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## Exploring the Lived Experiences of Afro-Caribbean Marriage and Family Therapists working with Persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning: An Interpretive Phenomenological Study

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by

Raquel Yvonne Campbell

A Dissertation Presented to the  
College of Arts, Humanities, and Social Sciences  
In Partial Fulfillment of the Requirements for the Degree of  
Doctor of Philosophy

Nova Southeastern University

2019

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Raquel Yvonne Campbell


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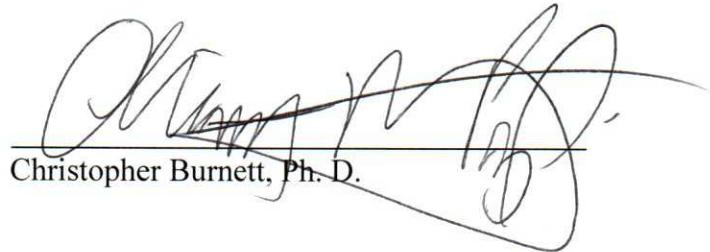
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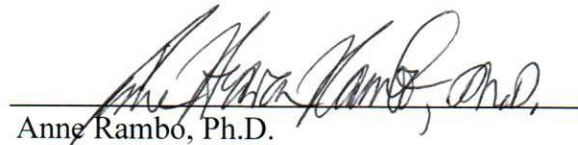
This dissertation was submitted by Raquel Yvonne Campbell under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Family Therapy at Nova Southeastern University.

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## **Abstract**

This study explored and highlighted the experiences of trained Marriage and Family Therapists of Afro-Caribbean descent in working with persons who identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ). The researcher utilized collected data to help to advance our understanding on the potential impact of the cultural experiences and how they may or may not contribute to institutionalized homophobia within the Caribbean, by Mental Health professionals, specifically Marriage and Family Therapists. The researcher conducted semi-structured interviews with 3 practicing Marriage and Family Therapists (MFTs) with strong Caribbean upbringing, values, and influences. For the purpose of this study, strong has been defined as having being born and/or raised in the Caribbean. This qualitative study employed the use of Interpretative Phenomenological Analysis (IPA) to aid in making sense of the data that was collected. Data gathered from the interviews of three participants revealed two prominent superordinate themes: “Homophobia” and “Evolving Views” with emerging subthemes that explored culture, religion, “checking yourself at the door” and connecting with persons who identify as LGBTQ. The findings from the study helped to add to the limited research available on the lived experiences of Marriage and Family Therapists of Afro-Caribbean descent and their work with persons who identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ).

*Keywords:* Afro-Caribbean, Marriage and Family Therapists, LGBTQ, interpretive phenomenological analysis, homophobia

## **Chapter I: Introduction**

Family therapy has existed for decades. In the 1960s, family therapy developed in response to an era of extensive challenge and tumultuous change. Civil rights, the burgeoning Women's movement, and the development of 70 million baby boomers into adults all contributed to the need for this transformation. The listed reform movements can be likened to the current movement for equality for individuals who identify as Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ), which similarly is a movement fighting for the rights of a historically oppressed group. Therapists, however, often have difficulty relating to individuals who identify as Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) in a meaningful way, especially when the therapists originate from intolerant cultures, more specifically, the Caribbean. It is therefore the goal of this dissertation to explore the experiences of Marriage and Family trained therapists of Caribbean descent, in order to close the gap between prejudice and meaningful care for LGBTQ clients. Although the term Caribbean can be broadly used to identify any individual who was born/raised in the West Indies, for the purpose of this study, the term Caribbean will ascribe to individuals born or originating from the Greater Antilles. Such countries will include but are not limited to: The Islands of the Bahamas, Turks and Caicos Islands, Cuba, Cayman Islands, Dominican Republic, Haiti, Jamaica, Puerto Rico and the Virgin Islands.

Beginning in the 1950s, what we now call family therapy was necessary in postwar America. The focus was on families with soldiers returning home and convincing women to turn away from their war time jobs and return to running their households (Imber-Black, 2014). There was boundless hope for the future, and family therapy emerged in response to the failures of psychoanalysis in the areas of major mental illness and juvenile delinquency. According to the

Ontario Ministry of Children and Youth Services (2013), who cite Englander (2007) and Bartol (2002), the basic psychoanalytic model did not address aggressive behavior or any other unmodified impulse, which should have been repressed in anyone who “experienced a normal childhood” (p. 1). Many theories of thought developed as a result of disagreement with previous practices, thereby setting the stage for the next departure (Imber-Black, 2014). Family therapy is one such theory that developed out of postwar America.

The subsequent decades have seen an explosion of women in the workforce, the acceptance of single parent households, and, most recently, the legalization of gay marriage in the U.S. While Western thinkers have embraced family therapy and equality for LGBTQ individuals, prejudiced against this marginalized group and a distrust of the field of mental health still exists the Caribbean Islands. Their spiritual beliefs are quite unlike those of western ideologies, and many view mental illness as the work of supernatural powers (James & Peltzer, 2011). This is quite a hurdle for modern medicine and psychiatry to bypass, as religion is a central focus of the Caribbean culture. It is my assumption that cultural upbringing and religion are two of the main barriers that help to perpetuate the disconnection and biases experienced by MFTs of Caribbean descent working with LGBTQ families.

Those who practice western spiritual tenets are exceptionally pious, and believe that God will heal any illness. Those who practice alternative religions believe in herbal remedies or various rites to which cure any mystic forces that may be at work (James & Peltzer, 2011). There is a lack of cohesion between Western and Caribbean medicinal treatments. This also coincides with the disparity in which both cultures approach mental health and their attitudes and views toward LGBTQ individuals.

Individuals who identify and are assumed to be LGBTQ face an extreme amount of prejudice not only from their family members but the community at large. LGBTQ couples share many of the same problems as heterosexual and minority couples, however many of their problems are exacerbated due to stigma and misunderstanding among medical professionals (Ritter, 2015; Lev, 2010; Shallcross, 2011). The common routines of their lives are similar, but the social context in which they live is extremely varied, mainly because of the influences of the dominant heterosexual culture and traditional societal norms that are expected to exist within a relationship (Shallcross, 2011; Ritter, 2015). As a result, many LGBTQ couples may contend with undue stress because common support systems, which typically exist for heterosexual couples are lacking in their lives.

These support systems could include familial, legal, religious, economic, or peer support networks. Most members of the LGBTQ community have experienced social discrimination in a variety of ways and have dealt with it variably on an internal level, but the impact of “minority stress,” or the effects of existing with prejudicial social considerations, is always an issue to one degree or another (Ritter, 2015). According to Linville and O’Neill (2016), the fact that many homosexual relationships often outlast many heterosexual unions, despite the challenges faced in society at large, is a testament to the resiliency of the members involved.

Like family interactions themselves, the history and treatment of LGBTQ individuals and their families is complex. In the beginning, homosexual orientation was viewed as a sickness and family dynamics were thought to be the cause (Lev, 2010). Later, it was thought that many homosexuals distanced themselves from, or were rejected by, their families and gravitated toward friendship networks that were referred to as families of choice (LaSala, 2013). Most

recently, the family is believed to be a resource for individuals who identify as LGBTQ, in which healthy relationships with other members can help protect them from a variety of health risks.

Additionally, an increasing number of LGBTQ couples are opting to become parents, overcoming both biological obstacles and social prejudices. However, this is the progressive norm of the Western society that promotes inclusivity and acceptance. For mental health professionals working in a western culture that they have grown accustomed to, the shift in thinking and in actions is a much smoother transition. This is not the same for mental health professionals who have been born and raised in the Caribbean, where you are taught intolerance; where the discrimination of LGBTQ individuals is passed on from generation to generation. It is far more difficult to adjust in thinking. But the question is, does the shift really occur? Do Afro-Caribbean Marriage and Family Therapists who have been born and raised in the Islands but have come to study abroad as adults have the same ability to readily shift their thinking and attitude toward individuals who identify as LGBTQ? Is that shift temporary? What happens if it does not occur at all? These are the questions that I remain curious about in order to add to the body of literature regarding Afro-Caribbean MFT who continue to struggle working with individuals who identify as LGBTQ.

Marital and Family Therapists dealing with this population continue to face challenges. Most Family Therapists do not grow up with exposure to same sex couples (Carlson et al., 2013). When people do not comply to socially-accepted sexual norms, even the most open-minded professionals find themselves somewhat bound to the Freudian beliefs that children need both a mother and father to develop solid gender identities (Lev, 2010). According to West (2014), children in the Caribbean are often raised in exceptionally intolerant households, in fact, and resultantly learn to be prejudiced or even hostile toward LGBTQ individuals.

Afro-Caribbean households belong to an extremely traditionalist culture. Jamaica has a known reputation for their deleterious treatment of homosexuals (Human Rights First, 2012). This small island in the Caribbean is infamous not only for its anti-gay laws, political hostility and violence, but also for its broad societal acceptance of severe sexual prejudice (West, 2014). In such a biased culture, it is often difficult for therapists to effectively treat this population.

Despite these biases, people who identify as LGBTQ are still in need of health care, both physically and mentally. Members of this population do get diseases, they get sick, and they worry about their health, complete with anxiety and reluctance. The latter circumstance is often to a greater extent than members of the heterosexual community (Rivas, 2014). Everyone is human and everyone seeks the advice of the medical expert from their culture when their health and well-being is an issue.

The problem lies in that most members of the LGBTQ community are too frightened to be truthful, or even worse, are not being asked the correct questions during a doctor's visit (Ritter, 2015). Medical students originate in all walks of life, both culturally and spiritually. Regardless of what the student's personal views or attitudes are, they will inevitably work with gay patients. The crucial concern ensues when the doctor fails to ask the right questions, in the right manner (Rivas, 2014). The adage, "it's not what you say, but how you say it", is especially true in these cases, and may be even more so in regard to therapy. Consequently, it may be a challenge to get members of homosexual couples into counselling in the first place.

In a therapy setting, these attitudes held by therapist could present as harmful and depending on the level of the lack of sensitivity could help to worsen the presenting problems that have led LGBTQ clients to therapy. According to (Michael Chaney), former president of the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling States., "Part of

the self-awareness is identifying one's heterosexual privileges and understanding how that might affect the therapeutic relationship with clients who are not heterosexual," (p. 4)

One example is the opportunity to marry. For instance, a straight therapist might put a picture of her husband on her desk. "Something as small as that could influence the relationship, possibly making the client feel less than," Chaney explains (Shallcross, 2011, p. 24). Cheney clarifies that he is not implying that therapists should remove their photos. He is simply making an example of a condition that people who do not recognize a heterosexist society may take for granted. Due to this possible blindness in terms of homosexual life, it is imperative that therapists seek out ways to become more sensitive to the differences within their clients.

Our spiritual upbringing may influence or inhibit our sensitivity training in working with clients that we have been traditionally taught to hate. There is a significant relationship between the level of clinical training that family therapy students receive in the realm of spirituality and religion and their philosophies about treating lesbian, gay, bisexual, and transgender (LGBT) clients (McGeorge, Carlson & Toomey, 2014). There are also moral influences dilemmas presented for some therapists, one of those being church. It may be viewed within the culture as hypocritical to show acceptance toward individuals who identify as LGBTQ, while faithfully attending and serving on some level in the church. As the researcher continues to address spirituality and religion moving forward, it is important to highlight that not all religions in the Caribbean shared the same views regarding homosexuality and individuals who identify as LGBTQ. Not all religions practice in the Caribbean can be and will be explored. The most prominent religious practices such as Protestantism, Catholicism, will be highlighted as they become more relevant later on.



While ethics prevent a clinician from refusing services, religious tenets can present barriers that exacerbate these issues (Levy, 2008). Carlson, McGeorge, and Toomey (2013) cite a number of sources when stating, “The available data suggest that LGBT identified individuals seek therapy services at a higher rate than heterosexual couples.” (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Bradford, Ryan & Rothblum, 1994; Cochran, Sullivan, & Mays, 2003; and Liddle, 1997 as cited in Carlson, McGeorge, & Toomey, 2013). Green & Bobele (1994) and Henke, Doherty and Simmons (1996) are cited when the authors quote, “Further, research has found that a significant proportion of couple and family therapists (CFT) report that they work with LGBT clients” (p. 209). The authors also note that more than half of all clinicians surveyed believed that they were not competent to work with homosexual individuals in therapy. These disparities are especially prevalent in the Afro-Caribbean culture, and the current research is exceptionally sparse.

This dissertation will therefore explore the experiences of Afro-Caribbean therapists in relation to their training and work with LGBTQ clients. This is an effort to understand their backgrounds and any cultural or experiential barriers between competency of care and biases for LGBTQ clients. As therapists, it is everyone’s goal to provide the best care possible.

## **Chapter II: Review of the Literature**

A number of studies have been conducted pertaining to the emergence of family therapy and the prevalence of homosexual clients seeking professional help. As many therapists have grown accustomed to a heterosexist society, more than half of those surveyed feel that they lack the competence to serve the members of the gay community (Carlson et al., 2013). Some researchers have explored the potential of spiritual training to alleviate these concerns, while others have focused on the theoretical principles of affirmative training (McGeorge et al., 2014). In exceptionally homophobic cultures, such as that of the Afro-Caribbean population, the extant literature is severely limited as to therapists' attitudes and experience concerning LGBTQ clients.

### **Historical Background**

Family therapy was developed in the 1960s (Ontario Ministry of Children and Youth Services, 2013). This was a decade of profound challenges and tumultuous change. The Civil Rights movement, the burgeoning Women's Liberation movement and the coming of age of tens of millions baby boomers all contributed to the need for what was initially an underground transformation of practice (Imber-Black, 2014). While it was ultimately developed in the 1960's, the movement toward family therapy began in the 1950s.

What is now known as family therapy was a response to the contemporary societal opinions in postwar America. Soldiers were returning home to be displaced in the workforce and women were reluctant to abandon their wartime jobs to return to managing their households and be full-time moms. Commercial markets were up and the majority of the population felt great optimism for the future (Imber-Black, 2014). Clinically, professionals were disillusioned with

psychoanalysis in terms of its lack of success with acute mental illness and juvenile delinquency (Ontario Ministry of Children and Youth Services, 2013). According to Imber-Black (2014), as with so many other historic developments, family therapy arose in opposition to the schools of thought that had predated it. As such, the seeds were sown to usher in the next departure from normative standards.

The paradigm shift from the singular person's internal life to the interactions between people and the behavior systems served as a catalyst for the treatment models that followed.

Imber-Black (2014) cites Gurman (2011) when stating that a movement known as model wars began among this first group of theorists (p. 373). This trend still continues today, with the exception of different models, each professing to be the only effective way to work.

Each of the original models, including Minuchin's Structural, Haley's

Strategic, the Mental Research Institute's Brief Therapy, Bowen's Intergenerational,

Boszormenyi-Nagy's Contextual, Whitaker's Symbolic-Interactional and Satir's Experiential, supplied its own explanation for family interactions, difficulties, indications, alteration, and the appropriate means by which to carry out therapy. Each model claimed to have universal uses,

and each neglected the redundancies between it and other existing theories, and instead

emphasized the contrasts (Imber-Black, 2014). Family therapy clinics cropped up all over North America, and a bit later, in Europe.

Such clinics were multidisciplinary and came long before the availability of Marriage and Family Therapy graduate degrees now offered in universities. Similar to the contemporary social movements born of the desire for profound change and later needing to be severely moderated, early family therapy theorists envisioned a revolution in the mental health industry. Everyone was enamored with their own belief that small changes would lead to profound results (Imber-

Black, 2014). Enthusiasm coupled with blind conceit caused everyone to disregard the power of traditional concerns in maintaining the status quo.

Nevertheless, a rousing multidisciplinary field was incepted. Nowhere else in the larger mental health field could one find psychiatrists, psychologists, social workers, and nurses working together in mainly nonhierarchical and cooperative groups. The field at first appealed to the extremists, those who would consider newer and alternative methods, creating clinics and training facilities that educated prodigies in these radical new methods (Imber-Black, 2014). In 1961, a therapeutic system known as family therapy was developed.

Family counsellors could find respect for their practice among the American Orthopsychiatric Association, which held seminars that attracted the curious in droves. This enabled the leaders of the fledgling field to exhibit their philosophies with live sessions in front of thousands of onlookers. The social justice obligations of the ortho field drove early family practitioners (Imber-Black, 2014). While these seminars grew in popularity with western, Christian thinkers, the ideal societal norms in this part of the world would still be decades in coming for those of non-Christian thought and spiritual beliefs, (James and Peltzer, 2011), such as those found in the Afro-Caribbean culture.

Additionally, the American community was slow in adopting these practices. In the 1970s, these theories were widely viewed as radical, liberalistic, and family therapy failed to overtake traditional psychotherapy as the chosen method for society at large (Imber-Black, 2014). The so-called revolution of the mental health industry was still more of a self-fulfilling prophesy among many family clinicians.

As such, Marriage and Family Therapy practitioners took pleasure in their station outside the realm of the normative field of mental health. Many of those who considered themselves

among the status-quo viewed family therapy as the somewhat illegitimate child of the mental health industry. It took patience and care to gain respect among the broader field. Family practitioners formed alliances which enabled them to share knowledge and continue to work toward having their theories pervade the larger mental health field (Imber-Black, 2014). In the midst of the sexual revolution and other radical liberal movements, family life was changing and many felt the need for counselling that accepted divorce and remarriage.

### **Caribbean- Perspective**

Today, family therapy, while highly esteemed in the United States and in Europe, has yet to pervade the Caribbean culture. Many therapists recommend Caribbean vacations for clients in need of couple's therapy, as the beautiful tropical surroundings help even the most stubborn and jaded thinkers unwind and open up. While strict Catholics, raised to keep their feelings bottled up, have so-called spiritual awakenings over tropical drinks at beachside bars (Kelly, 2010), dozens of the islands have yet to acclimate to the idea of counselling.

In fact, therapists training to work with clients from a Caribbean background are required to acclimate themselves to a far different frame of thought. The religious practices of those from a Caribbean background are quite different from those of a western conceptualization, and many view mental illness as the work of supernatural powers (James & Peltzer, 2011). This is quite a hurdle for modern medicine to bypass, as religion is an integral part of the Caribbean heritage. According to Premdas (1996), those who practice Western spiritual practices are dominant in the Caribbean Islands and believe that God will cure any affliction. Those who practice alternative religions make up just less than half of the overall population and many of the traditional religious sects believe that white magic can overcome whatever supernatural forces may be at work.

## **Caribbean-Religion**

Many religions in the Caribbean culture are of African origin. Overall, the African beliefs are integrated with Christian belief systems. Religions of African origins are most often practiced by people of low income or those who feel marginalized. The three most common Afro-Christian religions are Kumina, Revivalism, and Rastafarianism. Rastafarianism is among the fastest growing of all world religions (Miller, 2002). After many years of stern opposition, this spiritual dogma is beginning to be embraced among the middle class as well as those of lower income. Although this religious practice began its practices in the Caribbean in Jamaica, it has since been widely accepted in other Caribbean cultures.

Because spiritual practice is such a fundamental component of the lives of many inhabitants of the Caribbean islands, it is vital that it be included in the therapeutic process. It is not at all uncommon for clients to incorporate spiritual practices into their involvement with counselling, so those providing therapy must be equipped to address religious tenets wherever necessary. Addressing the spiritual practices of the inhabitants of the Caribbean Islands is of the utmost importance, because it is expected that therapy providers will provide all-inclusive therapy services that are sensitive to the clients' needs and ideologies (Miller, 2002). This is especially tricky for those immigrating from, or currently inhabiting the Caribbean Islands, as there are strict laws prohibiting homosexuality in countries such as Jamaica, Belize, Trinidad and Tobago, and Cayman Islands, just to name a few. There are countries as well where laws prohibiting homosexuality has been lifted such as the Bahamas and Turks and Caicos Islands, but the attitudes toward people who identify as LGBTQ and openly display same-sex affection still remain the same. It is easy to see how it may be difficult for Marriage and Family Therapists

with strong Caribbean roots to struggle in their thinking and practice of inclusivity in working with LGBTQ clients.

### **Caribbean-Laws**

The illegalization of homosexuality in Jamaica has been in effect since the 1864 Offences Against the Person Act, which makes it possible for those convicted of the so-called “abominable crime of buggery” to be detained in hard labor camps for up to ten years for their offense (Human Rights First, 2012). Members of the Jamaican homosexual community are disallowed basic privileges of societal institutions, including health care, and this has resulted in accelerated rates of homelessness and HIV infection. In spite of a history of maltreatment and ostracism, Caribbean gay rights activists are intensifying their battle against homophobia, prejudice, and violence (Human Rights First, 2012, p.1). Still, they have quite a long way to go.

Three various articles apply to laws against homosexuals. Article 76 outlaws any form of sodomy, while article 77 specifies that anyone engaged in an attempt to commit sodomy will serve seven years’ worth of hard labor and article 78 outlines punishment of up to two years in a labor camp for any male on male indecency (Human Rights First, 2012). While these laws are not actively enforced, they do create grounds for a great deal of societal discrimination.

While detention as a result of these laws is not the principal worry, they are used to validate the disregard for basic human rights among the gay community. These laws are used to legitimize bigotry and hate crimes toward members of the homosexual community based on sexual orientation or gender identity (Human Rights First, 2012).

In 2011, the Charter of Fundamental Rights and Freedoms was enacted by Jamaican Parliament. While the charter serves as an edict for defenses against discrimination, the list of protected classes does not include sexual orientation or gender identity. Gay rights advocates in

Jamaica lobbied for parliament to include general non-prejudicial language to guarantee defense against discrimination based on sexual orientation, health conditions, and disabilities. These campaigns were ineffective, however and language against prejudice based on sexual orientation was intentionally omitted from the charter (Human Rights First, 2012). In fact, violence against gays is still tolerated in much the same way that homosexuality is not tolerated.

### **Caribbean-Hate crimes**

Between 2009 and 2012, the Jamaican Forum for Lesbians, All-Sexuals, and Gays (J-FLAG) reported more than two hundred reports of prejudice and hate crimes based on gender identity or sexual orientation. Homosexuals were denied access to housing, work, and basic healthcare (Human Rights First, 2012). Brutality and intolerance are a common part of everyday life for many LGBTQ individuals in Jamaica, including young minors. As reported by the *Associated Press (2013)*, teenager Dwayne Jones was viciously murdered by a mob after wearing women's clothing to a party. He was bludgeoned, stabbed and shot after being outed by a female church member who was at the party, to whom he disclosed that he was dressing as female for the first time. After the murder, his parents did not see fit to claim his body. Jones had quit school, despite only having an eighth-grade education, at the age of fourteen due to relentless harassment by classmates about his feminine qualities. The widespread brutality and bigotry have forced some members of the gay community literally underground (Human Rights First, 2012). After being disowned by their families, some LGBTQ teenagers have taken respite in sewers to avoid such savagery. Jones was not the first LGBTQ teen who was brutally murdered in Jamaica that had made global news, yet still, the outcry for help and safety falls on deaf ears. It is imperative to illustrate how homophobia has been so deeply embedded in the soil and



culture of Caribbean cultures such as Jamaica in particular that even teenagers are not immune from punishment by death.

The masses continue to uphold status quo, however. In one survey, Eighty-eight percent of participants replied that they believe male homosexuality to be immoral, while eighty-four percent believe the same about female homosexuality (West, 2014). Even more startling, more than seventy-five percent of respondents do not believe the “buggery” law should be repealed, and sixty-five percent are opposed to revising the Charter of Fundamental Rights and Freedoms to prevent discrimination or violence against members of the gay community (Human Rights First, 2012). Journalists echo these results.

Most of the research that has been done about these concerns is corroborative. Keon West of The Guardian (2014) found the same opinions during his canvas of Jamaican streets in 2012. His survey of more than two thousand residents found that Jamaicans had an overwhelmingly unfavorable opinion of gays. Similarly, to the aforementioned evidence, West’s interviews found prejudice in resident’s attitudes of gays themselves as well as their perceptions of gay rights. He noted that Jamaica was, “the most homophobic place on Earth,” (p. 1). In addition, West comments that very little research is being done on this topic in the Caribbean Islands.

Researchers do, however, state that opinions are slowly changing among Jamaican residents. West (2014) notes that Jamaican residents in higher income brackets are less homophobic, while the Human Rights First organization (2012) quotes Jamaican Minister of Justice Mark Golding in response to Dwayne Jones’s murder:

All well-thinking Jamaicans must embrace the principle of respect for the basic human rights of all persons” which “requires tolerance towards minority groups and non-

violence in our dealings with those who manifest a lifestyle that differs from the majority of us (p. 1).

The Caribbean Islands has a long standing diplomatic, cultural and commercial relationship with the United States, and President Barrack Obama was quoted about his stance on gay rights:

You're more eager for progress that comes not by holding down any segment of society, but by holding up the rights of every human being, regardless of what we look like, or how we pray, or who we love. You care less about the world as it has been, and more about the world as it should be and can be. (Human Rights First, 2012, p. 1).

As the United States recently legalized gay marriage in 2015, many hope that the Caribbean Islands will soon amend their laws in order to liberate the homosexual community.

In the meantime, counselors in what are considered Western civilizations, are trying hard to acclimate themselves to the notion of providing therapy to those with gender or sexual identity crises. West (2014) found that much of the prejudice against gay men in Jamaica comes from the societal ideal of masculinity. The research implied that, in regard to unfavorable views of homosexuality, male gender was a primary indicator. Sex was a more powerful predictor than education, age or spiritual principles. This instigated other imperative questions about the male ideals in Jamaica: "What it is about those perceptions of masculinity that finds the existence of gays so unbearable? Is it that Jamaican masculinity has become overly focused on toughness and anti-femininity, at the expense of socially beneficial constructs such as responsibility?" (p. 1). West (2014) notes that this led researchers to conclude that mediations focused on rethinking gender ideals in the Caribbean may be worthwhile to reduce the negative attitude toward those who are currently seen as aberrant.

## **Religious Dilemmas and Spiritual Training**

Religion and sexual orientation are two issues that historically do not go hand and hand in any productive conversations. There are many religious practices throughout the Caribbean; with respect to this topic, none of them are a one size fits all. In reference to the Caribbean countries included in this study, the researcher has identified their major religious practices. In an effort to present concise and rich information, the most practiced religion will be highlighted as well as the second most practiced for comparative discussions. The researcher has listed below the Caribbean countries including in this study and their religious practices.

### **Turks and Caicos Islands Religions**

Religions: Protestant 72.8% (Baptist 35.8%, Church of God 11.7%, Anglican 10%, Methodist 9.3%, Seventh-Day Adventist 6%), Roman Catholic 11.4%, Jehovah's Witnesses 1.8%, other 14%

### **The Bahamas Religions**

Religions: Protestant 69.9% (includes Baptist 34.9%, Anglican 13.7%, Pentecostal 8.9% Seventh Day Adventist 4.4%, Methodist 3.6%, Church of God 1.9%, Brethren 1.6%), Roman Catholic 12%, other Christian 13% (includes Jehovah's Witness 1.1%), other 0.6%, none 1.9%, unspecified 2.6% (2010 est.)

### **Cayman Islands Religions**

Religions: Protestant 67.8% (includes Church of God 22.6%, Seventh Day Adventist 9.4%, Presbyterian/United Church 8.6%, Baptist 8.3%, Pentecostal 7.1%, non-denominational 5.3%, Anglican 4.1%, Wesleyan Holiness 2.4%), Roman Catholic 14.1%, Jehovah's Witness 1.1%, other 7%, none 9.3%, unspecified 0.7% (2010 est.)

### **Jamaica Religions**

Religions: Protestant 64.8% (includes Seventh Day Adventist 12.0%, Pentecostal 11.0%, Other Church of God 9.2%, New Testament Church of God 7.2%, Baptist 6.7%, Church of God in Jamaica 4.8%, Church of God of Prophecy 4.5%, Anglican 2.8%, United Church 2.1%, Methodist 1.6%, Revived 1.4%, Brethren 0.9%, and Moravian 0.7%), Roman Catholic 2.2%, Jehovah's Witness 1.9%, Rastafarian 1.1%, other 6.5%, none 21.3%, unspecified 2.3% (2011 est.)

### **Virgin Islands Religions**

Religions: Protestant 59% (Baptist 42%, Episcopalian 17%), Roman Catholic 34%, other 7%

### **Dominican Republic Religions**

Religions: Roman Catholic 95%, other 5%

### **Haiti Religions**

Religions: Roman Catholic (official) 54.7%, Protestant 28.5% (Baptist 15.4%, Pentecostal 7.9%, Adventist 3%, Methodist 1.5%, other 0.7%), voodoo (official) 2.1%, other 4.6%, none 10.2%

note: many Haitians practice elements of voodoo in addition to another religion, most often Roman Catholicism; voodoo was recognized as an official religion in 2003

#### Puerto Rico Religions

Religions: Roman Catholic 85%, Protestant and other 15%

Based on this information, conversations of religious views as it relates to attitudes toward persons who identify as LGBTQ, will highlight Protestant and Roman Catholic practices.

Persons who identify as LGBTQ that are spiritual and/or practice their faith may either struggle with their sexual orientation or choose not to confirm their sexual identity; creating an internal dilemma to remain hidden in the closet. The inclusion of same sex persons in premarital education classes creates a monumental dilemma for these affiliates. Unfortunately, while modern research is edging toward encouraging therapists to offer affirmations to those struggling with their sexual identity, churches are still analyzing the problem against theories that are decades out of date (Levy, 2008).

In order to modernize the church's view of homosexuality, Levy (2008) then applied concepts from 2001 in an attempt to resolve the legal and dogmatic dilemma. Divorce has constantly been on the rise in America for the past four decades. Until recently, the national rates have been much higher than those found among pious, church going couples among the Jewish population. As of 2001, these statistics began to be comparable (p. 155). This has caused concern among all of those who practice religions which hold the ideal of marriage as sacred.

The church credits premarital education for their lower divorce rates. Marriages end at a rate that is 18% lower when couples attend premarital education and counseling during their engagement. Levy, 2008 proposes that "It is often too late for interventions and positive outcomes once the couple is married and significant distress is experienced. Yet, only about a third of marrying couples participate in premarital education programs" (p.155). Churches

therefore once encouraged and even pressured couples into educational sessions prior to taking their vows. According to Linville and O'Neill (2016), gay couples work harder to solidify their bonds. This has led to a revolution among many churches and some have begun to focus on the importance of the bond between the couple, rather than the implications of their union and how it impacts the church.

Decades ago, in order to ensure an ideal outcome for all those concerned, the couple and their children, along with the couples' parents, and all the church affiliates were entirely vested in their successful union. According to Levy (1973), the church had, "perceptions of people, preferred outcomes for people and preferred instrumentalities for people," (Levy, 2008, p. 155). This led to many couples committing to their marriages for life, even after they stopped being happy.

The 21st century ushered in many changes for the western religious philosophies. Levy (2008) cites Beauchamp and Childress (2001) when stating that "ethical justification" must be applied, meaning that the church should love and accept all comers, despite race, social class or sexual orientation. Reform congregations now therefore accept gay couples without fear of retribution from church authority (p. 155-156).

Another study, largely spurred by circumstances, sought to establish the validity of affirmative training (Carlson et al., 2013). An overwhelming amount of extant research for this investigation demonstrated a need for more intensive training for family therapy students who are eager to work with members of the LGBT community. Carlson, McGeorge and Toomey (2013) cite multiple sources when noting that LGBT identified couples seek therapy at a higher rate than heterosexual couples (as cited in Bieschke et al., 2000; Bradford et al., 1994; Cochran et al., 2003; and Liddle, 1997). Green and Bobele (1994) and Henke et al. (2009) are additionally

referenced when the authors note that a high percentage of clinical family therapists (CFTs) have experience with counselling gay couples (p. 209). Despite these circumstances, many therapists believe that they are inadequately trained to provide competent services to LGBT clients.

Carlson et al. (2013) cite a survey conducted by Doherty and Simmons (1996) when noting that more than half of all CFTs express a feeling of clinical inadequacy when working with LGBT clients. While these results are somewhat outdated, Rock and colleagues (2010) are referenced in corroborative findings, adding that students' express feelings that their clinical skills were especially lacking when working with this population (p. 209). Scholars and educators wrangle over the level of training that is necessary to prepare students to work with homosexual clients.

The authors note several disparities in CFT training practices. Carlson and colleagues cite Rock et al. (2010) when noting that CFT educational programs fail to provide affirmative LGBT training, while 60.5% of all CFT students receive no training at all in regard to the homosexual community. Godfrey et al. (2006) and Long and Serovich (2003) are additionally referenced when the authors note that training programs by and large are relatively heterosexist (p. 209). Overall, students' feelings of inadequacy result from inept educational practices.

This leaves the LGBT population to be at the mercy of the clinicians' struggles with incompetence. Carlson et al. (2013) therefore sought to determine the extent to which CFT students are receiving education about LGBT clients. More than two hundred students participated, with degrees ranging from masters to doctoral. A quantitative design was utilized and surveys were distributed through conventional mail (Carlson et al., 2013). The authors formulated their own survey.

The result of the study was The Affirmative Training Inventory (ATI) which measures the extent to which LGBT training was provided, while the Sexual Orientation Counselor Competency Scale was utilized to measure students' perceptions about their own clinical competence (Carlson et al., 2013). The aim of the investigation was to determine whether there would be a correlation between affirmative training and students' feelings about their therapeutic adequacy.

Ancillary goals included measuring these correlations between genders. Researchers wanted to know whether or not men and women viewed homosexuality, as well as clinical competency, differently (Carlson et al., 2013). The objective of the study was to work toward closing the gap between clinical competence and the growing demand for family therapy among the LGBT population.

Results indicated that there is a significant correlation between affirmative training and students' perceptions about being adequately trained to serve the LGBT community. Additionally, it was found that male students had very similar attitudes about the gay community than women did, and each viewed clinical competence in much the same manner as well (Carlson, et al., 2013). Later studies delved deeper into the affirmative training approach.

Researchers are now exploring the attitudes of family therapy students in relation to spirituality, religion and sexual orientation in an effort to close the gap between the provision of quality therapy and societally-imposed conceptions of ideal unions. Along with the aforementioned developments, McGeorge and colleagues (2014) examined the relationship between clinical religious training and family therapy students' attitudes toward treating gay couples (McGeorge, Carlson & Toomey, 2014). Much of the extant literature reviewed for this

study revealed a significant correlation between religiosity and students' attitudes toward treating members of the LGBT community.

Religiosity generally resulted in therapeutic incompetence with LGBT populations. McGeorge and colleagues (2014) cite Balkin et al. (2009) when stating that there is a definite link between religious training and homophobia. Bowers et al. (2010), Fall et al. (2013) and Fischer and DeBord (2007) are additionally referenced when the authors note that religiosity creates a conflict for the clinicians in regard to quality care provision. Numerous studies have been conducted in the interest of adequately preparing students to work with diverse populations (p. 497). This investigation also found a link between spiritual training and students' attitudes toward same-sex couples.

More than three hundred family therapy students participated in this study. A quantitative design was used and online surveys were distributed. The aim was to determine how much influence spiritual or religious training had on family therapy students' attitudes toward gays. Specifically, the Spirituality Clinical Training Scale (SCTS) developed by Carlson and colleagues (2014) was used to compare students' experience with religion against their attitudes about providing therapy to LGBT identified clients (McGeorge et al., 2014). The results largely depended on this scale.

The measures consisted of the SCTS and five indicators of students' beliefs about providing therapy to the gay community, along with reported practices related to work with LGBT clients. The results proved to be encouraging, as many students provided responses that were consistent with the practice of LGBT affirmative therapy (McGeorge et al., 2014). This could be the result of higher levels of training.



### **Studies Conducted in the Caribbean Islands**

There is very little relevant literature pertaining to mental health in the Caribbean, and absolutely none about treatment for gay clients on any of the islands. Even more disappointing is how far behind the times the culture seems to be in terms of therapy. One very recent study sought to determine whether or not the deinstitutionalization of mental health care provision had reduced the stigma pertaining to mental health care (Hickling, Robertson-Hickling & Paisley, 2011). As of 2011, as many as one in three mental health patients believed their sickness to be the result of supernatural powers (James & Peltzer, 2011). It does appear that it would be exceptionally challenging to provide adequate couple's therapy to the LGBT population in this portion of the world.

The aim of one examination was to investigate standard and alternative treatment for mental illness in Jamaica (James & Peltzer, 2011). Researchers sought to compare patients' ideals and clinicians' attitudes. The study was comprised of sixty psychiatric patients selected from Ward 21 at the University of the West Indies, Kingston and Princess Margaret outpatient clinic, along with 30 Afro-centric psychiatric nurses, psychiatrist and clinical psychologists from St. Thomas, Jamaica comprised the sample (James & Peltzer, 2011). Patients were questioned with the Short Explanatory Model Interview (SEMI) and practitioners completed a self-report survey on views about traditional and unconventional treatment plans.

Findings stated that, among patients, 33% expressed the notion that the overall cause of their sickness was supernatural factors (James & Peltzer, 2011). Further, most of the patients believed that their insight into their disorders did not agree with the thoughts of western clinicians, which caused high degrees of anxiety for these patients. For those who believed in standard treatment options, they were more likely to be satisfied with the treatment they received

(James & Peltzer, 2011). The fact that western practitioners were treating so many patients with such profound spiritual beliefs speaks volumes about the lack of Caribbean mental health professionals.

Results from the practitioners indicated that, although they recognized the need for traditional practices in the treatment of mental illness, they believed that traditional treatments were ineffective (James & Peltzer, 2011). In general, when all three traditional methods were compared, alternative medicine was more highly regarded than traditional healing or herbal treatment. Therefore, there is a need to formulate models of care which support a feasible correlation between the two healing systems in treating mental illness (James & Peltzer, 2011).

The chief tenets of the British colonial public policy involved involuntary commitment and making the mentally ill wards of the state. These were the options for the criminally insane and the acutely disturbed in Jamaica and the West Indies in the decades following Jamaica's liberation from Great Britain (Hickling & Gibson, 2012). Over the years, a more evolved mental health system has arisen that has eliminated involuntary commitment and imprisonment.

This system has also advocated for family therapy and short stay treatment in traditional health care settings, and has supported standard treatment options as well as cultural therapies that have been extremely successful in both the treatment of mental illness and in decreasing the stigma attached to mental illness in Jamaica (Hickling & Gibson, 2012). Collaborations between the Jamaican Ministry of Health, the Pan American Health Organization and several universities have been central in the establishment of implementing new and transformative public policy initiatives.

These initiatives have minimized the effects of involuntary commitment that were inflicted on the population as a result of slavery and colonization. These alliances also induced

the psychiatric training of medical and mental health professionals and began the formulation of community mental health policy in Jamaica (Hickling & Gibson, 2012). There is still a great deal of stigma attached to mental health care in the Caribbean islands, however.

Research on Afro-Caribbean MFTs who serve the LGBT population is severely lacking. While the rest of the world is legalizing gay marriage and perfecting the craft of mental health, the Caribbean is still ways behind. The acknowledgment of the importance of mental health and receiving care is slowly seeping into the Caribbean health care system. An even slow process surrounds embracing a culture of love, acceptance and inclusion of persons who identify as LGBTQ. It is my assertion that one of the most effective ways to defeat a social injustice is to raise awareness. For these reasons, it is imperative to close the research gap by helping to shed light on the experiences of Afro-Caribbean MFTs and their work with Lesbian, Gay, Bisexual and Transgender persons.

### **Chapter III: Methodology**

The aim of the study was to explore and understand the experiences of Afro-Caribbean Marriage and Family Therapists who were currently working in the field with persons who identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ). Detailed in this chapter is an outline of how conducted the study. This researcher chose a qualitative research approach known as Interpretive Phenomenological Analysis to help in examining the meaning making process of the participants. The researcher hoped that the therapists who had been selected to fit this very unique and purposeful sample, would add valuable information that contributes to the body of literature that is lacking in the field on Afro-Caribbean therapists working with LGBTQ clients. The researcher highlighted the process proposed in selecting participants, recruitment through the use of ethical strategies, data collection and analysis.

#### **Qualitative Research**

Qualitative research provides opportunities for multiple stories and voices to be heard. Qualitative research is complex and organically systemic. It is personal, in-depth, and holistic in nature which made this methodology an appropriate fit for the population and phenomenon being studied. Creswell (2013) states that ‘we conduct qualitative research because a problem or issue needs to be explored’ (p.47). The researcher identified a need due to the lack of information available on Afro-Caribbean Therapists who have shared their experience in working with LGBTQ clients. This gap highlighted that the experiences of this identified population had not yet been explored. It is the assumption of the researcher based on personal experience that as an Afro-Caribbean Therapist, there may not have been many opportunities to safely share and learn from one’s experience in working with LGBTQ clients based on cultural upbringing and possible

backlash from one's community. The researcher assumed that this thinking led this population being silenced. Creswell (2013) asserts that using qualitative research is imperative 'when we want to empower individuals to share their stories, hear their voices, and minimize the power relationships that often exist between a researcher and the participant in the study' (p.48).

Creswell (2013) explains that there are unique characteristics of a qualitative study that makes it identifiably different from a quantitative study. In a qualitative study, the researcher is the key instrument as opposed to utilizing tools or instruments already developed. Additionally, the research occurs in its natural setting, which likely allows for a more organic process as opposed to a lab research setting. Other distinctions include multiple forms of data collection, all done by the researcher, analyzing patterns and themes and most importantly close collaboration with the participants involved in the study.

One of the benefits of conducting qualitative research is the opportunity to gather first-hand knowledge and data. Yin, 2016, states that this can be accomplished by 'studying the meaning of people's lives, in their real-world roles' (p.16). In utilizing a qualitative approach, the researcher is able to design and collect the data themselves. This manifested in the form of one-on-one interviews with the participants through the use of open-ended questions that helped to guide the conversation. In utilizing this qualitative research method, the researcher was able to gather individualized and rich stories of the participants' experiences, exploring their thoughts and feelings in the process, which are qualities uniquely embedded in the features of a qualitative study. Another benefit of conducting a qualitative study is that it is personable, it allows for the voices of both the researcher and participants to be heard, which is an attribute unfamiliar to quantitative studies. Yin, 2016, expressed that "researchers also can bring their own belief

system or worldview as the motivating force for defining and conducting research in the first place” (p.3).

### **Phenomenology**

The researcher employed a phenomenological research approach. A phenomenological research method pairs well with a qualitative study in that phenomenology helps to provide layers of context to what is being shared by the participants. Yin, 2016, adds that “the studies strive to be as faithful as possible to the lived experiences, especially as might be described by the participants’ own words” (p.3). The intent of a phenomenological approach is to gather firsthand account of the lived experiences of a phenomenon among a group of people. (Creswell, 2013) states that “Phenomenology can involve a streamlined form of data collection by including only single or multiple interviews with participants” (p.82). Due to the nature of narrative data being collected, a qualitative research design such as this was deemed appropriate. Greenfield and Jensen (2016) suggest that the lived experiences of individuals can be powerful research tools not only for providing new insights into their lives and work, but also for providing color to existing understandings of those individuals. While Greenfield and Jensen’s research centered on the experiences of patients, the same can be true of those who are engaging in unique work that is often understood. With this in mind, the study sought, at least in part, to gain understanding right from the source rather than attempting to guess at what life might be like for Marriage and Family Therapist of Afro-Caribbean background working with LGBTQ persons.

## **Interpretative Phenomenological Analysis**

Phenomenological analysis is an umbrella term with methods that can be branched and studied based on the definition and perspective of phenomenology. Interpretative phenomenological analysis as defined by (Smith, Flowers and Larkin, 2009) “is an approach to qualitative, experiential and psychological research which has been informed by concepts and debates from three key areas of the philosophy of knowledge: phenomenology, hermeneutics and ideography” (p.11). Phenomenology and hermeneutics can be explained as modalities of qualitative research that focuses on interpreting a single experience while ideography speaks to the uniqueness and specificity of the research as oppose to generalizations. DeMarrais, 2004, reports that “phenomenology enables researchers to examine every day human experience in close, detailed ways. This form of inquiry attempts to discover the meaning people place on their lived experiences. These projects result in contextual, holistic, thematic descriptions of particular experiences” (p.56). Moustakas, 1994, added that “from the individual descriptions general or universal meanings are derived, in other words the essences or structures of the experience” (p.13).

## **Theoretical Framework**

As the researcher continued to discuss the underpinnings of Interpretative Phenomenological Analysis and its fit for exploring the lived experiences of Afro-Caribbean Therapists working with persons who identify as LGBTQ, the term social construct came to mind. Our individual experiences are influenced by our social construct; language is socially constructed. The intent was to explore the meaning making process of Afro-Caribbean Therapists working with identified LGBTQ persons, a social constructionist theoretical

framework proved appropriate. McNamee & Gergen, 1992, explain that “For many critics of the traditional view of scientist-therapist, this focus on the social construction of the taken-for-granted is highly inviting. It enables critical theorists, feminists, ex-mental patients, and others to continue in their questioning of the current canons of truth within the profession.

Constructionism invites the kind of critical self-reflection that might open the future to alternative forms of understanding” (p.5). This self-reflection occurs individually among participants and researcher, and assumingly together during the interview and follow up process as the collaboration between participant and researcher emerges new understanding of the phenomenon. (Creswell, 2013), proposes that in social constructivism “individuals seek understanding of the world in which they live and work. They develop subjective meanings of their experiences-meanings directed toward certain objects or things” (p.24). In social constructivism, as in IPA, the voice of the participant is vital to the research; there is a collaboration between researcher and participants as they engage in conversations through interviews to help co-construct the meaning of the phenomenon being examined, in this case, their experiences in working with persons who identify as LGBTQ. The social constructionist framework continues to pair well with phenomenological work in that there is no single truth or reality, “multiple realities are constructed through our lived experiences and interactions with others” (Creswell, 2013, p.36), thus honoring the voices and experiences of every individual in the meaning-making process.



### Sampling and Participant Selection

In utilizing an IPA approach for this study, the participant selection is always intentional in that the participants need to have experienced the phenomenon being studied. This was accomplished by way of *purposeful sampling* (Creswell, 2013). As the name suggest, purposeful sampling speaks to the deliberate choice of selecting a participant for the study that would not only meet all the eligibility requirements, but, additionally add rich information regarding the phenomenon being studied. In purposefully selecting participants, the researcher was ensuring that the participant was knowledgeable and experienced and willing to be expressive and open about their work with persons who identify as LGBTQ. One of the most appealing aspects of conducting a qualitative research study is the sample size. A small sample size is an advantage for qualitative studies in that the process allows for a one to one collaboration between the researcher and the participant that is unrushed, in depth and personal. Yin, 2016 adds that “the instances in a qualitative study are intended to maximize information” as opposed to having a larger participation pool which is not relevant nor needed for qualitative research (p. 83). The researcher decided to have a sample size of three participants. Additional inclusion criteria for the purposeful sample process required participants to be English speaking, identify as being of Afro-Caribbean descent and have experience in working as a Marriage and Family Therapist with persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning. In full disclosure, I am aware that utilizing the term Afro-Caribbean to generalize my selected sample is not indicative of the representation of all Caribbean countries as it relates to varying beliefs and individualized perceptions on religious and cultural attitudes toward the LGBTQ community. The intentional generalization of the term Afro-Caribbean allowed for ample inclusivity and diversity in participant representation of Caribbean countries.

## **Recruitment**

Recruitment was initiated via approved posters placed at local mental health agencies and nearby universities. The researcher utilized the use of social media to increase visibility and engagement with individuals who may meet criteria. The posters and letters of interest provided pertinent information such as the researcher's name and contact information, the purpose of the study, participants' criteria and role in the study. Due to the sensitivity of the topic, there was some resistance in participants volunteering for the study. This researcher attended to participants' reluctance by highlighting and assuring confidentiality with the information shared and interviews conducted. Creswell, 2013, explains that "convincing individuals to participate in the study, building trust and credibility, and getting people from to respond" (p.171) are all important factors that may present as challenges in the recruitment process.

## **Data Collection Procedures**

The process of collecting data in qualitative research is an intricate one. Creswell, 2013, describes that the process involves "conducting a good qualitative sampling strategy, developing means for recording information both digitally and on paper, storing the data, and anticipating ethical issues that may arise" (p.145). The data collection process began once participants met criteria for the study and had been informed of the purpose and procedure in order for the participant to willingly sign the informed consent document. Creswell, 2013, acknowledges that 'in a phenomenological study in which the sample includes individuals who have experienced the phenomenon, it is important to obtain participants' written permission' (p.154). The researcher detailed in the informed consent time required to participate, benefits if any to the participant, processes for slowing down or taking time out during the semi-structured interview,

and ability to withdraw from participating without consequence should difficulties in participating arise. Information collected from participants during the interviewing stage of the study was handled in a confidential manner, within the limits of the law and was limited to people who have a need to review this information. All confidential data which include audio recordings, transcriptions, and correspondence with the interviewer—was secured in the researcher's private, password-protected computer and stored in a secure, locked cabinet in the researcher's home. The data was de-identified with the use of pseudonyms in place of participants' actual name. This data was made available to the researcher, the Institutional Review Board and my dissertation chair. If the results of the study are published in a scientific journal or book, participants will not be identified. All data will be kept for 36 months from the end of the study and destroyed after that time by the researcher.

### **Data Analysis**

The data analysis portion of a qualitative research study can be a daunting process; yet, it is the heart of the study in which the researcher is able to make sense of the rich stories collected during the interview from participants. This portion of the research requires reading and re-reading for accuracy and transcription of the data from the recorded interviews. Creswell, 2013, explains that the analysis portion “involves organizing the data, conducting a preliminary read-through of the database, coding and organizing themes, representing the data, and forming an interpretation of them” (p.179). The researcher saw these steps as not only connected but interdependent on each other, for an accurate representation of the data. As noted by Smith et al 2009, there are six notable steps outlined in the data analysis process for a qualitative study using IPA:

1. Read and re-reading.
2. Initial noting.
3. Developing emerging themes.
4. Searching for connections across emergent themes.
5. Moving to the next case.
6. Looking for patterns across cases.

This process was repeated for each of the participants' interviews. The process of 'bracketing' (setting aside biases/information), a term coined by Edmund Husserl, was important during this time as the researcher moved from one participant's story to the next, to allow new meanings and themes to occur, reducing influences from prior participants' experiences. The bracketing process will be explained further in the below when addressing the potential biases.

### **Ethical Considerations**

When utilizing qualitative research method, there is an intimate level of interaction between the participant and the researcher. It is at the forefront of this relationship that we must consider our biases and attend to ethical concerns from the planning stages of the research project and throughout. Due to the nature of the study and the method of conducting face-to-face interviews with the participants, maintaining confidentiality and anonymity was of utmost importance to the participants.

### **Potential Research Bias/ Self of the Researcher**

Although a qualitative methodological study differs from a quantitative one in that it provides direct rich data from participants, it is not free from bias, more specifically researcher bias. Researcher bias has the potential to skew the data in the researcher's favor, selectively

reading and interpreting information received directly from participants. The researcher understood that some cultures have historically embedded views and attitudes regarding homophobia, and that this could influence practice. The researcher, having been raised in a Caribbean culture saturated with homophobic beliefs, fully acknowledged these biases. However, the researcher also has a strong desire to see fairness for all clients. In an effort to alleviate potential researcher bias, a process of bracketing or “Epoche” as termed by Edmund Husserl occurred. Creswell, 2013, describes bracketing as a process “in which investigators set aside their experiences, as much as possible, to take a fresh perspective toward the phenomenon under examination” (p.80). This process is both helpful to the researcher and the participants involved in that it allows the phenomenon to be shared without being tainted; it creates space for the researcher to listen without judgement and preconceptions of the stories the participants will share. This process of bracketing took place prior to meeting with participants in an effort to set aside preconceived notions regarding the phenomenon, however it was a continuous process. Smith et al, 2009 add that “one will not necessarily be aware of all one’s preconceptions in advance of the reading, and so reflective practices, and a cyclical approach to bracketing, are required” (p.35). The researcher described this as a systemic interwoven process of reading and reflecting, and emotion checking, that cultivated and promoted curiosity within the researcher for a deeper understanding of the experiences told by the participants and also the researchers own experiences. To partake in this reflective process of bracketing throughout the study, the researcher utilized journaling to document biases throughout the process.

## **Conclusion**

Thus far, the researcher has presented historical information in the literature review that illustrated the need for conducting this study. The literature review has presented cultural views and attitudes perpetuated in the Caribbean regarding persons who identify as LGBTQ. The information presented by the researcher highlighted the gap in our field of study regarding this subject matter and specific population. The experiences shared by the participants will be groundbreaking information that adds to the body of empirical research as this avenue has yet to be explored in this manner. In chapter three, the researcher illustrated that with an interpretative phenomenological approach for this qualitative study, the voices of the participant would help to shed light on the experiences encountered as Afro-Caribbean therapists who work with the LGBTQ community. This was accomplished through semi-structured interviews with the participants, a collaborative approach allowing room for self and participant reflection to reduce error in researcher interpretation.

## **Chapter IV: Research Findings**

The purpose of this study was to explore and understand the lived experiences of Afro-Caribbean Marriage and family Therapists who have worked with persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning. The process for recruiting participants and attaining consent was a tedious one. Initial recruitment and flyer exposure led to approximately 20 perspectives that were interested in participating in the study. Out of the 20 perspectives interested in sharing their experiences, 3 participants were courageous enough to follow through with the process in its entirety. Based on the hesitation received and perceived in scheduling and committing to an interview date, one can only assume that those 17 interested perspectives that made the initial call experienced great anxiety in having to share their vulnerabilities and struggles in working with persons who identify as LGBTQ. I surmised that this reluctance may have been due to discomfort in verbalizing such vulnerabilities regarding their experiences in working with this population. Additionally, one can assume that perspectives may have felt there was a lack of anonymity and feared there may have been job-related consequences in sharing their experiences regarding such a sensitive topic.

Thankfully, three participants willingly agreed to share their experiences in working with persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning. The stories told by the participants helped to highlight emerging themes that were analyzed from the semi-structured interview that was conducted. The data consisted of transcripts of interviews with three selected participants. The constant comparative method, which involves iterative reading of the transcripts, was utilized in order to draw out and formulate key themes from the data (Merriam, 2009). Through this process, two superordinate themes were identified, with two subordinates' themes under each of the superordinate themes. Each of these themes from the data

were delineated in turn, with ample support in the form of direct quotations from the interview transcripts.

## Participant Demographics

*Table 1: Participant Demographics*

Participant (Pseudonym)	Culture of Origin	Sexuality	Religion	Years of Experience
<b>Sergio</b>	Jamaica	Straight	Christian	7+
<b>Samantha</b>	Puerto Rico	Bisexual	Christian	7+
<b>Gaylia</b>	Barbados	Straight	Christian	6

## Superordinate themes and relating subordinate themes

*Table 2: Superordinate themes and relating subordinate themes.*

Superordinate Themes	Subordinate Themes
<b>1. Homophobia</b>	1A. Culture
	1B. Religion
<b>2. Evolving Views</b>	2A. Making a connection with the LGBTQ community
	2B. Checking yourself at the door



## Research Findings of Common Themes and Unique Factors in Interviews

*Table 3: Research Findings of Common Themes and Unique Factors in Interviews.*

Superordinate Themes	Sergio	Samantha	Gaylia
<b>1.Homophobia</b>	✓	✓	✓
<b>2. Evolving Views</b>	✓	✓	✓
<b>Subordinate Themes</b>			
<b>1A. Culture</b>	✓	✓	✓
<b>1B. Religion</b>		✓	✓
<b>2A. Making a connection with the LGBTQ community</b>	✓		
<b>2B. Checking yourself at the door</b>	✓	✓	✓
<b>Unique Factors</b>			
<b>Being born in the US</b>			✓
<b>Interconnection of racism and sexual orientation discrimination</b>			✓

The table above identifies common themes shared by all participants during the interview and unique factors that have been highlighted during the data analysis process. These common themes and unique factors will be explored in detail below.

### **Superordinate Theme 1: Homophobia**

#### **Subordinate Theme 1A: Culture**

The selected participants were of Afro-Caribbean heritage, and one of the main themes that emerged from the data was that their home cultures were, in fact, homophobic, with the most positive view generally consisting of not even talking about LGBTQ issues at all. Sergio, for

example, grew up in Jamaica, and he identified his home culture as "very homophobic." Sergio indicated the following (pauses and interjections omitted for the sake of clarity):

*"When I was growing up, they have derogatory terms or battyman. Battyman means homo, uh, a gay man, pretty much. And so, all the music, all the jokes, like if you had a guy friend and you're getting too close, it would be like battyman, right? So, guys would not be close."*

This is a clear indication that within the Jamaican culture in which Sergio grew up, there was a strong stigma against homosexuality, to the point that men were even afraid to appear too close to each other lest they are accused of being "battymen." Sergio also said:

*"People would literally have heard my uncle tell my little cousins, you know like threatened them that, if you know, you can't be gay and stuff like that."*

This was Sergio's initial exposure of understanding homosexuality and the attitudes toward persons who identified as LGBTQ; for him; this was a lasting impression until he came to the United States.

This cultural view regarding LGBTQ persons was also shared by Samantha, who said the following that can only seem shocking from a modern perspective:

*"So, the Puerto Ricans, thanked God that no one at the table was Gay..... Out loud! That was the prayer before dinner. . . . I knew on my dad's side of the family; they may have like mocked gay people." Samantha and I shared a moment of silence during the interview as we pondered the ramifications within her family of that prayer.*

This was Samantha's cultural upbringing. Homophobia rooted in slick remarks, casual conversations and prayer.

An interesting point that emerged in the interview with Samantha was that the stigma against male homosexuality was apparently far greater in Puerto Rican culture than the stigma against female homosexuality. Samantha shared a more accepting story about her mom's side of the family. The excerpt from the interview below, indicated Samantha's awareness and struggles in embracing her own sexual identity as she discovered that of her mom's.

**Samantha:** *So, I identify as bisexual. My older brother is gay-*

**Interviewer:** *Mm-hmm.*

**Samantha:** *-out openly gay. Um, and majority of my mom's side at the family who's mostly women are gay or bisexual. So, let me just say that.*

*[laughter]*

**Interviewer:** *Okay.*

**Samantha:** *Um, so the-- um, with my mom, o-- there was a lot of acceptance.*

**Interviewer:** *Mm-hmm.*

**Samantha:** *Now, a lot of things didn't come out about my family until I would say my siblings and cousins that were in my age till we were about high school.*

**Interviewer:** *Okay.*

**Samantha:** *So, we weren't like openly exposed to what we knew as gay lifestyle. But when things came out, when my mom came out to us, I was a junior in high school.*

**Interviewer:** *Okay.*

**Samantha:** *And, uh, all these people that were "aunties," my-- even my own godmother was like her partner, and she died. My Mom's partner died and, um, the inheritance got to my brother because they considered him his-- It was like this big old scandal of stuff.*

**Interviewer:** *Mm-hmm.*

**Samantha:** *And so that happened in a lot of different pockets of my mom's family,-*

**Samantha:** *Mm.*

**Samantha:** *-like they had been living these very secret lives until they felt like their kids were old enough to say.*

**Interviewer:** *What was that like for you having to live through that?*

**Samantha:** *I was pissed. I was so angry. Mainly because I wish that she would have told me sooner to make more sense of myself.*

**Interviewer:** *Mm-hmm.*

**Samantha:** *Um, it was interesting hearing her fear of being like, for some reason we would love her less because like we don't-- we didn't care.*

**Interviewer:** *Yeah.*

**Samantha:** *Um, and all the women she brought around were top-notch people. It's not like they were--they weren't bad people. They were great women-*

**Interviewer:** *Yeah.*

**Samantha:** *-that we enjoy being around. So they gave us all the feels, you know. So I-I think for all of us it was just disappointing that my mom wasn't more forthcoming. Granted, we were in high school, so, uh, I don't think we had like the best caps of judgments-*

Understandably, Samantha expressed feelings of anger as she continued to share of her experience of her childhood years, because she herself identified as Bisexual, such that hearing her mother's story sooner, she described, would have helped her make greater sense of herself.

Afro-Caribbean culture, though, would not seem to be altogether homogeneous regarding this matter. For example, participant Gaylia indicated that there was a split of sorts between urban areas and rural areas:

*"I would say it's still half and half. Meaning you can definitely see that there's some areas in Barbados, like when you go there where Gays and Lesbians are really accepted and then there's other pieces of it."*

An interesting point that emerges from the interview data, though, is that to a large extent, Afro-Caribbean culture would often seem to just ignore LGBTQ issues altogether. As Gaylia put the matter:

*"It's like you don't even talk about it and you don't act like it's there. It's man, woman—that's it."*

Likewise, Sergio said:

*"I literally have never seen [while growing up in Jamaica] at least publicly seen, a gay person ever, man or woman. Well, meaning man and man together, walking down the street. Holding hands, kissing. Until I came here to the United States."*

Sergio appeared hesitant to describe intimate, coupling gestures as he shared about his memories of being in Jamaica and then initially being exposed to the culture in the United States. In short, the main idea that comes across is that when the Afro-Caribbean culture was not overtly hostile toward homosexuality, it was primarily ignoring the fact that homosexuality was even a reality. Clearly, it is not ideal that totally ignoring the issue was the high point of the culture's treatment of the issue. That is, if ignoring the issue is the *best* that they do, then there is surely a great deal of room for progress.

It is clear that the Afro-Caribbean culture as a whole has been hostile toward LGBTQ issues. Samantha, for example, pointed out that her father could not even comprehend such issues in an equitable light, summarizing the problem simply as:

**Samantha:** *The older generation is just more cons-- it's just more conservative. It's not like they lack any love from my brother. I don't think they ever will.*

**Interviewer:** *Yeah.*

**Samantha:** *But they just are uncomfortable. And, you know, my dad is 74 years old. And he has loved my brother. He will forever love my brother. But he has a hard time even talking about it. It's again, 74 Puerto Rican man.*

**Interviewer:** *Mm-hmm.*

**Samantha:** *He cannot fathom my brother being with a man. Like it grosses him out. If he sees a man kissing on TV, grosses him out.*

It may also be true that outside the modern West, cultures, in general, are more traditional and conservative. One way or the other, though, it is clear that many Afro-Caribbean therapists would come from cultural backgrounds where homosexuality is either overtly stigmatized or else just simply ignored.

### **Subordinate Theme 1B: Religion**

There are often spiritual conflicts perceived and experienced when discussing religion and issues surrounding the LGBTQ culture in the same conversation. Some participants have shared their struggles related to this having identified both as a Christian and being Bi-sexual. Samantha indicated that this was *despite* the fact that her Christian background caused her to feel tension about working with LGBTQ individuals:

*"I felt like it would bring on so much controversy that I did not feel like dealing with, to be honest. I was like, 'I do not want Christians knocking on my door, sending me anything because I'm the Therapist for Gay people.'"*

What is impressive about Samantha's testimony is that her experiences taught her to love working as a therapist with persons who identify as LGBTQ despite the cultural and religious stigmas that she felt to not engage in that line of work. Samantha shared that she is now open to working with Gay and Lesbian individuals and families despite what she had been taught by her religion when she was young.

The theme of religiosity also emerged in the interview with Gaylia, who described the struggles of one of her gay clients in the following way:

*"So they said, yeah, you go to church and they say you're supposed to be this way, but this is how I feel. So what does that mean? Am I not supposed to feel this way? So how am I supposed to feel?"*

Although Gaylia is describing a client in this passage, the subtext is that this could be taken as a reflection of Afro-Caribbean therapists' own process of challenging their own culture's biases. For example, if a therapist is a practicing Christian, then it is true that many churches do in fact prescribe a specific negative view toward LGBTQ issues. The therapist would then need to struggle not with her own sexuality but rather with the views promoted by her church about the sexual identities and practices of others. It is a clear indication that cultural upbringing need not determine how one feels about cultural and religious controversies such as attitudes toward persons who identify as LGBTQ.

## **Superordinate Theme 2: Evolving Views**

### **Subordinate Theme 2A: Making a connection to the LGBTQ community**

The participants that were interviewed for the present study, all spoke of a significant shift that happened in their views as they gained education and became more aware of LGBTQ issues, especially through interactions with persons who have identified as LGBTQ. In other words, it is categorically *not* the case for the interviewed participants that their cultural backgrounds determined their feelings about the issue. Rather, there is a clear sense that their views on LGBTQ issues evolved over time, to the point that they sometimes even challenged

their perceptions of their families. As Samantha indicated regarding situations in which her family members are casually derogatory toward LGBTQ people:

*"So it's taken a lot of work directly addressing things, not backing down when I hear things that I won't tolerate."*

This is a case in which, one of the participants overtly turned against her own culture's biases. It is perhaps worth noting that this would have been personal for Samantha given that she herself identified as bisexual and her brother, who was previously in the military, is now openly gay.

Likewise, Sergio said the following about his own evolving views, after attending a panel in which he learned more about LGBTQ issues:

*"One of my closest friends was gay. And so, and I didn't know. And the fact that he told me and, you know, that shifted me because nothing was different."*

Sergio had discovered his friend's sexual identity after voicing his need to interview members of the LGBTQ community for an assignment and not knowing where to start. It was during this process that his friend came out to him. Sergio spoke of how connecting himself to the community allowed him to explore his own biases to allow for new understanding. Sergio indicated that given his cultural background and upbringing, he simply did not understand LGBTQ issues at first. For example, he was under the impression that gay people at some point decide to "switch" from being straight to being gay. As he gained more experience interacting with LGBTQ population and hearing their stories, his views began to develop and more so evolved. For example, when Sergio found out that one of his closest friends was gay, it helped him understand that people are people and that the fact that his friend was gay did not actually change anything about his experience with his friend. Sergio's cultural background had not prepared him for this, but he simply learned from his experiences.



Samantha had the following to say about evolving views on LGBTQ issues:

*"My first client ever was a gay man. It was a gay man and I loved him. I mean, you know, we did great work together, but like as a human being, I love change after a lot of the therapy with him. And then I worked with a gay couple for nearly a year."*

In general, actual experience with LGBTQ people is what proved to be the main catalyst when it came to the evolution of views regarding individuals who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning. For example, Gaylia said:

*"So, I have one cousin that I believe hasn't come out yet. I have one cousin that has come out, and there's no change."*

This lack of change in the relationship was also expressed by Sergio, as has been discussed above. Having actual experience with LGBTQ people and realizing that they are no different from anyone else and that a relationship with a specific person would be the same whether they were LGBTQ or not, thus helped the Afro-Caribbean therapists evolve in their views regarding these issues. Notably, this was the case even despite the fact that both the home culture and in many cases the home religion counseled against this kind of acceptance. This strongly suggests that the intolerance of the home culture is to a large extent rooted in ignorance, specifically, lacking of knowledge, and that when actual experience takes the place of that ignorance, views can change.

### **Subordinate Theme 2B: Checking yourself at the door**

As Gaylia put her own view of her role as a therapist:

*"What I'm doing as a therapist has nothing to do with someone's sexuality unless that's something, they want me to assist with because they're in that phase of uncertainty. . . ."*

*I'm just helping you go along the path of discovery so you can make that definition for yourself."*

In other words, Gaylia did not see it as her role to tell her client who they should be or how they are supposed to understand themselves. Nor did she see it as her role to impose her own beliefs and values on her client. Rather, Gaylia believed that being a therapist was fundamentally a matter of service and guidance. The point was to let the client set the terms of their own self-discovery, with the therapist then utilizing her professional expertise in order to help guide the client along that path. Essentially, Gaylia thought that if the therapist made the situation about herself, then this would be a serious problem:

*"If your goal is to work on how you feel inside, you're in the wrong position as a therapist."*

I can also echo Gaylia's sentiments; it is much easier to be an effective clinician when the goals and direction of therapy are motivated by the clients' wants and needs instead of our own internal struggles with how or what the client presents.

This is directly echoed by Samantha, in a passage that gives the current theme its name:

*"So I think early on, it does shift the whole idea of like—in a sense, you kinda have to check yourself at the door. So, we're not here to talk about me and my preferences and what I think is right or not right, but I'm here to serve you and however I can do that to the best of my ability, I will."*

The main idea is that even *if* the therapist somehow had negative views about LGBTQ issues, this should *still* not be relevant within the therapeutic situation, given that the therapist is fundamentally not there to express her own views about what the client should or should not do. This mindset would also remain true regarding any other biases that one would struggle with,

such as having sexual offenders, child abusers, or other emotion evoking issues presented in therapy. Rather, the therapist is a facilitator on the journey taken by the client, as per the terms set by the client. Of course, it would be non-ideal to have a therapist working with an LGBTQ client while having negative views on LGBTQ issues, but the overarching point is that professionally speaking, this should still not actually matter. This pairing may in fact be beneficial to both the client and therapist, if the therapist is open to working on barriers acknowledged and encountered in working with persons who identify as LGBTQ.

Gaylia makes this point even in relation to being in *support* of LGBTQ issues, within a situation in which the client himself may not see matters in those terms. Speaking of one client, Gaylia said the following:

*"You know, so they are—they don't even want to label whether they're gay or lesbian. They're like, I just am and that's fine. Like they are who they are. There's whoever they want to be with today. You're totally different tomorrow and that's okay."*

In this context, it would be problematic for the therapist to impose categories of sexual identity on a client who does not wish to think in terms of clearly defined identity. The point would thus be to neither oppose LGBTQ identity nor to enforce it, but rather to "flow" with the client's perspective and help the client progress on his/her own journey. The therapist's own beliefs and opinions should not infringe on the situation one way or the other.

Sergio indicated that if a therapist was unable to adopt this kind of neutrality, then the best option would be for the therapist to refer the LGBTQ client to someone else. This initially seems like discrimination, but it may in fact simply be a judgment call about whether or not the therapist would be able to offer high-quality services to the client. For example, Sergio discussed

a White therapist he knew who was from Alabama and was strongly opposed to homosexuality. Sergio's view on the matter was:

*"If that's your reaction to people that came to you for help, you might want to refer them because I don't think you're in a place to help them."*

In other words, a therapist who is unable to check himself at the door would not be an effectively good therapist, since the therapy sessions would then be more about the therapist's own feelings and internal drama than about the client's journey of development. This is a general principle that would be true about *any* strong biases that the therapist had that prevented him from adopting a standpoint of service toward the client. The example of LGBTQ issues would thus just be one particular example of this more overarching principle of professionalism.

Again, this can go both ways. For example, Gaylia said the following:

*"And if someone says, 'I want you to provide Christian counseling for me,' okay, fine. I'll bring in—we can utilize that. And if you're asking me to bring in Scripture I can, but it still doesn't mean that I'm fixing a problem because I'm utilizing this tool."*

Of course, some therapists may feel uncomfortable about using the Bible, just as some therapists may feel uncomfortable about providing counseling to LGBTQ clients. In such a situation, the best thing to do would be for the therapist to refer the client to someone else since the therapist would be unable to check herself at the door. Across the interview data, the main sentiment that emerged from the participants that it was morally wrong to judge or condemn LGBTQ people, but that if a therapist truly could not get over negative biases in this regard, then as a matter of professionalism the therapist should not be working with that client. The moral judgment against bigotry was thus combined with the professional judgment about what is actually expected of good therapists.

## Unique Factors

In listening to the experiences shared by the participants, there were relevant factors that stood out to me as I transcribed and analyzed the data. It appeared that Gaylia's journey and exposure to discrimination against persons who identified as LGBT appeared reverse; meaning she was more aware of the homophobia that existed as an adult rather than being taught this learnt thinking and behavior as a child as was the case with the other two participants. In analyzing the data, unique factors emerged that may have contributed to Gaylia's childhood experiences and influenced her attitude toward persons who identify as LGBTQ. Gaylia was the only participant that was born in the United States, residing in New York from childhood until young adulthood. She described her environment as *culturally blended; nobody was pointed out like, you're Black, you're Caribbean, you're Gay, you're Lesbian. You just were...* Having this perception early on, there may have been less opportunities for a cultural and societal predisposition for homophobic attitudes and beliefs.

Another unique factor discovered through Gaylia's shared experience was the interconnection of racism and sexual orientation discrimination. Gaylia voiced that it was easier to empathize with persons who identify as LGBTQ because she herself had experienced discrimination being a Black woman.

**Gaylia:** *You know, that's another form of racism through someone's sexuality-*

**Interviewer:** *Mm-hmm*

**Gaylia:** *- and pointing them out and putting them into a class, in a group. Why did I ask to be put in that group?*

**Interviewer:** *Mm-hmm.*

**Gaylia:** *No. You put me in that group. Right, so then if you put me there, then am I really the one with the problem or are you the one with the problem?*

This empathetic actualization has allowed Gaylia to remain nonjudgmental in her work with other marginalized groups including persons who identify as LGBTQ.

### **Summary**

In this chapter, the themes that united the stories shared by the participants in this study were explored and analyzed. The interviews and data transcription led to highlighting emerging superordinate themes such as Homophobia with culture and religion being subthemes; and Evolving Views with subthemes of making connections with the LGBTQ community and checking yourself at the door. Each semi-structured interview with the participants were uniquely different in terms of the journey experienced, however the themes were strong and consistent throughout. Chapter V will discuss a deeper connection to previous literature, implications and discussions of the study relevant to future practices within the field of Family Therapy.

## **Chapter V: Discussion and implications of the study**

This study was designed to explore and understand the lived experiences of Afro-Caribbean Marriage and Family Therapists working with persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning. This was successfully accomplished utilizing Interpretative Phenomenological Analysis which created the space for participants to share their unique experiences while simultaneously giving voice to my own experience. Due to the lack to research found during the literature review process, this exploration appeared to be uncharted territory. The collected and analyzed data will help to expand the existing body of literature, increasing the understanding of experiences lived and shared by Marriage and Family Therapists of Afro-Caribbean descent, in hopes of allowing other Afro-Caribbean Therapists to share their struggles as well so that we may learn from them.

### **What's the connection with the literature?**

#### **Similarities**

The experiences shared by the participants in the study about their earliest exposure and cultural attitudes experienced toward persons who identified as LGBTQ, echoed those of the exiting literature. For example, Sergio is of Jamaican descent shared of his initial awareness of homosexuality and how his thoughts and perception were formed by attitudes and comments made by his own family members. The early literature reports that Jamaica has a known reputation for their deleterious treatment of homosexuals (Human Rights First, 2012). This small island in the Caribbean is infamous not only for its anti-gay laws, political hostility and violence, but also for its broad societal acceptance of severe sexual prejudice (West, 2014). Gaylia shared

of the division of acceptance toward LGBTQ persons based on what town you were from in Barbados. It is worth noting that a similar divide could even be seen in America as well. The urban centers and the coastal states tend to be more open toward LGBTQ issues, while the South and in general the "red states" tends to be more closed off against such issues (Pew Research Center, 2014). In other words, the split between openness and closedmindedness described by Gaylia would not seem to be a unique feature of Afro-Caribbean culture per se. Rather, it would seem to be reflective of a liberal/conservative split that is occurring *within* most cultures, with liberalism being associated with urban areas and conservatism being associated with rural areas. This matches with the insight from the relevant literature that religiosity generally correlates with incompetence when dealing with LGBTQ issues (McGeorge, Carlson, & Toomey, 2014).

## **Differences**

In this study, different is ideally good. The data presented during the literature review process, were loaded with negative experiences, attitudes, and a high intolerance for persons who identified as LGBTQ. These were the views and experiences that researchers beforehand have discovered about the Caribbean culture. I am ecstatic that the stories and experiences shared by the participants tell a different narrative; one of inclusivity, acceptance and a more evolved culture from their respective countries of Jamaica, Barbados, and Puerto Rico. Much of the research exploring mental health clinicians' work with persons who identify as LGBTQ, highlighted connections between religion and competency of the clinician; asserting that their religious beliefs prohibited them from working effectively with this marginalized population. Going back to the existing literature, McGeorge and colleagues (2014) cite Balkin et al. (2009) when stating that there is a definite link between religious training and homophobia. Bowers et



al. (2010), Fall et al. (2013) and Fischer and DeBord (2007) are additionally referenced when the authors note that religiosity creates a conflict for the clinicians in regard to quality care provision. In 2019, having explored that same connection with all of the participants, the data shed a more positive light in that despite being of Christian faith, their competency to work with persons who identified as LGBTQ was not limited or influenced by their faith. In fact, participants shared that their religious beliefs have not wavered in their work within the field, including when working with persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning.

### **Strengths and limitation of the study**

This study helped to explore a phenomenon that has historically seen little to no research. One of the primary strengths of the study has been the use of IPA. In utilizing this method, I was able to build a rapport with the participants and establish a connection of trust that allowed them to share both their successes and struggles in working with persons who identified as LGBT. I do not believe that I would have gathered such intimate and rich data from each participant without utilizing this qualitative research method. The sample size proved to be an additional strength. All three participants of Afro-Caribbean descent shared quite a unique journey that led to the evolution of their thinking and practice, thus helping to enrich the common themes discovered, and add validity to the data collected. All three participants identified as being of Christian faith, helping to strengthen a homogenous view. The information collected has not been written about before thus adding new and relevant data to the limited research in the field regarding the experiences of Afro-Caribbean Marriage and Family Therapists and their experiences in working with persons who identify as LGBTQ.

As perceived, there were a few limitations that I would be remiss not to address. The researcher found the recruitment process to be a bit of a challenge. In utilizing the recruitment methods mentioned in chapter 3 where flyers were placed around mental health agencies and universities, the researcher assumed this would allow for maximum visibility in order to increase participation, however this method proved to be challenging. Although sufficient for the purpose of the study, the sample size was small. A larger and more diverse sample size in regards to gender and length of experience in the field would be more beneficial in increasing the research made available regarding the Afro-Caribbean demographic. Since, all of the participants have been practicing in the field for 5 plus years, the data collected might have been presented differently had the years of experience in the field been less than 5 years or a recent graduate.

### **Themes' connection to the gap in existing literature**

The two superordinate themes of Homophobia and Evolving Views, highlighted and explored in chapter 4 would seem to trace a rather elegant arc. The first theme sheds light on the historic influences of the Afro-Caribbean culture and its spread of homophobic beliefs rooted in its local culture and religion, such that the participants of the present study were generally socialized and brought up to see things in this manner. The second theme, though, illustrated that higher education, knowledge, and experience catalyzed the evolution of the participants' views in this regard, with actual experiences with LGBTQ people proving to be crucial of this positive shift in perspective and influence. This theme birthed a subordinate theme that points toward a nuanced view of professionalism in counseling, in which it is morally wrong to negatively judge LGBTQ people but also more broadly wrong at a strictly professional level for the therapist to bring his/her own personal baggage into the therapy session. The lived experience of the Afro-

Caribbean therapists can thus be characterized by development and evolution both in terms of personal views and in terms of professional ethos.

The hopeful note that can be drawn from the first theme, though, is that culture does not necessarily exert a determining influence on the views of individual people within that culture. However, for some of the participants and maybe other practitioners, the cultural influence at some point or another has tainted the perception of our knowledge and fair treatment of persons who identify as LGBTQ. In exploring and analyzing this theme of homophobic home culture, the main conclusion that can be reached is that in order for Afro-Caribbean therapists to work effectively with LGBTQ clients, it would have been necessary for them to overcome a great deal of cultural conditioning delivered to them by their home cultures. All three of the participants of the present study were brought up with a homophobic Caribbean cultural lens, and yet their views clearly evolved, to the point where the participants sometimes even challenged their own families' negative biases and perceptions. If change is to happen, then this is surely how it must happen. It would be more productive to encourage such developments rather than to simply condemn a culture as a whole.

One of the most interesting points that emerge from these findings, though, consists of the role that socialization *as therapists* can play in the treatment of personal biases. All three of the participants indicated that it would be wrong to impose their own personal values and views, whatever they may be, on the client. It would seem that being trained as a therapist can thus help professionals develop a kind of beneficent relativism, where it is understood that there are no "right" answers that are universally applicable to all people and that the right answer for any given client will consist not of what the therapist wants but rather of what the client him/herself wants. It would seem that getting into the practice of adopting this standpoint would in itself

steadily erode negative biases about a range of issues, including LGBTQ issues. It is as though the participants came to understand not only that LGBTQ people are not bad as a result of personal experiences with such people, but also through the basic fact that calling people "bad" in such categorical terms would be against the very ethos of their own profession.

### **Implications**

The findings of the current study add valuable information regarding the Afro-Caribbean clinicians in the field of Marriage and Family therapy. The data collected will serve as a tipping point to a larger systemic conversation that has been tabooed for long enough. Speaking from my own experience, it can be difficult to be transparent about struggles that one encounters as a clinician such as experiencing burnout or working with unknown when it is assumed that 'you're expected to know.' A key implication here is that therapists, irrespective of their cultural backgrounds, may tend toward open-mindedness and evolution of views at least in part as a result of their socialization as therapists. Further research would be needed in order to explore this assumption. What is clear, though, is that the participants of the present study each experienced significant growth and evolution over the course of their lived experiences. Therapist training programs can help to reinforce the elements that could give rise to this kind of progress. One of the participants shared that their turning point to being more open-minded about seeing persons who identify as LGBTQ in a different light, came about during an assignment in which he had to interview members of the LGBTQ community. It was through asking the wrong questions that maintained his ignorance that he found enlightenment and understanding about what he did not know about the population.

Ethical Implications

So, is it ethical? It has been established that therapists of Afro-Caribbean descent have mostly been pre-disposed to discriminate against persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning. This homophobic perspective has been rooted in their culture and additionally their religion. So, is it ethical? To refer out a client who identifies as LGBTQ? This has been a dilemma left unanswered in our field of Marriage and Family Therapy. However, it has occurred and unfortunately it will continue to occur if we allow our cultural and religious makeup to dictate who we treat. As Mental Health professionals, we are tasked with upholding the values that AAMFT embodies, those of acceptance, appreciation, and inclusion. Afro-Caribbean therapists, Afro-Caribbean, people of color have historically been a marginalized group. As professionals in the field of Marriage and Family Therapy it seems almost ironic that we would now want to exercise that same discrimination on to another marginalized group of people simply because of their sexual identity. Is it discrimination or lack of competence?

In his article in the *Family Therapy Magazine*, Caldwell (2011) wrote that,

Within the field of MFT, no consensus has emerged on how such a dilemma should be handled, and there has been no test case before the AAMFT Ethics Committee. In the absence of such guidance or consensus, MFTs, including supervisors and instructors, are left to implement the existing Code of Ethics as best they can. The result is a variety of positions on whether an MFT can ethically refuse to treat clients based on the therapist's religious views. (p.51)

This study has further implications for both current and future Marriage and Family Therapists and training programs. This is an opportunity to ensure that clinicians entering into

the field are well equipped and competent to handle any challenges presented without treading the thin lines of laws and ethics. Supervisors and training programs should aim to ensure that therapists leaving their respective academic programs are mentally and emotionally prepared to enter the diverse workforce. An increase in exposure and open dialogue to address concerns and barriers surrounding diverse and marginalized populations is vital. It is imperative that programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), continue to train and educate their students regarding taboo and uncomfortable topics. It is through creating awareness and sharing our biases in safe training environments that we will be able to reduce harm in our practice not only as an evolving clinician but additionally in our work with vulnerable clients. This can be accomplished on any educational level but would be extremely beneficial to students in the Master's programs prior to entry into clinical practicums and the work field via externships and post-graduation. The path of least resistance may accomplish completion in academic requirements, however unaddressed biases will not help you to prepare for challenges you may face as a clinician in order to provide effective treatment for clients that create positive and lasting change. It is our duty as experienced clinicians in the field to ensure that those that come after us are held to the highest standard of accountability to abide by the AAMFT Code of Ethics, not only when it is convenient or selective but all of the time, in its entirety. Pleading ignorance of the law of the AAMFT Code of Ethics, is not a justifiable excuse for covert discrimination against persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning.

## Future Research

It is possible that the participants selected for the present study were anomalous in some way. This would seem to be unlikely but given that there were only three participants from a single cultural background, future research should be conducted with other participants as well from different backgrounds. It would be helpful to know if other Afro-Caribbean Marriage and Family Therapists or Mental Health clinicians share the same sentiments, and/or if cultural and religious influences have impacted or prohibited their evolution of acceptance toward working with persons who identify as LGBTQ. In my observation as a Marriage and Family Therapist, it appears that the more experienced clinicians (meaning longer length of time as a practicing clinician) of Afro Caribbean descent may be more rigid in their thinking and resistant to being more accepting in working with LGBTQ individuals and families. I would be interested in conducting future research to explore my assumptions regarding this or if there may be alternative factors that influence their non-inclusion of working with this population. The majority of the findings in the existing literature and present study share attitudes and views regarding gay men with strong negative views attached, however little to no findings disclose of the cultural views and attitude surrounding lesbian females. I would be curious to know if this population share the same level of disdain by Caribbean cultures or if the attitudes and views toward female homosexual relationships are met with positive reception or seen as non-threatening. This study has explored the general perception and beliefs regarding persons who identify as LGBTQ in the Caribbean culture, future research exploring specific sexual identities such as persons who identify as Transgender would also help to the body of literature in the field of Family Therapy. The promising conclusion for now, though, is that a combination of personal

experience and professionalization can lead to significant evolution in therapists' views on LGBTQ issues.

### **Summarizing thoughts**

Being an Afro-Caribbean Marriage and Family Therapist working with LGBTQ individuals and families, it was an invaluable experience to see that there were other clinicians whose struggles mirrored my own. Growing up in the Turks and Caicos Islands, exposure to persons who identified as Lesbian, Gay, Bisexual, Transgender and/or Questioning were very limited at the time and even when the conversation occupied my kitchen table, it was discussed with high intolerance and dismissive. This left me conflicted when I came to the United States and I began my journey as a systemic thinking Marriage and Family Therapist. I did not feel that my forward thinking and open reception of the LGBTQ population would be met with acceptance in sharing my experiences with my Caribbean family who hold strong cultural and religious beliefs regarding this marginalized population. This is still a challenging process and a work in progress for me. However, through this research journey, I am hopeful that there is still an opportunity for positive change and inclusivity within my family of origin and my country, the Turks and Caicos Islands, as I have witnessed in my participants' family and country's culture. It is my hope that we can learn to see beyond the 'thing' that marginalizes us; beyond the sexual identity, beyond the color, beyond the biases. Effective mental health treatment services should be encouraged and utilized by everyone regardless of one's sexual identity, race, and/or religion. As Marriage and Family Therapist, if we can accomplish this, we can begin to see our clients beyond our biases and treat the clients' presenting problems.



## References

- Butler, C. (2009). Sexual and gender minority therapy and systemic practice. *Journal of Family Therapy*, 31(4), 338-358. doi:10.1111/j.1467-6427.2009.00472.x
- Caldwell, B. (n.d.). The Dilemma: Can a Religious Therapist Refuse to Treat Gay and Lesbian Clients? *Family Therapy Magazine, September/October* (2011), 50-52. Retrieved June 16, 2019, from <https://www.aamft.org/documents/FTM/SO11.FTM.pdf>
- Carlson, T.S., McGeorge, C.R. & Toomey, R.B. (2013, April). Establishing the validity of the affirmative training inventory: Assessing the relationship between lesbian, gay and bisexual affirmative training and students' clinical competence. *Journal of Marital and Family Therapy* 39 (2). 209-222. DOI: 10.1111/j.1752-0606.2012.00286.x Retrieved from <http://www.ebscohost.com>
- Creswell, J. W. (2013). *Qualitative Inquiry & Research Design: Choosing among Five Approaches* (3rd ed.). Thousand Oaks, CA: SAGE.
- DeMarrais, K. B., & Lapan, S. D. (2004). *Foundations for research: Methods of inquiry in education and the social sciences*. Mahwah, N.J: L. Erlbaum Associates.
- Greenfield, B. H., & Jensen, G. M. (2016). Understanding the lived experiences of patients: Application of a phenomenological approach to ethics. *Physical Therapy*, 90(8), 1185-1197.
- Hickling, F.W., Robertson-Hickling, H. & Paisley, V. (2011, March). Deinstitutionalization and attitudes toward mental illness in Jamaica: A qualitative study. *Rev Panam Salud Publica* 29 (3). 169-176. Retrieved from <http://www.scielosp.org/pdf/rpsp/v29n3/04.pdf>

- Hickling, F.W. & Gibson, R.C. (2012). Decolonization of psychiatric public policy in Jamaica. *West Indian Medical Journal* 61 (4). 437-441. Retrieved from <http://caribbean.scielo.org/pdf/wimj/v61n4/25.pdf>
- Human Rights First. (2012). Fact sheet. *LGBT issues in Jamaica*. p. 1 Retrieved from <http://www.humanrightsfirst.org/sites/default/files/Jamaica-LGBT-Fact-Sheet.pdf>
- Imber-Black, E. (2014). Eschewing certainties: The creation of family therapists in the 21<sup>st</sup> century. *Family Process* 53 (3) 371-380 DOI: 10.1111/famp.12091 Retrieved from <http://www.ebscohost.com>
- James, C.C. & Peltzer, K. (2011, Oct. 2). Traditional and alternative therapy for mental illness in Jamaica: Patients' conceptions and practitioners' attitudes. *Medline* 9 (1). 94-104. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/23983326>
- Kelly, E. (2010, July 26). Couples counselling saved my marriage. *CNN.com* p. 1 Retrieved from <http://www.cnn.com/2010/LIVING/07/26/couples.counseling.tf/>
- LaSala, M. C. (2000). Lesbians, gay men, and their parents: family therapy for the coming-out crisis. *Family Process*, 39(1), 67-81.
- LaSala, M.C. (2013). Out of the darkness: Three waves of family research and the emergence of family therapy for lesbian and gay people. *Clinical Social Work* 41. 267-276. DOI 10.1007/s10615-012-0434-x Retrieved from <http://www.ebscohost.com>
- Lev, A.I. (2010). How queer! -The development of gender identity and sexual orientation in LGBTQ-headed families. *Family Process* 49 (3) 268-291. Retrieved from <http://www.ebscohost.com>

- Levy, L. (2008). Including gay and lesbian couples in a premarital education program in reform congregations. *Journal of Jewish Communal Service* 83 (3). 155-164. Retrieved from <http://www.ebscohost.com>
- Linville, D. & O'Neil, M. (2016). Same sex couples and their children. *American Association for Marriage and Family Therapy*. p. 1 Retrieved from [https://www.aamft.org/imis15/aamft/Content/Consumer\\_Updates/Same-sex\\_Parents\\_and\\_Their\\_Children.aspx](https://www.aamft.org/imis15/aamft/Content/Consumer_Updates/Same-sex_Parents_and_Their_Children.aspx)
- Malley, M. (2002). Systemic therapy with lesbian and gay clients: a truly social approach to psychological practice. *Journal of Community & Applied Social Psychology*, 12(3), 237-241. doi:10.1002/casp.676
- McGeorge, C.R., Carlson, T.S. & Toomey, R.B. (2014). The intersection of spirituality, religion, sexual orientation and gender identity in family therapy training: An exploration of students' beliefs and practices. *Contemporary Family Therapy* 36. 497-506. DOI: 10.1007/s10591-014-9312-8 Retrieved from <http://www.ebscohost.com>
- McNamee, S & Gergen, K (1992). *Therapy as Social Construction (Inquiries in Social Construction series)*
- Miller, D. (2002). An introduction to Jamaican culture for rehabilitation service providers. *Cirrie*. p. 1 Retrieved from <http://cirrie.buffalo.edu/culture/monographs/jamaica/>
- Moustakas, C. E. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Ontario Ministry of Children and Youth Services (2013). Review of the roots of youth violence. *Literature Reviews* 5 (2). p. 1 Retrieved from

[http://www.children.gov.on.ca/htdocs/English/topics/youthandthelaw/roots/volume5/chapcha02\\_psychological\\_theories.aspx](http://www.children.gov.on.ca/htdocs/English/topics/youthandthelaw/roots/volume5/chapcha02_psychological_theories.aspx)

Perlesz, A., & McNair, R. (2004). Lesbian parenting: insiders' voices. *Australian & New Zealand Journal of Family Therapy*, 25(3), 129-140.

Perlesz, A., Brown, R., Lindsay, J., McNair, R., de Vaus, D., & Pitts, M. (2006). Family in transition: parents, children and grandparents in lesbian families give meaning to 'doing family'. *Journal of Family Therapy*, 28(2), 175-199. doi:10.1111/j.1467-6427.2006.00345.x

Premdas, R.R. (1996). Ethnicity and identity in the Caribbean: Decentering a myth. *Kellogg Institute for International Studies* 234. 1-47 Retrieved from <https://kellogg.nd.edu/publications/workingpapers/WPS/234.pdf>

Ritter, K. (2015). Therapeutic issues for same sex couples. *American Association for Marriage and Family Therapy*. p. 1 Retrieved from [https://www.aamft.org/iMIS15/AAMFT/Content/Consumer\\_Updates/Therapeutic\\_Issues\\_for\\_Same-sex\\_Couples.aspx](https://www.aamft.org/iMIS15/AAMFT/Content/Consumer_Updates/Therapeutic_Issues_for_Same-sex_Couples.aspx)

Shallcross, L. (2011, May). Come and be who you are. *Counselling Today*. 24-32. Retrieved from <http://www.ebscohost.com>

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, research, practice*. London: Sage.

Taylor, R., Forsythe-Brown, I., Taylor, H., & Chatters, L. (2014). Patterns of emotional social support and negative interactions among African American and Black Caribbean extended families. *Journal of African American Studies*, 18(2), 147-163. doi:10.1007/s12111-013-9258-1

West, K. (2014, June 6). Why do so many Jamaicans hate gay people? *The Guardian*. p. 1

Retrieved from <http://www.theguardian.com/commentisfree/2014/jun/06/jamaica-music-anti-gay-dancehall-homophobia>

Yin, R. K. (2016). *Qualitative research from start to finish*. New York: Guilford Press.

## **Appendices**

## **Appendix A: Interview Questions**

Title of Study: Exploring the Lived Experiences of Afro-Caribbean Marriage and Family Therapists working with Persons who identify as Lesbian, Gay, Bisexual, Transgender and/or

Questioning: An Interpretive Phenomenological Study

1. What are the views regarding LGBTQ persons in your country?
2. Tell me about the views and interactions you experienced with your family regarding LGBTQ persons and what influenced them.
3. Describe your social support and its influence on your continued work practice.
4. Since receiving education and training in working with gay and lesbian families, how have your views been impacted?
5. How have your conversations about LBGTQ persons with your family been impacted?

## Appendix B: Invitation Letter

Dear Prospective Participant

My name is Raquel Campbell. I am a Ph. D candidate in the Marriage and Family therapy (MFT) doctoral program at Nova Southeastern University. This is a qualitative research study to fulfill partial requirements for my doctorate degree.

Your consideration in participating in the study is greatly appreciated. Sharing your experience regarding this phenomenon, will help to add valuable information to the body of literature in moving the field of Family Therapy forward. The goal of this study is to explore the experiences of working Marriage and Family Therapists (MFTs) of Afro-Caribbean descent who work with persons who identify as lesbian, gay, bisexual, transgender and questioning (LGBTQ). This study will help to advance our understanding on the potential impact of the cultural experiences and how they may or may not contribute to institutionalized homophobia within the Caribbean, by Mental Health professionals, specifically Marriage and Family Therapists.

Eligibility criteria for the study only requires that participants have identified as a working Marriage and Family Therapist of Afro-Caribbean descent, having had experience past or present in working with persons who identify as LGBTQ. One face to face interview will take place between you and the researcher. The interview will last between 60-90 minutes at a mutually agreed upon location such as a private office or the participants' home. The interviews will be audio recorded to aid the researcher in accurately documenting your experiences shared.

Information we learn about you in this research study will be handled in a confidential manner. Your data will be de-identified with the use of pseudonyms in place of your actual name. This data will be available to the researcher, Raquel Campbell, the Institutional Review Board and my dissertation chair, Dr. Martha Marquez. All confidential data which include audio recordings, transcriptions, and correspondence with the interviewer—will be secured in the researcher's private, password-protected computer or stored in a secure, locked cabinet in the researcher's home.

Your participation in this study is entirely voluntary. You are free to withdraw at any time without consequence.

If you are interested in participating, have any questions regarding the requirements for participation, or questions regarding the research study in general, please contact the researcher, Raquel Campbell, via telephone at 954-213-4790, or email at [campragu@nova.edu](mailto:campragu@nova.edu). Thank you for your consideration in participating in this study.

Sincerely,  
Raquel Campbell, M.S.  
Ph.D. Candidate



## Appendix C: Informed Consent

Consent Form for Participation in the Research Study Entitled: *Exploring the Lived Experiences of Afro-Caribbean Marriage and Family Therapists working with Persons who identify as Lesbian, Gay, Bisexual, Transgender and/or Questioning: An Interpretive Phenomenological Study*

IRB protocol #:

School: Nova Southeastern University

College of Arts, Humanities, and Social Sciences  
Department of Family Therapy

Principal investigator  
Raquel Campbell, M.S.  
3101 Palm Trace Landings Drive #1303  
Davie, FL 33314  
954-213-4790

Dissertation Chair/Co-investigator  
Martha Marquez, Ph.D.  
3301 College Avenue  
Fort Lauderdale, FL 33314  
954-262-3056

Funding Source: None

### **What is the study about?**

You are invited to participate in a research study. The goal of this study is to explore the experiences of working Marriage and Family Therapists (MFTs) of Afro-Caribbean descent who work with persons who identify as lesbian, gay, bisexual, transgender and questioning (LGBTQ). This study will help to advance our understanding on the potential impact of cultural experiences and how they may or may not contribute to institutionalized homophobia within the Caribbean, by Mental Health professionals, specifically Marriage and Family Therapists.

### **Why are you asking me?**

You are being asked to participate in this study because you have identified as a working Marriage and Family Therapist of Afro-Caribbean descent, having had experience past or present in working with persons who identify as LGBTQ.

### **What will I be doing if I agree to be in the study?**

If you choose to participate in this study, the researcher will contact you by phone for screening to confirm eligibility criteria. You will then be asked to sign the consent form provided by the researcher who will answer any questions regarding the process at this time. One face-to-face interview will take place between you and the researcher. The interview will last between 60-90 minutes and will take place at a mutually agreed upon location such as a private office or the participants' home. The interview will consist of open-ended questions guided by the researcher, as well as follow up questions that may arise as a result of your

response(s). Your participation in this study is voluntary. There is no penalty for withdrawing from the study.

**Are there possible risks and discomforts to me?**

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life. Because of the sensitive nature of the research study in discussing personal feelings and experiences regarding cultural upbringing, family, and attitude toward persons who identify as LGBTQ, it is possible that you may experience some emotional discomfort while discussing your experiences during the interview. If you are asked a question that you do not feel comfortable answering, you may request to skip that question or take a break from the interview.

**What happens if I do not want to be in this research study?**

You have the right to leave this research study at any time or refuse to participate. If you decide to leave or you do not want to be in the study anymore, you will not get any penalty. If you choose to stop participating in the study before it is over, any information about you that was collected **before** the date you leave the study will be kept in the research records for 36 months from the end of the study and may be used as a part of the research.

**What if there is new information learned during the study that may affect my decision to remain in the study?**

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

**Are there any benefits for taking part in this research study?**

There are no direct benefits from being in this research study. We hope the information learned from this study will help to uncover valuable information that will add to the body of literature in our field of study.

**Will I be paid or be given compensation for being in the study?**

You will not be given any payments or compensation for being in this research study.

**Will it cost me anything?**

There are no costs to you for being in this research study.

**How will you keep my information private?**

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. All confidential data which include audio recordings, transcriptions, and correspondence with the interviewer—will be secured in the researcher's private, password-protected computer and/or stored in a secure, locked cabinet in the researcher's home. Your data will be de-identified with the use of pseudonyms in place of your actual name. This data will be available to the researcher, the Institutional Review Board and my dissertation chair, Dr. Marquez. If we publish the results of the study in a scientific journal or book, we will not identify you. All data will be kept for 36 months from the end of the study and destroyed after that time by the researcher, Raquel Campbell.

**Is there any audio or video recording?**

This research study involves audio recording of the interviews conducted. This audio recording will be available to the researcher, Ms. Campbell, the Institutional Review Board and the dissertation chair, Dr. Marquez. The recording will be kept, stored, and destroyed as stated in the section above. Because what is in the recording could be used to find out that it is you, it is not possible to be sure that the recording will always be kept confidential. The researcher will try to keep anyone not working on the research from listening to the recording.

**Whom can I contact if I have questions, concerns, comments, or complaints?**

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:

Raquel Campbell, M.S can be reached at (954)-213-4790

If primary is not available, contact:

Martha Marquez, PhD can be reached at (954)-262-3056

**Research Participants Rights**

For questions/concerns regarding your research rights, please contact:

Institutional Review Board

Nova Southeastern University

(954) 262-5369 / Toll Free: 1-866-499-0790

[IRB@nova.edu](mailto:IRB@nova.edu)

You may also visit the NSU IRB website at [www.nova.edu/irb/information-for-research-participants](http://www.nova.edu/irb/information-for-research-participants) for further information regarding your rights as a research participant.

**All space below was intentionally left blank.**

**Research Consent & Authorization Signature Section**

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

**SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:**

- You have read the above information.
- Your questions have been answered to your satisfaction about the research.

**Adult Signature Section**

I have voluntarily decided to take part in this research study.

\_\_\_\_\_

Printed Name of Participant

\_\_\_\_\_

Signature of Participant

\_\_\_\_\_

Date

## Biographical Sketch

Raquel Campbell is a native of the Turks and Caicos Islands. Through academic excellence she received a full scholarship upon graduating from Raymond Gardiner High School in 2004 to attend the University of her choosing, anywhere in the United States. Campbell attended Nova Southeastern University where she simultaneously worked full time and matriculated through her entire academic career. She received her Bachelor's degree in 2009 earning a Bachelor of Science in psychology with a minor in sociology and family studies. In that same year, she went on to pursue a Master's degree in Family Therapy, completing that journey in 2011. During that time, Raquel gained experience working in the clinic at the Brief Therapy Institute with individuals and families, both court mandated and voluntary addressing issues ranging from anxiety to substance abuse. Having been exposed to the inner workings of systemic thinking and intergenerational patterns as she discovered her own identity within her family of origin, her thirst for knowledge increased. She decided to enter the PhD program for Family Therapy, deepening her knowledge and clinical experience as a therapist.

Since 2011, Raquel has been working with at risk youth and vulnerable populations both in the school systems and children in relative and non-relative foster care. Raquel is passionate about helping youth to change their narratives, overcoming early childhood trauma that may be impacting their functioning as an adolescent and young adult. Currently, she is the only resident Clinical Therapist at a non-profit organization named HANDY, Inc. Raquel started the therapy program at HANDY, Inc. in 2016 and has been instrumental in creating and implementing therapeutic procedures servicing over 90+ children between the ages of 14-21 in a given year. Raquel gained her license in Marriage and Family Therapy in 2018, and has now successfully completed requirements in earning her PhD.

Raquel hopes to continue in her work with vulnerable populations addressing barriers and discovering best practices for all therapists who struggle in working with marginalized populations, especially Afro-Caribbean therapists. Additionally, her future career goals include entering the world of academia, teaching diversity and inclusivity to students across all higher learning levels. Raquel hopes to open her private practice, specializing in working with Caribbean individuals and families, addressing taboo topics and creating awareness within the community of covert discrimination that has been culturally engrained in us for generations.

One of Raquel's immediate goals focuses on helping doctoral students to effectively navigate through their dissertation process by means of a dissertation peer mentor. She believes that this will help to reduce 'extended breaks' not due to unforeseen circumstances, but also increase support and motivation among doctoral students in completing their dissertation in a timely manner.