact the appropriate sources, but then your phone number, current location and emergency contact will be destroyed once proper crisis sources have been reached.

Furthermore, I will not maintain as confidential, information about known or reasonably suspected incidents of danger to self, danger to others, abuse or neglect of a child, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she may be required to report this abuse to the proper authorities.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. The investigator may also withdraw you from this research if you appear to be under the influence of alcohol or another substance at the time of the interview, or if you show signs of psychological discomfort or distress throughout the interview process.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or completing only the items which you feel comfortable. Please note that if questions 3, 5, 6, 7, 8, 9, 10, 11, 12, 15, and 16 on the interview questionnaire, if one or all is left blank will eliminate participants' opportunity to be considered for the final results of the study.

EMERGENCY CARE AND COMPENSATION FOR INJURY

If you are injured as a direct result of research procedures you will receive medical treatment; however, you or your insurance will be responsible for the cost. Pepperdine University does not provide any monetary compensation for injury.

INVESTIGATOR'S CONTACT INFORMATION

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Melissa Duncan, M.A. at melissa.duncan@pepperdine.edu or her supervisor, Dr. Thema Bryant-Davis email at thema.s.bryant@pepperdine.edu, if I have any other questions or concerns about this research.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

AUDIO/VIDEO/PHOTOGRAPHS

□ I agree to be audio-recorded and (if applicable) have my art mediums photographed.
□ I do not want to be audio-recorded or have my art mediums photographed.

_____

Name of Participant

_____

Signature of Participant ***Date***

_____

SIGNATURE OF INVESTIGATOR

I have explained the research to the participants and answered all of her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed that participation is voluntary and that they may discontinue their participation in the study at any time, for any reason.

_____

Name of Person Obtaining Consent

_____

Signature of Person Obtaining Consent ***Date***

APPENDIX H

IRB Approval

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 09, 2023

Protocol Investigator Name: Melissa Duncan

Protocol #: 20-01-1267

Project Title: Physical Intimate Partner Violence of African American Women: Promising Practices

and Pitfalls In Treatment School: Graduate School of Education and Psychology

Dear Duncan:

Thank you for submitting your amended expedited application to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today February 09, 2023, and expires on November 10, 2023.

The consent form included in this protocol is considered final and has been approved by the IRB. You can only use copies of the consent that have been approved by the IRB to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond November 10, 2023, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the **Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual** at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist