Bridging the Dichotomy between Micro and Macro Practice in Social Work:

A Study of Clinical Social Work Practice with Domestic Violence Survivors

By

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Sur Ah Hahn

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K. Jean Peterson, D.S.W. (Co-Chair)

_____

Edward Scanlon, Ph.D. (Co-Chair)

_____

Stephen Kapp, Ph.D.

_____

Judy L. Postmus, Ph.D.

_____

Ann Schofield, Ph.D. (Outside Member)

Date Defended: April 9th, 2013

The Dissertation Committee for **Sur Ah Hahn**

certifies that this is the approved version of the following dissertation:

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K. Jean Peterson, D.S.W. (Co-Chair)

_____

Edward Scanlon, Ph.D. (Co-Chair)

Date approved: _____

ABSTRACT

This dissertation used qualitative interviews with social workers working with domestic violence (DV) survivors to explore how social workers integrate micro and macro practice in their daily practice. Clinical practice in DV organizations was chosen as the focus of this study because of the heavy influence of social change movement in the development of this practice setting as well as the historical criticism of therapeutic approach to DV as victim-blaming. The findings of this study showed that DV work continues to struggle to categorize its identity between service delivery and grassroots advocacy. Moreover, clinical social workers continue to experience tension between the clinical and non-clinical workers in DV organizations, a by-product of professionalization in the field. Clinical social workers have been attempting to circumvent the tension by conceptualizing therapy as another essential service for DV survivors to address the impact of abuse on these clients' psychological wellbeing. They also attempted to integrate micro and macro practice by building comprehensive, survivor-defined practice models based on existing models such as trauma-informed care model and Transtheoretical model. In addition, they have created alternative mental health service delivery systems in which clinicians explicitly address negative consequences of diagnosing for clients and critically evaluate exiting therapy models while considering power relations as the primary guideline for constructing domestic violence-specific therapy. Finally, working in the DV organizations with social change orientation seemed to influence these social workers' professional identity. Realizing that clinical social work is more than providing therapy, they have adopted advocacy as one their core practice components. By reconnecting clinical social work to social change work, clinical social workers are crossing the boundaries between micro and macro practice, shedding some light on the age old question of how to connect these two practice levels in social work.

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CHAPTER ONE: INTRODUCTION

The dual approach of providing individual service and promoting social change is one of the defining characteristics of social work as a profession. Yet, connecting these two levels of intervention in theory and practice has been a persistent challenge for the profession. The divide between individual service and environmental change, or the dichotomy between micro and macro practice, has plagued social work (Salas, Sen, & Segal, 2010). In the entry for "Social Work Practice" in the 20th edition of *the Encyclopedia of Social Work*, McNutt (2008) notes this dichotomous history of the social work profession as follows: "It is undeniable that direct service/casework is the primary practice orientation in social work. The orientation of social work practice often conflicts with its concerns for social justice and systems change" (p. 141).

The conflict between micro and macro practices has been the most polarizing debate in the history of the American social work profession (Haynes, 1998). The debate can be traced back to the famous fourteen-year debate (1909-1923) between Jane Addams, the leader of the settlement house movement to combat social injustice, and Mary Richmond, the founder of social case work , a social work practice method that provided services to individuals based on need through the Charity Organization Society (COS) (Addams, 1910; Richmond, 1917). Addams often criticized the charity organization movement for relying on a retail method of philanthropy, complaining that COS workers only paid attention to endless details about clients' problems while doing little to change the source of the clients' struggles (Dore, 1999). She denounced "the guarded care with which relief is given by a charity visitor to charity recipient," compared to "the emotional kindness with which relief is given by one poor neighbor to another poor neighbor"(Addams, 1902, pp. 19-20). On the other hand, Richmond believed that the wholesale change of settlement methods depended on the "sixth sense of neighborhood, not of

the experts" (p. 143) while failing to analyze unique situations of individual clients (Richmond, 1922). While recognizing the link between case work and social reform when she argued that case work facilitates the social reform movement by providing relevant observation and data, Richmond (1922) nevertheless believed that social reform and case work should operate separately. Moreover, her emphasis on scientific methods for case work and her wholesale devaluation of the methods employed by settlement workers did little to bridge between the two practices (Morell, 1987).

The dichotomy between macro and micro practice has fueled attacks on the professional identity of social work from scholars and practitioners both inside and outside social work (Epple, 2007). In their book, *Unfaithful angels: How social work abandoned its mission*, Harry Specht and Mark Courtney argued that social workers were embracing psychotherapy while abandoning their mission as agents of social change. For them, psychotherapy contributed to social work's "tendency to treat public issues as private troubles" (p.32) while the growth of private practices among social workers was evidence of the profession abdicating its responsibility of public services to the oppressed and vulnerable populations (Specht & Courtney, 1994).

The same criticism is voiced by social workers who believe social justice and social change should be the core values and main focus of social work. They lament the dominance of individual treatment as social work's primary practice method under the legacy of casework and psychiatric social work (Abramovitz, 1998; Jacobson, 2001). Similarly, Jacobson (2001) discusses the limitations of therapeutic modalities for social work, showing how ineffective they are in solving clients' problems stemming from poverty and other oppressions. In fact, by limiting its focus to individual conduct and intra-psychic functioning, therapeutic modalities may

have the effect of blaming the clients. Given that social reform is one of the most important practice components in professional mandates and social work scholarship, Abramovitz (1998) proposed that the profession should reclaim social reform as part of its mission by including the history of social activism and social reform in social work education.

Proponents of clinical social work called for careful examination of the actual activities of casework scholars and practitioners that founded clinical social work practice methods (Dore, 1999; Hiersteiner & Peterson, 1999), pointing out the critics' assumption that clinical social workers have blindly ignored larger social policy issues. To the claims that early caseworkers were preoccupied with diagnosing the individuals' intrapsychic functions in accordance with Freudian theory, Dore (1999) pointed out that this allegation came from an inaccurate understanding of history. For example, psychopathology had limited influence on the New York School, one of the early social work schools that developed clinical practice methods in America, contrary to the widely held belief that psychoanalysis had a strong hold over social work schools in the 1920s. Today, there are clinical social workers who lament the trend in social work practice to discount some valuable aspects of clinical practice in social work, as also seen in the shifting trend in the social work education curriculum towards a more generic curriculum with less emphasis on psychiatric theories in practices and clinical education in general (Danto, 2009; Epple, 2007; Goldstein, 2009; Philips, 2009).

In analyzing the works of early founders of direct practice in social work, Hiersteiner and Peterson added a gender lens to the debate by redefining direct practice as "care-centered practice" (Hiersteiner & Peterson, 1999, p. 144). According to them, despite their dominance in the social work field, case work and direct practice are devalued because of their relationship- and caretaking-centered characteristics, the characteristics associated with women, and thus seen

as inferior to scientific, macro system, and social justice models of action (Hiersteiner &

Peterson, 1999). This gendered analysis shows the complexity of this historical debate around

the micro and macro dichotomy in social work (Abrams & Curran, 2004; Kunzel, 1993).

This dichotomy has also defined the profession's primary practice focus in various

periods in history. Historians report how the social work profession shifted its focus between

macro and micro area of practice because of changes in the economic and political climate

(Gordon, 1988; Kunzel, 1993; Reisch, 1998). For instance, the focus of the profession shifted

from individual treatment in the 1920s to structural change with the advent of the Great

Depression of the 1930s. A similar shift occurred during the transition from post-World War II to

the 1960s and 70s when strong social movements drastically changed the American political

landscape (Trattner, 1999).

Purpose and Approach of the Study

The recognition of the need to integrate the micro and macro practice can be traced back

as early as the 1920s. Porter Lee (1929) defined social work as both cause and function. He

wrote, "For an outstanding problem of social work at the present time is that of developing its

service as a function of well-organized community life without sacrificing its capacity to inspire

in men enthusiasm for a cause" (p.5). Decades later, Chambers (1963) also argued that services

and political action could never arbitrarily be separated and every institution requires both "priest

and prophet." He added, "[i]ndeed, in the very process of offering individual services, the client

could be led to discover and release strength and energy, which in concert with others might

voluntarily be channeled toward the promotion of desirable social change"(p.89). For him, the

problem was to discover new methods of meeting the dual obligation by research and in practice (Chambers, 1963).

The integration efforts have been made in practice theories. For instance, Austin, Coombs and Barr (2005) reviewed such efforts in the theoretical and practice literature of the past several decades and divided the practice and models into eight categories, such as generalist practice, person-environmental practice, and the ecological life course model. Despite these efforts to integrate the two areas of practice, there is a dearth of research studies on how social workers experience this dichotomy in their daily practice and how they construct their practice to integrate these two areas. Thus, the purpose of this study is to understand how social workers experience the micro-macro dichotomy, what efforts are made to integrate the two areas, and how their experiences of the divide and integration affect their professional identity as social workers.

For the inquiry, this study focuses on clinical social work practice in domestic violence organizations. There are primary reasons for selecting this area for the study. The domestic violence organizations represent a practice setting in which their philosophy and mission statements are informed and influenced by a social change movement. Many, if not most, of existing domestic violence organizations were founded by the participants in the Battered Women's Movement (hereafter "BWM") that was part of the second wave feminist movement that began in 1970s. Given this pedigree, the debates on the conceptualization of the problem and the proper level of interventions are prevalent in these domestic violence organizations (Schechter, 1982). Historically, there has been a tension between clinical practice and the BWM, and at times, this tension is manifested as a suspicion toward professional workers in the organization (Whalen, 1996). Despite the incorporation of clinical practice in domestic violence

organizations over time, clinical practices and their therapeutic approaches to the issue of domestic violence has remained controversial in the BWM (Ferraro, 1983; Lehrner & Allen, 2009).

This study begins with a brief historical overview of the relations between domestic violence and the social work profession. The first part of the overview will review the first historical account of efforts to help the victims of wife-beating in the nineteenth century before the emergence of the social work profession. The second part will cover the early social work practices with domestic violence survivors and the profession's later response to the BWM. This examination of the historical relationship between social work and domestic violence will further contextualize the micro and macro dichotomy.

In this study, I use the term *domestic violence* to indicate the name of the phenomenon because it has been widely used in the field as well as in the public since the mid-1990s, despite the popularity of the term may imply the failure of feminist analysis of the issue (Pyles & Postmus, 2004). However, when historical literature utilize different terms, such as "wife-beating" , "domestic disputes," and "spouse abuse" in the following section, I adopt those terms to reveal specific context in which the term has been used in social work history and the BWM.

Social Work and Domestic Violence

The Temperance and the Social Purity Movement in the Nineteenth Century

The first movement to help "wife-beating victims" predates the social work profession. The Temperance Movement (1830-1870) was the first public effort against family violence in America. Succeeding the era of Puritanism, which regarded family violence as a sin to God, the

Temperance Movement (1830-1870) saw violence as an evil consequence of alcoholism. Although the Temperance Movement was the first to pay attention to the plight of women abused by their drunken husbands (Pleck, 1987), the main target for reform was men's intemperance and not violence itself. Believing intemperance itself to be the source of all the immoral acts, the women of the movement focused on making the sale of alcohol illegal and punishing saloon managers who sold alcohol to men instead of the abusive husbands. Their goal was to protect the sanctity of family from all the evils of intemperance (Gordon, 1990).

Other women of the movement had a different view of the violence. They did not see wife abuse simply as an evil consequence of alcohol but as an absolute wrong committed by men against women, and they argued that the only remedy for the abused wives was to escape from their abusive and intemperate husbands. To this end, the women of the movement began to focus on women's right to secure a divorce, own property and have custody of their children. This was the forerunner of the first women's rights movement in the U.S. led by Elizabeth Cady Stanton (1815-1902) and Susan B. Anthony (1820-1906), who later became known as antebellum feminists. Stanton was the force behind the divorce reform bill later introduced in New York State, challenging the institution of marriage that allowed the husband to regard his wife and children as personal property. She also criticized the view of family as the most sacred and primary unit. Susan B. Anthony, a close friend and colleague of Stanton, worked directly with the wife-beating victims, finding safe and secret lodgings for the 'fugitive wife' who escapes from her abusive husband. For challenging the ideals of family and marriages, they were seen as too radical and were eventually condemned as free love advocates, a labeling which put a stop to raising the issues of wife abuse and divorce reform (Pleck, 1987).

After the antebellum feminists' activism for aiding victims of violence, there were no similar organizational efforts until 1885. The first public efforts for providing organizational aids to victims of wife abuse came from the Social Purity Movement in the late nineteenth century. Women in this movement saw the differences between sexes as a dichotomy of women's moral and sexual purity versus men's brutishness, such as uncontrollable sexual desires. Based on this ideological scheme, they publicized forced sex by husbands as a form of wife abuse. The emergence of this issue as a critical issue for the movement is rooted in the historical context of the times. The anti-sexuality ideology of the Victorian Age was dominant at the time, and women regarded themselves as protector of moral values, such as modesty and sexual purity, while condemning men's unlimited sexual desire as brutish. In addition, a lack of proper birth control methods, which was linked to many health risks related to frequent child birth, was a pressing issue for many women at the time (Gordon, 1988).

The Social Purity Movement differed from the antebellum feminist movement in that they paid equal attention to punishing the abusive husbands as well as securing the rights of women and sought to establish permanent institutions to protect women victims. In 1885, the Protective Agency for Women and Children (PAWC), the first institution established by women for victims of violence, was founded in Chicago. Members of the PAWC came from various women's organizations, including the Women's Christian Temperance Union (WCTU), the Chicago Women's Club, the Cook County Women's Suffrage Association, and the Moral Education Association. The PAWC located the victims, visited them at home, inquired into the circumstances of the assault, provided diverse forms of legal aid and personal assistance to women and child victims, and referred abused women, as well as homeless girls, to a shelter operated by the Chicago Women's Club. Initially, the PAWC did not address such controversial

issues as divorce, fearing that their activities may be seen as breaking apart family unity. However, once they realized that separation of the women from their abusive husbands was inevitable to protect and aid women victims, they began to support divorce as a solution to end further victimization of women. Consequently, the PAWC was also perceived as an immodest and anti-family organization, deterring other women activists from following the organization's cause. In 1896, the PAWC was integrated into the Bureau of Justice in Chicago (Pleck, 1987).

Social Work's Response to Domestic Violence in the Twentieth Century

Social casework in child protection agencies and family courts

The social work profession first encountered "wife-beating" issues through child protection work that started in the late nineteenth century. In their work to save children from parental neglect and abuse, social caseworkers learned that often the mothers were also victims of violence by their husbands. But the child protection agencies avoided intervening between husbands and wives. Linda Gordon (1988), a historian of family violence, attributed case workers' reluctance to intervene to their ideology of two-parent family preservation and also to a lack of means to reform abusers at that time.

Unlike former women reformers, social case workers viewed wife-beating as a form of domestic dispute and not as a public issue. The abuser was not regarded as a criminal but merely ignorant, mentally deficient, and/or lazy. In situations in which they could not ignore the problem, case workers addressed the wife-beating cases through the legal system, but it was believed that a new type of court, other than the criminal court, was needed to deal with domestic

disputes, including family violence. Consequently, the family court, or the court of domestic

relations, was established in 1910 (Pleck, 1987).

With the goal of preserving the family, the court took a curative, rather than punitive,

approach. The court provided no physical protection for the victims because of its aversion to

issuing warrants for the arrest of abusive husbands. When women brought complaints to court,

the social worker would hold a conference with the women and their abusive husbands to listen

to both perspectives on the problem, and usually urge their reconciliation through marital

counseling. In some cases, caseworkers conducted perfunctory investigations, making extensive

inquiries into the family's history, economic conditions, present difficulties, and childcare

arrangement in order to prepare case reports. Some caseworkers would go to a woman's home to

learn what kind of housekeeper she was and to observe the neighborhood where the family lived

(Pleck, 1987).

This investigation reflected the ideology that correlated women's improper housekeeping

or unattractive appearance to the so-called "domestic dispute." This gender role ideology of

social workers was also reflected in modern social work theory and practice in the era of

professionalization, which shaped the activities of caseworkers with family. Mary Richmond

(1917), a key founder of modern social work, claimed that "the household speaks for the wife,

answering unasked questions about her as it does not about the husband" (p.147). In other words,

the marital violence was perceived as "a sign of wifely dysfunction" (Gordon, 1988, p. 282).

Although there were some caseworkers who tried to protect women by helping them

leave the marriage, most of them focused on trying to 'save' the marriage and the family unity,

and to maintain the division of gender role in the family. It was based on such a perspective that

caseworkers in child protection agencies often criticized women who left their abusive husbands

for putting themselves ahead of children and family. Furthermore, the tendency to blame women for the abuse became the norm in the social work profession when caseworkers of therapeutic orientation began to define it as a problem for the woman to work on. In the absence of an organized women's movement after 1920s, this victim-blaming in the profession gained strength from the psychiatric analysis of domestic violence and the role of women in it.

Psychiatric social work and female masochism

Beginning in 1920, psychiatric social work had the most influence on social work practice in "domestic disputes." Psychiatric social worker Harriet Mowrer and her husband Ernest R. Mowrer, a family sociologist, were the first to apply psychiatry to family social work, especially to "domestic discord" (Mowrer & Mowrer, 1928). According to the Mowrers, physical abuse among couples was a manifestation of domestic discord. Influenced by Freudian theory, and criticizing previous family casework with domestic discord as unscientific and outmoded, they recommended a deeper inquiry into the couple's emotional and sexual problems. Using medical terms, such as 'treatment' and 'patient', they focused on analyzing women's problems rather than men's, believing the answers were to be found in women's psyche, rather than in the violent behavior of their male partners.

In one case in which a woman suffered from her husband's excessive jealousy and control, Harriet Mower diagnosed the problem as resulting from the woman's incestuous attachment to her father. In another case, she diagnosed that her client's mental distress at home stemmed from her desire to escape from the responsibility of caring for the household and her child, and advised a psychiatric social worker to develop a treatment program to help the client adjust to her role and identity as housewife (Mowrer & Mowrer, 1928).

Despite the emphasis on "the scientific treatment of marital conflict" and introduction of some 'scientific' terms and concepts of psychoanalysis, it seemed that the Mowers' theory and method for practice were based on the prevalent social ideology of gendered roles, which was not so different from previous family caseworkers. Although the Mowers never established their own domestic discord clinic, they had a significant impact on the training of a generation of psychiatric social workers and the practice of family casework for marital difficulties.

The introduction of new practice theory and methods also had some positive impact on the direction of social work. Social workers placed more emphasis on the rights of the client/patient, maintained non-authoritative attitudes, and tried not to intervene in the client's decision making process, even if the client made potentially self-destructive decisions (Levey, 1929). However, effort to maintain professional neutrality led to negative consequences when psychiatric social workers failed to provide information on available remedies, such as emergency housing, charity, medical care, and legal aid.

Beginning in the 1940s, with the advent of psychiatric diagnoses, the focus of social work moved away from "domestic disputes" and wife-beating was seen as only an artifact of women's psychiatric disorders. Not only psychiatrists but also case workers began to diagnose women victims as masochists under the influences of Freudian theory, even in cases in which workers were sympathetic to women (Gordon, 1988). Although Freud never mentioned wife beating, Helen Deutsch, a former patient and disciple of Freud, applied her theory to the problem of wife abuse. In her classic book, *The Psychology of Women* (1944), Helene Deutsch developed a comprehensive theory of female masochism and used the theory to explain the wife abuse phenomenon. According to Deutsch, abused women tended to remain with their assailant because they secretly enjoy the pain that is inflicted on them (Deutsch, 1944). With the

prevalence of psychiatric social work, her theory had a significant and direct impact on family social work practice in the 1940s and 1950s, and caseworkers and counselors in private and public family service agencies working in the area of marital violence focused on the unconscious desire of wives to be abused.

Rather than questioning why men abused their wives, caseworkers placed emphasis on why women remained in abusive relationships. Margaret Lewis, District Secretary of the Family Service Association in Cleveland, Ohio, observed that women with alcoholic husbands displayed "a remarkable consistency both in the pathological personality patterns and in the background experiences of [these] women" (Lewis, 1954). According to Lewis (1954), the women are attracted to men who drink because of their unsatisfied oral needs from the childhood experience of emotional deprivation, which the men try to compensate for by drinking.

Even if both the conflict and abuse were caused by the husband, caseworkers looked to the wife's personality and sexuality to find the root of the problem. Therefore, the treatment only highlighted women's contribution to the problem rather than identifying and addressing their needs. This perspective on marital conflict and wife abuse continued to influence social work practice until the 1970s. A standard social work manual on women in marital conflict was filled with such "diagnostic" terms as mothers' excessive dependence, the need to suffer, rejection of femininity, and sexual response, while remaining completely silent about the accountability of men for the abuse (Gordon, 1988). Given this history of the social work profession in the area of domestic violence, it is not surprising that social work practice became a main target of criticism by the second wave feminist activists and feminist social workers in 1960s and 1970s (Fleming, 1979).

The Battered Women's Movement and Feminist Social Work Practices

Critique of traditional social work practices

Historians of social work have provided evidence that clients were never passive recipients of social services. Rather, they have been agents who actively put the services to their use and sometimes resisted the imposition of particular values by service providers in exchange for benefits (Kunzel, 1993). Battered women were not an exception. In early years of social work, battered wives virtually "dragged" the social caseworkers into wife-beating problems when these workers tried to ignore them and only focused on child welfare issues (Gordon, 1988).

As discussed above, the major approach to wife-beating in social work was based on gender-role ideology and victim-blaming in those years, even though some case workers did try to intervene with individual women's situation (Edleson, 1991). When the second-wave women's movement publicized the issue of battered wives as both a social and political problem, and not just a personal and family matter, battered women and feminists came together with scathing criticisms of social work's distorted perspectives on women's sexuality and the 'victim blaming' ideologies. In a way, the Battered Women's Movement was a movement for consumers to advocate for themselves in alliance with feminists whose approach to the domestic violence issues was drastically different from traditional social work practitioners. The BWM created its own practices and programs based on feminist principles, including services such as shelters and legal advocacy. Most of all, their primary focus was on social change, rather than changing women (Schechter, 1982; Yllo & Bograd, 1988).

Social work's response to the women's movement as a profession came relatively late. Although the women's movement began in the early-1960s, the first article on the feminist and

women's movements appeared in the newsletter of National Associations of Social Workers (NASW) in 1973. NASW formed its official task force named the "Women's Task Force Gears for Action" in 1974 (Simon, 1988). This late response was due partly to resistance from social work in accepting the messages of the women's movement. The resistance was particularly more salient among many psychiatric social workers and family caseworkers in traditional agencies who disapproved of the movement's challenges to the ideals of traditional family and heterosexuality as well as its anti-Freudian attitude.

However, many individual social workers took part in the movement even before NASW's official response. Many feminist social workers became actively involved in the movement, with some focusing on the issue of wife abuse. They criticized the existing perspectives of social work that attributed wife abuse to the pathology of women, and tried to reformulate this issue as a social and political problem, claiming that wife abuse results from power imbalances between women and men in patriarchal societies (Flynn, 1977; Nichols, 1976; Schyuler, 1976). For instance, Nichols (1976), a caseworker in a family counseling service, argued that, although wife abuse was very common in martial counseling cases, caseworkers rarely chose abuse as the focus for intervention and tended to ignore the symptom. Schuyler (1976) denounced post-Freudian clinicians because they failed to address other social variables that might account for a woman's decision to tolerate being abused. According to her, one of these variables was the strong cultural notion that being married is the only valid lifestyle for women. Similarly, many abused women remained in the abusive relationship because of the practical reason that they lacked alternative resources for living.

Focusing on services of traditional agencies, feminist social workers examined whether these services could provide sufficient resources for battered women. McShane (1979)

characterized the problems in the services provided by existing agencies in four categories: fragmentation, discontinuity, inaccessibility, and non-accountability. Comprehensive services were needed to provide effective support for abused women, such as laws to protect battered women and legal services for individual women who wanted to divorce or separate from their abusive husbands. In addition, various social services were needed, such as temporary financial assistance, day care, counseling and emergency housing, to help battered women become independent from their abusers (McShane, 1979).

Bass and Rice (1979) also pointed out that existing service providers tended to lack proper information for battered women, and agencies were reluctant to cooperate with or refer women to more suitable service agencies because they were competing for local funding. They proposed a consciousness-raising program for the existing service providers, coordination among the network of community agencies, and case integration. The consciousness raising program would include the following elements: (1) dispelling the prevailing myths about wife beating; (2) identifying external constraints that prevent women from leaving abusive situation; (3) understanding personal feelings about violence and about women; (4) exploring techniques of crisis intervention; (5) examining the role of the advocate; and (6) addressing the legal problems encountered by battered wives (Bass & Rice, 1979).

Programs and services for battered women provided by feminist social workers and advocates can be distinguished from other traditional agencies in several respects. First, as mentioned above, the perspective on wife-battering of the feminist groups differed from that of existing agencies. Feminists denounced victim-blaming perspectives and focused on lack of community and social resources for women to rely on. They also provided counseling and therapy for victims that were very different from the Freudian based psychoanalytic treatment.

For instance, they avoided using terms such as 'treatment.' Instead, they organized

consciousness-raising group work to help battered women understand that they were not to

blame for the abuse they suffered (Yllo & Bograd, 1988).

Secondly, feminist activists espoused progressive, if not radical, organizational principles

such as structures that were to be non-hierarchal and non-bureaucratic. They organized team

leadership instead of a single director system, and tried to eliminate a hierarchy between

professionals and non-professionals as well as between activists and women victims who came

to the organizations. They encouraged volunteers, many of whom were survivors of domestic

violence, to take part in group operation. These efforts resulted in high quality services for

battered women, and the alternative organizations were very successful and grew rapidly (Galper

& Washburne, 1977).

Debates on the institutionalization and professionalization

Although the BWM did attempt to retain their focus on social change as grassroots

organizations, the success of the movement led its organizations to the path toward

institutionalization (Lehrner & Allen, 2008). With many voluntary organizations of the

movement evolving to function as social service agencies for battered women, an issue of

cooptation and professionalization was raised and caused a heated discussion among participants

of the movement (Ahrens, 1980; Morgan, 1981; Schechter, 1988; Whalen, 1996).

Initially, feminist social workers and other activists in alternative groups tried to maintain

a distance from traditional agencies. However, realizing that they could not provide all the

services needed by women, they began to consider collaborating with those agencies. There was

also a need to be established as a legitimate agency to have referrals and to be taken seriously by

traditional agencies. Most of all, they wanted to bring about change in those agencies so that women could receive decent services from them as well (Galper & Washburne, 1977). Therefore, they began to educate and promote their perspective and approach to wife abuse problems in local communities.

As a result of these efforts, traditional agencies came to acknowledge the success of feminists groups in helping battered women. However, there were some unintended consequences as well. Instead of adopting the new practice, many traditional agencies simply referred the domestic violence cases to the women's alternative groups. This led to burn-out among staff and funding shortages in the alternative groups. This also caused some deterioration in service quality for women. More importantly, the funding shortage threatened the very survival of the agencies. With increasing demand for services from survivors, they were left with the alternatives of either securing funding or closing the agencies. When they chose to secure funding, they realized that they could no longer maintain the alternative organizational principles. They had to accept requirements from funding agencies even if the requirements would mean an end to their radical experiments at the organizational level (Ahrens, 1980).

Limited funding forced some staff to leave agencies, and it was forced by the funders to hire professionals who did not share the group's feminist views. This often created a hierarchy among the staff, and caused conflict and division among the group members, between professionals and lay advocates. Sometimes, this conflict would emerge in the form of debates between liberal feminists who regarded funding from government as granted resources, and radical/socialist feminists who viewed state intervention as a means of reproducing class and gender relations (Morgan, 1981).

Despite these issues around cooptation and emergence of new right power in the early 1980s, feminist social workers continued in their efforts to incorporate the issue of wife abuse into social work theory and practice. Some tried to establish shelter based on both feminist ideas and professional administrative skills (McNeely & Jones, 1980). Others proposed the development of more efficient and politically sensitive intervention methods by creating an alliance between social workers committed to women's issues and feminists with similar goals in preparation for the time when the battered women movement would lose their public attention and funding because of the backlash from the new right (Berlin & Kravits, 1981; Pfouts & Renz, 1981). Despite the tension between professionals and feminist activists in the movement, they fought together against the conservative government that cut off the funding for victims of domestic violence in 1980s (Schechter, 1988).

During the 1980s, a major change took place in the view of wife-abuse in the social work profession. Based on a review of major social work journal articles, Davis (1987) reported that the transformation occurred in the early 1980s. Wife abuse began to be perceived by social work not as a social problem created by sexist attitudes but as interpersonal relationship difficulties among family members. According to her, the shift in the view of wife abuse from one of personal pathology to one of social problem was short-lived in social work, and there was a renewed focus on the micro-level. This shift, Davis points out, was consistent with the prevailing political conservatism and depoliticization of feminism at that time. In addition to tracing the changes in social work's attitudes toward wife abuse, Davis and her colleagues' study of service providers for domestic violence survivors found that twenty four percent of programs were "co-opted" by traditional agencies which resulted in a loss of their feminist commitment (Davis, Hagen, & Early, 1994). Gutierrez (1987) also reported that the sociological perspective became

more popular in the social work community over time than feminist perspectives on the main cause of violence, after reviewing social work articles on domestic violence published between 1973 and 1985. The key appeal of sociological theories was that they allowed social workers to incorporate the effect of external factors without threatening the dominant value of intrapsychic factors as the primary focus of practice, whereas feminist theories were seen as a threat to the profession's aspiration to legitimacy (Gutierrez, 1987). According to Gutierrez, despite adoption of sociological perspectives that seemed to integrate the psychological with the external factors, social workers resisted full incorporation of the components of political and social activism espoused by the feminist movement to eradicate domestic violence.

This trend towards professionalization raised concerns among feminist social workers and lay advocates that incorporating social work practitioners into organizations would once again shift the focus of the movement away from social change to an individual-focused approach (Markowitz & Tice, 2002). For instance, Ferraro (1983) concluded, based on her case study of the shelters, that professionalization ushered in the therapeutic ideology into the shelter, which ultimately diminished the feminist practice principle of equal relationships between workers and women (Ferraro, 1983). Moreover, this historical shift in the intervention focus led some participants to conclude that the BWM lost its identity as a social change movement (Lehrner & Allen, 2008, 2009). In their recent qualitative research with workers in 16 domestic violence organizations in mid-western states, Lehrner and Allen (2009) confirmed that professionalization and therapeutically oriented social service agendas were replacing the social change orientation of the organizations. Quoting the lament of one state advocate, "the Battered Women's Movement went downhill when the MSW took over" (Danis & Lockhart, 2003).

Because of the prevalence and persistence of this view of social workers as psychotherapists without any commitments to social change, there is a strong ambivalence and guarded caution towards a clinical approach among social workers in the field (Chong, 2000; Kanuha, 1998). For instance, Chong (2000) observed a deeply embedded conflict between social activism and clinical orientation in the domestic violence organizations from her in-depth interviews with social workers in the domestic violence field. Some participants in the research showed a strong opposition to psychotherapy as a method of treating abused women for their victimization. On the other hand, other social workers complained of the misconceptions about the nature of clinical work and the general tendency in the field to associate psychotherapy only as a victim-blaming model of practice instead of recognizing its merits. They also acknowledged the necessity of direct service provision for victims as well as the challenges faced by the participants in the movement in striking a balance between direct service provisions and other social change efforts. Similarly, Conroy (1994) emphasized the critical role of clinical social work in the BWM, arguing that politics and clinical intervention are not necessarily incompatible. She wrote, "to teach that the lives of battered women exist on the same continuum as those of other women, other people, a continuum from mentally healthy to mentally ill, does not eradicate the political message that no woman deserves to be hit…clinical social workers need to learn what shelters learned over time and need to frame clinical expertise in a political context" (Conroy, 1994)

This historical overview of the relationship between social work and domestic violence show that social work practice in the field of domestic violence is an area of practice where the tension between individual services and social change has been particularly salient. Traditional social work practices were often criticized by the BWM for ignoring social change and blaming

the victim. The movement focused their attention on social change and built their programs on a feminist analysis of gender relations in society, while maintaining a distance from professional social work. However, with the institutionalization of the movement, the role of professionals in the movement became a hot issue among its participants. Social work, especially clinical social work practices, became the core issue of this debate, bringing our attention back to the dichotomy between individual and social change and on how these two areas are integrated in the practice.

Given this long history of macro and micro tension in the domestic violence field, this case study of clinical social work practice in domestic violence organizations will help to further illuminate our understanding of this longstanding issue. The foundation for this study will be the use of in-depth interviews with clinical social workers practicing therapy in domestic violence organizations. I intend to explore their responses as individuals and evaluate within and between groups of research participants to provide a description of emergent thematic content on how individual participants view their practice in terms of micro and macro dichotomy. More specifically, this study will address the following three research questions:

1. How do clinical social workers in domestic violence organizations experience the relationship between macro and macro level practice responsibilities?

2. In what ways, if any, do clinical social workers attempt to integrate these macro and micro practice responsibilities?

3. In what ways, if any, do these efforts at integration affect the professional identities of clinical social work in domestic violence organizations?

CHAPTER TWO: LITERATURE REVIEW

In this chapter, I provide a review of the theoretical and the empirical literature that helped to guide this study. In the first section of the chapter, I explore the theoretical efforts to integrate micro and macro practice in social work and other fields of study. In the second section of this chapter, I review the clinical models developed specifically for domestic violence survivors and outcome studies of clinical interventions in the field of domestic violence. In the last section of the chapter, I review existing empirical studies on the micro and macro dichotomy and integration in both social work and domestic violence fields.

Theories for Integration of Micro and Macro Practice

First, I review the social work literature that has attempted to integrate micro and macro practice, using theoretical frameworks and concepts. Next, I review the literatures of post-colonial psychology and feminist cultural analysis of mental disorders that show the intertwined nature of psychology and politics. These theories have been given considerable attention in the critical literature for their explicit focus on the way that sociopolitical structures and political movement affect mental health discourse and practice. For each section, I will summarize the key points of the literature guiding this research study.

Cause is Function: Integration of Micro and Macro Practice in Social Work

Despite the long standing tension between micro and macro practices, the efforts to integrate these practices have been ongoing in social work, by both the advocates of clinical social work and social action (Austin, Coombs, & Barr, 2005; Kondrat, 2002; Morell, 1987;

Pearlmutter, 2002; Sachs & Newdom, 1999; Salas et al., 2010; Vodde & Gallant, 2002;

Wakefield, 1988a, 1988b). Morell (1983) was one of the social work scholars that adopted the

feminist model for integrating individual change and social change in theory and practice. After

reviewing the early integration efforts by Porter Lee, Clark Chambers, and William Schwartz,

Morell challenged Porter Lee's famous statement that social work is "both cause and function."

To Morell, this statement should be corrected, since, in social work, cause is not separated from

function. Drawing from feminist principles, "personal is political," she maintained that the "why"

of social work is its "how," and the purpose and process are inseparable; thus, cause *is* function

In other words, when cause and function are not consciously aligned, social work values end up

being thwarted by social work's own practice. Therefore, Morell urged that social workers

confront any policies and procedures of the organizational settings that disrupt this alignment

and, if necessary, create an alternative practice environment which can ensure the consistency

between the political cause and values that social workers pursue and their content and forms of

practices to actualize those values. As an example of this alignment, she referred to the

alternative organizations and practices that were created by the feminist movement in the 1970s.

Morell's idea of "cause is function" is especially noteworthy for pointing out the centrality of

organizational practices in the integration of services to individuals and changes of the society

level.

Decades later, Pearlmutter (2002) attempted to integrate individual needs and social

action by introducing the concept of "political practice" based on her practice experience

working as a feminist community social worker. The author explains the steps for "a continuum

of practice approaches leading to political practice," and each step of the continuum involves (1)

a greater recognition of clients' needs and wants; (2) an increased valuing of clients' world view;

(3) an understanding of issues of power as they relate to clients' lives; (4) a distinct awareness of the impact of specific policies on clients' lives and willingness to work toward changing those policies; and (5) a clear intent to bring social change and build new organizations that will truly meet people's needs (p.34). The steps of the continuum are built based on the principles such as client-centeredness, reflective practice, empowerment, feminist practice, policy practice, and radical social work. However, despite the intention of integrating micro and macro practice in social work, Pearlmutter seemed to simply list several elements of practice that have social change principles rather than actively attempting to connect these different but much overlapping principles and practices into her integrated practice framework. This may be because of a lack of underlying theoretical foundation for integrating these different social change-oriented practice principles.

In a similar vein, Austin and his colleagues (2005) proposed community-based clinical practices for their framework to integrate the dichotomy. They first briefly reviewed previous integration efforts in social work, such as empowerment practice, policy practice, family-centered practice, strength-based practice, person-environment practice, and the ecological life course model. However, they found these frameworks lack clear definitions of community-based clinical practices and the theories that guide such practice. Also, there was a lack of research to describe the ways by which clinicians can engage in community-centered practice. In their framework of the community-centered clinical practice, practitioners can identify core micro, macro, and common practice skills in each case of practice. According to these authors, the definition of this integrated practice is a "multi-focused practice method that seeks to strengthen neighborhood and community institutions while also addressing the personal and interpersonal issues facing members of the community" (p. 13-14). However, this framework seemed to be

limited to identifying "skills" rather than focusing on the integration of these two practice areas, which they originally described as the gap in previous approaches.

In response to the lack of a theoretical foundation, some social workers turned to existing theories that could provide a unifying framework for integration. Critical theory is one such theoretical framework that has gained much attention in social work (Kondrat, 2002; Salas et al., 2010). Kondrat (2002) recasts the micro-macro relationship through the work of critical sociologist Anthony Giddens, with a special reference to his Structuration theory, noting that Structuration theory is an attempt to reconcile the accounts of human agency and the social structure in a way that bridges the traditional micro-macro divide. Specifically, the concept of recursive process of Structuration theory can help to shed light on the overlooked area in traditional social work theories. The recursive process of Structuration theory refers to the process in which a society and its structures shape the activity of individuals, which in turn is constituted by the very action of the same individuals. According to Kondrat, ecological and systems perspectives do not explain precisely how human reflection, free will and consciousness create new possibilities and changes in the social structures in which people live. She also points out that in early ecological or systems theory, the understanding of power remains primarily at the micro level while more attention was paid to the constraining aspects of power than to its facilitative aspects. Ultimately, this concept of individuals as co-constructors of social structures was applied to the practice of social workers. Practitioners are supposed to ask how structural consequences are being structured in the day-to-day routine of social work practices. In this respect, clinical social workers are considered to be critical activists in terms of their agency, which leads them to construct society through their choices in practices.

Salas and her colleagues also emphasized the potential of critical theory as a unifying framework (Salas et al., 2010). Influenced by the works of the Frankfurt school, critical pedagogy, and feminist theory, they noted the importance of examining power in the social order, and of analyzing historical context and raising awareness through self-reflection in social work practice. To them, even the dominant theories of social work, such as the empowerment and strengths perspectives, did not pay sufficient attention to power relationships and the role of history in creating oppressive social structures. The emphasis of the empowerment perspective is on personal and interpersonal empowerment with little attention being paid to political empowerment. In response, they proposed "a critical mode of practice" with which the social workers doing micro practices can facilitate a connection between private issues and structures of domination, while macro level practitioners assist individual clients dealing with the consequences of their oppression.

The literature shows that clinical social work has been very active in attempting to integrate clinical work and social action. This may be in reaction to the criticism that clinical social work had abandoned the social work mission of serving the oppressed. In response to the attack on clinical social work practices, some social workers cautioned that this criticism and subsequent weakening of clinical practice in social work may have deprived some clients of needed services. For instance, Epple (2007) questioned the possibility that "the profession's move away from the medical model, psychodynamic theory, and diagnosis puts clients who are in need of psychiatric services at greater risk, victimization, and lack of receiving appropriate services for their specific needs" (p. 271). She also added that, in the current era of managed care, social workers need to be prepared to work "within and against" structurally oppressive forces, such as the medical, pharmaceutical, insurance and licensing institutions, by designing and

providing the services attending to the interests of vulnerable clients with serious mental illnesses (Epple, 2007).

The literature showed that the strong belief in the necessity of clinical practice in social work has led clinical social workers to search for theoretical frameworks and concepts that would enable them to incorporate social action into their direct practices. One of the most widely explored concepts for the integration is the concept of social justice (McLaughlin, 2006, 2009; Swenson, 1998; Wakefield, 1988a, 1988b). This tendency is understandable considering that social justice is an essential component of social work profession, and it requires for all social workers—whether they are providing services to individuals or working with the community—to search for a way to work toward a 'social' level of change in their own practice areas. Moreover, for some social workers, social justice is a more convincing organizing value for social work than the construct of person in environment (PIE) because while social work is not the only profession to adopt the systems thinking, there is no other profession that has adopted social justice as a core professional value (Swenson, 1998).

One of the most widely cited approaches concerning clinical social work and social justice is Wakefield's (1988a, 1988b). Influenced by John Rawls' theory of distributive justice, Wakefield's approach pointed out that there is a "much larger overlap between the claims of justice and the practice of psychotherapy than there appears to be, so that clinical social work is a natural part of a justice-oriented profession" (p. 194). According to John Rawls' theory, justice is achieved not only through the distribution of economic goods and services, but also through a "fair allocation of nonmaterial socially produced goods," such as opportunity, power and the social bases of self-respect (Wakefield, 1988a). This self-respect, along with other social primary

goods, including self-confidence and problem solving skills, can be obtained by the practice of psychotherapy (Wakefield, 1988b).

In this way, social work can be conceived of as a profession engaged in "alleviating deprivation in all its varieties, from economic to psychological" (p.194). According to Wakefield, it is the focus on distributive justice that differentiates clinical social work from traditional psychotherapy since social workers are supposed to be concerned only with those clients who are disadvantaged, whereas concern for broader justice-related implications is lacking in other psychotherapeutic disciplines. Thus, to Wakefield, working for wealthy people in private practice or for people who suffer from mental illness with a biological etiology is not a proper task for clinical social workers. In this respect, he seemed to be in line with the criticism of the trend of clinical social workers working for middle class clients through private practice, while abandoning their mission to serve the poor and the oppressed.

Moreover, he maintained that this reality was a result of the mandate by society for the social work profession to engage in this "derived" task since they are equipped with the necessary skills and can provide cost-effective services compared to other mental health professionals. This claim is disputable since other critics regard the growth of private practice for middle-class clients as being in line with the professionals' pursuit of material rewards and self-interest, not necessarily requested by the society (Sachs & Newdom, 1999; Specht & Courtney, 1994). Wakefield also asserted that mental health and mental illnesses caused by biological factors are not matters of social justice since, he reasoned, mental illnesses with a biological etiology is not socially caused conditions. However, it is problematic to exclude work with clients with psychical and biologically based mental illness from justice-oriented

psychotherapeutic intervention since these clients are one of the most vulnerable populations in society regardless of the origins of their problems.

Some clinical social work scholars expanded on the social justice concept urging for more comprehensive framework for the integration of clinical work and social action by combining several different theories. As Swenson (1998) suggested in her review article on social justice related practice and theories in social work, clinical social work has been burdened with theories that are not particularly congruent with social work values because of the traditional view of theories as value free and objective. Therefore, social work scholars searched for theories, interventions, and arrangements that are congruent with social justice criteria and explored the theories that incorporate views such frameworks as postmodernism, critical theory and social constructionism.

Sachs and Newdom (1999) were just such authors. They actively evaluated theories and incorporated them into their integrated approach to clinical work and social action. From teaching clinical practices, they learned that while students valued clinical training, they were dissatisfied with the lack of social action elements in their education. To address the need for an integrated approach, they proposed a framework based on the integration of the following four theoretical foundations: phenomenology, psychodynamic theory, symbolic interactionism, and critical theory (Sachs & Newdom, 1999). The key criteria for selecting elements from these different theories was whether the elements are congruent with core professional values central to bridging the dichotomy in social work.

The concept of contradiction is central in this integrated framework since social workers are required to identify the forces that bring contradictions to their practices, as in the case where clinical workers are required to compromise their professional values in order to ensure an

agency's survival or its smooth functioning. When this happens, the authors encourage clinical social workers to begin the dialogue with the clients who are suffering from compromised practices caused by contradiction. Clinical social workers also need to reflect on their practices in terms of whether their anxiety or anger resulting from this contradiction is being targeted toward the clients, rather than toward the agency polices. In their efforts to address this contradiction, clinical social workers take their practices into either the organization or community level, which leads to the integration of clinical practice and social action.

Other clinical social workers find a great potential for integration in a particular therapeutic practice model based on postmodernism and critical pedagogy. For example, Vodde and Gallant (2002) contend that a narrative-deconstructive form of postmodern practice, embodied in the work of Michael White and David Epson, can lead to the integration of the micro and macro practices. In fact, they maintain that distinction between micro and macro is artificial in that the self-narratives at the micro level are internalizations of dominant macro discourses that are constituted by power relations and social forces (Vodde & Gallant, 2002). There are three strands of narrative-deconstructive practice to bridge the gap between micro and macro practice: externalizing grand narratives, empowering clients through building of community, and participating in collective actions by clients protesting against the effects of oppressive forces in their lives. In this practice, the role of clinicians is to facilitate the connection of clients with others so that they can collectively challenge and resist the authority, through activities such as letter writing and compilation of stories. They suggested that incorporating this practice model will call for changes in the practice environment and reorganization of social work education so that the students can have opportunities to learn this unified model in both classroom and field settings.

Based on the review of social work literature above, we can identify several key practice areas in which clinical social workers can integrate their micro and macro practice. One area is organizational practice since the organizational setting was emphasized in the literature as an important practice environment in which social worker can align their goal of individual services and broader social systems change. This can be achieved by either bringing changes in the organizational setting or creating alternative organizations. Practice knowledge that clinical social workers produce and apply in their daily practices can be another key area of integration. The literature suggested that it is important for social workers to be able to evaluate and select theories and apply to their practice those which are congruent with social work values. Here, social work education can be a crucial tool for familiarizing social workers with practice models with integrated approach and for preparing social workers for the task of producing such practice knowledge in their daily practice. It is also critical for social workers to be aware of how sociopolitical structures affect their day-to-day practices while considering how their own practices play a role in constructing those structures. In this respect, clinical social workers need to examine power in the social order and to analyze the historical and political context of their practice.

It is noteworthy that there was no consensus on the definitions of micro and macro practice. There were scholars who narrowly defined micro practice as therapeutic services while others defined it in more general terms, referring to any direct services for clients. Some scholars limited macro practice to organizational and administrative practice, while others took it to much broader community level. In this respect, the very definitions of micro and macro practice in social work can be area for exploration.

Psychopolitics and Subalterns' Voices in Postcolonial Psychology

In this section, I introduce post-colonial psychology and feminist mental health analyses, since these theories are expected to expand our understanding of how knowledge of human psychology and interventions are constructed by structural forces and resistance toward those oppressive forces, and of how the psychological working of power contributes to the reproduction of those oppressive structures. Postcolonial psychology articulated and critiqued colonial and gendered power from a psychological perspective, while showing how psychology can be a source of resistance and change. Feminist cultural histories concretely demonstrate how discourses on women's mental disorders have affected women's social status and their struggles to empower themselves and how women's organized political power have played significant roles in those power struggles. The insights from feminist cultural analysis are particularly important since they laid theoretical and ideological ground for the development of practice and programs for domestic violence survivors, which is the subject of this study.

Psychopolitics: Psychology as a vocabulary of political resistance

For clinical theorists interested in the liberation of the oppressed, postcolonial theories are regarded as one of the most useful theoretical resources. South African critical psychologist Derek Hook found postcolonial theories to be very useful because they provide a powerful framework for connecting the psychological and the political and they open up the possibilities of adopting psychology as a vocabulary of resistance (Hook, 2005).

In the effort to promote postcolonial psychology, Hook (2005) introduces the concept of "psychopolitics" inspired by the works of Frantz Fanon, a Black psychiatrist from Martinique

who treated people suffering from the historical trauma of being colonized under European imperialists. From this experience of treating the trauma of colonized people, Fanon found the necessity of a psychoanalytic account of racism and colonial violence, since it is this violence that causes the nervous condition, an anxious and agitated state in which one possesses little or no cultural resources of one's own. Because these cultural resources have been eradicated by the cultural imperialism of the colonizer, these colonized individuals end up having a deeply rooted sense of inferiority and a torturous sense of identity which is split and at war with itself (Fanon, 1963, 1967). In his book, *Black Skin, White Masks*, Fanon (1967) stated the following:

Every colonized people-in other words, every people in whose soul an inferiority complex has been created by the death and burial of its local cultural originality-finds itself face to face with the language of the civilizing nation; that is, with the culture of the mother country. The colonized is elevated above his jungle status in proportion to his adoption of the mother country's cultural standards. He becomes whiter as he renounces his blackness, his jungle. (p. 18)

He also commented in the same book as follows:

In the man of color there is a constant effort to run away from his own individuality, to annihilate his own presence…..Negro, having been made inferior, proceeds from humiliating insecurity through strongly voiced self-accusation to despair. The attitude of the black man toward the white, or toward his own race, often duplicates almost completely a constellation of delirium, frequently bordering on the region of the pathological. (p. 60)

In this respect, the concept of "psychopolitics" is particularly useful in demonstrating the indispensability of the psychological contribution to understanding racism, the persistence of racism, and its pronounced irrationality (Hook, 2005). Recognizing the need to go beyond conceptualizing how politics impacts psychology, Hook argues that critical psychologists should be aware of the psychological workings of power, whereby psychological concepts and explanations are employed to describe conditions of oppression. This is why, he concludes, we need to continue to return to a language of psychology to formulate resistance. The concept of psychopolitics from postcolonial criticism, therefore, offers new and expanded tools for clinicians who want to connect the political with psychology in their own local spheres (Hook, 2005).

Thus, the concept of psychopolitics based on postcolonial psychology provides a tool for clinical social workers to frame their practice as a source of finding languages for defining and resisting oppressive powers that cause clients' suffering. In this way, the client intervention can be a crucial practice area where clinical social workers incorporate the goal of social change into their direct services for individual clients.

Subaltern psychology: Clinical encounters as the source of change

Originally, the term 'subaltern' referred to the rank below British captain given to Indian officers in the British Army. The term regained currency in the 1990s when South Indian historians used it to refer to any groups in society whose status and identities were different from the colonizers and indigenous elites. The historians who founded subaltern studies specifically devoted themselves to the task of finding a way to discern the silenced voices of colonized subjects in the historical archives dominated by the voices of (colonial) elites (Swartz, 2005).

Gayatri Spivak (1988), one of the founders of subaltern studies, recognized that the task of reading these hidden voices would not be easy. She makes the point clear in her poignant analysis of Hindu practice of Sati, the Indian tradition of self-immolation of widows on the pyre of funeral of her dead husband, which had been especially prevalent in the Bengal area. The practice was outlawed by the British colonial government, where she characterizes a ban as "white men saving brown women from brown men," while Indian nationalists regarded the ban as another instance of cultural invasion, claiming that the "women actually wanted to die" (Spivak, 1988, p. 288). In these two contrary discourses, Spivak (1988) points out the impossibility of representation of women's voice since the discourses are invested in particular narratives that disallow the speech of the widows in the first place. Therefore, Spivak starts the inquiry by posing a fundamental question: Can the subaltern speak? (Spivak, 1988)

Some clinical practitioners in post-colonial societies have also wrestled with the task of hearing the authentic voices of their clients who suffer from the traumatic experiences of colonial violence. A South African feminist psychologist, Sally Swartz was one of the researchers to discover that the lives as well as the voices of women clients had been lost in the archives of clinical records in South African colonial history (Swartz, 1999). The efforts to recover those voices led her to subaltern psychology and to the question: Can the clinical subject speak? Swartz finds similarities between her clinical women patients and the subaltern, the Indian widows or the colonized Indians under British colonial dominance: both are bereft of speech in their status as the oppressed and marginalized (Swartz, 2005).

Like the case of "Sati," client voices are often left out in discourse in academia as well as in the political movements. For example, the mainstream psychiatry and psychology viewed people with mental illness as irrational beings in need of care by doctors. Similarly, client voices

were not represented in the anti-psychiatry movement that conceptualized people with mental illness as rebels against dominant social power, constructing "a clinical subject that is coherent inversion of dominant meaning" (Swartz, 2005). By leaving out clients' voices, the hegemonic as well as counter-hegemonic discourses, in effect, deny the clients the agency to tell their own stories.

Given the challenges in hearing the voice of clients as subalterns, Swartz (2006) suggests that clinicians pay attention to the intersubjective reality of clinical space. Intersubjectivity refers to the uniqueness of each therapeutic dyad, and how each influences the other in the interplay of the two subjectivities in a shared and unstable clinical space, where neither the clinician nor the client dominates (Swartz, 2005). Swartz (2006) argues that the notion of intersubjectivity makes it possible for clinicians to imagine the therapeutic encounter that is open for power negotiation, and "in taking seriously the search for individual meanings, it constructs a platform from which the clinical subject might speak and hear" (p. 433). Here, clinicians are not supposed to "speak for" their clients, but rather "speak to" them by listening for specific constellations of meaning in unique intersubjective spaces that are created at every moment of the clinical encounter.

To gain the skills of listening and speaking, clinicians will be required to understand the history that silenced the voices of the clients, since the clinical subaltern is always the product of very historical circumstances (Swartz, 2005). In addition, clinicians also need to pay attention to clients' expressions through their unconsciousness, such as their memories, dreams, and desires that have been ignored by preexisting, dominant discourses. Alternative methods of writing case notes are another way for clinicians to tap into the intersubjective reality of clinical encounters. However, clinicians should be given freedom in experimenting with these methods since clinical

records are usually subjected to power structures of institutions that are, as in managed care system, capable of limiting the care (Swartz, 2006).

Subaltern psychology based on postcolonial theory provides the tools for clinicians to frame the clinical encounters as "intersubjective" spaces in which the clients can be heard and speak. It opens up the possibility of viewing clinical encounters as ongoing negotiations of meanings and powers between two clinical subjects. Furthermore, subaltern psychology also requires that we pay specific attention to the history of social and political powers that silenced the clients, whether expressed in terms of gender, race, class, sexual orientation or nationality. At the same time, it cautions clinicians against the resistant discourses that could also hinder them from hearing the authentic voices of the clients.

Mental health as the Battlefield: Gender Analysis of Mental Disorders

Some Western feminist cultural historians who focused on the historical formulation of women's mental illness have identified a link between social power and discourse on mental disorder. To these historians, mental illness was not an objective fact waiting to be discovered, diagnosed and cured by men armed with scientific treatment methods. Rather, mental illness was a social construct that was shaped by power struggles among social groups. Cultural historian Elaine Showalter, who studied a history of psychiatry in modern England from a feminist perspective, showed this point clearly throughout her work. In nineteenth century England, psychiatry was a male-dominated profession with the power to determine normality and deviance, as well as the definition and treatment of mental disorder. It was also a period in which madness had become equated with "the female malady" since the main symptoms of mental disturbance

such as "emotional weakness" and "irrationality" were seen as attributes of the female nature as opposed to men's rationality and ability to control (Showalter, 1987).

Women were diagnosed as mentally ill whenever they tried to rise above their so-called "destined roles" imposed by the society. When middle-class women began to organize in the 1890s, diagnosis of female mental disorders became widely used as a tool to suppress women's efforts to change the conditions of their lives. Jane Addams and Beatrice Webb, pioneers of the social work profession in America and England, had been subjected to the social diagnosis of female nervousness disorder as young women. Jane Addams was once diagnosed as having "neurasthenia" and was prescribed "the rest cure," which meant she had to be isolated from her family and friends, confined to bed, forbidden to sit up, sew, read , write or to do any intellectual work since psychiatrists saw intellectual activities as the main obstacle to recovery. Whether intended or not, the labeling of these "New Women" as mentally ill by the male-dominated profession of psychiatry ultimately halted and discouraged some of these women's efforts to obtain individual autonomy (Showalter, 1987).

Even after women acquired professional status as mental health practitioners in the early twentieth century, their conditions had not changed. The failure to effect major change may be attributed primarily to the lack of a strong political feminist movement to support the efforts of these women to obtain influential position in the profession and to develop a feminist perspective in psychology. According to Showalter (1987), the feminist discourse within psychoanalysis collapsed "as female dissidents were marginalized or converted by the Freudian community, which pressed for internal cohesion and solidarity" and "was not revived until the 1970s, when important studies of the pre-Oedipal phase and its implications for female development by

Nancy Chodorow, Margaret Mahler, and Carol Gilligan, among others, reopened the field to feminist analysis" (p. 250).

It was not until the Second-Wave women's movement that women were able to claim their presence and political power to finally challenge the male dominated discourse in traditional psychiatry and introduce an alternative approach to female mental suffering through feminist mental health and therapy movement (Rosewater & Walker, 1985). The fight against misogynistic DSM-defined mental disorders, such as some Personality and Psychotic Disorders that were applied exclusively to women, would not have been possible without this support from the women's political movement (Ballou & Brown, 2002; Caplan, 1995).

In her groundbreaking work on psychological trauma, feminist psychiatrist Judith Herman also found a close link between political movements and the study of psychological trauma (Herman, 1997). According to Herman, the perpetrators of psychological trauma tend to seek any means to make people forget about their action; however, when the attempt fails, they resort to blaming the victims to escape accountability for their actions. When perpetrators are socially and politically powerful and victims powerless, the perpetrators' blaming the victim tactics tend to prevail. Thus, systematic studies of psychological trauma have always relied on the strong support of a political movement that would legitimate the victims' reality and voice to counteract the social processes of silencing and denial. As Herman (1997) poignantly points out, whether the "study of the psychological trauma can be pursued or discussed in public is itself a political question" (p.9).

Herman's point is clearly illustrated in her historical analysis of studies of hysteria in the late nineteenth century. When Sigmund Freud set out to study hysteria, he was on a quest to find the "true" cause of women's hysteria; however, what he discovered was not only unexpected but

also troublesome for him as well as his professional community. After extensive interviews with women, Freud discovered that underneath women's hysterical symptoms lay childhood sexual trauma. Unable to accept the radical and social implications of his own hypothesis, Freud repudiated his own findings. If he accepts the theory of trauma as the origin of hysteria, then he would have to accept the inevitable conclusion that childhood sexual trauma was truly endemic across the social classes, given that symptoms of hysteria were prevalent among women from working class as well as women from respectable bourgeois families which was his main client base. Faced with the dilemma, Freud stopped validating his female patients' feelings and began discounting the patients' accounts of childhood sexual abuse as untrue. Instead, he focused on exploring their feelings of erotic excitement as if the exploitative situation were a fantasy that was made up to fulfill their erotic desires (Herman, 1997).

Herman draws a connection between political movements and the study of psychological trauma when she points out why Freud was faced with the dilemma in the first place, namely the absence of political and social contexts to support the social implication of his theory. The only potential source of intellectual validation and support for this position at the time was the nascent feminist movement, but the movement did not have the political clout to persuade male doctors to admit and pursue the traumatic theory of women's hysteria given the radical nature of the theory in such a patriarchal social context. Neither did it have enough social and political power to give a voice to the disempowered victims who suffered emotionally because of sexual trauma. Therefore, it was not until the women's liberation movement of the 1970s that psychological trauma in women's lives was socially recognized as an undeniable reality. Whereas the investigators in nineteenth-century studies of hysteria refused to acknowledge that violence was a routine part of women's sexual and domestic life, the feminist investigators in the late

twentieth century finally validated women's experiences of sexual and domestic trauma and offered a new language for understanding the impact of this trauma in women's lives (Herman, 1997) .

Historical analyses of female mental disorder and psychological trauma reveal how inequality in power relations between genders affects the discourse of women's mental suffering and becomes a powerful weapon to discourage women's efforts to empower themselves. Herman warns that recognition of women's trauma and social power to define their own sufferings could disappear again without strong and persistent presence of a women's collective movement. Therefore, any mental health professional who works with powerless victims, including violence survivors, should not only acknowledge the importance of this political movement in the client's recovery but also be able to tap into the movement as indispensable resources for the client's healing and empowerment.

Clinical Practices in Domestic Violence Literature

In this section, I review clinical practice models and clinical intervention outcome studies in the field of domestic violence. Most of the clinical practice models included in this review has been developed based on insights from the feminist historical analysis of women and mental health that were examined in the previous section. In other words, these practice models reflect the belief that victim's mental health can only be understood in a broader socio-political context. On the other hand, the clinical intervention outcome studies reviewed here measured the effectiveness of both the conventional mental health approach and feminist clinical practice approach to the issue of domestic violence. Specifically, the outcome studies have focused on the

appropriateness of practice modality, such as individual or group practice, or the effectiveness of

PTSD "treatment" for domestic violence survivors.

Clinical Practice Models in Domestic Violence

One of the widely cited practice models for violence survivors is Judith Herman's Stages

of Recovery model for trauma (Herman, 1992). Based on research studies on the experiences of

soldiers traumatized by war experience and women who have been sexually or physically abused,

Herman discovered that the existing criteria in diagnosing PTSD fail to discern the complex

nature of trauma symptoms. She proposed the need for new diagnostic criteria and a therapeutic

framework for the complicated trauma symptoms that are caused by terror, disconnection and

captivity. The goal of the recovery model is to establish victims' safety, to achieve the

reintegration of traumatic experience into their lives, and finally, to obtain the reconnection with

themselves and others. Some of the suggested interventions are forming a supportive and

empowering relationship, validating the survivor's story, and working with survivors on their

loss and grief accompanying traumatic events and experiences.

Because it focuses on the complex nature of the trauma that abused victims are going

through and not pathologizing the symptoms they experience, this practice model has gained

considerable attention in feminist counseling as well as social work practice literature (Berg,

2002; Sands, 2001; Warshaw & Brashler, 2009). However, while it is a comprehensive model for

working with various trauma victims, it failed to take into account the special circumstances of

domestic violence survivors.

Mary Ann Dutton is one of the first feminist psychologists to develop the clinical practice

model for domestic violence survivors in early 1990s (Dutton, 1992). In her *Empowering and*

Healing the Battered Women, Dutton cites as the goals of the model for assessment and intervention to be protection, re-empowerment, and healing the effects of psychological trauma. She built her model based on a combination of trauma, cognitive behavioral and feminist theories. She provides detailed interventions and techniques to achieve each goal of the practice model. With the view that no single psychotherapeutic approach provides an adequate breadth of intervention, she adopted an eclectic approach. Key interventions are ensuring physical and emotional safety, educating about domestic violence, challenging socialized sex-role beliefs and providing advocacy. She also includes clients' involvement in social and political activism as the key intervention. What is unique about her model is its specific attention to the role of mediating factors affecting the battered women's response to abuse, such as institutional response, personal strengths, tangible resources and social support, which can be transformed into strategies for women to adopt in order to survive abuse.

Lenore Walker also proposed a clinical practice model, called Survivor Therapy, that was specifically designed for the abused women (Walker, 1994). Her practice model had similar goals to those of Dutton's, which are safety, re-empowerment, and healing of the trauma effects. She also based her model on the trauma theories and feminist psychology. What distinguishes her practice model from others is her conceptualization of the effects of abuse as "learned helplessness" and "Battered Women's Syndrome." She also paid special attention to the forensic issue involved in domestic violence cases. The possibility of involvement in the legal system was one of the reasons that led her to conclude that the clinicians should be trained and licensed therapists, especially given the credibility afforded to the testimonies of licensed professionals in the courtroom. When the clinicians need to secure additional resources and advocacy for the clients, she recommends referrals to local domestic violence programs. She also specifically

mentioned the need for individual therapy along with group therapy, since many times the

clinician is required to pay special attention to individual woman's unique issues, including

psychological issues caused by the trauma of abuse.

In addition, Walker recommended the use of various psychological testing and DSM-

based diagnosis as one of the assessment techniques since their use is well-established in legal

proceedings. Even though she acknowledged that the DSM does not provide as much detail as

would be useful for the abuse victim suffering PTSD, she thought that it still could provide a

legitimate framework for making sense of relevant assessment data. At the same time, she

cautioned that this diagnosis and testing should be considered as a hypothesis to be further

evaluated with other information, rather than being treated as an objective truth. However, the

use of psychological testing and conventional diagnosis is still debatable because not all

standardized testing instruments were tested with the domestic violence survivors and there is

always a chance that the result of the testing will be used against women. In addition, not every

licensed mental health professional, including social workers, can adopt psychological testing as

an assessment method.

While Herman, Dutton and Walker address interventions at the social level, with

advocacy practice as one of the practice components in their models, Mollie Whalen placed

political activism at the center of her "Subversive Model" of counseling to end violence against

women (Whalen, 1996), which is based on feminist radical therapy. The model emerged from

Whalen's qualitative case study of counselors working with survivors of domestic violence that

examined which counseling models were conceived and used by counselors in feminist social

change organizations. The Subversive Model acknowledges the significance of the role of

trained mental health professionals who hold radical feminist ideas about the battered women's

movement. Whalen criticized the anti-professionalism in the movement as the outdated bias that has created a false dichotomy between battered women and professionals. Unlike other models which assume their main audience to be the professionals working outside DV programs, the Subversive Model targeted the professionals working within the domestic violence programs.

The goal of the Subversive Model is to increase the collective strength of women, increase access to safety and resources and enhance the personal power and self-efficacy of the survivors. The recommended interventions to achieve these goals are consciousness raising, collective power building in relationships between advocates and women, volunteer training and direct action against abusers. Among other intervention techniques, Whalen emphasized the centrality of engaging clients in the political action through lobby and protest, and social and cultural action through media protest and education. In this model, the counselor participates in political action with clients as social activists. However, the model does not address the issue of self-determination and readiness of survivors to become involved in political or cultural action. For this reason, other scholars began looking for models that would enable the counselors to tailor their services to the survivors' readiness to end the violence in their own life.

The Stages of Changes model was developed based on the Transtheoretical Model (TM) which was originally developed for changing health behaviors, such as smoking and alcohol use (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Velicer, DiClemente, & Fava, 1988; Prochaska et al., 1994). The TM is premised on the view that changing behavior is a dynamic process and people progress through stages in trying to modify their behaviors. In the TM, the stages of changes are comprised of stages of precontemplation, contemplation, preparation, action and maintenance. Jody Brown was the first to adopt this model to explain the way the victims of domestic violence respond to the violence and

incrementally change their abusive relationship (Brown, 1997). Recognizing the limitations of existing outcome measures for instances of domestic violence and women leaving the abusers, Brown sought to develop a model that can measure the women's activities and cognition or their determination to make changes in their lives. Therefore, the goals of the Stages of Change model are to promote women's readiness for change in an abusive relationship, take actions to free themselves from violence, and support maintenance of those changes.

In terms of the interventions, this model is not linked to any particular intervention approach, but utilizes many different kinds of interventions to help women move through the stages of change. For instance, at the precontemplation stage, clinicians can help survivors move to the next stage by providing information about resources and by helping them to reevaluate the situation and themselves, so that they become aware that the abuse is not their fault. At the contemplation and preparation stage, conscious raising strategies through further education about the dynamics of DV and the abuser's power and control tactics, along with emotional support, can help women get ready to make changes in their relationship. At the action stage, strategies for countering the abuse will be needed, such as assertiveness training, group support, and grief counseling to help women mourn the losses caused by the abuse, including the loss of self. Finally, at the maintenance stage, the clinicians are required to help women affirm and reaffirm the new self as well as maintain whatever changes the women brought to their lives.

Because of its ability to capture complex processes leading to women's readiness for changing their abusive relationships, the Stages of Change model has gained considerable attention in both academic and practice settings. Clinicians in various practice settings have refined the model and the interventions based on quantitative and qualitative research studies on changes in behaviors of domestic violence survivors (Bliss, Ogley-Oliver, Jackson, Harp, &

Kaslow, 2008; Burke, Gielen, McDonnell, O'Campo, & Maman, 2001; Cluss et al., 2006; Edwards et al., 2006; Park, 2009). However, despite its great potential to integrate different levels of interventions, the detailed integration has not been systematically examined in academic and practice literature. In addition, there are few outcome studies testing the efficacy of the interventions in this model.

Based on the review of these five practice models, several points can be made on the characteristics of these models. First, all these models emphasized non-pathologizing characteristics and symptoms that survivors usually present. In this respect, most of the authors either warned about adopting DSM-based diagnoses and psychological testing, or actively reconstructed new criteria for diagnosis. Second, it was central in these models to select the appropriate treatment approach with sensitivity to abuse. Most of the models attempted to evaluate existing therapeutic approaches in terms of how they can empower and heal the survivors of abuse, and modified the techniques if necessary. Third, power analysis was a critical component in all the models. Clinicians are required to analyze power and control effects of abuse, to reflect on the power imbalance between clinicians and clients, or to pay attention to social and political powers that define the nature of suffering experienced by abuse victims. However, with the exception of the Subversive model, there was little attention to social or political action as an intervention strategy. Advocacy was the most common strategy for incorporating the macro level of interventions of the models. Finally, with the exception of the Subversive Model, all the practice models assumed that the practitioners are licensed professionals and working outside the domestic violence programs. (See Table 1 below for an outline of the models.)

Table 1: Clinical Practice Models for Domestic Violence Survivors

Model	Goals	Theoretical Foundations	Interventions /Techniques/Modality	Workers	Unique Features
Stages of Recovery from Trauma Model (Judith Herman, 1992)	Establishment of safety Remembrance and mourning Reconnection	Postmodern feminist theory Trauma theory	Supportive, empowering relationship Initial concern for safety issues Survivor controls her own recovery Listening to and validating the survivor's story Professional neutrality but not moral neutrality Grief work Connection with others Individual and group therapy	Mental health Professionals	Attention to diagnostic mislabeling Complex PTSD as alternatives to current diagnosis of PTSD
Empowering and Healing Model (Mary Ann Dutton, 1992)	Protection & Safety Reempowerment through decision-making and problem-solving skills Healing the effects of psychological trauma	Trauma Theories Cognitive Behavioral Theories Feminist Therapy Theories	Protection from suicide/homicide risk Ensuring emotional safety Validation &Facilitating hope Encouraging self-nurturance Increasing knowledge about DV Increasing social support & economic resources Challenging socialized sex-role beliefs Providing advocacy Encouraging involvement in social political activism	Mental health professionals outside DV agencies	Abuser's non-violent abusive and controlling behaviors Victims' survival strategies Understanding tolerance of abuse using cognitive theories The role of mediating factors The Impact of institutional victimization Political activism of the MH professionals

Model	Goals	Theoretical Foundations	Interventions /Techniques/Modality	Workers	Unique Features
Survivor Therapy (Lenore Walker, 1994)	Safety Reempowerment Healing trauma effects	Trauma Theories Feminist Psychology	Ensuring safety Validation Emphasis on strengths Understanding oppression Raising self-esteem Ending isolation Modified other therapy techniques Individual and group therapy	Trained/licensed therapist as professional expert	The concept of learned helplessness as the effect of abuse The use of various psychological testing and DSM-based diagnosis as hypothesis Forensic issues, including custody evaluation Referral to DV programs
Subversive Model (Mollie Whalen, 1996)	Increased collective strengths of women Increased social provision of material resources Increased access to resources, safety, intimate opportunities Enhanced personal power, competence, and self-efficacy	Feminist radical therapy theory	Relationship building Collective power in counseling and shelter Consciousness raising Volunteer training Direction action against abuser Political action through lobbying and protest with client Social and cultural action through education and media protest with client	Social activist	Targeted toward the workers in the DV organizations Incorporation of social change strategies into counseling model Relationship between counselor and client as the member and initiate in social movement
Stages of Change Model (Jody Brown, 1997)	Readiness for change in abusive relationship Action to free oneself from violence Maintenance of change	The Transtheoretical Model (The Stage of Chang) Precontemplation Contemplation Reparation Action Maintenance	<u>Precontemplation</u> Information about resources Consciousness raising <u>Contemplation and Preparation</u> Consciousness raising Support groups Emotional support <u>Action and Maintenance</u> Assertive training Greif counseling Emphasis on affirming and reaffirming the new self for maintenance of change	Health care and mental Health professionals DV program advocates	A spiral and cyclical process of change The effect of both internal and external constraints on the efforts to end violence The interventions tailored to each stage of change

Outcome Studies of Clinical Interventions with Domestic Violence Survivors

While there has been a debate about whether therapeutic approaches are appropriate for domestic violence survivors, the literature has shown that domestic violence does affect women's mental and emotional health (Warshaw, Brashler, & Gil, 2009; Wilson, Silberberg, Brown, & Yaggy, 2007) as abuse functions as an acute or chronic stressor that leads to adverse mental health and physical health outcomes (Lipsky & Caetano, 2007). The findings of research studies show that battered women have higher levels of depression, sucidality, and Post-Traumatic Stress Disorder (PTSD) than the general population. Golding (1999), in a meta-analysis of the mental health effects associated with domestic violence on women, found that the prevalence of depression among battered women across studies was 47.6% compared to rates ranging from 10.2% to 21.3% in the general population of women. This meta-analysis also showed that the prevalence of suicidality among battered women was 17.9%, higher than rates found in general female population (Golding, 1999). The prevalence of PTSD among battered women was 63.8% (Golding, 1999), compared to rates ranging from 1.3% to 12.3 % in general population of women (Golding, 1999; Jones, Huges, & Unterstaller, 2001). Literature on battered women also indicates that this client population usually suffers from very low self-esteem, weak ego, and self-blame for the abusive behavior of their intimate partners (Shamai, 2000), which is often the result of repeated, prolonged psychological abuse inflicted on victims by abusers, such as constant put downs, and physical or emotional isolation (Berry, 2000).

Along with this report of consequence of domestic violence on women's mental and emotional health, there have been research studies of clinical interventions with domestic violence survivors. However, many researchers have pointed out that the effectiveness of most interventions has been neither well researched nor well articulated in the field of domestic

violence (Abel, 2000; Jones et al., 2001; Lundy & Grossman, 2001). In fact, a meta-outcome study for all five clinical practice models reviewed above is virtually non-existent. Instead, each practice modality in these models has been separately examined in different research studies, such as individual counseling and support groups. In terms of effectiveness of intervention with specific symptoms, PTSD "treatments" is the most extensively studied in domestic violence literature. This is understandable, given the prevalence of PTSD among domestic violence survivors, even though the appropriateness of DSM-based diagnosis for these clients has been disputed among clinicians (Berg, 2002; Herman, 1992; Jones et al., 2001; Perez & Johnson, 2008)

The lack of outcome evaluation in the area of domestic violence can be explained several ways. One explanation is that advocates tend to be suspicious of clinicians who, they believe, fail to see domestic violence as a social problem (Lundy & Grossman, 2001). Considering that there is a persistent doubt about whether therapy is even appropriate (Tutty, Bidgood, & Rothery, 1996), it is not surprising that clinical interventions have not been emphasized in the research on domestic violence to date. Abel and her colleagues (2000) also point out that the absence of outcome studies can be attributed to the flexible and open-ended nature of practice that is unique to the field of domestic violence. Many women arrive at the agency in a state of active crisis, and may stay a few hours or a few weeks. Such a service delivery environment and related factors make it very difficult to design an effective outcome study. Moreover, given the emergency nature of intervention, delaying or withholding services in order to conduct studies to include experimental and control groups to study intervention effectiveness poses serious ethical concerns (Abel, 2000).

Another explanation for lack of outcome research studies in domestic violence field has to do with domestic violence organizations' hesitation to work with researchers because of

methodological and ethical issues related to research in general (Sullivan & Cain, 2004; Yllo, 1988). Yllo (1988) suggested that the hesitation stems from the underlying dichotomy between experts and non-experts of positivistic quantitative research, which assumes that researchers can achieve objective truth by following the protocol of the empirical research method. According to Yllo, this assumption often times resulted in dismissal of opinions and challenges offered by battered women and shelter workers as being subjective. In addition, some researchers showed a lack of understanding of unique ethical issues relevant to domestic violence, such as concerns about safety and confidentiality. Based on their extensive experience of outcome research in the domestic violence field, Sullivan and Cain (2004) addressed the problem by offering a detailed protocol with which researchers can consider these ethical issues when they collect information from or about battered women for research purpose.

Despite the controversies and difficulties around outcome evaluation study in this area, clinical interventions and evaluation of their efficacy is necessary, since many women are already receiving therapeutic services when they seek help (Lundy & Grossman, 2001; McNamara, Tamanini, & Pelletier-Walker, 2007). Despite the dearth of available outcome studies, researchers from various disciplines have attempted clinical outcome evaluation studies that can serve as a resource to identify evidenced-practices in this area.

Systematic review of intervention studies

Abel (2000) reviewed the outcome studies of psychosocial treatment interventions for battered women. Articles in this review include studies that focused on the interventions specific to domestic violence survivors such as shelter-based services, non-shelter support groups, shelter-based group treatment, advocacy services and follow-up treatment. The outcomes

measures adopted in the reviewed studies included (1) daily degree of partner's abusive behavior, (2) self-efficacy, (3) self-esteem and (4) interpersonal support. Research evidence shows that a short-term, group intervention process is associated with successful outcome, and the most often cited frameworks of practices were feminist, social support, and cognitive. Since most of the studies focused on a short-term, group intervention process, effectiveness of other intervention modalities, such as individual counseling, could not be identified in this review. Moreover, more than one half of research studies used very small study samples, while several studies had design weaknesses, such as lack of control or comparison groups or follow-up study. Lastly, because the evaluated interventions were often performed by inexperienced workers, Abel (2000) predicted that increased professionalization of providers could result in more successful treatment outcomes.

While studies in Abel's review centered on the practice modalities, Warshaw and Brashler (2009) focused on the treatment approach to mental health symptoms presented by survivors of intimate partner violence. Based on the review of trauma and domestic violence research, they outlined the best practice approaches as combining core principles of domestic violence advocacy work with evidence-informed trauma treatment. Specifically, they suggested that framework and treatment for complex trauma is potentially most helpful for mental health symptoms in the context of ongoing trauma, entrapment and danger, which is a typical situation for many domestic violence victims (Warshaw & Brashler, 2009). However, they found few research studies that addressed this complex trauma in the context of ongoing domestic violence, where legal, safety, and custody issues abound, while a fair amount of outcome research studies have supported the effectiveness of this framework for child abuse victims.

Support groups

As identified in Abel (2000)'s study, group interventions, specifically support group services, have been shown to be effective in improving client outcomes. Bowker and Maurer (1986) examined comparative effectiveness ratings among three sources of counseling: clergy, social service counseling agencies, and women's groups. The result of this study shows that women's groups were more highly rated than the other two groups in their effectiveness even though this group service was the least utilized among the three sources (Bowker & Maurer, 1986). The authors explained that modeling in women's groups contributed to this positive outcome, as group members who observe others who have become free of violence receive a strong boost in confidence and an increased belief that cessation of violence can also occur in her life.

This positive outcome for support group services was supported by two other outcome studies conducted almost a decade later by Tutty and her colleagues (1993; 1996). Tutty and her colleagues conducted a quasi-experimental research study with 76 women to identify the efficacy of support groups and found significant improvements in participants' self-esteem, sense of belonging, and coping skills with perceived stress (Tutty, Bidgood, & Rothery, 1993). The authors, however, did not find any significant associations between superior outcomes and client characteristics. For instance, both the clients residing with their partners and those living separately from their partners responded similarly to the groups. However, the data suggest some advantages over time to two-leader groups as compared to one-leader group (Tutty et al., 1996). One explanation, according to the authors, is that two leaders are likely to provide stronger role models and also allow one leader to attend to the content while the other monitors group process, thus providing a more effective leadership team. Moreover, regular attendance at

groups has been evidenced to bring a positive effect on clients, and programs should identify the barriers that make access to the groups difficult for women, such as an abuser's control and/or the lack of transportation or child care (Tutty et al., 1996).

Individual Counseling/Therapy

While support groups have been the most widely adopted intervention by domestic violence agencies, many studies highlight individual counseling as an effective way to assist the recovery process from negative impacts of violence on women's lives. Shamai (2000) examined the way battered women experience the entire treatment process using semi-structured in-depth interviews. In this study, the author identified specific needs for individual types of therapy sessions in participants, since individual sessions provide undivided attention from the therapist. This was the only way for them to feel that they are individuals apart from their roles as wife, mother or supportive group member (Shamai, 2000). Other than the need for individual counseling, the author suggested including the following considerations for treatment planning: (a) a short-term treatment of battered women is not effective because the therapeutic process is complex, involving different levels of consciousness and touching a deep emotional level; (b) it is important to avoid expectations for one concrete change, such as elimination of violence and the treatment change can occur on the cognitive or emotional level and not necessarily on the behavioral level; (c) a client-worker relationship that creates a containing and holding context is crucial for the continuation of the treatment; (d) all techniques that support, empathize, and increase self-esteem are significant to the women (Shamai, 2000).

Even though long-term therapy is considered as a desirable and effective intervention, there is evidence that short-term counseling also is as effective in certain service settings, such as

shelter. Cox and Stoltenberg (1991) examined the effectiveness of short-term personal and vocational counseling on self-esteem, locus of control, assertiveness, hostility, depression, anxiety and career maturity by using a cognitive-behavioral intervention model. The findings showed mixed results. While there was significant improvements from pre- to post-treatment on self-esteem and assertiveness, no significant result was found in career maturity. The author predicted that if women have dependent children, the idea of going to work may not be desirable, as their immediate goal is not to develop a career, but merely to obtain financial support (Cox & Stoltenberg, 1991).

McNamara and his colleague (2007) also examined the efficacy of short-term counseling at a domestic violence shelter equipped with a feminist orientation coupled with eclectic elements of cognitive behavioral, existential, solution-focused and family systems frameworks. In this quasi-experimental study, significant positive changes were identified over time in women's self-esteem, interpersonal relationship and symptom distress reduction. Since symptoms of distress were the best overall predictor of life functioning, reducing the level of symptoms seems to be an important treatment priority. On the other hand, there was a lack of progress in the work/employment area and family, which highlights a need for more emphasis in fostering interventions that focus on enhancing work skills, motivation, and employability in general. Also, alternative approaches are needed for women with primary child care responsibility or disability (McNamara et al., 2007).

While McNamara and colleagues (2007) suggest that symptom reduction should be given an important treatment priority as an outcome measure, Bennet and his colleagues (2004), based on feedback from domestic violence advocates, shifted the focus of counseling evaluation from psychological response (e.g. depression and anxiety) to whether counseling was helping women

make healthy decisions, rebuild and regain control of their lives, and increase their self-efficacy. These advocates' core concern on symptom reduction measures was that information about social and psychological dysfunction could be used against women in divorce or custody proceedings (Bennett, Riger, Schewe, Howard, & Wasco, 2004). These authors also conducted a comparative analysis of counseling outcomes between women who have been raped and battered by intimate partners and women who have been battered but not sexually assaulted by using a quasi-experimental research method (Bennett, Riger, Campbell, & Wasco, 2003). The results showed that the group of raped and battered women ended with lower level of improvements at post-counseling assessment, indicating that intimate partner rape has additional negative effects on women's self-esteem, coping skills, attribution of blame and feeling of shame. The authors recommended that different or additional care should be given for raped women, such as more counseling sessions, different types of counseling formats or techniques, and group counseling with other survivors of partner rape that focuses on both kinds of abuse (Bennett et al., 2003).

PTSD treatment

There has been an increasing awareness among mental health professionals about the impact of PTSD on outcomes for battered women. However, much of the PTSD treatment-outcome research has focused on women survivors of sexual abuse or assault to date, and previous reports of therapeutic approaches to battered women are largely descriptive, or anecdotal in nature (Jones et al., 2001). Based on their review of literatures on domestic violence and PTSD, Jones and her colleagues (2001) suggested that effective therapy for battered women focuses on the traumatic event and helps women obtain new skills to ensure their safety. According to their review of the literature, while treatment for the underlying depression is also

needed so that the women can mobilize resources on behalf of their own safety, treatment has to go beyond treating the depression to address PTSD (Jones et al., 2001).

In this respect, Kubany and his colleague's outcome study of cognitive therapy with battered women with PTSD was the first extensive treatment outcome evaluation research (Kubany et al., 2004). In this research, the authors examined the effectiveness of Cognitive Trauma Therapy for Battered Women (CTT-BW) that they developed targeting this specific client population. The results showed that 87% of women who received this therapy no longer met diagnostic criteria for PTSD with corresponding reductions in depression, guilt, and shame, and also significant improvement in self-esteem. Also, this therapeutic improvement was maintained at 3- and 6 months follow-up assessments. The treatment was efficacious across an ethnically diverse group of women. Most of all, the efficacious results were achieved by therapists with no formal psychotherapy training, suggesting that paraprofessionals in domestic violence agencies represent a large potential pool that could be trained to conduct CTT-BW.

Advocacy

Advocacy is a critical practice component in helping domestic violence survivors empower and heal themselves from violence trauma (Dutton, 1992; Warshaw & Brashler, 2009). Cris M. Sullivan and her colleagues were the first to test the efficacy of community advocacy services for domestic violence survivors (Sullivan & Bybee, 1999; Sullivan & Cain, 2004; Sullivan, Campbell, Angelique, Eby, & Davidson II, 1994; Sullivan & Davision II, 1991; Sullivan, Tan, Basta, Rumptz, & Davision II, 1992). More specifically, the findings of their two-year longitudinal experimental research study showed significant improvements in obtaining community resources and less victimization by ex- or current partners among women who

received services from paraprofessional advocates for 10 weeks after exiting shelter, compared to women who were randomly assigned to the control group that received no such services. They also identified the following specific elements of advocacy services to protect women from further abuse and to increase overall quality of life: 1) client-centeredness of intervention; 2) focus on systems change by making communities more responsive, instead of attempting to change survivors' thinking and belief system; and 3) belief in survivors' capabilities of making sound decisions for themselves (Sullivan & Bybee, 1999) .

In sum, evidence of effectiveness of services for DV survivors to recover a healthy sense of self and emotion indicates the following interventions as best practices: (1) the combination of support group and individual counseling services, (2) long-term or short-term counseling depending on service setting using feminist-oriented and cognitive therapeutic approaches, (3) focus on PTSD symptoms along with depression, anxiety, guilt, shame and low self-esteem, and (4) therapeutic services along with coordination of services, such as case management and advocacy.

The Review of Empirical Studies

Research Studies on Social Workers' Practice

While there have been some efforts to integrate the micro and macro dichotomy in social work at theoretical or conceptual level as reviewed above, there are few empirical research studies conducted on this subject. Two decades ago, Reeser and Epstein (1990) conducted a secondary analysis to test the wide spread assumption in the field that social workers in the past were engaged in more social activism and that professionalization was a conservatizing force

that led to the rejection of social action in social work. Although the authors did not directly address the micro and macro dichotomy in their research study, they viewed the professionalization of the social work in terms of increasing services to individual clients, as opposed to social workers' commitment to social activism. In this study, they compared the survey results in the sixties and the eighties on social workers' attitudes and beliefs toward professionalization and social activism as well as their background characteristics. The findings of this analysis showed that there was little empirical evidence supporting the position that professionalization is a conservatizing force. What they found instead was that social workers in the sixties were not necessarily more involved in activism than those in the eighties, but that both sets of social workers were committed to their own strategies of social change. The more crucial factor was social workers' background characteristics, such as gender and race and their political beliefs they brought to the field. Since more conservative social workers frequently reject social action efforts as "nonprofessional" or as potentially damaging to social work professionalization, it would be natural for observers to understand their conservatism in terms of professionalization. Therefore, the authors concluded that the widespread folklore about the negative relationship between professionalization and social activism in social work was a "political myth." Instead, future social work activism will be influenced by political movements external to social work and the background characteristics social workers bring to field, rather than the degree of professionalization of social work (Reeser & Epstein, 1990).

One of the most comprehensive research studies on this topic is a recent dissertation study conducted by McLaughlin (2006). As a social worker who served in the field of mental health for sixteen years, she became interested in why clinical social work is seen as abandoning its mission of social justice. McLaughlin conducted a qualitative study to explore

clinical social workers' understanding of social justice focusing on the following three research questions: (1) how do mental health social workers conceive of social justice, (2) how do they incorporate social justice in their work, and (3) what barriers do they encounter. Based on the results of in-depth interviews with 18 participants, she concluded that even though the participants' perception of social justice was heterogeneous and multilayered, most of them made efforts to incorporate social justice components into their clinical practices in their own ways. Social justice was understood as changes in social systems, access to resources and transformative respect in services to individual clients. Among various strategies, advocacy proved to be their best efforts to link clinical practice with social justice (McLaughlin, 2009).

The study also suggests that the treatment modality practiced by clinical social workers is not a dominant factor in whether or not they are reaching social justice aims if the practitioners pursued social justice as his or her aim and is firmly grounded in the person-in-environment perspective. This is an interesting finding since other literatures have emphasized the congruency of underlying theoretical approaches of micro practices with social change or social justice as core professional values (Sachs & Newdom, 1999). In addition, other participants in this study reported "a clinical trap" as the barrier to achieve social justice. The predominance of the medical model represented by the DSM prevented them from working toward social justice, and still others cited organizational barriers. To be active in social system change efforts is particularly challenging when working for government-funded or subsidized agencies since "you don't bite the hand that feeds you" (p. 135). At the conceptual level, when the participants perceived that social justice work is external to clinical work, they experienced difficulty in incorporating social justice into their clinical practice. For instance, some of these participants were afraid that social justice work might prevent them from addressing problems of individual

clients (McLaughlin, 2006). In this respect, the dichotomy in micro and macro practices seemed to persist at least at the conceptual level of these social workers' in spite of their efforts to incorporate social justice work into their practices.

Buchbinder and her colleagues (2004) grappled with the issue of this dichotomy at social worker's conceptual level. They conducted a qualitative study on Israeli social workers' subjective understanding of the balance between the psychological and the social, and of their strategies for dealing with the dual mission inherent in the psycho-social concept. They chose social workers from a variety of social services, ranging from most generic to most specialized, including public welfare, child welfare, mental health, and domestic violence. Thirteen workers held bachelors' degree while twenty two were master's level social workers. Also, the majority of participating social workers were women (29 out of 33). Through in-depth interviews with thirty five social workers, they categorized different types of social workers based on their practice focus between psychological and social. The first type of social workers focused predominantly on the individual characteristics and intrapsychic etiological explanations. They relied heavily on diagnostic language that distances social aspect from social worker's consciousness. The second type of social workers acknowledged that social aspects are integral part of intervention, while believing that the core of the problems lie in the individual person. They understood social aspects only in terms of community resources and their impact on the clients' ability to cope. The last category of social workers focused mainly on environmental changes and adopted social means to practice. They firmly believed that an overly individualistic approach leads to the loss of professional uniqueness and the values and mission of the profession.

What the authors found was that the widely used term *psychosocial* in the profession turned out to be a "conceptual mantra," but did not reflect a well-developed conceptual blend of the individual and the social; thus the concept of locating practice at the juncture between the individual and the social remains largely prescriptive. To the authors, the gap between what is prescribed and practiced by social workers seemed to be exacerbated by the profession's traditional eclecticism, with less attention paid to abstract theoretical concepts. Without a clear understanding of the integrated approach, individual social workers needed to find their location on the psycho-social continuum, based on their socialization within the profession or their individual belief system. Upon this finding, they suggested future research on this topic be conducted in specific working environments and cultural contexts, with following questions: At what points in the course of professional development do social workers make a commitment to one or the other orientation? What affects this decision? Is the decision determined by the working environment, by personal preferences, or by the nature of work and clients? How can social work develop practical ways to combine the two orientations? (Buchbinder, Eisikovits, & Karnieli-Miller, 2004)

In summary, this review of the literature on the integration between micro and macro practice in social work revealed several gaps. First and foremost, few empirical research studies have been carried out to understand the perception and actual practice of social workers on this topic. Second, further study is needed to examine the role of theories, and practice modalities in the integration efforts. Last, more attention should be directed to the practice environments and the nature of agencies, in terms of how these contextual factors affect social workers' efforts to link these two areas of practices.

Research Studies on Practitioners Working with Domestic Violence Survivors

While the number of domestic violence research publications has drastically increased over the past 20 years (National Center for Injury Prevention and Control, 2003), only a few studies have examined the practices of clinicians working with domestic violence survivors (Dudley, McCloskey, & Kustron, 2008; Harway & Hansen, 1993; McPhail, Busch, Kulkarni, & Rice, 2007; Whalen, 1996). The research of Dudley and her colleagues (2008) is the most recent study that examined the ability for the mental health professionals to effectively identify and intervene with domestic violence. It replicated the research procedure of Harway and colleagues' earlier work (1991; 1993) and compared the results with those studies. While there was an overall improvement in the therapists' ability to identify relationship conflict, the study also produced several disturbing results. First, it revealed that some mental health professionals still adopted the victim blaming stance. Some of these professionals still diagnosed an abused wife as masochistic or Conduct Disorder and focused the interventions solely on victims, or otherwise included her in couple's therapy, which could imply that both partners are responsible for the abuse. A more disturbing finding was that these therapists were unable to identify possible lethality in the case vignette presented to them. Generally, the study showed that these therapists can choose ineffective or even dangerous interventions that could increase client risk. The authors suggested inclusion of training on domestic violence issues in professional coursework or accreditation or licensure requirements. While clinical social workers are included in this study, the organizational setting in which they work is not discussed in this study. Considering that the results of the study report an ongoing victim blaming stance in the sample, we can only assume that they are probably not affiliated with domestic violence organizations.

On the other hand, most research studies on domestic violence organizations do not focus on the practices of their clinical staff (Chong, 2000; Ferraro, 1983; Hammons, 2004; Lehrner & Allen, 2008, 2009; Srinivasan & Davis, 1991; Tice, 1990). These studies, however, revealed an ongoing struggle with the integration of micro and macro interventions while showing the presence of persistent suspicion about the works of clinical staff or 'professionals' within the organizations. Among them, one study explored how staff in the domestic violence organizations is socialized to interpret the battering as social-psychological rather than as politicized language. Based on the findings from a case study of one battered women's shelter, Hammon (2004) showed that the social-psychological approach gave workers a sense of empowerment and effectiveness, which not only validated and reinforced the socialization process but also permitted them to appear as being knowledgeable about the field. This, in turn, gave them a sense of legitimacy as professionals. Interestingly, Hammons (2004) discovered that a private therapist who works with a domestic violence organization was more politicized on the issue than most of the shelter staff because this therapist was removed from the effects of socialization in the agency.

In this respect, Whalen's study (1991) is noteworthy in that she focused exclusively on the clinicians' practices within the domestic violence organizations. She conducted a case study of counselors working in domestic violence and sexual violence programs in Pennsylvania with the following research questions: What counseling models were used by counselors working in feminist social change programs and how did the ideology of the social movement inform those models? The results were unexpected and Whalen recognized that it was because these counselors "failed to avoid the fatal trap of individual psychological understanding and its implication for identifying the locus of the program of woman battering" (p.72). Disappointed

by the results, Whalen went on a quest for a counseling model that better fits the ideology of radical feminism and the Battered Women's Movement, which became the Subversive Counseling Model. Even though Whalen's study focused on clinicians working in domestic violence organizations, little is revealed about the professional backgrounds of these clinicians. In addition, Whalen assumed that the counselors would naturally incorporate the social movement ideology into their practices and did not inquire about other factors that might affect their decisions on whether to integrate the micro and macro practices or not.

In terms of specific practice models that practitioners adopt for working with domestic violence survivors, McPhail and her colleagues (2007) conducted a focus group study with frontline workers in domestic violence agencies about their experiences and practice with the feminist model. The focus group consisted of thirty three practitioners with a wide range of years of experience in domestic violence field. In the focus group, the participants reported that there were inconsistencies and tensions between assumptions of the feminist model and the reality. They also expressed a desire for a paradigm that would give them the flexibility to take useful elements from the feminist model as well as from other models. Upon these findings, the researchers proposed the Integrative Feminist Model (IFM) that requires scholars and practitioners to revisit factors that had been previously overlooked or rejected in the movement for being gender-biased, such as the role of physiological and neurological factors, childhood experience of violence, and even psychopathology from feminist perspectives (McPhail et al., 2007). More importantly, they viewed that incorporating this model into practice would require more training in clinical assessment and interventions, which would call for an even greater level of service professionalization.

According to McPhail and her colleagues, even though the professionalization has drawn criticism for depoliticizing violence in the women's movement, the IFM allows for "professionalism and activism to coexist productively"(p.836). However, their focus was not specifically on clinical social workers' practice, even though they attempted to develop an integrated model based on hands-on experiences of frontline workers.

The review of existing research on practices of clinicians in the field of domestic violence showed that no attention has been paid to how clinical social workers negotiate between the micro and macro practice in a field with a history of strong suspicion toward the therapeutic approach. Therefore, further research is needed to understand how clinical social workers in domestic violence agency settings perceive the dichotomy between micro and macro practice and how they construct their practice to integrate these different levels of interventions.

CHAPTER THREE: METHODOLOGY

This study uses naturalistic inquiry to explore how clinical social workers integrate micro and macro interventions in their professional practice. Naturalistic inquiry is based on the constructivist philosophy. Compared to a positivist paradigm, the constructivist paradigm has a different set of philosophical assumptions about the nature of reality, knowledge and human nature (Denzin & Lincoln, 2000, p. 27). In terms of the nature of reality, the constructivist paradigm assumes there is no single, observable reality and that realities are socially constructed. In this world view, individuals develop subjective meanings of their experiences through interaction and cultural norms that operate in their lives. Consequently, their meanings are varied and multiple, which lead researchers to look for the complexity of views. The constructive paradigm also aims at local, time-bound idiographic representations, not time and context-free predictions and generalizations. It does not aim to find linear causality; rather the paradigm assumes that all entities are in a state of mutual simultaneous shaping and that it is impossible to distinguish causes from effects. It searches to identify functional relationships, such as recurrent regularities that shape the relationships in a context (Lincoln & Guba, 1985).

The constructivist research paradigm also assumes that there is no objective distance between the knower and the known. In the research process, the inquirer and the "object" of inquiry interact to influence one another. In addition, the inquiry is value bound by the inquirer's choice of the problem to be researched, and by the values that are inherent in the environment of the inquiry (Rodwell, 1998). The recognition that the inquiry is value-laden sheds new light on the role of the attributes and the "bias" of the researchers in many other non-positivistic inquiry paradigms that share this epistemological stance with constructivist inquiry (Denzin & Lincoln, 2000). For instance, a feminist researcher steps beyond traditional criticism about researcher bias

and argue for "strong reflexivity" of the researcher's own part in the research (Olsen, 2000). They further argue that researcher reflexivity needs to be "tempered with acuity to what elements in the researchers' backgrounds, hidden or those of which they are unaware, contribute" (p.229).

This study of the integration between micro and macro practice was motivated by my involvement in the women's liberation movement in South Korea and my work in domestic violence organizations in the U.S., which included working as a clinical social work intern. I brought my feminist perspectives and my view of clinical social work practice to the research process, the encounters with research participants and the interpretation of the results. My social status and identity as a woman of color who grew up in a foreign country also affected the knowledge construction through data interpretation. For instance, I could have taken advantage of being an "outsider" and thus maintain a more objective stance when I interpret the data about the debate between different perspectives on domestic violence in the U.S. However, when participants expressed their criticism of feminisms and women's movement, I observed that I became defensive because of my feminist identity. With this observation, I made efforts to monitor and reflect on the impact of my ideological positions on data interpretation through reflective journaling. Throughout the research process, the assumptions and biases that I brought to the research was monitored through the strategies adopted to attain methodological rigor. I will discuss these strategies in detail in the last section of this chapter.

Research Questions

This research poses three questions in exploring integration of micro and macro practice in clinical social work. Although there have been efforts by some social work scholars to integrate these two areas of practice, the review of literature showed that there is a dearth of

research studies on how social workers experience this dichotomy in their daily practices and how they construct their practice to integrate these two areas. Thus, the purpose of this study is to understand how social workers experience the micro-macro dichotomy, what efforts are made to integrate the two areas, and how their experiences of integration affect their view of the profession and their professional identity as social workers. Major research questions for the research topic are as follows:

1. How do clinical social workers in domestic violence organizations experience the relationship between macro and macro level practice responsibilities?

2. In what ways, if any, do clinical social workers attempt to integrate these macro and micro practice responsibilities?

3. In what ways, if any, do these efforts at integration affect the professional identities of clinical social work in domestic violence organizations?

Definitions of Key Concepts

Clinical social work practice and *micro and macro intervention* are key concepts and terms that need to be defined for the current study.

Clinical social work practice

The National Association of Social Workers (1989) defines clinical social work as "the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders." Here, clinical social work practices are defined primarily as psychotherapeutic intervention methods to promote the mental and emotional health of the client system. While the term

"clinical" is often used interchangeably with "hands-on" care, consistent with the broad

definition of direct practices in other helping professionals, the NASW's way of defining clinical

social work has been widely accepted and utilized in the social work profession (Goldstein,

1996). Similarly, the terms "clinical social work" and "psychotherapy" are used interchangeably

when discussing the impact of adopting psychotherapy as a dominant practice method in the

social work profession (Goldstein, 1996; McLaughlin, 2002). Some research studies on these

practices in the domestic violence organizations showed that the term "clinical" is often

understood as referring to a psychotherapeutic approach to the issue (Chong, 2000). Most of the

participants in this study shared a similar understanding of the term "clinical" as shown in the

NASW definition and existing literature on the domestic violence agencies. With the aim of

exploring how the content and meaning of clinical social work practices are constructed and

negotiated in the specific practice setting, the study conducted an in-depth exploration of the

definition of clinical social work practice.

Micro intervention and macro intervention

The typology of social work practices into different levels of interventions has been

widely utilized in social work practice, theories and education (Miley, Michael, & DuBois, 2001).

Typically, those interventions are categorized as micro, mezzo and macro, depending on whether

the target level of helping or change is the individual, family, group, organization or society. In

the various usages of the term, micro intervention often includes practice at the individual and

family levels, while macro intervention refers to practices at the organizational level as well

social work practice targeting social change (Feit, 2003; Kirst-Ashman & Hull, 2006). In the

current study, the micro and macro interventions were defined, respectively, as individual level

and social level, since these levels more closely reflect the dichotomous distinction between clinical practice and practices for social reform found in the field of domestic violence work that is the context for this study. In the current study, the terms micro and macro level of interventions were used interchangeably with clinical intervention and policy change, or more broadly, psychotherapy and politics. In addition, the research participants were provided opportunities to share their own definition of micro and macro intervention as a part of the interview so that difference or similarities in definitions among practitioners and academic discourses can be explored.

Study Design

In this section, I will provide a rationale for the research design, followed by the sample selection and data collection method, including a plan for the pilot study. Next, I will explain the methodology and the detailed procedure for the data analysis. In the last section, the strategies used to obtain methodological rigor will be presented.

Rationale for Research Design

A qualitative research design was chosen to answer the previously delineated research questions. Qualitative research focuses on how people make sense out of their lives, delineate the process of meaning-making and how they interpret their experiences. Thus, a qualitative design best fits the purpose of this research study by allowing for deeper exploration of subjective understanding and meanings that clinical social workers have constructed as they encounter dichotomies between micro and macro practices and the possible integration of these two practices. Furthermore, a richly descriptive qualitative study can take the reader into the setting

in such a way that they can understand the phenomenon studied and draw their own interpretation about meanings and significance. Thick description is particularly useful when one needs to understand some particular problem or situation in great depth (Patton, 2002).

A qualitative study adopts an inductive process, which is best for situations where there is a lack of theory or an existing theory fails to adequately explain a phenomenon, even though inquiry can be informed by some discipline-specific theoretical framework. Therefore, the analysis is guided not by hypotheses but by questions, issues, and a search for patterns. The initial focus is on a more sophisticated understanding of individual cases before those unique cases are combined or aggregated. Theories that result from the findings are grounded in real world patterns. The findings are presented in the form of themes, categories, concepts or theories about a particular aspect of practice (Merriam, 2009). Although there have been efforts by social work scholars to integrate these two areas of practice, relatively few studies have been devoted to the concept or theory that guides us to understand how social workers experience this dichotomy in their daily practices and how they construct their practices to integrate these two areas. In this respect, a qualitative research was useful for this study.

Qualitative research emphasizes the process and meaning created in the very process, rather than aiming at prediction of the phenomenon. Furthermore, qualitative inquiry has a dynamic, developmental perspective which allows researchers to capture unanticipated consequences, changes and development of the event (Patton, 1987). Since the aim of this study is to understand how these practice components are constructed in specific environments, rather than to predict outcomes or to explain the causal relationship between variables of clinical social work practices, the aim could be better accomplished through a qualitative design.

Also, one of the main themes in qualitative research is its holistic perspective that allows researchers to search for unifying nature of social and political context essential for overall understanding of the events. Focusing on the context is crucial in this study, since the clinical practice in this case is embedded in the service settings that have been historically influenced by political processes. Without understanding this contextual impact on the construction of clinical practice, this study could not have captured the unique nature of the clinical social work practices that are constructed in this setting (Creswell, 1998; Merriam, 2009; Patton, 2002).

Methods for Data Collection

Data Sources and Participant Sampling

In this study, data was collected from clinical social workers who have formerly or are currently providing therapeutic services to domestic violence survivors within domestic violence agencies. The sample was drawn from domestic violence agencies located in two Midwestern states and one East Coast state. In keeping with principles of naturalistic inquiries, interview participants were purposefully selected through a network sampling process. A purposeful sampling approach is most often utilized in qualitative research when the investigator wants to gain insights on the phenomenon under study by selecting information-rich cases (Patton, 2002).

The following specific criteria were set for selecting participants. First, the participants should either have formerly or currently employed in clinical positions by domestic violence organizations, whether assigned to work as therapists at shelters or other community outreach programs. As for those formerly employed by a domestic violence organization, the study interviewed only those whose last employment with such an organization has not been more than

five years. If they met the above criteria, the directors of the clinical programs were also included in this study, although they did not provide direct services to the clients at the time of the study. Even though there are clinicians in other mental health care setting who have worked with domestic violence survivors, the study limited eligibility to those employed by domestic violence organizations. Traditionally this setting experienced a conflict between micro and macro intervention and this suggests it is a good contextual choice for this study.

Second, all participants were required to have at least a Master's Degree in Social Work (MSW) as a minimum professional degree for practicing psychotherapy. Since the licensed clinical social work (LCSW) credential is not always required for the entry-level social work therapist positions in the domestic violence organizations, the participants did not have to hold a clinical license, however, they should have social work education in clinical concentration in their master's program.

Network sampling, also known as snowball sampling was used as the sampling method. It is the most common form of the purposeful sampling approach, with which a researcher locates a few key participants who meet the selection criteria established for the study and ask these early participants to refer other participants to her (Merriam, 2009). This strategy was particularly useful since the staff information for domestic violence organizations is often not accessible because of safety concerns, while the participants were likely to have recent information concerning practice settings and their human resources through their networks. Therefore, utilization of informants' personal connections and referrals played a critical role in increasing my identification of and access to potential participants.

According to Patton (2002), the decision about what constitutes an adequate sample size depends on the extent to which the researcher is able to gather in-depth information. When using

in-depth interviews as a primary data collection method, researchers recommend conducting twelve to twenty interviews to achieve a wide range of perspectives (Kuzel, 1999). For the current study, the researcher conducted thirteen in-depth interviews with participants from five different organizations. This relatively small sample size was partly due to the limited number of domestic violence organizations that could afford to hire clinical social workers as in-house therapists. For those organizations with a clinical program, the size of the program and number of clinical social workers varied depending on the agencies' program focus and the availability of funding. While there were some large-scale programs with more than five clinical social workers, the number of interview participants was limited to three from each organization to avoid any specific organization's practice dominating the data. The sample size was also adjusted in the course of investigation for reasons such as generating redundancy in data or needing more information on specific questions (Corbin & Strauss, 2008; Merriam, 2009). The setting difference in the interview sites, combined with diverse approaches to practice of each social worker, yielded new information from each interview.

As for the sociodemographic characteristics of participants, the average age of the participants was forty years old and two out of thirteen participants were non-white. They all had Masters' Degree in Social Work, and eight of them held a clinical social work license. Average years of work in the domestic violence field were eleven years. Details are shown in the Table 2 below.

Human Subject's Protection

The proposed study meets the guidelines set forth by the Human Subjects Committee at the University of Kansas-Lawrence. A review for human subject's committee approval was

requested on September 23, 2010 and approval was received on October 2, 2010. The forms used

in this application, including a copy of the statement informed consent and the letter of approval,

can be found in the Appendix A.

Table 2: Participants' Demographic Characteristics and Work Experiences

Participant (Pseudonyms)	Age	Social Work Degrees and Licensure	Work Experience (Years)
Alice	34	MSW, LCSW	6
Brenda	35	LCSW	13
Grace	34	MSW, LCSW	3
Diane	54	MSW, LCSW	0.5
Nancy	36	MSW, LCSW	9
Michelle	40	LCSW	15
Helen	33	MSW	10.5
Laura	68	MSW	24
Sarah	47	BSW, MSW, LCSW	19
Rachel	32	MSW	10
Karen	30	MSW	10
Emily	28	MSW	7.5
Tracy	55	MSW, LCSW	16

Interviews as Data Collection

For the current study, in-depth individual interviews, conducted in person, was the

primary method for data collection. The interview is the best tool for data collection when one is

interested in how participants interpret the world around them (Merriam, 2009). Patton (1987)

also mentions the fundamental principle of qualitative interviewing is to "provide a framework

within which respondents can express their own understanding in their own terms" (p.115). Thus

the interview method was useful in the study, given that the purpose of the study was to

understand social workers' meaning making about micro and macro practices.

There are several ways to structure interviews. A highly structured interview in qualitative research is mainly used when the researcher intends to gain common socio-demographic data from respondents. In semi-structured interviews, the researcher usually prepares an interview guide with a mix of more and less structured questions, but all questions are used flexibly. This format allows the researcher to respond to the situation at hand, and to the emerging worldview of the participants. The unstructured interview is exploratory in nature, and is particularly useful when the researcher does not know enough about a phenomenon to ask relevant questions (Merriam, 2009). However, Merriam notes that, in most studies, "The researcher can combine all three types of interviewing so that some standardized information is obtained, some of the same open-ended questions are asked of all participants and some time is spent in an unstructured mode so that fresh insights and new information can emerge" (p.91). For this study, the semi-structured interview questions were adopted as a primary type of doing interviews. However, I also used structured questions to gather demographic data from every participant in the beginning of the interview, while some part of the interviews was quite unstructured if participants suggested new information or insights outside the topics that were laid out in prepared interview guide.

A preliminary version of the interview guide was approved by the dissertation committee. To ensure the quality of the interview guide, the researcher reviewed an initial interview guide with committee members and methodologist Edward Scanlon, Ph.D. The interview guide consisted of a set of open-ended questions designed to elicit participants' accounts of the topic under inquiry and focused on 3 research questions. The interview guide used in this work is included in the Appendix B. Interviews were conducted face-to-face and at the agencies where participants worked, either in their offices or other places they chose within their agencies.

Interviews were recorded on a digital voice recorder, with each interview lasting between 60 and 120 minutes per interview. At the outset of the study, participants were notified that member checks would be conducted after the interview. Before each interview, each participant was asked to give informed consent in writing, which provided a detailed account of the nature and purpose of the study, what is to be expected, and the measures to be adopted by the researcher for confidentiality. I also asked participants to share any documents related to their practices, such as a blank client intake form, training materials for practicum students and new clinicians, service protocols, handouts given to clients as part of service, and outcome measurement tools. These documents served only as supplemental materials to deepen my understanding of participants' practices. Immediately following each interview, I took field notes and reflexive journal to generate and preserve early insights that would be useful for analysis (Patton, 2002). Field notes for the current study included my observations of interviewees' non-verbal communication during the interview and the physical settings where interviews took place (e.g. work place settings).

All recorded interviews were transcribed verbatim. I transcribed the first two interviews. The initial data analysis took place concurrently by listening to interviews and transcribing them, which, in turn, allowed me to gain deeper understanding of participants' experiences and to identify critical meanings and stories created by participants. Due to time constraints, the rest of the interviews were transcribed by a professional transcriptionist. I proof read all the transcripts while simultaneously listening to the recorded interviews and corrected any errors and mistakes. Most errors were due to the transcriptionist's unfamiliarity with professional terms and languages that participants used during the interview. This process improved the accuracy of the transcripts and initial data analysis.

Transcripts were sent to the participants for review. Each participant was given three weeks to respond with comments and questions, and was provided with necessary mailing materials to return the transcript. Twelve out of thirteen participants mailed their transcripts back to me with comments, clarifications, and grammatical error corrections. Two participants requested the removal of certain parts from their interviews. With the exception of one in-person feedback, the follow up discussion of the transcript took place via phone or email.

Methodology for Data Analysis

Grounded Theory

Analysis of all data is based on principles and techniques of grounded theory (Corbin & Strauss, 2008), amended by constructivist paradigm as suggested by Charmaz (2000). Grounded theory provides a systematic analytic approach to qualitative analysis of empirical data because it consists of a set of specific strategies. Specifically, the strengths of grounded theory methods lie in (a) strategies that guide the researcher step by step through an analytic process, (b) the self-correcting nature of the data collection process, (c) the methods' inherent bent toward theory and the simultaneous turning away from acontextual description, and (d) the emphasis on comparative analytic methods (Charmaz, 2000). In constructivist grounded theory, the data is constructed from the interactive process and its cultural and structural contexts. In addition, researcher and participants frame that interaction and give meaning to it (Charmaz, 2000).

The Interplay of Inductive and Deductive Analysis

Grounded theory, as with other qualitative methods, is a primarily inductive method in the service of developing common themes or patterns or categories that cut across the data. Within its framework, however, grounded theory engages the interplay between inductive and deductive reasoning, in a way that the concepts that had been emerged and abstracted from data throughout the analysis will be utilized as a basis for deductive reasoning (Corbin & Strauss, 2008). In addition, grounded theory does not preclude the use of preexisting ideas or concepts from the literature. According to Corbin and Strauss (2008), a predefined theoretical framework or set of concepts can be useful in some instances. As long as a researcher remains open to new ideas and concepts and is willing to let go if she or he discovers that certain "imported" concepts do not fit the data, a previously identified theoretical framework can provide insight, direction, and a useful list of initial concepts. Clarke (2005) introduces "the sensitizing concepts," which gives the user a general sense of reference and guidance in approaching empirical instances. Thus, key concepts gleaned from existing literature, such as *psychopolitics* and *the equation of cause and function*, were used to deductively guide the research and analytic process.

Coding and Constant Comparison

In qualitative research based on grounded theory, analysis is an ongoing process. In fact, the analysis begins with collection of the first piece of data (Merriam, 2009). Especially at the beginning of a project, this initial analysis process can provide a sense of direction, promote greater sensitivity to data, and enable the researcher to redirect and revise interview questions or observations for next round of data collection (Corbin & Strauss, 2008)

More specifically, grounded methodology uses various coding processes and a constant comparison of data as they are collected (Corbin & Strauss, 2008). In this study, coding began with open coding, a process of examining and breaking apart transcribed texts to categorize data. Code names and categories had to fit or emerge from the data. Looking for themes, the researcher identified codes and key terms used by participants through line-by-line coding, which focuses on analyzing specific descriptions (Charmaz, 2000). The researcher also used "in-vivo codes" that were concepts using form the actual words of participants when better terms could not be found (Corbin & Strauss, 2008).

With the assistance of a qualitative data analysis program (ATLAS.ti), a range of codes was created to symbolize important attributes and meanings embedded in participants' words in each unit. ATLAS.ti computer software is a program specifically designed for interpretive approaches to qualitative inquiries and theory building. Despite the controversy around computer-assisted analysis (Charmaz, 2000; Lincoln & Guba, 1985), there are some advantages from using the software as it offers an organized filing system for data and analysis that saves time and efforts and allows a close examination of the data (Merriam, 2009). Each code was systematically retrieved with quotations and memos that I marked in the software program. A listing of theses codes and example of memo can be found in Appendix C and Appendix D.

Along with coding procedures, constant comparison, another key technique of grounded theory research, was used for the comparison of data from different sources. Data were compared as to similarities within and across cases. These comparisons included comparing different participants (such as their views, situations, actions, accounts, and experiences) and comparing data from the same individuals with themselves at different points in time. Memo writing, as a

written record of analysis, was accompanied with the coding procedures and cross case-analyses to identify and develop the properties and dimensions of concepts and categories.

According to Lincoln and Guba (1985), the essential tasks of categorizing are to bring together into provisional categories the codes that are apparently related to the same content. The categories are sometimes referred to as themes (Corbin & Strauss, 2008). Throughout the constant comparison, the actual labeling of categories happened and each category label was defined by the researcher. The researcher continued to add or eliminate categories with data as needed until possible relationships between the categories began to emerge. Identifying the overarching categories with clear relationships was the goal of this data reconstruction (Rodwell, 1998). Finally, the information was compiled and prepared for writing the initial case study report containing findings pertaining to the analyzed data.

Trustworthiness

While the criteria for achieving methodological rigor in quantitative research center on validity, reliability, and generalizability, the criteria for naturalistic inquiry focus on the issue of trustworthiness (Lincoln & Guba, 1985). Trustworthiness standards were used to evaluate the appropriateness of researcher's decisions regarding data collection, analysis, and representation in this study (Rodwell, 1998). These standards are credibility, transferability, dependability, and confirmability.

Credibility

Credibility refers to the extent to the researcher's representations and interpretations of the data are considered as credible for the participants as well as those reading the research

findings (Lincoln & Guba, 1985). Credibility is achieved when the researcher's analysis and interpretation are believable to those who participated in the construction of the reality represented in the study (Rodwell, 1998). This study utilized four strategies suggested by Lincoln and Guba (1985) to achieve credibility.

First, prolonged engagement refers to the duration of time and effort I have expended in studying the topic at hand. I was involved in the women's movement in South Korea for over 15 years, and received formal training as a clinical social worker in the U.S., including working as a student therapist at a domestic violence agency for one year. The practicum experience provided an opportunity to observe and participate in the practice of clinical social worker in a domestic violence agency setting. Personal experience in the social change movement as well as clinical social work practice in domestic violence field enriched my understanding of both contexts. In addition, the research design of the current study enabled me to pursue participant's interpretations and meanings over time. Prolonged engagement was documented in the reflective journal.

Second, triangulation refers to actions and information which are derived from differing areas that provide confirmation of an observation. In this study, triangulation was sought through the use of multiple cases, and different agency settings to confirm findings. More specifically, I cross-checked data collected through observations at different times or in different places, or interview data collected from people with different perspectives or from follow-up interviews with the same people. The use of ATLAS.ti as well as the constant comparative method served as a form of analytical triangulation. The process of triangulation was recorded in the memo that accompanied data analysis.

Third, peer debriefing refers to consultation with another regarding observations or processing of information. The primary purpose of the debriefing sessions is to probe inquirer's biases, to explore the meanings, and to clarify the basis for interpretation. For the current study, peer debriefing was conducted with a dissertation committee member who has vast experience in the field of clinical practice, social policy analysis and the women's movement.

Fourth, member checking refers to checking with participants in the study to ensure my interpretations and understanding is the same as participants. Member checking is considered by Lincoln and Guba (1985) to be the most crucial technique for establishing credibility. The process involved in member checking is to take the preliminary analysis back to some of the participants and ask whether the interpretation makes sense to them. Thus, it provides an opportunity to check the data, analytic categories, interpretations, and conclusions with the original sources of the data. In this study, informal member checking was ongoing throughout the interviewing process by paraphrasing and summarizing interviews so that the participants had immediate opportunities to correct errors of fact and challenge what they perceive to be incorrect interpretations. In addition, I sent the transcripts back to each participant and conducted a follow up session via in-person meeting, emails, or telephone to clarify and discuss the interviews.

Transferability

Transferability is concerned with the extent to which the findings of one study can be applied to other situations. The extent to which a study's findings apply to other situations depend on the people in those situations who decide whether the findings can apply to their particular situations. In naturalistic inquiry, the most crucial technique for ensuring this transferability is for the researcher to provide the thick description necessary to "enable someone

interested in making a transfer to make a decision about whether transfer can be considered as a possibility" (Lincoln & Guba, 1985, p.36). The thick description is a detailed description of the setting and participants of the study, field notes, documents, and the findings with adequate evidence presented in the form of quotes from participant interviews. The research provides thick description in the findings chapter to enable readers to make transferability decisions.

Dependability and Confirmability

Dependability refers to the replicability of research findings in similar settings and contexts. However, naturalistic inquiry does not insist on exact replicability to establish "reliable" findings. Rather, the criterion of dependability requires that the same study undertaken in the same context would generate similar results and that variations in interpretation are intelligible to external reviewers. Confirmability refers to the extent of the findings of the study that is grounded in the study, rather than in the bias and assumption of the researcher. A primary strategy for establishing dependability and confirmability is the provision of an audit trail. The audit trail contains information about instrument development, raw data, analysis and reduction, data reconstruction, and notes about the research process (Lincoln & Guba, 1985). I provided a detailed description of how data were collected, how categories were derived, and how decisions were made throughout the inquiry (See Table 3: Audit Trail Components).

In order to construct this trail, I maintained a research journal throughout the process. In this journal, I documented reflection on my inner biases and assumptions, issues or ideas I encountered in collecting data, the decisions made with regard to problems, and strategies devised to cope with or resolve the barriers to understanding the situation under study. Such clarifications allow the reader to better understand how the individual researcher might have

arrived at the particular interpretations of the data (Merriam, 2009). The methodologist for this dissertation conducted an audit for the study, which took place at three points in time: immediately following the first interview, after the development of the coding guide, and during the final writing of finding chapter.

Table 3: Audit Trail Components

Audit Trail Category	Materials provided for the Audit Trail
Instrument Development	- Initial interview guide - Final interview guide - Reflexive journal
Raw Data	- The electronic files of recorded interviews. - Transcripts - Reflexive journal
Data Reduction and Analysis	Reflexive journal
Data Reconstruction and Synthesis	- Methodological notes about development of categories, themes, and relationships between categories - Reflexive journal
Process Notes	- Methodological notes - Notes from meeting with committee members
Intention and Deposition	- Research proposal (Methodology Chapter) - Correspondence - HSC-L approval - Reflexive journal
Findings and Conclusions	Total data set

This study utilized qualitative research methods to explore three research questions on practice of clinical social workers in the domestic violence organizations, in terms of their experiences with dual responsibilities of micro and macro practice, and the impact of their practice on their professional identity. The researcher conducted in-depth interviews with thirteen clinical social workers from different agencies. Various methods were implemented and utilized to ensure trustworthiness of the study, including member checking and audit trail. The

interview data was coded and analyzed by the researcher using constant comparison methods. The result of the analysis will be presented in the next chapter on findings.

CHAPTER 4: FINDINGS

Emergence of Service Delivery Model and Professionalization

The findings of interviews with clinical social workers showed that tension between micro and macro practice in the domestic violence field has centered around three themes: the transition from grassroots advocacy models to service delivery models, the emergence of professionalization, and the increasing role for therapy in domestic violence work. Participants reported that grassroots advocates have expressed concerns that these changes are leading to the loss of the social change movement element in domestic violence work. Reporting the prevalence of misconceptions about therapy among grassroots advocates, participants pointed out that grassroots advocates need to come to terms with the changes and recognize that there are different ways of achieving social change goals.

Grassroots Advocacy vs. Service Delivery: Debate on the identity of DV work.

When asked if they feel any tension between micro and macro practice in their work, participants had varying responses based on their work experience, position, and their definition of micro and macro practice. While some participants stated that they did not experience any tension in their work, one participant who had worked with other advocates at the national level observed that there is still on-going tension in the field. This participant defined the tension as between grassroots advocacy models and service delivery models.

> What's our role? Should we be focusing on working more in the community and doing social marketing and challenging social norms? Or should we focus more on service delivery? So what we've tried to do is to figure it out, making sure that we are balancing the two a little bit. But I think we are lacking in institutional advocacy. Because we are

operating from such a service delivery model, which often is dictated by our funders, or by mental health foundations who are saying you have to have this accountability in place, because we are going to do quality assurance and you have to make sure these things are happening. And then you've turned into a social service delivery model. So this is actually what's being talked about in the field as well. (Alice)

Alice also pointed out that there is still a fear of losing identity as a social movement among grassroots advocates because people in the field do not know what it means to be balancing the two models. The greatest resistance to change was found among those who have been working in the domestic violence field for a long time, and they defined the tension as a generational one, between older and newer generations of workers in the field.

This tension becomes particularly salient when it comes to particular issues, such as agency rules and survivor participation in programming. For instance, when grassroots advocates want greater engagement of survivors in the programming process, they might run into opposition from clinicians who believe that the survivors are not ready to participate since they are still healing from trauma. Debates about shelter rules is another locus of tension in which grassroots advocates feel that there is too much focus on service delivery. Their fear is that with too many rules and regulations, shelters are becoming more like mental health wards. Behind this fear is also an assumption that too much focus on clinical services can lead to an environment that is too controlling for women. The debate raises another critical question about what empowerment means for these survivors of violence.

> I am not sure if those are tangible enough, but you can really tell when you start talking about issues like, what rules do you have in your shelter? What rules do you have in your transitional housing program? Do you require that they are employed? How do you go about maintaining a community living environment, maintaining safety for staff and survivors but also allowing survivors to have autonomy and control over their lives and empowering them? What does it mean to empower someone? And if you ask different people, they might generally give you the same definition, but if you ask them to explain how this happens in their work, then it might look very different. I think it also comes up

when we look at our shared language, and we realize that we have some conflicts. What are our shared values? We realize that we might have some conflicts there, which generally gets played out when you are building programs and developing the policies and procedures and protocols around those programs. That's where I am seeing a lot of tension. (Alice)

Some participants agreed that the field needs to go beyond the service delivery model to achieve the goal of ending violence against women. However, for many, the Battered Women's Movement focused too much on criminal justice system change, whereas ending violence against women requires a broad approach. For instance, criminal justice system change is one part of social change that can be characterized as intervention rather than prevention. To effectively address the issue of domestic violence, the whole community and multiple stakeholders need to be engaged, including men as allies.

> We've got to really work toward helping our systems create more meaningful protections for battered women, not just focused on the criminal justice system. If you think about the way that our criminal system works, it works very black and white. This issue is not black and white. There are a lot of grays and lot of complexities, and so we need remedies that also incorporate the grays and the complexities. We need better accountability for batterers, but perhaps also better rehabilitative type of programs that really understand the problem and get at the problem. I think we've got to get back to our roots in some ways but also recognize our movement is changing and our work is changing. There is a real fear when I talk with other grassroots advocates, there's a real fear of losing ground, and that we may be taking some steps back, and I think it's a constant process. I think one of the directions that we need to go is getting men involved more as allies. Again, this is helping the community to understand that it's not a woman's issue, it's everybody's issue. And everybody's got to work to stop it and prevent it. (Alice)

In other words, these clinical social workers believe that the grassroots advocacy model has had too narrow a definition of social change, focusing too much on transformation of the criminal justice system, which ironically resulted in placing much greater emphasis on intervention rather than prevention. When participants point out that domestic violence is not just a woman's issue but one that impacts everyone, they seem to be criticizing what they perceive as

the grassroots advocacy models' exclusive focus on gender and calling for a broader approach to domestic violence.

Professionalization: Is it good or bad?

The tension between grassroots advocacy and service delivery model has been interpreted by some social workers as one between social work and feminism. This interpretation may be due to the timing of the transition to service delivery, which happened when more and more social workers started working in domestic violence organizations. For some participants, this tension stems from differences in practice standards between feminism and social work in working with survivors. Professional boundaries was a particular source of tension between social work and feminism, with feminists using self-disclosure as a way to equalize the relationship between staff and clients. For social workers self-disclosure is used only when it furthers the working relationship with the client.

> It probably, I mean the DV (domestic violence) movement was so deeply, like deeply entrenched with the feminist movement. It was so deeply entrenched with empowerment and trying to have, you know, survivor's voices heard. And I think that the social work movement is just a little bit different. It's very similar, but at the same time, you know, like social work ethics. Like you're not supposed to disclose certain identifying information about yourself. It's not about you; it's about the client. I think both social workers and grassroots activists use their own experience as a motivation for change, and I think that that's okay but that there's just a different level of professionalism or different, not professionalism but there's just different standards. (Emily)

In fact, the emergence of professionalization and professionalism was one of the most frequently mentioned themes by participants when they were asked about tension between micro and macro practice in the field. Many attribute professionalization to the historical organizational shift from a collective model based on feminist principles to a hierarchical, non-profit model.

Before professionalization, domestic violence work had been known for its grassroots advocacy movement for battered women. This transition to professionalization met with a strong resistance within organizations. One participant vividly remembered a strong reaction from the staff when the administration decided to hire professionals to provide mental health services and announced that the agency would adopt job titles such as case manager, advocate and counselor.

> A lot of them had been here for quite some time. Why are you saying I could do this for four years and now you're saying I can't do it at all? Am I not good enough to do that and was I not a good listener? Am I not a good at this, am I not a good at that? There was a lot of resistance. And I think if it had been a new program, we're going to do this, you're going to do that, but because they had been doing that role for so long, I think that's why they wondered: "okay, what am I going to do now?" "What am I supposed to do now?" "Are you saying I can't ask a woman how she's feeling?" There were just a lot of fears I think. I later learned that when the counselors were brought in there was a lot of tension. They do this; we do that, type thing. There was a huge split between the counseling staff and all the advocates. (Michelle)

However, this initial resistance was not against the provision of mental health services per se but against the idea that only staff with qualifying degrees can provide such services to women and that the existing staff without degrees that had been providing such service were no longer able do so. In one agency, for instance, prior to the implementation of various job titles, all the staff that provided direct services had been referred to as counselors regardless of their job responsibilities. In other words, counseling and "doing movement" were not two discrete activities but were part of an advocacy continuum. The movement work covered a broad range of activities of helping battered women, including providing emotional support. Today, the title of counselor is reserved only for licensed therapists, and other staff members are referred to as "advocates." This role division ushered in by professionalization seemed to have been the catalyst that created a tension among staff in many agencies.

Despite initial resistance and tension among staff, a majority of participants conceded that professionalization was inevitable for agencies' survival. While professionalization was required by funders, many also believed more funding was necessary for grassroots organizations to provide better quality of services. One participant who led the transition to professionalization as an executive director thought it was necessary to provide quality services to clients by improving facilities and developing staff with professional skills. For her, professionalization meant being able to provide better quality services with long-term benefit for clients.

> Oh, it was so grassroots you could see grass coming out of the front. In those days, because that was like 25 years ago. It was totally grassroots. And in fact, my hardest challenge at that time was getting a board of directors that was going to help to expand that agency because the board of directors was grassroots and they all just wanted to get into the everyday business of like who is going to get the van and how are we going to take care of people getting them here and there. So we really didn't provide all the necessary services to change people's lives. We kept people safe but did not provide them healing beyond the crisis. But they were horrible facilities. They were awful facilities. And so it was like I had to start from the grassroots to begin to build a board that was going to be able to bring in money. That was going to be able to help us to make better facilities that are going to be able to build programs. So when I first started we had advocates and that was it. (Laura)

Lack of funding and poor facilities was not the only problems challenging grassroots/collective organizations. Some identified as a problem the lack of proper respect for expertise of staff in the collective model-based organizations since these organizations often espouse the principle that every staff must have equal power in the decision-making process regardless of their work experience or positions. Other problems such as a lack of structure, boundaries with clients, and accountability were seen as hampering agencies' ability to provide needed services for clients. One participant identified these problems as the reason that her agency pushed for change towards a hieratical model despite strong resistance from some existing staff.

> We had a lot of staff there who, they would come in, oh I just, I am just not feeling it today, I am going home, and you are kind of supposed to go, okay, all right. But then, you kind of were left with twice the work, right? If that person was going to do hotline for four hours while you caught up on files or while you drove women to get food stamps, then all of sudden it's not helping the clients because you then had to answer the hotline because you can't leave hotline unattended, but then this woman doesn't get her food stamps because you can't drive her and she was counting on you to give her a ride. So there was all kinds of problems with collective approach, and I think whole piece with board of directors saying let's go more of hierarchy, it was meant to help, but there were a lot of hard feelings. (Brenda)

The transition to the new organizational model caused a feeling of ambivalence for her. While she welcomed having some structure in the organization, such as supervision, she also felt guilty for wanting a hierarchy. However, she could not share these feelings in the agency for a fear of "persecution" from her colleagues.

Despite the initial resistance and tension, there seems to be a tacit agreement among participants that professionalization is now a finished process. Participants seem to perceive that professionalization was something inevitable for all grassroots agencies and are curious about how other agencies weathered the transition. For many participants, however, the struggle of the transition was not something they experienced first-hand but was transmitted to them as stories that had been circulating in the field. Therefore, having colleagues with master's degrees and working under the guidelines and regulation of funding agencies are the norms for most of the participants. Several participants expressed gratitude for the social workers who weathered those struggles and paved the way for those who now work in the field.

But mixed feelings about the professionalization continue to linger. Regardless of where one stands on the topic, some, especially those who remembered the days of working in the grassroots organizations, agreed that there was something great about the grassroots way of working with clients. For instance, one participant pointed out the loss of intimacy with clients

when they moved to a bigger, office-like space as part of efforts to provide better professional

services.

> I think the pros are that it benefits the clients tremendously if you can get a facility and
> people with professional degrees to be benefiting them. I think because we kind of were
> grassroots when I started just because of the facility we were in and because we had just
> started getting professionals within those jobs. I miss the small intimacy of it and the idea
> like I knew the clients better when we were grassroots. Like they would sit outside the
> office and smoke and I could go talk to them because we didn't have as many clients and
> get to know them better that way and I miss that because of this facility, the way it's set up
> and the way that I'm so busy but I can't just go out because we have a gazebo and just sit
> at the gazebo and hang out with them like I used to be able to do. So it is pros and cons.
> Yeah, so I think the difference now is it feels more like staff/client, which I don't like. And
> before it was, we were all just there to be there and to help if we could. So I can understand
> them not wanting it to go. It's a tough transition. (Rachel)

Another theme that frequently emerged was the existence of an ongoing tension between

professionals and "lay advocates," especially between clinicians and advocates. As a result of

professionalization, there are advocates who feel they are not good enough because they lack

credentials or degrees and who feel confused about their roles, especially when clinicians want to

engage in advocacy for their clients. While most of the participants said that their opinion and

work were well respected by other staff, they also reported experiencing some tension with other

advocates around how they define clients' situations. Case reviews among staff are one of the

situations where those kinds of tension can often emerge. Following is an account of such

tension during a case review session witnessed by one participant:

> Sometimes in case reviews when decisions are being made I feel it. There is a case review
> team, which is comprised of the counselor, the advocate, and the case managers. It would
> be that team's responsibility to say this person needs to leave or they need to have their
> stay extended. And then within that team, you know, different people would have different
> thoughts. So you might have a case manager whose job it is to help this person get housing,
> get employment and she is being asked by her supervisor how many people have, when
> everybody exits, we ask were they able to find housing, were they able to do this. So
> obviously, the more people that say yes the better. And so her role is to help them with that

and she's got somebody who is just sitting there watching TV every day who keeps saying they're going to go look for a job but never does. So then that person is saying, well, she's not working on her goals so I don't think she needs an extension. Then you've got the counselor saying this person is suffering from severe depression. She's had an appointment with a psychiatrist but it's scheduled for five weeks away. We're trying to get the medication. The first appointment was cancelled, all these things. And so you've got the counselor saying no, this person needs an extension. We need to give her a chance to get on her meds, to have some time to then be able to work on those goals. And so you've got two different recommendations being made. And so that is the time when I feel some tension is there. (Michelle)

Courting funders has become the norm for nonprofit agencies, yet grant mandates continue to cause dilemmas and frustration for organizations and workers. Many participants expressed concerns about how funding threatened organizational identity. One participant described this trend as "everything is grant-driven" and "funders don't pay for social change."

I think you can do more work in terms of advocacy and social change, but the reality is it keeps going back to grants, that this grant will pay for this, this, this, this but they don't pay for this, this, this. And so, where are you going to get the money to do whatever? They're saying we want to see evidence-based practice, because that's what they want. I don't know that there's a lot of money for the social change. (Tracy)

In sum, participants believe professionalization is responsible for introducing a service model into the domestic violence field, which is now seen as a social work practice model of working with survivors. The emergence of professionalization was accompanied by the role division between licensed professionals and lay advocates, between clinician and non-clinicians, which has been the source of the on-going tension in the field. Most participants advocated for professionalization because it meant better quality of services with more funding while some participants blamed funding-driven services for weakening the efforts for bigger scale social change. Social workers welcomed more structure and boundaries working with clients, while also lamenting a loss of intimacy with clients as a result of professional ways of doing work with

clients. Professionalization was perceived as a completed process, but ambivalence toward the process still remains even among professionals, including clinical social workers.

Therapy in Domestic Violence: Victim Blaming vs. Essential Service Needs

In the discussion about the tension between micro and macro practice in the domestic violence field, another recurring theme that emerged was how the movement perceived therapy as well as the need for therapy services. Although professionalization and therapy services were already in place for most of the participants when they joined their organizations, many reported observing a negative perception about therapy in the domestic violence field or movement. The biggest criticism is that domestic violence is not a mental health issue but a social structural issue. Therefore, therapy is not only unnecessary but may even be harmful to survivors. Critics of therapy feared that the mental health approach would fuel the victim blaming ideology that pathologizes women and places the blame on women for the abuse. Also, there are some concerns about the damaging consequences of mental health diagnosis for survivors, especially in context of potential disputes about child custody.

> And if it is a mental health-based funder, they have very specific ways how they define how services should be delivered, and I think grassroots advocates have a pretty hard time with that, because we are looking at making sure that our women have control and autonomy, and recognizing that domestic violence is not a mental health issue. Although it can be, not every survivor who's experienced violence has an underlying mental health disorder. In addition, how does that look when this person goes to court, and is in a custody battle, and the judge is ordering psychological evaluations, which can actually be incredibly harmful to her. So it's feeding that belief that victim blaming belief, that there's something wrong with the victim. Grassroots advocates are very fearful of diagnoses and labeling anything as mental health, so as we begin to talk about trauma-informed services and care, it's scary. When I've talked with other grassroots advocates, they'll say this is not about the trauma, this is not about the mental health, this is about social structures. (Alice)

This kind of criticism seemed to be more prevalent at the state or national level than at the individual agency level. One participant had to fight with a state coalition that did not recognize the value of clinical services for domestic violence survivors. To be heard by the people in the state coalition, she needed to overcome their preconceptions about therapy and to convince them that the therapeutic services for domestic violence survivors were not only different but also necessary.

> In the coalition, they've just completely downplayed clinical workers. We don't need clinical workers. We need to have advocates. I think it's shifting somewhat though, but I don't get involved at that level so it doesn't impact me much. I know it's still there. And maybe it's getting better there, I don't know. They wouldn't even have workshops about clinical stuff. And if you had to go to a workshop, that was an advocate. And many expressed the viewpoint that battered women were not sick and so they didn't need therapy. (Laura)

Also, the critics of therapeutic services and professionalization saw the provision of therapy by professionals as going against feminist principle of practice since the therapeutic relationship places the professional in the position of an authority who defines women's problems and prescribes solutions for them.

> So the idea of like doing therapy, of diagnosing and writing up case notes and coordinating with other agencies for the best interest for her mental health, coordinating with school districts on a therapeutic level to talk about what the kids might be experiencing because of the effects of trauma. I mean that was just like, "we don't do therapy. We don't do this; we do not!" And there were people who were very angry because it was like we are not here to be better than women who are abused. We are not here to diagnose them. We are not here to tell them what's wrong with them. And of course, I didn't view that way, right? I wasn't going into it to say I'm going to go tell all of these people what's wrong with them when I get my license, but I think there was a perception there and it was perceived as something that could be, could be very anti-feminist and could be very damaging (Brenda)

Participants reported that those who opposed therapy did so because they saw it as being anti-feminist, and therefore, anti-survivors. However, most participants saw this negative

perception of therapy as being too simplistic and misconceived. According to participants,

getting therapy does not always mean there is something wrong with the person; rather therapy

should be viewed as another form of support for women in their healing process.

> I do remember one time being at another shelter and somebody asked me, I heard you guys have what you call a treatment program. And I said, yes, and she said, "how can you call it that because it seems like then there's something wrong with the women who go there. And that was many years ago but it did stick with me. And so I can see how somebody might look at it in that point of view, but when I look at it through the lens of counseling, if somebody dies, you have the option to see a counselor. It doesn't mean that something is wrong with you. You want somebody to help you process the emotions, thoughts and feelings you're going through. If my house catches on fire, I might want to see a counselor to help process. And so I think counseling can be viewed many different ways. (Michelle)

Moreover, one participant stated that this misconception of therapy can stigmatize

women who receive therapy services. Instead, therapy should be viewed as just another

community resource for health and wellness, and it should be routinely accessible to everyone,

including domestic violence survivors.

> I had many people say to me battered women are not crazy, therefore don't need therapy. I never said battered women were crazy but I think that battered women, just like everyone else, should have the opportunity to have someone to talk through their issues with and to be able to help them heal from the trauma that they've experienced. That doesn't mean that they're crazy. That just means they need the same kind of support that anybody in the community might need who has experienced trauma or anybody. You know, it's not, there wasn't any judgment about anybody outside of being a battered women going to see a therapist. Why would we have a judgment about battered women seeing a therapist? So there was a lot of I guess friction or bad feelings, I guess you might say, at the very beginning where people would look at me and just, I mean I had several people say to me, I can't believe that you're working and that you think battered women are crazy. And so it was like there was this stigma about what we were trying to do and there was a lot of education that needed to happen around, that it was okay to provide mental health services for people without that being a label that there was something wrong with them. (Sarah)

This negative attitude towards therapy may have the unintended consequence of having a

labeling effect on women who seek therapy services as part of their healing process. As one

participant pointed out, it seems both the public as well as advocates in the domestic violence field need to be educated about therapy as well as the value of such services for domestic violence survivors. In fact, many participants stated that people in the domestic violence field need to have a better understanding of how therapeutic approaches can help domestic violence survivors. For participants, therapy is seen as critical in helping women regain a sense of control that had been taken away by their abusers and to augment their ability to deal with domestic violence.

> Our concept of utilizing a therapeutic process to help somebody meet her goals related to changes that she might be in control of in her life and changes that she might not be in control of in her life, but how to be more, feel more emotionally regulated; how to feel more confident as a parent after your authority has been stripped by your abuser, all those types of things. (Brenda)

One strong argument for the need for therapy is to heal survivors' mental and emotional health that has been damaged by domestic violence. Trauma, in particular, is the number one reason for survivors needing long-term therapeutic services. While domestic violence is a social structural issue, it impacts survivors' emotional health that requires healing in order for them to become fully empowered. In other words, a short-term intervention for safety, such as providing a shelter, is not enough for women to completely escape the effect of domestic violence. Without the long-term therapy services for healing, women may not be able to free themselves completely from the damaging effects of domestic violence. It was this recognition of the damaging effect of trauma that lead to the creation of therapy programs as essential components to help break the vicious cycle of women going back to abusive relationships.

> When domestic violence programs first started, a lot of them obviously were very grassroots and really doing whatever they could just to keep people safe, and so often it was that you just had a shelter where you had safe homes that people could go to that were

scattered out. And just really working on shoestring budgets and doing the best that they could. But then really I think what we were able to do was to be able to see that providing shelter alone isn't going to stop domestic violence. It's just a piece of the bigger picture and it's absolutely essential to have safe shelter, but that's not enough. We're not going to break the cycle if we don't do the other things, and so from the very beginning looking at what are those other things that we can do to impact and make a difference and really do what we can to break the cycle, and I think that's where this comprehensive approach came from that you have to look beyond just shelter. Because all we were was a revolving door. (Sarah)

For some participants, their recognition of the need for long-term services for domestic violence survivors was the main reason why they decided to become a therapist. One participant recalled the time when she realized that a safety plan and an emergency shelter were not sufficient for women to escape the cycle of domestic violence.

So I think it just kind of occurred to me one day, like this safety plan is really good for her this week, but it might not work for her next week and then what do you do? And then what would you do when the same woman is in a situation where she has to seek shelter five, six, eight, ten, twelve times? What is it? Because we did a good safety plan, so what's going on? And that's when I kind of I had to start learning that it's not always up to the woman to get out of the relationship and, as much she might try, he's not going to let her or abusers not going to let her. So it just, all those things kind of went through my head, and it was just if I could learn kind of how to deal with this on a therapeutic level, and if I could validate for the survivors, yeah, I understand you don't want to be in a shelter five times and now I understand that probably the reason you are here five times is because you've wanted to leave but you have not been allowed to leave and the more you try to leave, and more danger you are in. And every time you come in to the shelter, you are at greater risk than you were when you are even thinking about leaving, and just connecting the dots, connecting the dots and working all that out and finding a therapeutic avenue to use that. (Brenda)

However, long-term therapy was not always supported by the administrators or funders. The implementation and sustainability of such a program required the understanding and buy-in from funders, leaders, and regional coalition members about the value of long-term therapy. It made a big difference for therapeutic programming whether or not the organization's leaders had experience working as therapists. There appears to have been stronger commitment and support

for therapeutic programming and long-term therapy in agencies whose executive directors had

clinical training. In other agencies where the administrators had no therapeutic background, the

clinical staff had to struggle to convince their administrators and the funders about the need and

the value of long-term therapy services for survivors.

> Sometimes like one of our struggles is that clients become long-term clients that do receive services for multiple years, and I see the value that those clients are receiving and actually the need for the long-term therapy but that's sometimes hard to explain to people, and even our executive director. When she sees the same person coming for a year and she's like, why is this person still here? I'm like well, let me tell you. But I think that's hard sometimes. Like what I'm seeing now is like it's hard to balance people that do have a long-term, like you have such childhood trauma, like the trauma and the victimization goes back so far, like this isn't a six month resolution. Yeah, maybe we could, maybe deal with the current problem in that amount of time, but to truly work on breaking that cycle of violence that there's not going to be the next relationship that looks like that. It does, it turns into what can be long-term therapy and sometimes I feel like there are misconceptions about that. Like oh, well, sometimes I hear, you know, I can hear people's beliefs. Oh, they've just become dependent upon us. Or in some way we're enabling them. And it's really coming from the demand for services. (Helen)

Despite the heated debates around the therapeutic services at the national level or among

academics, local agencies appear to have embraced the value of therapy and view it as another

important resource for survivors of domestic violence. Increasingly domestic violence agencies

aim to provide comprehensive services by adopting a one-stop services model that includes a

shelter, court and hospital advocacy, as well as transitional housing programs. Similarly, therapy

services are seen as a natural addition to the one-stop services model.

> Now, I've been to some conferences that are kind of more in the rural area and there yes. I mean they're like wow, you have that available there? And so yeah, definitely in places that are more rural and have less resources. Yeah, I've noticed that. And it makes you very aware, wow, we do have all these services. I mean even as we've been talking today I'm like we are able to provide our clients with court services. We're able to provide them with advocacy services. We're able to provide them therapeutic services. That's just huge. A lot of agencies aren't able to stop at a one-stop place and receive all that. (Nancy)

One reason for advocating for inclusion of therapy services was that domestic violence therapy requires a special knowledge and skill set. Given that the staff in the domestic violence agencies understand the dynamics of domestic violence, it is only logical that they are in the best position to provide the therapy services specifically designed for the survivors rather than referring them out to the community.

> When we just focus on the advocacy and we don't do any of the clinical stuff, and then somebody else is doing the clinical stuff and sometimes they're giving the survivor of the domestic violence a very bad message; that it's your fault. That you can change and the situation might be different. So I see it kind of both ways; I think that the DV community, we want to be the ones that are doing sort of the more mental health work because we get it. Do you know what I mean? It's just a very skilled, it's a different skill set. Just because you're a social worker or just because you're a therapist doesn't mean you know domestic violence. (Emily)

In addition, there was a need to have staff on-site to respond to mental health emergencies. Many participants observed that mental health issues could cause many problems in the shelter. Not only were some of the women suffering from severe mental illness such as schizophrenia, the community living arrangement created triggers for those traumatized by severe abuse.

> Number one, first of all they're on site. They're here. So when things are happening, shelters are a chaotic environment. You have community living and 24-hours a day there's people everywhere…You have a lot of children and you have a lot of different personalities. You have a lot of different backgrounds. That kind of environment can be a trigger for people, whether they have mental health issues or not, but if they do it's certainly a trigger for somebody who has mental health issues. But even for those who have been traumatized, it can be a trigger. So to have somebody on site who has, our therapists are on call 24-hours a day. So they have that ability to respond immediately to the crisis. The other thing is that our therapists are trained in domestic violence. So they understand domestic violence inside and out so they can really address those issues with them and our goal is that the service providers in the community are trained as well, but we all know that they're not all trained. If you don't understand the dynamics of domestic violence, you're going to have difficulty working with battered women. So I think those

are really the key things for us, is that we can respond immediately. We can respond to their needs and we understand those issues. (Sarah)

One persistent observation reported by participants was the recent increase in incidences of mental health issues among their client population. One participant reported that 25% of clients who now come to her agency for services have a mental health issue, which is about 15% higher than six years ago. There are several explanations for this drastic increase of mental health issues found among domestic violence survivors. One can be attributed to the recent funding cuts for community mental health services. Since therapy services are free of charge in domestic violence agencies, the agencies became the stopgap for what the community failed to provide.

Part of that, there's just some, that whole national cuts the programs have had. Some of the organizations that have normally been able to help and assist these clients are no longer; they don't have the fund to be able to do that. Or it's limited, much more limited. And so what they can do with them isn't quite what they could do before, and so they just need another stable place to get those services or they've kind of fallen off the radar and people have to connect them back to their catchment area. To stay here, they have to have a domestic violence incident that's happened. But for outreach services, they can see a counselor for outreach services. Typically, most of the time there is a domestic incident and that's what brings them to us. But oftentimes throughout that process they'll work through some of that domestic violence but will continue counseling services just to continue to have that support and work towards some other goals that they have for their emotional health. (Nancy)

In addition to mental health issues, substance abuse issues are also prevalent among women who seek services from the domestic violence agencies. According to one participant, it was the changes in the society at large, such as the introduction and prevalence of crack cocaine and crystal meth that also shifted the nature of challenges confronted by the domestic violence movement.

We don't just have battered women; we have people who have a lot of different things going, so the social change movement that existed in the 70's or even the early 80's is very different. We didn't have crack cocaine then. We didn't have all this crystal meth. So when

we get a woman in here who is actually an addict, that's a problem. So then it shifts. (Tracy)

A dramatic rise in mental health problems and substance among the client population has made therapy services even more relevant and necessary in domestic violence agencies. But most of all, clinical services are necessary because women with these additional challenges tend to be at a higher risk of being revictimized. According to participants, the members of the Battered Women's Movement need to acknowledge that many battered women suffer from mental health problems and overcome the fear that such acknowledgement may reinforce the victim-blaming ideology.

> If you have a mental health issue that's not being addressed, then you become even more at risk of being victimized, so in my opinion, it's even more important that we make sure that we're addressing their needs so that they aren't going to be high risk of being victimized, but also just so that they can be imagining what it's like to have a mental health issue that's not being addressed. You're in chaos all the time. Your life is chaotic. You're hearing voices. You're seeing whatever. We don't wish that on anyone. So I feel like we, as a movement, need to acknowledge that those people exist as well and they need our attention as well. I personally don't know how agencies that don't have therapists are able to navigate through those issues unless they just say you can't come into our facility because we don't have the resources to take care of you. We are very fortunate that we have the resources that we can offer services to those people and can hopefully help them to get onto a path that's functioning for them. And that was like a bad word to say that for the longest time. Now you really are saying battered women are crazy. No, I'm not saying that, but there are some battered women who have mental health issues. I mean looking at the population there's a certain percentage that has mental health issues. Some of them are going to be battered women. (Sarah)

Participants agreed the prevalent perception that therapy is victim-blaming and anti-feminist is too simplistic and that such a misconception could further stigmatize women who need mental health services. Participants also stressed the significance of having on-site therapy as a part of comprehensive services that are provided by workers who understand the dynamics of domestic violence. The domestic violence field needs to be educated on the intersectionality

of domestic violence and mental health to prevent women from being revictimized for their mental health condition.

Bridging the Two Worlds: Integration of Micro and Macro Practice in DV Work

Although being faced with tension between micro and macro practice in domestic violence work, clinical social workers have attempted to integrate those two areas of practice in their working with survivors. In this section, what compelled participants to incorporate components of macro practice into their clinical practice, and how clinical social workers initiated this integration at their agency as well as their individual practice will be explored.

Why We Need Integration: Systemic Barriers and Challenges for Survivors

While participants emphasized the need for professional therapy in the domestic violence agencies, they were well aware that their clients have faced many systemic barriers in their path of healing. During the interviews, participants shared many instances in which their clients could not even meet their basic needs, such as nutrition, housing, and health care. For them, these clients are one of the most disadvantaged groups in the society that have to grapple with multiple challenges.

> When I was in private practice, those folks were employed. Most of them had insurance. Most of them had a home to live in. I mean they had the basic needs. It was just relationship problems that they were having trouble with or addictions or similar, but it hadn't interfered in their life enough that they couldn't function. It hadn't affected them legally, socially. Maybe they were divorced or something like that, but they still were basically functioning well. In the mental health centers, some people were functioning well and some people weren't. And then in the mental health centers I saw a lot more of a persistent and severe mental illness and lots of medications, needing lots of support in the community, that kind of thing. And some homeless, not a whole lot, but some homeless and some without jobs and no money and that kind of thing. But here it's just a whole

different ball of wax because I'd say 80 to 90% of the people, they don't have a place to live. They don't have a job. They don't have any income. Insurance is so far down the line. They don't have transportation. Even if there were resources out there, they don't have a way to get there. And then on an emotional level, their body is set in this constant alarmed state. It's like the fire truck, the police, and the ambulance are in their head there all the time. So to be able to calm down, focus, and get things turned around is just a real challenge. And then also they have just such a low sense of self, that they're so drawn back to the person that doesn't treat them well. (Diane)

Besides lacking in basic resources, social policies add yet another layer of barriers to survivors in their efforts to escape violence. For example, immigrant victims of domestic violence are not eligible for even essential social services and benefits due to the changes in social welfare policies. This means that immigrant victims face greater challenges in their path toward survival and independence. Even in the therapy context, there may be more challenges in the healing process for immigrant women due to different cultural and/or legal contexts in which domestic violence is perceived or even tolerated.

I just think with immigrant population, it can be different because, also, when you come from a country where what's happening to you is not abuse, and then you go to another country and it's abuse, that's confusing, right? So then it's not only like batterer's minimization coming into play, but it's your own minimization or it's you own denial. And we see obviously that happens too with whatever, African American or Caucasian or Hispanic women who is a citizen and has lived here her whole life. Obviously that happens there too, that there is still denial, and there is still I don't want to look at this, but I think it's a very different thing when you were raised with a society that has laws that says if you punch someone in the face, that's considered assault. You grow up knowing that's a law, versus you're in another country and, okay, if you punch someone in the face we may or may not care on a legal level and there is very possibly a lot of justification available for you based on the reason that you used to do that, so. (Brenda)

Lack of health care resources, according to participants, was another significant systemic barrier for domestic violence survivors. Many survivors have multiple chronic and serious physical health issues in addition to the injuries due to the abuse. One participant stated that she has never seen such a magnitude of physical health problems as she has seen among the shelter

clients. However, many of them could not afford to purchase health insurance. In addition, the

fact that women often rely on their spouses for health insurance is also a barrier to accessing

health care.

> People are coming in with physical health issues that we have never seen before. We've had heart attacks and strokes and people leaving here in ambulances and dying at the hospital. We have never experienced that before and within the last few years we're seeing more and more. It's not, I mean there's an ambulance at our locations at least once a week at least, and minimum once a week and that's a low really. There are just a lot of physical issues that are going on with our clients and they think, and that doesn't surprise me so much with the economy. That if they don't have health coverage, they're trying to survive and people are surviving with so much less than what they had before that their health issues go…with battered women they're already low on the list anyway, but if you don't have insurance that would just cause even more financial troubles. So we're seeing lots more of that too. (Sarah)

These multiple systematic barriers and resource scarcities faced by survivors have

compelled some participants to incorporate some type of macro practice components into their

clinical practice. In other words, they have tried to address and remove these systemic barriers

although it means that they have to go beyond the typical way of doing therapy. In fact, a

majority of participants agreed that both micro and macro practice are necessary to achieve

healing and empowerment for survivors of domestic violence. To this end, some participants

stressed that the field need to overcome the divide between clinical practice and macro practice

and strike the balance between the two.

> I do feel that sometimes the DV world has become a little bit too clinical and we do lose sight of maybe some of the more macro level change. Or you're so focused on the more clinical needs and then sometimes even the advocacy of the clients I think tends to be a little bit less. I've just seen it in different intensities. You see where the therapist is kind of drawn to helping the client maybe decrease her symptoms of PTSD but then they're not doing anything to help her advocate for housing or welfare. And those are such major events for survival of domestic violence…So I think that there needs to be a balance, and I really believe that. I think we need people, you know, I always hate when there's a divide between the grassroots and the social worker or the more clinical people because there's

value in each person that comes into this arena. And the more expansive we are and the more inclusive we are the better off as a field. (Emily)

Other participants also maintained that for domestic violence work to continue to stay influential as a movement in the society, service delivery groups and grassroots advocacy groups must come together to create one collective voice. However, when asked to share their opinion about integrating micro and macro practice, participants' responses ranged from bafflement to a complete embracing of the idea. For example, one participant seemed baffled by the question because she could not grasp what it would mean to promote social change through practice. On the other hand, some participants had a very clear idea about integration of the two practices and firmly believed in the need for integration. In fact, one participant professed that it was her mission in life to bridge the two worlds of mental health and social justice.

> It's actually my mission in life at this point. It's to try to bridge the gap because I learned from the grass roots advocates and I learned from…really the mental health perspective and the social justice. So I've got sort of pieces, and I am in a generation that's looked at as a sort of threat to the movement. Yet, I learned. So part of my mission is how I carry on advocacy and grassroots advocacy while also bridging that with understanding the trauma and then need for people who really get it and are trained well. It's tough stuff. (Alice)

For the participants who embrace integration, it is critical that the two practices be skillfully combined to fully benefit survivors of domestic violence. As one participant pointed out, domestic violence is a "humanely integrated problem, affecting every level of reality as a person." To achieve the goal of healing, clients need integrated wraparound services that include both individual therapy and mass social change movement.

> My opinion about individual therapy services and mass movement services being mutually exclusive, my reaction to that is that, those who hold that point of view have a fairly narrow comfort zone and a fairly narrow focus for what they think should be done and are not that comfortable considering the next step trying to combine services. And that doesn't mean that those services couldn't be helpful if they're narrowly focused. It just means I

think it's a reflection of the service provider. It's not a reflection of the phenomenon. I don't think it's true that people benefit, particularly who experience and survive domestic violence, from only one kind of service at a time. I think an integrated cloth wraparound of the kind of services are generally more helpful because of how broad this issue is, and that requires lots of coordination and organization and effort and it's quite demanding. (Grace)

The key agenda for those who embraced the integration was how to successfully integrate these two levels of practice. The interviews revealed that agencies have achieved varying levels of integration. Some agencies focused on achieving integration at the agency level, while other agencies focused their integration efforts at the level of individual service provider practice. Also, individual social workers may have varying approaches to integration and implementation even within the same agency.

Survivor-centeredness as the Key Principle for Integration at Agency Level

Several participants' agencies were already engaged in the efforts to integrate micro and macro practice at the agency level. There were various approaches to integration adopted by the agencies, with the belief that all agency activities needed to focus on survivor-centeredness. Some agencies used an integrated practice model, while other agencies were more flexible and creative, adopting multiple approaches to integration. In the first approach, an integrated practice model that includes micro and macro practice was adopted for every level of practice, including advocacy, therapy and management. Through these efforts to integrate practices, opportunities were created for different program staff to learn from each other and to cross train in each other's practice area. In addition, agency rules and policies were changed to allow for flexibility to accommodate survivors' needs and situation.

Creating integrated practice model: Trauma-Informed Care and Stages Model.

Trauma-informed care was identified by participants as one of the most promising

practice models for integrating micro and macro practice. Although it was originally created for

adult survivors of childhood abuse, trauma-informed care has gained popularity in the domestic

violence field for its comprehensiveness as an agency practice model and for its effectiveness for

trauma survivors (Bloom, 2010; Madsen, Blitz, McCorkle, & Panzer, 2003; Panzer, Phillip, &

Anna, 2000). One participant stated that it was one of the best practice models she has ever

encountered in her twenty years of practice. Another participant was a firm believer that the

trauma-informed care framework can bring the two practice worlds together since it provides a

useful guide for social workers engaged in either micro or macro practice.

> It's a guide to help teach and center advocates around what survivors are experiencing,
> what they need, and how can we be therapeutic and healing in every single interaction with
> a survivor. So when she's in shelter and she comes to the front desk, and she's not being
> listened to, she's frustrated, she's experienced trauma, and she's in a very chaotic
> environment, sensory-wise, she's overwhelmed. She gets upset when she asks for a comb,
> we only have a brush, and we don't understand why that is so important in the moment. Or
> she lashes out in anger because she is feeling so incredibly disempowered, and the sense of
> injustice just increased tenfold when she walks into the community living environment,
> because she realizes that, not only do I have to jump through these hoops but I have to be
> in a place that's not my home, that's filled with other women I don't know. It's chaotic,
> it's noisy, it's scary, it's different and that just increases her sense of injustice. To be good
> advocates, we have to be able to recognize the way she's feeling disempowered, but also
> the way she has been traumatized and its impact on her. And to help her navigate this
> really scary, frustrating environment at times. So we have to pay attention to the
> relationships. So that's what the advocacy tool does is that it helps us put our working in
> context. (Alice)

According to her, the trauma-informed care framework applies at every level of practice,

whether a social worker is assisting the survivor at the shelter, in a court or is strategizing for a

policy change. In short, all the activities of social workers, whether in micro or macro practice

mode, are targeted for survivors' healing and empowerment. In this way, the trauma-informed care model itself ensures that every social worker, in whatever capacity and role, becomes a better advocate.

The Stages Model is another framework recommended by participants for integrating different levels of practice. The Stages model was adapted from the Transtheoretical Model that was originally developed for health behavior change, such as smoking and addiction (Burke et al., 2001; Prochaska et al., 1992). This model was adopted by one of the participants' agencies as its official framework of practice and outcome measurement. The basic premise of the model is that survivors go through various stages of healing. Before the stage of working towards self-recovery, survivors often go through a stage of denial due to their extended exposure to brain washing by their abusers. Every staff person in the agency is trained to be aware of where survivors are in the various stages of healing and to understand why survivors may be exhibiting certain behaviors and emotions. The training helps workers to normalize survivors' trauma responses rather than seeing them as problems. Workers are also expected to apply appropriate interventions for survivors in different stages. For survivors going through a certain stage, case management and advocacy may be the most appropriate and effective interventions, while intensive therapeutic intervention may be the best intervention for others going through a different stage of healing. In short, the choice of intervention is very individualized based on where the client is in the stages of healing. In addition to clinical staff, the agency also uses the stages model to train non-clinical staff as well as advocates.

> From there, we realized, oh, this is a great advocacy teaching tool to help advocates center around: how do I build relationship with someone and not just become more task-focused. And not try to fix it, but understand that this really is about building authentic, trusting relationship, which is really the Stages are all about. So we began to expand the model yet again to apply it to the work of advocates. And now we've just sort of come full circle that

this is one of the best teaching tools again, and that's because it is really reflective of a battered woman's experience, the internal experience. So we are using it again, we are training the community, we are training internally, and it's really become more a framework for an agency. I believe that's really helped us as an agency. I think it's been the stages of healing that's helped us bridge that gap between the service delivery model and grassroots advocacy, because it has implications of both. They both have to work in tandem and collaboratively to really look out for survivors. (Alice)

As with the trauma-informed care, the stages model seems to help advocates better understand survivors' experience in terms of individual survivors' healing process, thus making them become "better advocates." Although it was initially adopted as a practice model for clinicians, it soon became a critical tool for integrating clinical services and advocacy.

In creating an integrated practice model, having a shared perspective and a common language was cited by participants as an important prerequisite for integrating micro and macro practice. One way to achieve a shared perspective and a common language among agency staff is adopting a training model that allows all employees to understand their respective roles and to have opportunities to reflect on their practice whether they are micro or macro practitioners. The training session can provide an opportunity to learn about other areas of practice as well as to learn from each other among the staff. For instance, advocates would benefit from gaining a better understanding about the impact of prolonged trauma or underlying mental health disorders in domestic violence survivors. Similarly, therapists would gain knowledge that would be helpful for their clients by learning about other programs in the agency, such as economic empowerment program for domestic violence survivors.

Some participants believed that such mutual learning should occur between direct service providers and administrators. For these participants, macro practice refers to mainly administrative tasks, and this view is based on their own experience in the domestic violence field. There were two participants with background as both therapists and agency directors. Both

emphasized the benefits of having both experiences and how this helped them to see the whole

process of their work. One of them shared how her experience of working as a therapist helped

her job as the agency director.

> I think for me it's helpful in that I feel like I have an understanding of the clients that we
> work with and, because I came from the programs, I understand the programs pretty much
> inside and out because I've been here for so long and I did direct service. So for me
> personally that was helpful that I didn't just have the administrative background but that I
> could, and the decisions that are made are made with the lens of what's-not-I think other
> CEOs do that as well, but for me personally it helps that I can always look at things
> through the filter of what is going to benefit the clients and understanding that from the
> therapeutic perspective, and then looking at the program and the bigger picture of that. So I
> feel like it's been helpful for me. (Sarah)

Going flexible and creative: Agency rules and funding regulations

Survivor-centeredness was the underlying principle in some agencies' effort to create an

integrated practice model. They had to find a way to both sustain the organization while ensuring

its every activity is survivor-centered. In other words, every practice, policy and procedure must

be through the lens of the survivor. This seemingly uncontroversial principle, however, met with

resistance from advocates who had worked in the field for a long time. These advocates were set

in what they considered to be best practices, whereas the survivor-centeredness principle requires

flexibility in practice since what is considered appropriate intervention and practice depends on

where each client is in her healing process. For example, whether to adopt a therapeutic approach

for a client does not depend on the advocate's judgment of what is helpful for the client but

based on the client's needs. Another good example is mandating counseling for every resident at

a shelter versus providing the service based on individual residents' need and situation.

Not all agencies have rules and policies with built in flexibility to accommodate the

varying needs and situations of individual clients. For some of the participants' agencies,

adopting this survivor-centered principle for every level of practice would be tantamount to a

paradigm shift. Commitment to this principle requires deep reflection about practice at both

the individual and the agency level. As a result of this kind of reflection, some agencies were

able to come up with an innovative organizational model that combined what they considered to

be positive aspects from both collective and hierarchical organizational models.

> The agency seems to be a cutting edge agency and, it has been able to make its own
> standards, for the most part, about how it does its work, to self-define. And I wonder, I
> don't know this but I wonder if part of that or much of that has come out of a collective
> beginning of management. However, I also wonder if its more recent success is due to a
> more hierarchal arrangement. I think there are positive things, generally speaking, about
> both arrangements and at first glance, this agency to me looks like, in total in view of its
> history, a combination of the two. And maintaining a balance between some of the
> strengths that each bring is important and I think is an ongoing challenge for the agency.
> (Grace)

Finding a creative way to use funding to serve various needs of the clients was another

theme that emerged from participants' discussions about integrating micro and macro practice.

Most of the participants' agencies rely on outside funding sources to provide free therapy

services to clients. Only one agency had a sliding scale system based on income, but a client

without any income can still receive the service free of charge. In addition to providing free

services, some agencies adopted flexibility in the way their services are provided to

accommodate their clients' needs. One example is being flexible about providing services

outside the conventional 9 to 5 office hours as well as about the duration of the therapy session.

The next participant, a bilingual therapist whose clients are primarily Spanish speaking

immigrant survivors, shares a client encounter that illustrates the importance of flexibility in

service provision for her clients who face so many barriers.

It doesn't matter if her English is flawless, if you are trying to navigate the court system or a legal system even in your own language, in your own country, it's difficult at best. So when you are being an immigrant and trying to understand that, and then going to helping agency, it takes time. So it was very hard to have sessions within that hour, right? And I remember one time I had a woman and I met with her and she talked for about a half hour about how the abuse affected her children and she talked about what she was struggling with her children, and then she said something I got this in the mail. Well, the court was asking her to do victim impact statement. She had no idea what that was. You know, in her country she wasn't really even considered as victim, right? So all of sudden, not only be a victim but asked to provide a victim impact statement to be read at the sentencing hearing for her batterer who had done awful things and committed unspeakable acts of violence against her in front of her children. That doesn't fit into an hour. It's just doesn't. And you add on top of that like the transportation barriers and child care barriers, it's like if I have her in my office and she had a ride that day and her kids had a caregiver that day, I am not saying you know what I really only have 55 minutes with you today. Can you come back tomorrow, right? Because to me that's closing the door. (Brenda)

For her, this flexibility was not just about having the freedom to see clients for more than 55 minutes per session, but to "practice in a way that feels more survivor-centered." Her clinical practice includes case management and advocacy because some survivors need those services depending on where they are in their recovery process. Given this reality of survivor-centered practice, her agency added "therapeutic case management and advocacy" as part of clinicians' job description in the funding proposal so that therapists can feel free to use their time for advocacy for their clients. Whether rewriting the job description in the funding proposal as a way to integrate micro and macro practice at the agency level, integration efforts seem to require constant negotiation and collective creativity.

Challenging the Norms: Integration in Individual Practice

Along with the efforts to integrate micro and macro practice at the agency level, individual practitioners reported incorporating macro practice into their daily work with clients. The degree of participants' awareness of their efforts as integrating the practices or of the way

they incorporated the macro practice in their practice varied based on their understanding of what constitutes macro practice. For some participants, case management and advocacy were both integral to their clinical practice. Others tried to integrate the practices as a way to remove systematic barriers by taking the role of liaison between domestic violence field and other systems in which clients are frequently involved, such as child welfare system. However, integrating the two different practices in their work takes promethean efforts even though participants understand that macro level engagement is an important part of their work.

Direct practice: Incorporating advocacy and effecting systems' change

As mentioned in the previous section, many participants agreed that they put their clients' unmet basic needs first in their work with clients. While therapy is the primary job of clinical social workers, they also recognize that therapy is not very helpful when clients are without adequate food and housing. Therefore, many participants have incorporated case management and case advocacy into their practice. But not all agencies are supportive of the combining of practices by therapists, so one participant thought she was lucky to have that freedom to incorporate advocacy into her clinical work.

> I am trying to understand what type of assistance that this woman is needing and she says she has a food stamp application in and can you tell me where you are at processing her application or can you tell me how much she's going to be getting. I am going to fax you this release. I can do that and I can be friendly neighbor and then, if it's gets to the point, if there is some kind of problem or something like that, I could go down to the office with her, and that's nice because therapy is great and therapy is helpful, but if you can't eat, therapy is really not that useful….I mean she's been working very hard for several years, so it's great to be able to do therapy but her goal is getting food on the table for her kids. So that's what we need to do and I love being able to do that with her and help with that because it's horrible to say, oh, you could come in and talk about how awful you feel about not being able to eat and we can talk about how you'd like to explain that to your kids and what you can do when you feel like you're going to start crying and you can't stop. You

can do that, but I can't help you at all with your application and I can't talk to the food stamps worker and I can't go to the office with you. I mean that would be really awful to have to tell her that, so I am glad I don't have to. (Brenda)

Some participants decided to take different roles than therapist in order to change the systems that domestic violence survivors are frequently involved in, such as becoming a liaison. Many domestic violence agencies locate their advocates in systems, such as courts and hospitals, in order to educate staff in these systems on domestic violence, and also assist survivors to navigate complicated systems. One participant, who used to be a therapist for survivors, works now as a liaison in child welfare system. She has been educating child welfare workers to help them understand the dynamics of domestic violence as a way to prevent these workers from making the mistake of pathologizing mothers who were victims of domestic violence or referring them to couples counseling. Although she is not currently working as a therapist, she still uses her knowledge and experience of working as domestic violence therapist to effect systemic change.

> Co-working on the child protection side and my job was actually a combination of micro and macro practice, providing consultation to places with child protection workers, helping them train on safe interventions with domestic violence. You know, kind of being part of conversations about policy on child protection, rolling out the new protocol and was part of training it with the collaboration and child welfare training on that one. And then doing of course co-facilitating group works here and providing direct services to survivors. So the liaison position is really, it's just an amazing collaboration. When I first started, I'm sure you know a lot about the history of child welfare and domestic violence. So, historically children were being removed from victims of domestic violence for "failure to protect" and this idea that mom exposed their child to domestic violence, or the victim exposed their child to domestic violence and she was negligent as well. So that was very much the mindset when I kind of went into the child protection system. … So I've been in that world for three years and we've seen incredible change. You know, when I first started I was this outsider coming in but we built bridges. We built like amazing bridges. (Emily)

Even though participants had been engaged in tasks and activities that can be characterized as the integration of micro and macro practice, some of them struggled with the

idea of incorporating macro practice into their daily practice when macro practice is narrowly defined as effecting legal change for survivors.

> …I don't think anybody is wrong. I think we are all right. I think as much as it's, hey, call this person today or write this person the letter today, I think that is just as important as I need to call and find a bed for somebody because they both have value and they're both working toward the same goal. But when you have somebody's life [that] could be in an immediate danger that day, to me that's always going to trump a letter or a phone call, and I think administrative-wise would too. It's just that an administrator, or somebody who's on more of a macro level, is not always hearing the stories in the moment. They're getting those stories in a grant report. They are getting stories in a grant proposal. They are getting those stories at survivor forums or at a panel or something, but they are not getting them always in real time, you know? (Brenda)

Intellectual Work: Constructing domestic violence therapy

Integration of practices did not just happen at the actual practice level. It also happened when practitioners performed intellectual tasks to put together the most effective practice for clients they serve. Interviews of participants in this study showed that they are constantly evaluating frameworks, theories, and practice models to find the most helpful approach for each client. In doing so, they discovered a need to have a set of criteria for evaluating and selecting theories and practices.

> School is very linear, very intellectual, very practice model oriented. We learned a bunch of practice models, just what they were, and I remember when being exposed to them, finding things I liked and things I didn't like in most of them. But how to put those together in practice, which I feel is most important, but also intellectually is one of the biggest challenges of my job, and that's largely what it's about for me. From what I know, what I've been exposed to, what works for who is sitting across from me and how do I understand what that is and describe it to people and organize treatment around it, all of that stuff. I find it very, it's very challenging. It keeps me very busy. But also, it's very important and very interesting to me. (Grace)

Given their practice environment where power relations are questioned and social change might be emphasized, the interviews explored how this macro-perspective and practice component has been integrated into their intellectual tasks. The first part of this section will explore the question of how and with what criteria clinical social workers have evaluated theories and perspectives to frame problems and to select practice models. The second section will explore the question of how participants viewed the use of mental health diagnosis and the use of Diagnostic and Statistical Manual (DSM).

Convergence and Divergence: Evaluation of theories and perspectives.

Responses varied when asked if the participants have any preferred theories or perspectives to frame domestic violence. Some mentioned family system's theory as their primary framework, while others stated that psychological theories were needed to understand why domestic violence occurs to some women and not to others. The intergenerational cycle of violence was also frequently mentioned by participants. Their views differed on the effectiveness of feminist thought as a framework for conceptualizing domestic violence or for formulating practice for survivors. The varying views seemed to originate from their different understanding of what feminism is, but most of them felt that they needed to adopt several different theories and perspectives to grasp such a broad, complex problem as domestic violence. Despite the heated debates among academics and researchers regarding the cause of domestic violence, practitioners did not seem to subscribe to any one specific school of thought. In fact, they adopted theories which best explained the situation of the individual clients they were serving. For most participants, the knowledge gained from direct practice with individual clients seemed to have shaped the evaluation and selection of frameworks. Similarly, the legacy of the domestic

violence movement and aggregate practice wisdom from grassroots advocacy also influenced

participants' selection of frameworks and theories.

Throughout the interviews, feminism was one of the most discussed topics related to

theories and practice. Perhaps this is no surprise given the strong historical influence of feminist

movement on domestic violence work. For some, feminism was the most important framework

in evaluating their practice as well as to understanding the problems confronted by their clients.

In short, the key question they asked in evaluating their practice was whether it was consistent

with feminism. But not all participants mentioned feminism as their primary theoretical and

practice framework. These participants saw feminism as having too narrow a focus to explain the

complexity of domestic violence, capturing only a partial picture of the problem. For these

participants, feminism was seen as putting more emphasis on social aspects of the problem than

individual characteristics when in their practice these individual characteristics play a significant

role in domestic violence.

> As I began working a lot with people, I really could see, yes, there is that one piece of
> believing that domestic violence is a cycle, and it is due to being learned behavior.
> Truthfully, I don't believe that it's all learned behavior. I think everybody that participates
> in domestic violence has got personal pain and there are some people that are sociopaths.
> There are some men who are psychopaths. There's a whole continuum of abusers out there.
> They all look different, so you can't just put them all in one category and say they learned
> that because they watched dad shove mom and that's how I'm going to do it. It is so much
> deeper than that and the pain and the psychological pain and why kids do that and why
> they grow up to be abusers or victims is so much deeper than just saying it's something
> that you've learned by witnessing or saying it's okay…The pain level of the people that are
> participating in DV is greater than just saying something as trite as it's learned behavior.
> It's too trite. It doesn't cover it all. And if you only offer it from that place, you're not
> going to help everybody. (Laura)

Finding feminism to be inadequate to heal trauma in domestic violence survivors, some participants recognized a need for other theories and tools to address psychological injuries suffered by women.

> I feel like it gives us a lens for seeing the origination of some of the problems. And I think that that's something that we help our clients to see and there's a piece of empowerment that comes with that, but I think sometimes my experience is that, like it can only take clients so far sometimes. Like it doesn't necessarily heal some of the trauma that they've experienced because of the feminist framework and where we see some of these issues coming from in our society. So I think it's an important perspective to bring into it but I don't think that can be the only perspective. (Helen)

Even those who subscribe to the feminist understanding of domestic violence reject defining domestic violence only as a gender issue. According to them, there are men who do not abuse women and who are against any form of violence against women, just as there is domestic violence in same sex relationships in which a partner is violent against the other partner who is of the same sex. Rather than seeing domestic violence in terms of gender, men against women, it is more accurate to view it as stemming from power differentials between intimate partners. One participant pointed out that domestic violence can occur even to those women who believe in gender equality. Similarly, if a woman accepts domestic violence as natural part of life because of her family history of violence or because it has become a pattern for her relationships, it should be viewed as an individualized issue rather than as a gender issue. This participant makes the following observation of generational differences in how survivors view domestic violence.

> Well, I think in some cases it's very appropriate. They're in that mindset that women should be submissive. They have no power and really working through that if we can be equals we can be powerful. But I'm starting to see right now with some generations, like the 20-some, that's not even where their mindset is. They believe they're equal but, because they deal with generations of domestic violence in the family, it's a pattern. It's a pattern that they've learned that that's what a relationship looks like. So it's not as much as

maybe my client's in a different generation who believe men should be in charge…There's an issue about power and control with men and women but I'm seeing it more as not really because he's a man but because he's my partner. So I see this in same sex relationships as well. If you've had a family history of domestic violence, it doesn't matter if there's a same sex issue, you believe that's what the relationship should look like. (Rachel)

Another participant stated that some clients feel intimidated, or even scared, by feminist thinking because of the stereotypical image of feminist as radical or militant. Therefore, taking the feminist approach to engage women who are experiencing severe trauma is not always effective.

I am not a feminist. But I've seen that in operation and I think that the women get real scared of it because they feel intimidated by feminists and their thinking, you know, in social work the first thing you have to do is engage. And that's crucial. And having worked with the mandated clients, if you don't engage, you've lost them. And so what I've learned is that the feminist approach for me wouldn't work, because from what I've seen, for example we get a new person here. The staff told me so and so got admitted. I go into the cafeteria and I use the softest voice I have and I say, hi. I'm the women's therapist. What's your name? And they'll say oh, okay. I heard about you. They'll tell me their name and I say you know, I'd like to schedule an appointment with you. Very nonthreatening because that person's been traumatized. And I think, from what I've observed, sometimes feminists, they come on pretty strong and that scares people. (Tracy)

Another participant, however, cautioned against abandoning the feminist perspective since it provides some critical grounding for social workers working with survivors. She maintained that feminism allows practitioners to view domestic violence in the framework of social privileges and other oppressions. Although others view feminism's focus on the social and political as its shortcomings, it is this focus, for her, which provided a critical lens for understanding why women, much more than men, are the primary victims in domestic violence.

Understanding it through a feminist framework and understanding that this idea of privilege and how privilege impacts, is connected to domestic violence. So I think when you think of the idea of privilege and social control, I think that's a huge part of having a feminist framework….Feminism isn't just something that happens sort of in a vacuum. It

helps me conceptualize other forms of isms. So, you can't talk about domestic violence without talking about heterosexism or classism and understanding how the welfare system, how if you look at research on welfare politics, looking at that through a feminist lens and then kind of seeing the difficulties that women face in that system and then coming here or how women don't make as much money as men and to understand how those things impact people and people's lives I think really helps you think about this world a little bit differently and domestic violence. (Emily)

She also cautioned against reaching a premature conclusion that domestic violence is not a gender issue. For her, it was still an issue of violence against women because of the lower status women occupy in our society. Among the participants, she was the only person who made a reference to the debate around gender symmetry of IPV.

I think we've probably lost a lot, like lost sight of a lot of it, but I don't think we should. You know, if you look at the research on domestic violence and know it's still an issue, it's still an issue of violence against women. It's not gender neutral. It's an issue. So, like for example for me in the child protection world, a lot of times when I train on domestic violence, I talk about the fact that the majority of batterers are male and the majority of survivors are female and I think it's a filter issue because we often get a lot of cross complaints in the child protection system…We can't just say because we have a simple assault charge on both people that that means that the violence is bidirectional. It means that we have to ask a lot more questions. We need to understand the framework, of course, of control. We need to understand who is controlling who and more often than not, there's the social male privilege of how does that impact. So not to say that we think that every case that's coming across your desk that has cross complaints is in one direction, but I think having that framework certainly has you think about things a little bit more skeptically. To look at it and to really ask the questions and try to tease it out. (Emily)

Systems theory, more specifically family systems theory, was mentioned by some participants as their primary framework to understand domestic violence and its consequences. For these participants, systems theory helped them to see a problem from a more objective point of view without being overly judgmental toward abusers. This is possible since family systems theory proposes that violence may be a byproduct of families trying to maintain equilibrium to preserve family functions (Bograd, 1984; Nicolaidis & Paranjape, 2009). Another participant

who identified herself as a feminist shared that she has become more accepting of family systems theory since it provides her with a more integrated framework to explain the problem. However, she cautioned that abusers should not be included in the concept of family in actual practice.

> I think that it's like care of the whole family. And I've never been a family systems person that much before, but I've become more because we're all integral and I really recognize it. I don't think, when I say family systems, I'm not talking about doing therapy with abusers. No, I'm not saying that at all. In fact it is dangerous to even consider such an option. We consider the victim and her children as a family. (Laura)

Only one participant mentioned psychodynamic theory as a helpful framework for working with domestic violence survivors. While recognizing the controversy and criticism against psychodynamic theory in the field, she found some of the elements of the theory to be useful regarding the role and power of therapists in domestic violence counseling. When power and control constitute an important dynamics in abusive relationships, the theoretical tool to reflect and analyze power dynamics in the therapeutic relationship can be very helpful to prevent further harms on victims. Here, psychodynamic theory is used not so much as an explanatory framework for the etiology of domestic violence but as a theoretical tool for formulating effective interventions.

> Freud had a bad reputation when I was in graduate school for being blaming toward women and toward clients and then I believe that that's not unfounded; that there is truth to that and I think he was practicing in a very sexist culture at a very sexist time in the history of humanity, not all that different from today. And there are some things in his work in theory that ought to be really thought through because they don't seem to work very well for us now, but there are other things that are more of a central part of his intellectual legacy that are helpful and their application is useful. And countertransference and transference has been very useful for me. I have found those to be very good descriptors of the process of doing therapy with my clients. I didn't use the words 'transference and countertransference' earlier but that's exactly what I meant when I was describing about being self-aware and being aware of the client, particularly with something like domestic violence where stakes are very high. DV survivors have always been hurt in the context of

relationship and I think it's very important, because it makes the injury so much more complex and so much more harmful because there's always the sense of safety trust and identity involved. For example, when I meet with clients there is a power dynamic. I am in a role of a professional and this encounter has been set up for them to see my help to benefit them, which is true, but often gets exaggerated I think and it's exaggerated traditionally in that my job is to be an expert and fix a broken person who is ignorant of this stuff, for whatever reason. And I don't find that that's the way it works at all. Although, both my client and I have been set up to expect and anticipate both their neediness and my expertise and I read that in them and they read that in me, and that's an example of client transference and helper countertransference about how the roles work. What's the role of the client and what's the role of a therapist that I feel the need to be very aware of and is regularly present in the work that I do with my clients. (Grace)

In addition to the theories that help explain domestic violence mentioned above, two

theories were most frequently mentioned as being useful for interventions: the strengths

perspective and empowerment theories. The Strengths perspective was seen as particularly

critical when working with domestic violence survivors because most clients come into the

therapy with the view that they are worthless. The Strengths perspective provides a theoretical

and practice framework to help clients to find their own strengths and self-esteem.

Empowerment was the other frequently mentioned practice-theory by participants. Whereas

participants did not show any particular differences in their conception of the strengths

perspective, they expressed different views about what it means to empower domestic violence

survivors. The definition of empowerment was closely related not only to their direct practice

with clients, but also with programming and policies of their agencies. One critical issue was

how much autonomy and control should be given to the survivors given some of competing

interests of agency policies and procedures. While empowerment as a concept has been widely

accepted as critical in working with domestic violence survivors, agencies varied in the

implementation of this philosophy in actual practice setting. For some participants, survivors'

self-determination is a critical aspect of empowerment practice. For instance, this applies to rules

and policies around how much contact the survivors could have with their abusers, or whether to

mandate counseling at the shelter.

> Well, many people believe that my job here is to try to keep the woman away from her partner, that I'm going to try to convince her to stay here, that I'm going to tell her what to do. People who aren't educated about how to empower survivors of domestic violence. I know that there are some shelters that forbid contact with their partners. They tell them you cannot contact your husband while you're here. He can't know your phone number. He can't do this. You can't call him. We've never had that as long as I've been here. The thing that we focus on is safety and that he cannot know your physical location here because that could put you and us at risk. If I'm having a discussion with a woman who is trying to figure out what to do, I'm not going to tell her don't go back. I'm going to safety plan with her, listen to what she wants....I do believe that it is wrong to mandate counseling services. I shudder to even think that I was a part of that, and I'm so glad that I'm not now. I really feel very strongly about that, and that's why I said if I know somebody knows about my appointment, I leave lots of reminders. If I see her in the hall I'll say, I'll see you at ten tomorrow. And if she doesn't show up, I'm not going to go knock on her door because obviously she doesn't want the service, and that's fine. She could be talking to her best friend. She could be writing in a journal. She could be praying. She could be talking to the chaplain. Just because I'm the counselor doesn't make my service any more valuable than anybody else's here. She has her own way of healing and if counseling it is, then great, but if it's not then that's great too. (Michelle)

On a similar note, one participant stated that the goal of practice should be to give

survivors options and resources without therapists telling them what to do as their abusers had

done previously. Therefore, helping survivors to make an informed choice for them is the central

aspect of empowerment practice. For another participant, empowerment meant helping clients to

be aware that they are victimized, but not victims, and therefore they could take responsibilities

to take care of themselves.

> Well, if they're just really upset and kind of in crisis, I just get as calm as I can and use a really quiet voice and take them away somewhere where it's just one-on-one, get them calmed down and just let them do whatever it is they need to do. And then when that piece is done, whether it's cry or whatever, just validate how they feel and then my goal personally is to start moving them or planting thoughts in their mind that they are not a victim. They've been victimized and bad things have happened to them, but they're not a

victim. So what do they need to do to take care of themselves? And I try as soon as possible to start placing that responsibility on them for two reasons. One is I think that empowers them, for them to know that they can do it and if they don't know what to do, then that's what we're for; to help support. And then the second reason I do that is because it keeps me from doing too much from over functioning and jumping in and doing it for them, because that's my natural response, is just to jump in there and start doing it for them and then they don't learn it. They don't learn to do it themselves. (Diane)

Just as feminism was used as an explanatory framework for some participants, participants used empowerment theories in various ways in their practice. For some participants empowerment meant client self-determination and autonomy, while for others it means emphasizing clients taking on more responsibility as a way of empowering themselves. These different approaches to the same theoretical framework led to differences in therapy practices among different domestic violence organizations. However, the power relations, whether between abusers and victims or between therapist and clients, seemed to be a key consideration for evaluating and interpreting practice theories.

Politics of Mental Health Diagnosis: Stigmatizing or Normalizing?

Mental health diagnosis was another topic that involves considerations of social meanings and power relations. None of the participants' agencies required their therapists to have a diagnosis for the clients. Diagnoses are required for insurance reimbursements, and since all the domestic violence agencies do not seek reimbursement for their services, diagnosis is not necessary. In fact, a "no diagnosis policy" is seen as having a positive effect on domestic violence survivors who have been manipulated by their abusers into thinking that there is something wrong with them.

We don't [do diagnosis] here and I think in many ways that it's a huge strength because I think a lot of our clients come here and think that there's something wrong with them. And

I think that the fact that we don't have to give a diagnosis for insurance or something like that is really empowering. It's really empowering to people to know that there's nothing wrong with them. (Emily)

Some participants also mentioned the labeling effect of diagnosing clients as the reason why they personally do not agree with the practice of mental health diagnosis. Instead of diagnosis, they try to focus only on symptoms or behaviors especially when those are related to facilitating the healing process for their clients.

I don't get hung up on diagnoses because you just look at the symptoms. Here's the person's goal and here's what's going on. It's become an obstacle to their goal. So if medication is going to be a tool that we use, then I guess the diagnosis can be important but it's still the symptoms that we're looking at. And I'm not really big on labeling people because then they kind of hang their hat on that, well I'm bipolar so that's just what I do. No. So I think it helps for insurance companies and for reimbursement and it's a way to kind of get some kind of organization type, but as far as really being beneficial to the client, I think just what are your symptoms? How are these interfering with the goals that you want to get to and what do we need to do about it? To me it's much more valuable than label, label, label. I think the diagnosis helps from an organizational reimbursement standpoint. (Diane)

In addition, there are other negative consequences of having a mental health diagnosis. Many participants reported that there have been cases in which a mental health diagnosis is used against survivors in court proceedings such as in custody battles between abusers and survivors. In other cases, survivors have received misdiagnosis by therapists without any domestic violence background when they confuse trauma symptoms with other mental disorders. Therefore, domestic violence therapists tend to be very cautious with using mental health diagnosis language.

Another thing that we do is we talk about the ways in which we document, the language that we use, how we are framing what's going on. Not omitting anything, but often it's the way you describe you know and how you document that ends up hurting someone in court

down the line. It's not to say that, because someone is a battered woman and they have the mental health problem that there are times when they are not fit to take care of their children, absolutely. But the fear is, if you diagnose someone and you use that to explain trauma symptoms--and there are a lot of misdiagnoses out, a lot of misdiagnoses. So it's another way that we try to conduct outreach, is to train medical professionals to understand trauma and what it looks like. And let's not be so quick to put a diagnosis on someone for a mental health disorder, if actually a lot of the symptoms may be are masking trauma. It's looking like a bi-polar disorder, or paranoid personality disorder, but actually it's a trauma symptom. (Alice)

In addition to the concern about negative consequences of mental health diagnosis, some participants raised the issue of the DSM lacking information about trauma related to domestic violence.

The DSM is from the mental health perspective, and sometimes that's relevant for battered women, but sometimes that's not. It's never going to be the end all, be all. But I don't think we've done a very good job in capturing the complexities of a trauma response, and recognizing and honoring different types of traumas and where they can overlap. We are talking about really complex experiences and an impact that's hard to define. As the next version of DSM comes up, I don't know how it's going to be defined, but I am hearing little bits of information here and there, but I am not hearing discussions about this. Who's representing victims of this type of trauma, when we are talking about the DSM. I don't know who's on those work groups, but somebody is, and who's representing a survivor's voice, of any of those types of, really that individuation type of trauma. Trauma that affects how we see ourselves as individuals and our role in the world, and our autonomy, and the level of autonomy and our personal liberties. (Alice)

However, some participants found identifying a DSM diagnosis to be useful when working with a client. For some clients having a name for the symptoms they experience can be validating.

I don't have a strong opposition to it and I don't. My staff don't. They are not gung ho to be so clinical that we diagnose everyone. That is not something that I think, I hope that we never had to get to that point that we have to do that. And at the same time, there are times when I'm working with a client that I see, especially when we're working with posttraumatic stress disorder. Like there's been so many times that like I've shared the criteria for that with them and they're like tremendously relieved. It's validating and

normalizing to hear that what they're experiencing is normal and it even has a name. (Helen)

Participants also reported an upward trend of mental health issues. According to one participant, about 50-75% of her clients have at least one mental health diagnosis.

We see everything here. It plays out. Everything. If a woman comes in and says I'm having severe mania, I mean, and the speech is pressured as we're talking. How do you ignore that? You've got to deal with that, and I don't think you're labeling when you do that. I know there's a lot of discussion in literature about labeling. But you have to deal with people's psychiatric issues. (Tracy)

In some cases, abusers use mental health problems to control victims by interfering with accessing proper services. In these cases, therapists are required to help their clients access appropriate mental health services by referring them to mental health professionals.

Many of the clients that I see with a mental health diagnosis have already been involved in the system somehow. They've already done this, they've already done that. I used to take this medicine but then he wouldn't let me go to the doctor anymore. So many of them can tell me, oh, I have depression. I have anxiety attacks. I have this, I have that. I'd say for every ten clients I have that has a diagnosis, seven of them already know what it is and have already been on medication. I would say three of them are currently on their medication and are seeing a physician. Most of them are unmedicated and have not been to see a psychiatrist in a long time, or what I would consider a long time. We don't diagnose here but I can pretty quickly look at the symptoms of depression, the symptoms of bipolar, schizophrenia, etc. Most of the time they've definitely already been involved in the system. So that's why throughout the years we pretty much have always had a relationship with a community mental health provider. (Michelle)

To help clients with mental health issues, you need to know the diagnosis and related treatments despite the "no diagnosis" policy. Moreover, addressing clients' mental health issues is required to fully assist clients when other practice approaches are not effective. In this context, knowledge about mental health diagnoses and the DSM was considered as a good resource for clinicians as well as clients.

We don't formally diagnose our clients. We utilize the DSM to help us when we're struggling with treatment, but not the clinical term. Like we don't use that term with our clients either, but I would say that we use it more so when we're working with a client and we're finding that our interventions aren't being very effective. Like we'll pull out the DSM and we'll consider what's going on and help that maybe identify more effective interventions. So it's definitely not something that we pull out on every client, but it is useful as a resource. I would say we use it more as a resource. (Michelle)

Despite the negative consequences of mental health diagnoses and the politics around the formulations of DSM disorders, the reality experienced by participants is that the number of survivors who come to the domestic violence agency with a mental health diagnosis is on the rise. In addition to providing domestic violence related counseling, helping clients cope with mental health issues has become a significant part of the clinical practice for domestic violence workers. In other words, social work therapists working in the domestic violence field find themselves in the strange position of helping their clients to address their mental health issues while at the same time questioning mental health diagnoses, such as negative legal consequences of diagnoses and a lack of survivors' voices in the construction of DSM diagnostic categories. They also grapple with the conundrum of diagnosing clients in which diagnosing can be both stigmatizing and normalizing for survivors. While the creation of alternative health care independent of managed care systems has had empowering effect on the survivors, complicated politics around mental health diagnosis seemed to be a source of ongoing controversy in the field.

Psychology and Politics Intertwined: Evaluation of Therapy Models and Techniques

In addition to mental health diagnosis, participants were also asked about helpful therapy models and techniques for their clients. For helpful therapy models, the most common answer was that taking an eclectic approach rather than using one specific model has been most helpful since no one therapy method can address all the issues related to domestic violence. Instead of

using a particular therapy model, they adopted a combination of helpful therapy techniques from various models to address the issues and symptoms confronting their clients. In other words, it was the issues and symptoms confronting each client that determined what techniques and models were used.

> Unfortunately, not one fits all, because domestic violence is not a mental health problem. It's a social problem that can exacerbate mental health issues. So there isn't a therapy model I've seen that really captures them all. We are trying to look at that but it's going to be eclectic in nature. I think there are a lot of great frameworks to draw from and techniques that can be used. If we are looking purely at symptoms, regardless of how they are framed, such as affect regulation, which makes sense, because one's internal resources have become overwhelmed as a result of trauma. It makes a lot of sense from a trauma standpoint. But it doesn't mean that she's got a borderline personality disorder, for instance. But there have been a lot of helpful therapy models that I believe are very relevant, some of the dialectical behavioral therapy techniques can be very helpful, because it really gets at mindfulness and understanding, and experiencing and connecting with emotions but accepting those emotions (Alice)

Some participants emphasized the need to be cautious in using such a mode of choosing therapeutic techniques. First, therapists should not confuse individual symptoms with diagnosis. For example, just because one uses dialectical behavior treatment (DBT) with a client, it does not mean that the client has the diagnosis of borderline personality disorder. Second, the helpfulness of a therapy technique or model depends on the individual situation and where the individual client is in the process of recovery. For example, using solution-focused therapy might be too premature for clients with severe trauma. If the client has just been admitted to the shelter, crisis intervention should come before introducing other therapy models. Third, even though individual symptoms can be addressed through a specific therapy technique, therapists should always keep in mind that there might be external factors that are beyond the control of clients in domestic violence cases. For instance, cognitive behavioral therapy (CBT) is cited by many participants as one of the most helpful techniques as many domestic violence survivors may suffer from

distorted cognition due to years of control and oppression experienced in the hands of their

abusers.

> We try to do a lot of cognitive behavioral stuff just because people have been in situations where they have been so controlled and so oppressed that they just think that they are such bad people and that they must be horrible because of what's happened to them. So we really try to reframe and help them change some of that thought process and looking at their behaviors and actions and how it impacts their future towards change. So we really believe that's a nice place to start. (Nancy)

However, one of the risks of using CBT techniques is that it can send a message to clients

that once they change their thoughts about the situation they can change everything, including

how they feel about violence and about staying with abuser. In other words, therapists should

take extra caution and be mindful of the message CBT can send about how cognitive change can

lead to a change in a domestic violence situation, which may minimize external factors and

ignore the abuser's responsibility for initiating violence.

> Some of the cognitive behavioral work can be very helpful, but we have to be careful with that, because if you think about the underpinning beliefs about cognitive behavioral therapy, you know, changing your thoughts leads to changing the way you feel, which leads to changing what you actually do, which just reinforces. That can be very very helpful, but it's not for everyone. And we certainly want women to understand that they are not responsible for the violence that has occurred in their relationship. So we have to be very careful because we don't want them to think if I just change my thoughts, it will change the way I feel about my partner, and then we can be together and be okay and be safe. That would be very irresponsible of us. We need to help her understand the dynamics of the power and control, which is why the power and control wheel is a great way to educate around domestic violence. The cognitive behavioral therapy can be very helpful down the road. (Alice)

Taking environmental factors into consideration is also critical since that is central to the

role of social work. In the domestic violence context, the ongoing presence of abuse in client's

life should be considered as the most important factor in adopting any therapy technique.

Like with CBT because someone who is living a very simple life might be able to do the homework, whereas my clients, you don't know sometimes where they're going to be the next week, like for writing in a notebook about your feelings. So I feel like the clients who either are still with the abuser or are dealing with the abuser in like a co-parenting happening, but I think something like CBT or DBT, they don't have control over a lot and so they, with emotion regulation, like how can you do that when someone is threatening you? You know? Like if you are careful about what I'm going to be assigning. There's always that, assignment, but yeah, like how you're working with someone, but that's just being a social worker anyway. It's like we're always taking their environment into account, you know. They don't come here in vacuums, so. (Karen)

The Transtheoretical Model was also mentioned as one of the most useful practice models for domestic violence survivors. The Transtheoretical Model provides a structure for creating an intervention plan for each step based on the process of change model. Again the therapist should also be mindful that domestic violence survivors often face external factors that prevent them from changing their situation and healing from trauma. These factors include abusers' control and interference with clients' healing as well as other systemic barrier that interfere with their ability to escape violence.

I think something else that can be, maybe not dangerous, but not as helpful is thinking about in terms of being recovering from substance abuse, or stopping smoking or reducing weight, changing a health behavior. We know that there is a process of change that occurs, as there is when you are healing from domestic violence. But a lot of the way that we've looked at those behaviors and modifying those behaviors is really about that person's readiness to change. Domestic violence victims can be ready and willing, but we are talking how safe is it, and what is her batterer doing. We are talking about a lot of external forces at play that she doesn't have control over. So I think that's one of the key differences, so we have to be really really careful when we are looking at techniques. Transtheoretical Stages of Change, it's great because it really does help frame moving through the experience of domestic violence as a change process, and it is a process. It's often a very lengthy process. But I think it misses the boat a little bit, that's what I really like about the Stages Model in our field, it wasn't the retrofitting a survivor's experience into an old model or a prior model. It was truly taking survivors' experiences, and trying to look at what the common thread was. So it came from their stories, from their experiences, and it actually reframes even the process of going in and out of the relationship as a part of the healing process, as a critical part of the healing process, not seen as relapse, like in a medical model or disease model. It's not seen as a relapse, because that would insinuate it's her fault, there is something wrong with her. It's just about her readiness to change,

and we know that there are so many more factors that are preventing her from moving along healing process and really getting to safety. Factors that are really out of her control. (Alice)

Support groups proved to be one of the most effective practices for domestic violence survivors in several ways. First, survivors can view their problem not as something unique but as a social one that is affecting many people. This is why the domestic violence movement used this method as a primary practice for survivors: to help women realize what they saw as their personal problem is in fact a social and a political problem experienced by other women as well. Second, support groups also function as a resource group for the participants. Especially in the self-help group setting, women are able to share tips and resources with one another in their efforts to escape and survive violent relationships (Tutty et al., 1993, 1996). Participants stated that support groups are still very helpful for their clients. However, when a support group is run as a clinical group, different rules and principles apply, and this can create different dynamics as well as goals for the group.

> In the shelter we weren't clinical therapists. We didn't have training on therapy or anything like that, and so there was a group leader but it wasn't therapy. So that I would say was more like a self-help group and I think for many women it really, it gave them the space to be more free and just say whatever they need to say. I think that for many women that that was really helpful. To really just have it be like a self-help and share resources and to give each other advice. In the clinical, in the social, in the more clinical groups that we run here, one of the group guidelines is no advice-giving. Try to speak from your own experience. So you know, I see that as the pros and cons because some women need that from other women with sort of the disclaimer that what works for me might not work for you. But then kind of running or co-facilitating the drop in support group here, I know more about what to do if somebody is triggered. I know what to do if somebody is, I have more tools in my toolbox as like a supportive person. So I go back and forth. I really do. (Emily)

Along with helpful or useful models, participants were asked what they thought were not helpful or dangerous practice models or techniques for domestic violence survivors. Many participants mentioned the traditional therapy as not helpful because of its problem-focused and

pathology-based approach to domestic violence. They were aware of the feminist criticism of traditional therapeutic approach to domestic violence survivors for its victim blaming. Similarly, confrontational approaches were also mentioned as not helpful for domestic violence therapy, especially because this often assumes that the clinician know the best answer for clients.

> I know I don't use a lot of like confrontation type stuff and some people seem to think, especially we have a couple of substance abuse counselors that really have to call people out on things and are really, you know, I believe in being direct with people but not necessarily in your face trying to make you tell the truth or whatever because I believe that what they're sharing with me is their truth as they see it and that's where we have to start from. I think it makes me feel one up and one down and it makes them feel like they're not important and I wouldn't be here if they weren't important. They're the reason I'm here, so I'm going to start where they want to start. (Nancy)

Participants also mentioned that there are some dangerous models for domestic violence survivors because of their safety concerns. Couples counseling or therapy was the most frequently identified as a dangerous practice for clients. One of the dangers of couples counseling is that what is said by the survivor may be used against her by the abuser, which is another form of abuse.

> I've heard about pretty awful experiences with it. Like either they can't be truthful in session because they'll be abused when they get home or, if they are truthful, their abuser will be very charming and turn the pages on them. So it's not really couples counseling. It becomes another format for abuse. The therapist doing couples counseling might not be aware there's even domestic violence because maybe they're not honest about what's going on. Or if they are, it would be very hard to, I would think, maintain boundaries. I would think it would take a special counselor to really understand what's going on in that situation. (Interviewer: Special counselor?) Domestic violence work, yeah. Many years of it. (Nancy)

Many participants also noted that many couples counselors lack understanding of and experience in domestic violence work. While some participants would refer a female client to couples counseling only when there is a good reason to believe that the client would be safe,

others were concerned about victim blaming that could happen in couples counseling as well as survivor's safety being compromised.

> I see a lot of couples counseling. I see child protection workers with really great intentions confronting batterers not understanding how that might be for the victim. Confronting with, your wife said x, y, and z that you did and not seeing, thinking that part of bringing the family together is putting all these issues on the table and not understanding how that might mean for people. I've seen therapists kind of resay some of the things that batterers say. You know, maybe you could try this. Maybe you could try that, and then your husband wouldn't be so abusive. (Emily)

All participants indicated that they spend a great deal of effort in considering the clinical effectiveness of various therapy techniques and theoretical frameworks. However, in evaluating clinical effectiveness, they also must consider external factors such as the power and control of abusers, social barriers, and the evidence of effectiveness from research. In other words, the intellectual work performed by clinical social workers in the context of domestic violence work has challenged the existing mental health models' focus on intrapsychic causality by stressing external factors, such as the abuser's power and control as well as other systematic barriers, including poverty and discriminations, and by prioritizing survivors' experiences. Considerations such as power imbalance between abusers and victims and other power dynamics affecting survivors' chance of escaping violence are inevitable in the selection and application of theories and practice in domestic violence field. In this way, clinical social workers interweave psychology and politics in their work with domestic violence survivors.

Impact of Domestic Violence on Professional Identity as a Social Worker

This section explores how working in the domestic violence field has influenced participants' professional identification as a social worker. Along with their experiences of

working in the domestic violence field, participants' personal values and educational

backgrounds, including social work education, played an important role in shaping their

professional identities. Despite all these differences, however, working in a field that requires

broader perspectives than focusing on individual services compelled them to reflect on the

essence of social work practice and what is unique about being a social work clinician, and what

makes having a social work perspective different from therapists trained in other disciplines.

Interviews with participants revealed that definition of macro practice varied for

administrative work, advocacy and policy practice. However, for many participants, the work

they did in the DV field made them realize more integration of micro and macro work is needed

to match the reality of practice and their clients' needs. Rachel, who started her work as a

therapist, was invited to run the organization because of her professional background as a social

worker at the time professionalization started in the field. With her experience of working at both

micro and macro levels, she understood how beneficial it is for organizations when workers have

knowledge and understand about each other's practices and perspectives.

> I focused on micro but I needed to know the bigger picture to understand, and luckily I had a job that helped me with that. I understood where my grants were coming from and funding. Because what I see when people don't understand and getting very frustrated with the macro level people in their agency. And then what I see from macro if they don't understand micro and not understanding what maybe some of the issues they're going through and some of maybe the countertransference issues and the fatigue and those kind of issues that could come up. So it would be nice if there was more of an overlap so people could understand what each other does. I don't know how you would do that though. (Rachel)

For others, working with domestic violence survivors challenged them to integrate

various skills from micro and macro practice since these clients usually presented such a broad

range of needs that required them to go beyond the typical tasks of therapists. Even though they

were aware that other macro practice skills might be necessary for their work in the future

through social work education, it was not until they started working in the domestic violence

field that they felt the need to incorporate those skills into their clinical practice.

> And [clinical skills] were taught separate from community organization skills or general advocacy skills or case management skills. It's implied or suggested or mentioned that they overlap but I don't remember getting much of a sense of what that meant or how that worked. They were separate….it's hard for me to imagine clients with as severe and as broad of needs as survivors of domestic violence. I mean there's just all kinds of stuff that they need that's difficult to get. And there are probably other examples, but since that's the field that I work in it's immediately familiar to me and immediately clear to me that there are a very broad, overlapping array of needs that our clients have and challenges that they face to get them. It wasn't clear to me in school how involved a variety of services could be to try to support one family or one client, both. And then they need all of that. They need more than that. So it didn't go that far. I think I learned in school to understand that a variety of services could be useful to any client but I didn't get how far that went until I started working in this field. (Grace)

Whether it is doing administrative work, advocacy, or community organization, working

in the domestic violence field has led many participants to recognize that social work is more

than just clinical practice. This recognition, in turn, prompted them to re-conceptualize their

professional identity. Some participants who have worked in the field a long time viewed

themselves primarily as "advocates" no matter what job title they held.

> I really see myself as an advocate; an advocate for the women and children who have lost their voice. So when I think about, and that truly has come from my experience of doing this for so long, but that is really what I'm about. That's who I am and what my job is. My job is to speak for them and then help them speak for themselves. So it's not just doing it for them, but I do it for them at the state level, at the national level, even at the local level and then, by providing the programming that we do, help them to do it themselves. So I do think that the longer I've been here the more solid that has become (Sarah)

And this identification as an advocate led them to conclude that the essence of social

work should be advocacy. In other words, their training and practice in the domestic violence

field with its strong emphasis on advocacy seemed to have shaped their view of what constitutes

true social work. For these participants, advocacy is an integral part of social work practice no

matter what social workers do day-to-day in their jobs.

> I think first and foremost I am an advocate. You know, my business cards say therapist, because they need to say therapist because people need to know who they are calling, right? But I first foremost I am an advocate. I hope that anyone who has a social work degree is first and foremost an advocate for underserved populations, or trauma survivors, or immigrant victims of whatever, or people living in the poverty. I mean I think that advocacy piece is sort of what has to be at the core because if you don't feel that there is so much injustice, and that there are so many social problems on such a large level, then it's kind of like why would you become a social worker? You almost have to feel that on some level it doesn't matter if you are doing clinical, if you are doing administration, if you are going to write social work books, whatever you plan to do, you are going to teach social work classes, you are going to design a workbook; you are going to discuss compassion fatigue. Whatever you are going to do, it sort of kind of derives from that root that you believe that there is a great deal of injustice and you believe that there are a great deal of things that need attention given to them, things need improving. And so for me that is advocacy. (Brenda)

On the other hand, there were participants who identified themselves as therapists because

it was what they do primarily in their daily practice or it is their job title. However, some of them

added that they would introduce themselves as "a therapist with a social work background."

When asked what it meant for them to work as a therapist from a social work perspective, one

participant responded that it was about having more collective approach than individualistic one.

She also added that the "social" part in social work made her work with clients different from

other mental health professionals from different disciplines.

> I think I have a more collective identity and more collective approach. The traditional social work seems to me to be more a collective, collectively based, socially based. That's why the word 'social' is in it, because it values how people function together on various levels, intimate partner relationships, family systems and government institutions and so on and so on and so on. And I agree with that and subscribe to that and always have and I think that's why I am a social worker and not a psychologist. Also, there seems to be

something that I identify in social work as being very authentically oriented towards what helps people no matter what it is. (Grace)

Some participants explicitly stated that their professional identity is a social worker whose job is to provide therapy for domestic violence survivors. For these participants, staying connected to the social work perspective was important; however, they also acknowledged that it was easy to lose that connection when their job is primarily working as therapist.

> Usually I say I'm a social worker. But if someone asks me what I do I say I do therapy. But I usually identify first as a social worker because I think that's important…Because I'm licensed as a social worker. So I think first my view of therapy or the view of how I work with clients comes from social work. But then if someone asks what do you do as a social worker because it's such a broad profession, then I'll say I'm a clinical therapist and I work with domestic violence victims. (Rachel)

> Well, I'm kind of still figuring that out right now. Because I've had this position now for like six months. Before I always identified as a therapist, a children's therapist…when I say social worker I don't feel like that really tells people what I do. I still like, at heart I feel like a social worker. I still have that identity. I don't know. I think sometimes, when you're working as a therapist and it is easier to kind of stop and identify with that social work piece. (Helen)

As shown above, interviews showed that most participants have faced challenges of embracing both practices in their work with clients and struggle with the question of what it means to do therapy from social work perspectives in their daily practice at domestic violence agencies. However, some participants shared that, through these challenges and struggles, they came to truly believe that the essence of social work is social justice work in whatever form. And this belief allowed them to see that domestic violence work is ultimately connected to the core value of social work. When they came to this realization, they felt proud of being a social worker regardless of the historically rooted hostilities and suspicion toward social work from grassroots advocates in the field.

I wasn't very well liked as a social work professional when I started this work. They are coming around. Especially when we see more social workers entering the field of domestic violence. It's evolved. And again, that's where I started to feel some resistance myself but also felt this tension was-social workers weren't very well-liked by the grassroots advocates because I believe the professionalizational piece of our field, and that was scary. It's served as a threat, I think, to grassroots advocates' work. As if we were come in and take over and make everything about service delivery and that would be a risk for victims of violence because we see them all as there's something wrong with them, they need help, and they have mental health disorders and issues. So it's been an evolving process from I was really really proud of my social work background when I entered this field and I realized that I wasn't well liked or well heard at times, and so I felt that I need to prove myself and really learn about both worlds: both the clinical world but also the advocacy world. And you do. We talk about that. Social justice was there, and that is a value that is deeply rooted when you get your social work degree. (Alice)

As one participant noted, people criticize social workers for being "too professional" or "not professional enough." Faced with this criticism, social workers have struggled and stumbled. However, as this study shows, they have made sincere efforts to demonstrate that professionalization and commitment to social justice are not mutually exclusive. Moreover, there are social workers who have willingly embraced the role of bridging the separate worlds of micro and macro practice as they understand them and have opened possibilities of going beyond the dichotomy of individual treatment and social change.

CHAPTER 5: DISCUSSION AND IMPLICATIONS

The purpose of this study was to explore how clinical social workers negotiate dual responsibilities of micro and macro practice in social movement-oriented service organizations, such as domestic violence organizations, and how they construct their practice to integrate these two levels of practice to achieve the critical social work missions of both individual adaptation and social change. The findings of this study showed several major points. First, clinical social workers positioned themselves outside the dichotomous categorization of social service and social change, while recognizing the persistence of the tension between these two models in the field. For instance, while clinical social workers accepted institutionalization as inevitable, they were concerned about losing a social change focus as a result of transitioning to a social service delivery model along with professionalization which accompanied that process. They also challenged the definition of social change, and called for a broader framework to include various tactics of resolving the issue of domestic violence.

Second, clinical social workers and their organizations have attempted to develop integrated models of practice that cover broader levels and types of practice and to create alternative service delivery systems. Recognizing that theories alone could not explain or resolve complicated issue such as domestic violence, "survivor-centeredness" has been a guiding principle in the efforts to bridge social services and social change. Also, aligning all services with this key value of survivor-centeredness helped to include every practitioner in the social change movement, regardless of the individual's role in the agency. However, macro practice methods such as community organizing and policy advocacy were often seen as missing in the integrated models due to the different nature of such methods from direct service methods.

Integration of non-micro practice methods was focused on organizational practice and service programming.

Third, clinical social workers engaged in critical evaluation of each practice theory and method based on their analyses of power differentials impacting survivors' lives. More specifically, power and control in abusive relationships and other social oppressions functioned as primary criteria in these critical analyses of theories and methods. Accordingly, existing mental health diagnostic systems, major practice theories and therapeutic techniques were assessed for their effectiveness in healing and empowering survivors. In other words, psychology and politics were intertwined in clinical social workers' daily intellectual practice. One of the notable findings was social workers' various views on feminism in terms of its utility in their practice with domestic violence survivors.

Beyond the Dichotomous Categorization: Social Change vs. Social Services

Findings of this study showed that clinical social workers did not espouse any clear-cut position on controversial topics that have been debated in the literature, such as the etiology of domestic violence, and the direction and identity of domestic violence work. While the rising presence of licensed clinical social workers is often blamed for the loss of a social change focus in the Battered Women's Movement and for the shift of focus to a clinical approach and mental health model (Danis & Lockhart, 2003; Lehrner & Allen, 2009; Miller, 2010), participants in this study whose job was to provide clinical services for domestic violence survivors also shared some of those concerns about a lack of systems change focus in the field. They were aware of the shift from a grassroots advocacy model to a service delivery model in the field since the beginning of the Battered Women's Movement. Most of them seemed to believe that the transition and accompanying professionalization were inevitable; the organizations necessarily

had to meet the service needs and to provide better quality services to women and children. At the same time, they were clearly concerned about focusing solely on service delivery and recognized the need for more institutional advocacy in the field. In short, the views and practice of these clinical social workers were not as dichotomous as they have been characterized in the literature (Lehrner & Allen, 2009; Miller, 2006, 2010).

Participants also pointed out that the existing model of social change in the field needs to be redefined or expanded. For instance, systems of targeted changes should be more inclusive than merely changes in the criminal justice system. There is a great need for more prevention efforts as well as efforts to help the public recognize that domestic violence is everyone's issue, not just an issue of concern to women. Accordingly, more men should be involved in the movement as allies. This idea can also be found in the programs of organizations such as Men Stopping Violence (MSV) (Douglas, Bathrick, & Perry, 2008). According to Douglas et al (2008), MSV uses an ecological, community-based accountability model in analyzing the problem of male violence against women as well as in its work with individuals and in communities. This model exposes the cultural and historical mechanisms that sustain violence against women and strategies for disrupting traditions of abuse and dominance at the individual, familial, local, national, and global level. MSV programs are founded on the premise that a greater involvement by men as allies has the potential for increasing the safety of the women who live in communities. For instance, their program called "Because We Have Daughters" helps men raise their awareness of the culture of violence and find ways to create changes in their communities. Clinical social workers in this study also voiced a need to place domestic violence in a broader framework that would allow for prevention and intervention efforts, service provisions, and systems change efforts. As for the future direction of the Battered Women'

Movement, the clinical social workers called for a more comprehensive and integrated framework to accurately reflect the needs of individual survivors and to mobilize the forces for community and social change.

This study also revealed clinical social workers' ambivalence about institutionalization and professionalization of the movement. Although there was a general consensus that such changes were inevitable, some of the clinical social workers, especially those who had experienced "grassroots" ways of working with survivors, lamented the loss of intimacy with women in those early days and changes in the nature of the relationship into one of clear distinctions between clients and staff. Quite a few participants supported the concerns expressed by others about every service being grant-driven, which undermined the role of social change efforts in the field because "funders don't pay for social change"(INCITE!, 2007). As one social worker in the study by McLaughlin (2006) stated "you don't bite the hand that feeds you." The reliance on grants and accompanying mandates have been barriers in social workers' efforts to incorporate more social change-focused practice into their daily practice and the operation of their organizations. Despite these challenges, this study also showed that organizations and social workers have come up with creative solutions, such as inserting advocacy components into therapy services and allowing for flexibility in the provision of services.

Along with institutionalization of the movement, professionalization has been another hot-button topic in both the literature and the domestic violence field. For some, it symbolized the cooptation of the movement (Markowitz & Tice, 2002; Morgan, 1981; Sullivan, 1982) while others viewed it as a necessary change for the survival of organizations and improving the quality of services for survivors (Chong, 2000; Conroy, 1994). The latter view was predominant among the participants in this study. Participants pointed out that it was not just outside funders

pressuring for professionalization and the transition to a NGO model; this was also propelled by advocates within organizations who saw the need for setting clearer boundaries with women who utilize services and for more supervision and systematic training for advocates. For them, professionalization also meant better facilities and more accountability to the users of their services. In terms of organizational models, some participants explicitly identified problems with a collective model based on feminist principles. One key source of the problems was its principle that everyone has equal input in decision making for the everyday operation of the organizations, which some felt did not pay due respect to seasoned advocates' years of expertise. However, the same issue is also found even among NGO-type organizations which utilize hierarchical models when they lack mechanisms to respect and acknowledge the expertise of their seasoned members without professional credentials.

In this respect, some organizations seemed to have grappled with very difficult yet critical questions, such as how to make the organization flexible enough to acknowledge the expertise of staff regardless of their credentials to prevent unnecessary tensions among staff as well as to be able to benefit from the expertise of all members. How can organizations provide proper structures for practice and provide supervision for workers, and at the same time guarantee democratic input from all the staff? How do organizations overcome remoteness in staff/client relationships while maintaining proper boundaries in practice? The findings of this study showed that answers to these questions may lie in not being rigidly committed to one particular organizational model but combining beneficial elements from different organizational models (i.e. collective and hierarchical models) to create an innovative organizational structure that fits the mission and the vision of the organization. Some organizations featured in this study have already begun this experiment of creating alternatives. These efforts in the field of practice,

in turn, calls for a more sophisticated and evolved conceptualization of alternative organizations, a form of practice that feminist social workers have long attempted to introduce into the profession as a vital way to integrate values and practice (Morell, 1987; Pearlmutter, 2002).

Principles in Practice Models: Integration of Social Services and Social Change

In addition to creating an organizational structure to ensure alternative "professional practice," developing practice models to promote macro level change as well as to effectively serve individual survivors was yet another significant task for social workers and agencies. As mentioned above, a guiding principle in establishing integrated practice models for the participants in the study was their social work values rather than any specific theoretical or ideological approach. For the clinical social workers, achieving "survivor-centeredness," that is aligning their social work values with the service models and delivery structure, was their way of participating in the social change movement. In this approach, service delivery and social change efforts were no longer dichotomous but were integral parts.

As the findings showed, most clinical social workers in this study recognized that the integration of micro and macro practice was essential for effectively helping survivors on their path to healing and empowerment. Domestic violence survivors and their children often face a myriad of challenges and barriers in achieving safety and independence. While some of these barriers are intrapsychic in nature, most of them are systematic hurdles that significantly prevent survivors from accessing resources that are essential for meeting their urgent needs. Most importantly, survivors are usually subject to power and control tactics used by abusers during their journey to safety and independence. These external factors, coupled with the legacy of the social change focus of the domestic violence movement, were what impelled clinical social

workers to view their practice from different perspectives from those adopted by practitioners working in more "conventional" mental health service settings.

Those differences were manifested in several ways in the findings of this study. First, clinical social workers and their organizations were critical of conventional mental health diagnoses while recognizing the importance of mental health services as a resource for survivors. As a result, they created their own mental health services that are different from the service delivery model under managed care systems. Second, they created integrated practice models that are built on the practice philosophy of survivor-defined services and advocacy. In other words, trauma and survivors' readiness to move forward defined their services. Third, existing theories, perspectives and therapeutic techniques were filtered through the lens of power and control. As a result of this intellectual practice, they differentiated helpful models from harmful ones, and took cautionary approaches even to the use of presumably helpful techniques. Among these theories and perspectives, "feminism," the foundational ideology of the Battered Women's Movement, was the theory most frequently revisited and debated by clinical social workers.

Freedom from Managed Care and Creation of Alternative Mental Health Services

Whether to consider psychotherapy as a valid practice for domestic violence survivors has been one of the most debated issues in the field (Walker, 2002; Warshaw, Gugenheim, Moroney, & Barnes, 2003). Critics of psychotherapy maintain that domestic violence is not a mental health issue but a social structural issue, and view the mental health model as victim-blaming, and therefore anti-feminist and anti-survivor. Given the history of psychiatric practices that blamed the victims for abuse before the Battered Women's Movement redefined the issue and criminalized such violence, it is no wonder that advocates have been particularly wary about mental health approaches to domestic violence. Participants in this study, however, pointed out

not all mental health approaches lead to victim blaming and that this characterization of psychotherapy is outdated and misleading. Moreover, this mischaracterization of psychotherapy may potentially lead to stigmatizing survivors who need mental health services for their trauma and other emotional suffering stemming from abuse. Some participants even went as far as stating that mental health services should be recognized as a vital community resource to which all members of society have a right to access. This view seems to echo Wakefield's conceptualization of psychotherapy as a socially produced good that needs to be fairly distributed to disadvantaged clients, based on John Rawls' theory of justice (Wakefield, 1988a, 1988b). The participants redefined mental health services (micro practice) by placing it within the social justice framework (macro perspective), assuaging deep-rooted suspicion toward the provision of mental health services for domestic violence survivors.

Practicing therapy for domestic violence survivors requires specialized knowledge and skills sets. Clinical social workers in this study recognized that there were important differences between therapy services provided by domestic violence agencies and other mental health service settings. One difference identified by participants was in therapeutic approaches. When mental health professionals lack any deep understanding of the dynamics of domestic violence, they may fall prey to the "blame-the-victim" mentality. This concern about mental health professionals' practice with domestic violence survivors can also be found in research studies conducted by feminist family therapists (Harway & Hansen, 1993). Given their knowledge of domestic violence, clinicians in domestic violence organizations are in the best position to provide services without further harming the survivors who are already traumatized from abuse.

Participants in this study also pointed out the need for more awareness of the intersectionality between domestic violence and mental health in the field. The reality that

abusers' control tactics could have mental health consequences for survivors was addressed as the most critical reason why the members of the domestic violence movement should pay more attention to the provision of proper mental health services to survivors (Warshaw et al., 2009). In addition to the mental health issues stemming from domestic violence, clinical social workers in this study observed an increased rate of mental health issues among women who have sought help from their agencies. In general, there are higher rates of poverty, physical health problems, and mental health issues among their clients, and the dwindling of community resources and support for alleviating these problems in the past decades has not helped either. As one participant pointed out, when the Battered Women's Movement started in the 1970s, they did not have the mental health crisis confronting clinical social workers today. Without taking into account the changes in this social and historical context, the domestic violence movement in this country would fail to achieve its goal of effectively serving and empowering victims.

While clinical social workers in this study agreed that mental health issues among survivors must be given proper attention, they were ambivalent toward diagnosing clients with a mental disorder, and about using the Diagnostic and Statistical Manual of Mental Health Disorders (DSM). Their ambivalence stemmed from several concerns. One had to do with the stigmatizing effect of diagnosing a client with a mental disorder since it may have the effect of giving the message that there is "something wrong with them." Therefore, many participants viewed the "no diagnosis policy" adopted by most domestic violence organizations as empowering for women. Another source of concern was when a survivor is misdiagnosed by a therapist who lacks knowledge about domestic violence, especially when some symptoms are due to trauma from abuse, which have not been properly accounted for in the DSM (Herman, 1992; Warshaw & Brashler, 2009). Moreover, in the context of domestic violence where a

mental disorder diagnosis may be used as an ammunition by the abuser against the victim in the legal system, such as in a child custody case, a cautious approach to mental health diagnosis and the use of the DSM is regarded as a necessary measure to protect women's interests and prevent further abuse (Meier, 2009).

Some clinical social workers echoed the feminist view that diagnosis of mental illness could be used as a tool to suppress women's empowerment (Ballou & Brown, 2002; Showalter, 1987). Others criticized the DSM's definition of PTSD as too narrow in that it does not reflect the trauma experienced by survivors stemming from being subjected to prolonged abuse. They also created alternative service systems where clinicians are not required to diagnose clients and use the DSM for the reimbursement unlike other mental health service settings (Frazer, Westhuis, Daley, & Phillips, 2009). This freedom from the managed care system helped clinicians to avoid the "clinical trap" of the medical model espoused by the DSM (McLaughlin, 2006) and enabled them to focus on interpersonal power relations and other environmental factors (Gomory, Wong, & Lacasse, 2011).

In some situations, however, clinical social workers found the DSM to be a useful resource. The DSM can assist clinicians to better understand clients' symptoms and behaviors when they are not directly related to domestic violence-related issues. It can also be used as a tool to validate survivors' experiences and feelings. Clinical social workers reported that their clients felt relieved and validated knowing that what they were experiencing had a clinical name. Moreover, many survivors were already "involved in the [mental health] system" when they sought help from domestic violence agencies. This is another reason why clinical social workers identified the need to have good knowledge of the DSM diagnoses and other psychiatric

approaches, including psychotropic medications, even though they may not agree with those psychiatric approaches.

In sum, clinical social workers did not completely discount the usefulness of the DSM, especially for its normalizing effect on survivors. They recognized the reality of the current mental health system where the DSM dominates as a mental health assessment tool. This mixed attitude among clinical social workers toward mental health diagnosis in general and the DSM in particular may reflect the bifurcated positions on this issue in the social work profession itself. While the majority of social work scholars and practitioners have advocated for the use of the DSM as a primary assessment tool for mental disorders, some of the strongest critics of the DSM have also come from social work (Gomory et al., 2011). Because of this ambivalent position toward the DSM and the psychiatric approach within the field, clinical social workers might be trained to use the DSM for their practice while critiquing it at the same time (Frazer et al., 2009; Lacasse & Gomory, 2003).

Many clinical social workers in this study also shared this dual approach to mental health diagnosis and the psychiatric approach. However, it should be noted that they have also attempted to build their own alternative tools and service systems that are independent of the managed care and mainstream psychiatric interventions. In other words, they created a system of care that is free of charge, thus readily accessible to those who need services, which is unique in the history of community mental health care systems. This might have been possible because clinicians in the domestic violence field assessed their services within the social change framework, which led to collective efforts to create a system that aims to achieve psychological wellbeing of clients within the political economy of mental health care systems.

Creation of Survivor-Centered Practice and Service Models

Among the practice models that were reviewed from the existing literature, two were mentioned by social workers in this study as those utilized in their individual practice or at their agencies: Stages of Change Model and Trauma-informed model (Brown, 1997; Herman, 1992; Prochaska & DiClemente, 1983). Even though Judith Herman's trauma model was not directly mentioned in the interviews, her idea about the uniqueness of trauma related to prolonged abuse seemed to inform the participants' thoughts on integrated practice model, including the idea about comprehensive trauma not covered in the DSM diagnosis for the PTSD.

No participant mentioned any of the theories adopted by social work scholars to integrate micro and macro social work practice, such as critical theory and narrative theory (Kondrat, 2002; Salas et al., 2010; Vodde & Gallant, 2002). Instead, they used the term "eclectic" as a way to describe their approach to helping domestic violence survivors, because they believed "no single psychotherapeutic approach provides an adequate breadth of intervention" and "it is not just mental health problems, but social structural issues that affect mental health of victims." Instead of one particular theory or a set of theories, they chose "values" as the basis for practice integration and evaluation. Among the various values discussed in the interviews, "survivor-centeredness" emerged as the most significant. The Stages Model's biggest appeal to clinical social workers in the domestic violence field may be in the model's close attention to where survivors are in terms of their physical and emotional safety to ascertain survivors' readiness to move forward. For instance, under this practice framework, no one could force women to leave their abusers if they are not ready. This model also helps practitioners understand why their clients displays certain emotions and behaviors at certain points and identify when survivors are most in need of practical help and advocacy.

Emphasis on hearing survivors' authentic voices in the Stages Model also resonates with the feminist "subaltern" psychology that grappled with the challenge of capturing marginalized women's voices doubly buried in both hegemonic and resistant discourses in colonialized society (Spivak, 1988; Swartz, 1999, 2005). In the Stages Model, what becomes the priority for practitioners is the survivor-defined path to healing and empowerment. In fact, what advocates in the domestic violence movement are beginning to recognize is that the very discourses of the domestic violence movement may be yet another form of oppression that is imposed on survivors. For instance, advocates are now asking the very difficult question of "what if the survivor wants to stay in the abusive relationship?" and making efforts to develop programs and advocacy practice that respect the desires of survivors (Davies, 2009; Peled, Eisikovits, Enosh, & Winstok, 2000). They are also grappling with the perennial controversy about shelter rules in order to reinstitute survivors' autonomy and to respect the diversity among survivors (Lyon, Lane, & Menard, 2008; The Missouri Coalition Against Domestic & Sexual Violence, 2012). It seems that "survivor-defined" services may be the principle in reviving the spirit of the Battered Women's Movement in today's changed context of institutionalization and professionalization.

Social workers may readily accept survivor-centeredness as it corresponds to one of the foundational tenets of the social work profession: commitment to client-centeredness. With this guiding principle of practice, social workers are in a good position to advance the agenda of listening and reflecting survivors' voices and needs and to develop a practice model that truly embraces starting from "where the client is." Ironically, the profession's traditional eclecticism, the very factor that is given as a reason for the social work profession lacking a well-developed theoretical basis for integrated practice(Buchbinder, Eisikovitz, & Karnieli-Miller, 2004) , might be what made it easier for social workers to respect clients' desires regarding services without

being rigidly committed to any specific perspective. As mentioned above, clinical social workers in this study did not prescribe to any one particular theory or perspective, not even to feminism which is a major theoretical and ideological basis for the domestic violence movement. Instead, they stressed the importance of using an individualized approach to each client's unique situation and needs, which parallels the uniqueness of each therapeutic dyad that was emphasized in postcolonial psychology. Under this framework, clinicians search for individual clients' meaning making and pay attention to how power is distributed and negotiated between therapists and clients (Hook, 2008; Swartz, 2005).

Along with the Stages Model and the survivor-centeredness model, the significance of trauma and the trauma-informed care as a practice model in domestic violence work was mentioned throughout the study. As discussed above, trauma here refers to a much broader concept than the DSM-defined PTSD. It is a complex form of trauma caused by prolonged abuse and control, which is typical in domestic violence situations. With the increased understanding of the role trauma plays in the survivor's life, the trauma-informed care model began to gain attention from advocates and social workers in the field. As participants in this study informed us, the application of the trauma-informed care model to work with domestic violence survivors is one of the most promising practice frameworks in the field. What is particularly unique about the trauma-informed care is that this model covers all levels of practice, from individual services, advocacy, to administration. In other words, the model requires that every person within the organization, regardless of her position or job description, is trained to understand how trauma impacts clients' lives and to develop services based on that understanding. In other words, knowledge about trauma is not just for clinicians but for everyone, and every activity within the organization must be informed by this understanding of trauma, whether receiving hot-line calls

in shelter case management, advocating at the court, managing the organization, or greeting clients in the reception area (Madsen et al., 2003; Panzer et al., 2000). In addition, trauma-informed care addresses the issue of vicarious traumatization of the practitioners in anti-violence work settings (Clemans, 2004; Lipsky & Burk, 2009). The trauma-informed care model can be a tool to restructure and improve practices within entire organizations. Unlike the other clinical practice models reviewed in this study which focus on services provided at the individual level by therapists (Dutton, 1992; Hansen & Harway, 1993; Walker, 1994; Whalen, 1996), the trauma-informed care model can serve as a comprehensive framework to combine different types of services throughout the entire agency.

The Stages Model and the trauma-informed care model are the two practice models identified as most promising for integrating different practice levels (i.e. micro, mezzo and macro) and types of practice (i.e. therapy, case management, and advocacy) for achieving the agency's goal of empowering and healing domestic violence survivors. Both of these practice models are also applicable to organizational practice that covers services and activities at all levels in the agency. The Stages Model also served as a tool for assessment and outcome monitoring in direct practice with survivors. The trauma-informed care model of service delivery guides all staff members regardless of their specific job description. In this way, these clinically-informed models provide ways for every staff member to become a better advocate equipped with the knowledge and skills to identify where the survivor is in the stage of healing and understand how trauma impacts the survivor's recovery process.

Central to these two practice frameworks seems to be the idea that social change can be achieved through services and programs when they are critically aligned with a philosophy of survivor-centeredness and empowerment. In other words, whether social workers are providing

therapy or working in the shelter, they are participating in the social change movement if the organization's programs and services are designed in a way that is in tune with the philosophy or the mission of the domestic violence movement. This way the binary distinction between the social change movement and social service work becomes obscured.

While the trauma-informed care model was mentioned by participants as a prominent practice model for domestic violence organizations, participants' agencies varied in the degree of implementation of the model in both therapeutic and organizational practices. For a better assessment of the effectiveness of the model for working with survivors of domestic violence, more agencies that have fully implemented the model are needed.

 In terms of integration, it should be noted that there was little discussion or mention of institutional advocacy as a critical part of a practice model, even though some clinical social workers in this study were clearly aware of the need for systems change efforts. In fact, the biggest difficulty for the clinical social workers seemed to be in incorporating policy advocacy, which is the most widely utilized macro practice for social change, to their everyday direct service activities. Meanwhile, other forms of advocacy such as case management or case advocacy were far easier for clinical social workers to incorporate as part of their therapy services. This may be because these activities are essentially direct services. Given the difficulty of combining different levels of practice, some social workers believed that lobbying organizations at the state or national levels should be responsible for policy practice. Under such a division of labor, local organizations would function primarily as social service agencies and not as the locus of policy or systems change.

Especially critical is ensuring that all services and programs are accountable to survivors. Some critics of current domestic violence services point to cases of minority clients being

denied proper social and advocacy services by domestic violence shelters because of their sexual

orientation and ethnic background (INCITE! Women of Color Against Violence, 2006). These

critics call for explicit mechanisms to ensure that survivors have the power to counter any

oppressive practices by domestic violence agencies (Koyama, 2006). One way to address these

concerns and ensure that services are truly survivor-centered is to partner with grassroots or

community groups for minorities. Implementation of this bottom-up accountability or

accountability to communities is needed for organizations to reinforce any integrated models

based on the philosophy of survivor-centeredness, which can lead to the goal of empowering

survivors both through social services and promoting changes in communities (Kivel, 2007).

Critical Evaluation of Theories and Practices: Power, Control, and Oppressions

It was clear from the interviews that clinical social workers were constantly evaluating

existing theories and therapeutic interventions as they applied them in their practice. One

important criterion seemed to be how well the theories and interventions addressed the dynamics

of domestic violence and how helpful they were in healing survivors, not whether they were

scientifically objective. For example, social workers use environmental and social factors as

criteria in selecting or adapting theories for their practice, such as the power and control of

abusers and oppressive social forces that can hinder survivors' efforts to escape violence. With

social work training that emphasizes the "person in environment," considering these broader

factors is second nature to social workers.

With this explicit focus on external factors affecting clients' lives, clinical social workers'

decision to adopt or reject certain therapeutic techniques and their theoretical premises became

both an individualized and contextualized process. For instance, the cognitive therapeutic

approach was reported to be effective for working with domestic violence survivors in some

outcome studies (Cox & Stoltenberg, 1991; Kubany, Hill, & Owens, 2003; Kubany et al., 2004).

However, some clinical social workers were reluctant to use the cognitive behavioral approach

that aims to change the subject's cognition and behaviors with survivors since it is the abusers,

not the survivors, who are accountable for the violence. Under both trauma-informed care and

the Stages model, the clinician would take into account the influence of abuser's use of power

and control tactics on the survivor. Under these two practice models, the survivor's decision to

change alone is not enough since various systematic barriers as well as the abuser's controlling

tactics can often get in the way of the survivor achieving a life free of abuse (Burke et al., 2001).

All participants agreed that couples counseling can put a survivor in serious danger.

Some viewed it as another form of abuse because what the survivor shares during therapy could

be used against her by the abuser. A therapist who engages in the practice of couples counseling

without any proper understanding of the dynamics of domestic violence can harm survivors. The

therapist's use of the "objective approach" can unintentionally bolster the abuser's claim and

result in victim blaming. Confronting the abuser during counseling can also place the survivor in

danger because the abuser can blame the victim for being accused by the therapist. This

unanimous view of couples counseling among clinical social workers seemed to be contrary to

the dichotomous approach in the age-old debate between "family violence" and "violence against

women" camps (Loseke, Gelles, & Cavanaugh, 2005; Nicolaidis & Paranjape, 2009). Scholars

and practitioners working from a family violence perspective argue that domestic violence is not

a women's issue but a family issue and that women are just as capable of being violent as men.

Their argument is based on family systems theory, and they are strong advocates for family

therapy or couples counseling as a way to resolve "disputes" between couples (Mills, 2008).

Those with feminist perspectives, on the other hand, maintain that gendered inequality is the

cause of domestic violence, which explains why the majority of victims are women (Bograd, 1984; Yillo, 2005). Interestingly, none of the clinical social workers in this study subscribed to either perspective. Instead, they would selectively adopt tenets from both camps and evaluate them against their own practice experience. Even those participants who considered family systems theory as the most helpful theoretical framework in understanding domestic violence were unequivocally opposed to couples counseling for domestic violence survivors. Moreover, in conceptualizing "family" for domestic violence survivors, these clinical social workers excluded the abuser from the family unit.

Another interesting finding was the mixed opinions about feminism among clinical social workers. With a few exceptions, the majority of participants were reluctant to fully accept feminism as the most significant explanatory and practice framework for domestic violence work. Most of them were aware that the Battered Women's Movement was initiated by the second wave women's movement, which laid the foundations for domestic violence services. However, they felt that feminism was not comprehensive enough to explain an issue as complex as domestic violence. Clinical social workers believed that other theories should be combined with feminism to fully understand the root causes of domestic violence. Some participants believed that psychological theories are needed to understand why certain men become abusive toward their partners. Others admitted that feminism helped them to understand the etiology of domestic violence but felt that it was inadequate as a healing framework to help with survivors' trauma. The same mixed views are also found in other research studies. In their study on the practice of domestic violence advocates, McPhail and her colleagues (2007) also found inconsistencies and tensions between assumptions of the feminist model and the realities perceived among workers. Accordingly, these workers expressed a desire for a more flexible paradigm that allows the

practitioner to cherry pick from various theories and practice models, such as empowerment of women from the feminist model, and to be able to use knowledge from other disciplines, such as neurology and psychology (McPhail et al., 2007).

Except for the few participants who stated feminism as the primary principle by which they evaluate their own practice, no participant mentioned the icons in the feminist therapy movement, who provided feminist analyses of mental disorders and feminist-oriented mental health practice (Jordan, 1997; Mirkin, 1994; Mirkin, Suyemoto, & Okun, 2005; Rosewater & Walker, 1985; Worell & Remer, 2003). Similarly, no one discussed domestic violence counseling models that combine feminist and trauma theories (Dutton, 1992; Herman, 1992; Walker, 1994). The lack of discussion on these counseling models is notable, given that feminist theories on mental health and psychology provided one of the theoretical foundations for the trauma-informed care model applied in domestic violence agency settings (Bloom, 1997, 2010; Madsen et al., 2003; Panzer et al., 2000). It is not clear why these connections were not specifically addressed by the participants.

However, there were intimations of participants' views and impressions about feminism throughout the interviews. For some, feminism was equated with the images of the "radical" and the intimidating women, much like the images of feminists portrayed by the mass media and those ingrained in the public's mind (Faludi, 1991). Others seemed to accept the post-feminist message of feminism being no longer relevant to today's society (Modleski, 1991). Applied to domestic violence situations, some social workers believed that domestic violence is caused by certain patterns of individual relationships or by the intergenerational transmission of violence rather than gender inequality. Clinicians might have needed to find alternative explanations especially for why domestic violence keeps occurring to young women when these women take

gender equality as a natural state, unlike the women in previous generations. However, in domestic violence situations, what matters are the abuser's beliefs and attitudes toward gender equality, not those of the victims. Although we have made progress in achieving gender equality in institutional realms, as indicated by an increased rate of women working in the public sphere, cultural expectations for gender roles have not changed significantly. For instance, women are still expected to be the primary caregiver in the family even though they also work full-time outside the home (Marlow, 1993). For adolescent girls, cultural norms of desirable femininity, including social obsession with feminine beauty and heterosexual romantic relationships, lower their self-esteem as many young women struggle to meet those impossible standards of "ideal femininity" (Bordo, 1993; Orenstein, 1995; Walter & Peterson, 2002). Therefore, without a deeper understanding of how cultural norms of patriarchy operate in women's lives, it would be hard to understand why women continue to be subjected to intimate partner violence despite the widespread belief that gender analysis and feminism are no longer necessary to understand and improve women's lives today.

Similarly, we might ask how social workers understand other differences among women, such as race and ethnicity, within the framework of feminism. Clinical social workers voiced their commitment to effectively serve women from diverse backgrounds, such as immigrants and impoverished survivors. However, except for a few participants, most participants' understanding of feminism did not seem to correlate with their views on diversity among women. Considering that minority women groups are strong critics of existing domestic violence services, it would be important to evaluate how the commitment to diversity is being applied to creating integrated practice models. In addition, considering the renewed focus on the intersectionality of gender and other social oppressions with the emergence of third wave feminism (Baumgardner

& Richards, 2000; Crenshaw, 1991; Hulko, 2009; Josephson, 2005; Samuels & Ross-Sheriff, 2008), the question remains why there is a disconnect between social workers' embrace of diversity and their understanding of feminism. Answers to this question may be found in the historically intertwined relationships between feminisms and social work.

Recent investigations by social work scholars on feminism's place in the social work profession concluded that whereas social work feminism thrived under the influence of second wave feminism in the 1980s, feminist social work theorists failed to develop theories with a strong commitment to recognizing differences among women while being capable of sustaining dynamic commitment to solidarity (Gringeri & Roche, 2010; Kemp & Brandwein, 2010). Due to this lapse in theoretical development, feminism lost its "currency and vigor" in the social work profession and consequently recently trained social workers are unable to articulate the theoretical foundations of both feminist practice and feminist research (Gringeri, Wahab, & Anderson-Nathe, 2010; Kemp & Brandwein, 2010). Based on this evaluation, social work scholars called for a new conceptualization of feminisms in social work to include the discussion of intersectionality and the agenda of the third wave feminism, which should, in turn, be incorporated into social work education, research and practice.

Implications for Social Work Research

The purpose of this study was to explore how clinical social workers in domestic violence organizations construct their practice to integrate micro and macro practice. Findings showed that they have developed comprehensive, integrated practice models that include various modes of practice, such as case management, client advocacy, and psychotherapy. In these models, clinical knowledge, such as trauma and stages of changes in behaviors, plays a central role in informing both clinicians and non-clinicians to become more effective advocates in various

service settings. They have also created mental health delivery systems that are independent of

mainstream managed care by providing free therapy services and adopting a "no-diagnosis

policy."

However, there is a dearth of information about the efficacy of these practice models and

such research is sorely needed. There have been a few attempts to test the reliability and validity

of the measurement tools and practice guidelines based on the Stages of Change model

(Dienemann, Campbell, Landenburger, & Curry, 2002; Dienemann, Glass, Hanson, & Lunsford,

2007; Dienemann, Neese, & Lowry, 2009). More research is needed to assess the effectiveness

of these practice models in helping survivors achieve the goals of empowerment and healing.

Similarly, more outcome research studies are needed for the trauma-informed model to

determine its efficacy with domestic violence survivors. There have been a few attempts to test

the effectiveness of the therapeutic approach to treat PTSD with domestic violence survivors

(Jones et al., 2001; Kubany et al., 2003; Kubany et al., 2004). However, there have been few

outcome studies to establish the efficacy of comprehensive practice frameworks (such as trauma-

informed services), which often entail restructuring of entire organizations, especially in the

domestic violence agency settings (Bloom, 2005; Bloom et al., 2003).

In addition, challenging tasks remain for researchers, such as developing the

methodologies needed to test the effectiveness of these broad-scoped models covering different

levels and types of practice. Some preliminary questions for choosing proper methodologies

would be: What types of research methods would truly reflect feedback from domestic violence

survivors who utilize services from agencies? How do we measure the success of organizational

restructuring and performances of practitioners working at different levels or positions? Given

the long-standing feminist critique of positivistic research in the field and controversies on

evidence-based practice in the social work profession (Gambrill, 1999; Klein & Bloom, 1995; Malena & Moxley, 2002; McCracken & Marsh, 2008; Mullen, Bledsoe, & Bellamy, 2008; Olsen, 2000; Proctor & Rosen, 2008; Thyer, 2008; Yllo, 1988), it would entail deliberate but active discussion among practitioners and researchers to find ways to answer these challenging questions.

Another area of future research lies in case studies of organizations that have successfully combined a social service framework and social change efforts in the context of professionalization and institutionalization. The integration of social service and social change has been a significant and urgent agenda for many grassroots social change movements because participants have been consistently faced with challenges of providing social services to communities while maintaining their identity as social change agents (Binder, 2007; Egger & Yoon, 2004; Fried, 1994; McDonald, 2005; Rodriquez, 2007; Smith, 2007). These case studies could inform us about the philosophy, strategies, and practice methods that contributed to their successful integration of social service and social change work in specific contexts. In turn, theses case studies can lay the foundation for further research on the effectiveness of each practice framework and method, leading ultimately to the development of the practice models to be replicated in other organizational settings.

In addition, more research on the topic of professionalization in social change movement organizations would be valuable for a deeper understanding of the process, including identifying the most salient issues to be resolved and how agencies can align this difficult transition with their missions (Wies, 2006). Therefore, further research on relationships between professionalization and social movement may help us out of dichotomous perceptions of professionalization and institutionalization, as manifested in the statements such as "all

professionalization is bad, therefore it should be avoided at any cost." In fact, some social

workers showed in their research that the conservatism of the profession was influenced by

social workers' demographic characteristics, such as their gender, race, and political beliefs,

rather than by the degree of professionalization (Reeser & Epstein, 1990). Thus, we might ask

what aspects of this transition can help or hamper in achieving the mission of the movement.

Last, it would be interesting to further explore the question of why feminism did not

appeal to social workers working in fields like domestic violence where there is a heavy focus on

gender. Despite feminist social workers' long efforts to incorporate feminism into the social

work profession, many report that feminism has lost its influence on social work, whether in

social work research, education or practice (Gringeri et al., 2010; Kemp & Brandwein, 2010).

One can find some research studies that investigated feminisms' place in social work (Barretti,

2001; Davis, 2001; Nes & Iadicola, 1989; Valentich, 1996), but there is a dearth of research on

the actual perception of practitioners on feminism. One study showed that when feminisms

appear to focus on social change and political activism, social workers tended to embrace a more

individualized approach (Gutierrez, 1987). Thus, social workers' perception of feminism could

impact their choices of practice methods and their efforts to integrate micro and macro practice.

More research in this area will help to augment the recent efforts by feminist scholars to revive

feminisms in social work as a way to reinvigorate the profession's commitments to social justice

and social change (Gringeri & Roche, 2010).

Implication for Social Work Education

Domestic violence is considered as one of the most important topics in social work

education by social work scholars and education, because of its prevalence across practice

settings, including child welfare, health care and public welfare settings (Hagen, 2001; Macy,

Ferron, & Crosby, 2009; Postmus & Ortega, 2005). With few exceptions, the history of the

Battered Women's Movement is often not covered in social work education on domestic

violence (Danis & Lockhart, 2003) or in the description of general social welfare history in the

U.S. Trattner's (1999) book, one of the most widely used and cited social work history textbooks,

does not include the Battered Women's Movement and practice with domestic violence survivors

as a major social work practice area, while other historical consumer movements which led to the

formulation of social work practice, such as mental health and child welfare, are cited in the

history of the social work profession. Given its historical struggles and its evolution in the social

and political consciousness, domestic violence is a powerful example of how political and

historical context affects our understanding of an issue. Moreover, social work scholars have

noted that the non-professional programs launched by grassroots advocates, such as the safe

houses and shelter for battered women, led to the recognition of the need for feminist social work

practice (Kemp & Brandwein, 2010; Valentich, 1996). Therefore, the influence of the Battered

Women's Movement and domestic violence practice on current social work practice should be

duly recognized in social work history and education.

     More specifically, in terms of clinical social work education, it is important for clinical

social work students to be familiar with the history around the definition or diagnosis of clients'

suffering and political movements related to the issues. For example, clinical social workers who

work with domestic violence survivors should be aware of the historical struggle in defining the

psychological suffering of these women, such as the political battle between mainstream mental

health disciplines and the Battered Women's Movement. Also, social work educators should

teach these histories as part of social work practice courses in domestic violence and social work

practice.

More importantly, clinical social workers should be able to analyze the ongoing effects of various political movements and discourses around domestic violence and appreciate the significance of such movements on the direction of clinical work with survivors. Clinical social workers should recognize the importance of having a strong political movement in helping to legitimize clients' mental suffering and in supporting their healing process at the societal level (Herman, 1992). Social workers also need to acknowledge that it is important for domestic violence survivors to keep the movement strong and alive so that their voices can be heard and their sufferings redressed. Otherwise, it is always possible for perpetrators to use these women's suffering against them, undermining their healing process and empowerment. This is a critical historical lesson that clinical social workers should never ignore.

Along with teaching about the domestic violence movement, some scholars argued that professional education should include the history of other political activism and social reforms that have occurred inside and outside the profession to truly reclaim social change as part of its mission (Abramovitz, 1998). Understanding the historical relationships of the profession to social change movements will help students to understand how the profession has developed and to consider desirable directions for the future (Pyles, 2009; Reisch & Andrews, 2001). In addition to becoming knowledgeable about social reforms and movements, more social actions and community practice should be incorporated into the social work curriculum and field education. Han and Chow (2010) showed in their longitudinal study that social action involvement and placement in macro practice-oriented agencies helped students to retain the dual mission of individual adaptation and social changes as a goal to work towards in resolving social problems. The current study also showed that work experiences in social change-oriented organizations, such as domestic violence agencies, had a significant influence on clinical social

workers' perception on the dual mission. As a result, many social workers perceived advocacy as a core component of social work practice and tried to incorporate it in their daily social work practice.

In this research study, the scope of macro practice adopted by social workers was comprised mostly of case advocacy or administrative practice while little attention was given to community organizing and social action. Despite clinical social workers' training on these practice methods at the foundational level of education, there was a disconnection from these macro practices when students graduated as clinical social workers. In addition to integrating more content on community organizing and social movement into the curriculum, further efforts may need to be directed to strengthen the connection between generalist education and clinical training.

In addition, content on gender and feminism should be included in academic education and field-based education, especially when students wish to work with a client population facing gender-related issues, such as domestic and sexual violence. Goldblatt and Buchbinder (2003), who studied the impact of working with battered women on female social work students, stressed that education on gender in social work is very important because working with domestic violence survivors can reshape students' gender roles, self-identity and personal relationships. Thus, increasing gender sensitivity in social work education is significant not just for benefiting clients, but for social work students and practitioners as well. Also, in order for social work education to reflect diverse students' views and experiences, the content on interlocking oppressions, including sexism, racism, and heterosexism, should be clearly addressed in education on gender and feminisms (Bograd, 1999; Crenshaw, 1991; Hulko, 2009; INCITE!

Women of Color Against Violence, 2006; Samuels & Ross-Sheriff, 2008; Sokoloff & Dupont, 2005; Yillo, 2005).

Conclusion

The goal of this dissertation research was to explore how social workers construct their practice to serve social work's dual mission of individual services and social change. To explore this question, clinical social workers in domestic violence agencies were chosen as the target population because of the field's history of having a strong focus on social change. The research questions were formulated by reviewing the historical relationship between the social work profession and domestic violence movement, and literatures that address the intersection of psychology and politics as well as integration of social services and social change.

Qualitative inquiry examined the practices of thirteen clinical social workers providing therapy services to domestic violence survivors. In this inquiry, clinical social workers were asked how they experience and negotiate micro and macro responsibilities, especially in a field with a heavy focus on social reform and political activism. They were also asked about how they have constructed their therapeutic practice with domestic violence survivors in a way that it incorporates macro practice components. Findings of this study showed that they developed comprehensive practice models that are applied to different types of practices, such as case management, case advocacy, and psychotherapy. In this endeavor, the guiding framework was that what is considered appropriate is defined by the survivors. Also, critical analysis of power relations in clients' lives played a central role in constructing practice models and evaluating theories. Based on this critical approach to adopting practice methods, social workers and organizations established alternative service delivery systems to existing mental health care

systems. However, this study also found that more efforts are needed to include social actions and community organization for effecting systems change in integrated practice models.

This study has several limitations that need to be addressed. First, the sample is not representative of all clinical social workers working with domestic violence survivors. The sample was recruited from only three different states in the U.S. and the organizations from which sample was drawn are concentrated in urban settings. Therefore, this study did not explore the possible impact of geographical differences on practice of clinical social workers and the focus of their organizations. For instance, organizations in more progressive states may be more focused on social change and community organizing, while it is possible that agencies in more conservative ones are prone to utilize a service delivery model. In addition, this study did not include any social workers who are working in organizations specifically established for minority clients. It is possible that organizations working with more marginalized populations are more social change oriented; therefore, social workers' practice could be influenced by that orientation. Future research should include practitioners working with ethnic minority and immigrant population on the issue of violence against women.

Second, since this research study rested solely on interview methods, it is possible that the actual practice of social workers is different from what they stated during the interviews. Even though I had an opportunity to observe practice as a student therapist at a similar organizational setting, the trustworthiness of this study might have been enhanced if the research method of prolonged observation had been adopted along with interviewing. In addition, social desirability bias might have been present in this study when social workers shared their individual and agency practice. It is recommended that future research adopts several different methods to reinforce the robustness of the findings.

Last, this research study did not reflect the perspectives of survivors who utilized services and programs provided by the clinical social workers in this study. Throughout this study, survivor-centeredness has been emphasized by participants as a primary principle to create and develop their practice model. However, what survivors want from services had to be filtered through social workers' perspectives since the focus of this study is limited to clinical social workers' viewpoints and stories. Future research studies would need to include survivors' voices, which can guide social workers in their search for an integrated practice model that truly benefits the clients they serve.

In spite of these limitations, this dissertation is one of the first empirical research studies to explore the practice of clinical social workers working in the domestic violence field. As much as clinicians need to pay attention to social change efforts, both the domestic violence movement and social work profession should acknowledge the role social workers played in building more integrated and alternative practice models with a field that long doubted the value of clinical services. In addition, clinical social workers should be viewed as resources for (re)formulating "the vocabulary of resistance for social change" (Hook, 2005). Inspired by psychiatrist Frantz Fanon's works, postcolonial psychologist Derek Hook argues that psychological concepts and explanations are employed to describe conditions of oppression and this is why we need to continue to return to a language of psychology to formulate resistance (Fanon, 1963, 1967; Hook, 2005, 2008). When applied to domestic violence cases, clinical social workers can identify changing power and control tactics used by abusers that disempower their victims psychologically; this could contribute to updating the language of the resistance movement to reflect women's authentic voices and their desire for empowerment on their own terms.

By crossing the boundaries of psychology and politics, or social service and social change frameworks, the practice of clinical social workers may help us find ways to move beyond the age-old debate on the identity and mission of social work profession between individual treatment and social reform.

REFERENCES

Abel, E. M. (2000). Psychosocial treatments for battered women: A review of empirical research. *Research on Social Work Practice, 10*(1), 55-77.

Abramovitz, M. (1998). Social work and social reform: An arena of struggle. *Social Work, 43*(6), 512-526.

Abrams, L. S., & Curran, L. (2004). Between women: Gender and social work in historical perspective. *Social Service Review*, 429-446.

Addams, J. (1902). *Democracy and social ethics*. New York: Macmillan.

Addams, J. (1910). *Twenty years at Hull-House*. New York: New American Library.

Ahrens, L. (1980). Battered women's refuges:Feminist cooperatives vs. social service institutions. *Radical America, 14*(3), 41-47.

Austin, M. J., Coombs, M., & Barr, B. (2005). Community-centered clinical practice: Is the integration of micro and macro social work practice possible? *Journal of Community Practice, 13*(4), 9-30.

Ballou, M., & Brown, L. S. (Eds.). (2002). *Rethinking mental health and disorder: Feminist perspctives*. New York: The Guilford Press.

Barretti, M. (2001). Social work, women, and feminism: A review of social work journals, 1988-1997. *Affilia, 16*(3), 266-294.

Bass, D., & Rice, J. (1979). Agency response to the abused wife. *Social Casework, 60*, 338-342.

Baumgardner, J., & Richards, A. (2000). *Manifesta: Young women, feminism, and the future*. New York: Farrar, Straus and Giroux.

Bennett, L., Riger, S., Campbell, R., & Wasco, S. (2003). Counseling services for battered women: A comparison of outcomes for physical and sexual assault survivors. *Journal of Interpersonal Violence, 18*(7), 717-734.

Bennett, L., Riger, S., Schewe, P., Howard, A., & Wasco, S. (2004). Effectiveness of hotline, advocacy, counseling, and shelter services for victims of domestic violence: A statewide evaluation. *Journal of Interpersonal Violence, 19*(7), 815-829.

Berg, S. H. (2002). The PTSD Diagnosis: Is It Good for Women? *Affilia, 17*(1), 55-68. doi: 10.1177/0886109902017001004

Berlin, S., & Kravits, D. (1981). Women as victim:A feminist social work perspective. *Social Work, 26*, 447-449.

Berry, D. B. (2000). *The domestic violence sourcebook*. Lincolnwood, IL: Lowell House.

Binder, A. (2007). For love and money: Organizations' creative responses to multiple enviornmental logis. *Theory and Society, 36*, 547-571.

Bliss, M. J., Ogley-Oliver, E., Jackson, E., Harp, S. E., & Kaslow, N. (2008). African American women's readiness to change abusive relationship. *Journal of Family Violence, 23*, 161-171.

Bloom, S. L. (1997). *Creating sanctuary: Toward the evolution of sane societies*. New York: Routledge.

Bloom, S. L. (2005). The Santuary model of organizational change for children's residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 26*(1), 65-81.

Bloom, S. L. (2010). Mental health aspects of IPV/DV: Survivors, professionals, and systems. In A. P. Giardino & E. R. Giardino (Eds.), *Intimate partner violence, domestic violence, and*

spousal abuse: A resource for professoinals working with children and families (pp. 1-38). St. Louis, MO: GW Medical Publishing

Bloom, S. L., Bennington-Davis, M., Farragher, B., McCorkle, D., Nice-Martini, K., & Wellbank, K. (2003). Multiple opportunities for creating sanctuary. *Psychiatric Quarterly, 74*(2), 173-190.

Bograd, M. (1984). Family systems approaches to wife battering: A feminist critique. *American Journal of Orthopsychiatry 54*(4), 558-568.

Bograd, M. (1999). Strengthening domestic violence theories: Intersections of race, class, sexual orientation, and gender. *Journal of Marital and Family Therapy, 25*(3), 275-289.

Bordo, S. (1993). *Unbearable weight: Feminism, western culture and the body*. Berkeley, CA: University of California Press.

Bowker, L. H., & Maurer, L. (1986). The effectiveness of counseling services utilized by battered women. *Women & Therapy, 5*(4), 65-82.

Brown, J. (1997). Working toward freedom from violence: The process of change in battered women. *Violence Against Women, 3*(1), 5-26.

Buchbinder, Eisikovits, & Karnieli-Miller, O. (2004). Social workers' perceptions of the balance between the psychological and the social. *Social Service Review, December*, 531-552.

Buchbinder, E., Eisikovitz, Z., & Karnieli-Miller, O. (2004). Social workers' perceptions of the balance between the psychological and the social *Social Service Review, December*, 531-552.

Burke, J. G., Gielen, A. C., McDonnell, K. A., O'Campo, P., & Maman, S. (2001). The process of ending abuse in intimate relationships: A qualitative exploration of the Transtheoretical Model. *Violence Against Women, 7*(10), 1144-1163.

Caplan, P. J. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who's normal*. Reading, Massachusetts: Addison-Wesley Publishing Company.

Chambers, C. A. (1963). Social service and social reform: A historical essay. *Social Service Review, 37*(1), 76-90.

Charmaz, K. (2000). Grounded Theory: Objectivist and Constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 509-535). Thousands Oaks, CA: Sage Publications, Inc.

Chong, H. S. (2000). *Social workers' experiences with victims of domestic violence: Visions, struggles, growth, and needs.* Ph.D. Dissertation, Columbia University, New York.

Clemans, S. E. (2004). Recognizing vicarious traumatization: A single session group model for trauma workers. *Social Work with Groups, 27*(2/3), 55-74.

Cluss, P., Chang, J. C., Hawker, L., Scholle, S. H., Dado, D., Buranosky, R., & Goldstrohm, S. (2006). The process of change for victims of intimate partner violence: support for a psychosocial readiness model. *Women's Health Issues, 16*(5), 262-274.

Conroy, K. (1994). The battered women's movement and the role of clinical social work. Retrieved from www.columbia.edu/~rhm5/BWMOVT.html

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing Grounded Theory* (3rd ed.). Los Angeles: SAGE.

Cox, J. W., & Stoltenberg, C. D. (1991). Evaluation of a treatment program for battered wives. *Journal of Family Violence, 6*(4), 395-413.

Crenshaw, K. W. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Standford Law Review, 43*(6), 1241-1299.

Creswell, J. W. (1998). *Qualitative inquiry and reserach design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications, Inc.

Danis, F. S., & Lockhart, L. (2003). Domestic violence and social work education: What do we know, what do we need to know? *Journal of Social Work Education, 39*(2), 215-220.

Danto, E. A. (2009). "A new sort of 'Salvation Army'": Historical perspectives on the confluence of psychoanalysis and social work. *Clinical Social Work Journal, 37*, 67-76.

Davies, J. (2009). *Advocacy beyond leaving: Helping battered women in contact with current for formern partners*. San Francisco, CA: Family Violence Prevention Fund.

Davis, L. V. (2001). Why we still need a women's agenda for social work. In J. K. Peterson & A. Lieberman (Eds.), *Building on women's strengths: A social work agenda for the twenty-first century* (pp. 1-22). New York: The Haworth Social Work Practice Press.

Davis, L. V., Hagen, J. L., & Early, T. J. (1994). Social services for battered women: Are they adequate, acessible and appropriate? *Social Work, 39*(6), 695-704.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Deutsch, H. (1944). *The Psychology of Women*. New York: Grune & Stratton.

Dienemann, J., Campbell, J., Landenburger, K., & Curry, M. A. (2002). The domestic violence survivor assessment: A tool for counseling women in intimate partner violence relationships. *Patient Education and Counseling, 46*, 221-228.

Dienemann, J., Glass, N., Hanson, G., & Lunsford, K. (2007). The Domestic Violence Survivor Assessment (DVSA): A tool for individual counseling with women experiencing intimate partner violence. *Issues in Mental Health Nursing, 28*, 913-925.

Dienemann, J., Neese, J., & Lowry, S. (2009). Psychometric properties of the Domestic Violence Survivor Assessment. *Archives of Psychiatric Nursing, 23*(2), 111-118.

Dore, M. M. (1999). The retail method of social work: The role of the New York School in the development of clinical practice. *Social Service Review, June*, 168-190.

Douglas, U., Bathrick, D., & Perry, P. A. (2008). Deconstructing male violence against women: The Men Stopping Violence Community-Accountability Model. *Violence Against Women, 14*(2), 247-261.

Dudley, D. R., McCloskey, K., & Kustron, D. A. (2008). Therapist perceptions of intimate partner violence: A replication of Harway and Hansen's study after more than a decade. *Journal of Aggression, Maltreatment & Trauma, 17*(1), 80-102.

Dutton, M. A. (1992). *Empowering and healing the battered woman: A model for assessment and intervention*. New York: Springer publishing Company

Edleson, J. (1991). Social workers' intervention in woman abuse: 1907-1945. *Social Service Review, June* 304-311.

Edwards, T. A., Houry, D., Kemball, R. S., Harp, S. E., McNutt, L.-A., Straus, H., . . . Kaslow, N. (2006). Stages of change as a correlate of mental health symptoms in abused, low-income African American women. *Journal of Clinical Psychology, 62*(12), 1531-1543.

Egger, R., & Yoon, H. (2004). *Begging for change: The dollars and sense of making nonprofits responsive, efficient, and rewarding for all*. New York: HarperCollins.

Epple, D. M. (2007). Inter and intra professional social work differences: Social work challenge. *Clinical Social Work Journal, 35*, 267-276.

Faludi, S. (1991). *Backlash : The undeclared war against American women*. New York: Crown Publishing Group.

Fanon, F. (1963). *The wretched of the earth* (C. Farrington, Trans.). New York: Grove Press.

Fanon, F. (1967). *Black skin white masks* (C. L. Markmann, Trans.). New York: Grove Press.

Feit, M. D. (2003). Toward a definition of social work practice: Reframing the dichotomy. *Research on Social Work, 13*(3), 357-365.

Ferraro, K. J. (1983). Negotiating trouble in a battered women's shelter. *Journal of Contemporary Ethnography, 12*(3), 287-306.

Fleming, J. B. (1979). *Stopping wife abuse*. Garden City, NY: Anchor Press.

Flynn, J. P. (1977). Recent findings related to wife abuse. *Social Casework, 58*, 13-20.

Frazer, P., Westhuis, D., Daley, J. G., & Phillips, I. (2009). How clinical social workers are using the DSM-IV: A national study. *Social Work in Mental Health, 7*(4), 325-339.

Fried, A. (1994). "It's hard to change what we want to change": Rape crisis centers as organizations. *Gender & Society, 8*(4), 562-563.

Galper, M., & Washburne, G. K. (1977). Maximizing the impact of an alternative agency. *Journal of sociology and social welfare, 4*, 248-257.

Gambrill, E. (1999). Evidence based practice: An alternative to authority based practice. *Families in Society: The Journal of Contemporary Human Services, 80*(4), 341-350.

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A metal analysis. *Journal of Family Violence, 14*(99-133).

Goldstein, E. G. (1996). What is clinical social work? Looking back to move ahead. *Clinical Social Work Journal, 24*(1), 89-104.

Goldstein, E. G. (2009). The relationship between social work and psychoanalysis: The future impact of soical workers. *Clinical Social Work Journal, 37*(7-13).

Gomory, T., Wong, S. E., & Lacasse, J. R. (2011). Clinical social work and the biomedical industrial complex. *journal of Sociology & Social Welfare, 38*(4), 135-165.

Gordon, L. (1988). *Heroes of their own lives: The Politics of history of family violence, Boston, 1880-1960*. New York: Penguin.

Gordon, L. (1990). Family violence, feminism, and social control. In L. Gorden (Ed.), *Women, the state, and welfare* (pp. 178-198). Madison, WI: The University of Wisconsin Press.

Gringeri, C. E., & Roche, S. E. (2010). Beyond the binary: Critical feminisms in social work. [Guest Editorial for Special Issue on Critical Feminisms]. *Affilia, 25*(4), 337-340.

Gringeri, C. E., Wahab, S., & Anderson-Nathe, B. (2010). What makes it feminist?: Mapping the landscape of feminist social work research. [Research]. *Affilia, 25*(4), 390-405.

Gutierrez, L. M. (1987). Social work theories and practice with battered women: A conflict-of-value analysis. *Affilia*, 36-52.

Hagen, J. L. (2001). Women, welfare, and violence: A look at the Family Violence Option. In K. J. Peterson & A. Lieberman (Eds.), *Building on women's strengths: A social work agenda for the twenty-first century* (pp. 119-143). New York: The Haworth Social Work Practice Press.

Hammons, S. A. (2004). "Family violence": The language of legitimacy. *Affilia, 19*(3), 273-288.

Han, M., & Chow, J. (2010). What changes MSW students' view on the mission of social work? *Social Work Education, 29*(2), 205-221.

Hansen, M., & Harway, M. (Eds.). (1993). *Battering and family therapy: A feminist perspective*. Newbury Park: Sage Publications.

Harway, M., & Hansen, M. (1993). Therapist perceptions of family violence. In M. Hansen & M. Harway (Eds.), *Battering and family therapy: A feminist perspective* (pp. 42-53). Newbury Park: Sage Publications.

Haynes, K. S. (1998). The one hundred-year debate: Social reform versus individual treatment. *Social Work, 43*(6), 501-509.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror*. New York: Basic Books.

Herman, J. (1997). *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror*. New York: Basic Books.

Hiersteiner, C., & Peterson, K. J. (1999). "Crafting a usable past": The care-centered practice narrative in social work. *Affilia, 14*(2), 144-161.

Hook, D. (2005). A critical psychology of the postcolonial. *Theory & Psychology, 15*(4), 475-503.

Hook, D. (2008). Postcolonial psychoanalysis. *Theory & Psychology, 18*(2), 269-283.

Hulko, W. (2009). The time-and context-contingent nature of intersectionality and interlocking oppressions. *Affilia, 24*(44), 44-55.

INCITE! (Ed.). (2007). *The revolution will not be funded: Beyond the non-profit industrial complex*. Cambridge, Massachusetts: South End Press.

INCITE! Women of Color Against Violence (Ed.). (2006). *Color of violence: The INCITE! anthology*. Cambridge, Massachusetts: South End Press.

Jacobson, W. B. (2001). Beyond therapy: Bringing social work back to human services reform. *Social Work, 46*(1), 51-61.

Jones, L., Huges, M., & Unterstaller, U. (2001). Post-Traumatic Stress Disorder (PTSD) in victims of domestic violence: A review of research *Trauma, Violence, & Abuse, 2*(2), 99-119.

Jordan, J. V. (Ed.). (1997). *Women's growth in diversity: More writings from the Stone Center*. New York: The Guilford Press.

Josephson, J. (2005). The intersectionality of domestic violence and welfare in the lives of poor women. In N. J. Sokoloff & C. Pratt (Eds.), *Domestic Violence at the Margins* (pp. 83-101). New Brunswick, NJ: Rutgers University Press.

Kanuha, V. (1998). Professional social work and the battered women's movement: Contextualizing the challenges of domestic violence work. *International Journal of Continuing Social Work Education, 1*(2), 4-18.

Kemp, S., & Brandwein, R. (2010). Feminisms and social work in the United States: An inertwined history. [History, Review]. *Affilia, 25*(4), 341-364.

Kirst-Ashman, K. K., & Hull, J., Grafton H. (2006). *Understanding generalist practice* (4th ed.). Belmot, CA: Thomson Brooks/Cole.

Kivel, P. (2007). Social service or social change? In INCITE! Women of Color Against Violence (Ed.), *The revolution will not be funded: Beyond the non-profit industrial complex* (pp. 129-149). Cambridge, Massachusetts: South End Press.

Klein, W. C., & Bloom, M. (1995). Practice wisdom. *Social Work, 40*(6), 799-807.

Kondrat, M. E. (2002). Actor-centered social work: Re-visioning "Person-in-Environment" through a critical theory lens. *Social Work, 47*(4), 435-448.

Koyama, E. (2006). Disloyal to feminism: Abuse of survivors within the domestic violence

shelter system. In INCITE! Women of Color Against Violence (Ed.), *Color of violence:*

The INCITE! anthology (pp. 208-222). Cambridge, Massachusetts: South End Press.

Kubany, E. S., Hill, E. E., & Owens, J. A. (2003). Cognitive Trauma Therapy for battered

women with PTSD: Preliminary findings. *Journal of Traumatic Stress, 16*(1), 81-91.

Kubany, E. S., Hill, E. E., Owens, J. A., Iannce-Spencer, C., McCaig, M. A., & Tremayne, K. J.

(2004). Cognitive trauma therapy for battered women with PTSD (CTT-BW). *Journal of*

Consulting and Clinical Psychology, 72(1), 3-18.

Kunzel, R. G. (1993). *Fallen women, problem girls: Unmarried mothers and the*

professionalization of social work, 1890-1945. New Haven, Conn.: Yale University Press.

Kuzel, A. J. (1999). Sampling in qualitative inquiry In B. F. Crabtree & W. L. Miller (Eds.),

Doing qualitative research

 (2nd ed.). Thousand Oaks, CA: Sage.

Lacasse, J. R., & Gomory, T. (2003). Is graduate social work education promoting a critical

approach to mental health practice? *Journal of Social Work Education, 39*(3), 383-408.

Lee, P. (1929). Social work as cause and function *Proceedings of the national conference of*

social work 1929 (pp. 3-20). Chicago: University of Chicago Press.

Lehrner, A., & Allen, N. E. (2008). Social change movements and the struggle over meaning-

making: A case study of domestic violence. *American Journal of Community Psychology,*

42, 220-234.

Lehrner, A., & Allen, N. E. (2009). Still a movement after all these years?: Current tensions in

the domestic violence movement. *Violence Against Women, 15*(6), 656-677.

Levey, B. Z. (1929). New trends in psychiatric social treatment in the family agency. *Mental Hygiene*, pp.129-131.

Lewis, M. L. (1954). The initial contact with wives of alcoholics. *Social Casework, 35*(1), 8-14.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lipsky, L. v. D., & Burk, C. (2009). *Trauma stewardship: A every day guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler Publishers, Inc.

Lipsky, S., & Caetano, R. (2007). Impact of intimate partner violence on unmet need for mental health care: Results from USDUH. *Psychiatric Services, 58*(6), 822-829.

Loseke, D. R., Gelles, R. J., & Cavanaugh, M. M. (Eds.). (2005). *Current controversies on family violence* (2nd ed.). Thousand Oaks, CA: SAGE.

Lundy, M., & Grossman, S. (2001). Clinical research and practice with battered women: What we know, what we need to know. *Trauma, Violence & Abuse, 2*(2), 120-141.

Lyon, E., Lane, S., & Menard, A. (2008). *Meeting Survivors' Needs: A multi-state study of domestic violence shelter experiences*. Washington D.C.: University of Conneticut School of Social Work and National Resource Center on Domestic Violence

Macy, R. J., Ferron, J., & Crosby, C. (2009). Partner violence and survivors' chronic health problems: Informing social work practice. *Social Work, 54*(1), 29-43.

Madsen, L. H., Blitz, L. V., McCorkle, D., & Panzer, P. G. (2003). Sanctuary in a domestic violence shelter: A team approach to healing. *Psychiatric Quarterly, 74*(2), 155-171.

Malena, R. W., & Moxley, D. P. (2002). Best practices as agency-based knowledge in social welfare. *Administration in Social Work, 26*(4), 1-23.

Markowitz, L., & Tice, K. W. (2002). Paradoxes of professionalization: Parallel dilemmas in women's organizations in the Americas. *Gender & Society, 16*(6), 941-958.

Marlow, C. (1993). Coping with multiple roles: Family configuration and the need for workplace services. *Affilia, 8*(1), 40-55.

McCracken, S. G., & Marsh, J. C. (2008). Practitioner Expertise in Evidence-Based Practice Decision Making. *Research on Social Work Practice, 18*(4), 301-310. doi: 10.1177/1049731507308143

McDonald, J. (2005). Neo-liberalism and the pathologising of public issues: The displacement of feminist service models in domestic violence support services. *Australian Social Work 58*(3), 276-284.

McLaughlin, A. M. (2002). Social work's legacy: Irreconcilable differences. *Clinical Social Work Journal, 30*(2), 187-198.

McLaughlin, A. M. (2006). *Clinical social work and social justice.* Ph.D Dissertation, University of Calgary, Calgary, Alberta.

McLaughlin, A. M. (2009). Clinical social work: Advocates for social justice. *Advances in Social Work, 10*(1), 51-68.

McNamara, J. R., Tamanini, K., & Pelletier-Walker, S. (2007). The impact of short-term counseling at a domestic violence shelter. *Research on Social Work Practice*, 1-5. doi: doi:10.1177/1049731507307790

McNeely, R. L., & Jones, J. M. (1980). Refuge from violence: Establishing shelter services for battered women. *Administration in Social Work, 4*(4), 71-82.

McNutt, J. (2008). Social work practice. In T.Mizrah & L. E. Davis (Eds.), *Encyclopedia of social work* (pp. 138-141). Washington D.C.: NASW Press & Oxford University Press.

McPhail, B. A., Busch, N. B., Kulkarni, S., & Rice, G. (2007). An integrative feminist model: The evolving feminist perspective on intimate partner violence. *Affilia, 13*(8), 817-841.

McShane, C. (1979). Community services for battered women. *Social Work, 24*, 34-39.

Meier, J. (2009). Parental Alienation Syndrome and Parental Alienation: Research reveiws (Vol. January, pp. 1-17). National Online Research Center on Violence Against Women.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco: John Wiley&Sons.

Miley, K. K., Michael, O. M., & DuBois, B. (2001). *Generalist social work practice: An empowering approach* (3rd ed.). Needham Heights, MA: A Pearson Education Company.

Miller, E. (2006). *Women helping women: The Battered Women's Movement in Lawrence, Kansas.* M.A. Unpublished Thesis University of Kansas Lawrence, KS.

Miller, E. (2010). *Moving to the head of the river: The early years of the U.S. Battered Women's Movement.* Ph.D Dissertation, The University of Kansas, Lawrence.

Mills, L. G. (2008). *Violent partners:A breakthrough plan for ending the cycle of abuse*. New York: Basic Books.

Mirkin, M. P. (Ed.). (1994). *Women in context: Toward a feminist reconstruction of psychotherapy*. New York: The Guilford Press.

Mirkin, M. P., Suyemoto, K. L., & Okun, B. F. (Eds.). (2005). *Psychotherapy with women: Exploring diverse contexts and identities*. New York: The Guilford Press.

Modleski, T. (1991). *Feminism without women: Culture and criticism in a "Postfeminist" age*. New York: Routledge.

Morell, C. (1987). *Cause* is function: Toward a feminist model of integration for social work. *Social Service Review, March*, 144-155.

Morgan, P. (1981). From battered wife to program client: the state's shaping of social problems. *kapitalistate, 9*, 17-40.

Mowrer, E. R., & Mowrer, H. R. (1928). *Domestic discord: Its analysis and treatment*. Chicago, Illinois: The University of Chicago Press.

Mullen, E. J., Bledsoe, S. E., & Bellamy, J. L. (2008). Implementing Evidence-Based Social Work Practice. *Research on Social Work Practice, 18*(4), 325-338. doi: 10.1177/1049731506297827

Nes, J. A., & Iadicola, P. (1989). Toward a definition of feminist social work: A comparison of Liberal, Radical, and Socialists models. *Social Work, 34*(1), 12-21.

Nichols, B. B. (1976). The abused wife problem. *Social Casework, 57*, 27-32.

Nicolaidis, C., & Paranjape, A. (2009). Defining intimate partner violence: Controversies and implications. In C. Mitchell & D. Anglin (Eds.), *Intimate partner violence: A health-based perspective* (pp. 19-29). New York: Oxford University Press.

Olsen, V. L. (2000). Feminisms and qualitative research at and into the millennium. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 215-256). Thousand Oaks, CA: Sage publications.

Orenstein, P. (1995). *Schoolgirls: Young women, self-esteem, and the confidence gap*. New York: Anchor Books.

Panzer, P. G., Phillip, M. B., & Anna, H. (2000). Trends in domestic violence service and leadership: Implications for an integratd shelter model. *Administration and Policy in Mental Health, 27*(5), 339.

Park, E. (2009). *Battered women's help-seeking: A turning point from victimization to readiness.* Ph.D Doctorate Dissertation Univerisity of Minnesota, Twin Cities.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks,

CA: Sage Publications, Inc.

Pearlmutter, S. (2002). Achieving political practice: Integrating individual need and social action.

Journal of Progressive Human Services, 13(1), 31-51.

Peled, E., Eisikovits, Z., Enosh, G., & Winstok, Z. (2000). Choice and empowerment for battered

women who stay: Toward a constructivist model. *Social Work, 45*(1), 9-25.

Perez, S., & Johnson, D. M. (2008). PTSD Compromises Battered Women's Future Safety. *J

Interpers Violence, 23*(5), 635-651. doi: 10.1177/0886260507313528

Pfouts, J., & Renz, C. (1981). The future of wife abuse programs. *Social Work, 26*, 451-455.

Philips, D. G. (2009). Clinical social work and psychoanalysis: Introduction to the special issue.

Clinical Social Work Journal, 37, 1-6.

Pleck, E. (1987). *Domestic tyranny:The making of social policy against family violence from

colonial times to the present*. New York: Oxford University Press.

Postmus, J. L., & Ortega, D. (2005). Serving two masters: When domestic violence and child

abuse overlap. *Families in Society: The Journal of Contemporary Human Services, 86*(4),

483-490.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking:

Toward an integrative model of change. *Journal of Counseling and Clinical Psychology,

51*(3), 390.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change:

Applications to addictive behaviors. *American Psychologist, 47*(9), 1102-1114.

Prochaska, J. O., Velicer, W. F., DiClemente, C. C., & Fava, J. (1988). Measuring processes of change: Applications to the cessation of smoking. *Journal of Consulting and Clincial Psychology, 56*(4), 520.

Prochaska, J. O., Velicer, W. F., Rossi, J. S., Goldstein, M. G., Marcus, B. H., Rakowski, W., . . . Rossi, S. R. (1994). Stage of change and decisional balance for 12 problem behaviors. *Health Psychology, 13*(1), 39-46.

Proctor, E. K., & Rosen, A. (2008). From Knowledge Production to Implementation: Research Challenges and Imperatives. *Research on Social Work Practice, 18*(4), 285-291. doi: 10.1177/1049731507302263

Pyles, L. (2009). *Progressive community organizing: A critical approach for a globalizing world*. New York: Routledge

Pyles, L., & Postmus, J. L. (2004). Addressing the problem of domestic violence: How far have we come? *Affilia, 19*(4), 376-388.

Reeser, L. C., & Epstein, I. (1990). *Professionalization and activism in social work: The sixties, the eighties, and the future*. New York: Columbia University Press.

Reisch, M. (1998). The sociopolitical context and social work method, 1890-1950. *Social Service Review, June*, 162-181.

Reisch, M., & Andrews, J. (2001). *The road not taken: A history of radical social work in the United States*. New York: Routledge.

Richmond, M. E. (1917). *Social diagnosis*. New York: Russell Sage Foundation.

Richmond, M. E. (1922). *What is social case work?* . New York: Russell Sage Foundation.

Rodriquez, D. (2007). The political logic of the non-profit industrial complex. In INCITE! (Ed.), *The Revolution will not be funded: Beyond the non-profit complex* (pp. 21-40). Cambridge, Massachusetts: South End Press.

Rodwell, M. K. (1998). *Social work constructivist research*. New York: Garland Publishing, Inc.

Rosewater, L. B., & Walker, L. E. A. (Eds.). (1985). *Handbook of feminist therapy: Women's issues in psychotherapy*. New York: Springer Publishing Company.

Sachs, J., & Newdom, F. (1999). *Clinical work and social action: An integrative approach*. New York: The Haworth Press.

Salas, L. M., Sen, S., & Segal, E. A. (2010). Critical theory: Pathway from dichotomous to integrated social work practice. *Families in Society, 91*(1), 91-96.

Samuels, G. M., & Ross-Sheriff, F. (2008). Identity, oppression and power: Feminisms and intersectionality theory. *Affilia, 23*(5), 5-9.

Sands, R. G. (2001). Postmodern feminist theory and practice *Clinical social work practice in behavioral mental health* (pp. 116-137). Boston, MA: Allyn & Bacon.

Schechter, S. (1982). *Women and male violence: The visions and struggle of the Battered Women's Movement*. Cambridge, MA: South End Press.

Schechter, S. (1988). Building bridges between activists, professionals, and researchers. In K. Yllo & M. Bograd (Eds.), *Feminist perspective on wife abuse* (pp. 299-312). Newbury Park: Sage.

Schyuler, M. (1976). Battered wives: An emerging social problem. *Social Work, 21*, 488-491.

Shamai, M. (2000). Rebirth of the self: How battered women experience treatment. *Clinical Social Work Journal, 28*(1), 85-103.

Showalter, E. (1987). *The Female Malady: Women, madness and English culture 1830-1980*. London: Virago Press.

Smith, A. (2007). Introduction: The revolution will not be funded. In INCITE! (Ed.), *The revolution will not be funded: Beyond the non-profit industrial complex* (pp. 1-18). Cambridge, Massachusetts: South End Press.

Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women, 11*(1), 38-64.

Specht, H., & Courtney, M. E. (1994). *Unfaithful Angels:How social work has abandoned its mission*. New York: The Free Press.

Spivak, G. C. (1988). Can the subaltern speak? In C. Nelson & L. Grossberg (Eds.), *Marxism and the interpretation of culture* (pp. 271-313). Chicago: University of Illinois Press.

Srinivasan, M., & Davis, L. V. (1991). A shelter: An organization like any other? *Affilia, 6*(1), 38-57.

Sullivan, C. M., & Bybee, D. I. (1999). Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology, 67*(1), 43-53.

Sullivan, C. M., & Cain, D. (2004). Ethical and safety considerations when obtaining information from or about battered women for reserach purposes. *Journal of Interpersonal Violence, 19*(5), 603-618.

Sullivan, C. M., Campbell, R., Angelique, H., Eby, K. K., & Davidson II, W. S. (1994). An advocacy intervention program for women with abusive partners: Six-month follow-up. *American Journal of Community Psychology, 22*(1), 101-122.

Sullivan, C. M., & Davision II, W. S. (1991). The provision of advocacy services to women leaving abusive partners: An examination of short-term effects. *American Journal of Community Psychology, 19*(6), 953-960.

Sullivan, C. M., Tan, C., Basta, J., Rumptz, M., & Davision II, W. S. (1992). An advocacy intervention program for women with abusive partners: Initial evaluation. *American Journal of Community Psychology, 20*(3), 309-332.

Sullivan, G. (1982). Cooptation of alternative services:The battered women's movement as a case study. *Catalyst, 14*, 38-56.

Swartz, S. (1999). Lost lives: Gender, history and mental illness in the cape, 1891-1910. *Feminism & Psychology, 9*(2), 152-158.

Swartz, S. (2005). Can the clinical subject speak? Some thoughts on subaltern psychology. *Theory & Psychology, 15*(4), 505-525.

Swartz, S. (2006). The thrid voice: Writing case-notes. *Feminism & Psychology, 16*(4), 427-444.

Swenson, C. R. (1998). Clinical Social Work's Contribution to a Social Justice Perspective. *Social Work, 43*(6), 527-537.

The Missouri Coalition Against Domestic & Sexual Violence. (2012). *How the earth didn't fly into the sun: Missouri's project to reduce rules in domestic violence shelter*. Retrieved from www.mocadvs.org

Thyer, B. A. (2008). The Quest for Evidence-Based Practice?: We Are All Positivists! *Research on Social Work Practice, 18*(4), 339-345. doi: 10.1177/1049731507313998

Tice, K. W. (1990). A case study of battered women's shelters in Appalachia. *Affilia, 5*(3), 83-100.

Trattner, W. I. (1999). *From poor law to welfare state: A history of social welfare in America* (6th ed.). New York: Free Press.

Tutty, L. M., Bidgood, B. A., & Rothery, M. A. (1993). Support groups for battered women: Research on their efficacy. *Journal of Family Violence 8*(4), 325-343.

Tutty, L. M., Bidgood, B. A., & Rothery, M. A. (1996). Evalutating the effect of group process and client variables in support grouops for battered women. *Research on Social Work Practice, 6*(3), 308-324.

Valentich, M. (1996). Feminist theory and social work practice. In F. J. Turner (Ed.), *Social work treatment: Interlocking theoretical practices* (pp. 282-318). New York: The Free Press.

Vodde, R., & Gallant, J. P. (2002). Bridging the gap between micro and macro practice: Large scale change and a unified model of narrative-deconstructive practice. *Journal of Social Work Education, 38*(3), 439-458.

Wakefield, J. C. (1988a). Psychotherapy, distributive justice and social work: Part 1: Distributive justice as a conceptual framework for social work *Social Service Review, 62*(2), 187-210.

Wakefield, J. C. (1988b). Psychotherapy, distributive justice, and social work: Part 2: Psychotherapy and the pursuit of justice. *Social Service Review, 62*(3), 353-382.

Walker, L. E. A. (1994). *Abused women and survivor therapy: A practical guide for the psychotherapist* Washington, D. C.: American Psychological Association.

Walker, L. E. A. (2002). Politics, psychology and the battered women's movement. *Journal of Trauma Practice, 1*(1), 81-102.

Walter, U. M., & Peterson, J. K. (2002). Gendered differences: Postmodern feminist

    perspectives and young women identified as "emotioanlly disabled". *Families in Society:*

    The Journal of Contemporary Human Services, 83(5/6), 596-603.

Warshaw, C., & Brashler, P. (2009). Mental health treatment for survivors of intimate partner

    violence. In C. Mitchell & D. Anglin (Eds.), *Intimate partner violence: A health-based*

    perspective (pp. 335-387). New York: Oxford University Press.

Warshaw, C., Brashler, P., & Gil, J. (2009). Mental health consequences of intimate partner

    violence. In C. Mitchell & D. Anglin (Eds.), *Intimate Partner Violence: A health-based*

    perspective (pp. 147-171). New York: Oxford University.

Warshaw, C., Gugenheim, A. M., Moroney, G., & Barnes, H. (2003). Fragmented services,

    unmet needs:Buidling collaboration between the mental health and domestic violence

    communities. *Health Affairs, 22*(5), 230-234.

Whalen, M. (1996). *Counseling to end violence against women: A subversive model.* Thousand

    Oaks, CA: SAGE Publications.

Wies, J. R. (2006). *The changing relationships of women helping women: Patterns and trends in*

    domestic violence advocacy. Ph.D Dissertation The University of Kentucky, Lexington,

    Kentucky.

Wilson, K. S., Silberberg, M. R., Brown, A. J., & Yaggy, S. D. (2007). Health needs and barriers

    to healthcare of women who have experienced intimate partner violence. *Journal of*

    Women's Health, 16(10), 1485-1498.

Worell, J., & Remer, P. (2003). Empowerment feminist therapy. In J. Worell & P. Remer (Eds.),

    Feminist perspectives in therapy: Empowering diverse women (pp. 60-86). Hoboken, NJ:

    John Wiley & Sons, Inc.

Yillo, K. A. (2005). Through a feminist lens: Gender, diversity, and violence: Extending the feminist framework. In D. R. Loseke, R. J. Gelles & M. M. Cavanaugh (Eds.), *Current controversies on family violence* (pp. 19-34). Thousand Oaks, CA: Sage.

Yllo, K. (1988). Political and methodological debates in wife abuse reserach. In K. Yllo & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 28-50). Newbury park, CA: SAGE

Yllo, K., & Bograd, M. (Eds.). (1988). *Feminist perspectives on wife abuse*. Newbury Park: Sage.

Appendix A: Human Subject's Application and Approval Letter

2/2010 HSCL #_____
<div style="text-align:right">(to be assigned)</div>

UNIVERSITY OF KANSAS
Human Subjects Committee Lawrence
Application for Project Approval

1. Name of Investigator(s) Sur Ah Hahn
2. Department Affiliation School of Social Welfare
3. Campus or Home Mailing Address: 1545 Lilac Lane, Lawrence, KS 66044-3184
   a. Email address:hypatia@ku.edu
   Phone Number(s): (a) Campus:864-8966 (b) Home 764-0392
5. Name of Faculty Member Responsible for Project: Edward Scanlon, PhD
HSCL must receive faculty approval via email notification or hard copy signature before a student application may be processed.
   a. Email address of Faculty Member: escanlon@ku.edu
6. Type of investigator and nature of activity. (Check appropriate categories)
   ☐ Faculty or staff of University of Kansas
   ☐ Project to be submitted for extramural funding; Agency:_____
   KU/KUCR project number:_____
(HSCL must compare all protocols in grant applications with the protocols in the corresponding HSCL application)
   ☐ Project to be submitted for intramural funding; Source: _____
   ☒ Project unfunded
   ☐ Other: _____
   ☐ Student at University of Kansas: ☐ Graduate ☐ Undergraduate ☐ Special
   ☐ Class project (number & title of class): _____
   ☐ Independent study (name of faculty supervisor): _____
   ☐ Other (please explain): _____
   ☐ Investigators not from the Lawrence campus but using subjects obtained through the
       University of Kansas
7.a. Title of investigation: Bridging the dichotomy between micro and macro practice in social work: A qualitative study on clinical social work practice with domestic violence survivors

7.b. Title of sponsored project, if different from above: _____

8. Individuals other than faculty, staff, or students at Kansas University.
   Please identify investigators and research group:

_____

9. Certifications: By submitting this application via email or hard copy I am certifying that I have read, understand, and will comply with the policies and procedures of the University of Kansas regarding human subjects in research. I subscribe to the standards and will adhere to the policies and procedures of the HSCL, and I am familiar with the published guidelines for the ethical treatment of subjects associated with my particular field of study.

Date: September 27, 2010   Date: _____
Signature: Sur Ah Hahn_____   Signature: _____
             First Investigator   Faculty Supervisor

Signature:_____   Signature: _____

_no_ p. other data that may increase participant risk (46.101 (b) (2) (ii) in the areas listed
☐ criminal ☐ civil, ☐ financial, ☐ employment, ☐ reputation

11. If any of the key personnel or research team members of this project have a financial interest* in a project sponsor or a provider of goods or services to the project, the individual and the relationship must be disclosed.

☒ Neither I nor any member of the research team has a financial interest in the project sponsor or a provider of goods or services to this project.

☐ I am disclosing the following financial interest(s)** :

Name of Individual	Role on Project	Financial Interest Entity

* An individual's financial interests include those of the individual, his or her spouse, dependent children, and other members of the personal household (i.e., ownership, compensation received or anticipated, a position of officer or director, or receipt of fees or commissions).

** If this financial interest has not already been disclosed on a Conflict of Interest report, an ad hoc disclosure via the Conflict of Interest reporting form may also be required. Direct inquiries to coi@ku.edu. COI resource information is also available at the following link:
http://www.rcr.ku.edu/coi/index.shtml

Additional COI Notes:

Certification: By submitting this application via email or hard copy, I am certifying that I have verified and disclosed any potential conflict of interest between myself and/or my team members and the project sponsor.

Date: _____
Signature: _____
    Faculty Supervisor or First Investigator

Complete the following questions on this page. Please do not use continuation sheets.

12. Approximate number of subjects to be involved in the research: 15

13. Project Purpose(s):

> The purpose of the project is to explore how clinical social workers in the domestic violence organizations experience the relationship between micro and macro level practice responsibilities. Further, if they experience any division between these two area of practices, the proposed project would explore how they attempt to integrate these macro and micro practice responsibilities and how these integration efforts affect their professional identities as social workers. The study results would provide a contribution to the development of practice theories that help the profession bridge the micro and macro areas of practices based on actual practice experiences of social workers.

14. Describe the proposed subjects (age, sex, race, or other special characteristics). If there is a physical or mental health condition that characterizes the subjects to be included in the study, please indicate this here as well.

> These clinical social workers (n=15) would range in age (approximately) from mid-20s to mid-50s, would be employed in domestic violence organizations, would have advanced social work education in psychotherapy. Racial, ethnic and gender of participants is unknown at this time, but is expected to be varied.

15. Describe how the subjects are to be selected. Please indicate how you will gain access to, and recruit these subjects for participation in the project. That is, will you recruit participants through word-of-mouth, fliers or poster, newspaper ads, public or private membership or employee lists, etc. Drawings/raffles are not permitted for payment or recruiting. (If subjects are to be recruited from a cooperating institution, such as a clinic or other service organization be aware that subjects' names and other private information, such as medical diagnosis, may not be obtained without the subjects' written permission.)

> The subjects will be selected through word of mouth. The researcher has worked in the field of study and has gained contacts and information about potential participants through community networking.

16. Single page abstract of the proposed procedures in the project – consent to the post-project security measures. (The abstract should be a succinct overview of the project without jargon, unexplained abbreviations, or technical terminology. Here is where you must provide details about Yes answers to items under question 10.a through 10.p of the application: drugs, cooperating institutions, medical information requested, security measures and post-project plans for tapes, questionnaires, surveys, and other data, and detailed debriefing procedures for deception projects.)

This project proposes to interview 15 local clinical social workers working in the domestic violence field about how they negotiate the division between the clincial intervention and the macro practices of social change in their every day practices. The interviews with the partipants will be audio recorded using a digital voice recorder. The recorded files will be de-identified and will be kept confidential in the reseracher's computer. The interviews will be transcribed, and the trascripts will be analyzed for thematic content. The final result will be published as the principal investigator's dissertation. No identifying information will be used.

10L: Each interview will last approximately 60-90 mintues in which the content outlined above will be discussed. The audio files will be de-identified by the reseracher using the numerical code. The audio files with the numerical code will be password-protected in the researcher's computer and will be maintained separately from the coding sheet that contains identifying information. The audio files and the numerical code sheet will be permanently deleted 6 months following the completion of the dissertation study.

10N: The participants will be asked to sign a statement of informed consent included in this packet.

KU RESEARCH &
GRADUATE STUDIES
The University of Kansas

10/2/10
HSCL #18957

Sur Hahn
SOC WEL
Twente Hall

The Human Subjects Committee Lawrence reviewed your research update application for project

18957   Hahn/Scanlon (SOC WEL) Bridging the Dichotomy Between Micro and Macro Practice in Social Work:
A Qualitative Study on Clinical Social Work Practice with Domestic Violence Survivors

and approved this project under the expedited procedure provided in 45 CFR 46.110 (f) (7) Research on
individual or group characteristics or behavior (including, but not limited to, research on perception, cognition,
motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research
employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality
assurance methodologies. As described, the project complies with all the requirements and policies established by
the University for protection of human subjects in research. Unless renewed, approval lapses one year after
approval date.

The Office for Human Research Protections requires that your consent form must include the note of HSCL
approval and expiration date, which has been entered on the consent form sent back to you with this approval.

1. At designated intervals until the project is completed, a Project Status Report must be returned to the HSCL
   office.
2. Any significant change in the experimental procedure as described should be reviewed by this Committee prior
   to altering the project.
3. Notify HSCL about any new investigators not named in original application. Note that new investigators must
   take the online tutorial at http://www.rcr.ku.edu/hscl/hsp_tutorial/000.shtml.
4. Any injury to a subject because of the research procedure must be reported to the Committee immediately.
5. When signed consent documents are required, the primary investigator must retain the signed consent
   documents for at least three years past completion of the research activity. If you use a signed consent form,
   provide a copy of the consent form to subjects at the time of consent.
6. If this is a funded project, keep a copy of this approval letter with your proposal/grant file.

Please inform HSCL when this project is terminated. You must also provide HSCL with an annual status report to
maintain HSCL approval. Unless renewed, approval lapses one year after approval date. If your project receives
funding which requests an annual update approval, you must request this from HSCL one month prior to the
annual update. Thanks for your cooperation. If you have any questions, please contact me.

Sincerely,

Jan Butin
HSCL Associate Coordinator
University of Kansas

cc: Edward Scanlon

Statement of Informed Consent

Bridging the dichotomy between micro and macro practice in social work: A qualitative study on clinical social work practice with domestic violence survivors

The School of Social Welfare at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the study I am conducting as a part of my dissertation. You may refuse to sign this form and not participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time. If you do withdraw from this study, it will not affect your relationship with this unit, the services it may provide to you, or the University of Kansas.

The purpose of the study is to understand how clinical social workers in domestic violence organizations experience and negotiate the relationship between micro and macro level practice responsibilities. It is hoped that the ultimate benefit of this work will lie in providing a starting point for developing practice theories that help us bridge the micro and macro areas of practices based on actual practice experiences of social workers. I will be asking about your professional education and work, in terms of your thoughts and experiences around relationship between micro and macro level of practices. The interview questions will not require any level of disclosure about your clients individually. I do not believe that there are any risks to you associated with this study.

Participation in this study will require the following: One face-to-face interview with me that should last approximately 60-90 minutes, a review of the interview transcript, and a follow up telephone call if you or I have any further questions or comments. I will audio record (audio only) each interview. The audio file will be numbered and will NOT contain any identifying information about the participants. These numbered files will be transcribed by a transcriptionist, and the typed transcript will NOT contain any identifying information. Moreover, the transcriptionist will NOT have access to any identifying information to protect your privacy and confidentiality. **Only this researcher will have the listing of identifying information of the participants.** I will mail you a copy of your transcript and provide you with means to mail the transcript back to me. You can make any corrections, changes, and comments. I will follow up with a phone call upon receipt of your corrections, changes, and comments. We can further discuss the final version of the transcript if either of us feels that is necessary. The audio files will be permanently deleted 6 months after the completion of the dissertation study. In acknowledgement of your valuable contribution to this study, you will receive a $50 Gift Card.

The study will be published as my dissertation, and it will be archived at the Watson Library at the University of Kansas. I may use parts of the study as publications in professional journals. Your name will not be associated in any publication or presentation of the research findings from this study. The researcher will use a pseudonym or some other method to protect your confidentiality. Moreover, the name of your organization will not be used or mentioned in the study. No identifying information will be shared unless required by law or by your written permission.

You are not required to sign this Consent and Authorization Form, and you may refuse to do so without affecting your right to any services you are receiving or may receive from the University of Kansas or to participate in any programs or events of the University of Kansas. You may also withdraw your consent to participate in this study at any time. You also have the right to cancel your permission to use and disclose further information collected about you, in writing, at any time, by sending your written request to: **Sur Ah Hahn, KU School of Social Welfare, Twente Hall, Lawrence, Kansas 66044-3184.** Once you withdraw your permission to use your information, the researcher will stop collecting additional information about you. If you would like additional information regarding the study, at any time during the process or following the completion of the study, please feel free to contact me via telephone or email (contact information listed at the end of this consent form).

PARTICIPANT CERTIFICATION:

I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or (785) 864-7385, write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7568, or email mdenning@ku.edu.

I agree to take part in this study as a research participant. By my signature I affirm that I am at least 18 years old and that I have received a copy of this Consent and Authorization form. I further agree to the uses and disclosures of my information as described above.

_____   _____
    Type/Print Participant's Name   Date

_____
        Participant's Signature

Researcher Contact Information

Sur Ah Hahn, MA, MSW   Edward Scanlon, Ph.D.
Principal Investigator   Faculty Supervisor
School of Social Welfare   School of Social Welfare
Twente Hall   Twente Hall
University of Kansas   University of Kansas
Lawrence, KS 66044-3184   Lawrence, KS 66044-3184
Office: 785.864.8966   Office: 785.864.8555
Email: hypatia@ku.edu   Email: escanlon@ku.edu

Appendix B: Interview Guide

Interview Guide

1. **Introduction**

   Thank you so much for meeting with me. (Explain briefly my research topic). Before I start our interview, I would like to review the informed consent form.

   1) can withdraw anytime

   2) purpose of the study

   3) de-identified

   4) it will be audio-recorded for transcription so that you could check its accuracy later.

   5) gift card

   1) Get signed consent form and give the participant her copy with the gift card.

   2) Ask the participant to fill out the social demographic questions.

   3) Turn on the voice recorder, check to see that it is working properly.

2. **Beginning Discussion** (does not address specific research question)

   a. Tell me about your work experience as social worker and how you came to work in a domestic violence organization?

   b. Tell me more about history of program, wondering about how and when it started. (Or, ask about how they know about the history of the program)

   c. Tell me about your typical day at work.

   d. About the clients you work with: In addition to domestic violence, what kind of problem they are experiencing.

3. **Research question 1: How do clinical social workers in domestic violence organizations experience the relationship between micro and macro level practice responsibilities?**

   a. There has been much discussion about the tension between micro and macro practice in social work field. Also, some discussion about two areas of practice should be combined or both included in practice with clients.

      i. First, how would you define micro and macro practice?

      ii. Going back to the time when you were MSW student, did you recognize any tension between these two practices in your program, and if so, can you describe the cases when it was expressed in the program?

      iii. Can you tell me how you felt about this tension back then or you opinion about it?

b. In the domestic violence field, this tension between micro and macro practices centers on the role of professional counseling in anti-domestic violence movement. Some people would say that counseling and therapy work weakened the identity of domestic violence work as a social change movement.

      i. Have you heard about this view? What is your opinion about this view? What is your view of the role of psychotherapeutic intervention in the anti-domestic violence work?

      ii. Do you recognize any tension in your agency? If so, can you describe the situations when you felt such a tension in your agency?

      iii. Did you ever experience this tension when you practice?

      iv. What forces/factors do you think are fostering this tension?

4.**Research Question 2: In what ways, if any, do clinical social workers attempt to integrate these macro and micro practice responsibilities?**

a. Going back to the time when you were in school,

      i. Have you learned about how to integrate these two areas in your social work education program? If so, describe the experience?

      ii. In your agency or your own practice setting, is there any effort to combine, to integrate micro and macro practice. If so, can you describe how you integrate these two areas in your own practice?

      iii. What are the challenges you or your agency face trying to integrate the two areas of practices? (prompt: personnel, time, funding etc.)

b. Now I would like to ask about your practice in more detail.

      i. Can you tell me about theoretical frameworks you to understand clients, such as their choices and situation?

      ii. What is your opinion about diagnosing clients? (Prompt: DSM diagnosis?). If you don't diagnose clients, what kind of assessment you use? If you use DSM, is there any additional assessment tool you use? Can I get a sample?

      iii. Can you tell me how do I help them address power relations in clients' lives? (Prompt: issue of power inequality, oppressions, or power relationship between them and abusers in clients' lives?)

      iv. Is there any particular therapeutic method you use in your practice with your clients, and if so, can you tell me more about why you prefer this method practice?

v. Are there any particular therapeutic techniques that you refuse to use in your practice? If so, can you tell me about what are the reasons for refusing to use these techniques?

vi. Can you tell me how you monitor outcome of client's progress?

vii. Does the wisdom or knowledge you get from work clients get shared with non-clinical staff? Is there is any mechanism or channel to do that in your agency?

viii. Are you involved in any activities outside your role of counselor that address the systematic changes that affect your client population?   (Prompt: for example, social policy change, program development, advocacy for clients, or public education or outreach)

5.Research Question3: In what ways, if any, do these efforts at integration affect the professional identities of clinical social work in domestic violence organizations?

Questions to guide the discussion:

a. Tell me about how you identify professionally and explain why you identify as such? (i.e. psychotherapist, advocate or social worker?)

b. Do you think there is something unique about doing therapy work in DV setting, compare to doing one in some other social work setting?

c. What do you think are the major differences between therapeutic intervention by clinical social workers and one by other mental health professionals, such as psychiatrist, psychologist and family/marriage therapist?

6. Is there anything else you would like to talk about, or that you think I should know, relative to my questions?

7. Do you have any questions?

__Tell the participant about the follow-up interview, and his/her preferred method__
__Ask the participant help with referrals within and outside the agency__
__Ask the participant for her/his email address__

Appendix C: Codes Lists (Atlas/Ti Document)

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Code-Filter: All

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HU:    Diss Analysis
File:  [C:\Users\hypatia\Atlas ti-Diss Interviews\Diss Analysis.hpr6]
Edited by:Super
Date/Time:2012-03-23 16:26:36

_____

Assessment in DV Therapy: Loss of Self
Assessment in DV Therapy: Mental Health Assessment

Basic Needs First: Case Management and Advocacy in DV Therapy

Caution in DV Therapy: CBT
Caution in DV Therapy: Transtheoretical Model

Challenges in Working with Immigrant Clients
Challenges: Burn Out
Challenges: Vicarious Trauma
Challenges: Working with Clients with Multiple Issues
Challenges: Working with Clients in Child Welfare Systems
Challenges: Working with Clients with Mental Health Issues
Challenges: Working with Clients with Physical Health Issues
Challenges: Working with Immigrant Clients
Changes in DV Work: "Its not just DV anymore"
Changes in DV Work: Less Advocacy, Less Movement
Changes in DV Work: More Resources Available

Client-Centeredness: Criteria for Clinical Programming
Client-Centeredness: Flexible with Rules
Client-Centeredness: Survivor-Centered as Core Values
Clinical Social Work: Less Expertise on Clinical Subjects
Clinical Social Work: More Connection to Community Support

Counseling vs. Therapy in DV: Practice
Counseling vs. Therapy in DV: Terms

Creative Solutions: Practice: Intake Advocacy
Creative Solutions: Practice: Using Interns

Dangerous Therapies for DV Client: Couples Counseling

Diagnosis: clients Already Involved in System
Diagnosis: Danger of Misdiagnosing Clients
Diagnosis: Just for Funding
Diagnosis: Labeling Clients
Diagnosis: DSM

Difference Among Staff: Cultural Differences
Difference between SW and other MH Professionals
Difference between DV and Other MH services

DV in Social Work Education

Freedom to do more survivor-centered practice
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Funding: Challenges
Funding: Mixed Feelings
Funding: Supportive Funders
Funding: Finding Creative Solutions

Gender of DV Therapist

Helpful Therapies for DV Clients

Integration of Micro and Macro Practice: "it's humanly integrated problem"
Integration of Micro and Macro Practice: "Therapeutic Case Management and Advocacy"
Integration of Micro and Macro Practice: Agency Efforts
Integration of Micro and Macro Practice: Applying Core Values
Integration of Micro and Macro Practice: Attention to Importance of Language
Integration of Micro and Macro Practice: Bridging the MH and Social Justice
Integration of Micro and Macro Practice: Cross-Training
Integration of Micro and Macro Practice: Dealing with Systemic Barriers in Therapy
Integration of Micro and Macro Practice: Different Path the Same Goal
Integration of Micro and Macro Practice: Engaging in Other Works than Therapy
Integration of Micro and Macro Practice: Having Both Practice Experiences
Integration of Micro and Macro Practice: Institutional Advocacy
Integration of Micro and Macro Practice: Mutual Learning
Integration of Micro and Macro Practice: Public Education
Integration of Micro and Macro Practice: Trauma-Informed Care
Integration of Micro and Macro Practice: Working as a Liaison to Change the System
Integration of Micro and Macro Practice: Working with Macro Practitioners
Integration of Micro and Macro Practice: Wraparound Services
Integration of Micro and Macro Practice: Reflection on Power Differentials in Therapy
Integration of Micro and Macro Practice: Professionalism with Feminist Awareness
Integration of Micro and Macro Practice: Stages Model

Internalized Oppressions: DV and SW

Micro and Macro Practice in DV Field: Definition
Micro and Macro Practice in DV Field: Fear of Battered Women's Movement
Micro and Macro Practice in DV Field: Not Tension, but Just Hierarchy
Micro and Macro Practice in DV Field: Recognizing Tension
Micro and Macro Practice in DV Field: Role Division: Movement and Service
Micro and Macro Practice in DV Field: Role Division: Therapy and Advocacy
Micro and Macro Practice in DV Field: Tension: Agency Support for Therapy
Micro and Macro Practice in DV Field: Tension: Agency Rules for Women
Micro and Macro Practice in DV Field: Tension: Boundaries
Micro and Macro Practice in DV Field: Tension: Credentials/Training
Micro and Macro Practice in DV Field: Tension: Feminist vs. Social Work Ethics
Micro and Macro Practice in DV Field: Tension: Older and New Generation
Micro and Macro Practice in DV Field: Tension: Service Delivery vs. Social Change
Micro and Macro Practice in DV Field: Tension: Survivor Participation
Micro and Macro Practice in DV Field: Tension: Violence against Women vs. Family Violence
Micro and Macro Practice in DV Field: Tension: Advocates vs. Clinicians
Micro and Macro Practice in DV Field: Tension: Professional Standards vs. Women-Defined Advocacy
Micro vs. Macro in Social Work Education: Lack of Education on Integration
Micro vs. Macro in Social Work Education: Learning Contract
Micro vs. Macro in Social Work Education: More Education Needed on Social Justice
Micro vs. Macro in Social Work Education: Students' Perception and Experiences
Micro vs. Macro in Social Work Education: Advocacy in Clinical Courses

Need for Comprehensive Approach: Shelter is Not Enough

Need for Long-Term Therapy in DV

Need for Professional Therapy in DV Field

Not Helpful Practice Model: Confrontational Approach
Not Helpful Practice Model: Solution-Focused
Not Helpful Practice Model: Traditional Therapy

Outcome Measurement for DV Therapy
Outcome Measurement for DV Therapy: Back to Basics (DV)
Outcome Measurement for DV Therapy: GAF
Outcome Measurement in DV Therapy: No Other Tools Applied

Paths to DV Therapist

Perception of Therapy: A Lack of Understanding
Perception of Therapy: Another Resource
Perception of Therapy: Battered Movement
Perception of Therapy: Coalition's Downplay
Perception of Therapy: DV Advocates
Perception of Therapy: Supportive Agency

Practice Model: Eclectic
Practice Model: Evidenced-Based Practice
Problem with Community Resources

Professional Identity: Advocate
Professional Identity: Becoming Proud as a Social Worker in DV Field
Professional Identity: Impact of DV Work
Professional Identity: Social Worker
Professional identity: Therapist

Professionalization: Universal struggles
Professionalization: "not a whole lot" of tension
Professionalization: "unfunded mandates"
Professionalization: Accountability
Professionalization: Decent pay, Services for Healing
Professionalization: Different Roles, but All Professionals
Professionalization: Finished Business
Professionalization: Funding: Inevitable Change To Survive:
Professionalization: Influence of Physical Space
Professionalization: Initial Resistance
Professionalization: Mixed Feeling
Professionalization: More power with Degrees
Professionalization: More Services
Professionalization: Problem with Grassroots Collective Model
Professionalization: Pros and Cons
Professionalization: Setting the Boundaries
Professionalization: Social Work Education
Professionalization: Start of Clinical Program
Professionalization: Success: Combination of Collective and Hierarchical Model
Professionalization: Supervision
Professionalization: Losing Intimacy with Clients

Social Work: "not professional enough or too professional"
Social Work: Advocacy as Core Identity
Social Work: Covering Broad Field
Social Work: Funders don't pay for social change
Social Work: Importance of Personal Values
Social Work: Influence of Individualism
Social Work: Mission and Practice as Separate
Social Work: More Collective Identity
Social Work: Not Enough Macro Practice
Social Work: Working with Middle Class

Social Work: "It's not just for giving to the poor"

The Role of Counselors: Facilitator of Case Discussion

Theories: Empowerment
Theories: Family Systems
Theories: Feminism
Theories: Psychodynamic Theory
Theories: Strengths Perspective
Theories: Systems Theory
Theories: Trauma

Therapy Services in DV Agencies: More Resources
Therapy Services in DV Agencies: Break the Cycle of Violence
Therapy Services in DV: Not Pathologizing, But Healing the Trauma

Working in the Shelter Environment: Burnout
Working in the Shelter Environment: Clients without Resources
Working in the Shelter: Meaning of Counseling
Working with Community Resources: Mental Health Services

Appendix D: Memo Example (Atlas/Ti Document)

MEMO: RQ3: Micro and Macro P in DV field (0 Quotations) (Super, 2011-10-10 14:02:27)

Codes:[Definition: Macro and Micro tension in DV field] [Different perspectives on values: empowerment] [Fear of consequences of MH Services in DV] [Integration DV: Clinicians/advocates' mutual learning] [Integration DV: Survivor-Centered] [Lacking in institutional advocacy in DV] [Manifestation DV: Service Delivery vs. Social Change] [Manifestation of tension DV: agency rules for women] [Tension between older and newer generation]

RQ3: Tension/separation between Micro and Macro practice in DV field
 1) grassroots advocacy model and professionalization
   - tensions between professional standards and women' defined advocacy
 2) older and newer generation
 3) Programming: support therapy or not?
 4) Fear of consequences of MH services- "it's not
    mental health, it's social structure"
 5) Rules (shelter, transitional housing program) for
    women: safe heaven vs. mental health wards;
     personal responsibility, empowerment
 6) Service Delivery vs. Social Change
   : acknowledging a lack of system change effort
 7) Resistance from old generation toward working together of different roles based on survivors' lenses

MEMO: RQ5: Integration of Micro and Macro practice in DV (0 Quotations) (Super, 2011-10-10 14:22:57)

Codes:[Fear of consequences of MH Services in DV] [Manifestation of tension in DV: Programming]
No memos
Type:Memo

RQ: How the DV organizations try to integrate micro and macro practice?
1) "Bridging the gap": Stages of Healing Model
2) Engaging in more institutional advocacy
3) Trauma-informed care
   - Need to understand intersection between MH/SA and DV
4) Seeking more of a shared perspective and a common language: e.g. what is empowering women?
5) "Interdisciplinary" approach to tensions around professionalization: Honoring both experience and
education
6) Honoring practice wisdom
7) Survivor-centered: reflect on power of clinicians over lay advocates and clients; "clients are true experts"
8) Clinicians expected to be great advocates, and advocates to be understanding trauma
9) Criteria for integrating: make sure the policies and procedures are aligned with core values being
"survivor-centered"
     -vicarious trauma to promote welcoming services for clients
     -culturally competent services
    - Physical environment
    - feedback from clients
10) Training
     - to help frontline/direct services staff have bigger picture- e.g. social change based on
       survivors' voices
    - Cross-training among staff with different roles and with community members
11) Refection: Are we survivor-centered?
12) Creating/designing the assessment and outcome measurement tool specifically for DV
    - Teaching tool for advocates to help them understand internal experience of DV survivors
13) Stages model: framework and teaching tool to help understand all staff and community members to
understand unique healing process of DV survivors: tool to bridge the gap between service delivery and grassroots
advocacy model