A case study of a community-based program on domestic violence in Chile.

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ABSTRACT

Theoretical foundations of a community program on prevention and assistance of domestic violence held in Chile are described as a case study. The program derives from a Psycho-Social Wellness Model that focuses on individual and community "competencies" and resources to solve human problems. The intervention reflects the application of concepts of crisis intervention; the empowerment of natural networks to provide support; and, as needed, the referral of victims to specialized services. During its initial stages, the program was provided to the medical staff of a local hospital. Participants included Emergency Room, Pediatric Unit and Obstetrics nurse-aides, nurses, doctors, social workers, social work-aides and other personnel. Team cohesion was emphasized and information regarding domestic violence, crisis intervention and referral strategies were provided. In a second stage, prevention and education strategies will be targeted to community organizations and educational institutions.

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During the 1990's, significant increases occurred in the number of women in leadership roles throughout developed nations. During that same decade, increasing numbers of women assumed important roles in both the private and the public sectors, as women attained high positions in commercial, professional and political fields. In spite of this progress, however a form of *emotional slavery*, reflected in the continuing problem of domestic violence, continued to exist in these societies and even more so in developing nations. In attempting to conceptualize this phenomenon, Barudy (1999) suggested that domestic violence represented one example of abusive interpersonal systems involving at least three participants: a) an abuser who has the power; b) a victim; and c) a witness(es). Each member of this system is bound by a pact of silence that prevents each of them from revealing the abuse. Each may share the sense that the system is immutable and simply reflective of the "way things are". In effect, each is locked within the system in a way which inhibits each from initiating a process which can change the system.

Abusive situations tend to be of most concern to society when they occur within a family. In such cases, the victim(s) is (are) typically the weakest member(s), children and/or a wife. The system leaves each victim battered and abused, often over an extended period of time by an aggressor, i.e., a husband and/or father, whom society expects will protect and love them. Domestic violence may be more harmful than other kinds of violence because it generates in its

victims a basic mistrust of and lack of confidence in others which, in turn, and thereby undermines the establishment of close and permanent relationships. Abuse and violence within a family has a deleteriously corrosive effect on the self-esteem of its victims. Over time, children and wives perceive themselves as not deserving of the respect of others. Subjected to systematic and repetitive abuse, family members develop an attitude of learned helplessness that traps them in a cycle of violence from which they cannot escape.

Abuse of children and women is not a new problem in many countries. Yet only in the last decades has it been recognized as such in Chile. Cultural taboos about this subject, especially with respect to sexual abuse and incest represent one reason for the longstanding silence within this predominantly Catholic country. Each time a case involving domestic violence becomes public, however, many additional cases of abuse and maltreatment suddenly begin to surface. Before such public revelations, such cases had remained hidden, often even from the victim's relatives and friends. This pattern suggests that the actual prevalence of domestic violence far exceeds estimates based solely on reported cases. Even now, however, when cases of sexual abuse are publicized in Chile, those in positions of authority still try to deny its occurrence and downplay its prevalence.

In the United States, one out of three girls and one out of seven boys has been sexually abused before the age of eighteen. Abusers tend to be heterosexual men and members of the victims(s)' family (Gelles, 1978). Whether those numbers and that pattern apply to Chile are, to this point, unknown. Too little research on sexual abuse has been conducted in Chile to answer such questions. Traditional attitudes and longstanding resistance to acknowledging this aspect of Chilean society have prevented health care settings and professionals from recognizing and acknowledging cases of child abuse when these victims appear before them with physical or

psychological symptoms (Sename, 1991; Larrain, Vega & Delgado, 1997).

This pattern of denial, however, cannot continue! Attention to child abuse is necessary on humanitarian, legal and ethical grounds. Children have inalienable rights ratified by the International Act of Children Human Rights. Child abuse violates the most basic responsibilities of the family and the community, i.e., the protection and care of children. Beyond this basic humanitarian tenet, however, there are multiple social and economic reasons for recognizing and responding to child abuse (Alvarez, 1992). A substantial body of evidence, for example, reveals that abused children are at risk to become abusers when they grow up (Barudy, 1999; Larrain, Vega & Delgado, 1997). Thus intervention with abused children protects not only the immediate victims but over time can interrupt the cycle of domestic violence. Decreases in rates of domestic violence can also lead to reductions in health costs and improved educational outcomes. Overall, the prevention of child abuse and neglect can promote a sense of general well-being and improve the quality of life for all who live in a community.

Historically, the abuse and battering of women has been socially and culturally accepted in Chilean society because events occurring within the home have been viewed as private family matters. This perspective has limited its public discussion and thereby undermined recognition of domestic violence as a serious social problem. It has also obstructed efforts to pass laws protecting women and children, to punish abusers and to develop programs to help families in which one or more members have been victimized by violence. Attempts to help these families must ultimately have at least two goals: a) to stop current episodes of violence and b) to prevent future episodes to or by the victim(s). The latter goal is important because it is evident that anecdotal clinical evidence and empirical findings are slowly building which reveal that

aggression and frustration accumulated over years leads some abused women to become (much to their dislike) child abusers and leads some abused children to become abusive themselves when they grow up.

Domestic violence affects men and women of different ages, religious backgrounds and socio-economic levels**.** The most prevalent patterns of abuse is of women and children as victims and men as perpetrators. Although cases of men abused by women have been reported in the clinical literature these have been quite rare in Chile. Typically, they have occurred in couples in which the man has some form of handicapping condition. Clinical cases of battered husbands are rarely seen because men are usually stronger than women and men can leave the home more easily than women (Sullivan & Everstine, 1983). In all likelihood, men are also considerably less likely than women (especially in a Latin country) to report being physically abused by a spouse.

Programs targeting battered women and children must be very cautious because they can result in a second, unintended victimization. Even though they are recognized as the victim, abused children may be punished a second time by being removed from their families, their friends and their homes and then sent to institutions. In Chile, institutions for abused children rarely provide the conditions and resources necessary for optimal development. Very few provide a context of love and protection in which children can thrive and existing emotional wounds can heal. A family may also be re-victimized if their abuser is sentenced to jail. Although his incarceration may interrupt the cycle of violence, it is also likely to cause serious economic hardship to the family due to the loss of a father or husband's income. When released, the abuser is likely to resume his behavior. In some cases he may even take revenge against his spouse and children for breaking the vow of silence and he may abuse them with even more intensity than the events that sent him to jail.

Domestic violence in Chile

Chile's population exceeds thirteen million people. Including its Antarctic territory, the nation covers an area of 2,000,000 square kilometers. Forty percent of Chileans live in Santiago, the capital city, 14% live in rural areas, and 46% live in other urban areas. In the past decade, Chile's economic growth has placed that nation among the fastest growing countries in Latin America. .In spite of the nation's economic gains, however, there remain wide gaps across the population's economic levels. A recent survey of Chilean income distribution reveals that 44% of the population, i.e., over five million people, live in poverty (UNICEF, 1991). Domestic violence is not, however, limited to the poor. For them, the impacts of domestic violence are particularly intense because of their lack of resources, of access to legal assistance and of the likelihood of receiving therapeutic help.

A recent study reports that one out of every four Chilean women are abused within their family (Larrain, 1990). These figures are consistent with findings from other countries in Latin America which show that more than 50% of the female population has been abused al least once by their partners and that 25% of women experience some form of chronic abuse (Ferreira, 1989). Consistent with these findings, national data indicates that between 25% and 30% of female homicides occur at home. Compared with men, women are most likely to kill their partners perhaps in self defense (Azócar, Kuzmanic & Lucar, 1991). As Gelles points out "...the most common relationship between murder and victim is a family relationship." (Gelles, 1978, p. 172).

Concern about child abuse has only recently attracted the attention of Chilean authorities and professionals. For many of the reasons noted above, it has been difficult to estimate the

prevalence of the problem using medical archives by checking charts in Pediatric and Emergency departments. Rarely is domestic violence noted as such since it is seldom recognized or, if suspected, acknowledged.. In Santiago, few hospitals attach the diagnosis of child abuse syndrome to a case (Exequiel González Cortés, Calvo Mackena and Sótero del Río) **ANA MARIA PLEASE COMPLETE THESE REFERENCES**. Even if some cases are documented, however, it seems unlikely that hospital records reflect more then 10% of the actual prevalence (UNICEF 1991).

The Legal System

Laws defining domestic violence as an crime have been passed in Chile only within the past decade (i.e., since 1994). Before then, seriously injured women who contacted the police were treated like any other victim of an assault by a stranger. In 1989, the Chilean Civil Code regarding marital issues was changed in ways that improved the legal status of wives. Mandated obedience of wives to their husbands and the right of the husband to determine the residence of the wife were two serious obstacles to protecting female victims of domestic violence. Since legal divorce does not exist in Chile, women who leave their husband because of violence have no legal protection. **ANA MARIA - WHAT WERE THE CHANGES AND HOW DID THEY IMPROVE THE SITUATION FOR MARRIED WOMEN**?

In 1990, the National Women Service (SERNAM, i.e., Servicio Nacional de la Mujer), a division of government with ministry status, was created by the Chilean Government. Among SERNAM's responsibilities, was raising consciousness about domestic violence within the community and developing preventive and remedial programs. SERNAM has also promoted and supported initiatives to discuss and pass laws about divorce. SERNAM has opened offices across the country that provide legal and therapeutic assistance to victimized women and their families.

The Educational System

One way for Chilean citizens to change their understanding of domestic violence is through education. At present, Chile's educational system provides students access to an optional pre-school (i.e., kindergarten) level, eight years of mandatory elementary school (Educación Básica) and four years of high school (Educación Media). The educational system is decentralized and thus is funded and administrated by each of the nation's Municipal districts. The local educational system, especially in the large urban areas, include both public and private schools, many of which are religiously based. Currently, domestic violence is rarely discussed in schools. Discussion of gender discrimination and its implications for educational and personal development has only recently been added to the curriculum (Alcalay, Torretti & Milicic, 1992; Arón & Milicic, 1999; Arón & Milicic, 2000). Before that change, the implicit as well as explicit messages delivered by teachers and textbooks, supported gender discrimination and the subordinate status of girls and women in Chilean society. Thus, the messages most children received at school have, until recently, only reinforced what they observed at home.

The beginnings of a move away from those traditional perspectives are found in actions of the Ministry of Education which has recently initiated a project funded by the World Bank to improve both educational quality and equalit (MECE, Mejoramiento de la Calidad y Equidad en la Educación). On the topic of ¨Personal Development", for example this project introduces the concept of gender equity and equal employment opportunities for boys and girls. It seeks to open young Chilean's to consideration of different ways to define relationships between men and women, husbands and wives and fathers and mothers. It also brings attention to issues such as personal respect and respect for others as an alternative to the use of violence for interpersonal

problem solving (Alcalay, Arón & Milicic, 1993).

Psycho-Social Well-being v/s Mental Health:

How can psychology contribute to resolution of the multiple emotional, behavioral and social issues arising from longstanding patterns of domestic violence in Chile? Traditional clinical psychology models in mental health are very similar both theoretically and practically to those of psychiatry. In the sixties, development of the "community perspectives" presented new conceptual opportunities for expanding traditional clinical perspectives. Clinical interventions derived from intrapsychic formulations came under attack for their restricted usefulness in dealing with real-life concerns (Heller & Monahan, 1977). In 1952, Eysenck claimed that psychotherapy did not add more beneficial effects beyond those obtained from spontaneous remission (Eysenck, 1952). This paper reflected dissatisfaction with psychotherapy as the exclusive mode of psychological intervention. Beyond its effectiveness the *social utility* of psychotherapy has long been questioned. The criticism claimed it was a lengthy and exclusive method applicable to only a restricted set of problems, namely *neurotic* problems, ignoring the more serious and more socially relevant problems (e.g., alcoholism, drug abuse, violence)

This traditional approach was also called the *waiting* mode of delivering mental health services, since the mental health professional passively depends on the client seeking or being sent for treatment (Cowen, 2000). Traditional models of mental health have a *deficit* orientation, i.e., clinical interventions target deficits or problems that need to be remedied. Reflecting reaction to this prevailing attitude among clinical and community practitioners important changes have occurred in clinical thinking resulting in a shift from *deficit model* to *competency model* (Albee. 1980; Cowen, 2000; Lorion, 2000). This change can be described as varying along three dimensions: a) a theoretical shift from a deficit orientation to competency orientation; b) an

ecological shift from a focus on the individual level of intervention to a focus on the organizational and community levels and c) a strategic shift from intervening later in development to intervening earlier in the pathogenic process (Heller & Monahan, 1977; Cowen, 1980; Lorion, 2000).

The approach based on the medical model emphasizes pathology. Accordingly, *normality* is defined as *the absence of disorder*, disregarding the possibility of describing mental health in "positive terms" (Cowen; 2000; Puentes-Markides, 1992). The traditional view also assumes that problem solving in mental health has to be accomplished only by medically or professionally trained personnel and that major interventions might involve hospitalization, drugs and, in extreme case, institutionalization even imprisonment.

Beginning to emerge in Chile is an alternative to a deficit model is which focuses on psychological *strengths* and *competencies*. *Competency*, in this case, refers to the development of psycho- social strengths including problem solving skills, social competence and social skills or survival skills. This alternative represents far more than a semantic shift for it has implications for how one conceptualizes behavior and how one designs and delivers interventions. Professionals working within this approach are less likely to speak about "mental health" and “mental illness” and instead refer to this growing field as *Psycho-Social Wellness* , indicating that normality refers to a state that goes beyond the absence of disorder, including well-being in physical, mental and social domains ((Pemjean, 1989; Gyarmaty, 1992; Engel, 1980; McDaniel, 1992; Seaburn *et al*., 1996). Under this view, health is an indicator of psycho-social well-being, but it is not the only criterion for designing and evaluating interventions. Needs satisfaction and the development of person´s potential, are also included in this broader

concept of psycho social well-being.

Within this perspective, the focus of intervention shifts from treatment and rehabilitation to the prevention of disorder and the promotion of health. This shift moves Chilean service providers toward the development of interventions that could be used at earlier points in time to avoid the occurrence of anticipated deficits and to "counteract harmful circumstances before they have the chance to produce illness" (Caplan, 1964, p.26).

As explained in a recent assessment of the state of prevention science (Mrazek & Haggerty, 1997), prevention programs can be designed to intervene at different ecological levels, focusing on persons (indicated interventions), groups (selective interventions) or an entire community (universal interventions). The latter tend to include interventions aimed to "ameliorate harmful environmental conditions or to support the resistance of population to unavoidable future harmful experiences" (Heller & Monahan, 1977, p.14). At the community level, media programs designed to build immunity to stressful psychological events are an example of an early competency-based intervention. The shift from *deficits* to *competencies*, and from *pathology* to *strengths*, has other implications in terms of who is to be responsible for the community mental health, or *psycho-social well-being*. Within the deficit approach, mental health is the responsibility of medical professional responsibility, and only highly qualified personnel can be in charge of handling mental health problems. In the competency approach, well-being standards and the quality of life is the responsibility of every member of the community.

Social networks

The concept of a personal social network refers to the ties a person maintains with other individuals and groups. These ties have a health enhancing and sustaining effect on a variety of

diseases and health conditions (Gottlieb & Green,1984). Social networks represent the structural basis for social support, that, in turn, provides individuals with emotional support, information sharing, and a variety of tangible goods and services. Social support can be defined as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (Shumaker & Brownell, 1984, pg. 11).

A person's social network can serve as a resource for coping and thereby moderate or buffer the stressful impacts of negative events. Psychological and social coping resources vary with education, income, community and family ties (Kessler & Cleary, 1980), subgroups of the population (e.g., the poor, the uneducated and women) may be differentially vulnerable (Gottlieb, 1987). Many community programs are based on evidence that one of the main factors associated with resistance to stress is the availability of social support (Speck & Atteneave, 1976). If access to a supportive social network can moderate the impact of stressful events, then the enhancement of coping and social skills to enable one to activate a community´s natural social support resources may play a key preventive role in mitigating the effects of stressful events (Arón, 2000). In Chile, we have found that violent families are usually isolated and seldom establish supportive ties with relatives, friends and salient elements within the community (Arón, 2000). A key element to a preventive intervention for potential victims of domestic violence, therefore, would be the activation and empowerment of personal social networks.

Crisis Intervention

It has been noted that "the Chinese character for 'crisis' is said to combine the character symbolizing 'danger' with that symbolizing 'opportunity'. The components of crisis are a

dangerous situation and the opportunity for resolving it" (Minuchin & Barcai, 1972). Crisis is defined as a temporary situation of distress that is so radically different from the ordinary that the individual is forced to change in order to cope with it. Therefore inherent to a crisis is the opportunity for change. There are different types of crises: normative crises, related to the life cycle and the family cycle, that occur when the individual passes from one stage of development to the next. They are also called “expected” crisis. Accidental or circumstantial crises are unexpected events caused by factors such as natural disasters, the unexpected death of a relative, job loss, family conflicts and domestic violence, among others. The individual's response to crisis depends upon the severity of the event, personal resources to cope with it and social resources available at the moment of the stressful event. People’s reactions in crisis are characterized by disorganization, vulnerability and coping problems. They experience strong feeling of fatigue and exhaustion, inadequacy and confusion, anxiety, disorganized functioning of social and family relationships (Slaikeu, 1988). People in crisis are in a very vulnerable situation. Successful resolution of a life crisis can contribute to personal growth. At the same time, it must be recognized that many emotional disorders begin or worsen after an important life crisis. Many victims of domestic violence are most appropriately described as being in crisis (Slaikeu, 1988; Sullivan & Everstine, 1983). Those who experience a chronic state of crisis typically lose their ability to cope with traumatic events. For this reason, crisis intervention techniques should be included within any preventive intervention targeting domestic violence.

Crisis intervention can be defined as a process of helping a person or a family cope with a traumatic event by weakening the negative effects and enhancing the probability of positive effect such as personal growth (Slaikeu, 1988). Crisis intervention typically must occur immediately or close in time to the occurrence of the critical event. Crisis intervention usually

represents a form of psychological "first-aid" and includes emotional support, information, instrumental help and services. It can be delivered by non professional helpers, who tend to be emotionally closer and more available to victims than professional service providers. Ideally, professional resources can contribute to crisis intervention programs by training and supervising non-professional helpers.

A preventive approach to domestic violence in Chile:

The theoretical framework of the program described in this paper is based on a Psycho-Social-Wellness Model that emphasizes individual and community *competencies* as a main problem solving resource. The intervention's main goal was to develop a program on domestic violence which fit within the community's natural social networks and provided services across multiple levels of preventive intervention. Our professional team' goal was to establish a support system for groups and institutions working in the community with victims of domestic violence. To achieve our overarching goal, we emphasized the empowerment of natural community networks to provide immediate crisis intervention and, as required, to refer victims to specialized intervention services and agencies.

The program was designed by the staff of the Outpatient Psychological Clinic of the Psychology Department at the Catholic University of Chile (Consultorio Externo de la Escuela de Psicología) and implemented in San Bernardo, a city of 200,000 people on the outskirts of Santiago The Clinic has a multi-disciplinary professional staff, composed of psychologists, psychiatrists, neurologists, special education teachers and speech therapists. The *Domestic Violence Team* of fifteen psychologists and a child psychiatrist were organized into two subgroups, one team focused on the children and youth who were victimized and the other team focused on the

women who were abused. Since appreciation of gender-related differences in thinking about domestic violence was considered an important program element in addressing domestic violence, the Team included two men to balance the female perspective of the problem. Thus, the intervention's overarching goals included:

1. To sensitize community members about the problem of domestic violence, including child abuse and battered women.

2. To identify the organizations available in the community that provide support, assistance and education regarding domestic violence

3. To become a professional resource to the community that provides support, assistance, training and supervision regarding domestic violence.

4. To activate intermediate community networks to support and assist victims of domestic violence and their families.

To reach these goals, the intervention pursued the following specific objectives:

1. Exploration of community social networks systems:

This task was carried out by different members of the *Domestic Violence Team*, at different levels of the community organization. It consisted of visiting key informants in the community (e.g., the Governor of the County; the Catholic Bishop; the Director of the local Hospital, doctors, teachers and other community members), and through the resulting exchanges, identification of organizations in the community's system of social services and supports that seemed relevant to the domestic violence intervention.

2. Selection of community social system organizations as program partners:

Key organizations that appeared to be appropriate entry points to the community were selected and invited to participate in the project. The local Hospital, the Mental Health Center,

the County Educational Department, the Justice Department, various neighborhood associations, the City Council's Office for Women's Affairs, and some N.G.O. (non-government-organizations), were recruited for involvement in the first stages of program implementation.

3. Developing a contractual partnership with selected community organizations:

Contact with key people within each organization was made with specific attention to that organization's potentially unique relationship with the *domestic violence team* and members of other community organizations. At times, negotiations became very strained and difficult since the team was identified with the Catholic University, which is perceived as a very conservative and highly prestigious academic institution. The perception of the university as an elitist entity interfered with the establishment of genuine partnerships between the *university team* and community groups. Often, the latter groups perceived us as experts rather than peers. We struggled continuously against this separation for building and maintaining an egalitarian team approach with community organizations was considered essential if we were to accomplish our program goals.

4. To plan strategic interventions to cope with domestic violence problems:

Insofar as possible, we attempted to begin our work and negotiations by focusing initially on each organization's identified needs and on the community available resources for responding to those needs. As we merged with an organization's staff, we worked with them to identify and respond to the needs of each community group in terms of support, information, training, supervision and consultation.

5. To identify natural leaders and eventual monitors in different community settings (e.g., hospital, schools, community organizations and others).

The focus of this objective was to increase a community's capacity to respond to needs of its residents by building leadership capacity within its ranks. Our hope was that these leaders would, in turn, take responsibility for the development of self-help groups for victims of domestic violence and members of violent families.

6. To act as an *interface* between different community organizations working with domestic violence.

Insert Figure 1 about here

This aspect of our work was designed to assist community organizations to create linkages among themselves and to establish a social network system that provides support, information and supervision to people working with domestic violence. Figure 1 depicts how level of interventions and planned activities were organized. The main targets of the Domestic Violence Program are the County's Health System including the local Hospital, Outpatient Clinics and Mental Health Center; the County's Educational System including the City Council Counseling Department, Teachers, Parents Associations and Students; the County's Judicial System including the Courts, Legal Assistance Department; the City Council (i.e., the Office for Women and Family affairs); and Community groups including Neighborhood Associations, Religious groups, N.G.O. and other informal groups.

Interventions were planned at three levels of prevention, i.e., primary, secondary and tertiary. Tertiary prevention activities included crisis intervention, psychological assistance and appropriate referral of victims of domestic violence to specialized services. These activities were provided at the local Hospital, at the Council's Office of Women and Family Affairs and at the

Psychological Clinic of the University. Psychological assistance was focused on individual women and children, couples, families and their primary social networks. Secondary prevention activities included crisis intervention, training groups, supervision and activation of self-help groups. Those groups targeted at this level included the County's Health System, the County's Educational System, the County's Judicial System, the County's Office of Women Affairs and Community Groups. Primary prevention activities included sensitization of different groups, training key members of a community and neighborhood in prevention programs, planning of prevention programs and consultation to organizations working in the field of domestic violence. These activities focused primarily on the County's Educational System but also included the Health System and Community groups.

We conceptualized our efforts as proceeding through a series of stages or steps. The first stage, exploring the community: establishing links, involved identifying and making contact with community organizations such as hospitals, schools and neighborhood organizations. Regular field trips were scheduled to develop collaborative ties with people in key positions within these community organizations.

Insert figure 2 about here

Figure 2 depicts the relationship between the *Domestic Violence Team* and the various community organizations. The ultimate goal of our work was to reach families at risk, including children and women who were actual victims of domestic violence and those who were at risk of being victimized. We were also intent on locating members of violent families and their primary social networks. We recognized that as family's *primary social*

network is formed by relatives, friends and acquaintances that have significant relationships with a person and a family. Since the *Domestic Violence Team* was not a part of the community, it could not expect to reach victims and families directly. For that reason, a first step in our intervention was to make contact with vulnerable families' *secondary social networks*, formed by professionals and members of community organizations that deliver public services (e.g., hospitals, schools, City Council organizations). These secondary networks give specialized help, relevant information and eventually, support in times of crisis to community family members. To elements of such networks, the program offered training, supervision, consultation and assistance in the field of domestic violence.

A second step in our approach was to identify people with natural helping skills who would qualify as monitors in supportive and self-help groups, both among members of the secondary networks and among survivors of violent families who have been assisted by the Program. A third step was to activate what we have called *Intermediate Network* or open network, that is groups formed by those members of the community organizations that naturally or after training have the capacity to provide emotional support, crisis support and specialized help to victims and members of violent families. Self help groups and supportive groups for victims of domestic violence are examples of the *intermediate social network.*

The primary target for the first stage was the medical staff at the local Hospital. Our first activity was to organize and conduct a formal training group for staff from the Emergency Room, the Pediatric and the Obstetric units. Over three months, weekly sessions were held with nurse aides, nurses, doctors, social workers and social worker aides. A participatory workshop approach was used, including sensitization activities, information about domestic violence and crisis intervention.

The second stage of our work admittedly tested the frustration tolerance of the members of our team. As usual, despite the initial good will of the hospital staff, a natural resistance to change working styles and compromising with new working areas appeared. We recognized that this was a crucial stage for the project's success. We encountered resistance in multiple forms: a) participants had problems attending scheduled events because of other demands and dealines; b) unexpected conflicts arose as last minute activities were announced by hospital administrators which overlapped with training sessions; c) participants simply forgot to attend the previous accorded time schedule; and d) assigned rooms were suddenly unavailable for scheduled training sessions. Each of these forms of resistance had a negative impact on the team spirit leading to discouragement and questions about the value of continuing the program.

During the second stage, we focused our work primarily on four target groups: the Hospital (Emergency room, Pediatric and Obstetric Units), the County's Office for Education, the County's Office for Women Affairs and Judicial Courts. Only our intervention with the Hospital will be described in detail. Following completion of the first stage, separate meetings were held with the *Children Staff* (i.e., pediatrician, pediatric aids, pediatric nurse, pediatric social worker) and the *Women Staff* (i.e., emergency room staff, social worker, obstetrics department staff). During these meetings, participants designed specific strategies for admitting victims of domestic violence into their units and established procedures to discuss cases and to make referrals. For instance, the group decided that nurse aides were the most appropriate people to make the first contact with battered women, since they were more likely to be perceived as peers than the doctors or nurses. A second decision was to determine where to make the initial contact with battered women. Participants appreciated that the Emergency Room was a very

crowded place in which it would be difficult to create the close and protected emotional atmosphere to allow victims can talk about their problems. The group decided that victimized women would be removed to a special isolated room originally intended for emergency patients with severe conditions, in order to create a context of intimacy necessary to support them and allow them to talk more freely. Since battered woman are usually frightened to talk about their problem and often refuse medical help when it is first offered, the medical staff would justify their involvement "to check blood pressure" with the abused woman in order to provide a second opportunity for a woman to receive help.

Psychologists from the Program team begun to provide psychotherapy to battered women referred by the medical staff. During the time spent by the psychologists at the Hospital informal talking about cases and the medical staff problems, was considered by our group as a potent mean of changing attitudes. These non-programed activities between the University team and the Hospital staff were considered as *informal training.* This form of informal training also included two policemen that work at the Emergency Room and serve as key people in the area of domestic violence. They often have the first contact with the victim who enters with suspicious injuries. The policemen's attitude toward the victim was viewed as crucial, since their reaction could result in a victim returning home with a sense of guilty and shame or, ideally with a sense that they deserved and would receive special help.

In addition to the aforementioned informal training, an *in vivo* mode of training also occurred, i.e., psychologists on the team stayed with nurse-aides during their regular duties and thus had the opportunity to share and discuss immediately difficulties encountered with specific victims. This component of our training occurred in the Emergency Room, Pediatric and Obstetric Units.

The final stage involved preparing for our departure and evaluation of the program and focused on community network activation. As noted above, the program served as a catalyst for networking different elements of the community web. Toward that end, we conducted a series of meetings that brought together individuals from different community institutions and organizations. The Police offered their social club to run the meetings. Most of the participants at these meetings had previously encountered each other but were unaware of their mutual interests. Meeting served to (re)establish links between them and facilitated what we have called the "linked referral". This occurs when a professional refers a client to another agency rather than simply sending him or her away, he tells her: "I'm going to send you to the Hospital, or the Court, or the County's Office. When you get there, you will talk to Mrs. Gonzalez, a brown-hair lady that wears eyeglasses. Her office is on the second floor. Please tell her that I sent you and I'm sure she will take care of you...". Another example of linked referral occurs when the professional picks up the phone and talk to the other professional in front of the client which provides to the client a sense of being cared for and respected. This procedure not only helps the victim but also help the professional who feels more confident and increases his sense of professional competence. These meetings also served to ensure that activities begun by the program would continue in the community. Evidence of program continuity was the addition of a course on Domestic Violence within the Continuing Education Program of the Emergency Room at the Hospital. This course was planned and held by the medical, nurse and nurse-aides staff that was trained by the Program. All the Emergency Room Staff attended to the classes.

From the beginning, each organization new that the program will finished in a period of time, thus the last stage prepared the retreat of the team Program from San Bernardo, although

they new that we remain as a professional resource for the community. This link continues in terms of consulting activities, case supervision, crisis intervention and consultant referrals to the University Clinic.

Reflections on program development:

It seems important to add thoughts about some of our experiences during the first stage. During sensitization activities with the medical staff, the main problems we encountered were biases and myths about women battering, the insidious prevalence of the patriarchal model, gender problems among the staff and male participants fear of losing power. During training activities, one of the main problems we encountered was the presence of abusers and abused people in the same groups. We also found that participants would accept information about violence at an intellectual level but reject it at an emotional level. some displayed intense levels of cognitive dissonance that triggered defensive attitudes. Others displaced their aggression toward abusers to trainers and/or toward members of the victims' group. Still others externalized their personal conflicts to the group or the training situation. Problems encountered among team members included becoming uncomfortable in the face of challenges of one's underlying assumptions about gender roles and reverting back to the role of "expert" and thereby undermining our pursuit of more equitable roles between helper and helpee.

The high rate of demand for psychological assistance and the high rate of drop out among victims made it critical that a model for assisting domestic violence victims and members of violent families be developed which took into account community characteristics and used community resources. This is one of the challenges for the next stage of our program.

The first stage of the program has emphasized team building and team self-care. This was true for the domestic violence team and also transmitted to every team working with this subject.

Working with victims of violence has a strong impact upon service providers which may be expressed as aggression and conflicts among team members, fragmentation within the victims' group and finally, if not properly managed, it may lead to group dissolution. Care of individuals and of the entire team has been a priority. It began with training activities for the team and continued with weekly meetings where problems and conflicts are ventilated. Workshops with external supervisors and emotional supportive activities were planned and conducted for the whole group. The experience in this program underlines the importance of "caring for those who care", i.e., recognizing that professionals working with victims of violence are at serious risk of burnout and team traumatization. Appropriate time and space must be devoted to providing care to individual team members as well as to the team as a whole. The future of the overall program depends ultimately on that!

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