

TENSIONS AMIDST VIOLENCE: ENCOUNTERING THE EVERYDAY REVELATION

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The following narrative describes the author's experience conducting an exploratory assessment project designed to examine the intersection of Domestic Violence and Sexual Violence (DV/SV) programs and the mental health service system in a small New England state. Although this particular project focused on the standpoint of DV/SV program staff, it is as much her story about what she found as assessor. It was conceived as "Part 1" of a larger project. Future efforts will explore the positions of mental health staff and address the experience of survivors of DV/SV.

"As I work within the movement today, I am still amazed at what has been accomplished, surprised and disappointed by what we fail to foresee, and awed by the passion, pain and renewal in the work of liberating women from tyranny and violence. Luckily for me, revelations continue. May they also continue for those who come next!"

- Susan Schechter, DV/SV scholar and activist, April 2003, deceased February, 3, 2004

This narrative about an assessment project is one sided on at least two levels. In addition to its purposeful and exclusive emphasis on the experiences and beliefs of DV/SV program staff, it is also, more narrowly, my story as program researcher. In it I act as a solitary, certainly not "objective," inquirer with a particular personal work history as a social work practitioner in the mainstream mental health system. In this story I meet up with another system, the grass roots DV/SV movement, in which there are unique and incredibly resilient people who are occupied in some of the most contested work the human needs workplace has to serve up. For me, this is a story of revelations.

Arriving Here: Looking Back

The miserable, dripping rain was bone chilling on an early spring afternoon as I got into my car to drive some 35 miles to interview the director of one of the state's DV/SV programs. Having luxuriated all winter in the spare but cozy, inside haven of my home-office while on sabbatical, I began to question whose idea this project was, even though it was certainly mine. What grimmer combination could anyone come up with than

DV/SV and mental illness—unless it was DV/SV and mental illness in a cold, gray drizzle? I reminded myself that this was the real world and that my privilege in enjoying a sabbatical did not mean that I was entitled to confine my experiences to the warm and pleasant. Resolute, I robotically followed the directions I had scribbled in my date book. Missed one turn, caught it right away. Swung around the block and parked in a grocery store lot down the street. A little early, I decided just to sit and regroup in my car, going over my interview questions and getting my bearings.

Instead, my thoughts wandered and rather than preparing me for the conversation to follow, they returned me to how I came to this point. I had fallen in love with the "mental health population" in graduate school when I was (almost literally) commandeered into taking a 24-hour-a-week job as residential staff member in a group home for people with psychiatric disabilities. It was the perfect graduate school "shift," Friday night to Saturday night with an informal but explicit agreement that I would find my replacement when I completed my degree. Rather alarmed at first at the apparently disjointed conversations of the residents and the

expressions of alternative realities that made me uneasy, I tried hard to listen, to stay present. Slowly I became engaged, conversation by conversation, began to appreciate the gifts of different drummers, and found my emotions responding in a way I had no name for. Sometimes I felt tearful; sometimes jubilant; sometimes outraged at the cosmically wacky world in which courts and medications and who happens to be "on" in a hospital admissions department can shape the lives and sometimes blunt the futures of human beings. This experience was so significant for me that after finishing (temporarily) graduate school, I accepted a position as a line social worker at the state hospital. For years I loved it, recognizing the perverse and teeming establishment it was, guilty of all the excesses for which institutions are damned in this postmodern world. It was also vital and intense and provided rare glimpses, remote as they might have been, into the worlds of people whose lives kept unexpectedly touching mine. Many, of course, were women. And many were women who experienced violence every day of their lives in one way or another. I was not oblivious to that but its power eluded me somehow. This pervasive violence, I sensed, was a function of the oppression of mental illness. Not that the violence was imagined, but rather that violence was another of the obstacles that seemed simply to accompany, in inordinate percentages, women and all those people with mental illnesses. Violence in the family made it so much harder for women to go home and get adequate treatment in the community. Violence was a placement problem.

When I took a temporary hiatus from hospital mental health work to become clinical supervisor for a community youth/family center, I found myself, rather by chance, in training to co-facilitate a domestic violence group for men adjudicated by the courts for battering. I inundated myself with the Power and Control Wheel, the dynamics of culture

and society that supported male violence against women, and was horrified at how charming some of the group members were. Having two teenage daughters at the time, I recognized how pleased I'd be if any one of several of the men came calling. Some of them were hugely appealing. And I was learning fast.

When I began to teach at the university, I came to know colleagues in my home department whose commitment to ending violence against women was a major work of the heart. Other colleagues were steeped in critical theory and questioned the nature of our institutions. I was surrounded by academics whose perspectives on the professions and societal arrangements that were always a part of my life were very different from mine. I listened. The complexities of grass roots efforts as they intersect with traditional professionalism provided a fertile and challenging field for self critique on many counts, but especially in relation to my work in mental health.

Coincidentally (and ironically), I started to get calls as the faculty member who "did" mental health, requesting that I work with local agencies and their staffs on mental health issues. Several of these calls came from the local women's shelter and its larger DV/SV program. What did they need to know to work with women who were clearly in mental health distress? Why are there so many women in shelters who show signs of delusions? What do those psychiatric medications do to women? What to do when some of the women scare other residents? How to manage them? What to think about them? How to help? How to be safe? How to avoid re-victimizing them?

Although it would seem intuitive, I began to consider in more depth the idea that intimate partner violence is bad for one's mental health. I steeped myself in understanding such violence as a comprehensive, worldwide, and substantive violation of basic human rights. I

also understood it as a powerfully personal experience. It hit home for me that in the U.S., in each of the states, in cities and villages, at home, in the kitchen, and in the bedroom, nearly one-third of American women (31%) report being physically or sexually abused by a husband or acquaintance at some point in their lives (Commonwealth Fund, 1998) resulting in a "severe" level of injuring, with over a quarter requiring hospitalization. Seven out of 16 of one state's 1999 homicides met the definition of domestic violence related fatalities (Vermont Domestic Violence Fatality Review Commission, 2003).

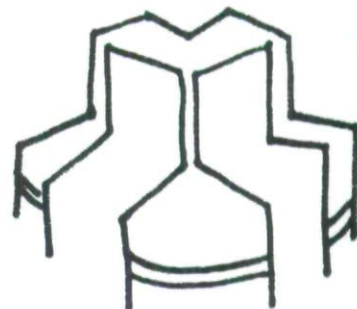
I began to see DV/SV as a complicated and pervasive sociocultural issue. Not in itself defined as a mental health issue, it inevitably creates threats and barriers to all kinds of health. The complex interface between violence and mental health has had a tendency to be illusive at great costs to women and children. The two responding systems at this intersection, community mental health services and DV/SV programs, historically have had vastly different worldviews, different agendas, and a fragmented relationship, precluding an effective, integrated response (Gondolf, 1998). Emerging from the mental health world, I was slow in making meaningful sense of all this. Thick, you might say. DV/SV poses many more significant repercussions for an individual than a simple placement problem. Although it is relatively obvious that it would be central to a person's experience of life and her capacity to think and act clearly and with agency, it became clear to me that it also impacts and jeopardizes the cultural fabric of the society in which all of us live.

Having survived the academy's ancient and relatively odious tenure process, I became interested in applying for a sabbatical. I had been asked to write a book, but I wanted to do something additional with the year, something that would allow me to explore further some murky areas for me and something that would possibly provide some

service to the practice community in which I am rooted. By then I also had some close ties to the relevant players in the state's network of DV/SV programs. I knew that the questions and issues arising in local programs about how to work with women service users who obviously experienced mental health challenges created a growing concern among the staff at all levels. This seemed like a natural place for me to conduct some exploration. After several email exchanges and a few face-to-face meetings, my colleagues at the state level and I began to shape the assessment project whose ultimate purpose is to contribute to a more effective community response to survivors of DV/SV. To that end, the present inquiry was limited to the mental-health related experiences of DV/SV program staff since these were an integral part of that response. Specifically, the assessment was directed toward the following five issues:

- (1) Determination of the types and frequencies of mental illness diagnoses of the women served in the DV/SV programs across the state.
- (2) The behavioral concomitants associated with mental illness that are brought to the attention of agency and shelter staff.
- (3) The types of "in house" (within the program) interventions or management strategies that have been introduced and their effectiveness.
- (4) The types of referrals that work and do not.
- (5) Any areas that are identified by program staff as missing in the above emphases.

When I looked at my watch again, I saw that I now had about a minute before my appointment ("respectable enough," I thought) and so made my way through the leftover slush in the parking lot and up the street to the shelter. I was greeted by the director's warm



smile and an expansive laugh as she proclaimed the wetness a gift from the gods! This was my first glimpse into a very different perspective (if only about the weather)—only one of which I was about to encounter on this adventure.

Getting Started: Reviewing the Literature

Before completing the arrangements to carry out this assessment, I engaged in a literature research to get a sense of what had been studied formally and what ideas were current. Historical perspectives on both the mental health system and the DV/SV movement separately seemed important as well as the relationship between them that has occurred since the inception of “the women’s movement” of the late 1960’s.

Mental Health. I came to this project understanding that in U.S. culture, mental health has been seen as the property of the medical establishment for over 200 years. In graduate school we were amused to discover that in earlier days mental illness was thought to be connected to bodily fluids or “humours.” “Bad bile,” for example, was thought to create bizarre behaviors. The eugenics movement of the first third of the 20th century referred to the “defective germ plasm” (Whitaker, 2002, p. 57)—a horrifying phrase—of people with mental illness. In today’s emphasis on brain biochemistry, another kind of connection between physiology and mental health is made. But, however its link to the body is characterized, mental health is only rarely associated with social issues or environmental context. Mental health exists, as far as one can tell from today’s currency, *within* and is bound and protected by the parameters of the body-mind constellation. In a largely Western-oriented view, mental health is observed and treated from the outside, by an expert who studies it. “Alienists” and physicians, “shrinks” and therapists, have all contributed to the literature that conceptualizes

mental health as a commodity within the individual’s repertoire. One has it or not. This seems to create a natural segue for women with mental health struggles who experience violence to be seen as flawed and somehow at fault, as if they bring on their own brutalization by their partners. Terms like “lack of ego” and “poor self esteem,” which at one time made sense to me, began to seem suspect. Still they make a malevolent kind of sense given the assumptions of inner mental defectiveness.

DV/SV. In contrast, I came to understand this movement as characterized by its grassroots origins and emphasis on the *social* and *political* aspects of the problem of battering women. Although I have lived through successive portraits of the batterer as ill, criminal, blameworthy, and generational, the DV/SV movement tends to put responsibility for violence jointly on the individual executing it and on the culture that supports, tolerates, and often condones it. This characterization sometimes feeds a portrayal of feminist advocates as humorless, critical, and negative “man haters.” This has been unsettling for me, not only because I think this view of feminism is nonsense, but because I feel certain the assertions made about the role of culture in sustaining violence are in fact operant. The challenge for me then, has been to hold this conviction without abandoning a basically positive view of people’s capacity for change.

Intersection: Perspectives

The perspectives here of mental health and DV/SV represent important differences in worldview that are “not to be minimized” (Warshaw, 2003, p. 6). This is not just because of the implications for current theoretical approaches, but also because of a lingering sense of threatened identity, each system by the other. This is where the going gets sticky. For example, some DV/SV advocates are fearful that any

“professionalizing” of their programs will dilute their grassroots commitment to empowerment and to the conviction that this kind of violence is *socially* constituted and sustained. Likewise, mental health workers (perhaps like me in the past) may minimize the important impact of social experience and are committed to the discipline of sharply honed diagnoses, among other medical trappings, that bear the countenance of “science,” which is highly valued.

Longtime antiviolence writer Edward Gondolf (1998) added to my understanding of this phenomenon as he writes about the disconnects between these two systems in the way they originated and have been sustained through some 40 years. The dimensions of difference relate to how each system analyzes the issue DV/SV, defines the problem, characterizes the dynamics, prioritizes the objective of intervention, offers service, and envisions the system’s social aim.

Intersection: Experience

With these theoretical dimensions more fully expanded in the literature, I began to see the question of worldview as critical and I wanted to explore accounts of how they play out with real people in real life seeking real help. The context of serious mental illness exacerbates and confounds the experience of domestic violence in women (Elizabeth Stone House, 1986). This seemed to me tantamount to saying violence isn’t good for your mental health and vice versa, that fragile mental health does not deal well with violence. The notion of determining which comes first becomes increasingly inconsequential. Experiential accounts of women with established mental health issues prior to the experience of violence and similar accounts of those whose mental health challenges are intricately woven into previous or childhood violence highlight an extremely complex relationship in which the establishment of cause and effect timing variables are muddled at best. Yet, the

repercussions of violence for those with serious mental health problems seem, by all accounts rather ominous.

At this stage, I began to feel some trepidation. The literature seems to augur a rocky course in the integration of perspectives and experience and a certain sense of weight enveloped me. No wonder this is a problem, I thought, and where will it lead? How will it be to carry out this exploration while negotiating the polarized dimensions of mental health in DV/SV work?

Inventing Instruments

Initially, I worked with a member of the statewide coordinating office to develop several interview guides, informed by the literature, which would structure my meetings with various program staff in their particular roles. For example, we aimed a group of questions at shelter staff to address the specific issues encountered vis-a-vis the service users of shelter. Likewise, we crafted a set of questions to explore the experiences of court advocates as they worked with the legal system on behalf of women with mental health challenges. We also worked at developing questions for workers who primarily were focused on children and the effects that DV/SV and mental health issues of their (usually) mothers had on them. The emphasis of programs dealing with sexual violence (only) was somewhat distinctive from those whose main focus was domestic violence; this created different service dynamics. For example, a woman’s experience of flashbacks of sexual violence (a psychological or mental health phenomenon) might precipitate an offer of shelter in a sexual violence program. Shelter is likely to be limited in battering situations to women who are at immediate, physical risk.

This process of instrument invention was (not surprisingly) painstaking and stressful for a time. Although not exactly a tribulation, it was certainly a challenge. For example, the

first question regarding the frequency of mental health issues seen by staff took a lot of honing, with the issue being (basically) "What do you mean by mental health issue?" This is, to be sure, a tricky question in the context of violence. We finally decided to make several distinctions at the beginning of each focus group and each individual interview regarding the language of "mental health issues" as it was used in this inquiry. Differentiation was made among (1) those with formal contacts in the mental health system and with a documented *Diagnostic and Statistical Manual of Mental Disorders, T-R* (DSM-IV-TR) (APA, 2000) diagnosis, (2) those who would (in the participant's judgment) probably be diagnosed if they participated in the system, and (3) those who seemed to experience mental health distress as a relatively mild and logical (and not meeting *DSM* criteria) repercussion of the experience of violence. This last category, of course, remained subject to a lot of individual interpretation. Substance use/abuse was included in this terminology as a *DSM-IV-TR* category. The two primary reasons we made this distinction among distress levels were to create a common language base and to get a sense of how extensively individuals in the DV/SV system were connected (or not) to the mental health system.

As I became increasingly involved in its potential duplicity, I became more engaged in the dynamics of the language, particularly as it reflected the varied political positions held. In this frustration of nuance, I recognized the ambiguity of language that fills the literature and the everyday practice world. For example, some program staff are much more likely than others to accept the language of diagnosis as it is set out by the psychiatric establishment and the *DSM*. Others tighten their jaws and let it be known that such language is part of an oppressive discourse in itself that blames women for, among other things, experiencing violence at the hands of

their partners. Yet others see challenging symptoms as reasonable responses to the experience of torture. Self medication through alcohol or drugs is seen both as problematic in some contexts and as a natural method of self preservation in others. Even raising the possibility of mental health in connection with violence against women suggests to some that there is a misplaced emphasis on the individual over the society that creates and condones violence on many levels. As these issues emerged, it became surprising that we were able to develop the language of our interview guides at all! These tensions, between the conceptualizations and experience of both violence and mental illness, permeated the entire project and surfaced, sometimes quite eloquently, in the responses of study participants. There was also a certain amount of walking on eggshells in the first moments of a group meeting or individual interview so as not to offend, inadvertently through the use of some term or other, from the very beginning.

Devising Method

I had no budget for this project beyond my general sabbatical support, and so I wanted to curtail postage and phone bills; but I was able to donate the costs of driving to various sites. In order to minimize the time commitment for very busy staff, I generally conducted group interviews in the form of focus groups during already scheduled meetings, usually in the central part of this small state. I was able to get on the agenda through connections with the statewide organization. Occasionally, I traveled a bit further and did interviews alone, particularly with program directors. Most interviews were face to face with a few conducted over the telephone or by written questionnaire, the latter two means posing more difficulties in terms of establishing rapport. Each of the group meetings was tape recorded and all individual interviews were coded later

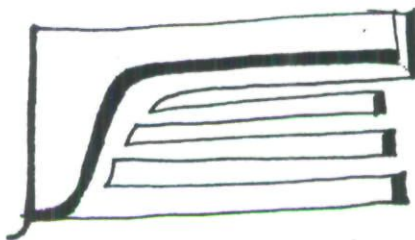
according to a basic content analysis structure. A graduate student working as an intern at the statewide agency was assigned to assist in some of the phone interviews. All of the 16 programs were represented to some degree in the interviews, either through the participation of directors, shelter coordinators, court advocates, sexual violence team members, child advocates, or a combination of these.

I came to relish these conversations. Whether in a group or individual settings, I found myself constantly wondering about new questions, inspired by the energy and commitment of the working staff, and thoroughly impressed with their abilities to remain upbeat and enthusiastic about their work in spite of the very clear sense of swimming upstream that it represented. This was clearly one of the substantial rewards of this project—it felt like an unexpected gift. I also found myself, however, inevitably looking back at my own work as a mental health practitioner in a setting in which DV/SV was more or less viewed as yet another obstacle. This was and has been the opening for a new perspective; it also carries with it a sense of regret on my part for lacking the foresight to mesh the perspectives of mental health and violence before in a way that could have been more relevant for the women I worked with. What had once seemed like minutiae, the particulars of so many cases and their outcomes flooded my memory—situations when the hospital psychiatrist didn't trust a woman's account of violence at home and I swallowed my objections, or a battering husband was appointed guardian of a hospitalized survivor against her strongest wishes, or a disturbed young woman patient made a claim of violence in the night and was immediately medicated to ease her "delusions."

Discovery

In all meetings I drew upon my social work training and experience and was increasingly able to hear what my informants were telling me. Much of my inquiry was aimed at specific information, such as how often program staff saw women with mental illnesses, what kind of services the agency provides, or how the court system responds to women with mental illness.

In each of these questions, participants supplied interesting, often provocative, responses that reflected their views of DV/SV issues in particular and sometimes their general view of the world and of people as well. For me, though, the most meaningful findings came in the discussion of the tensions that program staff experience in their work. By meaningful, I mean poignant, surprising, saddening, perplexing, or even exhilarating. These seemed to me to be especially difficult to resolve and at the same time the stuff of forward movement. I will recount here a selected sample of these tensions, grouped here as general, shelter specific, SV specific, and individualized tensions.



General Tensions

Most programs registered a variety of generalized tensions in consideration of survivors with mental health issues and how best to respond to them. The most significant of these follow:

- Program staff felt they need to know more about mental health issues as they increasingly encounter them and are also clear that they don't want to learn diagnosis or become clinicians. Many of these

conversations reflected a sense that they weren't quite sure what they wanted or needed to know. Others distinguished purposefully between diagnosing and learning to handle troubling behaviors, although even in this group, some registered confusion about whether one might be more effective if she knew what the service user "had" in the way of illness. These conversations overall reflected a tenacious, and to me admirable, resistance to blaming women or searching for pathology in them. This sentiment was complicated by the consideration that, in one staff member's words, "violence makes you crazy."

- The specific relationship between DV/SV agencies and the mental health system is strained to varying degrees. Some program staff clearly have developed relationships with local mental health providers so that they can better serve the women they see who would benefit from them. Others feel somewhat bitterly demeaned by mental health workers and assert that many have little understanding of DV/SV or of the role DV/SV programs play. For example, local hospital staff once discharged a woman who made a suicide attempt only hours before to a shelter that had no overnight staff. Or, women will be coerced into seeking shelter care because they are seen as troublesome to deal with by medical staff. Further, many DV/SV program staff feel their opinions are discarded by mental health workers who are more likely to have academic degrees, certifications, and other formal credentials. Although most (not all) programs indicate that an improved relationship with mental health services would be beneficial to the women they work with, this tense manifestation of the divide between the two systems described in the literature seems a persistent obstacle. The push-pull dynamic between collaborative efforts and more assertive advocacy was a dominant theme.

- In addition to their concern for limited health care resources, excessive waiting times, occasionally disrespectful approaches, and minimization of the importance of violence, many program staff are concerned about the content *quality* of the mental health treatment itself that is available. Specifically, many find recommendations for limited contact with abusive partners, "dating," and other reunifying plans that do not address the violence *directly* to be both dangerous and grossly unjust. This seemed to reflect a rather basic worldview-related split about intervention in domestic violence and the nature of power relations in the marital dyad.

- As a program resource issue, staff want to be responsive to survivors and are not sure how to encourage appropriate use of program hotlines, how to respond to survivor complaints about mental health providers, and/or how or to what extent to respond to issues that are not related to DV/SV. This complex tension arises out of the common use of DV/SV program hotlines by women who are stressed and who have no other supportive connections. Hotline staff report that mental health workers go home at night and are not available to "just talk" even though that's what the service user seems to need. Some staff are concerned that excessively long, non-emergency hotline calls clog up the phone lines for women in danger. A few are concerned about a dependent relationship developing over the phone with a worker who is not trained in mental health issues. The parameters of the work seemed to be at issue here: Who DV/SV program workers are professionally and how they fit into the overall system of services are questions that arise frequently.

- Staff are reticent to participate in a process that labels survivors and also frequently think a mental health referral would be helpful. This sentiment is at the heart of the interface between the DV/SV and mental health systems and mirrors basic philosophical

differences related to power and system-replicated abuse. This overarching tension is reflected in the ambivalence some programs feel about identifying mental health issues of survivors as a concern at all, while others cite them as creating a nagging, tenacious ache encountered every day.

Shelter-Specific Tensions

The programs that include shelter as a service reflect unique struggles in relation to shelter procedures that complicate their work. These include:

- A concern that the shelter environment may not be helpful and in fact may be out-and-out harmful for a survivor with severe mental illness. Several shelter staff relayed heartfelt stories of women who came to shelter somewhat confused and left abjectly terrified. The stresses of rules required for group living, the fear and sometimes hostility of other shelter residents, and the sheer disorientation of dislocation inspired some women to return to abusive households because they were, at least, familiar.

- A concern for meeting the needs of *all* residents so that “stable” residents are not frightened or alienated by those whose behaviors reflect severe mental health issues. The “other side” in some respects of the issue above, this tension reflected the difficulties that all shelter residents might experience, given their own struggles, when they confront another resident who exhibits florid, frightening symptoms, accuses them of imagined injustices, or who, conversely, withdraws and may not speak out of paralyzing depression and grief.

- A concern for establishing an accepting rapport while articulating and enforcing shelter rules and consequences which may seem punitive. Shelter staff painfully described this tension as one in which they were truly torn. Committed to responding to the needs of troubled women with mental health issues who

have experienced violence, they know at the same time they need to keep some sort of order through enforcing the shelter rules. Several admitted to a generalized suspicion or aversion to any institutionalized rules, which seemed to complicate this dynamic. They described this with both frustration and sadness—trying to support a woman’s ability, for example, to be responsible for her active children when she seems hardly to know where she is.

- A more specific concern for mitigating the negative combined effects of violence and mental health issues on the capacities of survivors to parent effectively without blaming or labeling survivors. This reflects another tension that was markedly distressing to some shelter staff. Further, it manifested itself differently in staff who work primarily with women and those who work primarily with children. The latter seemed to struggle more with judgmental attitudes toward women who appear to neglect their children, those who discipline them more harshly than is comfortable to witness, or especially those who seem to abdicate their roles by making children responsible for their mother’s caretaking and emotional bolstering. Some women appear unable to attend to their children’s needs because of depression or disorganization. Others seem unable to understand developmental issues in children because of cognitive difficulties. Even so, to a person, all of the staff that registered this temptation to be judgmental struggled with it as antithetical to their commitments to the shelter and to a feminist philosophy. One young staff member said this judgment was the subject of a great deal of personal turbulence as she questioned her own suitability for the work.

SV-Specific Tensions

A number of unique tensions were identified by the SV programs and corroborated by members of DV programs

who work particularly with survivors of sexual violence:

- Approaches taken in the work against sexual violence may differ from those taken against domestic violence and may sometimes operate within quite incompatible paradigms. Partly because of the inordinate power of early childhood sexual violence, which is often associated with devastating and sometimes lifelong mental health repercussions, some SV programs may take up the mental health medical model more easily than DV programs which often tend to embrace a criminal justice model. Accordingly, there is a frequent philosophical tension between concentrated efforts on getting women into mental health services and on holding men accountable for battering.

- SV program workers may struggle with encouraging an independent decision by a survivor regarding the decision to press legal charges. This arises when staff experience suggests that the legal process is rarely empowering for the survivor nor are court decisions always just or timely. The occurrence of negative outcomes is thought to be exacerbated when the survivor has mental health issues. Staff in SV programs have often accompanied women through months or even years of grueling, demeaning court appearances in addition to dismissal or ridicule by the community. When the woman also has mental health issues, the chances of her being taken seriously are even more unlikely. A woman with a prior history of assault may be called a "frequent flyer" or otherwise degraded. Although most staff would be gratified to see a conviction of a rapist or abuser, their experience tells them the cost may be of devastating proportions to the survivor. In general they attempt to give the survivor an account that is as unbiased as possible of what they know about the process, but there is sometimes a lingering uneasiness.

- As a more specific example of program advocates struggling with where they fit into the system, SV staff are constantly working through differing perspectives and building relationships with hospital staff. They recognize that pursuit of a rape substantiation may take a nurse out of the emergency room for several hours, thereby contributing to hospital staff shortages. Further, medical staff often seem to be motivated to help "deserving victims" of sexual violence (usually meaning first time, coherent, respectably dressed, clean lifestyle, sober, "innocent") while advocates generally assert that *all* survivors should receive medical intervention if they request it. The tension between advocating for a woman's rights aggressively and respecting medical staff's perspectives and time pressures is one that persists. In general, program advocates describe trying to get what survivors need without undue confrontation that will damage the relationship with medical staff and therefore jeopardize the care of future survivors.

Individualized Tensions

Several more individualized concerns were also identified by some programs:

- Advocates want to provide a positive role model to survivors with mental health issues without appearing as "superwomen," saviors, or rescuers. Staff who often have experienced domestic/sexual violence themselves, or who have been closely touched by mental health issues, may sometimes feel great pressure to be more than they can be. They can't, as they say, change lives. At the same time, they want to demonstrate hopefulness to survivors.

- Some rural programs face explicit conflict-of-interest scenarios when they serve batterers, survivors, and children, any of whom may have mental health issues. Multiple family members may also seek services in relation to the same family contest. In areas in which services are extremely sparse, and

staff members few, there may be no possibility of referral to another agency or even to another worker in the same agency.

The tensions I've described here have provided the most interesting and compelling (to me) challenges of this systems interface. Others might find entirely different issues as paramount. It is clear to me that who I am and what I brought to this project is what shaped this experience for me.

The Gifts of Inquiry

From that bleak rainy day in March until the end of the project in June, I went from cautious reluctance to full engagement. I had always admired the energy and stamina of DV/SV workers for the thorny work they do, but at the conclusion of my interviews, I found myself grappling with the complexities of legacy and vision, savvy politics and hope, tale of the past and story of the future. Each of the 16 programs whose staff I met with encounter enormous challenges in their work. With an exhausting lack of resources and often limited training and formal education, they are undaunted in trying to mitigate an egregious aspect of contemporary social life. Such violence is not only pervasive and worldwide but also intricately connected to social dimensions that are both global and local, like poverty, child abuse, and trafficking.

Along with this connection comes a struggle to fit into the organizational structure of contemporary human services. How much like mental health professionals do they want to be? How many roles can they and should they fill? Program staff support survivors and provide some of the most basic necessities of community life. They are in constant, sometimes abrasive, interface with schools and courts, churches and child protection agencies, welfare and housing concerns, and mental health and spiritual health needs. A powerful perspective among them regarding their primary mission and goals seems to

reflect substantial agreement. Yet the gritty details of how to carry out those collective goals pose substantial complications.

Like most exploratory assessments, this project led me to more questions than answers. The philosophical perspectives relating to how the DV/SV movement fits in or should interface with other social institutions, such as the mental health system, constitutes a central place in this discrepancy, especially since so many survivors never come into contact with either DV/SV or mental health services. The tensions between these two realities arise out of the lived experience of multiple perspectives, each felt clearly and passionately as the "truth." This is the crux of the issue for me, and it also provides the richness of the inquiry. Through a postmodern lens, I view these seemingly contradictory positions as supplying that much more substance in the real and contradictory world. This is the issue to which Susan Schechter alludes. How best to empower *all* women, especially those never seen in any system? Do all mainstream institutions, such as mental health, disempower survivors, and what is the price for distancing from them? Is it necessary for all institutions to adopt the grass roots paradigm(s) of DV/SV in order to work with survivors who have mental health issues? Urban programs often differ from highly rural programs in that the context of services and collaboration varies. As noted earlier, SV programs sometimes have a different perspective regarding particular issues in mental health from primarily DV programs. Shelter programs experience different demands from those without shelter. Are these differences sustainable considering the challenges they face?

Epilogue

The remarkably good-natured resilience and persistent commitment for carrying out this daunting work every day displayed by program staff may ease the way for the tasks

that workers defined for themselves. There is clearly much to be done and while progress is heartbreakingly slow at times and so much is lost in every situation of DV/SV, each advocate contacted in this assessment expressed hope for the future. What needs to be done to bridge the worlds of DV/SV and the mental health system in many cases is not a mystery—they know many of the tasks ahead of them. Their overall challenge will be to unify to the extent necessary (and to recognize the parameters of that point of tension) for an effective mobilization of community response. Through relentless education, training, and connective collaboration with other institutions, they will continue on the very long road leading to change in how the world views women who are survivors of personal violence and also have mental health challenges. The status quo embodies a haunting reminder of our cultural failure to stop violence against women. It is then compounded by our penchant to blame them for “going crazy.” There is much work to do, and it is work for every day until it is finished.

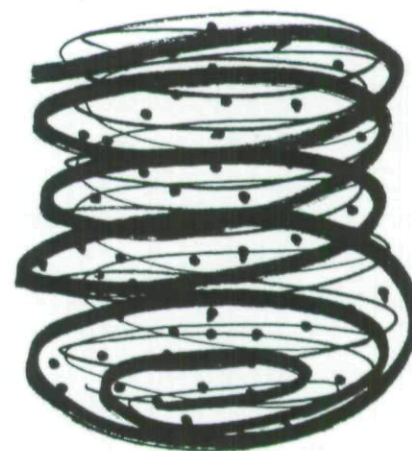
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