DOMESTIC VIOLENCE AND MENTAL HEALTH: THE EXPERIENCES OF WORKERS IN DOMESTIC VIOLENCE SHELTERS

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Abstract

This qualitative research project focuses on mental health in female victims of domestic violence. More specifically, it looks at 1) shelter workers' perspectives on women who experience both domestic violence and mental health problems; 2) the approaches used when working with these women; and 3) the challenges workers face in their work with these women, as well as possible solutions to overcome these challenges. Data was collected by interviewing four workers in two domestic violence shelters in Ottawa. The research participants had between one and ten years experience working in shelters. The results demonstrate that, according to the shelter workers, women who experience domestic violence also experience a significant amount of mental health problems, including anxiety and depression, and women who experience both domestic violence and mental health problems tend to require more time and attention from the workers. The approaches used by the workers vary significantly, with a trauma-informed approach being the most common. Moreover, according to the participants, obtaining a diagnosis can open the door for multiple services. Furthermore, not being experts in mental health and women's substance use were reported as the most important challenges they face when working with this population. Other challenges included not having enough staff, working with aggressive or violent women, and feeling powerless when working with women experiencing mental health problems. Several structural challenges were also identified, such as the lack of affordable housing in Ottawa, problematic laws regarding violence against women, and the long waiting list for mental health services, which prevent women from successfully transition to living independently in the community.

Keywords: Domestic violence, domestic violence shelter, mental health, substance use, intervention approaches

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List of abbreviations

BPD – Borderline Personality Disorder

CAS - Children's Aid Society

CACSW - Canadian Council on the Status of Women

CMHA – Canadian Mental Health Association

ODSP – Ontario Disability Support Program

OW – Ontario Works

PTSD - Post-traumatic Stress Disorder

ROH – Royal Ottawa Mental Health Centre

VAW – Violence against women

Introduction

Women are four times more likely than men to become victims of domestic violence, and account for eighty-three percent of victims of domestic violence (Battered Women's Support Services, 2017; Ministry of the Status of Women, 2015). When a woman decides to leave an abusive relationship, she may seek help at a domestic violence shelter. In 2009/2010, there were 31,000 admissions of women and children to the 171 domestic violence shelters in Ontario (Ministry of the Status of Women, 2015). These shelters offer a wide array of services, including refuge, support, advocacy, social services referrals, and legal resources (Johnson & Zlotnick, 2009).

Moreover, research evidence shows that domestic violence affects women's lives, including women's mental health. Indeed, women who experience domestic violence have an increased risk of developing post-traumatic stress disorder, depression, suicidal ideation, substance abuse, and chronic pain (Martinez-Torteya, Bogat, Von Eye, Levendosky, & William, 2009; Feder, Hutson, Ramsay, & Taket, 2006; Howard, et al., 2010). Nonetheless, we know little about how shelter workers address this issue.

Therefore, this qualitative study explores shelter workers' perspectives on women who experience both domestic violence and mental health problems. More specifically, this research project explores 1) shelter workers' perspectives on women who experience both domestic violence and mental health problems; 2) the approaches used when working with these women; and 3) the challenges workers face in their work with these women, as well as possible solutions to overcome these challenges.

The first chapter will provide a review of the literature on domestic violence, its impacts on women's mental health, and the approaches used in domestic violence shelters. The second chapter presents the theoretical framework, which draws upon both the medical model and feminist paradigms that have been used over the last few decades to understand women's mental health. These paradigms will help to make sense of the workers' perspectives on abused women's mental health problems, and the approaches used in their work. The following chapter presents the research methodology used in this project. This qualitative study focuses on the

workers' perspectives with data that was gathered through individual interviews. I then address the ethical considerations and the limitations of the study. The fourth, fifth, and sixth chapters will present the results of the research. Each chapter represents one of the following themes: the workers' perspectives on women who experience both domestic violence and mental health problems; the workers interventions with these women; and challenges and possible solutions to helping women who experience both domestic violence and mental health problems. The seventh chapter is a discussion of the results. This discussion will examine the presence of both the medical and the feminist paradigms, as well as certain concepts from the literature review, as they emerge in the participants' accounts.

Chapter 1 : Mental health in Victims of Domestic Violence

This first chapter presents a review of the literature on domestic violence and feminist intervention. I will introduce the history of domestic violence in Canada. I will then elaborate on the concept of coercive control as outlined by Evan Stark and address the different forms of domestic violence and the cycle of violence. I will then present the impacts of domestic violence with a focus on women's mental health. In the following section, I will provide the history of domestic violence shelters in Canada as well as the different intervention approaches used in shelters. This chapter will conclude with the presentation of my research question and objectives.

History of domestic violence

From the middle ages through to the mid-nineteenth century, women were considered to be the legal property of their fathers and, once married were considered the property of their husbands (Sheehy, 1999). The laws during those times made it such that women did not have a legal identity and were therefore "restricted in their ability to accumulate property and wealth, to assert control over their children and their own destiny, and to protect or claim their own physical integrity" (Sheehy, 1999, p. 63). In the mid-eighteenth century, husbands had "by law, power and domination over his wife, and may keep her by force within the bounds of duty, and may beat her, but not in a violent manner" (Sheehy, 1999, p. 63). These laws reflected an outdated perception of the role of the husband where "a husband has the right to have sexual access to his wife, that nagging women […] often provoke the beating they receive, that wives and children need a male economic provider, and the law should not disrupt this traditional pattern of support" (Dutton, 2006, p. 9). Therefore, the violence between married partners was not only socially accepted but was deemed appropriate in the eyes of the law. In addition, Canada's first Criminal Code, which was adopted in 1892, did not consider marital rape a crime, it was only punished by the Canadian Criminal Code if it was committed by a man other than the woman's husband (Sheehy, 1999). Progress began to be made in the nineteenth century where courts punished husbands when permanent injuries were inflicted (Dutton, 2006). Assault against one's wife became illegal in Canada by the end of the 19th century, but the justice system often ignored domestic violence unless a murder was involved (Dutton, 2006). In the late 1970's and

early 1980's, a growing interest in the criminal justice system's awareness to domestic violence grew with the work of different feminist groups and organizations (Department of Justice Canada, 2002). In 1979, the Canadian Council on the Status of Women (CACSW) conducted a nation-wide study on wife battering to document the extent of domestic violence and to recommend solutions to make the issue of domestic violence more visible (Currie, 1990). The recommendations from the study included: better funding, more support services, and better crisis intervention services (Currie, 1990). Laws were already in place to protect women in violent relationships, but "accepted legal procedures and exceptions written into the law for the purpose of protecting the unity of the family made convictions virtually impossible" (Currie, 1990, p. 84). In present times, there are charging and prosecutions policies on domestic violence in effect in all Canadian provinces and territories with a primary objective to criminalize domestic violence (Department of Justice Canada, 2002). However, more progress needs to be made as victims of domestic violence are still facing many challenges regarding the criminal justice system. For instance, police continue to charge women with engaging in mutual violence when in reality they are defending themselves (Chewter, 2003). In addition, there are mandatory prosecutions policies put in place to protect women from coercion from the perpetrators, but this forces women to assist in the criminal prosecution regardless of their wishes (Chewter, 2003). More work needs to be done in order to protect and help victims of domestic violence.

Defining domestic violence

The concept of patriarchy is fundamental to understand domestic violence and its impacts on women. The patriarchal society in which we live has given men the power to subordinate their female partners (Robertson & Murachver, 2011). Johnson describes a society as being patriarchal "to the degree that it promotes male privilege by being male dominated, male identified, and male centered" (Johnson, 2005, p. 5). Thus, patriarchy has created a foundation that has put men in a position of power, which has made way for men to be absolved of blame for domestic violence, shifting that blame to the women.

Coercive control

Evan Stark (2007) proposes the concept of coercive control in order to define domestic violence. Stark (2007) points out that coercive control in the context of a heterosexual couple is a "gendered phenomenon made possible by the historical and current oppression of women" (cited in Crossman & Hardesty, 2017, p. 2). There are two components to Stark's theory: coercion and control. He defines coercion as the use of threats to incite a particular response which can not only cause "pain, injury, fear, or death, [but] coercion can have long-term physical, behavioral, or psychological consequences" (Stark, 2007, p. 228). Control is defined as:

> Structural forms of deprivation, exploitation, and command that compel obedience indirectly by monopolizing vital resources, dictating preferred choices, microregulating a partner's behavior, limiting her options, and depriving her of supports needed to exercise independent judgment. (Stark, 2007, p. 229)

Therefore, control is gained by using "tactics such as isolation and intimidation, […] to create a foundation for one partner to exert and maintain power over another partner" (Crossman & Hardesty, 2017, p. 1). When both coercion and control are used together, it results in an entrapment of the victim (Crossman & Hardesty, 2017).

When selecting means, the perpetrators individualize the power strategies according to their victim's personalities, preferences, situational variables, and their perceived efficacy (Stark, 2007). Because the perpetrators have access to a wealth of personal information about their partners, this allows them to select the most effective strategies (Crossman & Hardesty, 2017). Therefore, tactics that may appear neutral such as rewarding their partners with gifts may have ulterior motives to build a foundation of control and power (Crossman & Hardesty, 2017).

Obtaining power and control

The different tactics used by abusive men to maintain power and control are illustrated through Duluth's wheel of power and control (Appendix A). According to this wheel, men can use isolation by keeping their partners away from everyone, making themselves her only source of information, support, money, etc. (Johnson, 2008). When all the methods demonstrated in the wheel of power and control are put together, the perpetrators manage to create a web of abuse where they entrap and enslave their partners (Johnson, 2008). Violence is depicted as the rim of the wheel because when the nonviolent tactics in the center of the wheel are accompanied by

violence, the perpetrator takes “on a new, powerful, and frightening meaning, controlling the victim not only through their own specific constraints, but also through their association with the general knowledge that her partner will do anything to maintain control of the relationship, even attack her physically” (Johnson, 2008, p. 9).

Forms of violence

An organisation promoting public awareness on the warning signs of domestic violence: Voisins, amis et familles (2015), identifies eight different forms of violence: economic, physical, psychological, sexual, spiritual, verbal, cyber-violence, and femicide. Economic violence is an act of domination and control that deprives the victims of economic independence or prevents the victims from meeting their needs such as food, shelter, clothing. Physical violence is the most well-known form of violence that manifests with, for example, the slapping, punching, or kicking of the victim. Psychological violence is characterized by using threats and comments to maintain control. According to Gravel (2017), psychological violence is the most common form of domestic violence. Between 2012 and 2017, twelve percent of people who were in a couple, who had been a couple, or who had been in contact with an ex spouse had been subjected to psychological violence compared to three percent that had been subjected to physical abuse (Gravel, 2017). Sexual violence includes sexual exploitation, touching, rape, and any other sexual act that the victims consider degrading, humiliating, or painful. Spiritual violence is when the abusers prevent the victims from expressing their religious or spiritual beliefs. Verbal abuse is an act of domination by speech; the abusers can frequently or repeatedly use words, cries, or silences. Cyberviolence is repeated, unsolicited, and threatening behaviour through communication technologies to terrorize and harass the victims. Last is femicide, the ultimate form of violence which is the murder of a woman because she is a woman.

Cycle of violence

Together, these forms of violence and the coercive control tactics are repeated through a cycle of violence, a model initially developed by Lenore Walker (Peterman & Dixon, 2003). The cycle of violence helps explain domestic violence through three phases that vary in intensity and duration throughout the relationship (Coleman, 1997; Peterman & Dixon, 2003)(Appendix

B). The first phase is tension building, which can last for days, weeks, or months (Peterman & Dixon, 2003). During this phase "unresolved conflict and unexpressed anger collect and there is a sense of walking on eggshells" (Coleman, 1997, p. 422). The victim tries to relieve the stress of her partner by being nurturing, compliant, or staying out of the way (Peterman & Dixon, 2003). The sense of walking on eggshells expressed by Coleman (1997), represents the victim's fear of not wanting to provoke her partner. The second stage is the acute battering incident or the explosion stage (Coleman, 1997; Peterman & Dixon, 2003). It is in this stage where the violent incident occurs, which may be emotional, verbal, physical or any of the other forms of abuse mentioned previously (Coleman, 1997). After the violent incident, the victim is "shaken, nervous, afraid, disoriented, dazed, and shocked that their partner is capable of hurting them" (Peterman & Dixon, 2003, p. 42). During this phase, both partners tend to rationalize or minimize the abuse (Peterman & Dixon, 2003). The last phase is the honeymoon phase, which is characterized by peaceful, loving, and kind behaviour (Peterman & Dixon, 2003). During this phase, the perpetrator will "beg for forgiveness, profess their love, and promise to never abuse their partner again" (Peterman & Dixon, 2003, p. 42). It is during this phase that the victim will most likely leave, but the perpetrator will use "guilt to keep the victim in the relationship and convince the victim that something awful will happen if the victim leaves, such as threatening to commit suicide" (Walker, 2000 cited in Peterman & Dixon, 2003, p. 42). Each time this cycle is played out, the domestic violence tends to increase in severity and frequency (Coleman, 1997). Also, the victim is the most vulnerable when she decides to leave the relationship because this means that the perpetrator's usual tactics no longer work, he is likely to resort to more extreme acts of violence (Coleman, 1997).

Although Walker's original model of the cycle of abuse has three phases, many domestic violence shelters or coalitions have added a fourth phase to the cycle. In Walker's second phase, the explosion, there is the violent incident followed by a denial and justification (Coleman, 1997; Peterman & Dixon, 2003). Many shelters have broken down this phase to add what they call the denial/justification phase (Appendix C). Shelters describe this phase as a moment where the perpetrator makes excuses for what he did, tries to justify his actions and blames his partner for the abuse (Interval House , 2017).

Impacts of domestic violence on women's mental health

Many scholars have indicated that women living with domestic violence are likely to experience mental health problems. Women who live with domestic violence have an increased risk of experiencing post-traumatic stress disorder, depression, suicidal ideation, substance abuse, and chronic pain (Feder, Hutson, Ramsay, & Taket, 2006; Howard, et al., 2010; Martinez-Torteya, Bogat, Von Eye, Levendosky, & William, 2009). In addition, "data from a systematic review found that rates of depression declined over time once the abuse had ceased, and the severity or duration of violence was associated with the prevalence or severity of depression" (Golding, 1999, cited in Howard, et al., 2010, p.882). There is therefore a causal relationship between domestic violence and women's mental health with post-traumatic stress disorder and depression being two of the most common problems (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008).

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) is one of the most common mental health problems in women victims of domestic violence (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008). A diagnosis of PTSD involves being exposed to or involved in a traumatic event or sequence of events that is followed by a pattern of distressing physical and psychological responses (Woods, 2000). The characteristics of PTSD include the following symptoms: "flashbacks of the events, avoidance behaviors (avoiding people or situations that remind the survivor of their [abuse]), negative alterations in cognitions or affect (e.g., cognitions that the world is unsafe place), and hyper-arousal (e.g., being easily startled)" (Snipes, Calton, Green, Perrin, & Benotsch, 2017, p. 2454). Some women turn to alcohol or drugs to help cope with these symptoms (Campbell, 2002).

The documented prevalence rates of PTSD in women victims of domestic violence vary in literature. Helfrich, Fujiura & Rutkowski-Kmitta (2008) compared numerous studies looking at the prevalence of PTSD in victims of domestic violence and found that the prevalence of victims of domestic violence experiencing mild to severe PTSD ranges from fifty-five to ninety-two percent. Although there is a significant gap, these numbers are noteworthy when compared to the percentage of people in the general population experiencing PTSD in the United States

which is around ten percent (National Center for Post-Traumatic Stress Disorder 2006, cited in Helfrich, Fujiura & Rutkowski-Kmitta, 2008).

PTSD can greatly affect women's functioning. Abused women experiencing PTSD "often avoid places such as work and familiar social environments where their abuser may be able to locate them, thus becoming increasingly more isolated and functionally limited" (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008, p. 440). These women can live in a constant state of nervousness and anxiety for fear that they will be found by the perpetrator (Riger, Raja, & Camacho, 2002).

Depression

There is evidence indicating that depression can be triggered by domestic violence (Campbell, 2002). Although less common than PTSD, depression is found in thirty-five to seventy percent of victims of domestic violence, compared to twelve percent of women in the general population (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008). Depression in women victims of domestic violence "has also been associated with other life stressors that accompany domestic violence such as: childhood abuse, daily stressors, many children, changes in residence, forced sex, marital separations, negative life events, and child behaviours problems" (Campbell, 2002, p. 1333). Depression can impact a woman's daily functioning such as her "ability to establish and maintain relationships, contributing to social isolation and decreased access to social support" (Carlson et al., 2002, cited in Helfrich, Fujiura & Rutkowski-Kmitta, 2008, p.439). In addition, depression can affect a woman's ability to parent her children, perform day-to-day activities, pursue goals in employment and education, and plan for the future (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008).

In conclusion, there is significant research indicating a correlation between domestic violence and mental health problems. Although victims of domestic violence may experience mental health problems, it is important to recognize and acknowledge the trauma that they have survived. As shown in the literature, there is a causal relationship between domestic violence and mental health, but "women's experiences of depression, post-traumatic stress, and self-harm can be understood as 'symptoms' or the effects of living with violence and abuse" (Humphreys & Thiara, 2003, p. 223).

Substance abuse

In the literature, substance abuse in often mentioned in relation to mental health problems when discussing victims of domestic violence. Substance abuse can be defined as a "problematic pattern of substance use leading to clinically significant impairment or distress" (Saunders, 2017, p. 231). Substance abuse is not only limited to the use of illegal drugs but also the misuse of prescription drugs for non-medical reasons, or the misuse of legal substances such as alcohol, or tobacco (Government of Canada, 2017; Saunders, 2017).

There are many reasons why a woman may turn to drugs or alcohol during or after a violent relationship. Using substances like alcohol or drugs as a coping mechanism is one of the most commonly cited reasons (Campbell, 2002; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; O'Brien, et al., 2016). First of all, "after a violent assault, women may increase substance use to cope with assault-related PTSD or other assault-related mental health problems" (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997, p. 835). In addition, some women may use substances to avoid the negative feelings associated with the stress of the relationship such as anger, fear, and humiliation while others use substances to help them cope with the abusive relationship (O'Brien, et al., 2016). Women can also seek to escape the reality of domestic violence by using drugs or alcohol (Campbell, 2002). Although not all women in domestic violence relationships turn to drugs or alcohol, these substances can provide them with a tool to help them cope and escape momentarily from the abusive relationship.

Domestic violence shelters in Canada

No more than fifty years ago, there were few resources to help victims of domestic violence (Tutty, 2006). In the late 1960's the battered women's movement saw battering as the product of patriarchy and saw the state as "maintaining, enforcing, and legitimizing male violence against women" (Schneider, 2000, p. 182). This movement rejected the idea that the state should be trusted to protect women and therefore developed their own shelters, safe houses, and alternative institutions. In an attempt to respond to the needs of victims of domestic violence "some women's drop-in centres began to provide overnight accommodations, and some families volunteered the use of their homes for refuge, called safe-houses" (Tutty, 2006, p. 15).

Grassroot feminist activists raised awareness for women victims of domestic violence and created the first domestic violence shelters in Canada in the 1970's (Alberta Council of Women's Shelters, 2009; Côté, 2016; Tutty, 2006). These shelters were developed by and for women to offer a physical space where women and their children could seek refuge, but their political character distinguished them from other emergency shelters of the time (Côté, 2016). These domestic violence shelters embraced a feminist perspective on domestic violence and "emphasized socio-political of violence against women, promoted a sense of sisterhood among those who ran and stayed in shelters, eschewed hierarchical power structures, and tried to remain independent of outside service providers and funders" (Rodriguez, 1988; Westlund, 1999 cited in Glenn & Goodman, 2015, p.1483). Today, most shelters have specific rules related to admission criteria, maintaining confidentiality of the shelter's location, completion of chores, maintenance of the shelter living space, curfews, job/housing searches, and prohibition around substance use and violence (Glenn & Goodman, 2015). In addition, the present day has seen a certain professionalization happening in certain domestic violence shelters, which can create a risk of losing some core values such as equality, solidarity, and social justice (Côté, 2016). In certain shelters, the dynamic between the workers and the women residing at the shelter has taken the form of a more professional relationships where the women find themselves in the role of "clients" receiving a service (Côté, 2016). This professionalization has created a divide where there are two different types of shelter workers, those who whish to be considered "professionals" and those who consider themselves feminist activists, with the latter wanting to maintain core feminist principles in their work. (Côté, 2016). The "professionals" find the lack of training on mental health issues problematic, whereas the feminist activists critique the lack of interest and implication in changing patriarchal social structures (Côté, 2016). This tension creates difficulties in shelters where one group wants to become more professional and specialised, and the other wants to maintain core feminist values and political activism.

Feminist intervention in domestic violence shelters

The intervention strategies used in domestic violence shelters were developed by feminist activists who sought to offer women an alternative to psychological interventions that have a tendency to blame them for the difficulties that they experience (Côté, 2016). They were inspired by the anti-psychiatry movement, which challenged the role of psychiatrists and asylums as well

as their abusive practices (Corbeil & Marchand, 2010). The goal of feminist intervention was to help and support women, not to "treat" them as in psychological approaches (Côté, 2016). Considering many social organisations were male dominated and that all women could one day become victim of violence against women, these activists decided that a feminist approach to intervention would be used in domestic violence shelters (Prud'homme, 2010). According to Corbeil & Marchand (2010), feminist intervention has eight main objectives and strategies. The first objective is to support and respect women in their efforts. By listening to women's stories, workers encourage women to express themselves freely and share their emotions or stories if they feel confident and ready to do so. The second objective is to respect women's choices, values, and needs. It is important that workers do not judge women and that women do not feel pressured by the workers to conform to a certain set of ideologies or requests. The third objective is to be in an alliance with the women and to foster a trusting relationship. By respecting women and encouraging them to express themselves, this can foster a trusting relationship. The fourth objective is to encourage empowerment. The workers help the women take back the power by helping them to not be scared to express themselves and by encouraging the women make their own decisions on their objectives. The workers try and help build up the women's self-esteem by deconstructing the negative stereotypes and messages that these women have internalized. Empowering women is helping them find their voice, so they can make their own decisions on what is best for them. The fifth objective is working to raise women's awareness by taking into account the plurality and complexity of oppression experiences. This consists of examining the effects of patriarchal and oppressive systems on the perception of self and of life conditions. The sixth objective is to favour an egalitarian rapport. Although workers in a domestic violence shelter may have a certain educational background, the purpose of this objective is to view the woman as the expert on her own life. She knows what is best for her, the workers should support and encourage her instead of imposing their own ideas on her. The seventh objective is to break the isolation of women and create a feeling of solidarity. A good way of doing this is in group intervention where women can see that they are not alone and that other women have lived similar experiences. The final objective is to fight for individual and social change. Workers can encourage women to become involved in their communities and to participate in activities that promote social justice and equality.

Shelters provide a safe environment for women and children (Jonker, Jansen, Christians, & Wolf, 2014). Although safety is their main goal, shelters also offer multiple services to women including support, advocacy, legal and financial resources, social service referrals, recourses for children, transitional housing, safety planning, mental health and substance use referrals, and housing services and referrals (Jonker, Jansen, Christians, & Wolf, 2014; Jonker, Sijbrandii, & Judith, 2012). In this regard, a Dutch study found that help with finding safe housing, safe and suitable care for their children, and a personalized and respectful approach were the three priorities for workers and for women residing in shelters (Jonker, Jansen, Christians, & Wolf, 2014).

Mental health and substance use practices in domestic violence shelters

As mentioned above, substance abuse is often connected to mental health problems, but there is limited research investigating shelter practices with women experiencing both mental health and substance use problems. The only policies surrounding these issues documented in literature focus on women using substances or being under the influence of substances while residing at the shelter. Domestic violence shelters policies vary from shelters not admitting women into the shelters if they are intoxicated at the intake, to asking women who used substances to leave the shelter, to allowing women who use substances to be admitted and remain at the shelter (Schumacher & Holt, 2012). These policies seem to focus more on substance use than on the use of substances. There is still a lot left to be discovered when talking about intervention approaches used with women experiencing mental health and substance use problems in shelters.

Research question and objectives

This research project explores shelter workers' perspectives on women who experience both domestic violence and mental health problems. More specifically, this research project explores 1) shelter workers' perspectives on women who experience both domestic violence and mental health problems; 2) the approaches used when working with these women; and 3) the challenges workers face in their work with these women, as well as possible solutions to overcome these challenges.

Chapter 2 : Theoretical Framework

Different paradigms have been used to understand women's mental health. This chapter presents two paradigms: the medical model, which remains the dominant paradigm in the mental health field, and a feminist perspective of mental health. Before the presentation of the paradigms, I will briefly outline the history of psychiatry and women.

History of psychiatry and women

The history of psychiatry sheds a light on how the male dominated field of psychiatry has viewed women's mental health over time. The early explanation for madness stemmed from the theory of humours (Burstow, 1992). It was thought that the body contained fine substances called humours, and mental difficulties arose when there was an imbalance in these humours (Burstow, 1992). Evolving through history, various groups of people were designated to treat mentally ill people. From the middle ages, the Church played a predominant role in treating mental illnesses. The church attributed madness to possession by the devil and would use torturous measures to cast the devil out of the body (Burstow, 1992). Following, was witches, midwives, and wise women who tended to emotional and physical problems by bringing natural herbs and counsel to those in distress (Burstow, 1992). However, in 1484, Pope Innocent VIII accused these women of witchcraft and gave the inquisition extensive powers to confine, try, torture, and burn people accused of witchcraft (Burstow, 1992). This prosecution left the male dominated churches and medical professions in charge of helping people considered to be mad (Burstow, 1992).

In the 17th century, the age of asylums began (Burstow, 1992). People were confined to institutions for being poor, unemployed, different or criminals (Burstow, 1992). The percentage of women that found themselves in asylums was considerably more than the percentage of men (Burstow, 1992). In the 19th century, the appearance of hysteria came to light. Hysteria was a mental illness particular to women where doctors believed that women's uteruses kept rising up in their bodies and causing problems (Burstow, 1992). Hysteria made a reappearance in 1960 signalling a more traditional conception of women's roles in the face of changing gender relationships (Jimenez, 1997). The symptoms of modern hysteria were remarkably similar to those of the 19th century hysteria such as: excitability, emotional instability, over-reactivity,

attention seeking, seductive, immature, and self-centered (Jimenez, 1997). In todays modern times, the diagnosis of hysteria has been replaced with borderline personality disorder (Jimenez, 1997). Throughout history there has been a trend to pathologize undesirable characteristics in women. However, what is deemed pathological varies greatly upon subjective interpretations.

Medical paradigm

The medical model has been the dominant paradigm in the mental health field (Beecher, 2009). The medical model was developed as a reaction to "historical notions that individuals with mental illness were possessed, mad, or at fault for their illnesses and is supported by studies that show mental disorders are influenced by genetics" (Zastrow & Kirst-Ashman, 2007, cited in Beecher, 2009, p.10). The medical model, also referred to as the biological model states that mental illnesses consist of a disorder of the brain or a disturbance in the central nervous system that can be treated by pharmacological or physical treatment (Beecher, 2009). This model "assumes that mental health problems like schizophrenia, major depressive disorder, attention deficit/hyperactivity disorder, and substance use disorders are biologically-based brain diseases" (Deacon, 2013, p. 847). The medical model assumes that mental health problems are accounted for by biological changes in the body, not taking into account psychosocial contributions to mental health problems (Deacon, 2013). For example, the medical model would attribute a depression to women's hormonal and reproductive changes (Halliday, 2005). This model has been criticized for being too simplistic and not accounting for the variables in a person's external environment (Beecher, 2009).

In practice, the medical model consists of finding the root causes of the problem through diagnosis and prescribing treatment, usually in the form of medication, to fix the problem (Beecher, 2009). The treatment approach is a biological treatment consisting of prescribing psychotropic medications to correct the imbalance in neurotransmitters in the brain that cause mental health problems (Deacon, 2013). Biological treatments are dominating the mental health field where "anti-depressants are the third most commonly used class of prescription medication of any kind in the United States" (Deacon, 2013).

Clinical psychology has also been profoundly shaped by the medical paradigm (Deacon, 2013). Psychotherapy is often used in combination with psychotropic medication and evidence

suggest that combination therapy is superior to single modality treatment (Craighead & Dunlop, 2014). For example, a treatment plan could include anti-depressant medication used in conjunction with evidenced-based psychotherapies (Craighead & Dunlop, 2014). Evidenced-based psychotherapies for depression include: cognitive-behavioural therapy, interpersonal therapy, and behavioural activation (Ibid., 2014). These therapies look at the nature of the disorder and the psychological factors that allow its persistence to reduce the symptoms of the disorder (Ibid., 2014).

Feminist criticisms of mental health

Feminist perspectives have viewed psychiatry as an institution that treats men and women differently (Bluhm, 2011). Feminist scholars have criticized psychiatry for numerous reasons related to gender inequality. First, psychiatry labels certain behaviours associated with women as being problematic, such as being emotional, which can cause a woman to act "irrational and insane" where as men are thought to always be rational beings (Bluhm, 2011). Also, psychiatry has viewed women's reproductive and hormonal characteristics as an instability causing them to become more susceptible than men to develop mental health problems. This inequality has created certain gender imbalances in mental health diagnostics (Berg, 2002; Swartz, 2013). The diagnosis of borderline personality disorder (BPD) is a great example of this gender imbalance. The diagnosis of BPD is predominantly applied to women and pathologizes undesirable characteristics in them such as expressing anger and aggression and being promiscuous (Shaw & Proctor, 2005).

A final feminist criticism of psychiatry is that it serves "the interest of patriarchal capitalism, which has little tolerance for differences, believes in quantification and control, and seeks to imprison, infantilize, correct, or incapacitate those who deviate from the assigned roles" (Burstow, 1992, p. 28). Psychiatry is assumed to be "a sexist body because it exists within a culture that fosters and uses sexism to keep patriarchy in place" (Berg, 2002, p. 60). Certain feminist believe that mental health problems are socially constructed (Halliday, 2005). Therefore, if women do not conform to society's accepted gendered roles, they will receive a mental health diagnosis. More radical feminists view mental health diagnoses as being more problematic than helpful for women, as it pathologizes women, encourages infantilization, and regresses them into permanent consumers of mental health services (Berg, 2002).

Feminist interventions with women experiencing mental health problems

Corbeil and Marchand (2010) presented the eight core values of feminist intervention as the following: supporting and respecting women, establishing rapport and building an alliance with women, empowerment, favoring egalitarian relationships, working on conscious raising by taking into account the complexity of women's oppression, breaking isolation, and fighting for individual and societal change.

There are many ways to apply these core principles when working with women experiencing mental health problems. Since feminist interventions have the goal of developing more egalitarian structures and relationships during interventions, this can be done by working in collaboration with the women (Hill & Ballou, 1998). On an individual level, it is important to value women's experiences. When feminists work with women experiencing mental health problems, they change the focus from "the woman's inherent defect to her reaction to injurious external events, thus elevating her symptoms to the status of survival skills and life-saving behaviours" (Berg, 2002, p. 58). This helps to see a woman's mental health symptoms, as a reaction to a traumatic event rather than an individual defect, thus eliminating self-blame.

Another goal of feminist interventions is to help change women's perspectives on mental health problems by helping them understand the various oppressions that they face (Hill & Ballou, 1998). Feminist recognize that a lot of the distress that makes women seek out help is socio-culturally based (Hill & Ballou, 1998). Consequently, feminists put poverty, lack of power, lack of choices, social exclusion, and the care burden as key factors in women's mental health problems (Halliday, 2005). The analysis of oppression is integrated by understanding how sex/gender as well as race/ethnicity, sexual orientation, class, religion, size, disability and age are integral parts of a woman's experiences (Hill & Ballou, 1998). When feminists work with women experiencing mental health problems, their work can include consciousness raising, support and advocacy to help women meet their needs (Berg, 2002). A lot of the conscious raising involves education around how different forms of oppressions such as class and gender can influence women's mental health (Berg, 2002). If we use PTSD as an example which is often male-to-female violence, feminists view this diagnosis as not only a "material description of the effects of sexist-based abuse but an indictment of the systems that support and maintain sexism" (Berg, 2002, p. 65). By helping women understand how the multiple oppressions they face may

have caused their mental health problems, it can also break women's feeling of isolation as these oppressions affect many women.

Lastly, feminist interventions also focus on a larger social and collective change. Feminist interventions focus on political activism where they "reject traditional psychotherapy in favor of consciousness-raising, self-help support groups and the mobilization of women toward political activism" (Berg, 2002, p. 60). The main goals of intervening with women who have mental health problems is "fostering the understanding that personal problems have their roots in patriarchy and that sex-gender oppression is the basis of all other forms of domination" (Berg, 2002, p. 61). Women are encouraged to recognize that every aspect of their lives are defined by male dominance in order to "effect larger changes in the environment, and work to establish alternatives for women outside the parameters of patriarchy" (Berg, 2002, p. 61). By creating this awareness, both the workers and the women can work together to incite political change and changes in the mental health institutions.

Chapter 3 : Research Methodology

This chapter presents the methodology of this research project, starting with the methodological approach. Next, I elaborate on the sampling and recruitment process and on the characteristics of the four research participants. I then explain the data collection and data analysis processes. Finally, I address the ethical considerations and the limitations of this research project.

Methodological approach

This research project adopts a qualitative research methodology. I chose a qualitative methodology because it is "interested in the multiple meanings that people attach to their subjective experiences and seeks to identify, describe, and interpret the social structures, spaces and processes that shape these meanings" (Smith & Caddick, 2012, p. 61). Qualitative research allows me to explore the various experiences of workers in domestic violence shelters and embrace complexity rather than adopting a simplistic view of their practices (Smith & Caddick, 2012).

Sampling and recruitment

In order to recruit participants, I sent the directors of five domestic violence shelters in Ottawa an email explaining the aim and the modalities of the research project. I asked them if they would agree to invite their workers to participate in my research project (Appendix D). Of those five shelters, directors from three shelters agreed to invite their staff to participate. The participants had to have a minimum of one-year experience working in a domestic violence shelter. They had to work full-time at a shelter in Ottawa, and speak English.

Once the directors agreed, I asked them to email the eligible workers to invite them to participate in the research project. I provided the directors with an email script to send to their staff (Appendix E). I also asked them to attach the recruitment letter to the email (Appendix F). Once the workers received the recruitment information, they were able to contact me directly to indicate their interest in participating in the research project. Five workers from two different shelters emailed me, but I was only able to accept four participants because the fifth participant

expressed an interest too late and the time constraints of this research project did not allow for the time to interview her.

I replied to the participants either by email or by phone as per their request. During this first contact, I confirmed their interest in the research, answered any questions, and explained the research objectives. The participants choose a date, time, and place for the interview.

Research participants' characteristics

Four (n=4) participants took part in my research project. The participants had between one and fifteen years experience working in a domestic violence shelter. At the time of the interviews, they were either a front-line worker, women's counsellor, or executive director. The executive director had previous experience as a front-line worker. The participants education varied significantly, as two participants had a social work background, one had a child and youth counselling diploma, and one had a psychology and public relations degree. The characteristics of the participants are summarized in Table 1.

Table 1 - Characteristics of the participants

Participants	Years experience as a shelter worker	Current position at the shelter	Education background
Participant 1	Fifteen years	Executive director	Social service diploma, and uncompleted psychology degree
Participant 2	Seven years	Women's counsellor	Master of Social Work, teaching degree, and theater degree
Participant 3	Six years	Front-line worker	Child and Youth Counselling diploma
Participant 4	One year	Front-line worker	Public relations diploma, and psychology degree

Data collection

The workers were asked to participate in one individual semi-structured interview. A semi-structured interview involves prepared questioning that is guided by themes to help direct

the conversation toward specific topics and issues that the interviewer has deemed to be important (Qu & Dumay, 2011). The average time of the interviews was 90 minutes. Each participant was only met once. Two interviews were held at the shelter and two were conducted at a coffee shop as per the participants' preference.

In semi-structured interviews, the interview guide is composed of open-ended questions rather than closed ended question that elicit a very limited answer or just a yes or no response (Smith & Caddick, 2012). Consequently, the interview questions focused on the following three themes: workers' perspectives on women who experience both domestic violence and mental health problems, interventions with these women, and challenges, barriers, and solutions to working with that population (Appendix G). All interviews were audio recorded.

Data analysis

Following the interviews, I analysed the data in a thematic analysis process that was broken down into six steps (Smith & Caddick, 2012). The first step consisted of making notes "after each interview regarding the topics talked about in that interview" (Burnard, 1991, p. 462). In these notes I wrote ideas or anything that attracted my attention (Burnard, 1991). In my notes I also wrote down my emotions and any other situation or context that was relevant during the interview that would not be present in the verbal recording. I think it is important to include these notes because it captures information that the recording cannot. The second step of my analysis was transcribing the verbal data. The verbal data was transcribed by me, the main researcher. The third step was to read through the verbatim and make notes on general themes and ideas that appear in the transcription (Burnard, 1991). Some scholars refer to this process as coding. The fourth step was searching for and identifying themes through the codes. I searched through all the codes and notes in order to find broader themes. Through this process I created a coding tree containing the themes expressed in the interviews (Appendix H). Next, I reviewed the themes. This was done in two steps, first I saw if the themes worked in relation to the codes extracted and secondly, I saw if they appeared to form a coherent pattern. The last step was defining and naming the themes. In this step, I identified "the 'essence' of what each theme is about and determining what aspect of the data each theme captures" (Smith & Caddick, 2012, p. 65).

Ethical considerations

This research project had been reviewed and approved by the University of Ottawa's Office of Research, Ethics and Integrity. Participation in the study was voluntary, and the participants could withdraw from the study at any time and refuse to answer any questions without facing any negative consequences. In this regard, it was also important that I had the participants' free and informed consent. Once we met in person for the interview, I asked them to read and sign the consent form (Appendix I).

Given that the workers' participation entailed sharing their experiences working with women who have experienced domestic violence and mental health problems, there was a potential risk that they felt an emotional discomfort during the interview. Efforts were made to minimize this risk, and the participants did not have to answer questions that made them feel uncomfortable. I also provided them with information regarding crisis lines for additional support, if needed following the interview.

Moreover, a main ethical concern was the respect of the participants' privacy (Creswell & Poth, 2018). Participants were asked not to disclose the names of other workers at the shelter, the name of the shelter, and the names of women residing at the shelter when answering interview questions. If information allowing the identification the participants, the shelter, or the women residing at the shelter was shared during the interviews, it was deleted once the recordings were transcribed.

All data collected including the transcriptions of the interviews was stored on the main researcher's computer, which was protected by a password. The consent forms were kept under lock and key at the research project director's office at the University of Ottawa. The data will be retained for a period of five years after the end of the data collection.

Limitations of the research

This research has a number of methodological limitations. First, the number of participants does not allow a generalisation of the results. Moreover, the participants were from two domestic violence shelters in Ottawa, so the results are not representative of all domestic violence shelters in Ottawa or elsewhere in Canada. I chose to interview only four participants because this number of participants allowed me to obtain an appropriate amount of information in the time that was planned to complete the research project (one academic year).

In addition, the experiences of women who have experienced domestic violence and mental health problems were not represented in this research project. We do not know their views on shelter practices. Their opinions may be very different than the workers'.

Also, the front-line workers' desire to portray a positive picture of the shelter and of themselves as workers may have influenced how they responded to the research questions. In an attempt to portray the shelter practices in a positive light, they may have neglected to share information that may make themselves or the shelter appear negatively.

Chapter 4 : Shelter Workers' Perspectives on Women Who Experience Both Domestic Violence and Mental Health Problems

This chapter presents the shelter workers' perspectives on women who experience both domestic violence and mental health problems. First, women's state of mental health upon arrival at the shelter and throughout their stay is explored. Following, the mental health diagnoses frequently associated with victims of domestic violence will be presented. The workers also elaborated on several advantages and disadvantages with obtaining a mental health diagnosis. Next, the link between mental health problems, substance use problems, and domestic violence will be discussed. Although the results focus on women who experience both domestic violence and mental health problems, substance use is frequently mentioned as well. The workers have often seen mental health and substance abuse problems experienced concurrently by the women at the shelter. The last section details the specific needs of the women who experience both domestic violence and mental health problems.

State of mental health upon arrival at a domestic violence shelter

The participants mentioned that most women tend to arrive at a domestic violence shelter in a state of crisis. The state of crisis was described as resembling mental health problems. The symptoms resembling a mental health problem could be exacerbated by the women having just experienced some form of trauma and now having to relocate themselves and their children. Moreover, the women may be in shock from leaving an abusive situation and having their lives changed over night.

> So almost every woman who walks through our doors is in crisis […] so she's experienced some kind of trauma, and there may be physical injuries, but 100% of the time there are psychological and emotional injuries or stuff. (Participant 1)

> [Women arrive] scattered, very…women who sometimes don't suffer from any mental health problems will appear like their suffering from mental health problems because they're so…scrambled is like the best word I think, like they come and they're beside themselves. (Participant 3)

One participant made an interesting observation, claiming that a woman may be presenting as having a mental health problem when in reality she is in crisis:

> when women come in we say if she might have mental health problems we may need to maybe work with her this way instead of that way right? And so, we talk to each other, colleagues and say you know: "let's give her a couple days, let's let her brain settle" […] and see where she's at there because it really could just be that she's still in crisis mode right? (Participant 3)

State of mental health throughout their stay at the shelter

The participants noted that the residents' state of crisis tends to improve after they have been at the shelter for a few days. Their state of crisis improves throughout their stay because they are no longer in shock, they are safe and supported, and they are taking steps towards finding housing.

> it [state of mental health at arrival] generally improves… yeah. Especially the people who sort of come with that initial shock. Once they sort of are a little bit more climatized to being here and start taking those steps to move out it improves pretty well. (Participant 2)

> Yeah, a lot of women will come down, after they realize that they're being supported […] and that we're there to actually help them out. And they…their bodies can feel safer than were they were than their brains kind of let them relax a little bit. (Participant 3)

Another variable that may reduce the women's state of crisis upon arrival at a domestic violence shelter is familiarity with domestic violence related services. Indeed, women who have accessed shelters or other domestic violence resources before are not as overwhelmed when they arrive at the shelter because they have experienced relocating and are familiar with various social services.

> like I think when we have women who haven't experienced any mental health, I don't wanna say that because everybody will over their life, but sort of aren't living with a sort of more chronic. When this happens they're very shocked but if you've had sort of a more history than you're a little bit more experienced in the system and all the rest of it, and there isn't necessarily that initial shock always. (Participant 2)

Mental health diagnoses frequently seen

All four participants indicated that the most frequent mental health problems seen in women residing at the shelters are anxiety and depression. Although the women's state of crisis improves throughout their stay, three participants stated that almost every woman residing at the shelter is presenting symptoms of either anxiety or depression. The workers are not qualified to

diagnose the women but have indicated that they are very familiar with common symptoms of certain mental problems that they commonly see. Therefore, despite not having a diagnosis, workers are confident that they can identify certain mental health problems in women based on their symptoms.

> most women who come here do not have any kind of diagnosis, but I would guess that 100% of the woman who come here experience depression to a certain extent, and anxiety to a certain extent. I would say about 100%. (Participant 1)

One participant viewed women's mental health problems as a direct reaction to the traumatic situation of being in an abusive relationship and leaving said relationship. According to this participant, if the women were not victims of domestic violence, they would not be experiencing mental health problems.

> yeah well, I mean a lot of them are suffering from what I think could be diagnosed as depression and anxiety, I think that'd be across the board like potentially maybe even all of them […] but that might also be what I've heard is being called like situation specific depression and anxiety disorders right? […] so, there are people where it's like a life long thing that they're always going to be grappling with to one extent or another to certain degrees and then there are people who are having situation specific depression and anxiety which is completely understandable. (Participant 4)

Other mental health problems experienced by women residing at the shelter include borderline personality disorder and post-traumatic stress disorder, but they are not as common as anxiety and depression.

> […] we see things like um post-traumatic stress disorder, we see, we see borderline personality disorder, we see um, anxiety, depression, um we've had a few women diagnosed with schizoid affective disorder and that sort of thing but that's more rare. (Participant1)

> yeah and the PTSD diagnosis, some people have that diagnosis, some people don't. Some people are like self diagnosing based on…symptoms. (Participant 2)

Benefits and disadvantages of having a mental health diagnosis

All the participants identified more benefits than disadvantages regarding obtaining a mental health diagnosis. The greatest benefit was identified as the ability to access specific mental health services such as a case worker from CMHA, supportive housing, and mental health counselling. These services would help women live independently and allow them to overcome

the struggles experienced from living with a mental health problem and being a victim of domestic violence. These specific services are primarily available to people with a mental health diagnosis.

> But my view is that it's very clear to me that women are experiencing mental health and it's also very clear to me that in order for them to access services they need a diagnosis. (Participant 1)

> Sometimes there strait up is an advantage to having a diagnosis because it allows women to have access to help […] there are a lot of programs in the city available to help people that you can only have access to if you have a diagnosis. So, I have seen women in a situation where they're not able to access helpful services that could really really be beneficial to them because they don't have a diagnosis. (Participant 4)

The second benefit to obtaining a diagnosis was that women with mental health diagnoses tended to do a lot better once they left the shelter compared to women who were experiencing mental health problems but did not receive a diagnosis.

> So, what I do know is the women who come here with a diagnosis and who are accessing community supports like CMHA and like maybe have a worker, they tend to do better overall […] like they do better staying with us because they have an extra support they can access because here we are single staffed most of the time. (Participant 1)

> So, we find when women who are connected with resources and that who have mental health problems, and they have diagnoses…they do so well […]. It's amazing the difference […] and sometimes we're like: "oh man, it's going to be really though working with this person" and they do so well because they have all the supports in place right? (Participant 3)

This difference in success was explained by the fact that the majority of women with a diagnosis were connected with outside resources so they were better supported out in the community. These resources could include a case worker that checks in on them on a regular basis, ensuring that they are thriving in their new home. In addition, if a woman was struggling once she left the shelter, she would already have support in place to prevent her mental health from deteriorating.

> it's very clear that the women who have mental health supports fare much better when they move back out into the community because its an extra person, kind of… I think part of it is accountability, like they have someone that's, they know someone is going to be checking in on them, and so they…so that if something goes wrong it's picked up sooner than if they're just out there on their own. (Participant 1)

> […] yeah, they do so well! Cuz they know right, they know "oh if I'm having a crisis, I know who to call, I know where I can go, I know what I can do, I've been given the tools to get myself through this". (Participant 3)

The fact that women with mental health diagnoses do better when they are out in the community shows the importance of connecting women to appropriate resources once they leave the shelter. However, it seems like the most efficient way to connect women to those resources is for them to receive a diagnosis.

Two participants also mentioned that having a diagnosis allows women to have access to medication, which can help the women regulate their symptoms.

> And sometimes medication can help calm that down and normalize it. (Participant 2)

> And I mean medication as well right? […] Some women do a lot better on medication. (Participant 3)

One participant stated that having a diagnosis can help normalize women's experience of mental health, as it can help explain why they are reacting or feeling a certain way. In this regard, the participant said that it helps women realize that what they are experiencing is not due to a personal failure but to their mental health condition. This can lead them to accept their experiences. This participant used an example of a woman who received a borderline personality disorder diagnosis while residing at the shelter:

> We had somebody who was here getting a borderline personality diagnosis and she found it reassuring because it meant that there's a reason behind the behaviours that she has been having her whole life, and why she struggles with relationships and why these things are difficult to her when they don't seem to be difficult to other people. (Participant 2)

One participant indicated that having a diagnosis would allow women to collect disability income from the Ontario Disability Support Program (ODSP) instead of Ontario works (OW). ODSP provides financial assistance to people with a physical or mental disability where as OW is social assistance. Receiving money from ODSP would help these women to financially support themselves and their family compared to the amount of money they would receive through OW.

> With a diagnosis you could you know have disability instead of… [Ontario Works] exactly and so you have more money, right? Which is good especially if you have kids right? (Participant 3)

One participant stated that obtaining a diagnosis allows the workers and the women to speak with a shared language of mental health. It allows them to recognize and understand symptoms, and helps workers better meet the women's needs.

> Um another way a diagnosis could potentially help, […] for me to recognize, ok you're manic right now, or this is a PTSD response so […] recognizing the people that are living with them and working with them recognizing that this is a PTSD response, or that this is a whatever response helps us respond in a way that is going to be most helpful to them. (Participant 4)

Overall the participants named numerous benefits to having a mental health diagnosis. In contrast, there were only two disadvantages named by the participants regarding obtaining a mental health diagnosis. All four participants agreed that there is a certain stigma attached to mental health diagnoses. This stigma can be expressed by external service providers or people that have a negative preconceived notion of people with mental health problems. Although obtaining a diagnosis was mentioned as a benefit as it allows access to many services, it can unfortunately have the opposite effect. One participant shared that some women experiencing mental health problems have been refused services due to the stigma associated with mental health problems.

> [there] is a lot of stigma attached to mental health issues, and sometimes women are not believed like if they experience abuse again and they try and access services it's hard for them to access services because they have a diagnosis and often when women have a diagnosis they'll say that. (Participant 1)

> Other times I think people get…they don't like the idea of labels, they don't like the idea of having to disclose this, they don't like the idea of the world knowing that they have this. And there's still associations of you know the stigma associated to all of it. Like we're a safe place but is the next place a safe place. (Participant 2)

Correspondingly, some women internalise the stigma and carry a lot of shame and guilt surrounding their mental health diagnosis. They view the diagnosis in and of itself as something negative and do not want to be associated with any sort of mental health problem.

> A lot of women don't like to acknowledge that they have mental health problems […] um you know, and we try to educate as well. We say: "it's definitely not your fault if you do" […] "abuse can do that to you, abuse can cause a lot of mental health problems for sure right?" um but they don't want to be a person…that stigma right? Of someone with you know a mental disability, right? (Participant 3)

The second disadvantage to obtaining a diagnosis was stated to be women being prescribed and encouraged to take medication. A participant said that some women do not want to take medication for fear that it will change their natural chemistry.

> and then we have other people who get other diagnosis that they struggle with, one that is not applicable to them and they don't want to take medication because they don't want to change their brain chemistry and they don't… they reject that label of these things. (Participant 2)

Link between mental health, substance use problems and domestic violence

Substance use and mental health problems are often concurrent, as women with substance use problems frequently experience some sort of mental health problems. During the interviews, the participants tended not to make distinction between substance use and substance abuse. When the participants referred to substance use, they were referencing a problematic or abusive use of substances. The participants' views on the link between mental health, substance abuse problems, and domestic violence varied.

First, all the participants agreed that substance use can be used by victims of domestic violence as a coping mechanism. The participants thought that women who experience abuse can turn to substances to help them cope with the experience of being a victim of domestic violence as well as a way to numb the emotions associated with being a victim of domestic violence.

> I know that women who experience abuse are also like more likely to use substances to cope, and to develop mental health issues because of the constant stress that they're under. (Participant 1)

> So, for sure, it's a huge coping mechanism to numb from their experience. (Participant 3)

Three participants also stated that substances can be used by the perpetrators to maintain power and control over their victims. For instance, the perpetrators can force their victims to consume drugs or alcohol so that they develop a dependence on these substances. This dependence on drugs or alcohol causes the women to stay in the abusive relationship in order to be able to continue to use the drugs or alcohol that they are now dependant on.

> you know we've had that with a couple of women whose partners have forced heroin on them, or and then they become hooked on the heroin (coughing) and then they get abused in order to get the heroin like it just becomes that vicious cycle. (Participant 2)

> Substance use can also be used as a part of violence against women […] so for an example we had a woman who was staying with us recently […] and I know that her abuser was using substances to kind of keep her trapped in the relationship with him in this loop of abuse right […] the abuser will feed them substances to get them addicted to have power and control over them. Because a big part of the abuse is power. (Participant 4)

However, the participants' accounts diverged on whether mental health and substance use problems are a consequence of abuse, or whether they put women into vulnerable positions to become abused. Two participants viewed mental health as stemming from domestic violence.

> If I was being abused for years and someone putting me down and you know kicking my ass and making me feel like nothing, yeah, I totally can see myself drowning into depression and using drugs to cope right? […] I think it's more the consequence, yeah. (Participant 3)

> well I mean it's definitely all connected. So, I see…I should put it this way I see mental health and substance use as coming from violence as opposed to the other way around. […] I think that violence is like a societal thing, and a patriarchal thing and there's all sorts of roots to violence but that substance use and mental health comes as a reaction and it can be intertwined with abuse as well. (Participant 4)

While two participants viewed mental health and substance use problems as a consequence of domestic violence, the other two participants viewed substance use and mental health problems as a form of vulnerability to become a victim of domestic violence. Therefore, the participants thought that women who experience either mental health problems or substance abuse prior to entering into a relationship are more likely to become victims of domestic violence. Using substances can create instability in a woman's life, causing her to find herself in unsafe situations. Similarly, mental health problems can cause women to become more at risk of being taken advantage of by a perpetrator.

> well I mean when you're using substances sometimes, you know it can create instability in your life, and it can create a situation where, you know, you're not housed, you're having to rely on friends and family, your couch surfing and sometimes when you're using your judgment is off, and so it just puts women sometimes, in unsafe situations […] and so again it's just about women being taken advantage of when they're in that kind of state, or being in a relationship that's unhealthy and just not being able to set boundaries, to leave or to. (Participant 1)

> So, you can have a mental health issue that you find the substance helps you cope with it but between the mental health and addictions you get yourself into some vulnerabilities that then lend you to be abused […], the abuse causes anxiety which then may increase

> substance use, which then puts you back in a vulnerability for abuse. So, I definitely see them as all sort of tying in together. (Participant 2)

Needs of women with mental health problems

When discussing the needs of women with mental health problems, the participants had mixed opinions. Although the focus is on mental health, substance abuse is often tied in with mental health problems, therefore the participants testimonies will often mention both. Two participants thought that women with mental health problems did not have more needs than the other women at the shelter. The participants believed that women's needs do not vary based on the presence of mental health problems, their needs are just individual regardless of mental health.

> I don't think so. I think it's the same thing, they [women with mental health or substance use] just need support and resources. […] I always say like every single individual needs something different than the woman beside her right? Um but across the board it's just support and whatever that support looks like to that person. (Participant 3)

> I would say…so like you do really get to know the women individually um so…I wouldn't…yeah like the needs of the women vary, I'm trying to think about if they vary based on mental health kind of clusters or diagnoses…I really say it's more individual than that […] you know? (Participant 4)

In contrast, two participants found that women with mental health problems have much greater needs when compared to women without mental health. The workers often have to spend more time working with these women as they need: reminders to complete daily activities, more support completing paper work for housing, and more verbal validation that they are adhering to shelter expectations. When the women are struggling with their mental health, they need more support doing basic things because their mental health problems are preventing them from either remembering or finding the motivation to complete daily tasks.

> yeah I mean, their [women with mental health problems] needs are so much greater, [we] recently we had a woman who was staying with us and she needed SOOO much support from our staff, like she needed reminders to shower, she needed reminders to get up, she needed reminders to eat, […] and so she was taking up many hours on each shift, and so this is sort of a regular thing that we're seeing now, that women coming in and they're just so unwell. (Participant 1)

> Um women with mental health problems and addictions I think need more time with staff than women who don't […] they definitely need more validation with certain things like

> "Am I doing the right thing, am I making the right choice. Am I doing this…?" and its like let's talk about it. You know so there's a lot more one on one I'd say. (Participant 3)

To conclude, the participants saw clear links between domestic violence, mental health problems, and substance use, but whether those problems developed as a consequence of the abuse or put women in vulnerable positions to become abused is still left up for discussion. This link between mental health problems and domestic violence is reinforced when observing the state of women's mental health throughout their stay. Although women's state of crisis improves throughout their stay at the shelter, the majority of the women are experiencing anxiety and depression. Women experiencing these mental health problems can have access to better mental health services if they obtain a diagnosis. However, this diagnosis can bring both internal and external stigma. Lastly, some participants viewed women with mental health problems as needing more support and attention from staff where as other participants viewed all the women as individuals with their own distinct set of needs regardless of mental health problems.

Chapter 5 : The Approaches Used When Working with Victims of Domestic Violence Experiencing Mental Health Problems

This chapter presents how workers intervene with victims of domestic violence experiencing mental health problems. First, the various approaches to intervention workers have adopted when intervening with women residing at the shelter will be presented. Following, the mental health and substance use policies adopted by the shelters will be explored. In addition to these policies, the participants also discuss the shelters' practises during intake regarding asking women if they have any mental health problems. The participants then elaborate on elements that have helped them gain confidence when working with victims of domestic violence experiencing mental health problems. Finally, the participants share examples of successful interventions they have had when working with this population.

Intervention approaches

The participants identified different approaches they use in their work with women who experience both domestic violence and mental health problems, including trauma-informed, feminist, client-centered, and a harm reduction approach.

Two participants said that they use a trauma-informed approach when working with women, which made it the most popular approach used by the participants. A trauma-informed approach includes understanding how trauma can impact a person's memory, reactions, behaviour, and mental health. One participant described her trauma-informed approach as:

> understanding that trauma does affect brain…the brain, it does. So, people might not remember all of the details. People might not keep track of these things. People stories might change. (Participant, 2)

> I think whatever we do in whatever techniques that we use its always trauma informed right? So, it's always coming from a place of we know you've had an experience, we know that's affected you right so let's work from there, let's…let's call it what it is basically, it's…your having a crisis because of X, Y, Z that you've experience right? Let's call it out right so that we can address it right? (Participant 3)

One participant said that she uses a feminist approach to intervention. The feminist approach was described as respecting the rhythm of women, eliminating hierarchal power

relationships, meeting the women where they are, not judging women's decisions, and letting the women guide the interventions. She described her feminist approach as the following:

> because I see women as agents in their own lives […] I sort of take the lead from them as to where they're at [and] how they're managing their life. […] I am not a service provider providing service for you, right? Like, ideally if feminist whatever is that there's no boss, it's a collective […] there's not the power structure that exist in other sorts of…so I try to as much as possible not necessarily assert a power […] and so the feministy part of it is sort of I'll meet you where you're at in terms of… and you guide where we're going with this. […] But I also know that it's their life and it's their decisions so if they're going to go back to their abuser than it's a non-judgment "return to you abuser, we're always here if you need us". (Participant 2)

Another participant described her approach as being client-centered. Being client-centered means viewing women as the experts of their own lives, empowering them, and letting the women take the lead on the interventions.

> So being client-centered to me means that the person I'm working with is the expert of their own life, of themselves. And so, I always want to be…Like I don't want to decide what they need […] I don't have a grocery list of things that you need to do or that we need to work on necessarily, I mean technically because of like the policies I do have certain things I have to do with them. But in terms of working with women I always want it to be um needs based, and based on what your perception of your needs are. […] right? So, I want them to be empowered, I want them to be the driver of their life and of their support. (Participant 4)

However, in her description of being client-centered she named a lot of the feminist principles including favouring a non-hierarchal relationship, breaking women's feeling of isolation, and helping women remove their self blame of being a victim of domestic violence.

> […] one of the approaches that I take is like really trying to be like non-hierarchical, […] there's always going to be a power imbalance when somebody is coming to you for help and I'm the professional who's paid to be here and you're coming to me for help. I try to minimize that power imbalance by not over using jargon or like medical […]. (Participant 4)

> a lot of women feel very alone and very isolated and so one thing I like to do is talk about violence against women, or feminism, or the patriarchy and all these kinds of repercussions of it on a grand scale, I also use statistics sometimes and sociological trends to let them understand that they are not alone or they are not some crazy person, they're not the only person…because they have guilt right? And so, I believe that connecting them to a collective of women or societal trends or anything like that helps them feel not alone. (Participant 4)

> And so, I just want them to realize there's nothing wrong with them, they're not weak, they're not deserving of this, they're not guilty anything right? This could have happened to anyone and everything you did in the context of why you did it makes sense right? And so, I do a lot of that. (Participant 4)

In addition, three participants said that they use a harm reduction approach when working with women who use drugs or alcohol as well as with women who self-harm. A harm reduction approach involves providing women with safe inhalation and injection kits, sterile material if women self harm, condoms, and not forcing an abstinence-based mindset on the women residing at the shelter. When the participants spoke about this approach, it was presented as an addition to their every day interventions and not the core of their work with women.

> […] we also now distribute like safer inhalation kits, no one's ever taken us up on it cuz it's pretty new, and like safe injections kits and stuff […] Um we've done we've had um uhh folks from public health uh public health came to talk about harm reduction like the needle exchange program and stuff like that. (Participant 1)

> we do have harm reduction materials at the shelter, so we have condoms, we have pipes, we have syringes we have all this kind of stuff. (Participant 4)

One participant shared two examples demonstrating how she and other staff members at the shelter effectively integrated the harm reduction approach. The first example was a woman that was drinking in excess and who needed to use alcohol to prevent herself from having severe withdrawal symptoms. The shelter staff allowed the woman to consume small amounts of alcohol throughout the day to prevent her from going into withdrawals.

> We kept a bottle of alcohol in the front-line office and we said: "you know once or twice a day you take this, go off property, do what you need to do, come back bring us that bottle" […] Just to keep her healthy and safe right? Um but we still tried to work with her then, but it got to the point where we had her agree to go to detox and stuff and she found a place for her son to go for a while, so it worked out in the end, but we try to do whatever we can. Because some women just need to be in a shelter and just need that resource and the education and all that. (Participant 3)

The other example involved a woman who was engaging in self-harm. Instead of engaging in an abstinence-based discourse by demanding the woman stop self-harming, the staff at the shelter gave her safe and sterile materials to prevent any further harm being done such as infections when the woman was engaging in self-harm.

> Like we've had cutters and we just give them the materials and say: "that's your coping mechanism, we're not going to take that away from you because what are you going to do when we take away your coping mechanism right?" […] so that's hard too, because I

> almost categorize that the same as a drug, cuz that's her drug right? Like the cutting or the self harm, it's what she needs to do to get through her day. Right? (Participant 3)

Furthermore, two participants mentioned that they have received training on psychological approaches such as dialectical behaviour therapy (DBT), and cognitive behavioural therapy (CBT). Although these approaches do not constitute the core of their interventions, the participants use tools from these approaches to help the women residing at the shelter. One participant said that she uses a lot of the techniques she learned when intervening with women at the shelter and finds it very helpful. One tool in particular, which is called Coping Ahead, helps women prepare for stressful situations.

> So DBT is, it is useful, and I do use it but I find it's really helpful with women with specific mental health concerns right? […] Actually, one that I really like that I keep in my back pocket all the time is coping ahead right? So, I teach women like "ok you know, you have anxiety about this meeting or this whatever you have right? Let's envision worst case scenario, right? What is that gonna look like, what's it gonna feel like. What are you gonna do? Let's actually talk about what you're gonna do. How are you going to cope? How are you going to cope in this worst-case scenario?" So, when they go forward to that situation, if it is the worst-case scenario well they've already practised in their head what they can do to not escalate. (Participant 3)

Mental health and substance use policies

There is no specific mental health policy at the shelters. Their policy regarding allowing women to reside at the shelter focuses strictly on the women's behaviours. Therefore, women with mental health problems are allowed to stay at the shelters as long as they are demonstrating "appropriate" behaviour. According to the participants, "inappropriate" behaviour primarily means that they are verbally or physically aggressive or violent towards staff or towards other residents.

> Our policies are basically that we will serve people who have mental health issues and we will serve people who use substances. However, […] we focus on behaviour. […] so, if someone comes here and they either have a diagnosis or they don't, and they are um, they are using substances or not or they have a mental health issue. Like we will work with them, we will do all the same work we do with other people, we'll try and support them as best that we can and um most of the time that works. (Participant 1)

> Um where we stand now, it's more of a don't ask don't tell […] for both it's sort of if there's violence and aggression is where our end line for all of this is […]. People can have mental health and it's not, we don't have specific policies surrounding it if people

> are sort of getting what needs to get done done and it doesn't get into violence and aggression. (Participant 2)

In addition, there are certain expectations from the shelter workers regarding women's behaviour that women must comply with in order to continue their stay. The first expectation is the ability to care for their children that are residing at the shelter. If their substance use or mental health prevents women from doing so, further steps would have to be taken and the workers may have to involve CAS or ask the women to leave the shelter if she is unable to provide adequate care.

> one of our policies is that you need to supervise your kids at all times, right? (Participant 3)

Another expectation is women must also be able to live independently in the shelter. They must cook and clean for themselves, if they are not able to meet those expectations, they may be asked to leave the shelter.

> I mean generally, you have too…our policy is you have to be able to live independently so you have to cook and clean for yourself so if you're unable to do that because of any you know physical limitations or mental limitations than I mean there's other shelters that they might be more suited […]. (Participant 3)

Lastly, women residing at the shelter must actively be applying for housing. They are not allowed to live at the shelter indeterminately, they must have a plan to eventually leave the shelter.

> like they need to have ID for housing, they need to file…fill out the application. They need to do these…and if somebody does those basic things and then hangs out here for three months before they…then that's again one of those things, then that's fine because we know that there's going to be an end date. (Participant 2)

If these expectations are not being met, or if a woman is demonstrating aggressive or violent behaviours, she would be asked to leave the shelter.

> so we had one person, one woman in particular that it was becoming a big issue and the rehousing was because it was accompanying violent and aggressive behaviour and she wasn't working towards housing […] and so then we can kind of say: "you're not doing anything here with us that is helping you move forward in this, and you're being violent and aggressive, so this isn't working for us so we have to find you somewhere else to go". (Participant 2)

Therefore, the shelters' policies focus strictly on women's behaviours and it applies to all women residing at the shelters, regardless of their mental health.

> […] it's never sort of because of anybody's mental health, um it's not because of anybody's addictions it's sort of their ability to work with us. […] and that stands for people who don't have mental health and who don't have addictions. (Participant 2)

> and this applies for anyone, even folks without any substance use or mental health issues but if their behaviour is aggressive or if they're just not managing well in this environment then we will help them find a more appropriate space, but we don't tolerate any kind of abuse. (Participant 1)

While there is no mental health policy, there are specific policies regarding substance use in the shelters. In this regard, the participants indicated that their policies used to be based on abstinence of all substances but have changed over time.

> And so, we used to have uh just like a total, from what I understand kind of like absence, like you can't be intoxicated, you can't use any of that kind of stuff. I believe that was the policy before my time. And now we've moved to a harm reduction approach where we're saying, we understand that use can be part of the abuse and it can also be part of the coping mechanism right? (Participant 4)

According to the substance use policies, women are allowed to be at the shelter under the influence of drugs or alcohol as long as their behaviour is not aggressive or dangerous. Workers have seen many women come back to the shelter under the influence of drugs or alcohol. In these situations, they simply remind the women not to use on the property. As long as they are not aggressive or violent, they are welcome to stay at the shelter.

> we have a fair number of women who smoke pot which we don't care about. But for the sake of our rules now we just say: "if you don't mind going for a walk down the street and coming back we're fine" […] and we've had people come home drunk, and we've found bottles of wine but its not to the point where we'll ask people to leave because of it, we just sort of keep reminding them that we don't, we ask that this not be used on the property. (Participant 2)

> if you come back under the influence that's fine as long as you…you're not aggressive. It's more the behaviour, right? […] But we experience it often, women will come home high or coming down from a high. (Participant 3)

Although women can be under the influence of drugs or alcohol at the shelters, there are some specificities regarding where women can use substances and where they can store alcohol or drugs on the shelter property. Women staying at the shelters are not allowed to have drugs or alcohol in their bedrooms or other common rooms at the shelters.

> yeah so we say in our policy that there should be no drugs or alcohol on the premises […] Right now single women actually share a room with someone else which is part of the reason why we don't allow alcohol in the house is because some women identify trying

> to abstain … and it's really hard for them if they have a roommate who's then using in front of them or using or whatever, so we don't allow it now. (Participant 1)

> it's like the don't ask don't tell in terms of bringing drugs into the house so like we have conversations with women that you're free to use, you just can't use on property and you can't have the drugs with you on property that we can see. (Participant 2)

All medications including prescriptions for medical marijuana are stored safely in the workers' office. Therefore, women are allowed to have marijuana in the shelters as long as they have a prescription and it is in the office. In addition, the residents at the shelters are allowed to store their alcohol with staff instead of having to hide it in their bedrooms or throw it away. Illegal drugs are not allowed in the shelters and the workers will not store them in the office.

> Uh with alcohol we say, you can't drink on site, but if you have alcohol with you whether it be a mickey, a bottle of wine or whatever it is. If you go out and you buy some and you don't finish it, coming back to the shelter, um you don't have to throw that in a garbage can on your way home. You can leave it with front-line staff, the same way they leave their medication with front-line staff, or weapons. (Participant 4)

> So, if someone like has a prescription right for medicinal marijuana, that's fine, we just need a copy of their prescription and it has to be in their medical bin. (Participant 3)

Certain participants indicated that the shelter is starting to work towards changing their substance use policies in order to allow the residents to store their own prescribed medication. This would allow women to be in complete control of their medication.

> if they have medications we have like cubbies that we put them, and we give medications as they come to us whatever. […] so, if a resident says: "yes I've been diagnosed with this and I have these medications um but I'm not gonna take them and whatever" I'm not going to tell them to, I'm not gonna tell them to "take your meds" that's not my job and it's also not the way we operate. So, I'm not a nurse dispensing medication to people, I'm literally just kind of holding it in a safe place for them so that other people or whatever can't get at them. (Participant 3)

> So, we're actually gonna stop holding women's medications and they're going to start being completely in possession and in control of their own medication. (Participant 4)

In an even bigger step towards allowing the residents more autonomy, one participant indicated that the shelter is debating allowing women to use alcohol on the shelter property.

> we've also been talking about whether we might start allowing women to actually drink on site […] there was a lot of mixed emotions about that at the last meeting, so we haven't come to a conclusion yet. (Participant 4)

In this regard, the participants expressed a lot of ethical concerns regarding substance use on the shelter property. Mainly, there are women in recovery staying at the shelter, it can be triggering from them to see a woman using alcohol on the shelter property. There are also children staying at the shelter, and having women consume alcohol in excess in front of children raises concerns.

> Or triggering other people because a lot of women in the shelter um abuser may have been drunks, may have abused alcohol so seeing somebody who is really drunk could be very triggering to them. Or maybe they're going through their own path of recovery and they don't wanna see somebody who's wasted walking around the shelter because that's going to be really triggering for them. There's a lot of kids around, how do we feel about a woman being super drunk and walking around openly drinking from a wine bottle or something […] with children or like I said with easily triggered women around. That's a piece that I'm still grappling with personally. (Participant 4)

Evaluating women's mental health

The participants reported different protocols regarding asking women if they are experiencing any mental health problems during the intake process. In this regard, three participants explained that they always ask women if they have any mental health problems, diagnosed or not, when they arrive at the shelter.

> We ask the question…but they don't have to tell us anything…most women are pretty open about it, but some people are not and that's ok. (Participant 1)

> So, we do ask them, part of our intake process has all sorts of different questions and we do have questions around mental health, "like do you have any health issues?" And they'll tell us those, "do you have any mental health issues, diagnosed or non-diagnosed, are you on medications and then how do we support you around that?" So, the policy is basically that we do ask and uh we trust whatever they tell us. (Participant 3)

One of these participants mentioned that she tries to do it in a non-judgmental way:

> And so I'll try to say really easy, like I do gage their mental health but I do it in a very kind of relaxed way […] so that they don't feel like they're being kind of like […] interrogated or pulled apart. (Participant 4)

Another participant said that the benefit of asking women if they have any mental health problems is to help them work better with these women. The goal is not to label or judge them but rather to be better informed and to provide them with a better service.

> yeah and so we try not to label women right? So, if they come in we try not to post it everywhere "this person has PTSD or this person is borderline personality" right? We'll share it with each other because it's helpful in working with them because someone with borderline personality you have to be careful sometimes with the words that you use, or you know, presenting negative information you might need two staff instead of one and stuff like that […] we really try to not let that affect the way…the services that we provide. But it helps us to mold our services to that person. (Participant 3)

In contrast, the fourth participant said that it is not a common practice at the shelter to ask women about their mental health problems. Her shelter believes that it can be discriminatory to ask a woman about her mental health problems. In addition, she pointed out that most women self-disclose their mental health problems.

> no well actually we used to have it in our intake assessment and we were told that it's actually against the law to ask those questions… yeah because I think people were finding that, or what people were doing historically with these evaluations is if you disclosed your mental health, depending on what it was you were told you couldn't you wouldn't stay at the shelter. So, then it…as it should, became a question that people shouldn't be asking because you can't deny somebody something based on their mental health… (Participant 2)

Working with women experiencing mental health problems

Two participants stated that they do not see any differences when working with women experiencing mental health or substance use problems compared to working with the other women at the shelter. They viewed each woman as an individual with her own needs. The interventions are different and catered to the needs of each woman regardless of the state of their mental health.

> I really don't have a difference in how I deal with them because every…I might be working with a woman who has PTSD or a woman who has bipolar but in my eyes I've known you well enough to know that these are your triggers, and these are your reactions, and these are your behaviours and that's kind of how you operate as a person […] So having a name for the way one woman operates and not having a name for another women is really irrelevant. Yeah its about getting to know them and getting to know what their needs are. (Participant 4)

> I think I treat them generally all the same. […] I think especially that initial sort of getting to know you sorts of things and then we sort of get a sense of people's personalities and levels of volatility and response to you […] and so then and that can be tied to mental health and addiction and it can be just tied to personalities. (Participant 2)

In contrast, some participants found that there was a difference when working with women experiencing mental health problems compared to the other women. They found that women with mental health problems required more time and attention from staff. Workers tend to keep a closer watch on women struggling with mental health problems in order to ensure that they are doing well.

> If somebody self discloses that they have you know diagnosed depression or chronic whatever, um do I keep a different eye…do we all keep a different eye on that person? Yeah. We might keep a bit of a closer eye in case we notice struggles like we don't wanna leave people hanging, we don't wanna leave people to have to come to the office but we'll…so we'll sort of say: "ok we know this about this person so lets just keep an eye on how their doing". (Participant 2)

> again, like I think there's just more time and effort that's needed with women with addiction and mental health like…because there's more behaviours I think to work around. (Participant 3)

Gaining confidence as a shelter worker

When the participants were asked how confident they feel intervening with women experiencing mental health problems, they all answered that they feel confident today but that was not always the case. The main thing that helped them feel more comfortable in these situations was experience. The more they worked with women experiencing mental health problems, the more confident they grew to be.

> I think just with experience and education, right? […] so, you know sitting down and having a nice conversation with a woman with mental health problems is you know…not gonna learn a whole lot there, maybe through conversation, right? […] it's the crises that are where you learn those skills […] We're dealing with it two-five times a day, and over ten years… (Participant 3)

> um experience for sure, and also just seeing that I've been successfully able to help women who are having a mental health crisis […]. So, when you've never done it before you're not sure if you can do it, and then once you've done it once, and then twice and then 10 times, and then 100 times then you're like "alright, I can do this, I feel confident that I can help you". (Participant 4)

The second thing that has helped the participants feel more confident was mental health and substance use training, which helped them become more familiar with different mental health or substance use problems.

> and now lately I'd say in the last three or four years we've been doing a lot of training […] and a lot of training is you know around working with women with mental health, working with women with addictions, working with women in sex trade. Like you know and so we get the idea of what their individual needs are for most of those things right? […] So I feel a lot more comfortable. (Participant 3)

> I think it does help that I do have a mental health background, that I have my psych degree and that I do know a little bit about…when I'm working with women I can recognize like oh that's part of like…I can identify what's happening and why. The kind of like the motions and behaviours that they're going through. And because I think that I have that kind of tool in my pocket […] almost that like language, like a dictionary term like oh I can see what's happening here. Um I think that does help. (Participant 4)

One participant mentioned that having an extra staff member present helped her feel more confident when intervening with a woman that has mental health problems. She explained that women with mental health problems tend to misinterpret or perceive certain things said by workers in a negative way. Having another worker presents helped her to feel that she could intervene with a woman experiencing mental health problems without fear that the woman would go to the director to complain about something the worker said or did that may be false.

> it definitely feels better when there's another staff person, even if that staff person says nothing. If they're just there, as almost support for me you know it makes things easier […] And it's just like "Ok I can say what I need to say without feeling scared that she's going to say that I did something that I didn't or said something that I didn't" […] right which happens a lot with people who have mental health problems. (Participant 3)

Successful interventions with women experiencing mental health problems

Participants shared many stories of successful interventions, which consisted of being able to work in collaboration with women experiencing mental health problems and helping them achieve their goals. In this regard, the participants identified two factors that lead to successful interventions with women experiencing mental health problems: creating a good rapport and listening and respecting the women's needs.

Three participants indicated that creating a strong rapport with women helped in having successful interventions. The workers were able to build a strong rapport by being kind and fostering a trusting relationship with the women, where they would not feel judged.

> we had another woman stay with us a couple summers ago and she became, she identified as having borderline personality disorder and she also was a cutter… so we just, we worked with her and for her the biggest thing was developing trust with the staff because

> she didn't, she hadn't had a lot of positive relationships and she just really didn't trust people but when she got to know our team and a few workers in particular worked really really hard and really really well with her. She ended up settling and like the person, her behaviour when she came in compared to her behaviour when she left was like night and day like completely different. (Participant 1)

> From what has been reflected back to me I think that because I am not pushy and I'm able sort of able to build the rapport with women before I start…before we start getting into anything deep or hard or um and because I sort of put it on them they don't see me as sort of a like an agent of the system. (Participant 2)

A participant provided an example of a successful intervention with a woman with a substance use problem where they created a relapse prevention plan. The woman used the plan several times to stop herself from consuming alcohol. The intervention was successful because the worker built a strong rapport with the woman where the woman did not want to let the worker down.

> […] she and I got along well though […] We would spend a lot of time sort of talking where she's at with her mental health and dealing with her anxiety and she and I had created sort of that relapse plan and she did say that she had used it quite a few times to sort of stop herself from drinking […] and uh I had gone away for a period of time while she was staying, she was, when I came back she was like: "you were the Jiminy cricket in my mind every time" […] and then when she came back and visited us she sort of had said like how that had helped her at that time and how you know two years later in my head she's still…because I think she and I had sort of developed that…like a close relationship, […] rapport that she also didn't want to let me down […] and so that sort of had helped bridge that gap until she was able to sort of get the self motivation to maintain her own sobriety. (Participant 2)

Another participant shared a similar story where she was intervening with a woman with mental health problems and the positive rapport they had built helped make their interventions successful. They were able to form a strong bond because the worker followed her from the intake process through her entire stay at the shelter. This rapport allowed the worker and the woman to work together successfully and to meet the woman's needs.

> she was manic-depressive […] and so I just was able to develop a rapport with her and use different techniques. I think that I was just lucky to work with that woman because I was the one who did her crisis call, and her intake and so she almost like bonded with me really strong because I was the one that intook her and her kids into the shelter. And then uh my counselling style and her needs just lined up really well. (Participant 4)

In addition, three participants said that listening and respecting the needs of the women helped to make an intervention successful. The first participant was able to help meet the needs

of a woman with mental health problems simply by sitting down and listening to what she needed.

> I sat down with her and actually we put in in writing : "so when you're anxious, these are, like what are some things that can help" and she identified some things that helped her, like taking some deep breaths, like saying, like just saying the words "I can't talk to you right now because I'm getting really mad" […] and then I asked her to identify what staff could do to help her when she's in that moment and her response was something like "well just tell them to let me go" or like "ask them to remind me to take a break" or whatever. So, we put that all in writing and she had a copy and we had a copy and then she was ok because we followed that while she was staying here um so I think, yeah that's what we learnt form that situation, we should have those conversation sooner rather than later. (Participant 1)

Another participant said that listening to women when in crisis and breaking down the situation helped with providing an optimal intervention. This participant shared an example where she was able to listen to what the woman needed and helped in problem solving. The woman felt heard and respected which helped resolve the crisis situation.

> I mean we have women who come into the office in crisis everyday right? And it's really just talking them down to a place where it helps them organise their thoughts right? Cuz sometimes they just don't realize why they're in crisis. So, you have to say like: "alright lets break it down" […] but sometimes its just "what happened in the last 24 hours or hour" […] like what, what happened? Ok let's break that down, "Oh you got a call from your ex, oh it's cuz you have court coming up, oh you don't have a lawyer yet, ok well yeah of course you're panicking, let's do that". Like "Oh I have access to legal aid?" "yeah of course you do!" so lets…let's do that right? (Participant 3)

To conclude, the results presented in this chapter relate to direct interventions with women who experience both domestic violence and mental health problems. First, the intervention approach most commonly used was a trauma-informed approach, which attempts to understand how trauma can affect women. The policy regarding women's behaviours as well as the substance use policies shape how workers intervene with women. All women experiencing mental health or substance use problems are welcome to stay at the shelter as long as they are not aggressive or violent and they are continuously meeting shelter expectations. Many participants saw an advantage to asking women is they had any diagnosed or undiagnosed mental health problems as it could help them to better meet the women's needs. Additionally, working with women experiencing mental health problems may require more time and attention from staff, however the workers still feel confident working with this population. Lastly, creating a strong

rapport and listening and respecting women's needs were essential to having a successful intervention.

Chapter 6 : Challenges When Working with Women Experiencing Domestic Violence and Mental Health Problems

This chapter presents the challenges and potential solutions to helping victims of domestic violence experiencing mental health problems. First, I present the organisational challenges workers face working in the shelter with women experiencing mental health problems. These organisational challenges refer to the challenges found directly in the shelter which include workers not being experts in mental health, working with women demonstrating aggressive behaviours, not having enough staff on site, and feeling powerless. Following, I present structural challenges stemming from various external organisations and policies. These challenges include the housing crisis in Ottawa, long waiting list for mental health services, the laws surrounding violence against women, and police and CAS response to domestic violence. Lastly, this chapter concludes with potential solution to these challenges.

Organisational challenges

The participants expressed challenges they faced while working with women who had mental health problems. The challenges encountered included workers not being experts in mental health or substance use problems, the residents demonstrating threatening or aggressive behaviour, not having enough staff working at the shelter, and feeling powerless in certain situations.

The participants felt like their lack of expertise on mental health problems prevented them from helping women in addressing and overcoming their mental health problems. As two participants pointed out, they did not feel equipped to help these women:

> And I'm not sure what…you know I've talked a lot about this with [staff member] and my other co-workers and we can't necessarily know what we could have done better. But then again, none of us are addictions experts. (Participant 2)

> and I mean we're also not mental health professionals, right? So, it's hard not knowing everything about certain um…certain mental health problems. (Participant 3)

In this regard, a participant explained a typical situation where she would have a difficult time intervening with a woman with mental health problems. If a woman cannot be talked down

from an anxiety crisis, this worker does not feel like she has the tools to adequately help the woman overcome that mental health episode.

> Um if a woman just can't be talked down or um from hyperventilating, or anxiety where she can't cope right? And If were not really getting through to her or she just can't stop moving almost and she just can't stop physically moving. (Participant 3)

Two participants said that, when they are not able to manage the women's mental health problems, they will sometimes try and get women to go to a women's homeless shelter that specialises in mental health or refer them to other programs. They acknowledged that the women generally do not want to go to the homeless shelter, even though they can receive better mental health services there than at the domestic violence shelter.

> yeah and we do offer women, like single women that… [homeless shelter] […] they have mental health professionals there, they have nurses there, they have mobile crisis like there everyday, they've got everything, they have psychologist and psychiatrist that role through there everyday to speak to the women. […] we think actually she's gonna thrive there, she's gonna do great because she has those supports there she can get […] the resources that they have that we just don't […] yeah, it's sad, it'd be great if we did but we just don't. (Participant 3)

> because they've come to us we feel this obligation to keep them and continue working with them because we developed a relationship and they don't wanna go to [homeless shelter], or they don't wanna go to the hospital, but then at the end of the day when we're looking back we're thinking wow would this person have been better served at the Royal Ottawa or at [homeless shelter] where they would have had those mental health supports? […] it's tough, it's tough when you're trying your best to help people when they have concurrent problems. (Participant 4)

The second most common challenge experienced was when the workers had to face women's threatening or aggressive behaviour. Again, they did not have the tools to help women that were being aggressive. For example, one participant shared an example where a woman residing at the shelter was yelling at the other residents and staff. The workers had to prioritise the safety of the other residents and had to ask this woman to leave the shelter as her behaviour was too aggressive.

> we ended up having to ask her to leave… because she was um, she was yelling at, like just randomly going up to other residents and like yelling at them […] and yelling at staff and um when we intervened in those circumstances she wasn't able to think about the situation in any kind of logical manner […] she was yelling at people and she wasn't able to contain that behaviour long enough to be ok here. […] We're balancing the needs of everyone in the house it wasn't, we felt that it wasn't safe for the other clients for her to

> remain here […] we worried whether that verbal aggression would turn to physical aggression because it was pretty significant, and she was like getting up close to people's face. (Participant 1)

In addition, two participants said that not having enough staff on site makes intervening with a woman in a crisis much more difficult. Indeed, having more staff would provide workers with the necessary support, and help them feel safer.

> […] If I'm alone in the house and there's no other staff and there's you know a resident who had mental health and she's quite aggressive right? And I might fear for my safety a little bit that's where I feel like I'm not equipped to deal with the situation by myself […] so, I need either another staff to come in. Sometimes that's not possible because were non-profit right? We can't pay for that. (Participant 3)

One participant also said that the lack of staff on site does not allow her to know the residents as well as she would like, which could in turn allow certain preventable crises to happen. One participant elaborated on a situation where a woman got aggressive and threw water at her CAS worker. Because there is not enough staff at the shelter, the worker was not able to spend an appropriate amount of time getting to know the woman and learning what some of her triggers were. This resulted in a situation that escalated that could have been prevented had the worker had more one on one time with the woman.

> I think if I had been able to spend more time with that one client which it's hard because we're singled staffed and we have to manage fifteen people right? If I had gotten to know her more, had that time to spend with her, I probably would have recognized, ok like when she has meetings, she can't have things in her hand, she needs to be in a room where there's nothing around or let's have this meeting outside […]. So, there's things like that right? Which unfortunately we don't always get to know the women as well as we should right? Because then we would know even better how to work with them. (Participant 3)

The lack of staff also impacts the quality of service workers can provide to the women. Having more staff would enable them to better meet the needs of the women experiencing mental health problems, as they would be able to spend more time one on one with them and to offer additional programs.

> It's really hard for the women because they just need so much more than what we can give them, but we know that that doesn't actually really exist anywhere else, so were just doing the best we can with what we have but it's draining for the staff, it's draining and it's just also hard for them to do all the things they need to do.[…] we need more support for these women because were basically (pause and sigh) we're doing the best we can, but it's not enough. (Participant 1)

> I think I would like to see […] groups in the shelter for things like substance use, or…there could be a ton of different groups actually for things like mental health um whatever it maybe be, I would like to see that happen as well. […] Uh I think it's kind of dandy that we're encouraging women to find those services outside the shelter and if that's the best we could do right now then fine, but it would be great if we could make it more accessible to women by having it in house. (Participant 4)

Furthermore, two participants said that they had felt powerless in certain situations, especially when working with women with substance use problems. They found it difficult watching a woman suffer and misuse substances and not being able to do anything about it. This participant shared a story where a woman was using alcohol and Adderall in excess. Despite her best efforts, the participant felt powerless in this situation and the woman continued to misuse these substances.

> […] You would have a really great conversation with her [about not using] and then 20 minutes later she's gone up to her room and gotten drunk and then come back downstairs. And you're like "that wasn't our plan!" right? "our plan was for you to call me if you're feeling like…" and it would be like that, like that quick! It would be like we've had this really great conversation about whatever and she'd go upstairs and take two Adderall and you're like this is not where we're… (Participant 2)

A final organisational challenge is the amount of time women are allowed to stay at the shelter. The majority of the participants said that the average length of stay at the shelter is around three months, which does not allow them the time to help the women as much as they would like.

> yeah and depending on people's situations it can be a history of abuse and it can be a history of something to sort of try to work through in the 16 weeks while they're in here while they're in crisis. So, it's a little bit of a tricky situation. […] you know we can't support somebody for six months as they begin to work through that, because it becomes too…we'd be full all the time with people who haven't left here, and living here isn't healthy either. So, like it's a hard balance […]. (Participant 2)

Structural challenges

The participants named five structural challenges. Although some of these challenges may not address the issue of mental health directly, they impact the transition of women who experience mental health problems, from the shelter into the community as well as punish women for being victims of domestic violence. The challenges identified by the participants are the lack of subsidised housing, the long waiting lists for mental health services, the problematic

laws surrounding violence against women and the police and CAS's response to violence against women.

Two participants identified the lack of affordable housing in Ottawa as a challenge, as it results in women staying longer at the shelter. It should be noted that this situation also limits the shelters ability to help more women. In addition, if housing was more affordable, more women would be able to move out of the abusive relationship and relocate immediately in a new home instead of having to stay at a domestic violence shelter.

> […] so much of what we are able to do is limited by what we're able to do, like the external structures. I would like there to be more low-income housing […] we also know that there's a severe social housing shortage and that it's taking longer for people to get into like the good neighbourhoods and you know like so then people are here longer. (Participant 2)

> affordable housing [is a barrier] cuz housing is the number one reason that women experiencing violence end up in shelters instead of just moving out […] cuz they can't afford to move out […] and if they could afford to move out they wouldn't be in a shelter […] So the reason women need to be in shelters because there is no access to housing. (Participant 4)

Additionally, two participants thought that there needs to be significant changes in the laws for violence against women. They thought that the legal consequences for the perpetrators of domestic violence should be stronger, which would result in women not needing to go to a shelter. If men were punished more strongly, or if they were the ones being asked to leave the home instead of the women, there would not be as much of a need for domestic violence shelters.

> Ultimately, I would like the laws to change […] Violence against women. I would like to not have to have shelters. Like I would like the consequence of abuse to be stronger for men […] so that women don't have to come into shelters. That's my ultimate goal. (Participant 2)

> Like why do we need shelter? Why don't we have shelters for men who need to you know have their own counselling on … […] on not being abusive ass holes […] sorry it's true right? Like they have those programs, stick all the men there! […] why do women have to be sent. (Participant 3)

Two participants also mentioned that the waiting lists for counselling or mental health services are too long. Women are not getting the help they need when they leave the shelter which can cause their mental health to worsen. In this regard, one participant would like to see

counselling services immediately available, more longer-term support, and shorter waiting list for mental health case workers.

> adequate counselling services available so that it doesn't take six months for women to access counselling outside of a shelter […] I would like counselling to be available longer than 6-8 sessions in the community so that women who have had historical trauma, women who have experienced abuse are getting the more longer-term support that they need. We all know that they need. I would like there to not have a three to four-year waitlist for a CMHA worker […] I would like to not have to send women into vulnerable environments because we have…that's all that there is available. (Participant 2)

In addition, the second participant found that the mental health counselling waiting lists were too long. She found that by the time a woman could finally see a counsellor, so much damage had occurred to her mental health that it could be irreparable.

> the waitlists for counselling are honestly a human rights disaster, that waitlist for counselling are years. To get into addictions counselling in Ottawa at Amethysts or most places its years. People die on waitlists that are years […] and if they don't die then they get to the point where they're just…their lives are irreparably damaged. Yeah there's no coming back from it. And also, when you tell and individual that the waitlist is years […] you might as well tell them that the service doesn't exist. Because to somebody in crisis, days feels like a long time […] years basically doesn't exist. (Participant 4)

One participant said that there needs to be more education done with police and the Children's Aid Society as she felt that their response to women victims of domestic violence is often unempathetic and unhelpful. She indicated that police are penalising women for engaging in self defense from their perpetrator and are also doubting women when they come forward to make a complaint against their abuser.

> We're still seeing that women are being judged or almost penalised by police for calling the police […] yeah, we see women being charged for fighting back. Like the police will say: "oh you're being abused? You and your kid…if you don't like the situation you need to leave". […] Anyways it's just the police need to do a better job, they need to put more time into investigating than they do. They'll just come in like "oh you don't have any bruises, you obviously weren't abused". (Participant 3)

The participant said that CAS often tells women the only way to protect her children is to leave the abuser. Not only does this not help to end the cycle of abuse, it demonstrates that CAS does not completely understand the cycle of abuse.

> CAS will tell women: "we're going to apprehend your kids if you don't leave your partner", well that's hard for some women cuz at the end of the day they still love them. we've had these conversations with CAS where we'll sit down and they say: "well we

> have to have women leave, how else are we going to protect kids" and like well you're not doing anything to protect that woman […] yeah you're not helping her at all […] you're not helping end the cycle. (Participant 3)

Solutions

The participants all shared possible solutions to overcoming these organisational and structural challenges, which include mental health support in the shelter, more staff, and better housing options for women who experience both domestic violence and mental health problems.

First, the participants argued that mental health services could be offered directly in the shelters, in the form of either a mental health nurse or a mental health worker. These specialised workers would be able to address the women's mental health problems, while the front-line workers would be able to focus on both domestic violence and housing issues.

> If we could have our own mental health worker that would work with them here in the shelter and then follow them when they leave … to ensure that they maintain their housing and that they're stable and that they have that kind of accountability piece to check in with someone. Um yeah, that's what I think. They just need more support. (Participant 1)

Another participant thought that the mental health workers' expertise would be beneficial as it could help shelters better meet the needs of the women who experience both domestic violence and mental health problems. Also, if they were able to have a mental health nurse in the shelter, they would also be able to dispense medication to women in crisis.

> I mean their [mental health worker] knowledge right. They're gonna know a lot more than we do. They're gonna have more crisis intervention techniques with women specifically with mental health problems that we just don't right […] um…they might have access to more resources as well than we do or be able to get them in to see a doctor, or maybe they prescribe medications depending on what kind of mental health professional they are right? […] so not all women like medication but I mean sometimes in a crisis right there's some medications that work immediately […] yeah otherwise their a danger to themselves and to the people right? […] and we couldn't administer that right? (Participant 3)

According to the participants, another solution would be to create partnerships with mental health institutions like the Royal Ottawa Mental Health Centre, to allow women to have mental health assessments. This would help provide a diagnosis to women in a timely manner, which would allow support to be catered to their specific needs.

> I would like is for us as a shelter, and for all of the shelters to be able to do this for their clients is that we have in the house, we have mental health supports. I would love to have some kind of partnership with like the ROH or somewhere somewhere, or someone who could do um uh, priority assessments with women, just to have them assessed to figure out what is going on. Because some, some women like are not, they're not just going to get better. (Participant 1)

Another solution is for shelters to employ more staff. However, the participants mentioned that shelters would require more funding to be able to employ more workers.

> more staff would allow us to do so much more, we'll do more education because someone taking care of housing applications, if we had a housing worker and we had you know someone doing all these other things we'd have so much time to just sit and talk women down or you know so much more good could be done, we could educate them so much more. Right? Let's really talk about abuse and the cycle, like really get into it instead of you know one hour conversation about the cycle of violence which you know you'll retain for a bit and some women you know fully get it right? but I don't know we could do so much more. And so much more programs like we could run groups, like that would be amazing. (Participant 3)

To conclude, the most common organisational challenge the workers face is not being experts of mental health or substance use problems. They also have a difficult time intervening with women who are demonstrating threatening or aggressive behaviour. Additionally, the workers feel like the lack of staff at the shelter, as well as being powerless in certain situations creates many challenges with working with this population. There were many structural challenges named by the participants. The lack of affordable housing in Ottawa and the long waiting list for mental health services affects the women's transition from the shelter back into the community. The laws for violence against women are not resulting in the perpetrators being punished adequately which results in women having to go to a shelter in order to be safe. Furthermore, the police and CAS are not well educated about the cycle of abuse. Their lack of education is reinforcing the cycle of abuse to be continued. Participants named several solutions to overcome these challenges such that include more staff, mental health supports in the shelter, and shorter waitlist for mental health services.

Chapter 7 : Discussion

This discussion focuses on significant themes that arose in the results of this research project. First, I discuss the participants perception of domestic violence and mental health problems. The mental health diagnoses seen, and the participants view on the link between mental health and domestic violence will be examined in further detail. Next, I will dissect the advantages and disadvantages the participants perceived to obtaining a mental health diagnosis. Following, I debate the presence of a feminist paradigm in the intervention approaches and shelter policies. Finally, this chapter will conclude with a brief explanation of the current professionalization happening in the shelter.

This discussion will draw upon my theoretical framework, which encompasses both the medical and the feminist paradigms. The medical paradigm views mental health problems as a biological disorder that can be treated with both pharmacological treatments and/or psychotherapy (Beecher, 2009; Craighead & Dunlop, 2014). Conversely, the feminist paradigm views the development of women's mental health symptoms as a reaction to an event and to the multiple oppressions they face (Berg, 2002; Halliday, 2005). Both paradigms have opposing views of psychiatry and the appropriate or most successful way to intervene with women experiencing mental health problems. It is important to remember that historically, psychiatry has been a male dominated field that has pathologized undesirable characteristic in women as being problematic (Burstow, 1992). The feminist approach to intervention was first developed as an alternative to psychiatry and attempted to challenge the role of psychiatrists (Corbeil & Marchand, 2010; Côté, 2016). Consequently, shelters have traditionally used a feminist approach to intervention (Prud'homme, 2010). Feminist interventions focus on both individual and political change. They embrace a socio-political view of violence against women and continue to strive for collective and political change and activism (Corbeil & Marchand, 2010; Glenn & Goodman, 2015).

Domestic violence and women's mental health

The participants described the women arriving at the shelter as being in a state of crisis that could resemble a mental health problem. Although they said this state of crisis subsides throughout the women's stay at the shelter, the participants also said that almost all the women residing at the shelter experience symptoms of either anxiety or depression. It was interesting that PTSD was not identified as one of the most common mental health problem by the participants, as research suggests that it is the most common mental health problem in women victims of domestic violence (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008).

With regard to the link between domestic violence, mental health and substance use problems, the participants had opposing views. At times, participants' accounts reflected a feminist paradigm. In this regard, all of the participants viewed substance use as a coping mechanism which is one of the most commonly cited reason victims of domestic violence turn to substance use (Campbell, 2002; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; O'Brien, et al., 2016). Additionally, some participants viewed the development of mental health and substance use problems as stemming from domestic violence. A feminist paradigm not only attempts to understand how the various oppressions women face can impact their mental health, but also encourages women to see how her behaviours are a reaction to an event as opposed to a biological defect, therefore eliminating personal blame (Hill & Ballou, 1998; Berg, 2002).

Moreover, the participants engaged in a feminist paradigm by understanding how perpetrators can use drugs and alcohol as a way to maintain power and control over their victims. This also shows that the participants clearly understood that the core of domestic violence is a desire to maintain power and control over a person by using different tactics such as regulating her behaviours, exploitation, and intimidation (Stark, 2007). They considered that the perpetrators were controlling their victims' behaviours by creating a dependence to drugs or alcohol, by forcing the women to consume these substances, and then using drugs and alcohol as a tool to maintain power and control.

In contrast, some participants mentioned that both mental health and substance use problems can cause women to be more vulnerable to abuse. This discourse is problematic, as it blames the women's individual characteristics for being a victim of domestic violence. Indeed, the fact that women are seen as being vulnerable to abuse puts the blame on them as opposed to

the perpetrators. It is essential when using a feminist approach to avoid judging women and to especially avoid insinuating that women are in any way the ones responsible for the abuse (Corbeil & Marchand, 2010).

Mental health diagnosis

The majority of the participants asked women during the intake process if they had any mental health problems diagnosed or undiagnosed. This practice goes against a feminist paradigm. Feminists believe that a diagnosis reinforces the idea that the victim is defective (Berg, 2002). This tendency to identify mental health problems and to label women shows the influence of a medical paradigm, even in feminist organizations. Although women are not forced to disclose anything to the workers, by simply asking the question, the workers are positioning themselves in an authoritarian role and are viewing the women as a client, not an equal.

Moreover, the participants were able to identify certain mental health problems in women based on their behaviours with the absence of a diagnosis. One participant said that most women do not have a diagnosis but that almost all of them are experiencing anxiety or depression. Implying a diagnosis is pathologizing women's behaviours (Berg, 2002).

Additionally, the overwhelming consensus of the benefits of having a diagnosis is once again influenced by a medical paradigm. Some participants stated that a benefit of obtaining a diagnosis was the possibility of having prescribed medication to treat the mental health symptoms. In this regard, the participants considered medication the solution to fixing certain behaviours consistent with mental health problems such as anxiety.

According to the participants, a very interesting advantage of obtaining a diagnosis was that women had a higher chance of transitioning successfully to the community, as they would have better access to mental health services compared to women without diagnoses or a mental health problem. This speaks to the importance of supporting women with relevant resources once they leave the shelter. It is not necessarily the diagnosis that helps the women, but the extra resources available to them because of that diagnosis. In this context, some feminist workers struggle if they are critical of diagnoses and the institution of psychiatry but know that it is the only way for women to access certain resources once leaving the shelter.

The participants also mentioned that the primary disadvantage to obtaining a diagnosis was the stigma. Feminist have criticized psychiatry of pathologizing certain undesirable characteristics of women such as demonstrating anger and aggression (Shaw & Proctor, 2005). This can play a large part in the stigma associated with mental health problems. Women can internalize this pathology as there being something wrong with them.

Intervention approaches

A trauma-informed approach was more commonly used than a feminist approach in their work with women who experience both domestic violence and mental health problems. It could be argued that the trauma-informed approach named by two participants finds itself between a feminist and medical paradigm. The participants said that they try to understand how trauma can affect the brain and how this may influence the women's behaviours, which is deeply rooted in a medical paradigm. However, this approach was also described as understanding that the women's behaviours could be a reaction to a traumatic event as opposed to an individual defect (Berg, 2002). This helps remove blame from the women and helps them to see that they are simply in a state of survival following a traumatic event, which can understandably affect her behaviours and emotions.

One participant said she uses a feminist approach and another one said that she uses a client-centered approach. Although both participants labelled their approaches differently, I consider both of them as embracing certain key feminist principles in their interventions such as: respect, equality, empowerment, breaking isolation, and rebuilding self-esteem in their interventions (Corbeil & Marchand, 2010). The participants viewed the women as the experts of their own lives, they believe that women knew what their needs were. By viewing women as the experts, this also creates a relationship of equality between both the workers and the women. Their approaches also work on breaking isolation by helping women come to the realization that violence against women is a societal problem and that they are not alone. They also discuss how the multiple oppressions faced by women can affect their mental health (Berg, 2002; Corbeil & Marchand, 2010). Additionally, when discussing the components that made their interventions successful, the participants indicated the importance of establishing and maintaining a trusting relationship as well as supporting and respecting the rhythm and choices of women seem to

reflect key feminist principles (Corbeil & Marchand, 2010). These two concepts could be applied to all interventions, not just ones with women with mental health or substance use problems.

Although the participants applied certain feminist principles, I would not consider their intervention approaches exclusively feminist as they were missing important political components. One of the objectives of feminist interventions is to encourage women to become involved in their communities and to participate in activities that promote social justice and equality (Corbeil & Marchand, 2010). The political issues surrounding violence against women as well as those surrounding mental health were not subjects that were addressed in the interventions. This was surprising because, domestic violence shelters have historically prided themselves on their political character (Côté, 2016). The individual parts of their interventions adopted key feminist principles, but their inventions did not incite any collective change.

Additionally, a few participants indicated that they have received training for certain psychological approaches such as dialectical behavioural therapy, and cognitive behavioural therapy. These are typically used in psychology and have the goal of reducing symptoms of the mental health disorders (Craighead & Dunlop, 2014). The presence of psychology-based approaches in domestic violence shelters was interesting, given that shelters originated in an attempt to offer an alternative to traditional psychological approaches (Côté, 2016). Not only were psychological approaches being used in shelters, but the participants thought that the trainings they had received had been beneficial. It seems that workers are seeking to become more specialised in mental health therapies.

This specialisation in mental health interventions was also demonstrated with the participants desires to employ mental health workers and nurses at the shelter. The workers lack of expertise in mental health and substance use problems has been expressed as a significant challenge while working in the shelter. More mental health supports are seen as an asset to the workers.

Mental health and substance use policies

Shelter policies diverged significantly from a feminist paradigm. Although the participants stated that women with mental health or substance use problems are welcome at the

shelters, this policy focuses on the women's behaviour. It is giving the workers the power to decide what is an appropriate or an inappropriate behaviour. First, shelters have a zero-tolerance policy for violent or aggressive behaviours. Understandably, the safety of all the residents and the workers has to be taken into consideration, but the solution to a woman demonstrating threating behaviour is to find an alternative housing situation at the local homeless shelter. Asking these women to leave the shelter can place them in a very vulnerable position where they are at a greater risk of returning to their abuser. Additionally, the shelters have created an expectation for women to care for their children, to continuously apply for housing, and to live independently while they are residing at the shelter. Women are being asked to conform to these predetermined desired behaviours to ensure they can continue to stay at the shelter. The shelters are contributing to social oppression by forcing women to meet all the expectations and by excluding those with "inappropriate" behaviours. Psychiatry has been seen by feminist as an institution that has little tolerance for differences (Burstow, 1992). These shelter policies can be seen as subscribing to a medical paradigm by being intolerant of certain behaviours that they deem to be problematic.

Although these policies are not consistent with a feminist paradigm, they seem to be representative of current policies in domestic violence shelters. Shelter are creating rules related to admission criteria, maintaining confidentiality of the shelter's location, completion of chores, maintenance of the shelter living space, curfews, job/housing searches, and prohibition around substance use and violence (Glenn & Goodman, 2015).

Professionalization

According to the participants, the most difficult part of intervening with residents at the shelter who had mental health or substance use problems was that the shelter workers are not experts in mental health. The professionalization currently occurring in shelters was clearly demonstrated by the workers desires to become experts in the field of mental health (Côté, 2016). Although becoming more informed about mental health problems can help workers feel more comfortable working with this population, becoming more specialised is moving shelters away from a feminist paradigm.

This shift away from a feminist paradigm was evidenced by the absence of political activism. As stated previously, feminist intervention is rooted in helping women gain insight on their current oppression and using this insight to help incite a collective and political change (Corbeil & Marchand, 2010). The majority of the participants did not view the systemic oppression of women, gender-based policies for example, as a challenge in their interventions. The challenges that the workers face focused more on individual difficulties, such as not being experts in mental health and working with women demonstrating aggressive behaviours. Focusing on collective issues that impact victims of domestic violence is a core objective in feminist interventions (Corbeil & Marchand, 2010).

Other challenges mentioned by the participants included: lack of staffing, the limited length of stay at the shelter, the lack of affordable housing in Ottawa, the laws regarding violence against women, and the long mental health waiting list. The shelters are limited with the amount of funding that they receive, therefore, they are financially limited in the services they can provide. The feminist response to these problems would be to change the policies and laws surrounding domestic violence. However, it seems that engaging in that sort of political activism is not realistic for these shelters as they are already struggling to meet the needs of the women staying at the shelter and they do not have the resources to also fight for policy changes.

Conclusion

This qualitative research project explored 1) the shelter workers' perspectives on women who experience both domestic violence and mental health problems; 2) the approaches used when working with these women; and 3) the challenges workers face in their work with these women, as well as possible solutions to overcome these challenges. Four workers from two different domestic violence shelters in Ottawa took part a semi-structured interview. Their participation helped gain insight into the realities of victims of domestic violence experiencing mental health problems, as well as the realities of shelter workers.

The feminist approach to intervention has been the main approach used in domestic violence shelters (Prud'homme, 2010). However there appears to be a change in shelter practices in Ottawa, with a trauma-informed approach being favored when working with victims of domestic violence. As stated previously, there is a professionalization occurring in shelters where the workers seek to professionalize their practice by becoming experts in the domain of domestic violence (Côté, 2016). Mental health and substance use problems are becoming issues that need addressing during women's stay at domestic violence shelters. There seems to be a shift towards a more specialized approach where workers are becoming experts in various psychology-based approaches such as: harm reduction, trauma informed, and psychological approaches.

There are benefits in integrating more mental health training or specialisation into shelters as mental health problems are clearly a reality of victims of domestic violence. However, continuing to integrate a feminist perspective and a certain feminist criticism of psychiatry is equally important. Women with severe mental health problems may benefit from medication or psychological therapies, but the way we deliver these services can be done while applying key feminist principles. In anything that we do, it is important to respect the needs and rhythm of the women, to view them as the experts of their own lives, to avoid passing judgment, and to empower women. Additionally, it is important to incorporate political activism aimed at collective change during the interventions. This activism is necessary to improve not only the services available to victims of domestic violence experiencing mental health problems but the laws and policies that affect them directly. With the apparent professionalization happening in

Ottawa shelters, what kind of role would domestic violence shelters like to occupy in helping victims of domestic violence experiencing mental health problems?

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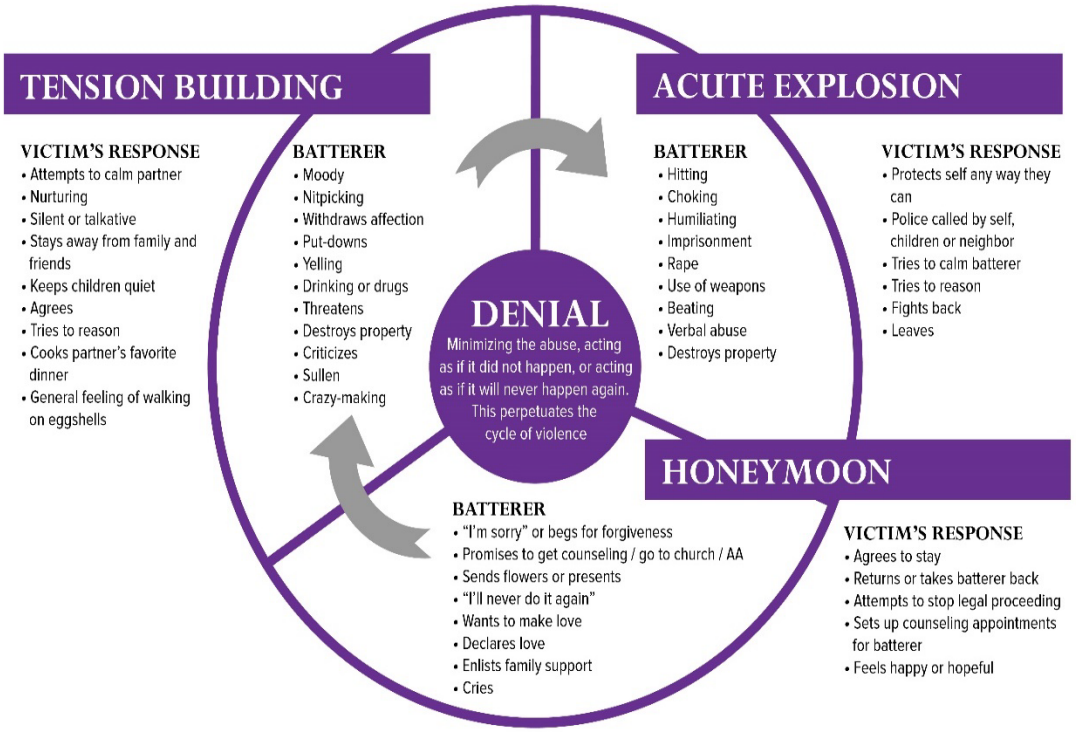
Appendices

Appendix A: Duluth's wheel of power and control

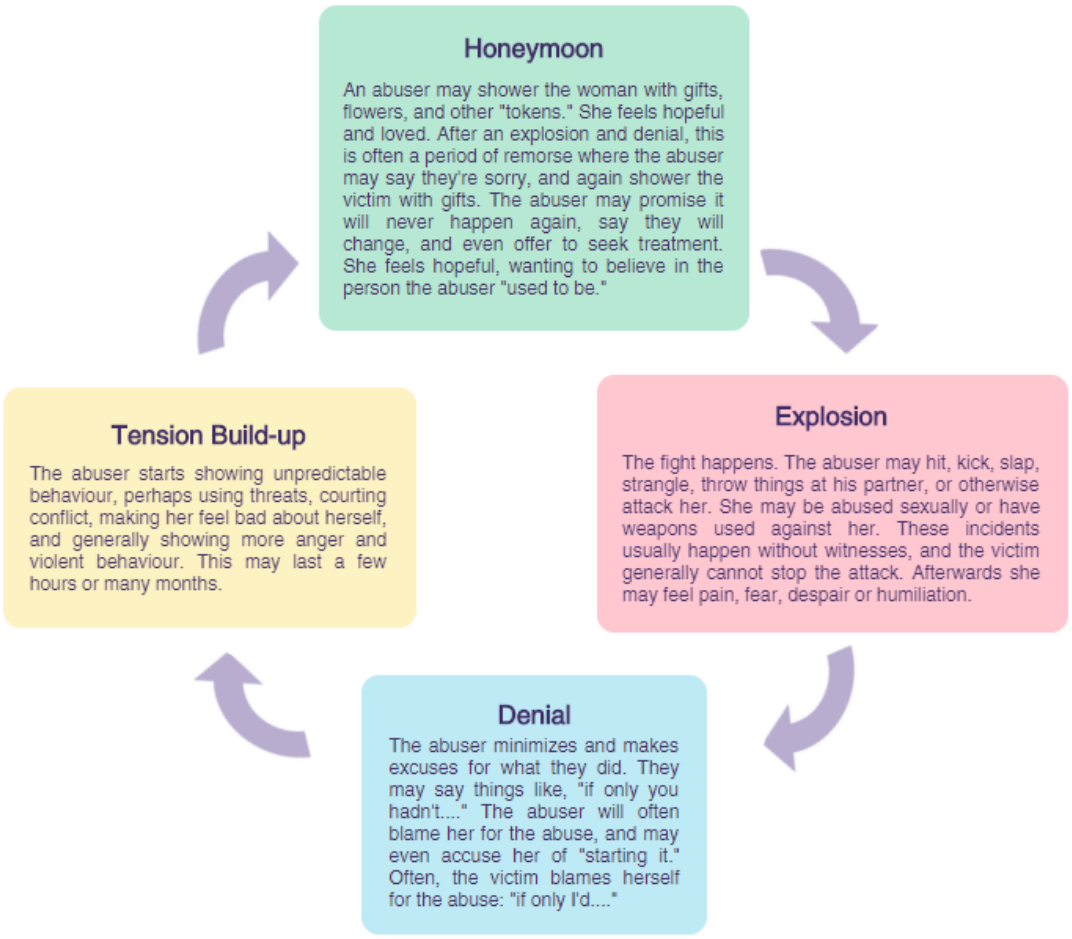
Source: Domestic Abuse Intervention Programs (2017). Wheel Gallery. Retrieved from https://www.theduluthmodel.org/wheel-gallery/

Appendix B: Cycle of violence



Source: DV Bleeding Heart (2016). Understanding the Cycle of Violence. Retrieved from http://dvbleedingheart.com/understanding-the-cycle-of-violence/

Appendix C: Updated cycle of violence



Source: Interval House (2017). Types of Abuse. Retrieved from https://www.intervalhouseottawa.org/types-of-abuse

Appendix D: Consent request for domestic violence shelter's directors

Hello, (name of director)I am requesting your consent to invite all fulltime front-line workers of your organisation that have a minimum of two years experience to participate in a research project entitled *Mental Health in Women Victims of Domestic Violence: The Experience of Workers in Domestic Violence Shelters.* This research project is conducted by, Michelle Migneault, a master student at the School of Social Work at the University of Ottawa, under the supervision of Simon Lapierre, Associate Professor in the School of Social Work.

This research aims to explore the experiences of front-line workers in domestic violence shelters regarding their work with women experiencing mental health problems. More specifically, this research aims to document 1) the workers' perception of mental health issues in women victims of domestic violence; 2) the intervention approaches used with women residing in the shelter that have mental health problems; and 3) the difficulties and barriers they face in relation to their interventions with women experiencing mental health problems.

The goal of this research project is to explore how front-line workers intervene with women victims of domestic violence experiencing mental health problems because there is a lack of research on this subject. This research will help gain new knowledge surrounding intervening with women victims of domestic violence experiencing mental health problems as well as discover approaches to intervention that can help workers in the field.

To share their experiences, the workers will be invited to take part in an individual interview. They must be full-time employees, have a minimum of two years experience working in domestic violence shelters and speak English. The interview will be held at a location of their preference. It will last between one and two hours and will be audio recorded.

If you believe that your organization would like to participate in this research, please reply to this email indicating your interest as well as the email of a designated administrative staff. Following your response, I will send the administrative staff an email script to forward to the eligible workers as well as the recruitment letter that must be attached to that email. If I do not hear from you within a week, I will call you to inquire about your interest in having front-line workers from your organisation participate in this research.

If you have any questions regarding the research project, please contact me by email: mmign061@uottawa.ca or my director Simon Lapierre: simon.lapierre@uottawa.ca.

In addition, this study has been reviewed and cleared by the University of Ottawa Research Ethics Board. If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

I would like to thank you in advance for your time and consideration,

Sincerely,

Michelle Migneault

Appendix E: Email script

Hello,

Michelle Migneault is inviting you to participate in a research project entitled *Mental Health in Women Victims of Domestic Violence: The Experience of Workers in Domestic Violence Shelters.* To be eligible you must be a full-time employee at a domestic violence shelter and have a minimum of two years experience working in a shelter. This research project is conducted independently from the shelter by Michelle Migneault, a master student at the School of Social Work at the University of Ottawa, under the supervisor of Simon Lapierre, Associate Professor in the School of Social Work.

This research aims to explore the experiences of front-line workers in domestic violence shelters regarding their work with women experiencing mental health problems. More specifically, this research aims to document a) the workers' perception of mental health issues in women victims of domestic violence; b) the intervention approaches used with women residing in the shelter that have mental health problems; and c) the difficulties and barriers they face in relation to their interventions with women experiencing mental health problems.

The goal of this research project is to explore how front-line workers intervene with women victims of domestic violence experiencing mental health problems because there is a lack of research on this subject. This research will help gain new knowledge surrounding intervening with women victims of domestic violence experiencing mental health problems as well as discover approaches to intervention that can help workers in the field.

You are invited to participate in an individual interview. The first-come, first-serve rule will be used to select participants. The interview will be held at a time and location of your preference. It will last between one and two hours and will be audio recorded.

Attached to this email you will find the formal recruitment letter containing all the details regarding the nature of participation.

After reading the recruitment letter, if you are interested in participating in this research project, please contact Michelle Migneault by email: mmign061@uottawa.ca.

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Appendix F: Recruitment letter

Mental Health in Women Victims of Domestic Violence: The Experience of Workers in Domestic Violence Shelters

I am inviting you to participate in a research project entitled *Mental Health in Women Victims of Domestic Violence: The Experience of Workers in Domestic Violence Shelters.* To be eligible for participation you must be a full-time employee at a domestic violence shelter, have a minimum of two years experience working in a shelter and speak English. This research is conducted independently from the shelter by me, Michelle Migneault, a master student at the School of Social Work at the University of Ottawa under the supervision of Simon Lapierre, Associate Professor in the School of Social Work.

This research aims to explore the experiences of front-line workers in domestic violence shelters regarding their work with women experiencing mental health problems. More specifically, this research aims to document a) the workers' perception of mental health issues in women victims of domestic violence; b) the intervention approaches used with women residing in the shelter that have mental health problems; and c) the difficulties and barriers they face in relation to their interventions with women experiencing mental health problems.

The goal of this research project is to explore how front-line workers intervene with women victims of domestic violence experiencing mental health problems because there is a lack of research on this subject. This research will help gain new knowledge surrounding intervening with women victims of domestic violence experiencing mental health problems as well as discover approaches to intervention that can help workers in the field.

Nature of participation

To share your experience, you are invited to participate in an individual interview. The first-come, first-serve rule will be used to select participants. The interview will be held at a time and location of your preference. It will last between one and two hours and will be audio recorded.

If you are interested in participating in this research project please contact Michelle Migneault, by email: mmign061@uottawa.ca.

In addition, this study has been reviewed and cleared by the University of Ottawa Research Ethics Board. If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5

Tel.: (613) 562-5387

Email: ethics@uottawa.ca

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120, rue Université / University Pvt.
Ottawa ON K1N 6N5

Appendix G: Interview guide

- Tell me a bit about yourself, how long have you been working in shelters, what kind of experience and education do you have?
- Tell me about your role here at the domestic violence shelter
- In general, what are the needs of the women residing at the shelter?

Theme 1: Mental health problems in women victims of domestic violence

- What are women's state of mental health when they first arrive at the shelter?
- How do you evaluate their state of mental health?
- What policies does your organisation have (at intake or during their stay at the shelter) regarding mental health and substance abuse problems?
- How do you perceive the link between women's experiences of domestic violence and women's mental health?
- And how do you perceive the link between domestic violence and mental health and drug or alcohol consumption
- You told me about the needs of the women in general at the shelter, how do the needs of women that have mental health problems differ?

Theme 2: Intervention approaches and difficulties

- What approach to intervention do you use with women?
- How do you think this approach helps meet the needs of women with mental health problems?
- Is there a difference in how you approach your interventions with a woman with mental health problems compared to the other women residing at the shelter?
    - If so, describe the difference
- How confident/equipped do you feel when you are intervening with a woman experiencing mental health or substance abuse problems?
    - What could help you feel more equipped
    - What has succeeded in helping you feel confident during your interventions
- Give me one or two examples of a difficult intervention you had with a woman that had mental health problems residing at the shelter
    - What do you think could have helped you to make that situation easier to handle?
    - Are there any other difficulties you have during your interventions with women experiencing mental health problems?
    - How do you overcome these difficulties?
- Give me one or two examples of a successful intervention you had with a woman that had mental health problems residing at the shelter
    - Why do you think this intervention was successful?

- Was there anything else you would like to add that was not discussed during the interview?

Appendix H: Coding tree

Theme 1: Front-line workers perception of the reality of victims of domestic violence experiencing mental health problems

1. Needs of the women at the shelter
   - 1.1 Basic Needs
   - 1.2 Emotional Needs
   - 1.3 Education
2. Needs of the women with mental health and/or substance use problems
   - 2.1 Needs are the same
   - 2.2 Needs are different
3. State of mental health upon arrival at a domestic violence shelter
   - 3.1 State of mental health throughout their stay at the shelter
4. Correlation between mental health and/or substance use, and domestic violence
   - 4.1 Mental health is a consequence of the abuse
   - 4.2 Substance abuse is a coping mechanism
   - 4.3 Form of vulnerability leading to the abuse
   - 4.4 Substance use is a form of abuse
5. Mental health diagnoses frequently seen
   - 5.1 Anxiety and depression
   - 5.2 Other
6. Benefits and disadvantages of having a mental health diagnosis
   - 6.1 Benefits
     - 6.1.1 Accessing specific services
     - 6.1.2 Doing better once they leave the shelter
     - 6.1.3 Medication
     - 6.1.4 Normalizing experiences
     - 6.1.5 Better financial benefits
     - 6.1.6 Collective language
   - 6.2 Disadvantages
     - 6.2.1 Stigma
     - 6.2.2 Difficulty obtaining a diagnosis

Theme 2: How front-line workers intervene with victims of domestic violence experiencing mental health and/or substance use problems

7. Evaluating mental health
   - 7.1 Asking during intake
   - 7.2 Not asking women
8. Mental health and substance use policies
   - 8.1 Behaviour
     - 8.1.1 Capability to care for their children
     - 8.1.2 Live independently
     - 8.1.3 Applying for housing
   - 8.2 Shelter stay termination
   - 8.3 Substance use policies
     - 8.3.1 Drug or alcohol use on the property

8.3.2 Change in policies
8.3.3 Ethical issues

9. Approaches to intervention
   9.1 Trauma informed interventions
   9.2 Feminist approach
   9.3 Client-centered
   9.4 Harm reduction
10. Intervention differences working with women experiencing mental health problems or substance use problems
    10.1 More support
    10.2 No change in intervention
11. Difficult interventions with women experiencing mental health problems and/or substance use problems
    11.1 Front-line workers are not experts in mental health/substance use
    11.2 Women are demonstrating threatening or aggressive behaviour
    11.3 Not enough staff on sight
    11.4 Being powerless in certain situations
12. Successful interventions with women experiencing mental health and/or substance use problems
    12.1 Creating a good rapport
    12.2 Listening to the women and respecting their needs
13. What helps workers feel more confident during their interventions
    13.1 Experience
    13.2 Training
    13.3 Having more staff present

Theme 3: Barriers and potential solutions to helping victims of domestic violence with mental health and/or substance use problems

14. External barriers
    14.1 Subsidised housing crisis
    14.2 Violence against women laws
    14.3 Mental health services waitlists
    14.4 Lack of transition resources
    14.5 Police and children's aid societies responses to domestic violence
15. Internal barriers
    15.1 Length of stay at the shelter
    15.2 Limited staff
16. Solutions
    16.1 Mental health support in the shelter
    16.2 More staff
    16.3 Better housing options

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Appendix I: Consent form

Mental Health in Women Victims of Domestic Violence: The Experience of Workers in Domestic Violence Shelters

Main researcher: Michelle Migneault, master student at the School of Social Work at the University of Ottawa
Contact information: mmign061@uottawa.ca,

Supervisor: Simon Lapierre, Associate Professor in the School of Social Work
Contact information: School of Social Work, University of Ottawa, 120 University Private, Room 12030, Ottawa, ON, K1N 6N5
Telephone: 613-562-5800 ext. 6392.
Email:simon.lapierre@uottawa.ca

Michelle Migneault is inviting you to participate in a research project entitled *Mental Health in Women Victims of Domestic Violence: The Experience of Workers in Domestic Violence Shelters.* This research is conducted independently from the shelter by Michelle Migneault, under the supervision of Simon Lapierre, Associate Professor in the School of Social Work.

To be eligible you must be a full-time employee at a domestic violence shelter, have a minimum of two years experience working in a shelter and speak English.

This research project aims to explore the experiences of front-line workers in domestic violence shelters regarding their work with women experiencing mental health problems. More specifically, this research aims to document a) the workers' perception of mental health issues in women victims of domestic violence; b) the intervention approaches used with women residing in the shelter that have mental health problems; and c) the difficulties and barriers they face in relation to their interventions with women experiencing mental health problems.

The goal of this research project is to explore how front-line workers intervene with women victims of domestic violence experiencing mental health problems because there is a lack of research on this subject. This research will help gain new knowledge surrounding intervening with women victims of domestic violence experiencing mental health problems as well as discover approaches to intervention that can help workers in the field.

Nature of participation
To share your experience, you are invited to participate in an individual interview. The interview will be held at a time and location of your preference. It will last between one and two hours and will be audio recorded.

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Risks
Your participation in this study will entail that you share information regarding your experiences working with women victims of domestic violence experiencing mental health problems. Sharing your experiences may cause you to feel an emotional discomfort. The main researcher will take every effort to minimize these risks. In addition to keeping all information confidential, you can contact the following crisis line if you need additional support following the interviews: Distress Centre of Ottawa 613-238-3311 or The Assaulted Women's Helpline 1-866-863-0511

Benefits
It is impossible to ensure that you will derive a personal benefit by participating in this research project. Nonetheless, it will give you the opportunity to express yourself freely on a subject that impacts you over the course of your work. This research project will also provide a better understanding of shelter practices, particularly with women who have experienced mental health problems.

Confidentiality
Steps will be taken to respect confidentiality during the dissemination of the research findings. First, only the main researcher and the project supervisor will have access to the consent form, the recording, and the transcription of the interviews. Consent forms will be kept in the office of the project supervisor at the University of Ottawa, and the recordings will be stored in a protected file in the main researcher's computer, which is protected by a password. Second, you will be asked to not reveal the names of any other workers at the shelter or women staying at the shelter when answering interview questions. Third, information which could identify you or your organisation will be deleted once the recordings are transcribed. Finally, all these documents will be deleted 5 years after the end of the study.

Voluntary Participation
You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be destroyed and will not be used in the analysis.

Acceptance
I, _____, *(name of participant)* agree to participate in the above study conducted by Michelle Migneault of the School of Social Work at the University of Ottawa, under the supervision of Simon Lapierre, Associate Professor in the School of Social Work.

If you have any questions regarding the ethical conduct of this study, you can contact Michelle Migneault at mmign061@uottawa.ca or Simon Lapierre at simon.lapierre@uottawa.ca.

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In addition, this study has been reviewed and cleared by the University of Ottawa Research Ethics Board. If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca
There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date:

Researcher's signature: _____ Date:

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