Gender based violence and mental health

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Brief Biography

Ines Zuchowski is a social worker, currently employed as a lecturer at James Cook University in field education. Ines graduated with a Bachelor of Social Work from James Cook University in the early 1990's. Since then she has worked primarily in community based organisations, focusing on violence prevention and women's services, and engaging with all groups of people through direct service delivery, group work, community work, policy development and management of services. Ines has been teaching at JCU since 2007 and enjoys engaging with students and the subject materials. She is currently undertaking a PhD in social work and her topic is 'External Supervision in Social Work Placements'.

Abstract

Violence against women is a serious violation of human rights, yet women across the globe are experiencing violence in private and public domains. Women are disproportionally affected by `...gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others' (World Health Organization, 2012). Violence has been identified as the leading cause of injury and harm against women and as the most common and exemplarily cause for depression in women.

In this chapter the connection of women's experience of violence and mental health is explored. Consideration is given to the extent and type of violence that women experience and the impact of it on their lives, with a particular focus on women's mental health. Social workers worldwide are responding to women who might have experienced violence and whose mental health is affected by this experience. Social workers are also engaged in community development aiming to improve wellbeing of the community as a whole. As such it is important for social workers to have a sound practice framework that enables them to address gender based violence. Social workers need to be equipped to deliver appropriate practice intervention at micro, meso and macro levels. Social Work practice strategies and practice reflections for working with

women, violence and mental health issues will be outlined and questions for consideration will be raised.

Introduction

The aim of this chapter is to raise awareness of the connection between violence against women and mental health outcomes and provide social work practitioners with tools to respond to violence in social welfare practice. To set the scene, the overall context of women, violence and mental health will be explored. Gender is a factor impacting both women's vulnerability to the experience of both violence and mental health. Gender is also a factor in the diagnosis of mental health. A focus of the chapter will be the exploration of how social work practitioners can work with women who present to them in practice, whether this in individual case work, group work or community work. To facilitate the audience's thinking on practice implications for working with women, three examples of social welfare services who are working in this field are presented and practice questions posed.

Throughout the chapter the need to consider the impact and context of women's experience of violence in mental health social work practice is highlighted. The conclusion that violence against women is a community concern is drawn. Social Work practitioners need to ensure that their practice leads to increased safety and wellbeing for women.

Women's Mental Health Issues

> *'Violence represents a crucial violation of women's rights as human beings. The experience of violence necessarily violates women's rights to liberty and security of person and to freedom from fear. The presence of violence is incompatible with the enjoyment of the highest attainable standard of physical and mental health' (World Health Organization, 2000, p. 66).*

In this article the World Health Organization's definition for mental health is taken as a guiding principle; 'Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (World Health Organization, 2000, p. 12).' While this definition does not mention gender, it is a factor in every aspect of mental health, and ' is critically implicated in the differential delivery

of justice and equality' (World Health Organization, 2000, p. 12). Mental Health will be examined in light of violence against women.

Violence against women is a world-wide occurrence and is permitted to continue through implicit societal support (Irwin & Thorpe, 1996). Examples of violence include the use of physical force, sexually unwanted behaviour, verbal attacks of put downs, restrictions on religious expressions or limiting the social contact with others (Ashfield, 2003). The use of violence in relationships is about one person or persons controlling the other (Oberoi, 2012). Violence against women and mental health outcomes are connected to gender, which is not a biological predetermining factor, but a social construct. Bottorff, Oliffe and Kelly (2012) highlight evidence that gender and gender relations impact on health outcomes. They outline that 'Gender is a social construct, a multidimensional determinant of health that intersects with culturally prescribed and experienced dimensions of femininity and masculinity, and emerges in diverse individual health practices' (Bottorff, et al., 2012, p. 435). The World Health Organization recognises gender as a determinant of health, and suggests that it helps explain the variations in health outcomes for women and men (World Health Organization, 2000). Addressing gender based violence is relevant to social work, whose global agenda seeks to promote social and economic equalities, to ensure the dignity and worth of the person, and to promote sustainable communities and wellbeing through sustainable human relationships (International Federation of Social Workers, International Association of Schools of Social Work, & International Council on Social Work, 2012).

Gender impacts mental health outcomes

When looking at the impact of gender on mental health, two main aspects will be highlighted here. First, gender impacts the lived experience of people and on their mental health. Structural analysis and feminist though highlight that women live within patriarchal structures that are oppressive, and place stress on women (Martin, 2003). Second, gender impacts the way mental illness is diagnosed (Martin, 2003).

It is important to recognise that gender impacts women's lived experience and consequently their mental health. The World Health Organization (2012) highlights the role of gender determinants in mental wellbeing and mental ill-health. Women's position in society across the globe impacts their physical and mental wellbeing. 'Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health

risks' (World Health Organization, 2012). The reality is, that many women across the world are '… caught up in struggles to survive, raise children, cope with poverty, natural disasters, corrupt regimes or varieties of social exclusion…' and the 'interrelations of gender with other power relations leave the inequalities and injustices of everyday life barely changed for the most disadvantaged' (Ramazanoglu & Holland, 2002, p. 169). Women are disproportionally affected by '…gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others' (World Health Organization, 2012). This context alone, the struggles of daily life that mean that they are more likely to experience hardship, persecution and have limited access to resources and status would have an impact of a person's sense of self and their experience of the world around them. Women's overall disadvantage and vulnerabilities influence their subjective well-being, the optimal development and use of mental abilities and their ability to achieve outcomes, elements that are pivotal in the above definition of mental health. It needs to be recognised that 'women continue to be placed in subservient roles that necessarily impact upon levels of health and wellbeing' (Martin, 2003, p. 157). Gender impacts women's overall mental health. Gender also impacts on women's safety and the incidence of violence they are suffering.

Violence against women

For women there are gender specific risk factors of mental disorders. Women's social position in the world has an impact on their life in terms of access to resources, but also in terms of their experience of safety and violence. Worldwide, violence is perpetrated against women. In western countries, for example, research shows that one in four women have suffered rape, and up to one in three girls sexual assault by a male member of their family, women experience harassment in the work place and in public spaces (Irwin & Thorpe, 1996). Across the world women are exposed to a range of violations that takes many forms '… forced abortions, female infanticide, female genital mutilations, acid throwing, child sexual abuse, rape, forced prostitution, dowry and honour violence, domestic violence, elder abuse and more' (Redfern & Aune, 2010, pp. 77-78). Oxfam (2004, p. 4) reports that violence against women in South Asia is wide-spread, 'It begins at the stage of conception; sex-selective abortions are frequent. ... Culture-specific forms of violence include domestic violence, rape, sexual harassment, incest, trafficking, honour killings, acid attacks, public mutilation, stove-burnings, and forced temple prostitution'. Oberoi (2012) points to the prevalence of acid throwing in India, which is committed on women '… for spurning suitors, for rejecting proposals of marriage, for denying dowry or dissatisfaction with dowry, arguing with partner etc.'

(Oberoi, 2012, p. 30). Violence against women is committed on an interpersonal level, yet, facilitated with societal support. 'Violence is embedded into many of the structures and institutions that are part of society and is, therefore, endemic in many aspects of women's lives' (Irwin & Thorpe, 1996, p. 7).

There are serious negative consequences for women experiencing violence. For example, the World Health organisation stresses that 'the high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post Traumatic Stress Disorder (PTSD) following such violence, renders women the largest single group of people affected by this disorder' (2012). Moreover, 'suicide is among the leading causes of death for women between the ages of 20 and 59 years globally and the second leading cause of death in the low- and middle-income countries of the WHO Western Pacific Region' (World Health Organization, 2009, p. 3). Research worldwide identifies the serious mental health the experience intimate partner violence '…can cause long-term psychological effects and that domestic violence is a predictor of psychological problems' (Avdibegović & Sinanović, 2006, pp. 739-740); poor health, limiting ability to care for themselves or others, suicide, and maternal and children morbidity and mortality (Bart Johnston & Naved, 2008; Koski, Stephenson, & Koenig, 2011). Research shows that women, who are accessing mental health services have often experienced violence, Martin, for instance highlights that '… as many as 50 per cent of women using mental health services are survivors of sexual assault' (Cox 1994 in Martin, 2003, p. 158). Furthermore, women who are diagnosed with a serious mental illness are in turn much more prone to experience violence from intimate partners (Laing, Irwin, & Toivonen, 2012).

The World Health Organisation (2009) surmises women's low status in society, their burden of work and the experience of violence as contributing factors to mental ill health. Consequently, women and men are affected differently by mental health. Women and men have different rates of mental disorders; women are more likely to be diagnosed with depression, anxiety and somatic health problem and are more likely to access health services. Men on the other hand are more likely to present with alcohol related disorders (World Health Organization, 2012). Violence against women has been identified as the most common and exemplarily cause for depression in women. 'This is because violence against women encapsulates all three features identified in social theories of depression - humiliation, inferior social ranking and subordination, and blocked escape or entrapment' (World Health Organization, 2000, p. 66). Women who are violated by their intimate partner or strangers are impacted in terms of their physical and mental health.

Diagnosing mental health in the context of women's experience of violence

While it is important to recognise that experiencing violence compromises women's health, a caution needs to be issued in terms of pathologising women's distress into a mental illness. Here the discussion now considers the second major impact of gender on mental health. Fiona Rummary in her work with women survivors of child sexual assault has found a significant correlation of incest survivors being diagnosed with a psychiatric illness. She reflects that the symptoms that had been used to diagnose mental illness in the women she had worked with, 'seemed to me to be normal reactions to abusive situations' (Rummery, 1996, p. 151). Rummery (1996, p. 152) argues that while '…some women may be genuinely suffering from psychiatric illnesses, there are also many whose emotions, responses and 'symptoms' are unnecessarily deemed 'sick' within a psychiatric framework'. Similarly, Martin suggests that many people end '… up in psychotherapy or counselling and believing that there is something wrong with them, when in fact their distress is often due to disempowerment and discrimination' (Martin, 2003, p. 158). She highlights that there is a '… gender bias within the formulation and application of psychiatric diagnoses' (Martin, 2003, p. 156 citing Chesler 1972; Sheppard 1991; Coppock and Hopton 2000) and that the main diagnostic tool used by health professionals, the Diagnostic and Statistical Manual, is biased in determining what seems normal and abnormal. The point to stress is, that it is important to acknowledge the impact of violence on women's health, and when women experience violence, the symptoms of mental ill health cannot be explored in isolation of violence in women's lives. Experiences of violence impact women's wellbeing. Thus the work of a social worker is influenced by practitioner's understanding of violence and mental health.

Working to improve the mental health of women

As part of addressing gender based violence it is important to work with people in various ways. Martin, for example, suggests that social workers could engage with individuals and groups to achieve empowerment and engage in community development activities and campaigns '…to address structural inequalities that necessarily impact on women's mental health and well-being' (Martin, 2003, p. 168). Addressing structural inequalities necessitates making sure that women have equal access to resources, protection and opportunities, for example. Change needs to be implemented across communities, social systems, politics and organisations and social workers can be part of

initiating and facilitating system change. Social workers engage in various fields of practice and apply a number of methods of intervention. Within their field of practice social workers could apply various methods simultaneously. The organisational context of their work, their own orientation towards change and their individual skills and knowledge impact their practice (Harms & Connolly, 2009). Thus, social workers have to be knowledgeable about issues that might impact their practice context. A social worker needs to reflect on the context of their organisation, the specifics of their client group, and the outcomes they want to achieve and how these can be achieved. This is a complex process, and is ideally facilitated through praxis, ' the process of ideologically strengthening our practice through critical reflection and reflexivity, challenging our values, ideology and beliefs and creative rethinking of issues with a view of facilitating macro change' (Harms & Connolly, 2009, p. 7). In working to improve the mental health of women a question to be pondered would be, am I, as a social work practitioner, aware of women's lived experience and how this impacts their mental health?

Working at the micro level

Social Workers will often work with women who are experiencing mental health issues. Part of their work will be working individually with women to improve their well-being and at times this work will include a case-management role. The ability to engage and communicate with women are critical social work skills in these settings (Mattes, 2010). Martin (2003, p. 162) highlights that 'The planning and delivery of mental health services for women must be developed in ways that are non-threatening, responsive, sensitive to age, cultural background, physical, emotional and social circumstances'. Social workers need to continue to talk and listen to women and recognise '… the uniqueness of individual women as well as their shared experiences as women' (Martin, 2003, p. 162).

Often a social worker's role may be within a health setting and multi-disciplinary team. Social workers can engage in case-management from a strengths based perspective. In mental health this means moving '...away from pathologising discourses towards a focus on 'resilience, rebound, possibility, and transformation'' (Saleeby 1996, p. 297 cited in Bland, Renouf, & Tullgren, 2009, p. 336). Strength-based practice recognises that 'All people have strengths and abilities, including the ability to build their competence, so service systems needs to be designed to give people the opportunity to display, use and build such strengths' (Bland, et al., 2009, p. 336). Social worker can bring a clear focus on social justice to these cases; they can focus on '…listening to the wisdom of consumers and carers who have valued highly the traditional role of social workers as potentially powerful mediators of power and resources as well as providers of counselling

and advocacy' (Harries, 2009, p. 245). Social workers in this context need to build effective relationships with clients, have an awareness of available resources and services, be able to liaise with other service providers and be '… able to work with clients to identify appropriate treatment goals, clarify problems and implement interventions with those clients and their families' (Briggs & Crowe, 2009, p. 226).

However, the focus of the social worker role needs to move beyond treatment options to identification of life choices and exploring the impact of mental health issues (Briggs & Crowe, 2009). What this means specifically for working with women who are experiencing or have experienced violence in their life, is, that social workers need to have an understanding of violence and power, as well as tools available to assess women's wellbeing and detect the presence of violence in their lives. Part of this understanding needs to be that women are often blamed for the violence they are experience, thus, for instance in the instance of rape, women's conduct is questioned and the responsibility for the rape they have suffered is placed at their feet (Redfern & Aune, 2010). Social work practitioners need to be knowledgeable of this and challenge those societal constructs (Fraser, 1996). Moreover, it is important to realise that '…women typically do not disclose [violence] unless asked about it and health care providers frequently do not ask' (Plitcha, 2007; Washaw & Alpett, 1999 in Laing, et al., 2012, p. 120).

Tools for identifying violence

Often women do not realise that they are in a relationship that is violent. They may experience violence without realising that this behaviour is not acceptable. At the same time social workers may not have an understanding of violence and the impact of violence. Thus, the World Health Organization (2009, p. 89) calls for, firstly, an '…improved detection of the depression and anxiety occurring within the context of a history of violent victimisation must occur.' Secondly, they identify the need to train health practitioners to better understand the links between violence and presenting somatic symptoms and disorders (World Health Organization, 2000). Laing et al. (2012) concur with both points and highlight the importance of cross-sector collaboration between health services and services who specifically respond to women experiencing violence.

It is essential to comprehend that violence does affect the mental and physical wellbeing of people. Violence is impacting on people's sense of self and their ability to function well. Women who are experiencing violence may assume that the behaviour that they are experiencing is normal, that as a woman this is what can be expected from a

relationship. As a result, women could consider the effects of the violence, such as feeling depressed, feeling worried and unable to cope with life's circumstances as a sign of mental illness, a sign that there is something wrong with them and the way they feel rather than identifying these as effects of experiencing violence. There are numerous studies cited by the World Health Organization that evidence that 'Women who have experienced violence, whether in childhood or adult life, have increased rates of depression and anxiety, stress related syndromes, pain syndromes, phobias, chemical dependency, substance use, suicidality, somatic and medical symptoms, negative health behaviours, poor subjective health and changes to health service utilization' (World Health Organization, 2000, p. 75).

Many women are experiencing violence in their own homes. '… Violence against women is perpetrated in 'peace' time in their own countries and their own homes, typically by those whom they know well and to a much lesser extent by strangers' (World Health Organization, 2000, p. 67). Importantly, violence in relationships needs to be recognised when it is happening. This can help acknowledge the woman's experience of being unwell and put this in a context of external factors that are impacting on her wellbeing. Moreover, unless violence is identified and named as such, it will not stop. 'Relationship violence is often a sign that a relationship is heading into serious trouble and that problems exist that will very likely not resolve without appropriate professional support and assistance. Once it is occurring, relationship violence usually worsen and becomes habitual' (Ashfield, 2003, p. 221). Stopping violence from occurring is important to the community as a whole. Bob Pease (2003) maintains that while most violence is perpetrated by men, not all men are violent. He argues, though, that 'Men's primary model for relationships tends to be hierarchical' and that this needs to be addressed as when there is an imbalance of power between women and men there is '… a greater likelihood of male coercion and domination…' (Pease, 2003, p. 131).

Social work practitioners can help people identify when they are experiencing violence in a relationship and are not feeling safe. The Word Health Organization recognises that 'Violence related mental health problems are also poorly identified' (World Health Organization, 2012). They (World Health Organization, 2012) point out that 'Women are reluctant to disclose a history of violent victimization unless' they are asked directly about it. If it is not recognised that women are experiencing violence, their symptoms of distress and pain may be misdiagnosed and they could be further impacted. Labelling women who display '…intense emotional distress as 'disordered ' or 'sick', effectively silences their disclosure of abuse' (Rummery, 1996, p. 161). A Social work practitioner can gently probe in discussions with the woman what are her life circumstances like,

whether she is feeling safe in her relationships and also check for the occurrence of violence with a checklist for violence. Sometimes women are not able to identify that they are experiencing violence until they actually see or hear what they are experiencing as a form of violence. One such tool is provided by Ashfield (2003), who maintains that both women and men can experience violence in relationships.

A checklist for Relationship Violence (Ashfield, 2003, pp. 217-219)

Tick the signs that are familiar:

Physical violence

◇ Pushing, shoving

◇ Punching, biting, scratching, kicking, slapping

◇ Holding roughly, biting, scratching, kicking, slapping

◇ Torturing, burning

◇ Destroying belongings

◇ Hurting or killing pet's

◇ Throwing objects as weapons

◇ Threatening the use of weapons or violence

Emotional and Verbal Violence

◇ Hurtful put-downs or name calling

◇ Humiliating or shaming

◇ Playing mind games

◇ Making partner frightened

◇ Being controlling or manipulative

Social violence

◇ Not allowing partner to choose their own friends

◇ Speaking badly about friends and family

◇ Humiliating, shaming or belittling partner in public

◇ Controlling partner's every move

Financial Violence

◇ Not allowing partner to have money

◇ Exploiting, manipulating, or taking advantage of partner financially

◇ Making partner beg for money

◇ Controlling or using partner's finances again their will

Religious Violence

◇ making partner feel inferior because they don't share same beliefs

◇ Making a partner feel unsafe, frightened , inferior or humiliated by coercing them to participate in certain religious gatherings, rituals or ceremonies

◇ using religious beliefs to control partner

Sexual Violence

◇ Forcing partner to have sex against their will

◇ Humiliating partner sexually

◇ Using object to violate partner sexually

(Adapted from Ashfield, 2003, pp. 217-219)

Once the social worker practitioner and the woman have identified that the women is living in a relationship that is violent, it is important to work out strategies that assist the woman to be safe. Unless violence is addressed the health of women is seriously compromised. 'Many women using mental health services are experiencing domestic violence or its ongoing effects on their health, but this is often not recognised, resulting in appropriate health intervention that can compound women's suffering and compromise their safety' (Humphreyes & Thiara, 2003; Laing, Irwin, et al., 2010 in Laing, et al., 2012, p. 122). The World Health Organisation stresses that the '… complexity of violence related health outcomes increases when victimization is undetected and results in high and costly rates of utilization of the health and mental health care system' (2012). Mental Health practitioners need to recognise and respond to domestic violence and develop treatment plans that include safety planning and referrals to domestic violence services (Laing, et al., 2012).

Responses to women who have experienced violence need to be centred around the women's experience. Rummery (1996), for example, outlines that in her work with women who have been sexually assaulted she focused on validating their feelings and memories, believing the women, and giving the women control over the counselling relationship. Moreover, she stresses that in her practice she clearly takes a non-neutral position in order to ' …challenge dominant constructions of power and knowledge' (Rummery, 1996, p. 159). In working with women it is important to allow for the space, opportunity and information to consider their individual experience of violence in the light of broader cultural and social contexts (Rummery, 1996). This helps women to commence a process of healing and regain a sense of self and self-worth.

Below is a social worker's reflection of working in a Women's Centre with women in socially just ways.

A Practitioner's reflection: Di Plum (Senior Counsellor)

The North Queensland Combined Women's Services Inc.

North Queensland Combined Women's Services Inc (The Women's Centre) promotes and enhances the holistic health, well being and safety of women through providing free and accessible counselling, advocacy, groups and activities, drop-in support and emergency relief. We actively encourage the development of a socially just, inclusive and respectful society in which women are valued and supported through challenging barriers and advocating for an end to violence against women.

Our framework for practice is informed by feminist principles, incorporating an analysis of the devastating impact of violence and trauma on women's mental health. Trauma informed care provides a safe therapeutic space in which the worker and woman collaborate to understand and grapple with the enduring disruption to the establishment of a healthy sense of self, as reflected through the development of mental health issues often resulting from violence and the associated traumatic response. Experiences of violence, violation and degradation are common place across the life span for thousands of women and children; such experiences can profoundly affect personal agency and autonomy as well as women's quality of life and participation in society.

When supporting women at The Women's Centre, an integrated response to women's needs enables an acknowledgement of how mental health issues have robbed women of their personal power. Women who display or disclose their experiences of depression, anxiety, bipolar disorder, suicidal ideation, obsessive compulsive disorder, personality disorder, post traumatic stress disorder or psychotic tendencies are accepted with unconditional positive regard, with an acknowledgement of how these conditions may have emerged when the intrinsic self was overwhelmed with violence and fear. Women are not judged or stigmatized for these manifestations of loss; instead, women are treated with respect and are actively included as part of the ever evolving Women's Centre "community". Workers who observe concerning behaviours which may place the woman herself and others at risk, either in the centre or in the community, respond to the woman within the context of duty of care, an intervention based on safety, respect and dignity. In this manner, women are provided with trauma informed care and support which values the woman's strengths and resilience, and facilitates a conversation in which clarity and honesty about the impact of the mental health issues can be addressed.

Recognising the trauma that impacts women's mental health is important. Laing et al. (2012, pp. 122-123) suggest that the '… development of integrated, trauma informed-therapy for women with histories of sexual and physical abuse and co-occurring mental health and substance issues (McHugo, et al., 2005; Noether, et al., 2005)' is a promising

advancement, but also highlight the importance of safety planning so women can escape violence.

Mental Health Concerns that need to be referred

Trauma such as experiencing violence can lead to mental ill health that needs collaboration with clinical mental health practitioners and thus at times a referral to a General Practitioner, the mental health unit of a hospital, or psychiatrists, etc.. might be necessary. As social work practitioners we need to consider what these professionals need to know, how work with them can be done in collaboration, and whether there is an advocacy role for the social worker.

Working at the meso level

Individual or meso level work is often the focus of intervention in Western countries, however, western notions of health and illness impose a medical biological framework on emotional and social concerns, yet from '… a non-Western view an illness model of mental health can be both alien and alienating' (Martin, 2003, p. 160). Using collective approaches might be more relevant to women of various cultures across the globe. In Australia, for example, research highlights the importance of mental health practice with Aboriginal and Torres Strait Islander people that adopt culturally competent community development approaches and primary care models (Walker & Sonn, 2010). Walker and Sonn (2010, p. 165) stress that to work effectively with Indigenous Australians a true partnership is needed, which is different to the '…conventional individualistic Western way of working'. Collective notions of mental health would stress ' … a holistic and collective approach, integration the individual, the family and community' (Martin, 2003, p. 160).

Meso level work considers the opportunities of social workers to work with other services and families and groups. Working with other services, building strong linkages, is important for providing services to women and social workers need to have a good understanding of what services are available and what services might have already been accessed by the women they are working with (Martin, 2003). It is essential to conduct interdisciplinary work, as 'Social work is only one contribution profession in the multidisciplinary mental health field that increasingly hinges on effective interprofessional working' (Bailey, 2002, p. 169). Social workers in multi-disciplinary teams may often be the advocates who highlight the lived experience of mental illness, the voices of clients and the importance of critical perspectives that go beyond bio-medical models. They have unique contributions to offer multi-disciplinary mental health teams, but need to be familiar with the social work informed skills, knowledge and

frameworks they are bringing to the team to be effective contributors (Bailey, 2002). This work '…can be an isolating experience for practitioners within a multidisciplinary team, where the power struggles associated with competing mental health discourse have the potential to thwart emancipatory relationships with users' (Bailey, 2002, p. 171). Thus, Social workers need to link with other social workers, their professional association, but also work to create linkages and understanding with other disciplines.

Other meso level work includes group and family work. Group work with women who have experienced domestic violence, for instance, has been found effective to improve the wellbeing of women and limit violence and similarly effective in challenging violence behaviour by perpetrators of violence (Mullender, 2002). Group work allows women to realise the endemic nature of violence, to access mutual support and may lead to consciousness raising and activism. Here group work skills and a comprehensive understanding of violence are important.

Working with women and their families might be useful; families can be sources of support, but also may need strengthening themselves. ' Social worker need to be sensitive to the needs of family members and other significant people in the woman's life and seek their involvement where appropriate' (Martin, 2003, p. 164). Importantly, though, it is always important not to make assumptions that families are always safe places for women. As the practice example from TMSG shows, social workers can work sensitively with women, allowing them to explore their experience individually and in groups.

A Practitioner's reflection: Meg Davis

The Townsville Multicultural Support Group Inc. (TMSG)

TMSG was started by a group of migrant and refugee women in the early 1990's. TMSG is committed to "addressing needs through greater participation in and contribution to a better quality of life for our multicultural society." Although there has been an increase in male clients in recent years, TMSG has a focus of ensuring that women's needs are met. In 2011, TMSG participated in the National Australian Women's Dialogues – contributing to a report "Hear our calls for Action."

TMSG is particularly aware of the vulnerabilities of the Refugee and Migrant women and their lived experience of the intersection of violence and mental health. Violence is not always recognized immediately, neither by workers nor the women themselves, yet it is often an issue. If there are any concerns raised about the mental health of women, the issue of having experienced violence pre-arrival in Australia and /or currently must be explored. When TMSG first welcomes refugee people, we have a welcoming/ orientation

meeting during which time, it is stressed that in Australia, women and men have equal rights. This information is always greeted with great enthusiasm from the women. However, the reality is that despite their expectations and hopes, violence often continues to be experienced. Information about the law and rights in Australia serves to 'open the door 'to further discussion.

Additionally, it is part of our practice that case managers meet with women separately from the men and children in the early phase of the settlement services provision. Failure to do this may result in minimizing the women's role in settlement and her specific needs. The perceived level of English proficiency of refugee and migrant women by a worker can influence a perception of mental health issues… acting as another form of isolation, imprisonment, or violence.

Group work is important as a means of discussing the different forms of violence. It is important to raise awareness that violence is much broader than physical violence. This work needs to done with women and men separately and often generates women seeking workers out for individual support. A successful group work tool is the use of story boards-learned through partnership with the Centre for Refugee Research, University of New South Wales. We have used this with women who have come under the visa category 'Women at Risk'. It is a way of acknowledging previous traumatic experiences of male violence, - including systematic rape. Storyboards provide an opportunity for women to share previous experiences, their strengths of survival and to explore strategies in their current situation to move through to a life free of violence. Doing this in a group setting is very empowering for women. They get support from each other, acknowledgement of their stories and they encourage each other. Discovering that non refugee and non migrant women experience violence provides stimulus to a discussion about male violence as a structure of society in general rather than being attributed solely to a background of war experiences.

Working at the macro level

Strategies to improve the wellbeing of women have to be also targeted at the community as a whole. 'Many of the main causes of women's morbidity and mortality – in both rich and poor countries – have their origins in societies' attitudes to women, which are reflected in the structures and systems that set policies, determine services and create opportunities' (World Health Organization, 2009, p. 5). As such domestic violence and other forms of violence are not so much about individual's anger problems, but rooted in the cultural and historical context of societies; 'Just as domestic abusers justify their actions by evoking patriarchal notions of male ownership, perpetrators of honour violence rationalize it through concepts of honour' (Redfern & Aune, 2010, p.

87). Much of the violence against women is systemic or structural violence that more implicit and indirect, yet directly affecting their lives and wellbeing. Irwin and Thorpe strongly argue that 'This insidious violence has to be challenged if the overall violence against women is to stop' (Irwin & Thorpe, 1996, p. 8). Thus, macro level work is essential for social work practice.

Importantly, public policies need fundamental change across the world to identify the risk and provide care for women (World Health Organization, 2009). This includes recognising that symptoms of mental illness can be due to the experience of violence, and intervention needs to be about recognising, acknowledging and responding to the violence and the experience of violence, rather than just labelling women mentally ill (Rummery, 1996). Social Action and community work can lead to societal change, but also to communities themselves taking on issues and finding solutions. For social work practitioners community work provides '… significant opportunities to engage with whole communities in planning to address health and well-being issues in a way that includes marginalised groups and considers the contextual issues that will impact on the program or services' (Taylor, Wilkinson, & Cheers, 2008, p. 5). Moreover, working with the whole community accesses a community's capacity and strength (Taylor, et al., 2008). Social work practice to address violence against women on a macro level includes public awareness campaigns, working to achieve legislative change and international cooperation, and organising prevention and education programs (Redfern & Aune, 2010). Change needs to occur both in terms of gender based inequalities, but also in terms of available resources to women in general and women with mental illness; '… what many women of these women want is access to appropriate, affordable housing, a sustainable income, education and employment, friendship and social supports, information and choice, and trust and respect' (Martin 1999; Coppock and Hopton 2000 cited in Martin, 2003, pp. 163-164).

Important in community work are cross-sectoral partnerships to '…enable the community field to come together to solve problems, discuss issues, and work on new programs and initiatives' (Taylor, et al., 2008, p. 180). This will benefit the community as a whole, women, children and as well as men. For, 'men's relationships with women will be impoverished as long as they continue to control and subordinate women (Sattel 1989)' (Pease, 2003, p. 128). Pease suggests that a consciousness of the cost of violence and the ways violence is reinforced needs to be built and '… collective political actions to challenge institutional violence' needs to be developed (Pease, 2003, p. 138).

The North Queensland Domestic Violence Service undertakes macro level social welfare practice to end violence in the community.

A Practitioner's reflection: Pauline Woodbridge (Coordinator)

The North Queensland Domestic Violence Resource Service

The North Queensland Domestic Violence Resource Service (NQDVRS) was established in 1994. The underpinning philosophy of the service is feminist and our practice is informed by an understanding that domestic violence is about power and control. It is a gender based manifestation of the social and systemic inequalities between women and men. NQDVRS values empowerment and strengths based responses to the victims of domestic violence, responding to each woman with the knowledge that she is the expert in her life.

This aspect can be a difficult concept for other parts of our society. Individually she will be held accountable for the violence by questioners who ask "why does she stay"? The effects for the violence can be misdiagnosed as mental illness or as behavioural issues. She may be characterised as a mother who fails to protect her children as she endures frequent violent attacks from the children's father. It may be considered that she provoked the violence and she may well believe that too and constantly modify her behaviour in attempts to avoid further abuse.

It is because of these misdirected, misguided myths and attitudes that it is important for NQDVRS also acts at the community and policy levels. Raising awareness and educating the local community is an important pathway to meeting our goal of stopping the violence against women and their children. Our public awareness campaigns such as the 'Help is Available' messages on the sides of buses and use of media to get anti-violence and healthy relationships messages out into the community, help with the understanding of the extent and seriousness of domestic violence. We are active in Domestic and Family Violence Prevention Month and the traditional Candlelight Ceremony reminds us all of the deaths of women, children and men as a result of domestic violence.

Using what we have learnt from the women who use our service, we tackle the systemic issues. Dovetail - Townsville's Integrated Approach to Domestic Violence is a monthly meeting of key organisations such as the police, the courts and a range of service providers who can monitor the systems, ensure transparency of our actions and problem solve issues.. State based networks are an important way to bring the voices and experiences of the victims and perpetrators to the broader policy development arena.

At the National level the Prime Minister convened a National Council to Reduce Violence Against Women and their Children, resulting in a National Plan. It is important that the

recommendations of the Plan are supported by funding but also by people who share the aim of reducing both domestic violence and sexual assault against women. These days there is a backlash against the feminist analysis of gender based violence.

Domestic violence can get confused with a plethora of other issues that can serve to obscure or excuse the use of violence. Alcohol, drugs or mental illness are not the cause of domestic violence; the societal and cultural attitudes that support violence against women is where our efforts must be focused if we want to achieve a world where non violence is the social and accepted norm.

Conclusion

Addressing violence against women needs to be a community concern and community responsibility as highlighted in the practice reflection of Ms Woodbridge. This needs to be a concerted effort and poses four critical challenges: '1 to challenge and change existing social and individual attitudes that accept violence against women as 'normal'; 2 to mobilise all sections of the family, community, and society to act to prevent violence against women; 3 to build popular pressure on the State to formulate and implement gender-equitable policies; 4 to bring together diverse local, national, regional, and international efforts working towards ending violence against women' (Oxfam, 2004, p. 2). Social Workers need to raise to meet these challenges.

Across the world violence against women has been identified as a policy concern and many countries have developed national action plans to address these concerns (Oxfam, 2004). However, in practice violence against women is still often viewed as a private concern, and work to address the roots of violence is challenging. Importantly this work needs to be undertaken, work at the community level is essential in order to achieve meaningful cultural and political change (Oxfam, 2004).

Summary

Clearly, violence against women is a major human rights concern and is impacting women's mental health and as such negatively affecting the wellbeing of the community as a whole. Addressing women's mental health concerns needs to include an investigation of the potential experience of violence and women's disadvantaged position in society. Working to end violence against women and respond to women who are experiencing mental health issues because of violence needs to involve social workers working at the individual, community and societal level. Violence against women concerns all of us. As social workers we can work to end violence against women.

Key Terms Explained

Gender is a social construct as opposed to just considering the biological attributes of being male or female. Gender suggests that being male or female in a society is influenced by cultural, historical and societal norms and expectations for women and men and not just determent by the sex of a person.

Macro level work refers to work undertaken at the societal level, for example work aiming to change organisational, political or legal systems or community attitudes.

Meso level work refers to work that is undertaken with families, groups and communities.

Micro level work refers to work undertaken with individuals or families to change their particular circumstances.

Pathologising describes the idea that a person's distress, ill-health or behaviour is labelled by finding a fault or defect in the individual. This label is then used as a lens to view the person and their situation rather than maintaining an openness to the person's experience.

Violence can take many forms, the checklist in this chapters indicates some of the behaviours that constitute violence.

Practice Questions

How could you respectfully and safely explore women's experience of violence?

What information would you need if you want to refer a woman who has experienced violence to a support group, another service, a mental health practitioner?

What can social workers do to end violence against women?

Other Web resources

Australian Domestic Violence & Family Violence Clearing House

http://www.adfvc.unsw.edu.au/home.html

North Queensland Combined Women's Services (Inc.)

http://www.thewomenscentre.org.au/

North Queensland Domestic Violence Resource Service

http://www.nqdvrs.org.au/

Oxfam international: Towards Ending Violence Against Women in South Asia

http://www.oxfam.org/en/policy/bp66-violence-against-women-sasia

Queensland Centre for Domestic and Family Violence

http://www.noviolence.com.au/

Townsvilel Mutlicultural Support Group

http://www.tmsg.org.au/

Vitorian Centres Abgainst Sexual Assult

http://www.casa.org.au/index.php?page_id=1

We Can End Violence Against Women. South Asia Regional Campaign

http://www.wecanendvaw.org/

World Health Organisation: Gender and Mental Health

http://www.who.int/mental_health/prevention/genderwomen/en/>.

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